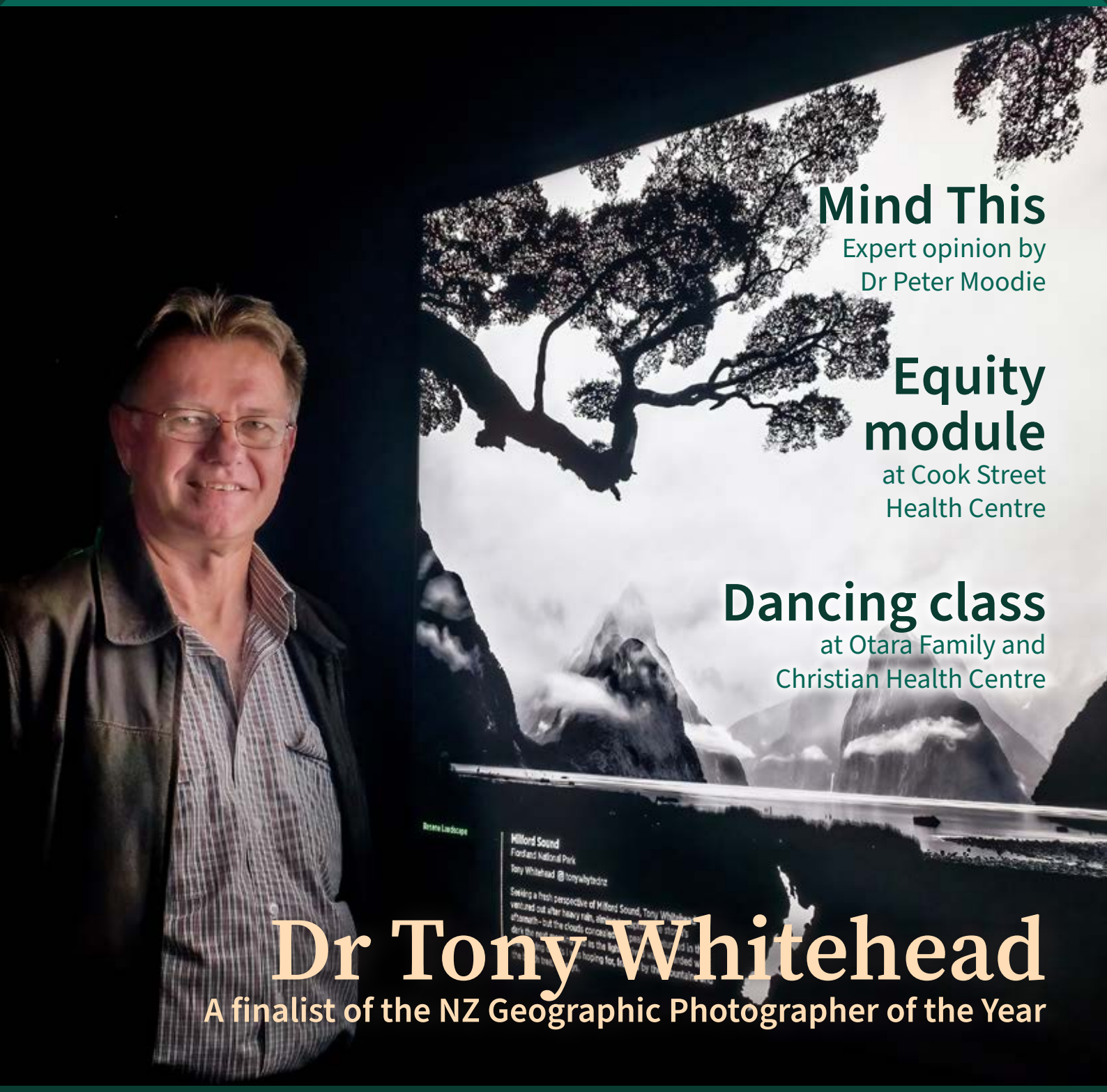
GP Voice

YOUR NEWS, YOUR VIEWS, YOUR VOICES



Mind This
Expert opinion by Dr Peter Moodie

Equity module
at Cook Street Health Centre

Dancing class
at Otara Family and Christian Health Centre

Dr Tony Whitehead
A finalist of the NZ Geographic Photographer of the Year

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

January 2024

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Editorial

Dr Samantha Murton

Dr Samantha Murton
President | Te Tumu Whakarae

Tēnā koutou

Happy New Year to you all. I hope those who were able to take some time over the holiday period managed to relax and spend time with family and loved ones. I hope those who worked through, especially those in our most popular holiday spots, can take an opportunity to rest and recharge before we get too far into 2024.

As I think ahead to what this year might have in store for us – three words spring to mind. Changes, challenges and hopefully, collaboration. As we get through this year, we'll hopefully get a better picture as to how these three words will affect us and the work that we do.

Luke and I will be continuing our mission to advocate for our specialist workforce and making sure our voices are heard, as we highlight the challenges and offer practical solutions to how we can address them. As well as the Minister, we are in regular contact with many organisations and individuals across the health sector through the various committees and groups that we sit on. This is incredibly useful as not only do we get to speak about our workforce, but we also get to hear first-hand how others are doing.

Within the College, as you would have read from our message sent out earlier this month, next Wednesday, 31 January, marks the last day in the office for College CEO Lynne Hayman, who has stepped down after almost five years in the role. I'd also like to take the opportunity to, on behalf of the Board, thank Lynne for her mahi and her commitment to the role over this time.

Recruitment to fill the CE role is under way and I'll be sure to keep you all updated. In the meantime, the Board and I will be on hand to provide any necessary advice and support.

To end, I'd like to welcome the 234 registrars who are starting in GPEP year 1 next Monday, 29 January. This intake is the highest on record and we are so happy to have this group become part of the next generation of our workforce who are deeply committed to improving the outcomes of communities right across Aotearoa.

I'm looking forward to what 2024 has in store and I look forward to connecting with as many of you as possible throughout the year.

50 years of the College

Celebrating our golden anniversary 1973–2023

While the College celebrates its 50th year, throughout December and January we were collecting memories and accounts from members in the form of submissions to our Summer Memoir contest. All members were invited to participate and to share their experiences – both struggles and achievements – that have links with the College and its 50 years of transformation.

Warm thanks to those who used the holiday season to reflect on their professional journeys through the medium of creative writing. We appreciate all the submissions you sent to us, including essays, short stories, poems and songs.

The best submissions will be announced next month and published in the February issue of *GP Voice*. The winners will receive a copy of Dr Glennis Mafi's memoir titled *I'm Ralph, I'm Dad*. Read more about the book in the previous issue of *GP Voice*.

Apply for funding

for research that benefits general practice

The College has been funding 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 will open 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 into the *Journal of Primary Health Care* and submit an abstract to present at the annual College conference GP24. To get in contact, email REC.

Briefing to the incoming Minister of Health

Simone White

Senior Communications Advisor, RNZCGP

The College has sent a **briefing** to the new health minister, Hon. Dr Shane Reti, highlighting the current issues facing general practice and primary care. The document identifies the five top priority areas that need immediate focus if we are to have a sustainable workforce in the future. They are:

1. Addressing the workforce crisis
2. Health equity
3. Sustainable funding of general practice
4. Valuing Fellowship
5. Supporting quality training.

Along with this briefing, the College was also one of 12 primary care organisations that worked together to develop a **joint briefing paper** for the Minister to highlight the urgent need for pay parity for our primary care nurses and health care workers.

Glossary of relevant terms

Specific interest: A defined area within the vocational scope of general practice or rural hospital medicine in which a member may have a particular interest. May include additional skills, knowledge and training, but this is not required.

Extended skills: A defined area within the scope of general practice or rural hospital medicine in which a Fellow demonstrates and is recognised for knowledge and skills beyond that required for Fellowship but applied within the context of their vocational scope. Additional qualifications may be required.

