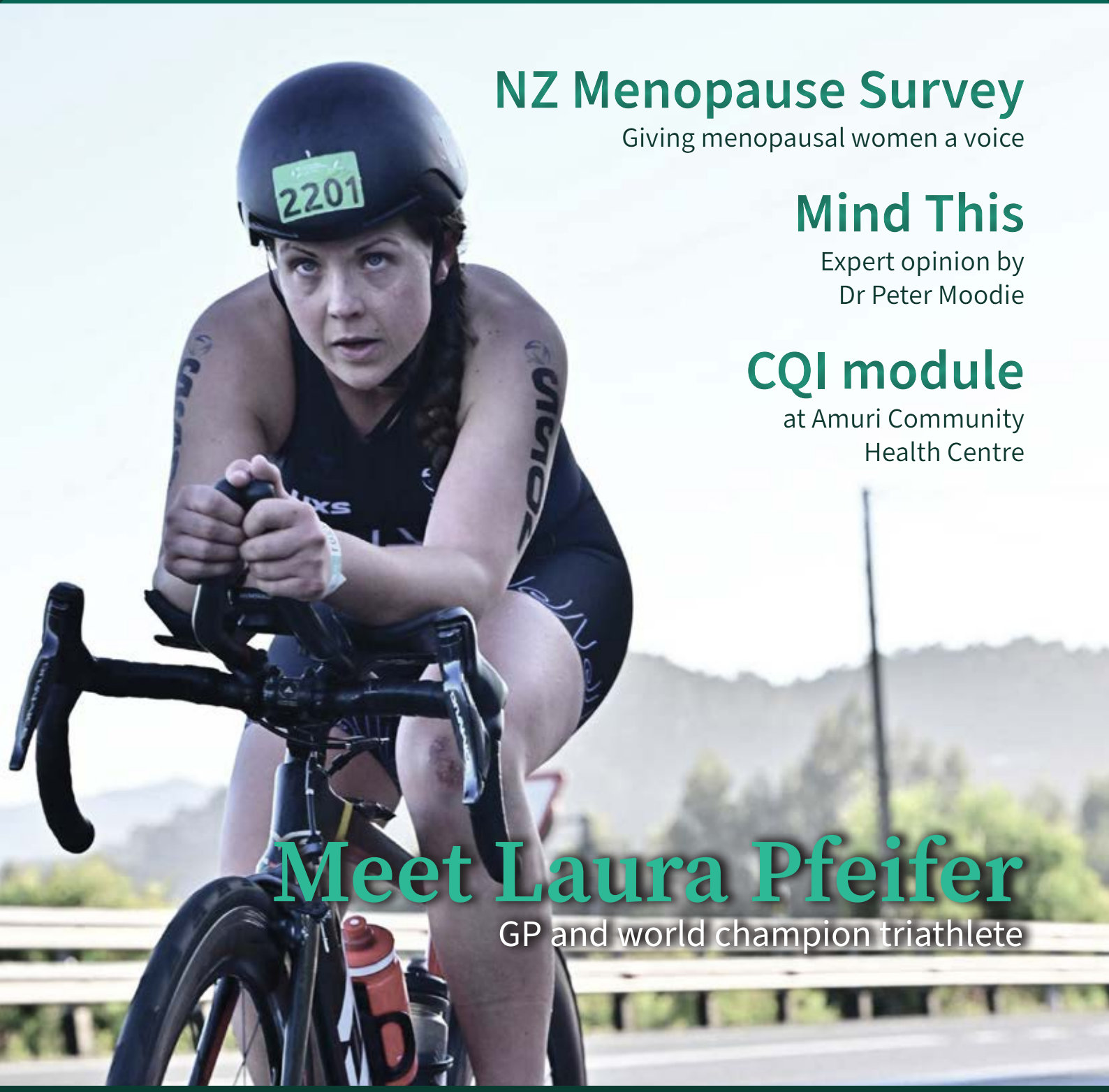
GP Voice

YOUR NEWS, YOUR VIEWS, YOUR VOICES



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The Royal New Zealand
College of General Practitioners
Te Whare Tohu Rata o Aotearoa

November 2023

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Editorial

Dr Samantha Murton

GP, President of the College

Welcome to the last issue of *GP Voice* for 2023. We're almost halfway through our 50th year of being The Royal New Zealand College of General Practitioners and I've really enjoyed hearing how members' experiences on the frontline of community medicine have evolved over the last half a century.

There's also a lot that has stayed the same when it comes to the benefits of continuity of care and the importance of working collaboratively with other practitioners and services to ensure the best care for your patient. This really does reinforce the belief that our workforce is a crucial part of the community and the health sector, so we need to keep pushing for the changes we need to continue providing this gold standard of care.

There's a lot of work going on within the College focusing on this – the *Your Work Counts* project being one of them. The data collected will help us to develop evidence-based guidelines around safe and sustainable patient loads, what a fair and reasonable 40-hour week looks like, and ratios for how many GPs per 100,000 patients each region and the country needs.

We've written to the new health minister Dr Shane Reti and have asked to meet with him to chat through what we think are quick changes and quick wins that can be implemented, as well as the long-term goals that need to be discussed and planned for.

As a specialist GP himself, none of what we'll be discussing will be a surprise to him. It's likely he'll have experienced many of the same concerns and frustrations that we have.

Also in this issue we highlight the funding that the College gives to those carrying out research that benefits general practice or rural hospital medicine. We highlight a recently approved piece of research, and I hope this inspires you to submit an application in 2024.

With the end of the year fast approaching, I hope you are also thinking about how and when you are able to take some well-deserved time off to relax and spend with your loved ones. I know for our friends working rurally, this isn't always possible as many of these beautiful places are inundated with holidaymakers. But it is important to take some time for ourselves and have a breather.

Thank you for all the amazing work you're doing out in the community. It does make a true difference, and for me this is one of the best parts of the job – seeing my patients happy and healthy.

Kia kaha,

Dr Samantha Murton
President | Te Tumu Whakarae

50 years of the College

Celebrating our golden anniversary 1973–2023

While the College celebrates its 50th year, we are collecting memories and accounts of the College's growth and change. In the **October issue** of *GP Voice* we published reflections of two GPs who had practised in Tonga and New Zealand. These professional journeys are treasured examples of how much general practice has evolved during that time and how much is yet to be addressed and improved.

As the temperature rises and Christmas begins to brighten general practices with garlands and baubles, we are encouraging you to use the upcoming holiday season to reflect on your professional journeys through the medium of creative writing. All members are cordially invited to participate in the **Summer Memoir contest**, and write essays, short stories, poems or songs (maximum 2000 words) in English, te reo Māori, or any other language in which you feel most comfortable (please include a translation).

We want to hear about your experiences, both your struggles and achievements, that link with the College and its 50 years of transformation. Please send your submissions to the editorial team at **communications@rnzcgp.org.nz** by 20 January 2024. The best submissions will receive a copy of Dr Glennis Mafi's **memoir** and will be published in *GP Voice*.

Summer Memoir contest submissions

Submit a reflection on your professional journey in an **essay**, **short story**, **poem**, or **song** (max. 2000 words) to the **Editorial team** team by **20 January 2024**.

Vaping and Smoking Position Statement

Simone White

Senior Communications Advisor at the College

In the short time since this position statement was published, the Government has announced its intention to remove requirements for denicotisation, remove the reduction in retail outlets that can sell tobacco and vapes, and remove the generation ban. The College released a media statement calling for these decisions to be reversed as it will be detrimental to the health of New Zealanders and undo years of good work to encourage smoking cessation.

Earlier this month, the College published its Smoking and Vaping Position Statement. The statement highlights that while the College believes vapes have a role to play in helping people to stop smoking, they have become too widely available and regulatory change is required.

The College has developed positions and grouped them into three sections:

To protect our rangatahi

- Vapes should only be available from Specialist Vape Retailers or Approved Tobacco Retailers. Dairies, supermarkets, service stations and other retailers should not be able to sell vapes.
- The number of Specialist Vape Retailers should be kept to a minimum and not be allowed to operate within close proximity to schools or marae.
- Ring-fenced funding should be allocated to effectively monitor and enforce adherence to vaping regulations.
- Online sales of vapes and tobacco should require a higher standard of age verification than a 'tick here if you are over 18'.

