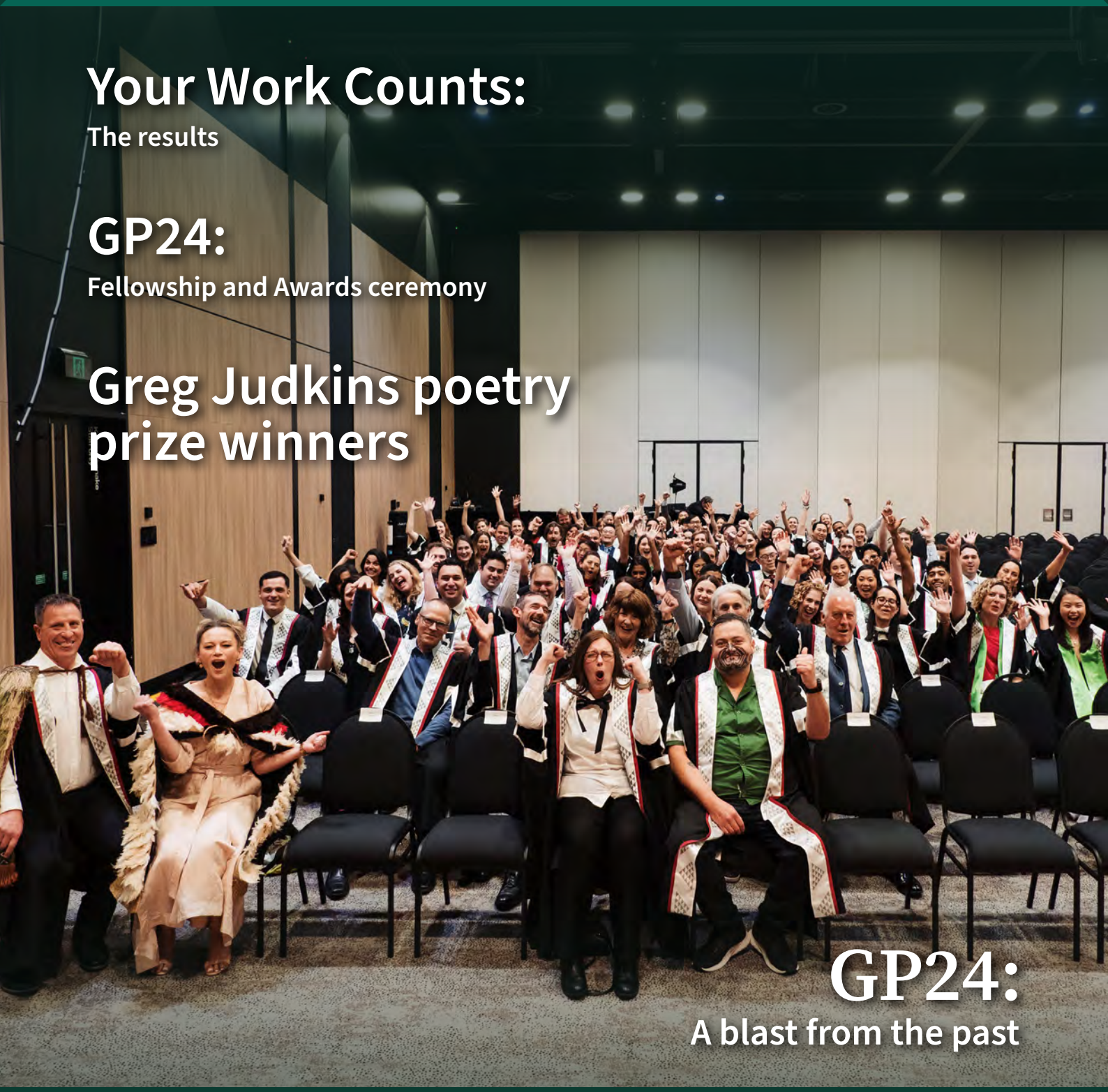
GP Voice

YOUR NEWS, YOUR VIEWS, YOUR VOICES

Your Work Counts:
The results

GP24:
Fellowship and Awards ceremony

Greg Judkins poetry prize winners



GP24:
A blast from the past

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

AUGUST 2024

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Editorial

Dr Luke Bradford

Dr Luke Bradford
Medical Director | Mātanga Hauora

Kia ora koutou,

To everyone that joined us in Wellington for GP24, I'd like to say thank you for making the conference such a success. Along with a hugely informative and educational programme, we were able to end our 50th anniversary on a high with the celebration gala dinner and not so subtle nod to the 1970s at the College stand!

Hopefully you took away some of the messages from Gilbert Enoka and Dr Michelle Dickinson to use in your everyday work and home life – whether that be about mental resilience - being where your feet are and changing the things that no-one can take away from you, the importance of belonging and creating a supportive culture, to ChatPDF, the correct way to use a microwave and not ingesting random white powders (which was sodium polyacrylate – the ingredient used in nappies to absorb moisture) in case you were wondering!

The three panel sessions received great feedback from the delegates. It was hardly surprising given they were covering topics that are all extremely relevant to our practice – AI and patient privacy, climate change in health and rural health.

Having the Minister speak to us for the first time since being in office was a great way to kick off the conference as was his willingness to speak for 30 minutes. There were a lot of questions submitted via the app during his session that weren't asked but we have exported those questions (keeping them anonymous) and we've passed them on, so he is aware of what is top of mind for us at the moment.

On a personal note, I appreciated the engagement with the Your Work Counts project during my plenary session, talking through the latest results and next steps for this important work that the College is undertaking. Your ongoing participation and support of the project will ensure we have robust data that can be used to create practical changes and solutions to address some of the challenges we are facing as a workforce. You can read a summary of the results (and download the slides and video of my presentation) on **page 11** of this issue. I'm also sharing this information with the Minister, Te Whatu Ora, other GP representative groups, universities and media.

This issue of GP Voice highlights GP24 and will be a good recap for those who were unable to join us. We also celebrate our newest GP and rural hospital medicine Fellows and acknowledge our award recipients and the work they are doing within the College and in their communities.

Enjoy this month's issue.

Luke

College advocacy work: A month in review

The College is a strong, constant advocate for general practice and rural hospital medicine and use our voices and experiences to inform Government, politicians, other sector organisations, the media and the public about importance of the work we do and the value we add to the sector and our communities. Here is a snapshot of the advocacy work from July.

PSAAP

Representation of those practices who have nominated the College as their contracted provider representative across caucus meetings, the PSAAP meetings and the System Level Measures (SLM) working group. The College advocated strongly for pass through of SLM monies to practices and supported the rejection of the capitation offer. **Read a full summary of the meeting.**

ADHD

Work continues in this space, focusing on preparing a consultation paper with Medsafe and Pharmac. Work is also beginning around how educational and CME providers can develop appropriate courses and materials to allow members to upskill if they desire.

Te Whatu Ora - gynecological procedures

Work has commenced with Te Whatu Ora around AUB investigation in primary care, concentrating on enabling those who are ready to deliver pipelle biopsies and managing the movement of patients to these GPs. The development of appropriate training opportunities for those wishing to provide this service is also included.

NZMSA – 'Behind the med school gates' webinar

Run annually by the NZ Medical Students' Association, the purpose of this webinar is to give final year medical students insight into the various work opportunities available to them as well as providing practical advice about training programmes. One of our Clinical Consultants Dr Sally Carter presented on behalf of the College to promote and highlight the flexibility a career in general practice/rural hospital medicine can have in terms of working hours, locations, the diversity of patients and the ability to also pursue special interests.

HQSC – Healing, learning and improving from harm: National adverse events policy 2023 – guidance development for general practices

The College has advocated for the need of relevant and practical guidance for general practices to meet the requirements of this policy as part of the Foundation Standard certification. As a result, key staff from the Health Quality and Safety Commission and Quality Programmes staff met with to commence work on the development of guidance for general practice.

Medicines Classification Committee (MCC) Decisions – 72nd Meeting

The College provided a submission on several proposals for medicine classification changes and we are pleased to share that the College's views are reflected in the MCC decisions. You can read our submission **here**. The **minutes** for the 72nd meeting of the Medicines Classification Committee are now available on the Medsafe website.

College submissions:

- **The Law Commission** – Review of adult decision-making capacity law
- **MOH** – Medical Abortion Reversal
- **Medsafe** – Medical Classifications Committee – 72nd Meeting – 12 June
- **Internal Affairs** – Preliminary notice of death
- **Te Whatu Ora, Allen & Clarke** – Clinical Guideline: testing for diagnosing and managing gestational diabetes

RANZCOG
Annual Scientific Meeting 2024

Upskill in women's health

Register today for the RANZCOG ASM 2024

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) is committed to the ongoing education of members of the Healthcare workforce who have an interest in Women's Health.

You don't have to be a RANZCOG member to attend workshops or our Annual Scientific Meeting (ASM). Both the Pre-Meeting Workshop and Scientific Programs have been formulated with General Practitioners in mind, as they make up a large percentage of the women's health workforce, particularly in regional and rural communities.

Gynaecological Skills Workshop

The perfect way to start your learning at the ASM. Take a deep dive into sessions on pressing issues in women's health, including delivering Abortion Care, updates in Cervical Screening Self Collection programs as well as learning new practical skills on insertion of LARCs.

When: 08:30-12:30, Saturday 12 October 2024

Where: Museum of New Zealand Te Papa Tongarewa

Registration Fee: $450*

OASI Workshop

Take a hands on approach and brush up on your third and fourth degree perineal tear skills with this half day workshop. Delegates will learn from experts on the most up-to-date methods of tear repair, with a series of presentations followed by hands on practical applications of repair with a team of expert facilitators.

