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

February 2024

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Editorial

Dr Luke Bradford

Dr Luke Bradford
Medical Director | Mātanga Hauora

Tēnā koutou

Thanks to the 400+ members who participated in the first 'Your Work Counts' diary exercise at the end of last year, we now have our first dataset to help us build our case around the project's three aims of identifying:

1. What does a fair and reasonable 40-hour week look like?
2. What is a safe and sustainable patient load?
3. What is the number of GPs we need regionally, and nationally?

This work is important because it gives us real-time examples of what we're working on, how long we're spending on these tasks, and if other tasks that we should be doing aren't getting the attention they deserve.

You can read a more detailed breakdown of the results and the project's next steps on page 4.

Before our conference in July, we hope to undertake one more diary study. Whether you participated last time or not, I encourage as many of you as possible to get involved, so when we look at the data from different points throughout the year, we can address the unrecognised and often non-remunerated work that specialist GPs put into caring for people throughout the course of their lives.

The data we collect will also act as a conversation starter to change the narrative around our work, the impact we have on health outcomes within our communities and our place within the sector.

The scope of practice we work within is one of the broadest. The value we add to the health outcomes of our communities is significant. But the gaps in remuneration between what we are funded to do and what we are actually doing, as well as the gaps between primary and secondary specialists, need addressing.

We need your help to make our case. Your work does count, so make sure it's counted.

Until next time,

Luke

50 years of the College – Summer Memoir

Last November, all College members were invited to participate in our Summer Memoir creative writing contest to share their experiences, both their struggles and achievements, that link with the College and its 50 years of transformation. Submissions were accepted until 20 January 2024 and then evaluated by the Editorial Team.

Results

Winner — Dr Lucy O'Hagan

Winner — Dr Lindsay Quennell

Special mention — Dr Greg Judkins

Prizes

The winners will receive a copy of Dr Glennis Mafi's memoir *I'm Ralph, I'm Dad*. The winning submissions are published in full on the College website, and excerpts are published in this issue of *GP Voice* on page 12 and page 13.

Congratulations to the winners and warm thanks to all members who sent their submissions.

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

Your Work Counts – diary study results

Dr Luke Bradford

Medical Director of the College

Working as a specialist general practitioner is a rewarding job that significantly improves the lives of those in our communities. However, over the years we have all seen an increase in patient needs and the complexities of their conditions. This, alongside the well-documented workforce shortages, has meant we are taking on more work, without additional resources, support or remuneration.

This frustration was one of the drivers that led the College's Policy, Advocacy and Insights team to develop and implement the '**Your Work Counts**' project. If we look at the data from the diary study and apply it to the first of the project's aims – to identify what a fair and sustainable 40-hour week looks like – the results aren't surprising. The patterns of behaviours and working styles are consistent with what we're hearing from the membership.

The results below are from the 417 respondents (out of the 423 who completed the exercise) who worked mainly in general practice during the diary exercise period which ran from Monday 20 November to Sunday 3 December 2023. Interestingly, there was consistency in the results from respondents across the regions (rural vs. urban) and genders, which showed that contact and non-contact clinical time are the two tasks that took up most of our time, while the other tasks of teaching, training (CPD) and clinical governance get less of our attention. Teaching (growing the workforce), training (growing our own knowledge) and clinical governance (quality) are important parts of our roles that we should be able to give proper and focused attention to within our working week.

Clinical contact time with patients was, not surprisingly, our biggest task, taking up 56.4 percent of respondents' time during the two-week diary exercise. The non-contact clinical time, which consists of all the paperwork, emails and admin that come out of our patient consults, came in at 30.8 percent of our time. This is the work that tends to take up our time after hours and at the weekends and is an important part of the comprehensive continuity of care that we provide our patients. It is also the work that we are not remunerated for. But imagine the consequences if we didn't do it.

Breaking down the working hours, the results told us that:

- 57 respondents (14%) worked all 14 days in the study
- 64 respondents (15%) worked all four weekend days
- 76 respondents (18%) worked at least one 50+ hour week
- 34 respondents (8%) worked 50+ hours each week
- 22 respondents (5%) worked at least one 60+ hour week
- 7 respondents (2%) worked 60+ hours each week.

There will be many reasons for the variations in working hours, as there are in any job, but when you think about how many extra hours we are working, effectively for free, then we need to ask the question why is the way our role funded so different to that of our specialist colleagues working in the hospital system?

In hospitals, clinical time accounts for approximately 70 percent of the role; however, this incorporates non-contact clinical work for their patients. All medical professionals have patient follow-up, so why aren't we recognised and remunerated for doing it when others are?

As mentioned in my editorial, we plan to do another diary study to collect more information on the time we're spending on key tasks. This data will help to inform the other two aims of the project, which are to identify:

1. what is a safe and sustainable patient load?
2. what is the number of GPs we need regionally and nationally?

When we think about a safe and sustainable patient load alongside a fair and reasonable 40-hour week, we also need to factor in time for breaks. The hours worked, as shown above, don't account for breaks, which are a compulsory and necessary part of any job. We must be clear with our language around "full-time" work. Your results show that 4.5 hours of consulting with patients necessitates 3.5 hours of other essential functions, i.e. a 40-hour work week (without breaks) involves 22.5 hours of patient contact.

With the 2024 Workforce Survey coming out later this year, we'll be asking for more information to support the results from this project. The data we collect supports our advocacy efforts to have our profession valued appropriately for the work we do and the complexity of the care we provide.

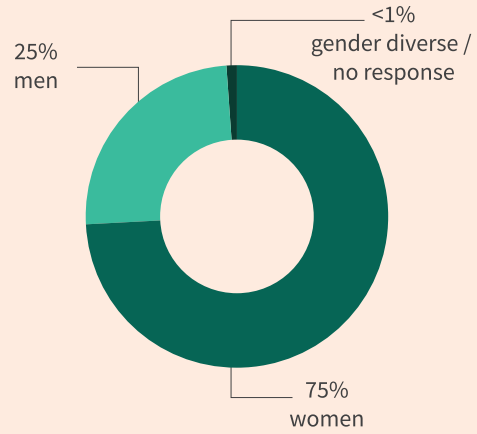
The work that goes on outside of our patient consults is immense. Ensuring we are properly supported and resourced to carry out this work in a way that doesn't see us working late into the night (and for free) will go a long way in reducing our burnout levels, keeping people in the job longer and encouraging more graduates to choose general practice or rural hospital medicine as their career.

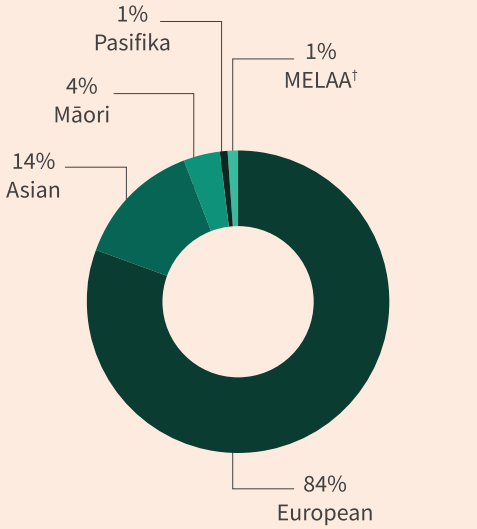
Demographic stats from the first diary study are shown in the panel on the right. NOTE: Some respondents chose not to provide this information.