To support people who smoke or who used to smoke

- Vapes should be as available as tobacco, so that people looking to become or remain smokefree do not face additional barriers.
- Smoking cessation guidance for general practice should be refreshed to align with the wider sector's focus on Māori, Pacific peoples, pregnant people, and users of mental health services.

To protect all people from the potential harm from vaping

- The Smokefree Generation policy, which bans the sale of tobacco to people born from 1 January 2009, should be expanded so that vape sales are banned to the same group.

> "We will continue to advocate for strong anti-smoking measures and a better regulatory response to vaping.

- As nicotine levels in tobacco are reduced, comparable reductions should be made to maximum nicotine levels in vapes.
- Vape packaging and display materials should be required to focus on smoking cessation and not designed to attract non-smokers into vaping.
- Existing tobacco cessation services should be funded to provide vaping cessation support to any vapers looking to quit, regardless of their previous smoking status.
- New guidance for general practice should be developed to support patients seeking to quit vaping.
- Funding and resources should be allocated to maintain a monitoring function that can collect and analyse any new evidence of harm arising from vaping.

The College will continue to work with other parts of the sector to update smoking cessation guidance for general practice and develop new guidance for vaping cessation. We will continue to advocate for strong anti-smoking measures and a better regulatory response to vaping.

Read the **position statement** which provides an overview of smoking and vaping in New Zealand, Te Tiriti o Waitangi, key issues and what we don't yet know about harm from vaping.

Journal
OF PRIMARY HEALTH CARE

The JPHC is a peer-reviewed quarterly journal that is supported by the College. JPHC publishes original research that is relevant to New Zealand, Australia, and Pacific nations, with a strong focus on Māori and Pasifika health issues.

Members receive each issue direct to their inbox. For between issue reading, visit the 'online early' section **here**.

Trending articles:

1. **Asian migrants navigating New Zealand primary care: a qualitative study**
2. **Do patients with mental health and substance use conditions experience discrimination and diagnostic overshadowing in primary care in Aotearoa New Zealand? Results from a national online survey**
3. **Barriers and facilitators to prescribing medicinal cannabis in New Zealand**
4. **Development and validation of PolyScan, an information technology triage tool for older adults with polypharmacy: a healthcare informatics study**

Action for Health and Climate Update

The College's Policy, Advocacy, and Insights team is your voice on many issues across the sector

Simon Wright

Principal Policy Advisor at the College

The College is acting on behalf of members to address climate change in ways that improve health and health equity. According to the World Health Organization, climate change is **the most significant** global health issue. Lack of effective action to reduce global greenhouse gas emissions makes it extremely urgent to act now. The *Lancet* Countdown says it is a '**code red for a healthy future**'.

In response to this call, the College has launched an initiative to simultaneously improve asthma care and significantly reduce climate emissions. This means continuing policy advocacy by **making submissions** to the Parliamentary Inquiry into Climate Adaptation and the Select Committee overseeing the Emergency Management Bill. In the new year, we will publish an updated version of the College's 2016 **climate change position statement**.

> "In the new year, we will publish an updated version of the College's 2016 climate change position statement.

Asthma and climate initiative

The College is promoting the rapid uptake of the 2020 **New Zealand Adolescent and Adult Asthma Guidelines** in general practice. The guidelines recommend that, for most patients, asthma should be treated and managed using dry powder inhalers (DPIs) rather than metered dose inhalers (MDIs). In addition to improving asthma care, the climate emissions associated with DPIs are a miniscule fraction of those from MDIs. This is because the propellants used in common MDIs are up to 2,500 times more potent greenhouse gases than carbon dioxide.

We are pleased to report that asthma-related climate emissions are trending down. Comparing January to August dispensing data for 2022 and 2023, it is estimated that overall emissions have reduced by 242 tonnes (3%) for reliever therapies, and by 2,840 tonnes (8%) for preventer therapies on a CO_2-equivalent basis. These figures show good uptake of the new guidelines. The challenge is to speed things up!

To help you get involved, the College is working with He Ako Hiringa and Te Whatu Ora on further development of the **EPiC dashboard for asthma prescribing** to include both clinical and climate emissions data. This will be available next year.

Climate advocacy

With input from members and other primary care professionals with emergency management experience from the Christchurch earthquakes and the 2023 Te Tairāwhiti floods, our recent submissions have tried to reframe the climate response from a discourse of cost and loss to one of opportunity. By developing emissions reduction, climate adaptation, and emergency management measures that also address the social determinants of ill health, the costs of these interventions can largely (or even completely) be **off-set by health care savings** and productivity gains associated with more healthy populations.

In addition, we have emphasised to policy makers that **90% of health issues** are dealt with by general practice and primary care providers (not hospitals) and that general practice must be represented in policy development and emergency management coordinating structures.

The College is pleased to help general practice do its bit in helping address climate change. Watch this space for further updates and opportunities to get involved in this work.

Your Work Counts

Tom Broadhead

Principal Policy Advisor at the College and project lead

As this issue goes to print, we'll almost be at the end of our first two-week diary study for the Your Work Counts project. We were delighted to have over 650 members sign up to take part in this important study.

We know that GPs and rural hospital doctors significantly improve the lives of those in their communities. However, over the years there has been an increase in patient needs and the complexities of their conditions. This, alongside the well-documented workforce shortages has meant that you're taking on more work without additional resources, support or remuneration.

The data that is collected in the diary studies will be used to show the gap between what GPs actually do and what you are funded to do, and it will help the College to develop evidence-based guidelines around:

- safe and sustainable patient loads
- what a fair and reasonable 40-hour week looks like
- ratios for how many GPs per 100,000 patient each region and the country needs.

If you weren't able to participate in this diary study, we hope to do more over the next 6–12 months, so keep an eye out in *ePulse* and on the **Your Work Counts page** on the College website for more information. All College members, including registrars, can participate.

Your work counts, so make sure it's counted.

> "All College members, including registrars, can participate.

Research funding

that benefits general practice

Simone White

Senior Communications Advisor at the College

Did you know that the College funds research and education that benefits general practice, rural general practice, and rural hospital medicine? There are three funding rounds a year, and applications are reviewed by the Research and Education Committee (REC).

You do not have to be a member of the College or a doctor to apply for funding, but the research topic does need to be relevant to the workforce, so members and people working within a general practice are encouraged to apply.

Auckland-based GP and College Board member Dr Karl Cole is part of a team who has recently been awarded funding through REC for a research project that will be looking into whether New Zealand's health care system provides equitable access to ADHD medications.

Working alongside an epidemiologist from the University of Auckland and a researcher with a focus on mental health in children and young people, this study will be collating and analysing nationwide trends in ADHD medication dispensing by sex, ethnicity and deprivation.

"The objective is to see if there has been an increase in inequity of ADHD medication dispensing since the COVID-19 pandemic around the country and highlight how increased demand for psychiatric and psychologist care in New Zealand is making it harder for GPs to get their patients seen.

"We hope this research will provide valuable data of the increasing inequity which has been observed and start an informed debate about the GP's role in the diagnosing and treatment of ADHD in children and young people," says Dr Cole.

How to apply

All the information you need, along with the application form can be found on the College website, along with the funding round dates for 2024.

Some examples of previously funded research include diabetes management in primary care, rural placement of health professionals, a clinician survey of STI management methods and the impact of HDC complaints and investigations.

Funding rounds and deadlines are advertised on the **College website**, in *New Zealand Doctor*, and in *ePulse*. Information on the funding rounds is also shared with external organisations who share the information with their networks.

The first funding round for 2024 will open on **30 January**.

"You do not have to be a member of the College or a doctor to apply for funding.

Funding

Grants are typically between $5,000 and $20,000, although up to $40,000 can be awarded. Individual and group applications can be submitted. Read more in the **application guidelines**.

Your application should reflect one (or more) of the following domains:

1. Advancing Māori health
2. Achieving health equity
3. Enhancing the practice of primary care through scientific discovery
4. Meeting the needs of rural general practice and/or rural hospital medicine.