When: 13:00-17:00, Saturday 12 October 2024

Where: Museum of New Zealand Te Papa Tongarewa

Registration Fee: $450*

If you register for both the Gynaecological Skills and OASI Workshops, you will receive a $100 discount on your combined registration costs.

Case Based Discussion Workshop

Unlock a world of insights in our dynamic half-day workshop designed for RANZCOG Associates (Procedural/Adv Procedural) and GPs working in private practice, locum positions, or rural areas. Tailored for busy professionals, this 4-hour session is a catalyst for knowledge sharing, critical thinking, and problem-solving in the field of Obstetrics and Gynaecology.

When: 08:30-12:30, Sunday 13 October 2024

Where: Museum of New Zealand Te Papa Tongarewa

Registration Fee: $350

We can't wait to see you in Wellington!

To register and, learn more about the RANZCOG ASM, scan the QR code or visit the link for more information.

ranzcogasm.com.au/registration

Spotlight on Manawatū Faculty

Over the past year, the Manawatū Faculty has created the Palmy Primary Care Practitioners Facebook Group for local GPs and NPs to connect and collaborate as a group, discuss local issues and to offer support and share information about local opportunities, vacancies and CPD events. The Group has grown under the administration of Dr Abhi Gotadki and now boasts 71 members.

A regional lunch meeting was hosted with Dr Ayesha Verrall - then Minister of Health - to address local concerns and challenges faced by GPs. The Annual GP Regional Conference was held the following day covering topics such as Endocrinology, Dermatology, Sports Medicine, Haematology and Sexual Health.

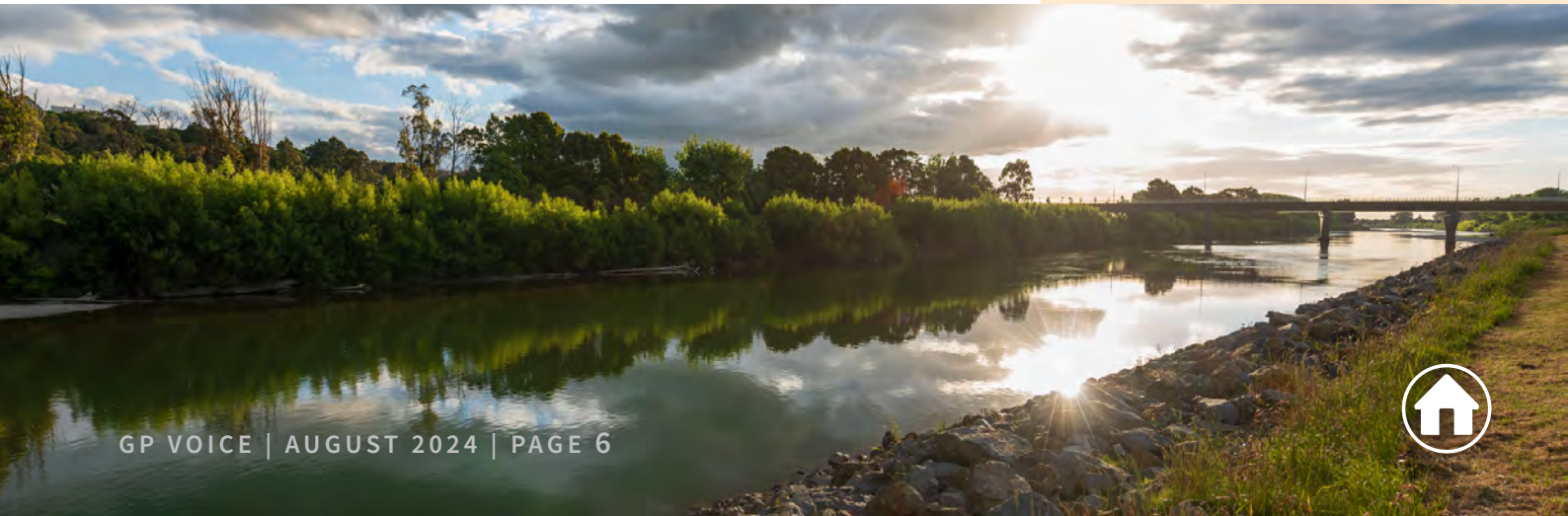
The Specialist GP Annual Dinner Meet and Greet was held at the Distinction Coachman Hotel in Palmerston North promoting networking and discussions about the necessity for GP liaison with attendance from over 100 local GPs and specialists.

A lunch meeting was held with Minister of Health Dr Shane Reti at Kauri Health - that is not his practice but Kauri Health is a practice in Palmy. Dr Reti discussed his views regarding local health targets and policies. Additionally, a Political Discussion Evening was organised - pre-election - at the Distinction Coachman Hotel, with representatives from the Labour, National, Act and Green parties. The Māori Party sent apologies due to COVID. The event attracted over 30 local GPs and NPs, centring on party policies and healthcare perspectives, including local issues such as imaging accessibility, ED wait times and the retention of the regional GP workforce and registrars.

Efforts are being made to establish a GP liaison with Te Whatu Ora to improve connections and fortify working relationships.

There is a focus on cultivating a sustainable workforce within the region. The faculty is engaging with GP registrars and actively seeking to recruit registrars/junior GPs to the committee. Plans are underway for a dinner event to welcome GP registrars, local GPs and specialists in at the GP Regional Conference this year.

The Faculty is also looking at community involvement initiatives such as the ‘Green Plant a Tree’ project can also serve as excellent team-building exercises.



GP24: A blast from the past

Our annual conference is a highlight in the College calendar and GP24: Conference for General Practice was no different. It was great to see so many members attend to celebrate our 50th year with us in a groovy 70s way. We had over 750 attendees at this year's conference, which was a huge turn out and a great way to celebrate!

The whole weekend was decked out in 70s fun from the dress up competition at the welcome function on Thursday night, to our 70s inspired branding, lolly bar and lounge on our College exhibition stand. Our team had a blast hosting you all over the weekend, so we hope you did too! And for those of you who were unable to attend, here are some highlights from the weekend.

Some GP24 highlights included:

- Our welcome function kicked off with a bang with a 70s dress up encouraging attendees to break out their Birkenstocks and flash their flares! Spot prizes were up for grabs for those that threw on some tie-dye threads or brought their best 70s vintage wear. Congratulations to Dr Buzz Burrell, Dr Justine Lancaster, Dr Jethro LeRoy, Dr Richard Medlicott and Dr Alistair Humphrey who all won spot prizes for their amazing costumes.
- The College's 50th celebration dinner was a glitz and glam evening full of reminiscing and reflection. GPEP year 2 registrar Dr Zarah Allport gave the Peter Anyon address during the dinner which was a fantastic story about her journey into general practice and her hopes for the future. You can read more about the dinner on page 9 and Dr Zarah Allport's Peter Anyon address on page 30.
- The keynote speakers for the weekend were phenomenal and so inspiring. Gilbert Enoka spoke about performance and pressure: managing the moments and how you can build organisational culture. Dr Michelle Dickinson talked about embracing the technological changes in medicine including some tips on how to do this.




- There were over 100 concurrent sessions run over the three days. Thank you to everyone who submitted an abstracts and presented their research. We will be sharing summaries of some of these in GP Voice over the next few months.
- The panel sessions focused on AI and privacy, climate change and the opportunities in rural health and they were well received by the delegates. Thank you to our members Dr Richard Medlicott (AI), Dr Kiyomi Kitagawa (Climate Change), Dr Fiona Bolden (rural), Dr Garry Nixon (rural), Dr Alex McLeod (rural) and Dr Andrew Laurenson (rural) who agreed to be on our panel.
- The Fellowship and Awards ceremony is always a highlight in our calendar and this year was no different. It was a fantastic evening filled with aroha, whānau, and celebration. You can read more about the ceremony on page 24.

Save the date for GP25

In President Dr Samantha Murton's closing address, she announced the dates for GP25 which will be held in Ōtautahi Christchurch, from 24-27 July 2025 at the Te Pae Christchurch Convention Centre.

You will be able to read more about GP24: Conference for General Practice throughout this issue – we hope to see you all next year!

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.

For between-issue reading, visit the 'online early' section.

Trending articles:

1. Exploring the role of physician associates in Aotearoa New Zealand primary health care
2. Attention deficit and hyperactivity disorder and use of psychostimulants in Aotearoa, New Zealand: exploring the treatment gap
3. Advanced practice physiotherapists in primary health care: stakeholders' views of a new scope of practice
4. The impact of nurse prescribing on health care delivery for patients with diabetes: a rapid review
5. Patient perceptions of barriers to attending annual diabetes review and foot assessment in general practice: a qualitative study

Glitz and Glam: The College's 50th Celebration Dinner

As part of GP24: Conference for General Practice, the College hosted a 50th anniversary celebration dinner for all current and past members, whānau and health care sector colleagues to celebrate this key milestone. It was a night of glitz and glam with everyone dressed to impress that was full of reminiscing, reflection and dancing which was facilitated by iconic Wellington band, Uncle Monkey.

President Sam Murton started the evening off by saying the 50th anniversary milestone felt like the right time and excuse to dress up and let our hair down. She then talked about the key moments through our history as the Royal New Zealand College of General Practitioners, starting from August 1973 when we were officially incorporated under the Charitable Trusts Act to 2024 being the year we have had the biggest ever cohort of registrars start in GPEP training.

To honour this anniversary the College has also put together a commemorative book of member interviews, photos and a detailed timeline of events that have shaped the College over the past 50 years. The book is a lovely snapshot of how far the College has come, and the many people who have influenced our journey over the past 50 years, all the while looking ahead to what we want to achieve before we turn 100.

Throughout the evening interviews with some of our members were played talking about their hopes and dreams for the next 50 years of the College and profession. You can view these on our YouTube channel **here**.