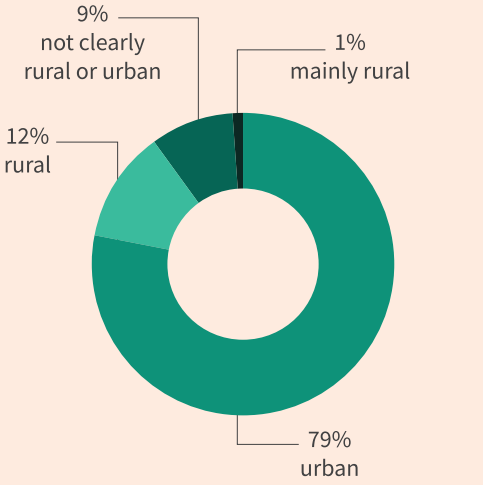
Across the 417 respondents, the time spent on tasks was:

56.4% Consults	**30.8%** Non-contact	**6.4%** Training
2.6% Governance	**3.3%** Management	**0.5%** Other

Survey respondents by gender, ethnicity and urban or rural location*







* Totals may not sum to 100% due to rounding

† Middle Eastern, Latin American or African

Study with us

Applications open for College training programmes

Jamie Lamberton
Communications Advisor, RNZCGP

On 21 February, the College opened applications for its two training programmes: General Practice Education Programme (GPEP) and Rural Hospital Medicine Training Programme (RHM).

The two qualifications, which can be taken together to obtain Dual Fellowship, are a mix of clinical and academic postgraduate training for people who already have a medical degree.

Dr Samantha Murton, Wellington GP and College President says, "We need to train more specialist general practitioners and rural hospital doctors who can continue to provide our high standard of comprehensive and equitable health care to our diverse population.

"We wholeheartedly welcome applications from doctors wanting to specialise in a field that delivers a meaningful difference to the health of our people right across the motu.

"General practice and rural hospital medicine is a vibrant and challenging profession. No two days, and no two patients are the same. If you want to form long-lasting connections with your patients while working through complex yet rewarding challenges in helping them to manage their health, come and join us," she said.

If you know anyone you think may be interested in specialising as a GP or rural hospital doctor, please direct them to the College's website. Applications will remain open until 12.00pm on Monday 8 April 2024.

> "The two qualifications, which can be undertaken separately, or together to obtain Dual Fellowship.

A tip from research

that benefits general practice

1

Colchicine is universally fatal at a dose of 1mg/kg and almost always fatal at just 0.5mg/kg. This should be considered carefully when issuing prescriptions with regard to number of tablets dispensed. Read the full story in the next issue of *GP Voice*.

Spotlight on the Registrars' Chapter

Miranda Millen

Communications Assistant, RNZCGP

The Registrar Chapter encompasses the registrars and associates in practice, and functions within the wider College as a representative group for the General Practice Education Programme (GPEP) and Rural Hospital Medicine Registrars (RHM).

The Chapter is proactive in their pastoral and collegial care of registrars within the College. This includes an advocacy role on behalf of their peers for the educational, pastoral and holistic registrar needs within the College training programme, in practices and other clinical training sites. A key objective for them this year is to contribute to the upcoming Medical Council Accreditation (MCNZ) visit in March in this capacity.

In preparation for this event, the Chapter has been engaging with their members to identify issues that have subsequently been raised with the College's Senior Leadership Team. The Chapter has also updated their mandate accordingly and sent out regular communications to keep registrars in the loop of the activities at the College.

Ongoing projects

In November 2023, the Chapter organised a two-hour workshop attended by 80 registrars, addressing contracting and employment issues targeted at GPEP year one registrars. The workshop was well received and filled an important gap not currently discussed or adequately covered elsewhere. Building on this success, the Chapter plans to host a similar workshop on employment conditions and contracting issues for GPEP registrars.

Members of the Chapter's executive team have been attending Te Ahuanga. Dr Hemi Enright attended the Wellington and Palmerston North based hui and enjoyed contributing to the programme. Dr Amanda Smith is attending the Northland and North Auckland hui, and Dr Isabelle Lewis is attending the Christchurch hui. Other executive members will be popping into GPEP1 teaching and other orientations around the mōtu.

Later in the year, the Chapter will fund the end-of-year GPEP1 regional dinners to celebrate their success as a group. The goal is to build a regional presence and engagement, so if you are a registrar, keep an eye out for another regional hui being held for GPEP2/3's.

Dr Hemi Enright is the Chair of the Registrars' Chapter, a representative at the National Advisory Council and a member of Te Akoranga a Māui.

New members

The Registrar Chapter is always seeking new members, particularly GPEP year one registrars to assist with the succession planning. It is worth considering because executive members are paid for their attendance at meetings and for approved activities they undertake to further the Chapter's objectives. There is also a funding arrangement with The New Zealand Resident Doctors' Association (NZRDA) Education Trust, enabling the members to complete professional development in governance and leadership. Most importantly, however, the Chapter gives an opportunity to get involved and support your peers! If you have any questions, please get in touch by **email**.

The core functions at glance

1. To represent and advocate for registrars in training;
2. To attract more doctors into the profession;
3. To be responsive to our members, i.e. registrar identified learning needs and educational matters;
4. To seek a mandate from the wider registrar body on an ongoing basis.

Activities of the Chapter

- Continuing to be involved in regular discussions on curriculum issues with the College.
- Raising the profile of general practice and Rural Hospital Medicine at both virtual and in-person events.
- Advocating for registrars within the training programme.
- Providing pastoral support where appropriate.
- Escalating trainee concerns to the appropriate person within the College.
- Dealing with and resolving complaints.
- Building relationships with other training bodies and external organisations.

The executive team

Meet the registrars who represent you:

Dr Mathanki Vivekananda – GPEP3 representative
Dr Ben Booker – Rural Hospital Medicine representative
Dr Ralston D'Souza – Treasurer and Board of Studies representative
Dr Hemi Enright – Chair, NAC representative and member of Te Akoranga a Māui
Dr Isabelle Lewis – Secretary and member of Te Akoranga a Māui
Dr Rex Liao – GPEP1 representative
Dr Ginette Musker – GPEP2 representative
Dr Darren O'Gorman – GPEP2 representative
Dr Amanda Smith – Te Akoranga a Māui representative (Tuakana)
Dr Visakham Sundgren – GPEP3 representative
Dr Leone Vadei – Pasifika representative

Dr Ginette Musker is a GPEP2 representative on the executive team.

Dr Mathanki Vivekananda is a GPEP3 representative on the executive team.