Advanced competency: An area of special interest approved by the MCNZ. Currently applies to cosmetic medicine within the vocational scope of general practice. Requires completion of a specific qualification.

Credentialling: Formal recognition by a pre-determined process, that a Fellow's knowledge, skills and/or qualifications meet the set standard for extended skills in a defined area of practice within their vocational scope.

Policy, Advocacy and Insights

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

Exploring specific interests and skills within general practice

Several times in the College history, work has been undertaken to explore possible mechanisms for members who have particular interest, skills and knowledge in a domain of practice to connect with others, continue to develop skills and be recognised for their expertise.

A complex topic

If it was simple, we would have a system in place to support members with specific skills and interests, but the complex nature of the issue has made it challenging for the College to progress.

Adding to the complexity is the range of nomenclature across different places and times. In the UK, General Practitioners with Special Interests (GPwSIs) became General Practitioners with Extended Roles (GPwERs). In Australia GPs can join specific interest groups and our own College history includes terms such as advanced competency and areas of supplementary training and competence. Underpinning some of the models are other terms including accreditation, certification and recognition.

The College is now building on previous work to find a way forward with language and clear definitions appropriate to the Aotearoa New Zealand context. We currently use the terms 'specific interests' and 'extended skills,' however, those terms are not yet confirmed and may change as the mahi develops (see the glossary).

Many voices have contributed to this mahi

We have proactively gathered information from a variety of stakeholders. RACGP and RCGP have shared information regarding their models. We continue to explore whether international models could be adapted for use within New Zealand regulatory requirements.

Your voice as members is crucial to the development of this work. The National Advisory Council have contributed their advice, as have many other members through a variety of means. All perspectives will be considered alongside the results of our ongoing research to inform our decision-making.

"We continue to explore whether international models could be adapted for use within New Zealand regulatory requirements.

Key considerations

The way forward requires careful consideration of factors including:

1. Regulatory

The vocational scopes for general practice and rural hospital medicine are described in secondary legislation as required by the Health Practitioners Assurance Act 2003. The model we adopt must be consistent with the generalist nature of these vocational scopes.

2. Future focus

To ensure we have a model that is adaptable and sustainable to withstand changes in the health system, we are working towards the development of a principles-based approach.

3. Sustainability

We must continue to fulfil College obligations to deliver vocational training and manage CPD to meet requirements of the Medical Council of New Zealand (MCNZ) accreditation. We aim to develop, implement and maintain a suitable model without impacting the cost of College membership.

4. Member benefits

Members have expressed a desire for a model that provides them with options for further development in their career pathways.

Questions

Other questions that we must consider include:

- What is the potential for achieving equity?
- If credentialling is to be implemented, what are the risks and practicalities of initial assessment and ongoing assurance of proficiency?
- If Fellows with specific interests or extended skills take on more work that has traditionally been delivered through secondary care, what are the possible impacts?

Moving forward

This workpiece is supported by the Academic Tāhuhu in response to member feedback. Once all feedback is collated, the Academic Tāhuhu will review and make a recommendation to the College Board in 2024.

We look forward to providing you with more information as we progress.

> “Your voice as members is crucial to the development of this work.

Coroner's findings

The coroner has shared with the College two recent findings regarding suicide and the use of medications. Medical Director Dr Luke Bradford has summarised the findings and highlighted relevant points for GPs to take into consideration during consultations.

Dr Luke Bradford
Medical Director | Mātanga Hauora

The first finding

It is a case of the suicide of an 85-year-old retired builder. It was reported to the coroner over six years ago in October 2017. The patient, Mr F, was in chronic respiratory failure and had at least one cerebral bleed following a fall. In the year of his death, he had been admitted to hospital nine times and his regular medicines included morphine and midazolam.

In August 2017 he was prescribed 300 mL of morphine (strength not stated) by his GP with instructions to take 5–10 mL four- to six-hourly as needed. On top of that the hospital gave him a 100 mL bottle of morphine (strength not stated) to be used at a dosage of 2 to 2.5 mL every 30 minutes as required.

The same month, Mrs F called an ambulance as she thought Mr F may have had a stroke but it became likely that he had taken an overdose of morphine. Mrs F agreed to control the dosage and store the medications safely.

The family reported that although he had been in relatively good health for most of his life Mr F's mood deteriorated over the two years before his death, possibly exacerbated by the fall that caused the cerebral bleed. Over that time Mr F expressed a wish to die on more than one occasion and in September, he asked for a family conference to consider assisted dying help. The family, however, refused to consider it.

On 5 October 2017 Mr F became acutely and increasingly short of breath and was admitted to hospital where he was diagnosed with morphine overdosage. He subsequently admitted to his wife and to a nurse that he had deliberately taken an overdose. He died some days later of multi-organ failure.

Learnings

The coroner referred the case to the College to highlight his view that medicines should be kept in a safe place and in the case of opioids, in a secure lockbox or safe. In fact, the references that the coroner quotes in support of his recommendations relate to preventing accidental ingestion by children rather than suicidal intents. In this case it's likely that the 400 mL (300 mL and 100 mL) of morphine that Mr F had been given in August would have been largely used up with his regular use of the medication. Further, the other bottle (likely the 100 mL one) was kept by his bedside in case he needed it during the night.

What can we do?

Those who prescribe medicines within a general practice should be advising patients that medicines must always be kept in a safe place to prevent accidental ingestion. We do acknowledge though that guarding against suicidal ideation is a more complicated task.

The second finding

The other recent coroner's finding into the use of sodium nitrate being used in six suicides in New Zealand has been released and raises some points for GPs to take into consideration.

We are aware of the use of sodium nitrate being promoted on several suicide and euthanasia websites, with people being advised to see their GP first to get a prescription for metoclopramide to take alongside it to prevent nausea and vomiting. Four of the six cases did just this.

For GPs, these findings come as a timely reminder to have awareness around patients who specifically request a prescription for metoclopramide, especially patients with a history of mental health disorders, or patients who are known to be going through trauma or having suicidal ideation. These requests should trigger further exploration by the GP.

> "Medicines should be kept in a safe place and in the case of opioids, in a secure lockbox or safe.

Tip from research

that benefits general practice

1

Research published in JAMA Psychiatry by Zhang et al. looked at the link between stimulant medication prescribed for ADHD and risk of Cardiovascular Disease (CVD). The sample consisted of 278,027 people in Sweden, who were diagnosed with and prescribed medication for ADHD for over five years with a median age of 34.6 years. The case control study looked at presence of HTN, arterial disease, CHF, arrhythmias and prolonged QTc in comparison to the general population. The researchers found that longer cumulative duration of stimulant medication was associated with increased risk of CVD, specifically hypertension and arterial disease, noting that the latter may have been induced by the former. There was no increase in the incidence of heart failure, QTc or arrythmias. READ MORE

Whilst we have always been aware of the need to measure BP in this cohort, the findings suggest we need to discuss with patients their individual risks when commencing and continuing medication. We should perhaps employ a lower threshold for managing low-end hypertension earlier in this cohort. Whilst the study was only over 5 years and longer-term outcomes are yet unclear, the increasing diagnosis and medical management of ADHD in adulthood and thus the continued use of stimulants past adolescence means we – as a specialty – need increased awareness of this data and the risks demonstrated.