Over the past half century, we would like to acknowledge all our inspiring members whose knowledge, innovation and commitment to the workforce has paved the way for the College today.

This year's conference whakataukī also reflected on this:

Kia whakatōmuri te haere whakamua

Walk backwards into the future with eyes fixed on the past

It is a reminder that we should draw on the knowledge, the experiences and the events of the last 50 year and of those who have gone before, as we look to what we need to do, and what needs to change to shape the next 50.

Dr Zarah Allport gave the Peter Anyon address as part of the evening, which was greeted with a standing ovation to her rousing call for action to "use this privilege, get creative, and advocate for whānau as hard as you can." She went on to say "I am proud to be here, I am proud to be Māori and I am incredibly proud to be a GP." You can read more about her address on **page 30**.

The evening finished with everyone congregating on the dance floor, dancing the night away to iconic band Uncle Monkey.

If you would like to receive a copy of the book, and haven't got one yet, please email **communications@rnzcgp.org.nz**

Your Work Counts - The results

The College Medical Director Dr Luke Bradford presented the latest results of the Your Work Counts project in the first plenary session after the Minister of Health at *GP24: the Conference for General Practice*.

The session was designed to provide an update on the project, share the results of the second (winter) diary study and show how these results compared to the first (summer) diary study from December 2023.

To recap, the aims of the Your Work Counts project are to identify:

1. What a fair and reasonable 40-hour week looks like for GPs
2. Safe and sustainable patient loads
3. Ratios for how many GPs per 100,000 patients each region and the country needs.

After outlining the ongoing work and results Dr Bradford said he would provide an answer for aim 1, offer a method for aim 2 and therefore a solution to aim 3.

He started by reminding delegates that for a long time our own terminology around work patterns has led to the impression that the only work GPs do is patient consultations and how the current model is funded is based almost entirely on those contacts and the 15-minute consult.

The Study Demographics

Figure 1

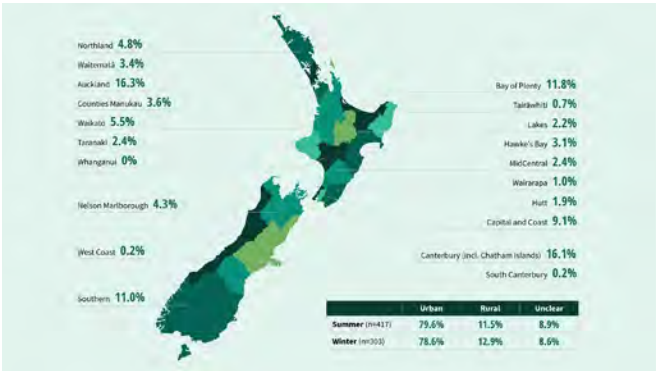


Figure 2

This shows the demographics of where the participants (for the summer study) were from, the urban and rural split from both studies, as well as whether participants are teaching in some capacity and who owned their practices.

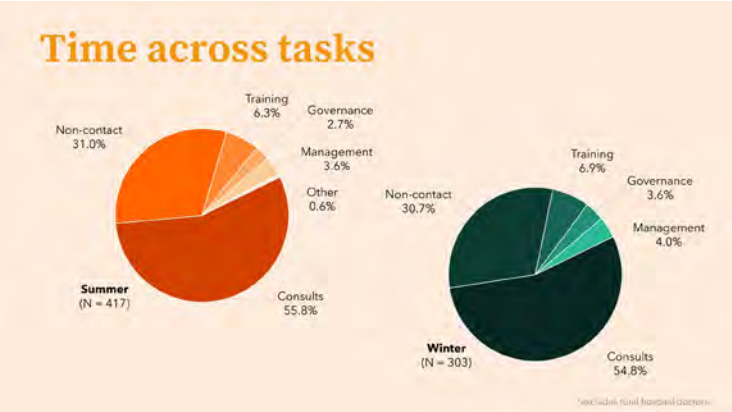
Other demographics told us that in both the summer and winter studies, females made up the bulk of the participants (74.8% in summer and 72.9% in winter), with the overall median age of participants staying consistent at 45 years in summer and 46 years in winter.

The ethnicity of participants across both studies was primarily European (84%), followed by Asian, Māori, "prefer not to say", Pasifika and Middle Eastern, Latin American and African (MELAA).

Results

The time spent across tasks

Figure 3



When looking at the breakdown of hours spent on the five key tasks, it is very similar between the two diary studies – keeping in mind that the summer study was over 14 days, the winter study over 7 days.

While the overall hours did increase, the proportion of workload remained remarkably consistent.

Weekend work

To free up more time to see patients, many of us says Dr Bradford are choosing to move our non-contact clinical work into the evenings or weekends, or we sacrifice training or clinical governance time to complete it. This is work that is often not remunerated despite it being a core part of our role.

Looking at work done over the weekend also showed consistent results between the two studies:

Summer:

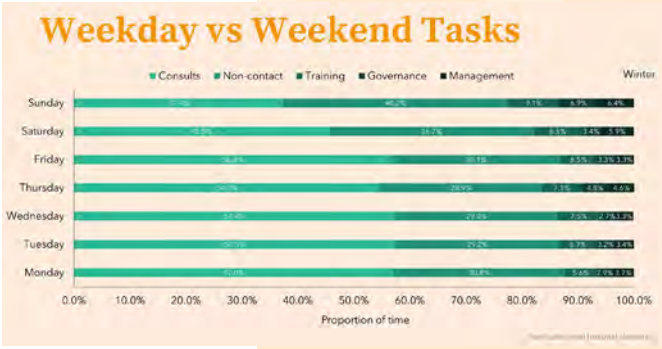
- Any weekend work = 71%, no weekend work = 29%

Winter:

- Any weekend work = 73%, no weekend work = 27%
- Only a quarter don't work at all during the weekend
- A third worked one day of the weekend
- Almost 2/5ths worked Saturday and Sunday

Figure 4

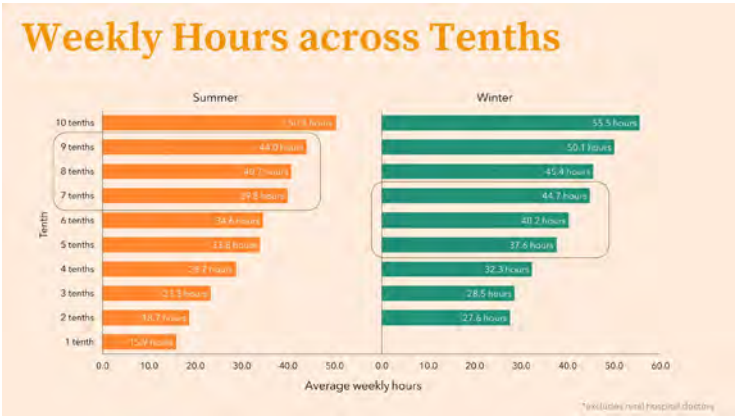
Figure 5



When the conference audience was asked to put up their hand if they work only the hours/10ths that they are employed to do – not surprisingly only a couple in a room of several hundred raised their hands.

"Part-time" vs. "Full-time"

Figure 6



In most professions, working 40 hours is seen as full-time. While there are many members who choose to be part-time, for a variety of reasons, Dr Bradford highlighted the need to be more aware of what part-time actually means.

Looking at this graph above (Figure 6), 6 and 7/10ths are likely to be full-time employed, with 4 and 5/10ths, who might call themselves part-time are actually still working around 30 hours.

What is a fair and reasonable 40-hour week?

To answer the project's aim of what a **fair and reasonable 40-hour week looks like**, Dr Bradford showed the graph below (Figure 7).

Figure 7

The pie chart takes into account the the averages across both studies to show the percentages of time spent across the five key tasks. The hours shown represent a 40-hour work week, noting that break times were not factored in. However, the College feels strongly that only 3 hours of teaching and CME per week is not sufficient when compared to other specialties.

When it comes to **aim 2: safe and sustainable patient loads**, Dr Bradford said that the changing models of care aren't reflected and the differentiation of GPs vs. non-medical input and consistency of data are an issue.

To come to an answer there needs to be an understanding about patient utilisation as well as variables across age, ethnicity, gender, socio-economic status and co-morbidities. To test this methodology, Dr Bradford ran a case study across 300 of the enrolled patients at his Tauranga practice.

For each of the 300 patients, their contact with the practice over a year was collated and showed that on average patients had 16 clinical contacts across the practice per year, which equals 250,000 contacts per year when looking at the practice's total enrolled population and equals over 80 million clinical contacts per year across the entire country.

Figure 8

Average engagement

CONTACT		NON-CONTACT	
Doctor's appointment	2.64	Script	1.5
Nurse Practitioner's appointment	0.10	Phone call from doctor	0.19
Allied Health appointment	1.56	Communications from secondary	2.42
Surgical appointment	0.07	Email to patient	0.28
Online consultation	1.97	Text from doctor	0.50
		Recall text	0.30
		Referral	0.57
		Lab request	1.57
		Lab result	1.86
		Radiology request	0.27
		Radiology result	0.53
		ACC documentation	0.27
		Text from patient	0.52
	6.34		**10.78**

So what now?

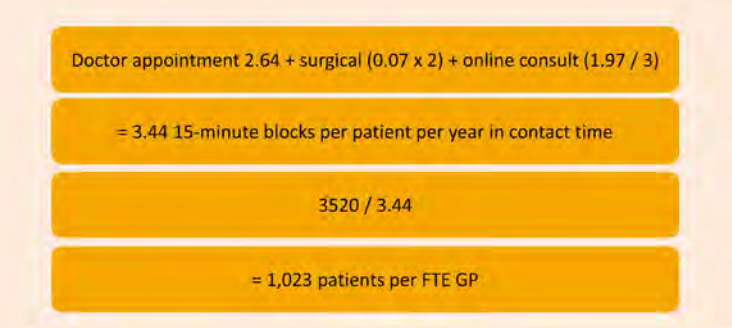
So, we've got the data, but what does it mean?