Educators Symposium

A Waikato/Bay of Plenty Faculty event

Dr Alison Fawdry

Chair of the Waikato/Bay of Plenty Faculty

It is said that teaching is the greatest act of optimism. The Waikato/Bay of Plenty Faculty ran an Educators Symposium in November that brought around 30 of these optimists together in Rotorua. We wanted to hold an event to encourage networking between GP trainers in our region and hopefully teach them something useful at the same time. An attendee gave this feedback: "Fantastic day, great company and lots of take-home skills," so our goal was achieved – at least for one person!

We had four very engaging presenters who each gave us useful tools to take forward in our future training journeys.

Dr Fiona Whitworth is an experienced GP educator from Tauranga. She shared with us some theoretical frameworks explaining learning styles, including the Honey and Mumford classification. We have learnt that one can also categorise a learner into Visual/Aural/Kinaesthetic/Read–Write groups. By understanding a student's predominant preference, the teacher can adapt their teaching sessions accordingly. Fiona also ran through the value and qualities of effective feedback.

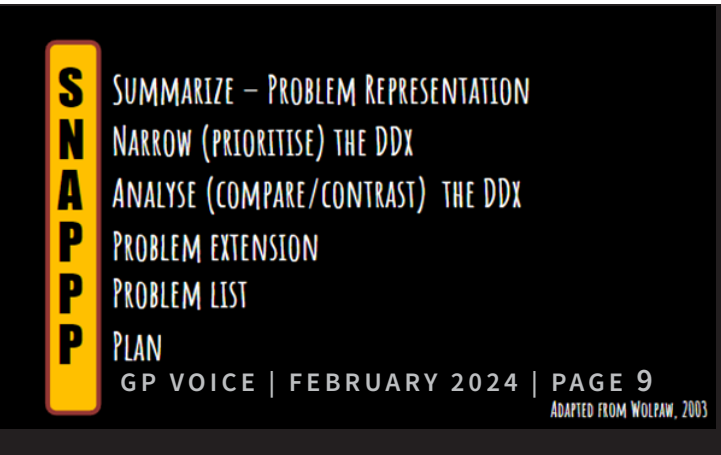
Dr Liza Lack from Hamilton has been a clinical educator for many years. She shared her highly helpful framework for approaching struggling learners. She used the foundation of approaching a clinical problem – namely history, examination, investigations, diagnosis and treatment plan – and adapted this to help us navigate the challenge of a trainee who may be in difficulty.

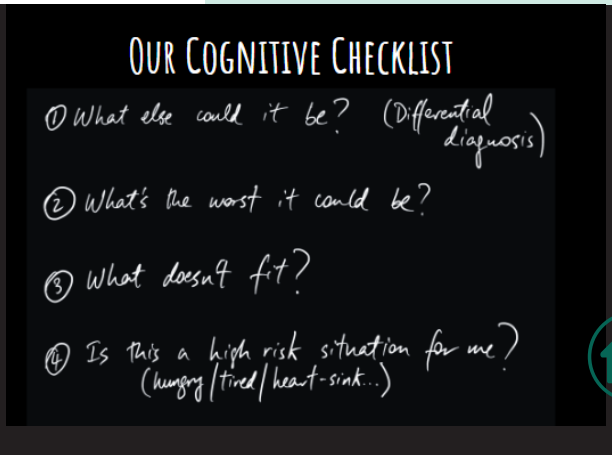
The highlight for many attendees was the session from Dr Art Nahill and Dr Nic Szecket who are the presenters of the acclaimed podcast 'IM Reasoning'. They gave a talk on teaching the diagnostic process, which is a much neglected but crucially important part of clinical education. They shared their 'Cognitive Checklist' and the acronym SNAPPP (see below) among other valuable tools.

Overall, the event had a heartening atmosphere of passion and enthusiasm for general practice from those who are training our next generation. It was a great opportunity to bring this group together and share valuable experiences.

Dr Liza Lack and Dr Fiona Whitworth

Dr Art Nahill and Dr Nic Szecket



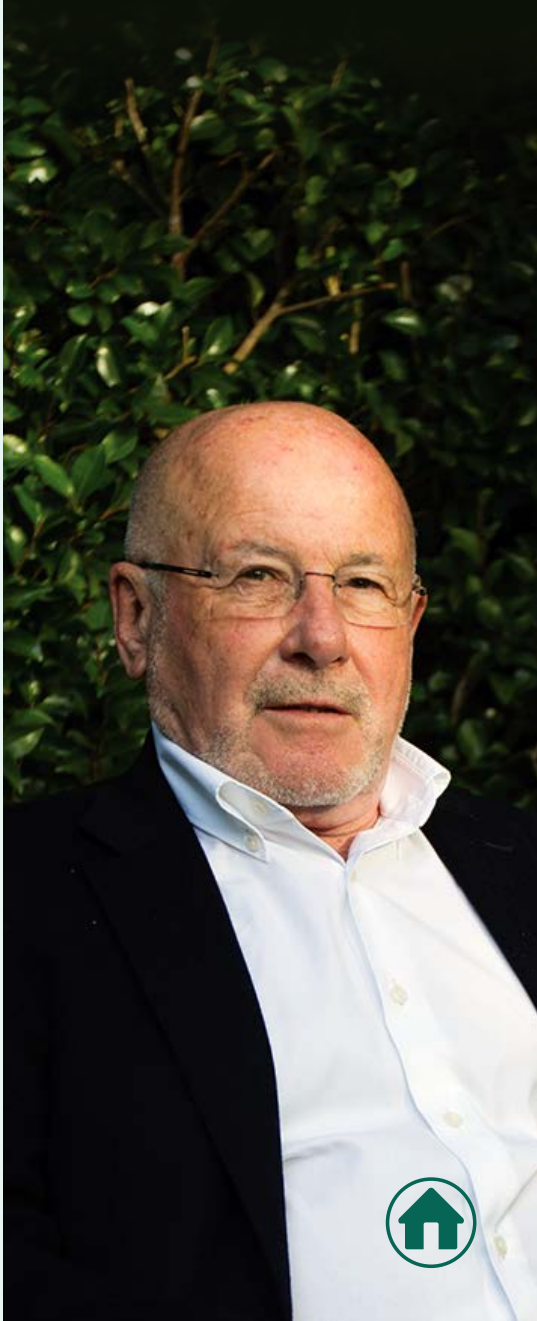


MIND THIS

HDC: Botox consent

Dr Peter Moodie

Peter Moodie is the College's Clinical Advisor



Overview

On 5 September 2020, the sole director and owner of a general practice (Dr B) authorised his 'clinical practice manager' to assess and administer cosmetic Botox to a new patient. Unfortunately, after a few hours the woman developed side effects, which were probably compounded by anxiety symptoms. Subsequently, she complained to the HDC, because she felt she had not been adequately informed of the procedure's risks.

Practising cosmetic medicine

All cosmetic procedures (including Botox injections, injectable fillers, chemical peels and platelet-rich plasma) had in the past been carried out under the direction of Dr B. He stated that due to ill health he did not see patients other than in his cosmetic medicine clinic. His Annual Practising Certificate (APC) had expired a month before the incident and has not been reactivated since. Curiously, although the Commissioner made that observation, she did not comment on the fact that he was continuing to write prescriptions for Botox.