Successful applicants are encouraged to submit their final papers to the *Journal of Primary Health Care* and to submit an abstract to present at the annual College conference, which in 2024 is being held in Wellington from 26 to 28 July.

To get in contact, email **rec@rnzcgp.org.nz**

Tips from research

that benefit general practice

1

Researchers writing in the *Journal of Neurology, Neurosurgery and Psychiatry* have shown that Tai Chi has positive effects on Parkinson's Disease. The improvement is both in motor and non-motor symptoms and shows a decrease in complications of the disease. The research looked at longer term use of the technique and demonstrated sustained improvement over the 4.3 years that participants were followed up. Recommending Tai Chi to our Parkinson's patients is a useful, non-pharmacological intervention we should consider. READ MORE

2

The Asthma and Respiratory Foundation has published the first local guidelines to help support young people quit vaping. This coincides with the release of our position statement on smoking and vaping. The guidelines focus on five steps around: (1) asking, (2) assessing dependence, (3) assessing readiness to quit, (4) making a plan, and (5) linking rangatahi to support services. The document includes some useful screening tools. READ MORE

Spotlight on the National Advisory Council

Dr Stephan Lombard

Chair of the NAC, an ex-officio member of the College's Board

I have been asked to explain what the College's National Advisory Council (NAC) is many times. Is it some sort of secret society that has a mysterious handshake and clandestine meetings up in the attic of the College building? Sadly, it's anything but.

The purpose of the NAC is broadly to:

- liaise between the Board and the membership;
- provide advice, guidance, and general direction to the Board on matters like policy and regional views;
- work on position statements that the College is asked to comment on, e.g. the Smoking and Vaping, Nurse Practitioners and Telehealth position statements.

The NAC is made up of member representation from each Faculty, Chapter and Te Akoranga a Māui. Currently we have 13 Faculties established by the Board, based on their geographic locations. Each Faculty nominates a member to be a part of the NAC – usually it's the Faculty chair.

We meet about three times a year in person in Wellington for a whole day. Each member is usually appointed for a three-year term so we can have continuity on the Council.

It is the responsibility of the NAC to be the "go between" for the Board and members. Sometimes the Board wants to know what the members feel about a certain topic. The topic will be put on the agenda and your NAC representative will bring it up in peer groups discussions with the purpose of gathering more information.

The NAC is not there to sort out operational matters at the College. During the meetings, we discuss the current "hot topics" in each Faculty, like the flooding in Hawke's Bay and Nelson. We share ideas on how the Faculties can support each other. We always meet with either the College's President Dr Samantha Murton or the Medical Director Dr Luke Bradford, so that each Faculty has an ear to the ground and are aware of what is happening at the "top level".

The NAC Chair is also an ex officio Board member. Two members of the NAC also serve on the Research and Education Committee. The NAC is a place where we speak up about inequity and inequality, where we can look at the different challenges each region is facing.

Dr Stephan Lombard was appointed to the NAC Chair role in 2022. He is a GP with over 30 years of experience and an owner of Cook Street Health Centre in Palmerston North.

Mentoring skills workshop

Waikato/Bay of Plenty Faculty initiative for GP educators

Last month, the Waikato/Bay of Plenty Faculty hosted a *Mentoring skills for GPs* workshop in Hamilton and in Tauranga, for people involved in GP education and/or mentorship. This one-day workshop covered core skills associated with effective mentoring, and provided a theoretical base and education tools, explained and facilitated by Dr Nigel Thompson.

The Faculty offered the workshops to GP teachers working alongside GPEP 1–3, medical student education, mentoring colleagues in the workplace, mentoring nurses in nurse prescribing or nurse practitioners, and others interested in becoming mentors on the Faculty **Ka Hono mentoring scheme** . As an extra enticement, participants were allowed to claim six hours of CME credits for Continuing Professional Development (CPD) purposes.

Over 45 GPs attended the workshops, varying in age and experience from GPEP 1–3 to Fellowship Assessors and Censors. As you can see through the feedback on the next page, it was a successful event that sparked interest in mentorship through the Ka Hono scheme.

What have you appreciated about today?

- *The opportunity to share learnings and consolidate prior learnings – dedicated time is rarely given to these topics.*
- *Inspiring room of people who are passionate about being great GP teachers.*
- *Realising I need to meet the learner where they are rather than teach them what I think is important.*
- *A richer understanding that mentoring is a skill to be continuously practised and developed beyond acquiring knowledge*.

What's a takeaway piece of learning for you from today?

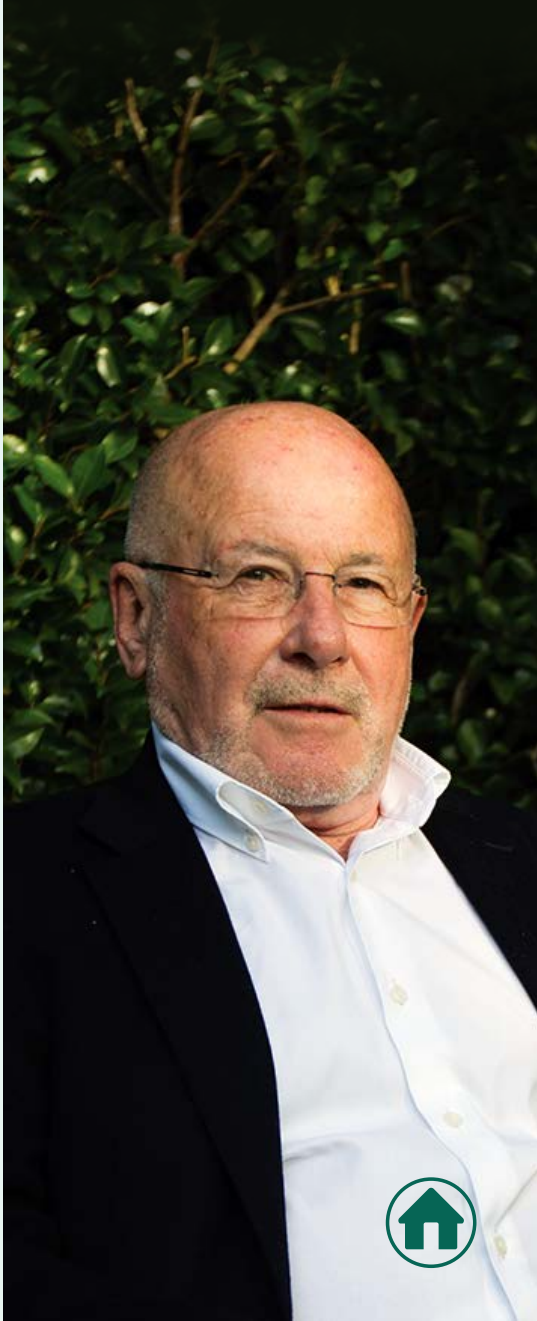
- *Many things; meeting the learner where they are, insights into my own style and concrete ideas for self-reflection/improvement in providing collegial support.*
- *How to ask open questions to facilitate feedback. Karpmann dramatic triangle.*
- *Reminding me to take the time to be a fully present listener (not always easy if there is time pressure).*
- *That there are like-minded GPs out there, and the value I put on this aspect of the career is justified and needs to be enabled for both myself and the profession.*

MIND THIS

Review of HDC cases

Dr Peter Moodie

Dr Peter Moodie is the College's Clinical Advisor



Over the last two and a half years the College has been invited to review Health and Disability Commissioner decisions that relate to general practice, along with selected Coroners' reports. We have covered 20 HDC decisions and 10 Coroners' reports.

Role of the HDC and the coroner

The purpose of a coronial investigation is to identify a cause of death and the coroner may also make recommendations as to how such a death may be avoided in the future. It is not their role to apportion blame to an individual.

On the other hand, HDC decisions can and will identify negligence as well as making recommendations for future management. The HDC will generally require at least an apology from the health professional involved and possibly some remedial action. If the case warrants it, the HDC may refer a doctor to the New Zealand Medical Council for a further competency review.

The HDC Act

The Health and Disability Commissioner Act was created nearly 30 years ago with the stated purpose *to promote and protect the rights of health consumers and disability service consumers, and to that end, to facilitate the fair, simple, speedy and efficient resolution of complaints relating to infringements of those rights*. As HDC decisions can take up to 3 years to be finalised they can hardly be called "speedy and efficient resolution".