If we have 22 hours of contact time per week (see the above pie chart), and we're doing 40 weeks of clinical work a year (which matches the SMO MECA) and assuming we're taking 15 minutes per consultation:

22 x 4 x 40 = 3,520 consults per year, per FTE

Breaking this down further to calculate the number of patients per GP that is safe and sustainable (aim 2):

Figure 9



Dr Bradford checked this working against his own practice where the doctors, including the trainees, are currently working 100 nominal 10ths.

If 7/10ths equal one FTE then there are 14.3 FTE of GPs for 15,000 enrolled patients in a Healthcare Home, multi-disciplinary team-based clinic.

The number of patients per FTE at his practice comes in at 1,049 – which is similar to the findings from the diary study results of 1,023 patients per FTE.

Next steps

1. The utilisation methodology used in this project, needs to be compared with what is being used by Sapere and Health New Zealand, and what will be seen in the Primary Care Data set to then decide on the most accurate model.
2. Doing this will allow us to determine a safe and sustainable patient load as well as the **workforce need across Aotearoa** (aim 3).
3. Testing this methodology across multiple practices and in different settings is also important. If anyone would like to get more involved and carry out their own utilisation study, please contact Luke: **luke.bradford@rnzcgp.org.nz**.

Thank you to everyone who has participated in the Your Work Counts study. Your work counted and it will be used to advocate for the workforce and the patients you serve.

Read through the **full presentation** from GP24 and keep an eye out for further advocacy and work in the coming months.

Goodfellow unit podcast: **Maternal immunisation**

Dr Esther Willing (Ngāti Toarangatira, Ngāti Koata, Ngā Ruahine) is an Associate Professor in Hauora Māori and the Director of Kōhatu Centre for Hauora Māori. Dr Amber Young is a pharmacist and an emerging researcher with whakapapa to Taranaki iwi.

In this podcast, Amber and Esther discuss protecting babies through immunisation of hapū māmā in pregnancy and in the newborn period in Aotearoa New Zealand.

Their take home messages from the podcast are:

- **maternal vaccination is safe and effective and recommended, even if they have been pregnant before**
- **vaccination coverage is improved by whānau being well-informed and supported**
- **all health professionals should provide information about maternal vaccination**
- **system-level changes are needed to remove existing barriers to vaccination**

Listen to the podcast

Monitoring of medications with known toxicity risks

Dr Luke Bradford, Medical Director

Note: *From time to time the College is requested to ensure our members are aware of certain key issues or information. In the case of the below text, the Deputy Health and Disability Commissioner has requested members are made aware of the potential issue with the long-term monitoring of patients who have been prescribed medications with a known toxicity risk, specifically lithium, while not identifying the case in question.*

Prescribing medications is a key aspect of our role as specialist GPs and rural hospital doctors.

Because of the number of patients we see, and the multiple medications that some of them are taking, there are high levels of responsibility on us when it comes to timely monitoring the effectiveness of these medications and how the patient is responding to the treatment.

Patients prescribed Lithium must undergo three-monthly blood test monitoring to check lithium levels. The Deputy Commissioner, and the College, acknowledges that long wait times for appointments alongside patients being difficult to contact for follow-ups or engage with regularly is a known issue and extends into the workforce and wider health sector.

Despite our constrained 15-minute consultations, and many patients presenting with more complex needs, we must remain vigilant when it comes to follow-up appointments, routine monitoring and screening and compiling up to date, clear and concise note taking on patient files.

What can you and your practice do?

For medications that are known to have risks of toxicity, ensuring there is, where possible, a team approach and a team knowledge about which patients are on these medications, what are the guidelines around monitoring, screening requirements, dose reviews and how are these flagged and followed-up with the patient is key to ensuring both a high level of continuity of care and patient safety.

Carrying out periodic audits is another way to capture all necessary patients and thoroughly review their history, conditions and medications, ensure that the appropriate actions are being taken and all those involved in the care of these patients are across the treatment plan and known medication risks.

For identified patients taking lithium but not keeping up with their regular monitoring, their treatment plans can be changed to include a face-to-face

consult to receive their next prescription and if required have bloods taken at the time of the consult if the patient can't get to the lab easily.

Identifying any challenges that makes compliance difficult (such as co-ordination of care issues) and highlighting opportunities for improving care and mitigating system and/or process issues is beneficial for the team, practice and the patient.

Fellows can claim credits under their 'Measuring Patient Outcomes' CDP category by completing clinical audits of their own cases, practice reaccreditation, feedback from the practice on patient outcomes, review of medical records, significant event analysis, and maintain and reflect on procedural logbook (if they are procedural GP locums).

Sharing any findings of note, such as how you improved a system or process change for the benefit of the practice and/or patient can also be shared wider such as in the Journal of Primary Health Care (JPHC) or in the College's monthly magazine to members, GP Voice.

Throughout our general practice and rural hospital medicine training programmes and our self-learning and education that we undertake as part of our annual CPD requirements we are taught about the importance of safe prescribing, good prescribing practices, adhering to best practice guidelines and how to manage multiple medications and contraindications in patients and it is essential that we keep this top of mind for all of our patients, but in particular for those who are on these types of medications.

Additional resources

- **Safer prescribing and monitoring of high-risk medications**
- **Lithium in general practice (BPac)**
- **UK primary care guide for monitoring medicines in primary care**
- **Good Prescribing Practice, MCNZ**
- **Good Medical Practice, MCNZ**

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

MIND THIS

Ultrasound errors

Dr Peter Moodie

Peter Moodie is the College's Clinical Advisor

The first consultation

In March 2019 Ms A, a woman in her 60s consulted Dr B because of post-menopausal bleeding. Dr B recorded that the bleeding had been present for "a few days". Dr B visualised the cervix, took a smear and carried out a bimanual examination none of which showed any abnormality.

Dr B then arranged for an ultrasound scan and documented that they would tell her if there was any abnormality. They also recorded that she should report back if there was any recurrence of the bleeding. Dr B noted that Ms A had mentioned bladder issues since having children and there were other screening matters to be attended to. Dr B invited her to return to deal with these issues "before long".

The local DHB did not have the capacity to accommodate primary care referrals. However, they did offer a "voucher system", which the practice could issue and providing certain criteria were met (and in this case they were) the patient could take the form to a private ultrasonography unit of their choice and there would be no charge. All this was apparently written on the form.

The practice had an automated logging system whereby significant investigations were tracked to ensure that they were carried out; however, the voucher process was not linked to this and had to be entered manually. Dr B forgot to manually enter the recall.

The second consultation 15 months later

15 months later on 8 June 2020, Ms A had a phone consultation with Dr B where she reported that she had been having recurrent post-menopausal bleeding over the last year and indeed stated that this had been going on for "some years". She also complained of abdominal discomfort which felt like premenstrual pains. Dr B further realised that Ms A had not had the ultrasound scan done which they had ordered over a year before.

Dr B arranged for an ultrasound scan which was done two days later on 10 June 2020 and showed to be abnormal. Ms A was seen by a gynaecologist eight days later, where it was recorded that she had had post menstrual bleed "for a year". An MRI showed that she had an advanced endometrial cancer. She had a palliative hysterectomy.

The complaint

Ms A made the following complaints:

- She was overly reassured at the March 2019 appointment that there was nothing to worry about and if she had been told that there was a possibility of cancer she would have acted differently.

- She thought that the ultrasound voucher was to be used only if she wanted to and she thought it would incur a cost.
- She had no memory of a request to return for further screening matters.

Dr C, who was a GP Ms A consulted in relation to a possible ACC claim for medical injury, stated:

- That the case notes were inadequate
- That Dr B had not responded to obvious red flags

The HDC medical advisor disagreed with both those statements.

The outcome

The HDC determined that although there was an element of personal responsibility by the patient, Dr B had breached the Code by not putting in place a memorandum to follow up the ultrasound request.

An adverse comment was made that Dr B had not adequately explained the reason for ultrasound, such that Ms A was falsely reassured that there was nothing to worry about.

An adverse comment was made about the practice regarding their not identifying that the voucher system was not integrated with their automated recall software. They were instructed to discuss this with Medtech and their PHO and report back on possible solutions.

The lessons

Firstly, a patient's recall of a consultation that took place at least 18 months earlier held more sway than Dr B's well written notes and recollection of events.

Secondly, while it is stated in College policy that a recall to ensure compliance with tasks is best practice, it now appears that this is being set as a standard of acceptable care. Systems exist within PMS programmes to allow significant investigations to be tracked. The College recommends that for imaging, biopsies or other tests requested by GPs, a process to ensure the results are seen and actioned is put in place. The question arises whether this applies to all tests including blood requests, or only for certain activities. In this case not monitoring patient compliance had a sad outcome but a similar outcome could occur even when even a simple test request is not complied with. However, system constraints need to be borne in mind and the college will continue to advocate for patient responsibility for more routine tests tracking.

Thirdly, the use of the voucher system which is essentially a manual system seems unnecessary. If the DHB is prepared to fund private radiology services in their area then this should simply be an option in the radiology request forms.

Finally, the HDC have instructed the practice to work with the PMS vendor and the PHO to improve the monitoring functions of their computer system. They are required to report back to the HDC on the outcome.

It is problematic whether the HDC would be better making generic comments about possible system changes rather than making specific change recommendations, as this is a complicated area and beyond the expertise of the HDC.

“

… Dr B had not adequately explained the reason for ultrasound, such that Ms A was falsely reassured that there was nothing to worry about.