Behind the scenes of the GPEP Exams

Stefanie Joe

Manager, GPEP1 Delivery, RNZCGP

Felicity Murray

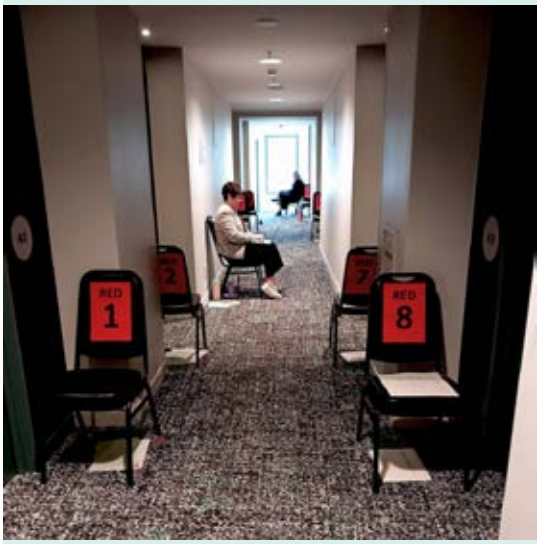
Senior Education Coordinator, RNZCGP

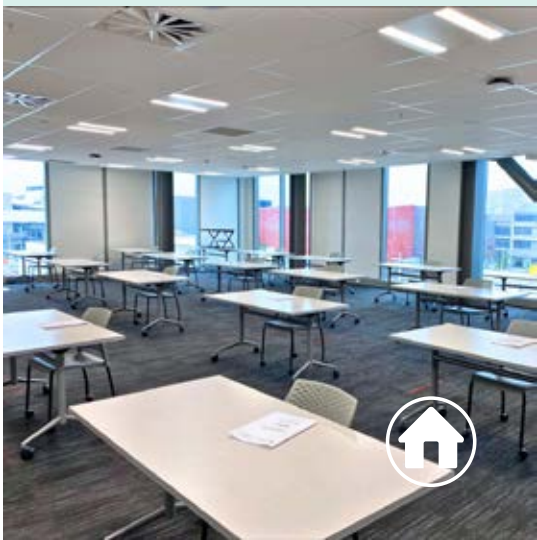
There are significant milestones in a registrar's pathway to becoming a Fellow of the College. Successfully completing the clinical and written examinations is one of them.

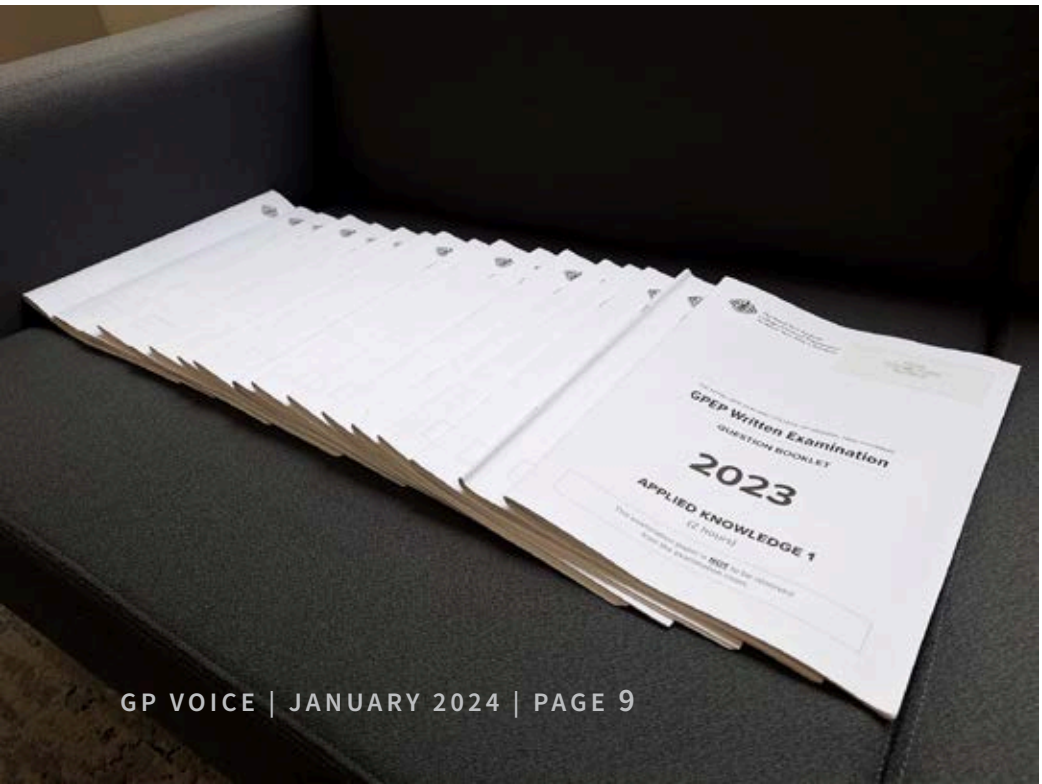
The 2023 clinical exam week was held from 27 November to 2 December at the Rydges Wellington Hotel. This involved 206 registrars sitting the clinical examinations, along with the Chief Clinical Examiner, eight senior examiners, 41 examiners,; 42 actors; and multiple College staff supporting this important stage of the General Practice Education Programme (GPEP).

The written examination was sat by 191 registrars in 12 locations around the country on Wednesday 13 December. Amidst cancelled flights, altered accommodation and late-night deliveries, the College team successfully ran, collected and delivered all examination papers back to the College for processing.

Examination results will be released to all candidates in mid-February. The College is now planning for an increase of 35% in the number of registrars sitting examinations in 2024, up to approximately 280 registrars.







Spotlight on the Rural GPs' Chapter

A rural voice and link within the College

Dr Mark Smith

GP, lecturer at Otago University, Chair of the Chapter

The goal of the Rural General Practitioners' Chapter is to improve the health and wellbeing of rural New Zealanders through the delivery and sustainability of high quality rural general practice. The Chapter endeavours to achieve this by looking after rural GPs and supporting rural GP training in various ways.

In 2022, Hauora Taiwhenua Rural Health Network was established and within it a Rural General Practice Chapter. Although the name of the chapter is similar to that of the College's, it represents the broader General Practice team while the College's Chapter is more specific to General Practitioners and their specialty. Hauora Taiwhenua supports broader rural advocacy work and health issue response, while the College Chapter focuses on rural aspects of training and practice, rural education and CME (including funding). Nevertheless, the two chapters collaborate on some overlapping aspects of rural GP support.

The essence of rural practice

Although rural practice exists within the umbrella of general practice, it is a unique context and area of practice. Practicing in a rural context means reduced access to emergency services, a nearby hospital, specialist outpatient clinics, specialist nurses and community services. In turn, rural medicine can involve a very broad scope of practice particularly in areas of urgent and emergency care, palliative care, provision of procedures and managing complexity without local specialist nurses or services. For these reasons, practising in the rural context requires finding creative solutions to a wide range of problems which keeps the job interesting.

Rural practice usually involves living in countryside among close-knit communities and beautiful parts of the motu. Afterhours care is often required which can be a struggle considering the current workforce and funding pressures. Whilst telehealth options are becoming more available and can contribute positively, they cannot replace a clinician on the ground. Despite these challenges, providing good after-hours services to one's community can be professionally fulfilling.

Overall, while rural practice can be challenging at times, it is that challenge alongside the breadth of practice, the satisfaction, at times excitement of the job and the community connection that attract many to go rural.

Addressing training and equity concerns

In recognition of the breadth and challenges of rural practice, the Chapter has contributed to the College's project of considering a targeted rural GP training pathway. Such education would be optional and offered to those GPEP registrars or fellows who are interested in undertaking training specifically designed to prepare them for practising in the rural context. The project is ongoing and the Chapter continues to support the College's work on this.

The Chapter also seeks to play a role in addressing the health disparities across the motu. While many people are aware of inequities in outcomes for certain ethnicities and socio-economic groups, recent data has shown some poorer outcomes for certain cohorts who live rurally. The Chapter is particularly concerned with the health and wellbeing inequities for rural Māori, which are more dire than urban Māori who – as we know – are worse off than non-Māori across many measures. Various socioeconomic factors, climate change and healthcare access amongst others, are all shown to be inequitably spread across the rurality spectrum and these hit hard in Te Ao Māori especially. The Chapter is active in both advocating on equity issues and looking at what can be done within the College's reach to reduce these inequities for rural New Zealanders and in particular for rural Māori.