Unlike most other countries there is no financial reparation for medical negligence; however, the time delay in coming to a decision can be a heavy burden on the health professional involved. At least one doctor has decided to take early retirement, and another who has restricted his patient numbers and will no longer work and after hours.

General themes

- Communication breakdowns in general.
- Several doctors seeing the same patient over a period of time.
- Misreading reports or not reading other people's case notes.
- An increasing focus on medical practices and the systems they have in place.

Specific themes

Communication issues

Communication is at the heart of many complaints, particularly where there are part-time associates and locums. When confronted with a patient who has been seen by another doctor it is critical to read the previous notes and laboratory results carefully while also keeping an open mind about other possible diagnoses.

It is common for there to be a breakdown between other members of the practice team, including reception staff and nurses. One case involved three different triage nurses on different days identifying that a two-year-old had sugar in her urine but on two occasions the doctors did not read the notes. Not reading the triage notes was the fundamental problem; however, while the nurses recorded the test, they didn't really make the connection that the child had type 1 diabetes. If they had, they would almost certainly have spoken to the doctor directly.

Communication breakdowns can also occur when a patient is in shared care with outside agencies. If a patient is discharged home, but under the supervision of a district nurse, who should be ultimately responsible for their care? In one case the patient was discharged home under district nursing care and the district nurses wanted to involve the GP but the patient objected on the basis of cost. This delayed a doctor's visit and communication with the doctor was via a receptionist. When she was finally admitted to hospital, she died of septicaemia a few hours later. She then became a coroner's case as the hospital clinicians would not sign a death certificate.

How we should be communicating with secondary care was highlighted in a coroner's report covering 5 murders carried out by 5 mental health patients in the Wellington area over an 18 month period. In each case the GPs involved had great difficulty getting help for their patient, possibly because of bed shortages, but also because of non-medical mental health staff acting independently. The lead consultant psychiatrist explained that she was aghast that the GPs did not insist on talking directly to the duty consultant psychiatrist! When difficulties arise, a peer-to-peer discussion with an on duty consultant may be the best way forward.

Case notes

Case notes will invariably be analysed in an almost forensic manner and will usually be found to be wanting. The MCNZ has a document outlining what a case note should contain but interestingly it does not specify, "safety netting", which the HDC regards as important.

In the absence of having junior medical staff vetting and then writing up detailed case notes, likely with a registrar then checking them, most general practitioners would struggle to find the time to write a medico-legally perfect record. The HDC does not hold great store by what you "said or did but didn't write down" and there is no scope to have a face-to-face discussion with the HDC.

> "It is not their role to apportion blame to an individual.

There needs to be more work done on what is an acceptable standard of case note writing and indeed what the purpose of those notes are. For example, does a simple URTI require documented safety netting and proof that antibiotic allergy was discussed? Should a certain level of competence be taken as a given, rather than trying to document every issue.

Letters from 2ary care

Various departments in 2ary care will at times decline a referral or a request for a procedure. A MCNZ document puts the onus on the GP to explain this to the patient. This needs to change with the requirement that the department must take responsibility for communicating with the patient.

It is easy to misread decline letters which often contain formulaic text which can easily be overlooked with the assumption that the test was declined on the grounds that it was unnecessary.

There is also a tendency with discharge letters to instruct the GP to make a further sub-specialty referral when this could have been done by the hospital itself.

These are system issues that need to be discussed at a national level and the risks explained. These system risks would not be tolerated in the aviation industry if they thought that the design of the letter was open to misinterpretation.

Sub-specialty expert opinion

The HDC relies on their in-house general practitioner for a lot of expert opinion, which is a good thing. He sometimes discusses cases with his peer group to achieve a consensus view; however, there is no formal general practice consensus process, and this may need to be discussed further.

Sub-specialty opinions tend to be quite critical of misdiagnoses, but this is with the benefit of hindsight. Further, these opinions are often given without considering that pre-test probability can be vanishingly small in primary care and the subspecialist often has greater access to various diagnostic procedures.

Guidelines and Health pathways

- The HDC relies heavily on guideline documents, including Health Pathways and if they are not followed, they are then treated as protocols.
- Clinicians must be aware that there is a guideline, and that the pathway is up to date, and evidence based.
- Some guidelines are heavily influenced by secondary care input but curiously do not necessarily apply to secondary care management.
- Curiously members of the public cannot access Health Pathways.

We may need to look more critically at guidelines, particularly if they do not apply to the entire medical profession.

“
This needs to change with the requirement that the department must take responsibility for communicating with the patient.

Generalisations from individual cases

The legal profession has a saying that “difficult cases make bad law” and this may well be the situation with clinical cases. As an example, a coroner recently opined that as a patient had deliberately taken a fatal overdose of his own morphine, all such drugs should be kept in a locked box!

Finally, we are lucky to have a system like the HDC but that doesn’t mean that it is perfect, and it should be open to regular review.

“We are lucky to have a system like the HDC but that doesn’t mean that it is perfect, and it should be open to regular review.

Meet Laura Pfeifer

Interview with a GP and a world champion triathlete

Tell us a bit about yourself?

I was raised on a capsicum farm in Kaiapoi in northern Canterbury. My older sister and I had the privilege of a childhood spent climbing trees, building tree huts, riding bikes, and making our own fun outdoors while our parents worked. My dad's idea of afterwork "fun" was swimming in a river, hiking the hills or riding mountain bikes, so I am sure this contributed to my love of the outdoors.

I trained at Otago University spending pre-clinical years in Dunedin, and clinical years in Christchurch. I worked at Canterbury DHB for 3 years post graduation. I applied for GP training and spent 2 years in Nelson before meeting my partner Jarrod and moving to Methven – a small rural community at the base of Mt Hutt ski field, just over an hour South and inland of Christchurch. My partner works as an outdoor pursuits/PE instructor at Mt Hutt College and he introduced me to cycling, as well as anything outside my comfort zone: snow sports, tramping, kayaking, rock climbing, and so on!

In 2022 I completed Lifestyle Physician Certification with the American College of Lifestyle Medicine. I work at Methven Medical Centre with a fantastic team, and like any general practice we are busy.

What drew you into rural general practice?

I love rural community attitudes and values. Everyone in the community knows one another, and sometimes pass along invaluable information about our patients. It's not unusual for us to hear from a concerned neighbour, hairdresser, cleaner or car mechanic about one of our patients. I also enjoy more urgent care work - we are the only medical centre for a large geographical area. During my first month in Methven, we had several families up the Rakaia Gorge without road access due to flooding, having to rely on helicoptered medications and other basics for weeks.

I love rural practice because working in the community allows me to see people more as their whole selves. I have a greater understanding for what management plans might work for an individual patient and can assist with the socioeconomic barriers that stop people from accessing healthcare.

What attracted you to lifestyle medicine?

I see lifestyle medicine as the basic foundation of all medicine. Our current healthcare system is an illness-care-system with little or no focus on improving health or preventing disease. While working in a hospital, I saw the tsunami of chronic health problems filling acute health departments. Most of these people's illnesses could have been entirely avoided, if they had addressed lifestyle factors a decade earlier.

> "Our current healthcare system is an illness-care-system with little or no focus on improving health or preventing disease.

Having always participated in fitness and sport, I have a particular interest in physiology and human performance, and a lot of this knowledge crosses over to lifestyle medicine. What a top athlete focuses on is what we are encouraging our patients to do: eat a variety of whole foods and mostly plants, sleep a minimum of seven hours a night, practice strength/conditioning/stretching, build a resilient mind, and move your body every day.

What is your personal philosophy and approach to practice?

Practice what you preach. In a small community it is important to me that my patients see me following my own advice: running or cycling about town, walking to work, buying fresh vegetables at the supermarket, etc. And never underestimate listening - 70% of what walks through the GP clinic entrance has a mental health component, and until that is acknowledged our treatment plans are pointless.

How did you become a world champion triathlete?