Rural Aotearoa New Zealand

Definitions, data, and the wild west of health outcomes?

By Dr Mark Smith, Chair of the College's Rural GPs' Chapter

I'm writing to discuss the intriguing geographical classification of health (GCH) and the recent and valuable **'Rural snapshot'**. If you are all over both and can tell your neighbour about them over the fence then feel free to turn to another article.

Otherwise, I invite you all to read on in the hope I can explain and summarise these two tools/publications that are so important for rural Aotearoa New Zealand (NZ), namely:

- the '**Geographic Classification for Health**' (GCH)[1]
- the '**Rural Health New Zealand Snapshot 2024**' recently put out by Hauora Taiwhenua Rural Health Network, (referred to here as **'Rural Snapshot'**)[2].

The mysterious GCH: What is it and why the big deal?

I don't feel as academic as some of my friends and colleagues so let me describe this in a way that makes sense to my brain. I was born in Winton (Central Southland), although I wasn't there long. As it turns out rural areas aren't always the safest placest for childbirth, and mum and I got a very quick trip to Kew Hospital in Invercargill as she waned from bleeding that was reluctant to stop. I spent my early years in the 80s on a small 60 acre block near Wallacetown (15 minutes from the 'town' of Invercargill), while my parents tried to seek out a living between shearing, the freezing works and farm the flood prone 60 acres. I travelled to rural lands for piano lessons in Riverton (35 minutes from town), and enjoyed venturing to 'the hut' with one of dad's friends which was more remote in Eric Elder territory on the banks of the (previously mighty) Waiau river near Tuatapere. Years later I felt really quite remote when based in the clinic at Panguru on the north side of the Hokianga Harbour.

So, was my birthplace rural? Did I grow up a 'rural' kid? Was my piano teacher rural? And finally, I'm sure no one questions that Eric Elder's community and Panguru are properly remote, or are they? It's all a matter of definitions, and correct or relevant ones at that.

For decades, New Zealand's health data showed no significant differences in health outcomes such as mortality when comparing urban to rural people[3]. This was surprising given other similar countries had reported higher mortality rates and lower life expectancies in those living rurally[3]. It turns out that prior to the GCH, New Zealand lacked a fit for purpose rural-urban classification

Dr Mark Smith, Chair of The College's Rural GPs' Chapter

designed for health use. The previous classifications we used had masked or covered up the differences between urban and rural outcomes[1]. This was best explained to me by Garry Nixon, a friend and colleague at Dunstan, who does health research as good if not better than how he swings the billy for a cup of tea in the bush (and he does that mighty well). An example of how the previous tools masked the truth was that the old classification would consider people on the outskirts of large cities as 'rural.' However, we know that often these people on the outskirts and on 'lifestyle' blocks have low deprivation, are still fairly close to secondary or tertiary services and generally have health outcomes that are really good, thus relatively improving outcomes for the rural data set. In addition people living in a medium sized town (along with their poorer health outcomes in many cases) may have previously been considered 'urban' (for example Tokoroa and Westport) no matter how remote that town is from main centres and secondary or tertiary services.

In recognition of this problem, a 'dream team' formed and developed the New Zealand 'Geographic Classification for Health' (GCH)[1]. This, more appropriately defines rurality from a health point of view, is robust and also 'aligns with a heuristic sense of what is understood to be rural' in our health context (1, p. 26). As per the table below, this takes into account distance from main centres but also proximity to and size of rural towns for folk living very distant to cities. **Visit this webpage** for helpful maps showing this in New Zealand.

SSGA18 Urban Category	Geographic Classification for Health				
	Urban		Rural		
	Urban 1 (U1)	Urban 1 (U2)	Rural 1 (R1)	Rural 2 (R2)	Rural 3 (R3)
Major urban (population ≥ 100,000)	≤ 25 min		≥ 25 - ≤ 60 min	≥ 60 - ≤ 90 min	≥ 90 min
Large urban (30,000 - 99,999		≤ 20 min	≥ 20 - ≤ 50 min	≥ 50 - ≤ 80 min	≥ 80 min
Medium urban (10,000 - 29,999)			≤ 25 min	≥ 25 - ≤ 60 min	≥ 60 min
Small urban (1,000 - 9,999)				≤ 25 min	≥ 25 min

Applying this geographically to the narrative we started with (noting this is from a health perspective): Winton's birthing unit was in an R1 area. I may have to surrender my claim to be 'rural born and bred' as I actually grew up in a U2 area (healthwise). Eric Elder practised in an R2 area (albeit on the border of R3) and, the Panguru community live in a remote R3 area as do most residents cared for by Hauora Hokianga.

GCH in use

The GCH is an incredible tool that has now been used to explore many rural-urban differences (or similarities) with regards to health, and has uncovered some important health data and rural-urban disparities. Some key findings include increased mortality rates in <60 years olds living in R1, R2 and R3 areas compared to those living in U1 areas[2]. Analysis using the GCH shows Māori mortality rates exceed non-Māori across the urban-rural spectrum (all 5 levels of GCH)[4]. In addition, rural Māori have excess mortality compared to urban Māori[4].

A lot more data has been determined using the GCH as a tool. A summary of some of this is available in the 'Rural Health New Zealand Snapshot 2024'[2], put together by Hauora Taiwhenua.

Rural Health New Zealand Snapshot 2024

This is a very useful summary for us to digest and share with others, particularly those in positions who can affect change in helping address rural inequities. Some key findings that are noted in the 'Rural snapshot'.[2]

Health outcomes

Māori under 30 years old living in remote R3 areas are twice as likely to die from a preventable cause than Māori living in U1 areas. Non-Māori (aged 30-44) living in the rural R2 and R3 areas are 1.8 times more likely to die from preventable causes than non-Māori in big cities. Increasing rurality is also associated with an increasing gap between Māori and non-Māori mortality rates.

Suicide rates are higher for rural than urban males (64% higher in the 15-44 year old group).

Population, ethnicity and age

19% of New Zealand's population is rural (according to GCH), just under 900,000. 65% of those living rurally are in R1 areas, with just 5% in R3 areas. The more rural the area the higher the proportion of Māori with R3 areas having 36% Māori, R1 areas 19% compared to urban areas which have 15% Māori.

Rural populations are older and have less young people[5]. 20% of the rural population is over 65 compared with 14% of the urban population. 33% of older Māori live in rural areas and 24% of older non-Māori live in rural areas.

Social determinants of health, education and connection

There is a significant overlap with rurality and deprivation, this is also connected to ethnicity[5]. For example 39% of those living in R3 are in 'social and economic deprivation quintile 5' (Q5) compared to 19% of those living in U1. Furthermore 73% of Māori in R3 areas are within Q5 compared to 37% in U1[5].

There are lower levels of education (both at secondary and tertiary levels) for rural people[5]. Rural areas also have reduced access to both cellphones and the internet[5] and 2.5% of rural households have no telecommunications access.

Rural GPs, rural hospitals and hospital admission rates

50% of rural GPs have unacceptably high GP to patient ratios and mid last year nearly 60% of practices advertised a GP vacancy.

Despite poorer health outcomes rural people are less likely to have a hospital admission (with people in R3 areas up to 37% less likely to have an admission compared to U2 rates). People in R3 areas have less access to ED and specialist services than all other groups.

In summary

Our rural areas have worse health outcomes, and worse data with regards to education and social determinants. In particular, health data is still worse for rural Māori. We are grateful for the GCH, and the work of Hauora Taiwhenua. Additionally, we all need to continue to stand and advocate for our rural communities, and do our bit.

References:

1. Whitehead J, Davie G, de Graaf B, Crengle S, Fearnley D, Smith M et al. Defining rural in Aotearoa New Zealand: a novel geographic classification for health purposes. New Zealand Medical Journal. 2022;135(1559).
2. Hauora Taiwhenua Rural Health Network. Rural Health New Zealand Snapshot 2024.
3. Nixon G, Davie G, Whitehead J, Miller R, deGraaf B, Lawrenson R, et al. Comparison of urban and rural mortality rates across the lifespan of Aotearoa/New Zealand: a population-level study. J Epidemiol Community Health. 2023;77(9):571-7.
4. Crengle S, Davie G, Whitehead J, de Graaf B, Lawrenson R, Nixon G. Mortality outcomes and inequities experienced by rural Māori in Aotearoa New Zealand. The Lancet Regional Health – Western Pacific. 2022;28.
5. Whitehead J, Atkinson J, Davie G, Eggleton K, Crengle S, Miller R, Blattner K, Nixon G. Comparison of the sociodemographic composition of rural and urban Aotearoa New Zealand: Insights from applying the Geographic Classification for Health to Census 2018. New Zealand Population Review. 2023;48:42

Goodfellow unit podcast:
Respiratory syncytial virus (RSV) in adults

Professor Nikki Turner is a Fellow of the College (general practitioner) and the Medical Director of the Immunisation Advisory Centre, University of Auckland.

Nikki discusses respiratory syncytial virus (RSV) in adults covering off symptoms, management of RSV in adults, vaccinations and prevention strategies.

The key take home messages from this podcast are:

- **RSV is less often recognised as causing illness in elderly particularly frail elderly and those with significant comorbidities.**
- **good adult RSV vaccines are now on the international market and one is soon to be on the NZ private market**
- **there in no New Zealand plan (as yet) to introduce RSV vaccines on the national schedule, but other countries have already done so.**

Listen to the podcast

GP24: Fellowship and Awards ceremony

The Fellowship and Awards ceremony is always a highlight of the College conference. It is a time where we celebrate new Fellows of the College and congratulate our peers who have been recognised for their outstanding work within the College and in their communities.