The practice did have a policy and procedure document relating to Botox injections, which stated that, "A cosmetic nurse or physician assistant shall be able to assess, consult and treat patients with Botox…" This was essentially a standing order.

The clinical practice manager was in fact a nurse. She was overseas trained and not registered in New Zealand. Like Dr B, she did therefore not have a valid APC, while Dr B plainly thought his standing order covered her under the category of "physician assistant". The manager minimised her clinical activity, but it was likely that she was carrying out an independent practice under the standing order.

Accessing standing orders

The Commissioner has determined that standing orders should only apply to registered health professionals and in this case, nurses only, and has asked the practice to remove the term "health assistant". This has implications for other situations where a practice feels that someone other than a registered health professional may be capable of performing a specific clinical task.

The Ministry of Health guidelines do not specifically state who can access a standing order, but they do specifically state the person must have appropriate training and competency. However, there is a New Zealand Society of Cosmetic

Medicine, which is apparently the only organisation the Medical Council recognises to train and regulate doctors in cosmetic medicine, and they specify that only appropriately trained doctors or nurses can carry out Botox injections. What are the guidelines around plastic surgeons carrying out these procedures too?

Adequate warnings

Notwithstanding the niceties of APCs and standing orders, this complaint was made because the patient felt she was not adequately warned of the risks of the procedure. Even though the patient signed a consent form, the Commissioner felt it did not give enough information, and the "clinical practice manager" countersigned the document under the heading of "Doctor".

Obtaining consent for procedures is becoming a much more complicated process, and practices need to be very careful about following the rules. In this particular procedure there is a Medical Council guideline that states that the assessment and the procedure should not be done on the same day so that the patient can carefully reflect on the issue, and consent must be checked again on the day of the procedure.

"

This complaint was made because the patient felt she was not adequately warned of the risks of the procedure.

Apply for funding

for research that benefits general practice

The College funds research and education projects that benefit general practice, rural general practice and rural hospital medicine. Each year there are three funding rounds and applications are reviewed by the College's Research and Education Committee (REC).

Applications are welcomed from any individual, group or organisation undertaking research in this field. Grants are typically between $5,000 and $20,000, although up to $40,000 can be awarded.

Applicants don't have to be members of the College or doctors to apply for funding. However, the research topic does need to be relevant to the workforce. 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.

Research topics should reflect one (or more) of the following domains:

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

The first funding round this year opened on 30 January 2024 and applications will be accepted until **12 March 2024**. More information can be found in the application guidelines or on the College website.

Successful applicants are encouraged to send their papers to the *Journal of Primary Health Care* and submit an abstract to present at the annual College conference GP24. To get in contact, email REC.

Summer Memoir contest winner: Dr Lucy O'Hagan

A GP and the author of *50 years of history*

Last November, all members were cordially invited to participate in our Summer Memoir creative writing contest to share their experiences, both their struggles and achievements, that link with the College and its 50 years of transformation. The editorial team read all the submissions and selected two that were outstanding both in terms of content and artistic value.

Meet Lucy

As well as being a GP, Dr Lucy O'Hagan is a medical educator, a mentor and a writer. Her contest submission outlines 50 years of the College, which she entwines around her personal story of growing up as the daughter of a GP, becoming a medical student, training as a GP, running a practice, teaching the future generation of doctors and dealing with burnout and change. The story is divided into decades and combines a personal memoir and an historical account of sociopolitical changes that shook New Zealand and the College.

An excerpt from the story

"When you have lived through it, you remember the feel of it, the shifts in the social and professional landscape.

1974

I was 10 when the RNZCGP started. I was no doubt oblivious to this, except that I was born in Southland where the first GP training in New Zealand began in 1972. I don't recall having a family GP, likely because my dad was a doctor, so why would we go to another one? In the next 40 years, the New Zealand Medical Council would put out a statement on giving care to those close to us.

I do have a vivid memory of my dad arriving in the living room where I was playing on the carpet, and injecting something into my arm. In another 30 years, the RNZCGP started Cornerstone accreditation, which included standards for managing the cold chain. Despite my father sounding like a slightly loose cannon, he was a well-respected teacher in that first GP training scheme. With that middle-class medical family, I was bound to end up a doctor, except that when I was a child, all the doctors I met were male and they had alongside them, backing them up, running their families, another person called the *doctor's wife*."

Click here to read the entire winning story.

The original office of the College in Christchurch

The College moved to Wellington in 1983

Summer Memoir contest winner: Dr Lindsay Quennell

A GP and the author of *A relic and an icecream*

Meet Lindsay

Dr Lindsay Quennell is a retired GP who, apart from being a Fellow of the College, was a chair of the Wellington Faculty and sat on the Panel of Examiners in the 1980s. His contest submission describes the establishment of the College and its training programmes in the ’60s and how they evolved and grew across the decades, shedding names, changing directors, gradually becoming what they are today. It is also a witty memoir of Lindsay’s personal journey spanning over 64 years, from his undergraduate studies, through working in a general practice in Southland in the ’60s and becoming a locum in the UK in the ’70s, then returning to New Zealand and getting involved with College activities, all the way to moving to Australia to work as a medical educator in the Victorian GP training programme. Lindsay’s story takes readers on a journey across decades and seas, commemorating those who led and shaped the College and what it means to be a GP.

An excerpt from the story

“On the last day of 2023, Lucy O’Hagan emailed me. Would I be interested in the RNZCGP summer memoir competition? Immediately I thought this is right up my alley with my long association with the College going back to 1972 and beyond. If anyone has outlasted me, they may well retort “Good god, is he still alive?!” Yes, I am still going but not as strong as I once was. I am nearing my 86th birthday. Most of my contact with the College was with the GP training programme but not exclusively. I had a false assumption that writing this memoir would be a pushover. Not so!

Let’s go back to 1964. The RNZCGP training program was first recognised as such in 1974, as was the NZ College itself – previously an off-shoot of The Royal College of General Practitioners. The GP training programme after much deliberation, additions, alterations including its name, made its first stuttering start in 1964 with Ken William and Ashley Aitken. The College (either the British version or the NZCGP) was much more than the vocational training programme, then known later as the GPTP. The College, in either version, was very involved in giving advice and encouragement to the training programme. It did not truly take over until an act of parliament in 1995 when the new Medical Practitioners Act was passed (the FMTP or was it the GPVTP?). At last it became a specialty.”

Click here to read the entire winning story.

The College moved to 23 Palmer Street in 1987

Premises of the College since 2015

Meet Dr Brendon Eade

Interview with the GP and the 2023 NZ Solo Champion in bagpiping

Tell us a bit about your personal and professional background.

I'm a Waikato lad, born and bred. I grew up in Hamilton Kirikiriroa, got a Bachelor of Science at Waikato University, then moved to Auckland where I did my medical training and my house jobs, mostly at North Shore Hospital. I did an elective in Scotland in 1997, and in 1999 I went back there to live and work for about five years. I returned to New Zealand in 2004 and settled back in the Waikato. I've been working in the same general practice, Health Te Aroha, a rural town East of Hamilton, ever since.