I have always participated in sport. At high school I played basketball, football, water-polo and did rowing. During university I learned to love trail running and fitness classes at the gym. I have competed in many 50 km trail marathons, won the 74 km Taupō Ultra in 2019, and placed second at the Taupo 100 km in 2020.

When I moved to Methven in 2021, I started road cycling. I had swum in primary-intermediate school years and thought it would be a good challenge to do an ironman event. I did a 70.3 miles (113 km) ironman at the end of 2021 as my first ever triathlon, and then I was hooked. I found the science behind the training fascinating - working with VO_2 and lactate thresholds for signs of improving fitness, and using HR (heart rate) and HRV (heart rate variability) as markers for recovery.

I am still relatively new to the sport, having started in 2021. I competed in the World Age Group Triathlon Championship in Pontevedra Spain in September 2023. I was selected after placing second at the New Zealand national champs in Mt Maunganui in November 2022.

I travelled to Spain alone for one week prior to the race. I competed against 50 other women in my age-group from around, and placed first in my age, and third female overall. The distance was 1500 m swim, 40 km bike, and 10 km run. I was coached by James Roderick from March with a 6-month training plan averaging 15 hours a week of swim, bike, run, and transition practice.

How do you balance work and life?

I work full-time (8 sessions per week) with one 24-hour on-call day each week, and about one in four-five weekends at work. It can be difficult, but I have a good network of people who support me. When I need to prioritise training, I build the rest of the day around it to make sure I am not missing training sessions. That meant training before, after or even during my workday.

> “Practice what you preach.

My colleagues have been supportive in allowing me flexibility with my appointment books. For example, in winter when its dark I swim indoors in the morning (in Ashburton which is a 30 minute drive each way!), start work early and condense my day to finish early enough to have some daylight at the end of the day for a run or bike. I also don't have kids yet, which helps me be selfish with my time!

What challenges or opportunities do you see emerging that you think will shape the future of our healthcare system?

I think we all acknowledge the problems with the system but need to put our energy into being solutions-focused. If we do not change the health behaviours of children, teenagers, and young adults, then we are always going to have chronic disease occupying the space of what is meant to be an acute/emergency tertiary care system. Sometimes I wonder what the outcomes might be, if the system was flipped upside down – an adequate and fully funded community care with a fee applied to hospital admissions.

What would you like to see change within our medical system to support better patient outcomes?

I could go on for hours about this. I suppose it comes down to strong public health policies that create healthy communities and reduce lifestyle factors that contribute to poor health outcomes. For example, food production being regulated to avoid added sugars and preservatives, the GST being removed from fruit and vegetables, a smoke/vape free NZ, limited alcohol sales, and avoidance of sedentary life.

Do you have a story you'd like to share?

Make your voice heard

Submit your article to the Editorial team:

communications@rnzcgp.org.nz

NZ Menopause Survey

Giving menopausal women a voice

Dr Linda Dear

GP and the director of Menodoctor

You've probably noticed that menopause has become a hot topic these days. There's been news reports, magazine articles and podcasts; menopause is finally going mainstream, which is welcome news for the many women who have long felt unheard and invisible during this phase in their life.

Last year, after hearing so many individual stories about menopause, I decided to give women the chance to put all their stories together. This was the motivation behind the NZ Menopause Survey, completed by 4,288 Kiwi women, making it the largest ever survey on menopause in New Zealand so far. So, what do the findings tell us about the menopause experience for women here in Aotearoa?

Symptoms

For most Kiwi women, menopause is not asymptomatic, as only 1% reported no symptoms at all. For those having symptoms, 58% described them as 'severe or very severe'. The symptoms reported were vast and varied. Apart from the more familiar ones like hot flushes or night sweats, women also reported sleep problems, body pains and low libido, as well as mood changes, including anxiety, low mood, and loss of confidence (see the graphs on the next page).

Despite the severity and breadth of symptoms, most women didn't realise what was causing them. Menopause (and perimenopause) are sneaky – with symptoms that come and go over time, as well as mimicking and overlapping with many other conditions. Menopause is a master of disguise – for doctors as well as for women. 35% reported that menopause had not been mentioned when they first sought help from their GP. This lack of awareness for both women and doctors alike, is the main reason why this life phase is so often missed, dismissed, or misdiagnosed.

Treatments

Hormone replacement therapy 'HRT' (or menopausal hormone therapy 'MHT'- as we are now supposed to call it but nobody does) emerged as the most effective treatment for menopausal symptoms. 80% of women voted HRT as the most helpful treatment. Second place was awarded to exercise, which 42% found most effective. In joint third place, came anti-depressants and diet changes, each having 33% of women voting them as most helpful.

Despite this clear victory of HRT, only 31% of surveyed women had used it. The number is staggering when compared with other treatments: 51% of participants had tried exercise, and 69% of participants had used supplements and/or herbal remedies.

Dr Linda Dear is the director of Menodoctor, a private menopause clinic offering in-person consultations in Tauranga and virtual consultations for women all over New Zealand.

The most common treatments being used by Kiwi women and whether they were voted most or least helpful:

	Number using the treatment	Helpful	Unhelpful
Exercise	2,167	42%	9%
Supplements	1,886	24%	26%
Diet changes	1,863	33%	19%
HRT	1,344	80%	8%
Herbal Treatments	1,069	28%	40%
Antidepressants	894	33%	22%

Impact

The last few sections in the survey focused on how menopause symptoms affect women's lives – at home and at work. The findings below demonstrate how this life-phase can knock some women way off course, as relationships are ended, careers are lost and sometimes lives are taken.

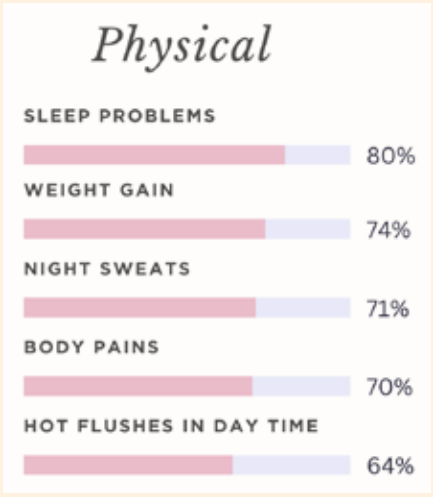
- **Work Impact:** 84% of working women said their symptoms had negatively affected them at work. 1 in 6 had seriously considered quitting, and 1 in 12 actually did.
- **Relationships Impact:** 88% of participants said menopause had negatively affected their relationship with their partner.
- **Mental Health Impact:** 69% of participants had symptoms of low mood, 64% had symptoms of anxiety, and 18% said menopause had made them consider ending their life.

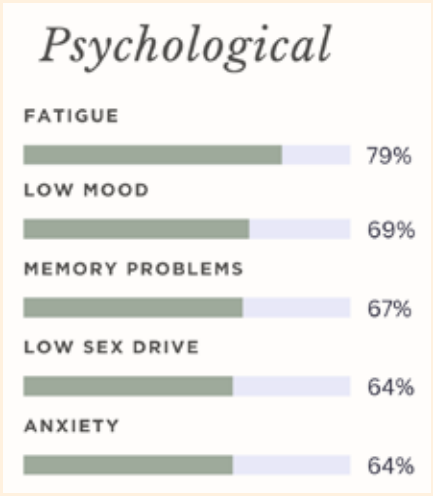
What does all this mean for GPs?

Patient surveys are full of biases. It's not possible to independently verify each response and confirm the symptoms and life impacts were all directly and solely due to menopause. Menopause is not just a Kiwi problem, and the findings echo those already reported in similar surveys from all over the globe – which gives the results more weight.

For a busy GP with a mere 15 minutes, too long a patient list, and way too full an inbox, the complexities of menopause care can feel overwhelming. But somehow amid the GP workload, it's important to know that menopause is never 'just menopause' for the vast majority of women. Let's get better at recognising its symptoms, acknowledging its impact and providing the best treatments. This is how we make menopause matter.

The top five most common physical and psychological symptoms reported by Kiwi women:





Not just a GP

More than just a memoir

Dr Tony Townsend MNZM

GP, Distinguished Fellow of the College

How many times have you been asked by somebody you have just met, "What do you do?" and you reply, "I'm a doctor." Which is immediately followed by, "So what is your specialty, or are you just a GP?"