But it wasn't just us doing the celebrating. Whānau and loved ones of all ages filled up the auditorium and acknowledged their special people as they walked across the stage.

Cheers, kids yelling, kapa haka, waiata and Pasifika drumming added to the celebratory mood of the evening.

This year around 90 children joined in the fun at the ceremony's after-party celebration and were kept entertained with a movie corner, popcorn and piles of hot chips, while the adults enjoyed canapes, drinks and socialising.

The College's Censor-in-Chief Dr Kerryn Lum plays a key role in the Fellowship and Awards ceremony each year. She says, " I love the mix of formality and families, the seriousness of wearing the College academic robes while feeding chicken nuggets to your toddler afterwards. It's such a celebration of this huge milestone for our new Fellows, and an opportunity to acknowledge their families and everyone who has supported them to this point.

"While the mood is celebratory, the stories behind each award recipient, and each new Fellow, are immensely meaningful. Presenting a post-humous Fellowship a couple of years ago was a most poignant moment that brought everything back into perspective.

"For me, it is important to pronounce every name correctly, and to remember the significance for everyone who crosses the stage as well as all those who are not present on the night.

"My academic robe was gifted to me when I became Censor in Chief, from Dr Tessa Turnbull, who was the College's first female President (1997-1998) and I wear it with pride and respect for the history that it carries. It's great to see more involvement from whānau and supporters during the ceremony each year; no matter how carefully we script the event, there are always wonderful surprises."

Congratulations to all new Fellows and award recipients. You can read the full list of our new Fellows and award recipients in the following pages.

"It's such a celebration of this huge milestone for our new Fellows, and an opportunity to acknowledge their families and everyone who has supported them to this point.

Class of 2024: New GP and Rural Hospital Doctor Fellows

On Saturday 27 July, the College hosted its Fellowship and Awards Ceremony as part of GP24: Conference for General Practice, at Tākina Conversion Centre in Te Whanganui-a-Tara Wellington.

The ceremony is always a highlight and this year was no different. It was a fantastic evening filled with aroha, whānau and celebration.

The members below received their Fellowship at the ceremony. Well done to all of you!

New Fellows Dual Fellowship

- Dr Sheng-Tsung (Dominique) Chiu
- Dr Rachel Wymer

New Fellows Māori

- Dr Mali Burke
- Dr Emma Carter
- Dr Nohoana Findlay
- Dr Erin Henare
- Dr Antony Inder
- Dr Kaea Matenga
- Dr Maree Park
- Dr Tipene Wairepo
- Dr Kiri Wicksteed

New Fellows Pasifika

- Dr Anthony Dewan
- Dr Shavonne Duffy
- Dr James Slater

New Fellows

- Dr Shaheen Ahamat
- Dr Ange Aitken
- Dr Ibrahim S. Al-Busaidi
- Dr William Angus
- Dr Antonia Arlidge
- Dr Juliana Bahadin
- Dr Matthew Bell Dr John Byron
- Dr Melissa Chan
- Dr Huan Chien Chan
- Dr Jessie Choong
- Dr Krithika Chouhan
- Dr Lara Elsie Clark (nee Manson)
- Dr Nicola Comer
- Dr Mark Conrad
- Dr Mariam Contractor
- Dr Celina Dewe
- Dr Isadora Ekawati
- Dr Geraldine Fancy
- Dr Eve Fitzgerald
- Dr Amanda Freeman
- Dr Hazel Fuiava
- Dr Lisa Go

- Dr Caleb Goh
- Dr Kate Gordon
- Dr Sam Harris
- Dr Samuel Haslam
- Dr Sarah Holmes
- Dr Victoria Horne
- Dr Hannah Hurst
- Dr Alex Kassianos
- Dr Nasir Khan
- Dr Hamish Kho
- Dr Marianne Kim
- Dr Michelle Kweon
- Dr Alex Yun Lee
- Dr Kee Ping Lim
- Dr Alicia May Li Loh
- Dr Su Ann Loo
- Dr E Luke Luk
- Dr Daniel James Manson
- Dr Jared McDonald
- Dr Rebecca Meffin
- Dr Lucy Morgan
- Dr Mohd Iqbal Bin Muhamad
- Dr Kelsi Nichols
- Dr Josephine O'Grady
- Dr Wenfei Ou
- Dr Rakesh Premkumar
- Dr Hanna Preston
- Dr Nalini Ramnarace
- Dr Kiri Renssen
- Dr Abdelazeem Salih
- Dr Ayesha Salman
- Dr Sophie Sharpe
- Dr Katie Shillito
- Dr David Shin
- Dr David Short
- Dr Theshini Siriwardene
- Dr Sam Strachan
- Dr Yuhui Sun
- Dr Arianna Sundick
- Dr Elizabeth Thomas
- Dr Kathryn Webster
- Dr Morgana Woolhouse-Williams
- Dr Ming Wu
- Dr Frank Yang
- Dr Meng-Chin Yen

At the celebration function after the ceremony, quotes from all the new Fellows were displayed on screens. Below is a selection of quotes.

I hope to always remember my love for medicine, always practise medicine consciously and never lose sight of life's most important priorities.

Dr Sheng-Tsung (Dominique) Chiu, Dual Fellowship

Mō te katoa te oranga - health is for everyone, let's aim for equity.

Dr Nohoana Findlay, GP Fellowship

Ta savavali fa'atasi, mo lau soifua maloloina. Walking alongside you, for a salubrious life.

Dr James Slater, GP Fellowship

It is a privilege to work in a career where you are continually learning and can advocate for and empower patients. Thank you to my family for their unending support.

Dr Antonia Arlidge

It's an honour to serve the Māwhera community, which has warmly embraced me in a place I now proudly call home.

Dr Huan Chien Chan

GP24: Award recipients

At the conference Fellowship and Awards ceremony on Saturday 27 July, College President Dr Samantha Murton had the privilege of congratulating our College award recipients as they crossed the stage.

Congratulations again to all who received a College award at GP24: the Conference for General Practice.

Distinguished Fellowship

Awarded for outstanding service to the College's or Division's work or the science or practice of medicine. Distinguished Fellows embody our motto '*cum scientia caritas*' – with knowledge, compassion,' and have made sustained contributions to general practice, medicine, or the health and wellbeing of the community.

Dr Tony Becker | Wairarapa

Dr Tony Farrell | Bay of Plenty

Dr David Maplesden | Hamilton

Dr Ranche Johnson (Ngā Puhi) | Auckland

Dr Veronica Lamplough | Auckland

Dr Mark Lankshear | Northland

Dr Rory Miller (DRHM) | Waikato

Honorary Fellowship

Awarded to individuals of distinction who have made an outstanding contribution to general practice or the medical profession in general. These people do not need to be graduates of medicine.

Dr Lesley Gray | Wellington

President's Service Medal

Recognises an outstanding contribution to the College or Division. For example, as a Faculty or Chapter committee member, medical educator, or long-standing employee.

Dr Andrew Morgan | Blenheim

Dr Jethro LeRoy (Ngati Ranginui) | Bay of Plenty

Dr Katrina Kirikino-Cox (Ngati Porou, Te Aitanga a Mate) | Auckland

Dr Lucy O'Hagan | Wellington

Community Service Medal

Recognises members who have made an outstanding contribution to general practice through work in their own communities.

Dr Jennifer Hall | Bay of Plenty

Dr Marta Kroo | Dannevirke

Dr Martin Henare (Ngāti Pūkenga, Ngāti Maru) | Waikato

Dr Vivek Patel | Auckland

Read more about the recipients and their achievements in the College media releases.

1. Distinguished Fellows
2. Honorary Fellow
3. President's Service medal
4. Community Service medal

Goodfellow unit podcast: **Neck lumps in adults**

Rajan Patel is the New Zealand Convener for World Head and Neck Cancer Day. He has been involved in Head and Neck Cancer treatment for 20 years.

In this podcast, Rajan discusses the critical red flags associated with neck lumps in adults. He covers when an urgent referral is necessary and what patients can expect during their visit to a neck surgeon for a red flag neck lump.

The key messages of this podcast are:

- **Familiarise yourself with the red flags**
- **Consider a malignant diagnosis**
- **Conduct a thorough head and neck exam**
- **Refer urgently if illicit suspicious/red flag symptoms or signs.**

Listen to the podcast

GP24: Peter Anyon address

The Peter Anyon Memorial Address is given by a GPEP year 2 registrar at the College's annual conference. The presentation is given in memory of Dr Peter Anyon, who is recognised as having made an should read important and valuable contribution to the vocational education of general practitioners.

At GP24: the Conference for General Practice, Auckland-based GPEP year 2 registrar Dr Zarah Allport delivered the address at the 50th anniversary gala dinner to around 200 guests.

Zarah spoke about her journey into general practice saying that she is a proud MAPAS graduate. She says that these programmes work, and they must be protected because it is a space where students are supported and encouraged to realise their potential to become amazing members of the healthcare community.

"Coming to Te Whānau o Waipareira and being able to change my approach to one steeped in community with the emphasis being always on "whānau first" it truly felt like the first time I had genuinely loved my mahi."

As doctors, Zarah says, there is a profound responsibility to advocate for patients, not only within the confines of our clinics but also in the broader societal context. It is crucial to help the public understand the complexities and challenges of navigating the health system. Many patients face real and significant barriers to accessing care, from financial constraints to logistical issues, and even systemic biases.

"My message to all of you is to use this privilege, get creative, advocate for whānau as hard as you can. I know our job is already busy and hard, but times are getting harder for everyone out there and with the current situation our patients, our whānau are going to need us more than ever.

Zarah ended by saying ,"I remain optimistic about the future, my own and that of primary care in general, and I cannot wait to see where the rest of my path leads.

"I am proud to be here, I am proud to be Māori and I am incredibly proud to be a GP."