Rural legends

The Chapter is proud of some incredible rural doctors who recently received awards during GP23. These include:

- **Dr Verne Smith** (top photo) – recipient of a Community Service Medal for 33 years of dedicated service to inhabitants of Ranfurly, Otago and for hosting medical students and trainee interns, some of whom have chosen to specialise in general practice.
- **Dr Jo Scott-Jones** (middle photo) – recipient of a Distinguished Fellowship for advocating for rural health and being an active member of rural practice advocacy groups , as well as focusing on achieving equity through general practice and addressing wellbeing in the sector.
- **Dr Greville Wood (**bottom photo) – recipient of an Eric Elder Medal awarded to a rural GP, nominated by their peers. Read the interview with him, published in a previous issue of *GP Voice*.
- **Dr Janine Lander** (top photo, previous page) – recipient of the James Reid Award, for a rural medical practitioner or trainee who has demonstrated excellence or innovation related to education or research in rural health.
- **Dr Toby Calvert** (bottom photo, previous page) – recipient of the Dr Amjad Hamid Medal, awarded to the top student of the University of Otago's GENA 728 paper, which is Cardiorespiratory Medicine in Rural Hospitals.

The Chapter is eager to bring together as many rural GPs around the country as possible. Apart from offering connection, collegiality and relevant support, the Chapter provides a link with the College for any queries or issues regarding rural GPs. If you are not yet a member, please consider joining us. For more information visit here or email.

The Auckland Faculty's end-of-year event

On 7 December, the Auckland Faculty held their 2023 GP end-of-year dinner and Christmas quiz. Two hundred Faculty members attended the event and participated in activities. Attendees were asked to form teams of four to nine people, come up with a fun team name and plan a team dress-up theme. The photos prove the Auckland Faculty knows how to have fun!

If you have anything fun going on in your Faculty, make sure to send it through to the *GP Voice* editorial team at **communications@rnzcgp.org.nz**

Above: The Amazing Quiz-Masters and future GPs

Left: Some of the winning team 'No I-Deers'

Below: Best theme teams 'Caroline's Angels' and some of the 'Dead Celebs'

Celebrating the local landscape

The mural at Taupō Health Centre

Simone White

Senior Communications Advisor, RNZCGP

When College President Dr Sam Murton received this photo from Dr Peter Fleischl, she thought it was too lovely to keep to herself. It presents the recently unveiled floor-to-ceiling mural at Taupō Health Centre, which has been gaining a lot of attention since it was installed in the main waiting room at the practice.

The mural was designed and drawn by well-known local artist Donovan Bixley. It depicts the beautiful landscape of Taupō; ngā maunga (the mountains), te awa (the Waikato River) and the meeting house of a local marae at Waipahīhī. Added to the scene are many of New Zealand's unique critters and native birds.

The team at the practice wished to have a local scene that children could recognise and then spend some time finding and identifying all the animals, insects and birds. Practice Manager Caroline Clarke says, "I heard one child point out his dad who was floating down the river and getting too close to Huka Falls."

If your practice has showcased the local landscape or history of your region, we'd love to share it in an upcoming issue of *GP Voice*. You can contact us at communications@rnzcgp.org.nz

Faculty events

Know what's happening where

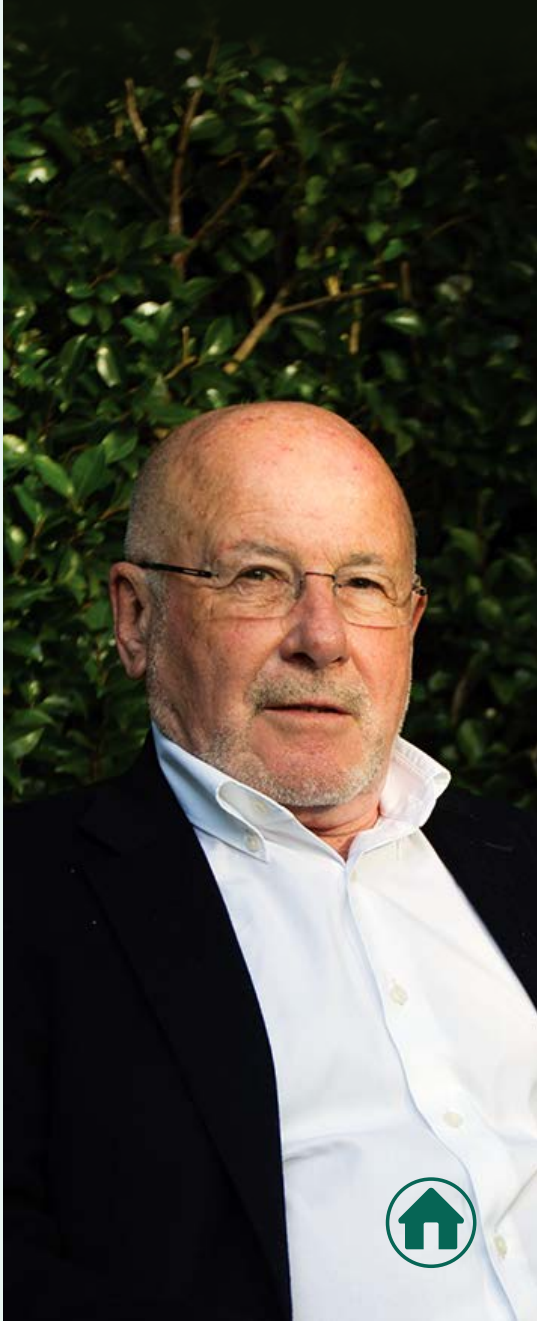
1. **The Auckland Faculty** organises their first and only whānau event of 2024: a walk or run (4km, 10km or 16km) on the coast to coast walkway, from Waitematā to Manukau harbour. Click here to register.
2. **The Wellington Faculty** hosts a morning of exercise and collegiality, moving the body (and mind) for fun on either 5.5 km, 10 km or half marathon distances Round the Bays on Sunday, 18 February 2024. Join the team *Wellington Faculty of GPs* and use the promo code *Faculty50* to register by Sunday, 28 January 2024.
3. **The Otago Faculty** will be holding a mini-conference, a collegial weekend of salty sea breeze, warm sun and scenic wonder at Kaka Point on 8–10 March 2024. Make sure you select the code to get the discount when registering. If you have any questions regarding the conference, please email the faculty.

MIND THIS

HDC: A missed pulmonary embolus

Dr Peter Moodie

Peter Moodie is the College's Clinical Advisor



Urgent presentation

In 2018, a woman in her 60s came to a 24-hour clinic with a painful swollen calf and some shortness of breath on exertion (SOBOE). Ms A had the calf pain for about a month and she had travelled overseas three months previously. She was described as having "generally kept good health". Hypertension had been noted but she was on no medication.

Ms A was seen by Dr D, a "senior medical officer" (qualifications not stated), who diagnosed a DVT and a possible pulmonary embolus (PE). She was started on Clexane, to be followed up with dabigatran. As she had no chest pain and was not short of breath in the clinic, a CTPA was not arranged and she was discharged.

General practice clinic

Three days later she was seen for a follow-up by her regular GP, Dr C, who noted the possibility of a PE but also considered CHF as a possible cause of the SOBOE. She ordered a chest X-ray and a BNP, both of which turned out normal. Although in generally good health, Ms A weighed 90 kilos with a BMI of 37.9 and this could have accounted for some of the SOBOE. Dr C was possibly influenced by Dr D, as she did not order a CTPA, but she continued the dabigatran for another six months.