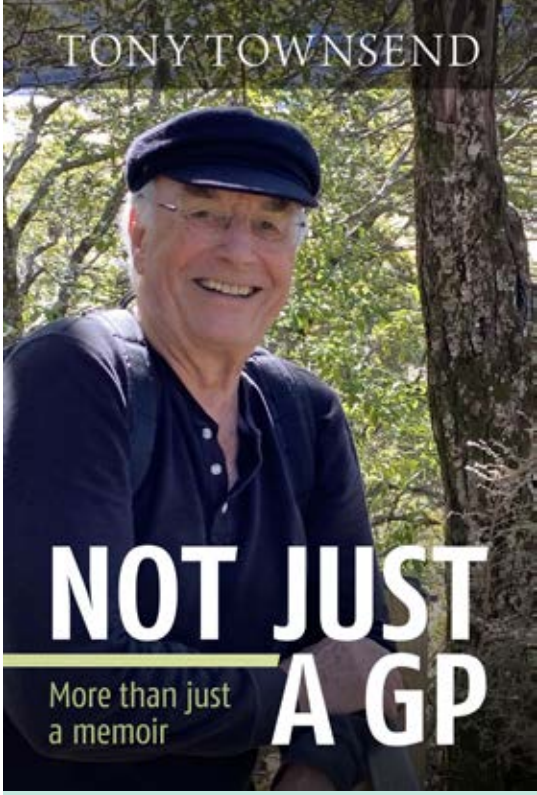
I graduated in 1969 and started my general practice career in 1974. I have experienced the evolution of general practice from a paternalistic, male-dominated, biomedical, subservient branch of medical practice to a person-centered, gender-equal, biopsychosocial, essential medical specialty. When I retired a few years ago, I had time to think about what I did and how I did it. I was becoming increasingly concerned that some of the fundamental values that define our specialty status, were under threat. Access, comprehensive care, continuity of care, primary personal care, and the management of complex medical problems are all, for various reasons, no doubt exacerbated by the recent pandemic, becoming seriously endangered.

I thought that it would be helpful to engage our patients, by explaining what we do, how we do it and why this is so important. Hence, I have written about doctors and patients, sickness, suffering and illness. I have written about difficulties that I had encountered: boundary issues, dying and death, decision-making, the science, and the art. I have also written about bias, emergency care, medical error, and my thoughts about preventing illness. I have not delved into detail in any of these areas, for I am a generalist, but I hope that I have explained what we do and how we do it in a way that people, who do not have a scientific background, will understand.

I am continuing to learn. I now realise that history, both the events that have shaped the culture of modern medicine and our personal history - those things that have made us who we are, enable us to make sense of our present and to plan for our future. Change is inevitable and important, but we can, and should, influence it. We all make assumptions, but before acting on these, we need to use evidence-based analytical thinking to ensure that we help patients to make informed decisions about their care.

I do not expect that all GPs will agree with everything that I have written, although I have endeavoured to keep this evidence-based and to acknowledge my many teachers by referencing my sources. Debate is healthy. I hope that some GPs will resonate with the difficult issues around decision-making and a systems-thinking approach to complex issues. Illness and suffering are complex systems, and we need to ensure that our person-centred interventions are helpful and achievable.

Have a read, think about it, and if you find it in any way helpful, recommend it to a patient.



Dr Tony Townsend MNZM is a Distinguished Fellow of the College and the author of the memoir *Not just a GP*. Over the years he has held a number of College positions, including Deputy Chair, Orator, member of the Education Committee, and the editor of *New Zealand Family Physician*.

I'm Ralph, I'm Dad

A daughter explores identity, relationship and a gentler dementia

Dr Glennis Mafi

GP, retired member of the College

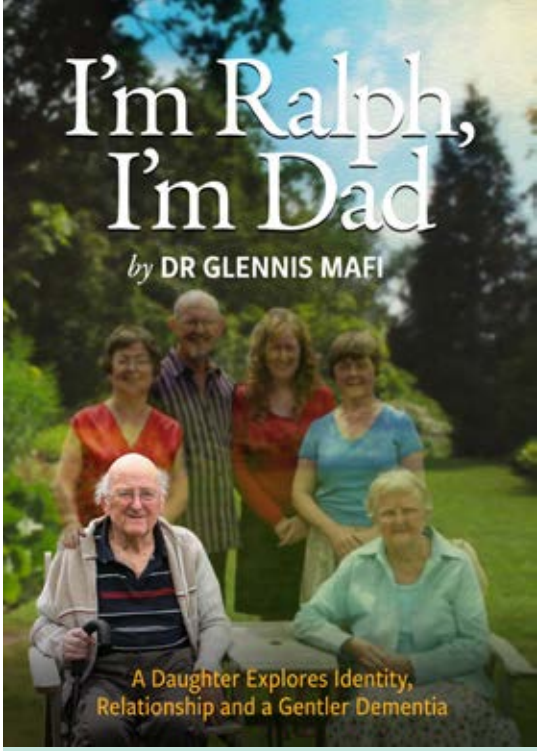
I have enjoyed creative writing from my early school days, whether essays, poems, speeches, or even assignments. But life was busy and at times "the flow" would cease. In April 2008, the Goodfellow Unit arranged a workshop with Dr Hilton Koppe (NSW) about writing as an outlet for stressed GPs and included a big blank hardcover notebook.

At the time, my father was becoming increasingly dependent with dementia and once after an evening of Dad-sitting, I remembered the red notebook and wrote my first poem about him. More poems followed and I began to realise that many of them reflected aspects of dementia, like day-to-day care, incontinence, the influence of old habits and interests, medication, spirituality, and these could inform, help, and perhaps comfort us.

I was also thinking a lot about what was going on in the mind of someone with dementia, ways of "seeing" people with dementia and whether common statements about dementia, like *He's no longer Dad*, or *She's a victim of dementia*, *It's a fate worse than death*, *It's the apparent dissolution of a human being* were helpful or even true. My father had many of the features of dementia, but there was much that was still uniquely him. I also realised that the way we as a family spoke about or to him, would affect how we felt and coped with his condition, and probably how he coped too.

The book progressed very slowly, rather like its topic, and during that time I was influenced by my observations of my Tongan patients with dementia, the attitudes of their families, insights of writers on the topic, especially Prof. John Swinton of University of Aberdeen, and the growing awareness that my own husband was also starting down the dementia path – his own unique version.

The final push came after I retired in November 2019, and the book *I'm Ralph, I'm Dad* was launched in 2020, and I subtitled it *A Daughter Explores Identity, Relationship and a Gentler Dementia*. The book is useful for GPs and the primary care team, to look at dementia from a different angle than usual. If I was still a GP, I would lend or recommend it to some of my patients with early dementia, their family and caregivers. It is available from **me directly**, from a number of retail and online bookshops, and as an ebook (Kindle and ePUB). Comments and feedback welcomed.



For 17 years **Dr Glennis Mafi** lived in Tonga where she set up a NZ-style general practice and was actively involved with the Tonga Medical Association. After returning to New Zealand in 2001, she continued to oversee the clinic, and worked for the Tongan Health Society in Auckland, until her retirement.

WONCA World Conference

26–29 October 2023 in Sydney

The Royal Australian College of General Practitioners hosted this years' WONCA World Conference at Sydney's International Convention Centre during the last weekend of October. The theme was Recovery, Reconnection and Revival, which was reflected in its scientific program aimed to share research and build best practice, and its social program available to delegates and their families.

The conference program offered a variety of accredited activities such as pre-conference workshops, clinical skills updates, CPR workshops and sessions for practice owners. As for the College's involvement, Medical Director Dr Luke Bradford together with our Fellow Dr Marie Burke ran a skill-building session on persistent pain management in primary care, and Distinguished Fellow Dr David Tipene-Leach gave a keynote address.

A few more of the College's members contributed to the program. Distinguished Fellow Dr Felicity Goodyear-Smith talked about her project of improving health outcomes for Pasifika in New Zealand. Distinguished Fellow Dr Apisalome Talemaitoga presented his research about strengthening health system responses to COVID-19 for minority populations. Fellow Dr Katelyn Costello gave an informative lecture on rural workforce outcomes for early career doctors in New Zealand. Associate in Practice Dr Tania Moerenhout explained ethical and professional considerations of active patient participation in the electronic health record, and Associate in Practice Dr Ruth Savage presented her research on general practice's impact on medicine and vaccine safety in New Zealand.