To hear more about Zarah's journey and experiences, read **her full speech here.**

"I remain optimistic about the future, my own and that of primary care in general, and I cannot wait to see where the rest of my path leads.

2024 Greg Judkins Prize for Reflective Poetry

Each year the College runs the Greg Judkins Prize for Reflective Poetry.

Dr Greg Judkins is a retired GP and Distinguished Fellow of the College, he's also a published poet and writer. Greg's life-long love of poetry and fiction led him to start creating short stories, inspired by glimpses of the extraordinary lives of the people he encounters in his medical work.

The 2024 competition

This year the theme was 'the consultation' and there were two categories:

- Short poem: Up to six lines
- Long poem: Up to 25 lines

The competition was open to all College members.

The judges

This year the competition was judged by Greg, alongside Dunedin poet Ruth Arnison and Dr Art Nahill, a recently retired poet-doctor.

The results

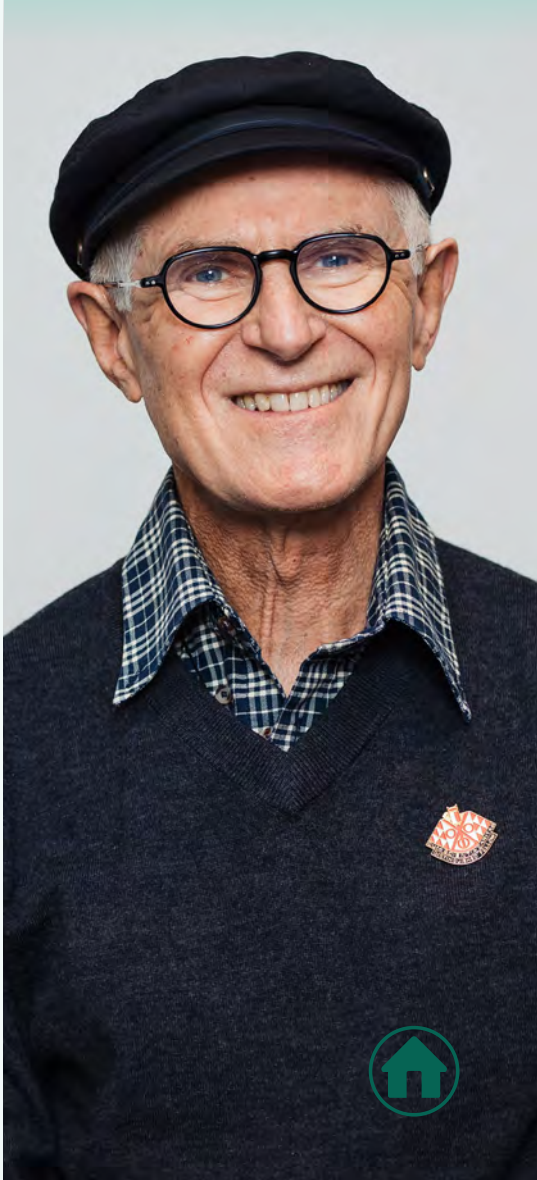
The winners were announced at the recent GP24: Conference for General Practice in Te Whanganui-a-Tara Wellington.

Short poem winner, Dr Lauren Arnold

The consultation

Every day; a parade
of fifteen minute smiles
of neat little bites, out of broken little people.
Every day ends;
and every body leaves
a mess.

Dr Greg Judkins retired GP and Distinguished Fellow of The College



Short poem runner up, Dr Emily Cavana

Disruption

I don't always listen very well.
I try, yet sometimes, what went before
intrudes.
My mind returns to it.
Like a tongue with a jagged tooth.

Long poem winner, Dr Fred Simpson

Drambuie

Old, even for a tree, his ears eaten by the sun
and surgery, Don would summon me when his wife
was ill, for a visit, and Drambuie – always
Drambuie – would be siphoned unsteadily
into glasses before I reached the door;

and I would sip, and he would sip, the
too-sweet liquor.

He would talk then, (as best he could through
manufactured teeth), about brotherhood in
war – about flying, bombing, bleeding,
dying as one – gripping honour like a nun's rosary,
to circumvent the obvious conundrum;

and I would sip, and he would sip, the
too-sweet liquor.

Then, one day in winter when only polyanthus
bloomed, it was his wife who summoned me to visit.
I entered through their open door, and shivered.
As before, he sat below a Lancaster, but only
in spirit; and after I had signed the certificate

she sipped, then I sipped, the
too-sweet liquor.

Long poem runner up, Dr Margaret Chavasse

The consultation

I prescribed a medicine for you
It tasted of aniseed
When we both first met.
You arrived with symptoms cut from Arial text
Consultations like peggy squares
A blanket, under which I slept.

Chekhov, William Carlos Williams, Keats,
Medical writers.
Heads filled with secret files.
Passions, pain
Dust covered dreams
Played out in this room again.

Now you arrive with a backpack of yearning
These walls, a plinth, a desk, a chair.
An open cage, a flock of birds
that land on this page as words.

Instead of a gift,
A handmade card, a transaction.
You bring your needs as a tealight.
We live with uncertainty.
It is, finally, a privilege.

I prescribe a medicine which tastes of aniseed,
And dreams, and fields,
Stories stirred,
Back in this room of a million words.

Primary hyperparathyroidism

Presenting as tiredness, fatigue and poor concentration. A curable condition.

Dr Francis Hall

The symptoms of hyperparathyroidism are commonly encountered in general practice and therefore easily overlooked. By reading this article my intention is that you will feel more confident to look out for, and subsequently screen for hyperparathyroidism.

Spare a moment to think about hyperparathyroidism.

In medical school we were taught the rhyme: stones, moans, bones and groans to help us remember the symptoms of hypercalcaemia.

Stones	Kidney stones
Moans	Abdominal pain: constipation, nausea, vomiting, peptic ulcers, pancreatitis
Bones	Bone and muscle pain, fractures, osteoporosis
Groans	Psychiatric: depression or psychosis

One of the most common causes of hypercalcaemia is primary hyperparathyroidism.

The other common causes of hypercalcaemia are cancer and excessive calcium intake.

The rhyme: stones, moans, bones, groans only applies to about 20% of patients with primary hyperparathyroidism.

> However, the most common symptoms of hyperparathyroidism are:
>
> chronic fatigue, body aches, difficulty sleeping, memory loss, poor concentration, depression, and headaches. (Parathyroid.com).

Fortunately, hyperparathyroidism is easily diagnosed with a simple blood test.

In hyperparathyroidism we see a raised PTH level and a raised serum calcium (adjusted calcium) level. It is important to exclude a secondary cause of hyperparathyroidism by checking the vitamin D level, creatinine and EGFR. Secondary causes of hyperparathyroidism include vitamin D deficiency and chronic kidney disease.

Once the diagnosis of hyperparathyroidism is made, I recommend you refer the patient to either a surgeon who performs parathyroidectomy or

Dr Francis Hall is Head of the Department of Otolaryngology Head and Neck Surgery at Counties Manukau DHB and has a private practice in Auckland. He is a New Zealand–trained ORL head and neck surgeon with extensive additional overseas training in head and neck surgery in Toronto, Sydney and Melbourne. He worked for five years as a head and neck/thyroid surgeon at Henry Ford Hospital in Detroit. He is an accomplished writer and presenter and loves to share his experiences with fellow specialists.

to an endocrinologist. The endocrinologist is likely to refer the patient to a parathyroid surgeon.

In the 2022 guidelines for Evaluation and Management of Primary Hyperparathyroidism[1] the indications for surgery are:

1. Serum calcium 0.25 mmol/L above the upper limit of normal or;
2. Skeletal involvement
3. Renal involvement
4. Kidney stones
5. Hypercalciuria (>250mg/day in women, >300mg/day in men)
6. Age <50

Guidelines indicating which patients with hyperparathyroidism benefit from surgery vary with some groups; the American Association of Endocrine Surgeons[2] and the German Association of Endocrine Surgeons[3] recommending surgery in patients with psychological (chronic fatigue, low mood) or neurocognitive symptoms (poor concentration, poor memory).

This contrasts with the fifth international workshop on primary hyperparathyroidism[1] stating, "surgery cannot be recommended to improve neurocognitive function, quality of life, because the evidence is inconclusive."

Let's look at some of that evidence.

In a ten-year prospective study of patients undergoing parathyroidectomy for primary hyperparathyroidism, Paseika JL et al[4] noted that the quality of life scores improved significantly and this improvement was still evident at 10 years. This study also showed improvement in the tiredness, mood swings, depression, and forgetfulness.

Roman SA et al[5] in a study of 212 patients with primary hyperparathyroidism concluded that there was a reduction in mood and anxiety symptoms and an improvement in memory in patients who underwent parathyroidectomy.

The problem with the evidence is that most studies looked at relatively low numbers of patients (less than 250 patients per study). Also the end points (tiredness, poor concentration, fatigue, mood) are difficult to measure and the way the end points are measured varies from study to study. This makes it difficult to perform a metanalysis of the data.

In my experience and that of many parathyroid surgeons[2,3];

Most patients with psychological and neurocognitive symptoms (tiredness, fatigue, insomnia, depressed mood, poor concentration, poor memory) and primary hyperparathyroidism are substantially better or cured after parathyroidectomy.

Take home messages:

1. It is recommended that patients with tiredness, fatigue, insomnia, depressed mood, poor concentration or poor memory be screened for primary hyperparathyroidism.
2. To screen for hyperparathyroidism, request the following blood tests: serum adjusted Ca, PTH, vitamin D, creatinine, EGFR.
3. Refer patients with a high PTH level and a high calcium level to a surgeon who performs parathyroidectomy or an endocrinologist.
4. In my experience and the experience of many other parathyroid surgeons[2,3], operating on patients with primary hyperparathyroidism often improves or cures tiredness, fatigue, insomnia, depressed mood, poor concentration and poor memory.

