GP Voice

YOUR NEWS, YOUR VIEWS, YOUR VOICES

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Spotlight on
Waikato/Bay of Plenty Faculty

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GP and Indian classical dancer

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

MAY 2024

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Dr Luke Bradford

Kia ora

April has been another busy month full of meetings, advocacy and planning for **GP24: the Conference for General Practice** happening from **25 to 28 July** in **Te Whanganui-a-Tara Wellington**.

The conference is a highlight of the College's event calendar, and with so many members in one place it is a fantastic opportunity for Sam and I to catch up and engage with you. Please come and introduce yourselves, chat about what's on your mind, what's happening in your practice or community that's going well, or what your concerns or frustrations are.

The conference is our time to get together as a membership and have quality discussions about our workforce and how we can get accountability from the political and wider sector leadership about the future and sustainability of general practice and rural hospital medicine. We have some great speakers and panel discussions planned, which will be updated on the GP24 website as they are confirmed.

But the conference isn't all serious. There is the social aspect, which I would argue is just as important. Catching up with old friends from med school or your registrar days, former colleagues, as well as connecting with new faces is a great way to reset and recharge your social batteries.

GP24 also marks the end of our 50th anniversary year and we'll be acknowledging that with a celebration gala dinner on Friday evening (26 July); we'd love to see as many of you there as possible. We'll be looking at the successes and achievements we've seen over the past 50 years, toasting our members and looking ahead to what we want to achieve for the next 50.

This year's conference programme will bring more workstreams with more clinical and academic information for you. We received a record number of abstracts (thank you to those who submitted), which showcases some great research that I know you will all benefit from hearing.

Register and find out more information about the programme, celebration dinner, Fellowship and Awards ceremony.

Until next time,

Dr Luke Bradford
Medical Director | Mātanga Hauora

Your Work Counts

– new diary study coming soon

Calls for participants in the second diary study for the Your Work Counts project will be coming out in *ePulse* soon. For this study, we'll ask participants to choose seven consecutive days within a three-week period to record the time spent each day on key tasks. This data will build on data from the first diary study and further support the College's advocacy efforts to have our profession valued appropriately for the work that we do and the complexity of care we provide.

Read more about Your Work Counts.

College advocacy work: A month in review

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

CMC webinar with the Minister

CMC Chair and College President Dr Sam Murton chaired a meeting with the Minister of Health presenting to the Council of Medical Colleges. Discussion included the Minister's areas of focus and questions from members about workforce development.

General Practice Leaders' Forum

The GPLF (that Sam also chairs) has finalised the process with Te Whatu Ora for changes to how contracted providers are represented at PSAAP negotiations. This has been a long time coming and it is gratifying to see the work come to fruition.

International panel on generalism

Dr Anders Svenson recently hosted a meeting with invited international guests to discuss how to increase generalism in the community for rural and remote areas in Norway. Sam discussed our Rural Hospital Medicine Training Programme and how this is implemented in New Zealand, alongside other novel programmes in the UK and USA.

Foundation Standard and immunisation

Although the College did not support all childhood immunisations being available in pharmacies, the support for general practices to manage the precall and recall process was welcome. The College presented to Te Whatu Ora the areas of Foundation Standard that demonstrate the process that all Foundation Standard practices undertake for recall of immunisations. This will ensure that there are no additional requirements of practices attached to the precall and recall funding.

ADHD advocacy

Along with several media interviews on ADHD medication prescribing, the College is engaging with wider sector leaders on how to increase access to diagnosis and treatment for patients by acknowledging that ADHD can and should be under the remit of vocationally registered GPs and noting that it does not fit within the current funding model.

Our advocacy work in April:

- CMC webinar with the Minister
- General Practice Leaders' Forum
- International panel on Generalism
- Foundation Standard and immunisation
- ADHD advocacy
- NRHC Panel Discussion on Business Model for General Practice
- Visit from Health Select Committee Chair
- HQSC
- HDC
- ACC
- Pharmac
- Te Whatu Ora
- Clinical leads

NRHC panel discussion on business model for general practice

Sam was invited to participate in a panel discussion at the National Rural Health Conference on the business model of general practice. This was a wide-ranging discussion on what is needed to make general practice sustainable but also reflecting on the nuances for rural practices and the models of care that have changed completely without substantive change to the way they are funded.

Visit from Health Select Committee Chair

Medical Director Dr Luke Bradford hosted the Chair of the Health Select Committee, Sam Uffindell and committee member Carlos Cheung at his practice in Tauranga to discuss the key role of general practice in the sector, the current deficits and the opportunities for improved health outcomes.

HQSC

We met with HQSC leadership on Quality standards and alignment of general practice with HQSC policies. Given our role in the health system, it is important for the College to be involved from the outset in the formulation of these papers.