Five days later, Ms A received the results of her tests. According to the HDC report, there was documentation that she should be considered for a "CT of her lungs". Dr C also stated that "she made a note to consider a CT chest scan". However, the HDC said that this was "inconsistent with her clinical notes" and further identified that she did not refer Ms A for a CTPA (see below).

Following visits

In the following seven months Ms A was seen on three occasions, but not with leg or chest pain. Firstly (some 14 months after her initial consultation,) Ms A presented with symptoms of "acute pain and heaviness in her left leg while walking". Dr C noted the past history of DVT but recorded that there was no shortness of breath. She ordered an ultrasound scan which turned out negative. A D-dimer was raised, but in the face of a negative USS no further treatment was arranged other than to tell her to return if the pain reoccurred.

Secondly (17 months later,) Ms A presented with two nose bleeds and an ear infection. There was no suggestion of SOBOE or pain. Thirdly (20 months later) during the COVID-19 lockdown, Dr E had a phone consultation with Ms A, as she had had three episodes of SOBOE. Dr E was aware of the history of DVT but he didn't perceive the symptoms as consistent with a DVT/PE.

Nevertheless, he ordered bloods, including a D-dimer and BNP along with a chest X-ray. The results revealed that the D-dimer was raised but the differential diagnosis was of CHF or possibly a chronic lung condition. It appears that Dr E, due to the raised D-dimer, ordered more bloods but there was a 19-day delay between his order and the practice contacting Ms A.

Some 11 days after the above consultation with Dr E, Ms A had a phone consult with Dr C, as she was developing serious SOBOE symptoms and she correctly identified a possible diagnosis of PE. Later that same evening, Dr C requested a "chest CT". On the request form, amongst other things she recorded "3/52 dyspnoea, DVT 2018, elevated D-dimer and ??PE".

Two hours later the CT request was declined stating: "CT chest requests must be by a recommendation from a hospital respiratory physician… Search CT chest on Health Pathways". There was also a message quoting the MCNZ requirements that declined requests must be discussed with the patient. Finally, there was an offer for the doctor to resubmit their request.

Dr C misread the report and interpreted the decline of the CT as an indication that the procedure was not required. Moreover, she didn't tell Ms A that the test had been declined. Strangely, there was no further contact with Ms A for another month during which she attended a consultation at Dr C's request. At that consultation, there was no further discussion of a possible PE and spirometry was carried out. Ms A reported that the bronchodilator made her feel better.

"Dr E was aware of the history of DVT but he didn't perceive the symptoms as consistent with a DVT/PE.

Outcomes

A few days after this last consultation, Ms A died suddenly. A postmortem showed both acute pulmonary emboli and evidence of chronic damage. The HDC may make an "adverse comment" or more seriously identify a "breach" of the patient's rights.

Dr D adverse comment:

- Dr D should have recorded the patient's respiratory rate, as well as a Well's and PERC score, along with a RGS. A PERC score might have made him admit Ms A as a suspected PE. It was, however, noted that the correct treatment was instigated and that Ms A was not short of breath.
- If admission had occurred and a CTPA had been performed, Dr C would have been put on a higher alert.

Medical centre adverse comment:

- Although it was acknowledged that the medical centre was under severe resource restraint (it was short of staff and could not recruit), it was criticised for a 19-day delay in actioning the blood request ordered by Dr E.

Dr E adverse comment:

- Following the abnormal D-dimer result, Dr E should have arranged a face-to-face consultation where the possibility of a PE might have been considered.
- Dr E was also criticised for stating that he had done a PERC score, when in fact this would have required a face-to-face consultation.

Dr C breach:

- Dr C was criticised for not following up the possible diagnosis of PE at her first consultation. It was noted, however, that she was on the correct medication for a PE. Curiously, this happened only three days after the consultation with Dr D.
- It was acknowledged that at the 14-month consultation the examination and investigations were adequate, but HealthPathways recommended that if there is continuing concern about a DVT, the investigation should be repeated in five to 10 days.
- During the 20-month phone consultation, there should have been a follow-up face-to-face meeting, preferably by urgent referral to an ED.
- The referral for a CT chest was inappropriate and indeed was the "wrong" request, even if it had been accepted (see below).
- That Dr C didn't follow up the declined referral and did not contact Ms A to explain the situation. Dr C argued that she had interpreted the declined request as a message that the test was unnecessary.
- That Dr C didn't follow up with Ms A for over a month and at that consultation did not discuss the declined imaging request, nor follow up on the diagnosis of PE.

Finally, Te Whatu Ora (TWO) was asked to comment on whether there should be changes to their messaging when declining a request. TWO (via an unnamed source) explained that:

- acute services are not provided by the community radiology service;
- CT chest was the wrong test for Ms A and it should have been a CTPA;
- in the region, a GP-requested imaging for PE is not recommended. Also, CT chest is only available if the request includes (amongst other sub-specialties) "a radiologist report advising CT chest";
- the community radiology service is not a clinical advisory service.

> "When a complaint arises, there will be an almost forensic review of the case notes, which at times seems to mitigate against a more holistic approach.

Take-home lesson

This is a long review but it does highlight some important issues:

1. When a complaint arises, there will be an almost forensic review of the case notes, which at times seems to mitigate against a more holistic approach.

2. There were two occasions where this tragedy could have been averted: (1) at the first consultation, if Dr D had ordered a CTPA and (2) if there had been better communication with Dr C by the imaging service. Indeed, why is this *not* a source of clinical advice?

3. The suggestion by the TWO's spokesperson that Dr C asked for the wrong test is simply incorrect. Dr C asked for a CT and raised the possibility that this was to exclude a PE. The only difference between a CT chest and a CTPA is the timing of the contrast injection and providing that the radiologist saw the words "PE", they would know what was being ordered. This raises the question as to whether it was a radiologist who triaged the request.

4. Although the HDC identified resource constraint in the practice as a mitigating factor, resource within TWO is accepted as a given.

Finally, the HDC dating system creates the impression that this patient was suffering from a chronic complaint over nearly two years; however, following the initial presentation there was some 14-month gap before the second event occurred. The third event occurred three months after that.

"Although the HDC identified resource constraint in the practice as a mitigating factor, resource within TWO is accepted as a given.

Have an opinion?

Make your voice heard

Join the conversation and leave a comment under **MIND THIS** posts:

@RNZCGP

Views on Your Work Counts

The College's Your Work Counts project team was collecting data from members over two weeks, from 20 November to 3 December 2023, 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 patients each region and the country needs.

Participants were asked to track their work by recording five types of tasks they were involved in, such as: consultations, non-contact clinical time, training and education, clinical governance and practice improvement and running the organisation.

While the data is being calculated and analysed to measure the gap between what GPs actually do and what they are funded to do, here is some of the feedback the project team received from participants:

"I feel that many GPs are putting the extra hours in to support their patients without the government really realising this, so I was pleased to be able to take part in this study."

"An interesting exercise – one thing that was not noted and I have done work on this myself, is how much of my work is funded and how much is not funded. I recently had 124 patient contacts in a day and only 34 of these had funding attached, e.g. consultation, script, insurance request. The rest were unfunded but still necessary for the care of my enrolled patients. This is untenable in the long term. I understand that this is not the remit of this diary, but I think that as general practice becomes squeezed and increasing numbers leave the profession, whether for other shores or through retirement, it will be important to ensure those that remain are properly remunerated."

"Surprisingly, it has been quite illuminating and affirming - I'm tempted to think that I'm too slow, or not very efficient, but I realise that our job is actually quite intense and requires a whole range of different skills, all of which can sap your energy and cause stress."

"I have to work every evening and weekend to keep up with the results, letters, prescriptions, questions and running of the Surgery. I am increasingly concerned that I will miss something and end up with a complaint or an HDC investigation. I have less and less time for continuing education, peer group and family."