Why did you want to become a GP?

I'd like to say it was all planned, but it really wasn't. I completed my first couple of years as a junior doctor, got married and moved to Scotland to settle for a few years. We were planning on spending the first months travelling around, doing the classic Kiwi thing in a beaten-up old Kombi van, following our noses, when it just happened: at a Highland Games where I was competing as a bagpiper. I bumped into a chap and we started talking, I told him I was a doctor, and he said his wife was a GP in Inverness and knew of someone who was looking for a GP trainee.

At med school I had a limited exposure to GP work, so I saw myself going more down the general surgical route. But at that moment it sounded like a pretty good option, so he went off to make the phone call, and then came back saying he got me an interview the next day. The practice was about an hour's drive from where we were, basically down the road.

I got the job, and once I started general practice, I was hooked. It's a satisfying, colourful occupation, and once you start, there's no going back. It was a bit of serendipity, really. That's kind of been the way my medical and piping lives have been since then.

How did you get into bagpiping?

I started playing piano at the age of seven, and at 10 I was looking to learn another instrument. My sister was involved in highland dancing, and I was attracted to the sound of the pipes. At the time Hamilton had – and still has – a successful local pipe band, and I was fortunate enough to find a tutor.

I continued to play the pipes until med school. I had to put them down to focus on my studies, so it was in the last year of med school that I picked up the pipes again. For our medical elective, we could go anywhere overseas, as long as we were self-funded, and I was eyeing up the Cook Islands initially. It was my mum who suggested Scotland. I managed to set up the elective in Edinburgh

> "Once I started general practice, I was hooked. It's a satisfying, colourful occupation, and once you start, there's no going back.

and the Isle of Skye, where I did some general practice with an internationally renowned piper and doctor, Angus MacDonald.

Later, during the five years in Scotland, I got a chance to do not only my GP training but also a lot more piping. I got some tuition and entered solo competitions, climbing the ladder.

Some of my ancestors came from Scotland, so it's in the genes. My sister is also well into her music; she's the associate principal flute with the New Zealand Symphony Orchestra. To me, piping has always been a hobby. I enjoyed the sciences, and once I made up my mind that I'd like to go to a med school, that was it, really. But piping shaped my medical career and got me into general practice. Through piping I met my wife, Meleana. It has had a big impact on my life.

What happened after Scotland, when you returned to New Zealand?

Piping took a slightly different direction for a while. We came back, took over the Hamilton band and set up a teaching programme. It was no longer about a solo career.

Currently, the pipe band movement is very healthy in New Zealand. We have a large number of young people involved in Hamilton, because we wanted to focus on what we could do locally to encourage kids to join and play alongside

“
I did some general practice with an internationally renowned piper and doctor, Angus MacDonald.

each other. Once they see it, they enjoy it, and they stay in the movement and progress from there. Meleana and I set up more of a sustainable structure. She does the bulk of work teaching beginners from scratch, while I tend to take on more advanced players.

Apart from the teaching programme, we run a juvenile band for 18 and unders called the "Lewis Turrell Memorial Juvenile Pipe Band". We also have another graded band without age restriction which participates in competitions. Both bands have done really well in the last couple of years, featuring regularly in the prizes at the national championships.

Is there an intersection between being a GP and a bagpiper?

Whilst most of us GPs find satisfaction and a lot of enjoyment in our professional lives, we need good support outside our workplaces to lessen the of risk of burnout. Piping gives me a whole other life outside the profession, a whole different support network. Plus we're doing some interesting things, like concerts or competitions.

I'm a competitive type. In Scotland there are different types of players, some in bands, some solo, and others focus on folk music. I'm into competition as a solo piper, and this competitive outlet has been very useful to me. Music is a discipline in itself that requires a different focus. It gave me opportunities to travel overseas regularly, it has been a welcome distraction from stress, and a creative outlet.

I compete in a professional category. I was a New Zealand Solo Champion in 2023, and won a variety of major prizes, such as Online World Solo Championships in 2020, CNP Gold Clasp in 2019, 2022 and 2023. I travelled overseas to France and other countries to perform at international events.

Last thoughts?

I've been a strong advocate and a passionate GP for over 20 years. I wouldn't be in the situation I am today without that additional extracurricular interest and support, whether it's music or sport or something else. I've been lucky enough to step into that rich culture of piping. It opened many doors for me and provided me a lot of support along the way.

I believe that having a strong interest or a passion outside the profession increases our ability to do our job better. A lot of people ask me how can I be a doctor and a piper performing at events, but in my view the two are mutually beneficial. The discipline taken from the medical studies can be applied while preparing for musical competitions. The pressure of performing in front of an audience makes me a more sensitive and personable doctor.

> "Through piping I met my wife, Meleana. It has had a big impact on my life.

Hosting PGY2 doctors

The barriers of providing PGY2 placements in general practice

Simone White

Senior Communications Advisor at the College

Increasing the amount of general practice and rural hospital medicine exposure that medical students and postgraduate doctors receive is key to ensuring more choose the specialty as their career. A **recent study** in the *Journal of Primary Health Care* (*JPHC*) has identified barriers that often restrict a practice's ability and willingness to host a PGY2 doctor and offers solutions to address them.

General practices are willing to host a PGY2 and give them an understanding of how important a thriving primary health care system is to improving health outcomes. However, a lack of extra space, a lack of time to spend supervising and supporting PGY doctors and the financial impact (such as the costs of providing clinical space) were identified in the study as barriers to hosting.

The study asked four general practices in the Otago/Southland region to host a PGY2 for each quarter in 2022 and to record the time and financial costs associated with hosting the PGY2 and then be interviewed about their experiences. In addition, GPs who had hosted PGY2 doctors for some time across the country were also interviewed about their experiences.

To help, WellSouth Primary Health Network funded each practice $13,000 (split over the four quarters) and provided ongoing medical educator training and support to the GP supervisors. The study's lead author, Dr Carol Atmore, a Dunedin-based GP and Clinical Director at WellSouth Primary Health Network says, "We wanted to encourage general practices in our district to host PGY2s and also to understand what it really costs practices to do so."

Hosting PGY2s provides practical experience, clinical confidence, and gives important insight into the differences between primary health care in a general practice versus hospital-level care and the way the two entities are run. "The funding and support required to provide this experience to junior doctors needs to be addressed and is what this paper is highlighting," says Dr Atmore.

"Hosting PGY2s provides practical experience, clinical confidence, and gives important insight.

Another of the study's co-authors, Dr Aisha Paulose, says, "Funding practices to host PGY doctors means supporting the option of bringing in additional workforce to the practice, so GP supervisors can have the capacity to provide PGY doctors with a broad general practice experience and help them grow their practical skills and clinical confidence."

The current 2024 intake of GPEP year 1 registrars was the highest intake on record, and it is crucial to keep up this momentum so we can build a well-resourced workforce for the 4.9 million New Zealanders who are enrolled at a general practice.