HDC

Meeting with the HDC Commissioner to discuss recent cases and their findings.

ACC

Meeting on recertification and sharing feedback from members about requests for information.

Pharmac

Luke met with Pharmac clinical leads on ADHD renewals, tacromlimus renewals, funding alternative oestrogen, MHT delivery system, CGMs, supply issues and Pharmac pressures.

Te Whatu Ora

Luke met with Te Whatu Ora analysts to gain practice demographic data for the Your Work Counts project as we work towards a position on recommendations on a suitable working week and safe patient numbers.

Clinical leads

The College participated in a meeting with the clinical leads from Te Whatu Ora, Ministry of Health, GPNZ and Haoura Taiwhenua Rural Health Network to discuss primary care.

Surgical Mesh Roundtable

The College continues to participate in the three-monthly Surgical Mesh Roundtable to advise establishment of a system to address and prevent surgical mesh injuries.

Spotlight on: Waikato/ Bay of Plenty Faculty

The Waikato/Bay of Plenty Faculty executive comprises 12 members, including Dr Alison Fawty (Chair), Dr Tangi Habib (Secretary), Dr Tariq Ali (Treasurer), Dr Liza Lack (NAC Rep), Dr Angela Glew, Dr Cecile de Groot, Dr Ralph Wiles, Dr Cate Mills, Dr Michelle Stewart (GPEP2), Dr Lorraine Brooking, Dr Geraldine Tennent and Dr Fiona Whitworth.

This year, the Faculty has set three main objectives.

1. To provide educational opportunities
2. To facilitate in-person networking opportunities following the challenges of COVID-19
3. To promote general practice as a specialty among medical students and junior doctors.

Social events

The first event of the year was the inaugural Quiz Night for BOP GPs and SMOs, which took place in March at the Tauranga Yacht Club. The event was attended by 50 participants with a diverse mix of GPs and SMOs who formed teams on the night, creating a lively and competitive atmosphere and providing an excellent opportunity for professional networking.

The winning team was 'The Killers', pictured below (from left to right): Dr Dan Catmull (GP), Dr June Cheng (GP), Dr Ken Belton (GP), Dr Wai Tze Cheng (GP), Dr Luke Szczebiot (vascular surgeon), Dr Justin Wilde (paediatrician), Dr Mark Morgan (vascular surgeon). There was a 'booby prize' for second to last. The Quiz Master was Dr Phil Asquith, a local care-of-the-elderly SMO.

> "This year, the executive set three main objectives: to provide educational opportunities, to facilitate in-person networking and to promote general practice among medical students and junior doctors.

Future social events planned include quiz nights in Hamilton and in Whakatāne, and the Faculty is looking to support social groups of young GPs in Rotorua and Hamilton. The Faculty also hosts a new Fellows' graduation lunch in Hamilton every two years in November for those who are unable to attend the conference, giving new Fellows a chance to wear the College gown and celebrate with family and colleagues.

Plans are also underway for a corporate team to participate in the Round the Bridges run in Hamilton in November.

Educational events

Another highlight in the calendar is the educational symposium, held every two years at a beautiful beach venue in Papamoa. The symposium runs over Friday and Saturday and offers a dinner on the Friday, usually with a non-educational speaker to inspire, followed by a full day of learning on Saturday, with local specialists sharing new guidelines and updates.

The Faculty also supports the Ka Hono initiative, providing collegial support for GPs in the region through funded sessions with trained mentors. **Read more about this in the March issue of GP Voice** (page 16).

As part of our promotion of general practice as a specialty, Faculty members attended the orientation of new PGY1 doctors at Tauranga Hospital to advocate for this career choice, which provided an opportunity to engage with junior doctors individually about their aspirations, with approximately one-third expressing interest in general practice.

Continuing to support its members, the Faculty provides registration discounts to promote attendance at the annual College conference and the encouragement of junior doctors with the GPEP1 Audit Prize, offering $500 for the best audit, as judged by a panel, and includes an equity lens in the criteria.

> “Future social events planned include quiz nights in Hamilton and in Whakatāne and the Faculty is looking to support social groups of young GPs in Rotorua and Hamilton.

Otago Medical School students embrace general practice

Jamie Lamberton
Communications Advisor

In mid-April, the College attended the Early Learning in Medicine Clinical Conference Otago (ECCO), which takes place annually for second- and third-year medical students.

Chyanne Jenness, GPEP Senior Support Advisor and Dr Anna Gilmour, GP and one of the College's lead medical educators attended the weekend conference to sell the benefits of the College's training programmes well before the students have completed their hospital placements.

There was a full schedule of seminars and students could pick which one they wanted to attend. This meant the group that attended the College's seminars were engaged and interested in finding out more about general practice and what a career could look like.