"The end of day "battery" idea is brilliant because again it reflected what sort of workday it was – mainly what type of patients have been seen that day and made me more aware of my mood before I get home and let loose on my family, who bear the brunt of our poor awareness of the personal toll of each day."

"There are so many issues in primary care and it feels like no one is listening. So thank you for at least looking at our work load. But there are so many other issues, and it's hard to know who to contact about them. Would be great if we could have a survey about all the other problems we encounter. Thanks :)"

"It will help change the way we view ourselves and our work and that is the first step to negotiating effective change. I would like general practice to continue to be the cornerstone of the health care in New Zealand – for my whānau and community."

College Medical Director Dr Luke Bradford and Principal Policy Advisor Tom Broadhead have been leading the project. We will be updating you regularly on the progress of **Your Work Counts**, so stay tuned!

Interview with Dr Tony Whitehead

Meet a finalist of the New Zealand Geographic Photographer of the Year

Tell us a bit about yourself, where you come from and what drew you to New Zealand?

I was born in South Africa where I spent the first 29 years of my life. I studied medicine in Cape Town and planned on working in the UK to fund a trip to New Zealand to fly-fish for trout, when a friend of mine from medical school advertised an assistant position in New Zealand. I offered to come for six months, he suggested a year, so I stayed longer. It's been 35 years now.

All this time I have been working at the same general practice in Kawerau, Bay of Plenty. Before New Zealand, I intended to specialise as an ophthalmologist and I had a registrar job to return to in South Africa. But after coming here, my wife and I realised it was a safe place to have children, so I decided to pursue rural general practice instead, completing my FRNZCGP in 1995. I feel it was the best decision I could have made.

What are some of the features of practising medicine in Aotearoa New Zealand that have surprised you and why?

I practised hospital medicine in South Africa, predominantly surgery and anaesthetics so cannot directly compare it with general practice in New Zealand. A significant part of my work was in trauma surgery, so after coming to New Zealand, I noticed a big difference with no massive levels of trauma to deal with. Instead of being up all night, operating on victims of stab wounds or gunshot wounds, there was none of that trauma.

As a surgical registrar one of my highlights as a junior doctor was skin surgery. I was lucky to have, as a house surgeon and as a registrar, a plastic surgery list every week so gained skills in facial excisions, flaps and grafts. I keep doing a lot of minor skin surgery for my patients in general practice in New Zealand, particularly skin cancer surgery. I now work two days a week in general practice and since 2007 one or two days in the practice for Hauora a Toi Bay of Plenty (BOPDHB) managing skin cancer cases referred by colleagues. I really enjoy it, but the variety in general practice is always intriguing and I like problem solving. Due to my reputation for skin work a lot of my of my general practice is now skin-related. General practice also allows the opportunity to expand your skills in area of interest. I completed a Diploma in Sports Medicine and have found that knowledge very useful for managing injuries of all types.

What I really enjoy about New Zealand rural medicine is the people. Small town people are just fantastic and the team I work with is amazing. My patients are

> "What I really enjoy about New Zealand rural medicine is the people.

very down to earth, they generally don't have unrealistic demands and are grateful for what we can do for them. I really love working with them. As a rural general practitioner, I now look after children and grandchildren of patients that were under my care when I first started.

How do you manage work-life balance, considering your passion for photography?

Photography and riding my bicycle are my work–life balance. Photography is a good distraction from the challenging work, because I've always thought it's important to have a creative outlet in life. Another essential is exercise while riding my bicycle. I live in Rotorua, very close to the forest where I ride mountain bike tracks regularly. Spending time in nature gives me time to clear my mind.

How did your adventure with photography begin?

My father was a very keen photographer and I grew up in a house where photos were taken all the time. I was the first child, so there was always a camera pointed at me. When I became old enough, I got a camera and began photographing. Seeing prints materialise while being developed was addictive, as was the entire image making process.

I was about twelve when I got my first camera and it's been a big part of my life ever since. Just as I followed in my father's footsteps, my daughter has followed in mine: photography is a genetic illness that passes down the generations in my family. Birds and photography are a bit of an obsession.

Tell us about your achievements in photography.

I was a finalist in the New Zealand Geographic Photographer of the Year four times: in 2016, 2017, 2022 and 2023. It's a bit strange because I don't see photography as a competitive sport. My daughter entered some competitions at a young age and has done very well, so we enter some comeptitions together, relying on each other's opinions when trying to select images to enter. We have twice been finalists together and the first time was a real surprise. It's always very exciting and more fun than if only one of us succeeds. I think we are the only father/daughter pair to have been finalists together.

We both had images in a wildlife photography exhibition in Auckland last year. Exhibiting is a time-intensive thing with a lot of cost associated and I don't have a lot of spare time. My photography is a very selfish pastime. It's something to keep myself sane. If people like my images, that's great, but I do it for myself, not for recognition. It's purely something creative that I enjoy.

Probably my most satisfying competition achievement was having two images recognised in the Bird Photographer of the Year competition in 2023. Bird photography is my passion and birds in flight is my real addiction so to have an image as only one of six chosen in this category in an international competiton and selected for the touring exhibition was very exciting.

I sold quite a few prints last year to a government department that was redecorating their offices, but there is a lot of work involved in making large

> "Photography is a good distraction from the challenging work, because I've always thought it's important to have a creative outlet in life.

prints and shipping them. I often supply images as donations or at discounted rates for conservation organisations for educational purposes. I have had a number of images used in books and usually supply them in exchange for a copy of the book as they are usually books that interest me.

Do you teach photography or share your passion with others in some other way?

In 2022 my daughter and I were offered an opportunity to run **wildlife photography workshops** in Otago. We've got one scheduled in May and another in October. They last four days cover bird and wildlife photography, from capture to print. Apart from photographing sea lions and rare bird species, the workshops include a boat charter around the Otago Peninsula and a visit to the Orokonui Ecosanctuary, with another highlight being a stay and dinner at the famous Larnach Castle. In October this Masterclass will be followed by a Catlins **wildlife photo tour**. It's a great opportunity to breathe out the stress.

I have published a **weekly blog** on matters photographic for the past 10 years. It initially took a bit of discipline but it is now part of my weekly routine. I look forward to a piece of time for photography, writing and reflection. I regularly share recent work on **Instagram** and **Facebook**.

What's the relationship between general practice and wildlife photography? Do they influence one another?

Wildlife photography helps me stay sane. I'm an introvert, dealing with people costs me a lot of energy and spending time in nature gives it back. General practice and wildlife photography balance each other out. The challenges of general practice shorten my life and photography time extends my life, hopefully it all balances out and I can achieve a normal lifespan.

> "Work is hard, photography is important, but time to spend with my wife is vital.

Growing up, I was always interested in nature, birds in particular, so biology was the one subject I loved in school. As a result, I studied human biology, medicine and got top marks in zoology which caught my special interest. I'm proud to say that my daughter became a zoologist and ornithologist and I'm lucky to have two lives through her.

Apart from wildlife, my wife is the reason for my life. We met at medical school and without her support I wouldn't be here. Work is hard, photography is important, but time to spend with my wife is vital. Demands of work are limitless so a good work–life balance should be prioritised.

Dancing class at Otara Family and Christian Health Centre

Dr Murray Hing

GP, Fellow of the College, accomplished dancer

Exercise for those who can't exercise

Like all GPs, I spend a significant amount of time of each day encouraging regular exercise or physical activity to many different kinds of patients. The overweight, those with chronic conditions (like heart failure, diabetes, ischaemic heart disease, COPD, which are all very prevalent in our practice population) and the elderly. For many of these patients, however, joining a gym is unrealistic and unaffordable. Even going for a regular walk has its barriers: weather, dog-ridden streets, lack of motivation. Green prescriptions drew a less than enthusiastic response.

Feeling increasingly frustrated at the lack of options for a group of patients for whom regular exercise or activity is vitally important, I started fortnightly one-hour sessions in my office, calling it "Exercise for those who can't exercise". These sessions could accommodate six to eight patients, once I removed my plinth.