"We must expose medical students and junior doctors to primary care and general practice throughout their learning journey, otherwise we won't have enough GPs in the future. The training and early years are so heavily focused on hospital-level care that it becomes 'the norm' and so being a GP becomes 'the other'. We need to change this perspective so that deciding to become a GP is a normal and attractive career option," says Dr Atmore.

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. Private practice model of physiotherapy: professional challenges identified through an exploratory qualitative study
2. Prompting lifestyle interventions to promote weight loss is safe, effective and patient-centred: No
3. Eating behaviour, body image, and mental health: updated estimates of adolescent health, well-being, and positive functioning in Aotearoa New Zealand
4. Barriers and facilitators to prescribing medicinal cannabis in New Zealand

Success of a bowel screening campaign

Findings from 2023 Primary Care Campaign of the National Bowel Screening Programme

Dr John McMenamin

GP/primary care lead for the National Screening Unit

In response to declining participation in bowel screening, particularly among Māori, Pacific, and Asian communities, the 2023 NBSP Primary Care Campaign was launched last May.

Findings from an earlier public campaign confirmed the important role of health care professionals in promoting screening. This insight led to the development of the NBSP Primary Care Campaign. The campaign aimed to increase screening participation by promoting conversations within general practices, facilitated by reminder systems and electronic kit requests.

The campaign pursued a number of objectives, including validating the impact of discussions on enhancing screening rates among Māori and Pacific groups, establishing conversations as a norm in general health care settings, sharing culturally sensitive approaches to these discussions, understanding the elements contributing to effective conversations, gaining insights into screening challenges for Māori and Pacific communities, exploring patient and family perspectives on cancer screening, and increasing awareness of modifiable factors within the health care system.

The Primary Care Campaign assessed whether prioritising opportunistic conversations in primary care could result in higher screening kit requests and increased participation rates among Māori and Pacific populations. Resources including patient information flip charts were also evaluated.

Around 400 general practices in New Zealand participated in the May 2023 campaign. The results are encouraging with an increase in kit requests reported for the participating practices. Key findings include:

- 86% of survey respondents would continue conversations / engage in another campaign;
- 68% reported being more confident in bowel screening conversations;
- 65% reported being confident in advising how to perform the test;
- 57% of surveyed respondents found flip charts helpful.

Dr John McMenamin is the GP/primary care lead for the National Screening Unit and is supporting the change management approach to transition and embed the HPV primary screening changes into the sector.
He is a Whanganui GP and is a study investigator on the University of Otago *Let's test for HPV... and prevent Cervical Cancer* research project.
His other roles include primary care implementation of National Bowel Screening Programme, and several national lead roles for tobacco, alcohol and early pregnancy care.

The data collected also showed:

- 41.7% increase in kit requests in May 2023 compared to January–April 2023;
- 78% increase in kit requests comparing May 2023 with May 2022;
- All ethnicities had an increased kit request rate;
- Māori kit requests increased by 37%;
- Kit request increase varied by region from zero to over 100%;
- Fewer kits requests were declined as ineligible for Māori and Pacific Peoples;
- Kit return rates are around 20%;
- Kits sent/returned per 10,000 eligible people by ethnicity are highest for Māori and Pacific peoples;
- Very low-cost access practices requested more kits for Māori and Pacific peoples;
- Kit request rates remain high for the months after the campaign.

This bowel screening primary care focus will be repeated in May 2024 and will provide an opportunity to gather more information on reminder systems (what are the issues affecting their use, and who in the practices is using them?) and on the value of demonstration kits (does demonstrating what is included in the kit increase kit completion?). A further focus will be on how to increase the return rate (does a follow-up call from the practice boost kit completion?). The lead-up to the campaign will be supported by educational activities in primary care, starting with a promotional stand at the Goodfellow Symposium in March.

A full report on the campaign is available **here**. Practices wanting to take part in the bowel screening primary care focus in May 2024 can email **bowelscreening@health.govt.nz** and ask to go on the list to be sent further information.

“The lead-up to the campaign will be supported by educational activities in primary care.

Benefits of digital CBT

Prevention and treatment of antenatal depression

Anna Elders

A clinical lead at Just a Thought

Perinatal mental health distress is now commonly identified as a significant risk factor in a child's neurobiological and cognitive development. One perhaps less known statistic is the higher rate of mental health distress experienced by women during the antenatal period compared to the postnatal period.

Identifying antenatal distress

Providing intervention and support for mothers experiencing antenatal distress is vital. Antenatal distress not only increases the risk of postnatal mental health challenges but has also been found to predict higher levels of early maternal parenting stress. In terms of impacts on the child, research indicates antenatal distress, even at subclinical levels, can negatively impact future academic outcomes, self-regulation and general level of wellbeing across their lifetime.

The window of opportunity for primary care to help shift the future trajectory for mothers, their children and wider whānau is immense. Perinatal mental health screening, when done well from conception with regular repeat screenings, can assist in identifying mothers at higher risk and those experiencing mental health distress at an early stage. Given the tragic rates of maternal suicide in New Zealand, perinatal mental health screening should be an essential suicide prevention measure, particularly due to the help-seeking challenges that women often experience.

Treating antenatal distress

In terms of treatment, cognitive behavioural therapy (CBT) continues to be the first-line and most evidence-based intervention for perinatal anxiety and depression – with or without medication, depending on the level of severity. The dose of CBT and level of specialist delivery matters and can be challenging due to lengthy wait times and regional workforce issues. There is now a significant number of our workforce in primary care, delivering elements of 'CBT treatment', particularly as a brief psychological intervention. At times, however, key elements of CBT may be diluted or get left out due to the range of activities and changing scopes of our therapist workforce in the primary care space.