Two 45-minute seminars were run over the course of the weekend.

Chyanne shared with the students:

- An overview of the College and its training programmes (the General Practice Education Programme and the Rural Hospital Medicine Training Programme)
- Requirements for admission into the programmes.

Dr Anna Gilmour shared with the students:

- Why she chose general practice
- Why general practice is a great path to take
- What is rewarding and challenging as a GP
- Travelling as a GP
- What it's like to be a practice owner.

Overall, it was a good event to explain more about the College to future potential applicants and an opportunity for them to ask questions.

> "The group that attended the College's seminars were engaged and interested in finding out more about general practice and what a career could look like.

If you know anyone interested in specialising as a GP or rural hospital doctor, please share our website with them.

Positive vibes at the Rural Hospital Medicine Training Programme Registrar Day

Sandra Suomikallio
RHM Senior Education Coordinator

Almost 60 Rural Hospital Medicine Training Programme registrars and DRHM Fellows gathered on a misty Wellington morning for a day of networking, learning about rural opportunities around Aotearoa and a hands-on workshop.

It had been more than a year and a half since the last Rural Registrar Day was organised, so everyone was eager to get together. The rural registrar day is an important part of the training programme, as there are few chances for the registrars to meet other rural registrars scattered across the country.

Registrars heard from rural hospital representatives about their hospital, positions available and what kind of work–life balance they can have working at their hospital. All the presentations showcased the gorgeous rural Aotearoa landscape and the lifestyle you can have working rurally.

After lunch the registrars listened to a presentation by Dr Alan Furniss on advanced suturing, after which the group was divided into two for the workshop

> “Based on feedback, the day was a success, with the highlights being the suturing workshop, socialising with other registrars and the positive vibes.

Dr Alan Furniss presenting the workshop on advanced suturing.

and sessions on peer groups and the feared exit exam StAMPS. To registrars' welcomed surprise Dr Samantha Murton, the College President, had donated her self-illustrated *Minor Surgery* books to all registrars to take home.

The programme ended with DRHM Fellows sharing their experiences and registrars being able to ask questions from a panel comprised of College and Division representatives. The most asked question was regarding funding. The panel emphasised the College and the Division are trying to secure funding after a proposal was sent to Te Whatu Ora in the spring of 2023.

As the registrar day concluded and the weather turned to custard, our unfazed rural Swiss-army-knife doctors braved the weather and headed to a social event for drinks and nibbles on the Wellington waterfront.

Based on feedback, the day was a success, with the highlights being the suturing workshop, socialising with other registrars and the positive vibes. The College wants to thank all attendees for their energy and feedback. The team has already received great suggestions for next year.

The Rural Registrar Day is an annual event organised by the Division as a pre-workshop event at the National Rural Health Conference.

See page 34 for highlights of the conference this 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.

Members receive each issue direct to their inbox. 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. Private practice model of physiotherapy: professional challenges identified through an exploratory qualitative study
3. Eating behaviour, body image and mental health: updated estimates of adolescent health, well-being and positive functioning in Aotearoa New Zealand
4. Do patients with mental health and substance use conditions experience discrimination and diagnostic overshadowing in primary care in Aotearoa New Zealand? Results from a national online survey
5. Prompting lifestyle interventions to promote weight loss is safe, effective and patient-centred: No

Foundation Standard Facilitator training courses

Carrie Hetherington
Quality Programmes Advisor – Training and Education Design

The College supports more than 1000 general practices across Aotearoa to provide safe, equitable and high-quality health care for people through its two Quality programmes – Foundation Standard and Cornerstone.

The College's Quality Programmes team observed high levels of staff turnover in general practices post-COVID. As a result of this movement, large numbers of new practice managers and other staff members required training around how to gain Foundation Standard certification and a general understanding of our Quality programmes.

Supporting practices post-COVID

We needed to offer detailed support on a larger scale, which resulted in the idea of running a Foundation Standard Facilitator training course.

College staff Heidi Bubendorfer, Principal Quality Programmes Advisor and Carrie Hetherington, Quality Programmes Advisor – Training and Education Design developed two Foundation Standard Facilitator training courses:

1. For general practice staff, mainly practice managers
2. For Quality leads and coordinators working in Primary Health Organisations (PHOs)

Recognising that both general practice and PHO staff are time-poor, the two courses are eLearning packages, designed with flexibility in mind. The courses are complete with resources, recorded webinars, interactive quizzes and activities.

To ensure maximum flexibility, the self-directed learning portion of the course is emailed directly to participants to work through over four weeks. Individuals then attend an online question and answer session led by Heidi and Carrie. One of the general practice participants expressed that, 'it felt like I was getting one-on-one support'.