Indeed, the College had a very strong representation at the conference. Apart from lectures, workshops, and sessions, we had a stand specially designed to lure delegates to consider New Zealand as the place to migrate to. Approximately 3,500 family doctors attended the conference, and the College staff encouraged them to think seriously about moving to Aotearoa to live and work.

Medical Director Dr Luke Bradford and President Dr Samantha Murton at Aotearoa New Zealand stand.

Distinguished Fellow Dr Tony Townsend MNZM and College Chief Executive Lynne Hayman upon donating 20 copies of his book Not just a GP *to the stand.*

Effects of El Niño on asthma

With El Niño weather conditions in full swing as summer nears, there is likely to be an influx of allergy sufferers seeking advice from their GPs to relieve and manage their symptoms. Here is what to look out for and how best to advise patients about the summer season allergies.

El Niño was officially declared at the end of September, meaning a windier, warmer, and drier summer, than usual. Ms Letitia Harding, the CEO of the Asthma and Respiratory Foundation NZ (pictured right), says these weather conditions can lead to wind-born triggers, like pollen, for asthma and allergy sufferers. To better manage their symptoms, which could flare-up during the summer months, patients need to ensure they have enough non-expired medication for the Christmas and New Year break, and always carry it with them, she adds. "It can be a difficult time of year for the respiratory community, but being prepared and taking some simple, but effective, steps can make all the difference."

The NZ Asthma Guidelines (both Child, Adolescent and Adult) recommend that all patients with asthma have an Asthma Action Plan so they can self-manage by recognising and responding to worsening asthma symptoms using their prescribed medication. Up to 80% of asthma is associated with an allergy, with one in eight adults and one in eight children in New Zealand suffering from the condition.

NIWA meteorologist Ben Noll says the big stand out from El Niño will be the wind across the country. "Strong winds can pick up pollen and circulate it around, so it could be that people in the north and east of both islands may be exposed to more pollen than is typical."

This year's El Niño would be one of the strongest Aotearoa has experienced in 80 years, Noll says. For patients seeking advice, the best solution is avoidance, but there are also some helpful tips GPs can share:

1. Avoid going outside when the pollen count is very high (midday is the peak)
2. Keep windows closed, particularly when out in the car
3. Use an asthma action plan to help adjust their medications
4. For hay fever symptoms, offer a corticosteroid nose spray regularly during exposure, or taking an oral antihistamine tablet or liquid when needed
5. Dry your clothes indoors – pollen will stick to them if they are outside
6. Invest in an air purifier with a HEPA (High-Efficiency Particulate Air) filter
7. Keep medication at hand in case of an emergency
8. Take a shower at night to wash the pollen off
9. Wear a mask when mowing, weeding and hedge-trimming as this can stir up pollen, dust and spores which are then inhaled
10. If mould is a trigger, avoid organic mulches such as tree bark and manures, and use gravel mulch instead
11. Remove any plants that exacerbate symptoms from your garden e.g. privet.

Reducing the risk of dementia

Dr Etuini Ma'u

Senior lecturer, clinical advisor at Alzheimers New Zealand

As the population in Aotearoa New Zealand ages, the number of people with dementia is projected to more than double from an estimated 70,000 people in 2020 to 170,000 in 2050. Māori and Pacific peoples are ageing at a faster rate, with dementia prevalence in these populations projected to almost triple in the same period. The economic costs associated with this projected increase are unsustainable and, in the absence of a cure, risk reduction needs to be prioritised. It is timely then that this is the theme of the 2023 World Alzheimer report Reducing Dementia Risk: Never too early, never too late.

12 risk factors

The 2020 Lancet Commission on dementia prevention, intervention, and care identified 12 potentially modifiable risk factors for dementia that can be broadly categorised into physical health factors (diabetes, smoking, alcohol, obesity, hypertension, traumatic brain injury, hearing loss, physical inactivity, air pollution), and brain health factors (low education, depression, social isolation). The prevention potential for dementia in Aotearoa New Zealand is high, estimated at 47.7% if all 12 risk factors were completely eliminated, and even higher again for Māori (51.4%) and Pacific peoples (50.8%).

Recent work by our research group has shown that ethnicity per se does not increase susceptibility to dementia risk factors, indicating the higher dementia prevention potential in Māori and Pacific peoples is better explained by the higher prevalence of risk factors in these populations. Many of these risk factors are also associated with deprivation, so measures to address the social determinants of health are urgently needed for equitable health outcomes given the overrepresentation of Māori and Pacific peoples in the highest levels of deprivation.

Prevention is key

While dementia is primarily a disease of older people, the impacts of many physical health risk factors for dementia begin up to 20 years earlier in midlife, and it is their incremental and cumulative cerebrovascular changes that eventually lead to dementia. This highlights the importance of primary prevention discussions around brain health in midlife, even when the immediate dementia risk is deemed to be low.

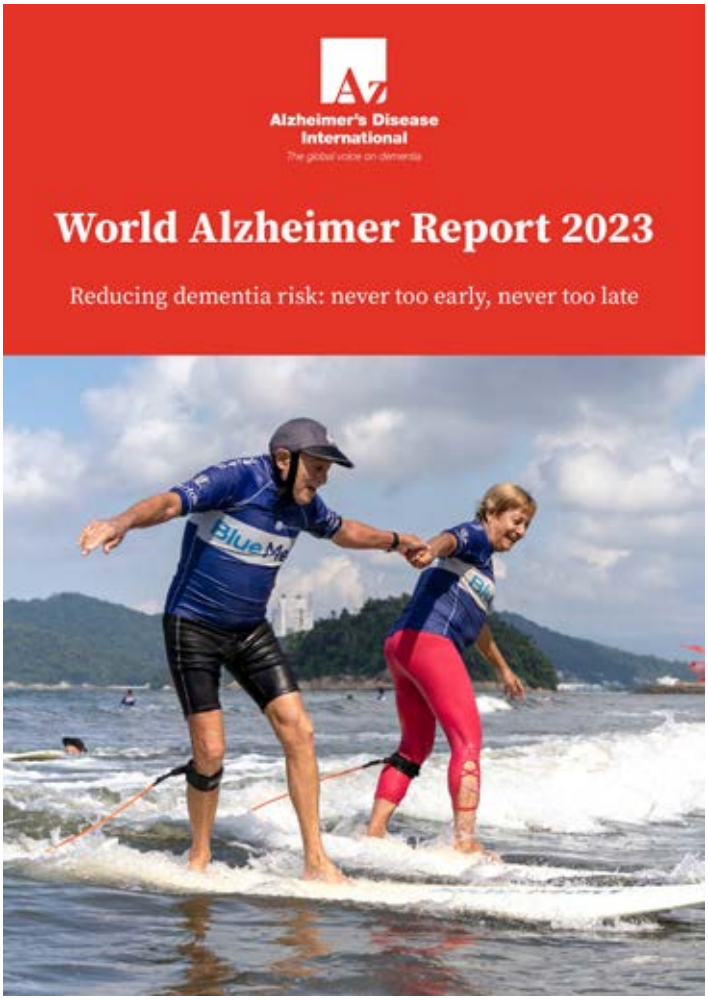
Secondary prevention has also been demonstrated to reduce dementia risk. Appropriate provision of hearing aids almost halves dementia risk associated with hearing impairment and adequate blood pressure control has been

Dr Etuini Ma'u is a senior lecturer in psychiatry at the University of Auckland, consultant old age psychiatrist with Te Whatu Ora Waikato, and a member of the Dementia Mate Wareware Leadership and Advisory Group. His research interests are in the fields of Pacific mental health, old age psychiatry, and dementia prevention.

shown to almost halve the risk of dementia in people with hypertension. Furthermore, severity and duration of exposure to a risk factor also contributes to dementia risk. For example, recent research out of the US indicates only 20% of the additional risk in Black Americans was due to their higher prevalence of hypertension, with the remaining 80% attributable to the downstream consequences of disease severity on cardiovascular morbidity. Cognitive changes have also been shown to be reversible with optimal treatment of diabetes, addressing alcohol use, and managing depression.