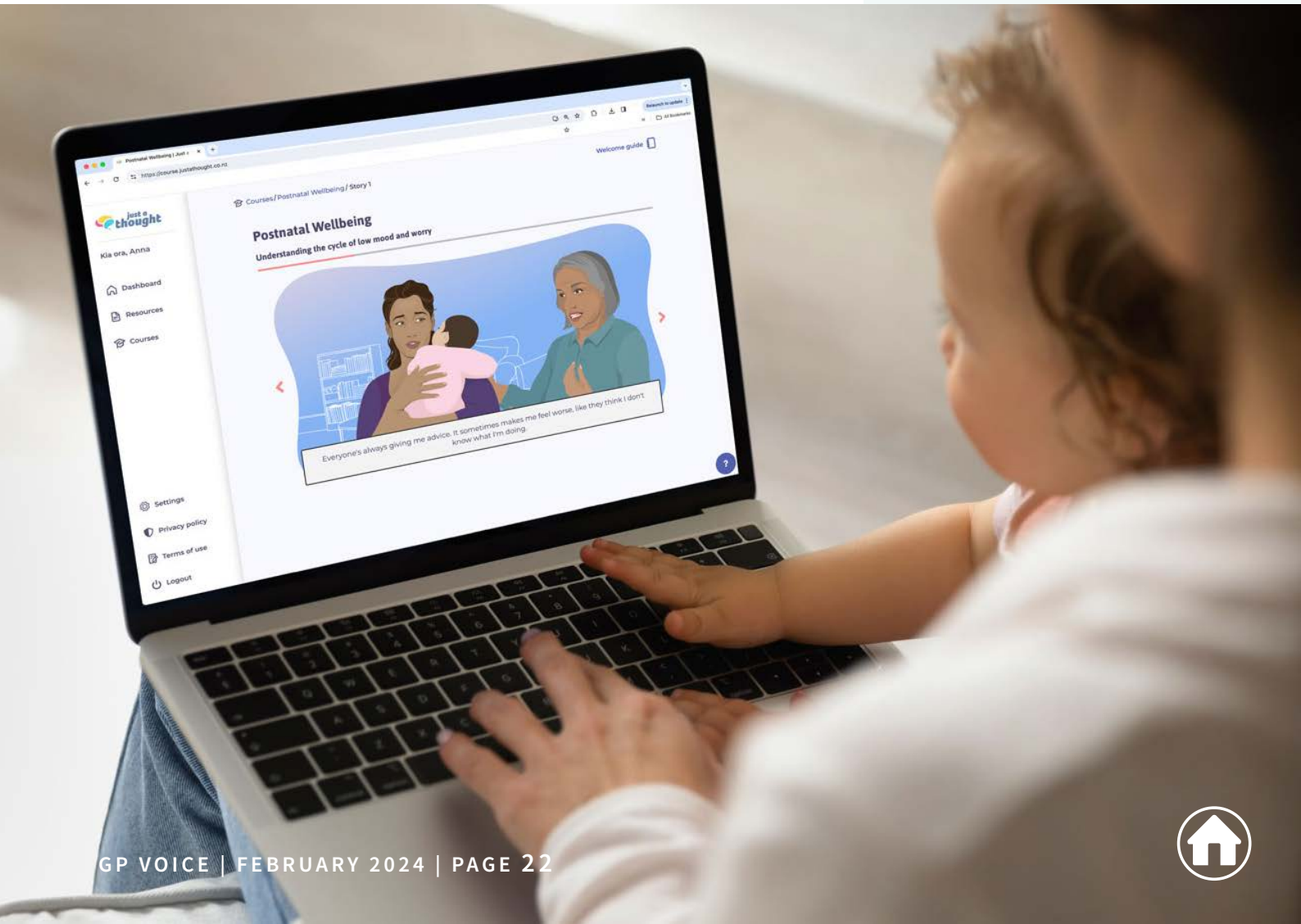
Anna Elders is an honorary teaching fellow at the University of Auckland, primary mental health clinical services lead for Poutiri Wellness Centre in the Bay of Plenty and clinical lead for online mental health platform, Just a Thought.

Educating expecting mothers

A major innovation that will significantly enhance access to CBT is the recently launched Just a Thought **Pregnancy Wellbeing and Postnatal Wellbeing courses**. The courses provide free, immediately accessible specialist CBT delivered via a digital course for women experiencing perinatal anxiety and depression. Both courses, alongside a range of other specialist courses for insomnia, social anxiety, OCD and more, are available to prescribe for patients on the **Just a Thought** website, and through the Specialists and Referrals link in Medtech in the near future.

Given the significant window of opportunity offered to primary care, let's work together to identify antenatal distress in women and deliver more effective, timely interventions to protect the wellbeing of the whole whānau into the future.

> "In terms of treatment, cognitive behavioural therapy (CBT) continues to be the first-line and most evidence-based intervention for perinatal anxiety and depression.



New name, same expert service

Family Planning becomes Sexual Wellbeing Aotearoa

Jackie Edmond

Chief Executive of Sexual Wellbeing Aotearoa

Family Planning New Zealand has been helping people access contraception, STI tests, fertility advice and abortion care for decades. This month, we changed our name to Sexual Wellbeing Aotearoa. Although our core service and the nationwide need for equity, access and choice hasn't changed – the name change represents quite a shift in how we put ourselves out there and what we're saying to people who need the services we offer.

While we have come a long way as a country since our "Sex Hygiene and Birth Regulation Society" days in the early 1930s, there is still a lot of work to be done in normalising important conversations around sexual wellbeing. Sexual and reproductive health is often approached as taboo and many people are unable to have an easy relationship with it or even talk about it openly. It seems crazy to say that in 2024, but it's the way it is. Changing our name is part of elevating that conversation. Changing our name means approaching that taboo with honesty and getting away from the euphemism, to just say what we mean.

We think this is especially key for rangatahi and in the age of the internet. The internet is causing as much or even more harm in a health context than it is a genuine source of quality information. Mis- and disinformation can be incredibly damaging, whether it keeps people from seeking expert, professional help, or has them undertaking dangerous home remedies, misunderstanding consent, or further spreading myths and half-truths. The way we beat that is by making organisations like Sexual Wellbeing Aotearoa a place they can come to and feel safe, no matter who they are, no matter what they know or don't know, no matter where they are on their journey.

We'll continue to provide our clinical services across Aotearoa New Zealand, where our clinical offerings include contraceptive care and advice, including long-acting reversible contraception, emergency contraception, STI testing and treatment, cervical and HPV screening, some gynaecological services, and advice related to menstruation and menopause, vaccinations, fertility advice and planning, pregnancy testing, and abortion services. We are one of the critical components of primary health care in Aotearoa New Zealand working alongside our colleagues in general practice to deliver sexual and reproductive health services.

Sexual Wellbeing Aotearoa is proud of our clinics and the service we deliver in communities, and we're delighted to have the opportunity to share this next stage of our evolution with the wider medical community. It is crucial that we continue to work together to ensure that Aotearoa's primary health care system can deliver equitable and accessible heath care services.

> "The name change represents quite a shift in how we put ourselves out there and what we're saying to people who need the services we offer.

Sexual Wellbeing Aotearoa

Who's ready for some hope?

Lessons from a quest to help my patients and our planet

Dr Meghan Davis

Canadian GP, Assistant Clinical Professor at McMaster University

You don't need me to tell you that the job of a general practitioner is getting harder. What you may appreciate hearing is that there's something you can do that might keep burnout at bay.

I've been a family doc in a high-needs area of Canada for a quarter century. Over the past five years, I've discovered there are practical, evidence-based steps I can take to improve my patients' health and help me address what I believe is the most important issue facing humanity today: climate change. This realization has transformed how I practise, how I feel about being a physician, and how I live my life. I'm hoping my story will inspire a similar transformation for you.

The beginning

The seeds were planted in a church basement in 2019, at a climate change presentation given by a well-respected environmental lawyer. Her words inspired me to take action. As I learned more about the subject, I knew that it made sense to start where I could have the greatest impact – at work.

But overwhelm was only a Google search away. Climate change touches everything. So does primary care. Then I learned that the biggest opportunity to reduce primary care's climate impact was in the care we provide, not our site emissions. The proverbial light bulb turned on. Low-carbon care is high-quality care. Addressing climate change within our clinical choices will also improve patient health.