A game changer

The two courses have been a game changer for general practice and PHO staff alike. A participant from the general practice course expressed that, "the fear of the unknown is very real" and the training course helped to "take the fear out of the Foundation [Standard] process".

Carrie Hetherington
Quality Programmes Advisor – Training and Education Design

Heidi Bubendorfer
Principal Quality Programmes Advisor

With overwhelming demand for the general practice staff course, 10 training sessions were conducted between October 2023 and February 2024. Over this period, 120 individuals were trained as Foundation Standard Facilitators. There is still a large waiting list for the course, so it has been implemented as an ongoing support tool that will be run regularly, ensuring that general practice staff can continue to receive assistance in a more interactive setting.

The future

Building on the success of the general practice course, the focus has now shifted towards training PHO staff, with the first three sessions being held in April. A participant from the first PHO training course we held shared that staff from their own practices had taken our course and are now recommending that staff at their PHO take the version designed for them.

There is a waitlist for the PHO course with further sessions to be scheduled throughout the year. The Quality Programmes team hope to train up to 90 PHO staff members by the end of 2024.

> “It felt like I was getting one-on-one support.

Funding for research

that benefits general practice

Did you know that the College funds research and education that benefits general practice, rural general practice and rural hospital medicine?

There are three funding rounds a year, and applications are reviewed by the Research and Education Committee (REC). **The second funding round for 2024 opens on 17 May, with applications accepted until 28 June.**

Chair of the Research and Education Committee (REC) Dr Stephan Lombard says, “If you have an area of interest or a research topic in mind that would benefit general practice and/or rural hospital medicine, I encourage you to apply for funding. Health research can provide us with incredibly important and innovative information about diseases or conditions, treatments, patterns of care, health care costs or workforce sustainability. Research findings can benefit both health care professionals and our patients alike.”

“A benefit of REC funding is that applicants don’t have to be a member of the College, or a doctor. The research just has to showcase benefits for our profession and the way we work, so please share this information with your colleagues, peers and health networks, and we look forward to receiving your applications.”

Funding

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

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.

Successful applicants are encouraged to submit their final papers to the *Journal of Primary Health Care* (JPHC) and submit an abstract to present at the annual College conference.

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

Q&A with Tōtara Health: Working through the Cornerstone modules

Interview with Gabrielle Banks, Tōtara Health Flaxmere Operations Manager

Tōtara Health have undertaken both the Cornerstone Continuous Quality Improvement (CQI) and Equity modules, kindly agreeing to share their experience with our *GP Voice* readers.

Tōtara Health has two clinics in the Hawke's Bay, serving a population of mostly low-income New Zealanders with a particular focus on Māori, Pacific and other high-needs communities. Tōtara Health has built and grown their practice specifically to serve these communities. As of April 2024, they have 15,455 enrolled patients across their two clinics. Of these patients:

- 6823 (44%) are Māori
- 1963 (12.7%) are Pasifika.
- 2094 (13.5%) are Community Services Card holders or living in quintile 5 areas but not Māori or Pasifika.

This means that 10,880 (70%) of their patients are Māori, Pasifika, Community Services Card holders or quintile 5.

What motivated your practice to complete the modules?

We know that some groups in New Zealand experience inequitable health outcomes and need different approaches to achieve the same health outcomes as other New Zealanders. This is significant given over 70% of our patients experience these inequitable health outcomes day to day.

We completed the Cornerstone modules so we could actively reflect on the work we do in clinic and adapt our approach to improve equity, quality of care and accessibility, with the goal of improving health outcomes for our patients. We believe our patients deserve the best care possible and more and these modules have helped us to deliver this.

We are also acutely aware of the GP shortages issue, so by completing the Cornerstone modules we can support and grow future GPs in Aotearoa through training.

> “We believe our patients deserve the best care possible and more, and these modules have helped us to deliver this.

What did you have to do or think about differently as you worked through the modules?

So many things! It made us think about small and big changes to improve quality of care, accessibility and equity. For example, it made us reflect on the ethnic composition of our staff in comparison to our patients. One of our goals is to increase Māori and Pasifika recruitment to reflect the ethnic distribution of our enrolled patient population. We'd like to increase our Māori and Pasifika GPs but believe this will be unachievable with the national shortage of GPs, so our focus will be on bolstering Māori and Pasifika staff in other areas at the practice.

It also made us consider communication between clinical and non-clinical staff and communication with patients. We discussed the pronunciation of names and what we can do to improve this for patients. Names hold mana, and we're working with our team to ensure they recognise this and ask patients what they would prefer to be called, not asking for another name because their name is "too difficult" to pronounce.

Following completion of the modules, what is the difference for your staff?