References:

1. **Bilezikian JP, et al. Evaluation and Management of Primary Hyperparathyroidism: Summary Statement and Guidelines from the Fifth International Workshop. J Bone and Mineral Research. 2022; 37: 2293-2314.**
2. **Wilhelm SM, et al. The American Association of Endocrine Surgeons Guidelines for Definitive Management of Primary Hyperparathyroidism. JAMA Surg. 2016;151:959-968.**
3. **Weber T, et al. Management of primary and renal hyperparathyroidism: guidelines from the German Association of Endocrine Surgeons. Lagenbeck's Archives of Surgery (2021) 406: 571-585.**
4. **Pasieka JL, et al. The long-term benefit of parathyroidectomy in primary hyperparathyroidism: A 10 year prospective surgical outcome study. Surgery 2009;146:1006-13.**
5. **Roman SA, et al. The Effects of Serum Calcium and Parathyroid Hormone Changes on Psychological and Cognitive Function in Patients Undergoing Parathyroidectomy for Primary Hyperparathyroidism. Ann Surg 2011; 253:131-137.**

GP24: Understanding the health of veterans

Dr Michael O'Reilly, Clinical Advisor for Veterans' Affairs attended GP24 to explain how primary care can support the veteran population of New Zealand.

Veterans' Affairs are a unit within the New Zealand Defence Force supporting veterans who have qualifying services and service-related injuries or illness.

Mike started his presentation by asking the audience to raise their hands if they were a veteran or if they had a patient who was veteran. Most the audience raised their hands which led perfectly into the quote:

"The route to understanding veterans in Aotearoa is through primary care."

Being a veteran becomes a part of someone's is identity and can go a long way towards building a relationship with the patient.

Little data on the mental health of veterans was collected between 1952 and 2022. Based on overseas data, we find that veterans are more likely than the general population to suffer from hearing loss, anxiety, depression, alcohol and drug problems.

Most veterans adapt well, some don't.

Free access to primary care and leaving that incredibly supportive environment into the civilian environment can be difficult.

You might be wondering how you, as a GP can help. And Michael gave one tip above all else.

Ask your patient one question – have you ever served in the New Zealand Defence Force? There is evidence that asking that one question can make a significant difference.

Visit the **Veterans' Affairs website** to find out more about their work and what conditions they will cover.

If you have any questions, please email Veterans' Affairs New Zealand Case Manager Tony Spice: **veterans@nzdf.mil.nz**

Dr Michael O'Reilly, Clinical Advisor for Veterans' Affairs speaking at GP24

GP24: Securing sustainable general practice in New Zealand

With long-standing and growing concern about the future sustainability of general practice in Aotearoa, in early 2023 General Practice New Zealand (GPNZ) commissioned Sapere to complete a current state analysis, examining four key areas:

1. stresses on primary health care including general practitioner shortages, funding and other workforce issues
2. primary care not fulfilling its potential, and the challenges of equity and unmet need – what more could be done if settings were to change
3. risks if nothing is done to address pressures on practices
4. what is needed to increase the speed of modernisation of general practice.

General Practice New Zealand Chief Executive Maura Thompson spoke at GP24: Conference for General Practice about the Sustainable General Practice in Aotearoa New Zealand 2024 report.

Maura explained that the environment we're in is not new. We're financially constrained, we know where we want to be, but how do we get there?

Maura asked the the audience for some ideas. Some of the comments included:

- There was a big piece of work in the UK about GP workforce and to understand why people left general practice early
- We keep approaching problems from the same point of view – it doesn't work because we keep doing the same thing
- How we can we use the data in our patient management systems to get the patients in earlier and prevent illnesses? There is a major blowout in hospital costs and we could prevent this.
- Fixing the funding would fix this problem but given that's unlikely to happen – what about practice ownership? If we are going to end up with large corporate ownership, what about the clinical leadership of those practices?

The report has been endorsed by the ministry and you can view it **here on the GPNZ website**.

> "We keep approaching problems from the same point of view – it doesn't work because we keep doing the same thing.

The 1 in 3 need our support

Dr Kate Gregory

Medical Co-director, Cancer Society of New Zealand

Daffodil Day – Friday 30 August – is just around the corner. It's the 34th year for our society's biggest nationwide fundraiser and awareness-raiser.

This year the Cancer Society's message is centred on the sobering statistic:

1 in 3 New Zealanders will get cancer in their lifetime.

In our public messaging we are saying 'the 1 in 3 could be me, you or someone you love' and encouraging people to donate this Daffodil Day.

The generous giving of everyday New Zealanders ensures the '1 in 3' get the vital support they need. It helps provide safe transport to and from cancer treatment, provides accommodation for those travelling for treatment, and helps make sure experienced nurses and counsellors are always there for people affected by cancer.

Beyond caring for people with cancer in the here and now, the Cancer Society is also looking out for those who may get cancer in the future – advocating to drive system level change, funding research and working hard in cancer prevention so that fewer people will get cancer in the future.

In your day to day working life, you will care for many of those '1 in 3'.

So, while we ask the public to give – be it giving a donation, giving their time or energy to volunteer, or giving active support to our cancer prevention activities and advocacy campaigns – our extra ask to those in the medical fraternity like you is to give referrals.

When you have a patient with cancer let them know about our services. The Cancer Society is there, with staff on the ground throughout the motu, to help anyone with any cancer.

GPs are the first port of call for most individuals and their whānau when they have a health concern. That means GPs and staff in their practices are often involved at the start of a patient's cancer journey and can help by directing patients to the Cancer Society's resources, and helping them to understand what to expect before, during and after treatment.

We've worked hard to demystify medical terms and processes, talking in everyday language about the impact and management of the cancer journey.

Patients can view our digital resources online on the Cancer Society website **www.cancer.org.nz**, can get in touch with their local Cancer Society for print and in-person information or can call our 0800 CANCER (0800 226 237) helpline.

Dr Kate Gregory with former Cancer Society NZ Chief Executive Rachael Hart at the Medicines Access Summit hosted at Parliament in April this year.

As an oncologist I also want to take this opportunity to share a few reflections with you on the challenges for our patients and the special role you play as GPs.

- Those dealing with a cancer diagnosis often have multiple specialists involved in their care, multiple treatment modalities and they often have to travel away from their local hospital to receive treatments. This means care can become fragmented and the GP is often a point of contact and reassurance for patients, especially if they have an established therapeutic relationship.
- Prevention and early detection are our best opportunities to decrease the cancer burden in our communities. GPs are critical in promoting healthy behaviours and facilitating screening.
- As more patients survive cancer it becomes increasingly important to address survivorship issues such as premature menopause, osteoporosis and permanent side effects of chemotherapy such as neuropathy. Often as a GP you will be at the forefront of this, and your support of the patients is invaluable.

For me Daffodil Day is an important touch point for the year, not only to raise funds for all the wraparound support services that the Cancer Society funds – a cancer helpline, one-on-one support, informational resources, psychology and counselling, transport to treatment, free accommodation in six main centres, support groups and more – but also to raise awareness of our role supporting world-class research into prevention, diagnosis and treatment, and our tireless work providing leadership and advocacy in cancer prevention and cancer control.

If anything here makes you raise your eyebrows thinking 'I didn't know the Cancer Society did that or provided that', then we encourage you to check out our website to find out more about what we are up to, follow our social media channel of your choice to keep up-to-date or even pop in and say hello at your local Cancer Society.

PlunketLine offers free online specialist breastfeeding support

If you have a patient struggling with breastfeeding, free online specialist support is available through PlunketLine's easy-to-access lactation support service.

Closing the gap: Breastfeeding support for all is the theme of this year's World Breastfeeding Week (1-7 August).

PlunketLine's International Board Certified Lactation Consultants (IBCLC®) are available to support people over the phone or via video call with any breastfeeding concerns no matter where they are, day or night, seven days a week.

PlunketLine Manager Andrew Ryan says breastfeeding can be a steep learning curve, especially in the early days.

"Having access to specialist support at the right time as well as supportive friends and family can make the world of difference.

"A lot of the calls we receive are from first time parents, many calls are about milk supply and positioning and latching pēpi. It's really rewarding that we are able to listen and be there for people when they need us most."

Demand for the online specialist breastfeeding support service has grown year-on-year since it started six years ago. This year PlunketLine's team of six lactation consultants provided 1560 one-on-one online sessions – up 50 percent on the previous year.

To meet the demand of the much-valued service, PlunketLine is in the process of training an extra three lactation consultants who'll be ready to join the team in the coming months.

"Having access to specialist support at the right time as well as supportive friends and family can make the world of difference.

How to refer patients

There are a few ways patients can access PlunketLine's online specialist breastfeeding support service:

- Fill in the patient referral form and send it through to **PlunketLine.VC@plunket.org.nz**
- Patients can self-refer by calling PlunketLine on 0800 933 922 at any time. Calls are answered by registered nurses will complete an assessment over the phone and book them in.
- Patients can book online by clicking on the following link **PlunketLine Video Call Booking (office365.com)**
- Once booked in, the patient will be sent a link (and instructions) for how to download Microsoft Teams, the secure and reliable video chat app used for consultations. The 30-45-minute consultation is carried out in a private environment.

About PlunketLine

- Call PlunketLine on 0800 933 922 for free 24/7 parenting and health support from a Registered Nurse about child wellbeing. We also have nurses who can speak other languages.
- Calls are also free from mobile phones, and patients don't need to be enrolled with Plunket to use PlunketLine.
- PlunketLine offers free online specialist video support for breastfeeding and sleep.