Embracing the lively rhythms

It started out as a series of mostly seated, low-impact exercises. The emphasis was on movement assisted and encouraged by our Health Coach Kerry Mataora. I used Latin dance music to stimulate movement and before long, patients were up and moving to the music, embracing the lively rhythms.

I am a keen and enthusiastic social dancer, enjoying Latin, ballroom and line dancing. My focus shifted to increasing the dance component of the sessions which required a bigger space. Fortunately, we had access to a much larger room at the premises and we could hold weekly sessions attended by ten to twenty people.

We start with a couple of Zumba routines using Latin dance steps, salsa and bachata. Next, we follow that up with line dancing, which incorporates rumba and cha-cha steps. So far the class has successfully learnt four line dances. In the final part of each session, we do some partner salsa dancing. Just very basic steps but the emphasis is on encouraging movement. Getting the right steps is secondary to having fun and enjoying moving.

Dr Murray Hing has been a GP for 34 years, practising in the Auckland suburb of Ōtara, which has a predominantly Pasifika and Māori population. He has a particular interest in the management of long-term, chronic health conditions.

The flow-on effect

I have been pleasantly surprised by the enthusiasm attendees have expressed and brought to the classes. Most have minimal previous dance experience. They enjoy the sense of achievement from learning a new skill, but it has also had a flow-on effect. Many have joined other programmes run by our Health Coach, such as circuit training and a walking group.

What have the benefits been? We have been able to document an improvement in HbAlC levels and weight reduction in diabetic patients. Patients with COPD have improved their respiratory function – as judged by them now able to complete a full dance without stopping!

The unexpected benefit, however, was the improvement in mental health of some patients. It has been inspiring to see people's confidence grow. We even had a group perform three line dances in front of the entire practice staff at our end-of-year lunch.

I hope to continue this initiative. After all, we may be the only general practice in the country that you can walk into, get a script for paracetamol for your flu and cha-cha-cha out!

Otara FAMILY AND CHRISTIAN HEALTH CENTRE
Helping people live Healthier Lives

Boost your self-confidence with the arts

Dr John Gillies

Retired physician, now full-time artist

Most doctors today appreciate that the medicine profession demands their undivided attention and that work-related stress, which confronts all health professionals at some time in their career, needs to be balanced by an activity that promotes both self-esteem and self-confidence: enter the arts.

The beginning

One day in 1989, when I happened to be in the Christchurch medical library I stumbled across an article about the International Association of Artist Doctors based in Barcelona, Spain. Thinking that they may be medical illustrators I dropped them a line. To my great surprise they replied: Te nombramos president de la union neozelandesa de medicos artistas. In other words, I had just been appointed the president of the New Zealand Association of Artist Doctors (NZAAD).

Eventually when the mirth settled I realised the potential value of such an organisation and gathered a group of like-minded individuals in order to draw up a constitution and get started. Our first event was held in the Medical School lecture theatre's foyer in 1990 and consisted of a display of a collection of items from doctors' hobbies. This created huge interest and so the next year we took the risk and held our first concert in the Great Hall of the Arts Centre in Christchurch. Tickets sold out in four days.

Annual concerts and art & craft shows followed so that now the performance section includes individuals, small groups and a fifty piece orchestra of doctors, family members and occasional associates, seconded for their special expertise. Last year our keynote item was Finlandia which was a most moving composition in the context of the current war in the Ukraine.

The future

Of course, the survival of our association depends upon participation and many doctors worry that the standard required makes participation beyond their reach. Naturally, there will be individuals who are exceptional and they need the opportunity to showcase their talent. However, the real purpose of the association is to bring together those who have a passion for their artistic interest but lack the confidence to perform, even in this closed environment of colleagues and friends. After all, the real strength of the association is not the performance, which at best must be regarded as "superb mediocrity", but the collegiate association that in this age of shared care is absolutely vital.

How often am I approached by doctors who have taken part in our concerts and art & craft shows and have progressed to the point where they can now celebrate with confidence that they have achieved something which had been a life-long desire and yet something that may have been unobtainable had it not been for the NZAAD. We are always on the lookout for new talent, so get out that old bassoon, bagpipes, paint brush, camera or crochet hook and **join the crew** on the NZAAD. If you think you have no artistic talent at all, then come along and watch. Either way, you will never regret it!

New Zealand's skin cancer epidemic

Providing best practice

Dr Chris Boberg

GP, President of the New Zealand Skin Cancer Doctor Society

Dr Chris Boberg is one of New Zealand's leading skin cancer experts, a co-char of the Melanoma Network of New Zealand (Melnet), RNZCGP delegate for New Zealand Skin Cancer Strategic Planning Group and conference convenor for the International Melanoma Summit. He is also a Founder and Director of SkinCheck Clinic in Auckland.

The New Zealand Skin Cancer Doctor Society (**NZSCD Society**) was established in 2017 by a group of GP skin cancer surgeons. The main drivers were the growing skin cancer epidemic and the need for cost-effective and efficient community skin cancer services.

In Aotearoa New Zealand each year it is estimated that:

- 90,000 non-melanoma skin cancers are diagnosed, with an estimated health care cost of **$129.4 million**
- about 2,800 invasive melanomas are diagnosed, with estimated health care costs of **$54.5 million**
- Over **4,000 people** are found to have in situ melanoma (melanoma that has not spread to other parts of the body).

In fact, more New Zealanders die from melanoma than die on our roads each year and by 2025 it is expected that the total cost of skin cancer treatment will grow to **$295 million**.

Are you concerned about missing a melanoma in your patients? **Join a complimentary course** on the basics of dermatoscopy and diagnosing melanomas. It is a superb resource and is designed for busy GPs.

Learning how to use the stethoscope of the skin – a dermatoscope – is the best way to ensure you find melanomas at the early survivable stage.

Another reason was the increasing research-based proof that the diagnosis of melanoma can be made with greater sensitivity and specificity by those proficient in dermatoscopy. As such, NZSCD aims to facilitate and support those who want to understand more about dermatoscopy.

It is now highly recommended (by most guidelines) for all practitioners involved in skin cancer care to be competent in using a dermatoscope.

NZSCD provides support to all health care providers involved in the management of skin cancer. Becoming an Associate member requires no prior training but gives you full access to a WhatsApp forum where you can post questions/ask for advice and much more. The group is very supportive and includes GPs, GPwSI in skin cancer and several surgeons, pathologists etc.

To date, NZSCD, in its fourth year since inception, has over 70 members and has established validation criteria for all skin cancer training courses (in

conjunction with Southern Cross) to enable credentialling and accreditation to full membership for those who wish to make skin cancer a major part of their practice. Many will prefer to be Associate members and enjoy peer support and educational opportunities. If you decide to become a full member at any time, you can study and work toward full member accreditation. You can apply directly for full membership if you have already met the accreditation requirements.

NZSCD also provides all members access to virtual CMEs from world-leading experts, the opportunity to connect with other members for closer one-on-one support, assistance with facility accreditation, training guidance and mentoring and an annual networking conference.

We have also developed positive relationships with the medical insurers and now most recognize NZSCD-accredited members and fund most procedures under the 'specialist' arm of their policies.

NZSCD has a vibrant and innovative executive team of experienced doctors who are also FRNZCGP: Drs Andrew MacGill, Antony Tam, Neil Anderson, Marcus Platts-Mills, Chris Boberg and Megan Reilly and who meet monthly.