The biggest difference is in our regular training for our staff. We have implemented a fortnightly training session for all staff where we can facilitate training in te reo Māori, equity, cultural safety, bias, privacy etc. It also gives us an opportunity to bring in external providers for education and awareness.

We have also incorporated annual training in wait times due to our quality improvement project to ensure staff understand why this is important and ways to improve communication with patients.

And what is the difference for the patient?

The difference is mostly around improved patient experience; for example:

- We advise patients of the estimated wait times. By communicating more openly and consistently with patients about wait times, we can promote relationship building by having respectful conversations, managing expectations, ensuring people understand their options and have time to consider them.
- Our focus when recruiting is to ensure applicants understand equity and how this applies to our patient population in particular. We want our staff to treat our patients with the respect, empathy and compassion they deserve. This has been notable in comments from patients like "they really care about your health" and "staff are always friendly." Feedback about reception staff prior was not great, but this has notably improved.
- Health coaches contact new Māori patients to offer an initial free consultation to introduce themselves and provide a tour.
- We now run a free walk-in clinic for māmā and their tamariki for immunisations, skin care, blood pressures, initial pregnancy consults, advice and support for pēpi, throat swabs and more.

> "We are also acutely aware of the GP shortages issue, and by completing the Cornerstone modules we can support and grow future GPs in Aotearoa through training.

GP24: The conference for General Practice

Kia whakatōmuri te haere whakamua

Walk backwards into the future with eyes fixed on the past

In this 50th year of the College and the Conference, we invite you to come and celebrate this significant anniversary collectively with our College community as part of GP24: The Conference for General Practice. As a College, the knowledge and experiences of the past 50 years will undoubtedly help shape our next 50 years and beyond.

Join us from Thursday 25 to Sunday 28 July 2024 in Te Whanganui-a-Tara Wellington. You'll find our full conference programme and exhibition hall right in the heart of Wellington at the Tākina Wellington Convention and Exhibition Centre.

The conference programme will be appealing to the interests of both GPs and rural hospital doctors as well as the wider primary health care sector, with informative plenary presentations, panel discussions and practical sessions featuring sector experts. The programme will also allow plenty of opportunity for you to network and engage in the exhibition space and at the social events.

While it will be important to acknowledge our past in celebration of our anniversary, we want the programme to be future- and solution-focused and create the space for delegates to bring their positive and innovative ideas and knowledge and look to how we can transform the health sector.

We will once again be offering a virtual registration option for those who are not able to attend the conference in person.

GP24 keynote speakers

Minister of Health, Hon Dr Shane Reti

Hon Dr Shane Reti is the Minister of Health and Minister for Pacific Peoples. He is also the MP for Whangārei. Dr Reti's career began in family medicine and dermatology in Whangārei where he practised for 16 years. He served three terms on the Board of the Northland District Health Board. He was awarded a Queen's Service Medal (QSM) for Public Service in the 2006 New Year Honours List. In 2007 Dr Reti was named the New Zealand Harkness Fellow to Harvard, where he was promoted to Assistant Professor. In 2014 Dr Reti became the first Māori MP to win the Whangārei seat, which he held from 2014 to 2020 and won again in 2023. Dr Reti is the first New Zealand graduate Māori Minister of Health.

Hon Dr Shane Reti

Gilbert Enoka

Gilbert has a long history of success as a mental skills coach with New Zealand's corporate and sporting elite. He is internationally renowned for his 23-year history with the All Blacks, first as their mental skills coach and then as All Blacks Manager – Leadership. He was with the All Blacks for over 300 tests, and during that time the team won back-to-back Rugby World Cups, a very close runner-up in 2023, one Laureus Award (for the best team in the world), 21 consecutive Bledisloe Cups, three Grand Slams, eight Tri Nations and nine Rugby Championships.

Gilbert has worked as a mental skills coach for the All Blacks, Canterbury Crusaders, the Silver Ferns and the Black Caps and strongly believes that players who are mentally prepared will perform better on the day. Gilbert is currently consulting with Chelsea Football Club in the UK.

He has also worked as a highly skilled practitioner, working on performance enhancement for over 30 years with top CEOs, businesses and sporting elite. Gilbert is philosophical in his approach to his own life and thrives on working with people who are in pursuit of excellence, consistency and sustained performance.

Gilbert Enoka

Dr Michelle Dickinson MNZM

Michelle is a Nanotechnologist and Materials Engineer. She has spent the last two decades contributing to cutting-edge technologies, researching solutions for medical and technology applications for clients who range from small start-ups to large corporates.

Having set up and run New Zealand's only nanomechanical testing laboratory that specialises in making and breaking tiny things (nano and micro), Michelle spends her time helping companies with board advisory around science and technology commercialisation, including technical consulting for investors and venture capitalists looking for ROI advice for high-tech start-ups. She says the key to success is not necessarily how great the technology is, but how well the science is communicated and how diverse the engineering team is.