It is never too early, never too late.

Dementia risk reduction must become a priority if we are to reduce the healthcare burden associated with the projected prevalence of dementia in the coming decades. While primary prevention is key, timely and optimal management of many risk factors can reduce their associated risk of dementia. In those diagnosed with dementia, optimising risk factor management can slow progression and maintain functioning for longer. Primary care is perfectly placed to provide targeted risk reduction at all stages of life.



Read the report here.

> While primary prevention is key, timely and optimal management of many risk factors can reduce their associated risk of dementia.

Parkrun everyone!

A lifestyle medicine initiative

Dr Andrew Boyd

FRCGP (UK), dip. IBLM, GP at Aspiring Medical Practice in Wanaka

Imagine a free, inclusive, safe event outdoors that welcomes anyone and everyone in the community on Saturday mornings in a local green space. Sounds too good to be true? At 43 (and counting!) locations across Aotearoa, parkrun offers exactly this!

The initiative

It started in 2004 in a blustery Bushy Park in London with 13 runners. Parkrun has grown to become a global phenomenon with weekly 5km events in 20 countries. This month, the incredible milestone of 100 million participations worldwide was reached, with over a million in New Zealand alone. But the core principles of parkrun remain: to harness the benefits of being outdoors with others from our community, running, walking, volunteering or spectating, to improve mental and physical wellbeing, and to create a healthier, happier planet.

And as lofty as this ultimate goal might be, it's why most of us landed in general practice in the first place. I've been a park runner for years, enjoying beginning the weekend in a positive way for my own physical and mental wellbeing, but it took me a while to make the connection between parkrun and primary care. I believe the solution for a lot of the problems that we see in our surgeries, lies outside of the traditional healthcare referral pathways. For those of us who have a parkrun event nearby, there is a safe welcoming social asset that you

Dr Andrew Boyd is a GP at Aspiring Medical Practice in Wanaka, a Clinical Advisor for Mental Health at WellSouth, and Health & Wellbeing ambassador of Parkrun New Zealand, as well as an enthusiastic cyclist, skier, park runner and peanut butter connoisseur.

Stock parkrun image used with permission.

can signpost patients and maybe yourself, too. Social isolation, low mood, prediabetes, obesity, rehab, or prehab – the list of conditions that can be helped is endless. But beyond the labels we bestow upon patients, the value of being together, moving together and having a chat before we say goodbye and go about our Saturday business, is undeniable and profound.

The partnership

In 2018, thanks to the indefatigable efforts and inspiration of the parkrun team in the UK, where I practiced until recently, a partnership was formed between parkrun and the Royal College of General Practitioners. To date, over 1700 UK practices have partnered with their local parkrun and are proud to call themselves 'parkrun practices'. Practice team supports patients to come to parkrun, often with help from practice health coaches. Practice teams have volunteered to marshal and support their local event on a one-off or regular basis; and others have even set up their own parkrun events.

Anecdotal and formal evaluation have shown benefits for patients, communities, and primary care teams themselves. It is a perfect example of how we can look after ourselves to best look after others.

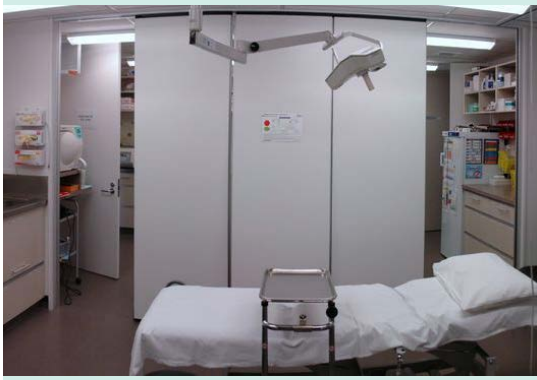
There are already a number of primary care teams in New Zealand which are involved with parkrun – thank you and well done to you. As a parkrun ambassador, I am passionate about supporting as many of you to connect and partner with your local parkrun. So, a call to arms: give parkrun a go, if you haven't already, and if you're interested in partnering with your local parkrun – please **get in touch**!

“There are already a number of primary care teams in New Zealand which are involved with parkrun.

Dr Andrew Boyd with his children at Wanaka parkrun.

Photo: Otago Daily Times

CQI module at Amuri Community Health Centre



Amuri Community Health Centre is the only general practice in Rotherham a town nested by the bank of Waiau Uwha River in Canterbury, in the northernmost part of the Amuri Plain. Originally it was a business operated by an individual GP, but it evolved into a general practice owned and managed by an NGO called the Amuri Community Trust. Its charitable status opens access to funding which would not be available otherwise. Community ownership is also an attractive alternative to provide best care in the everchanging environment, and to attract the finest health professionals.

In 2011, the centre moved into its premises built in accordance with the Government's Primary Health Care Strategy of an integrated Health Centre, which focuses on prevention rather than cure. In addition, a locum cottage was set up as a Red Zone to allow care of patients with COVID-19 symptoms. It is an example of the practice's commitment to manage safety of patients and the staff.

Currently, Amuri Community Health Centre proudly employs two GPs , Dr Margriet Dijkstra and Dr Sarah Ballam, one paramedic practitioner, one clinical-lead nurse, four PRIME trained nurse and two healthcare assistants, as well as admins, receptionists and cleaning crew. The centre is run by a community-appointed board of directors, and maintains a close relationship with eight District Nurses who work throughout the wider Hurunui District.

Forward thinking

Purchasing the CQI module was a result of a strategic meeting attended by the board, the entire staff and District Nurses. The goal of the meeting was to review procedures and processes, and to exchange ideas for what the future of the practice should look like. Monitoring care outcomes and reflecting on health needs of the community allows the centre to establish and maintain high-quality responsive healthcare which is both innovative and lifelong.

For a Fellowship assessment visit to take place, a practice must hold current Foundation certification and Cornerstone accreditation. Purchasing the modules also opens up a pathway to future teaching. As discussed during the meeting, going forward the centre is interested in hosting registrars, increasing the number of staff and promoting rural health care.

Lessons learnt

The centre's CQI project involved a review of the HbA1c in their current population and implementation of changes to improve management of Type 2

Diabetes with respect to glycaemic control. Their small-sample study revealed that the staff performs well in addressing diet and lifestyle factors, which was demonstrated by the fact that 85% of patients received documented advice. Two of the patients, however, whose HbA1c went up, required further referrals to a dietician. As a rural practice, the centre doesn't employ dieticians and therefore needed to consider other options, such as health coaching.

Under the new medication guidelines, the study showed an average reduction of 15.5% in HbA1c, which didn't reach the target level of 20%. Nevertheless, 40% of patients met the target, and 20% of patients received new agents for Type 2 Diabetes to try. Since the module incorporates elements of the New Zealand Triple Aim framework, the staff was pleased to learn that the centre is up-to-date with the latest medications, as recommended by the Diabetes Foundation Aotearoa.

Looking back

Doing the module was a useful experience. It revealed vulnerable areas requiring closer attention in terms of improving health outcomes. For example, the staff realised that diabetic patients are not well-managed and could benefit from a more functional type of medicine, such as health coaching. The 15-min model of attending to patients' needs makes it difficult to thoroughly address diabetes, particularly regarding the implementation of lifestyle changes. For this reason, the centre is considering either hiring a health coach or training one of the existing staff members to meet the demands. Overall, the process of comparing past and present treatments was a valuable experience which generated reflections on all aspects of providing high-quality health care.

General practice is challenging and sometimes what the staff would like to do is different from what they are able to do. Nevertheless, certain initiatives are already taking place. Rotherham has a large Filipino community, and the clinical-lead nurse started a discussion on their health needs and how the centre can address them better. It just so happens that one of the healthcare assistants is Filipino and can assist with English-Filipino translations during their visits. Rotherham has also a Māori community which the centre wishes to connect with in the next step. These initiatives show a systematic change and a patient-centred approach to holistic care of communities, taking into consideration their individual and cultural needs.

Amuri Community Health Centre