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. Barriers and facilitators to prescribing medicinal cannabis in New Zealand
2. The enrolment gap and the COVID-19 pandemic: an exploration of routinely collected primary care enrolment data from 2016 to 2023 in Aotearoa New Zealand
3. Timeliness of diagnosis and treatment of cutaneous melanoma with dermatology, general practice, plastics surgery collaboration – are we meeting standards?
4. What are green prescriptions? A scoping review

Equity module at Cook Street Health Centre

Jane Ayling

Director Quality and Culture, Cook Street Health Centre

About the centre

Cook Street Health Centre is a purpose-built, well-established general practice situated in Palmerston North that has been serving the community for 36 years, with an enrolled population of approximately 6000 people.

Our dedicated team consists of receptionists, nurses, health care assistant, nurse practitioners, general practitioners and a director of quality and culture, working alongside each other. The THINK Hauora (PHO)-employed Health Improvement Practitioner and LTC Nurse have scheduled clinics on-site and are an integral part of the Cook Street team.

The team strives to be early adopters and leaders in the region. Our centre is an active member of Ora Connect – a collective impact initiative that brings community organisations and resources together to activate 'A connected health community within the 4412' (meaning south-western suburbs of Palmerston North).

The equity team

Our equity journey began in November 2021 when we wanted to formalise what we had always done. This aligns with and provides evidence for the requirements of the Foundation Standard and the equity module. We are also a teaching practice and would like to continue teaching, advocating and promoting primary care to medical and nursing students, GP registrars and Nurse Practitioner interns.

> "We established an equity team to lead the staff on this journey.

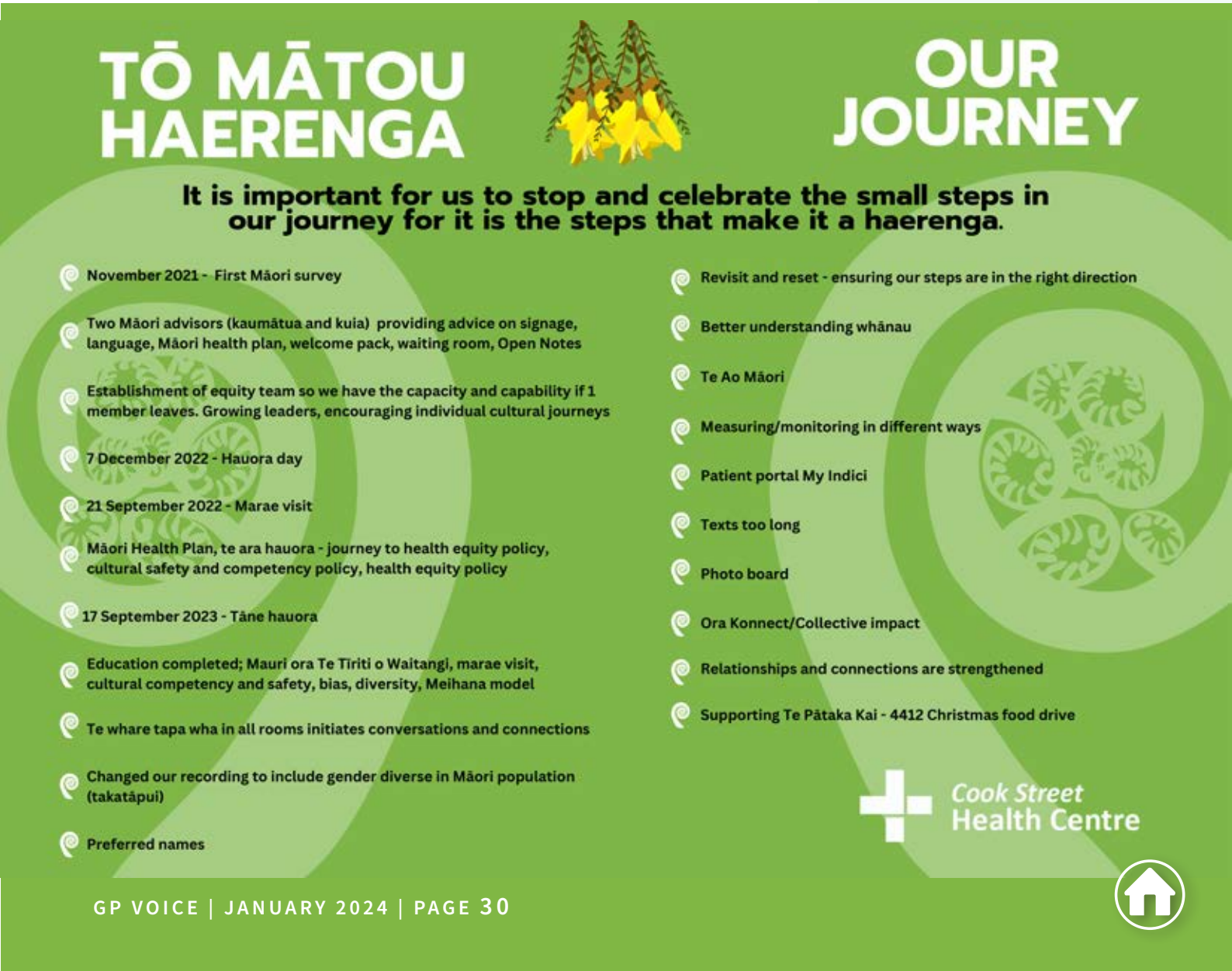
We established an equity team to lead the staff on this journey. The team includes: Jane Ayling, Dr Alice Tait-Jamieson (Ngati Tukorehe), Rachel Puts (Ngāti Hauiti) and Krystal Carrington (Ngāti Maniapoto). We gained feedback from our Māori population via email, phone calls and face to face interactions regarding what we were doing well and how could we improve experience of access and care. From this hui Wiremu & Trieste Te Awe Awe became Kaumatua & Kuia for the health centre providing guidance, support and advice.

The health centre closed for a day to enable the team to visit the marae of our kaumatua and kuia. Te Rangimarie marae at Rangiotū was built in 1858 to commemorate peace between the Ngāti Raukawa and Rangitāne peoples. We listened to their story and others bearing in the Māori history of the Manawatū. This was the first visit for some team members and one team member gave her first pepeha in Te Reo Māori. Team building and learning and discussing the Meihana model has further enabled the team to be empowered to continue to grow their cultural awareness and for it to become their norm.

> “People have noticed the greetings, the signage, the accessibility, the small attitude shifts and the language we use.

The feedback

Recently, there has been an increase of positive feedback from patients, both Māori and non-Māori, about how Cook Street Health Centre has become



warmer and more welcoming to them. People have noticed the greetings, signage, accessibility, small attitude shifts and the language we use. Following our first Māori and Pasifika Hauora day, during which we offered free services, we received positive and encouraging feedback that has guided and enabled us:

- to have Te Whare Tapa Whā model posters in each consulting room,
- to greet people in their Pacific language,
- to provide resources in an appropriate language,
- and to hold the event annually.

Two general practitioners and a primary health care nurse provided free health checks to tāne as part of the community driven Hā Tāne Hauora Mens Health. On the right, there is an example of feedback received.

In summary: From having visible Māori staff, normalising greetings in Te Reo Māori, signage that aligns with Te Ao Māori around the practice, clear leadership, documented plans, policies and processes, to facilitating protected time for all team members to attend noho marae and participate in education, the team is now more confident and competent in their ability to deliver high quality care within a culturally safe framework and be proud of the changes and new goals for the future. He maurea kai whiria - let's keep directing our efforts towards what is important!

The staff of Cook Street Health Centre during their visit to Te Rangimarie marae

"

Kia ora Cook St Health Centre.

I would like to express my appreciation to the Health checkup I received at the Haa Rollathon. The Nurses were fantastic and bubbly and made me feel safe and comfortable. The Doctor was great, heunderstood as a elder man what and where some of my concerns were and help me understand what my body is doing and going through.

Bonus: I received a fellow phone call when my blood results came through to advise me that they will be sent to my GP, and gave my results which was a pass on all accounts.

Great work team.

Ngā mihi koutou mo to tautoko me manakitanga.

"

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