Michelle's success comes from her hard work and lots of opportunities, allowing her to break the poverty cycle she grew up in through education. This experience led her to co-found Nanogirl Labs, a socially conscious business designed to create beautiful and engaging content to help everyone build confidence around STEM.

Michelle became a household name during New Zealand's COVID-19 response, often called upon by the media and government to present the complex happenings in layman's terms.

Michelle has been recognised for her many services to New Zealand for her work in STEM, including becoming a Member of the New Zealand Order of Merit for services to science in the 2015 Queen's Birthday Honours and being awarded the Sir Peter Blake Leadership award in 2015. She was the winner of the Women of Influence award for science and innovation in 2016, winner of the Prime Minister's Science Media Communication Prize and the New Zealand Association of Scientists Science Communicators Award in 2014.

Dr Michelle Dickinson MNZM

The celebration gala dinner

Over the past 12 months we've been celebrating the 50th anniversary of The Royal New Zealand College of General Practitioners. To mark the end of this milestone, we hope you'll join us to acknowledge the achievements and successes of the College over the past 50 years and make a toast to what we'll accomplish in the next 50.

This year's whakatauki, '*Kia whakatōmuri te haere whakamua – Walk backwards into the future with eyes fixed on the past'* was chosen with our 50th anniversary in mind, and our celebration dinner will be full of reminiscing and reflection.

We welcome current and past members and your whānau to be part of this special evening.

- Find out more
- Get your early bird tickets to the conference
- Find out more about sponsorship and exhibition

> "This year's whakatauki, kia whakatōmuri te haere whakamua – walking backwards into the future with eyes fixed on the past was chosen with our 50th anniversary in mind.

MIND THIS

Misread PSA reports

Dr Peter Moodie

In 2017 a man in his 60s had a radical prostatectomy for a carcinoma of the prostate. He was followed up for a further two years by a hospital urology department and regular PSA tests showed no antigen present.

In 2019 the patient was referred back to his medical practice by his urologist, Dr C, with a request that PSA tests should be done six-monthly for two years and then yearly, with the caution that any identification of PSA activity should be reported back to the urology department who would then consider radiotherapy treatment.

The practice

This was a rural practice with real recruitment problems and facing the reality of having to manage the inboxes of part-time workers. The practice policy was that discharge letters and other inbox issues were randomly distributed at a practice level rather than by the owner doctors/nurse practitioners.

When this discharge letter was processed it was obviously read by someone in the practice but possibly not Dr E (see below), and a six-monthly recall was set, but no specific alert was attached to the notes or the recall notice. Over a period of 35 months, seven PSA tests were done, which initially showed no abnormality, but by the 8th month showed a PSA of 0.10mcg/mL, 0.21 on the 13th month, 0.60 on the 20th month and then progressively rose to 5.7 on the 35th month.

Confusingly, some 13 months after the discharge from the urology department, a urology nurse activated a PSA request for the patient. Unfortunately she copied in the wrong urology consultant. She did, however, copy in Dr E, although there is confusion about whether he actually received the report, as there is evidence that the practice had to ring the laboratory for it. The hospital took no action on the raised PSA level.

Although the patient was under the care of Dr E, he did not take over care of the patient until 2018 and saw him only once over the entire period. The PSA results were signed off by several people including a nurse practitioner who each reported the results as “normal”. Obviously the report and the reassurances to the patient were based on the laboratory comment that this was “a normal result”, and indeed it is possible that the report “normal” was signed off without specifically opening of the case notes.

The patient was finally referred by a locum when the final PSA result of 5.7 was identified and the case notes carefully scanned. On referral the patient was found to have a carcinoma of the pancreas and metastases in his liver (origin not determined) and the possibility of nodal involvement in the pelvis (again source not determined but probably prostatic). He died soon after.

Peter Moodie is the College's Clinical Advisor

Communications

Although the HDC clinical advisor questioned the actions of the Te Whatu Ora hospital, no adverse comments were made about them.

The reality was that a urology department decided to pass on responsibility for this patient and instructed the practice to continue monitoring his PSA. This was done by letter, which was addressed to the wrong doctor in the practice. Poor communication is at the heart of many HDC complaints.

The practice

The practice had a less than ideal system for managing inbox data and this was again at the heart of the issues. However, the flawed systems were created to try to even out workload in an understaffed practice with a number of part-time workers.

Decisions

These cases are perfect examples of the "Swiss cheese analogy" and the practice was found in breach for not having robust processes in place. Dr E and the nurse practitioner had adverse comments made about their involvement.