In the end, I focused on a few areas, including prescribing habits, plant-rich eating, respiratory care and disease prevention. I tested each of the changes in my own practice to make sure they were practical and that patients and members of our health care team were receptive. Then we created tools, patient resources and professional education so we could share these changes widely.

Dr Meghan Davis is a GP in Hamilton, Ontario Canada, and an Assistant Clinical Professor in the Department of Family Medicine at McMaster University. She is the founder and project lead of the Hamilton Family Health Team's Green Initiative, and a frequent visitor to Aotearoa. In collaboration with the RNZCGP, she enjoys connecting Canada and New Zealand within her goal to find opportunities and share tools to enable us all to provide high-quality primary care that is also low-carbon care.

What's different now?

I had no idea when I started this project that it would be so transformational. First, I'm a better doctor. With high-quality, low-carbon care as the lens through which I look at my work, I'm able to include the quality improvement aspects of my job that can get lost in the frenzy of a typical clinic day. For example, I talk to at least one patient every day about the **many health benefits of eating a plant-rich diet**. I have regular conversations with patients about whether they want to stay on their **SSRIs and SNRIs**. Before renewing puffers for asthma, I check if the patient has had **confirmatory testing and follows evidence-based puffer choices**. I more carefully review **medication lists** to see if they're all still indicated, especially for my older patients. I use shared decision-making tools before starting **statins** and **bone density medication**. I have a renewed focus on **prevention**. And the list goes on.

This work can change you. My friendships and family connections are deeper, and I choose experiences over stuff. I eat a plant-rich diet, I have two vegetable gardens – one for me to get my hands dirty in and the other for neighbourhood kids to plant. I've changed how I heat my home. I grow native plants, I bike everywhere. When my beloved mother died, I chose to have her buried naturally, in a field of purple and pink wildflowers.

I'm no saint: I still fly from Canada to visit my daughter in Wellington and eat my friend's famous BBQ ribs. But making these personal and professional changes has been very meaningful. Joyful, even. They've become a powerful antidote to climate despair and professional burnout.

So… find your reason to take action. Maybe it's better patient care or strengthening your team relationships. Perhaps it's equity, diversity and inclusion – after all, climate change affects marginalised populations more than people with privilege. You may want to be a positive role model for your children, particularly if they're feeling scared about the future. Your motivation might even be economics, since some of the actions will save your clinic money. Maybe, like me, you believe Margaret Mead when she said that a small group of thoughtful, concerned citizens is the only thing that's ever changed the world.

Visit our **project's website** for practical ideas, including pre-recorded how-to webinars, evidence-based guides, posters and more. Our latest webinar on **green prescribing**, with New Zealand physician Dr Dee Mangin, was well attended by Kiwi GPs. Dee and I also co-presented at GP23. Read the College's **Greening General Practice Guide**. Join **OraTaiao**, the New Zealand Climate and Health Council, and take one or two small steps. Tell others what you're doing and watch your feelings about medicine – and maybe even your life – change for the better.

“Making these personal and professional changes has been very meaningful. Joyful, even. They've become a powerful antidote to climate despair and professional burnout.

Is burnout inevitable?

Wellbeing and personal strategies to prevent burnout

Dr Samantha King

GP, Medicolegal Consultant for the Medical Protection Society

The pressures in primary care are at an all-time high and morale is low. Even for the most resilient, we all have a breaking point. Burnout is real and impacts doctors at a higher rate than the general population. Not only do we need to recognise it in ourselves and others, but we also need to take steps to build resilience in order to thrive.

What is burnout?

"Burnout *occurs when passionate, committed people become deeply disillusioned with a job or career from which they have previously derived much of their identity and meaning. It comes as the things that inspire passion and enthusiasm are stripped away, and tedious or unpleasant things crowd in."* Burnout is a measurable analysis of stress, including assessing your energy levels, sense of satisfaction from your job, and any increase in cynicism. (reference Maslach Burnout Inventory Triad).

The likelihood of experiencing burnout

The College surveyed its members in 2020, with 31% rating themselves as high on the burnout scale. MPS conducted a survey of New Zealand members in 2019. Of the 300 respondents, 41% had considered leaving the profession for reasons of personal wellbeing, and 35% suspected that emotional exhaustion had contributed to an irreversible clinical error.

Steps to avoid burnout

1. Take regular brief breaks during the day

When we are HALTED (hungry, angry, late, tired, energy-depleted, or distracted) we never perform at our best. Taking even brief time out to stretch your legs, drink some water, look out the window between patients aids recovery and improves performance.

2. Develop positive habits

We all have habits. Some aren't serving us well. A 2° course change for a boat won't make a difference if crossing the Cook Straight, but it would if you were heading to South America. Forming a series of small but easily achievable positive habits can make a big difference over the years. It might be exercising regularly or practising gratitude.

Dr Samantha King is a graduate of Otago Medical School. She is a Fellow of The Royal New Zealand College of General Practitioners, holds a Diploma of Obstetrics and Gynaecology and a Masters in Healthcare Law and Ethics. She works full-time as a Medicolegal Consultant whilst working part-time as a South Auckland GP. Sam regularly presents at workshops, conferences and practices throughout New Zealand.

3. Be kind to yourself

Many of us are perfectionists, with unrealistic expectations of ourselves and others. Judging your day-to-day efforts through a filter of negativity will create distress. When we fail to meet our expectations, we often beat ourselves up and feel a sense of shame. Nobody is perfect. There are ways to overcome perfectionism: 1) learn to be kind to yourself by practising self-compassion; 2) outside of work, consider doing something creative; 3) follow the 80:20 rule – we achieve roughly 80% of our output with 20% of our input, and achieving the last 20% output requires another 80% input. Answer the questions: When is 80% enough? What 20% of your job gives you 80% of your enjoyment and can you do more of this?

4. Build your optimism

Wherever you sit on the optimism-pessimism spectrum, optimism can be learned by changing your internal dialogue. Let's say you received a complaint that a patient had a perforated uterus following Mirena insertion. Your beliefs about the situation impact your reaction. You may believe that you are a very poor proceduralist and therefore should stop all procedures. If you challenge your beliefs – it was an excessively busy session, your partner had just been in a car accident, it was a very difficult insertion – you realise that you aren't a bad proceduralist and feel more optimistic.

Let go of these explanatory styles:

- **permanent** (I'm never going to be skilled at procedures);
- **pervasive** (I am bad at all procedures);
- and **personal** (it's entirely my fault).

Raise your optimism by changing to these explanatory styles:

- **transient** (I'm going to improve my skill level),
- **specific** (it's only Mirena's that I have trouble with), and
- **external** (it was excessively busy that day, the patient had difficult anatomy) also raises your optimism.

Having a positive mindset to stress (it is a challenge that I rise to and not a threat I have to run from) can reduce stress-related symptoms by 23%.

> "Not only do we need to recognise it in ourselves and others, but we also need to take steps to build resilience in order to thrive.

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