How could this situation have been averted? Possible answers are:

- In an ideal world all inbox management should be undertaken by the "owner" doctor; however, with staff shortages and part-time workers this may not be practical.
- An alert in the case notes would have been very important BUT would only be useful if the person signing off the report actually opened up the case notes. As the HDC clinical advisor also pointed out, to do this for every normal result that a laboratory reported would be impractical. Furthermore, in the absence of an alert, Dr E would have to have not only looked at the patient diagnoses but also read all the outpatient letters.
- Laboratory results should have an explanation that a 'normal result' may not be 'normal' following a prostatectomy.
- When reviewing results for patients a clinician is not familiar with, notes should be opened. There are also certain red flag results, notably PSA, whereby 'normal' levels are entirely different dependent on patient history and should prompt additional process.

The practice, amongst other things has now updated its software systems so that there is greater accountability and auditability. Furthermore, they have also started using a portal so patients can see their actual results.

It is sobering to remember that this patient almost certainly didn't die from prostate cancer, but there was a remote possibility that the pancreatic cancer might have been picked up sooner.

Finally, if the patient had been more informed about the importance of a continuing zero PSA, he may well have alerted the practice to the oversight.

"

Poor communication is at the heart of many HDC complaints.

Meet Dr Sneha Nanjundaswamy: GP and Indian classical dancer

Jamie Lamberton
Communications Advisor

Christchurch-based GP Dr Sneha Nanjundaswamy emigrated to New Zealand from India in 2008, working in a variety of hospital roles before joining Riccarton Clinic in 2016.

At work, Sneha has a keen interest in paediatrics and women's health. Outside of work, she likes to unwind with her children and through dance.

Bharatanatyam dancer

Sneha is trained in Bharatanatyam, an Indian classical dance form believed to be about 2000 years old, with origin traces in ancient temples of South India.

"I started learning Bharatanatyam during the summer holidays when I was about 10, and it really sparked my love for dance. I'm no Bharatanatyam master but I like to call myself a hobby-dancer. Is that a word?" Sneha laughs.

When asked about the difference between Bharatanatyam and the form of Indian dance, Sneha explained that it's a very dedicated dance form.

"It's renowned for its expressive storytelling. Dancers convey intricate narratives, emotions and tales through a combination of facial expressions, hand gestures and body movements. What really makes Bharathanatyam stand out is its use of facial expressions, as this art form places emphasis on portraying your passion towards the audience."

"It keeps me connected to my roots," says Sneha.

Sneha had taken a break from dancing a few years ago, but after she'd had her second child, decided to get back into it after she found a school/dancing group in Christchurch.

"We meet once a week for about an hour, but we train and practice several times each week leading up to a big show. We recently had our annual showcase in February, which was attended by around 400 people and very well received," explains Sneha.

Sneha says adding a hobby to her routine is the best thing she's ever done, and that pursuing a hobby alongside her busy GP life is like a happy medium.

> "I started learning Bharatanatyam during the summer holidays when I was about 10, and it really sparked my love for dance.
>
> – Dr Sneha Nanjundaswamy

"Dance can be considered as an active form of non-competitive exercise… it's essentially yoga with added movement," says Sneha.

Sneha's biggest achievement was performing a solo piece at the NZ Association of Artist Doctors' Concert, saying she got such a buzz from performing.

"I look forward to the concert ever year and hope to perform alongside with my two daughters in the future," says Sneha.

Do you want to be profiled?

The College would like to profile more members who participate in interesting hobbies. If you're happy to be interviewed, please email:

communications@rnzcgp.org.nz

Dr Sneha Nanjundaswamy performing the Indian classical dance form, Bharatanatyam.

> "Sneha's biggest achievement was performing a solo piece at the NZ Association of Artist Doctors Concert, saying she got such a buzz from performing.

ADHD treatment in Aotearoa: a glaring example of health inequity

Opinion by Dr Steven Lillis FRNZCGP (Dist)

The paper I wrote on ADHD recently published in the *Journal of Primary Health Care* was in reaction to the sheer frustration that I feel at how our health care system treats those with ADHD. It's not just me. Many people with ADHD who come to me for health care are denied access to first-line treatment and become frustrated, angry and despondent. They know that stimulants are the best medication. In so many areas of Aotearoa, publicly funded secondary mental health teams will not see those with ADHD, and being told access to these medications requires a thousand dollars or more for private psychiatry opinion hammers home just how unfair the system is.

I work in student health and very few of my patients can afford an assessment by a private psychiatrist. When I talk to GP colleagues, almost all relay similar stories of a refusal by secondary mental health services to see those with a presumed diagnosis of ADHD and the unjust two-tier system that results.

What we have is one of the most egregious examples of health inequity that I have seen in the 35 years I have been in general practice. If you have presumed ADHD and are wealthy, you get good care. If you can't afford private care, you have to live with a set of issues that can cause chaos in life. As there are significant disparities in wealth and income in this country, ADHD is another example where Māori and Pasifika are disproportionately among those being failed by the current system.

The standard definition of health inequities is "differences which are unnecessary and avoidable, but in addition, are considered unfair and unjust". ADHD treatment in our system meets all these criteria.

The rationale for such austere prescribing restrictions may have been reasonable at the time they were implemented as there was little knowledge on what risks stimulant medications posed. We now have 20 years of research to better inform us and the arguments for maintaining the status quo are, at best, weak. The medications are safer than originally thought.

The belief that all cases of presumed ADHD require a consultant psychiatric opinion for diagnosis is flawed and does not recognise the diagnostic spectrum of simple to complex. It also doesn't recognise the work that mental health nurses and clinical psychologists can do in this area. I work with excellent mental health nurses in my clinic whose ADHD assessments are thorough.

"

The standard definition of health inequities is "differences which are unnecessary and avoidable, but in addition, are considered unfair and unjust". ADHD treatment in our system meets all these criteria.

The issue of stimulant abuse was addressed by the Auckland psychiatrist who stated, "There is little evidence of stimulant abuse by patients with ADHD, and no link has been found between treatment with stimulants and later development of substance abuse."

Reducing diversion of these medications is also offered as a reason for limiting their availability, yet diversion occurs with medications much more likely to cause harm such as narcotics and benzodiazepines. There are no such onerous requirements when I prescribe these. Diversion will always occur. Preventing thousands of people with ADHD from accessing the best therapy is a very high price to pay to reduce diversion.

Our current requirement for all patients to be reviewed by a psychiatrist every two years is unnecessary. It adds substantial and avoidable costs with little in the way of benefit. Secondary care advice should be reserved for those who need that level of expertise. Having psychiatrists undertake work that is comfortably within the capacity of general practitioners, nurse practitioners and mental health nurses is simply a waste of scarce health resources.

I'm angry, my patients are angry and their whānau are angry. I think this is true throughout Aotearoa. Our legislation and approach are 20 years out of date. For years the superseded Ministry of Health and now Te Whatu Ora have said that they are looking into it. All that has happened so far is relaxation of monthly to three-monthly prescriptions.

The only way forward is legislative change that substantially expands the pool of who can initiate stimulant prescribing and remove wasteful compulsory two-yearly psychiatric reviews. My patients with ADHD have every right to expect much more from our health system.

Read Dr Lillis' research paper titled **Attention deficit and hyperactivity disorder and use of psychostimulants in Aotearoa, New Zealand: exploring the treatment gap** in the latest issue of the *Journal of Primary Health Care*.

"Having psychiatrists undertake work that is comfortably within the capacity of general practitioners, nurse practitioners and mental health nurses is simply a waste of scarce health resources.

Update from Medical Director Dr Luke Bradford

Dr Lillis highlights an important issue, and I am advocating for the removal of both the two-year renewal criteria and the Gazette preventing primary care from diagnosing ADHD and prescribing medications to treat it. On 2 May, there is a Parliamentary hui happening which will highlight these issues in more depth. I will keep members updated on what comes out of the hui and the advocacy work.

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

Make your voice heard

Submit your article to the Editorial team

Dr Logan McLennan: A mentor to many GPs

Miranda Millen
Communications Assistant

Dr Logan McLennan grew up on a farm in Southland. His older sister moved to Dunedin to study at the teachers' training college where she met a medical student who went on to become the local doctor in Lumsden. "Dr Bruce Wilson was the GP there, and he was my hero. I said to my father, I'm not going to be a farmer; I'm going to be a doctor. And my father said, right, you better pass your exams, and I'll sell the farm."

His father sold the family farm and retired to Queenstown when Logan was a medical student. Unfortunately, in Logan's first year of medical school Dr Bruce Wilson was tragically killed in a car accident. "He was the reason why I headed into medicine. And why I wanted to be a family doctor right from the start. I knew before I went into medical school that I wanted to be a GP. Not a hospital doctor. And that was because of his modelling, I guess; he was very good".

Logan's early career

Logan began his career with the College as a registrar in the Hutt Valley registrar scheme, the General Practice Training Programme (GPTP) in 1975. He had previously been sent to work in New York at Harlem Hospital as a sixth-year medical student in 1970. He describes Harlem as a very rough area with really no primary care at all but says it was a great experience. "I learnt a lot about gunshot wounds and knife wounds that I've never had to use since." It was a terrifying experience, where he was thrown in as if he was a graduate doctor even though he was only a student and feeling outside of his comfort zone all the time. A key person who stood out for Logan was the boss of the surgical ward, Dr John Relland. As a young Ivy League student, John had worked off the Vietnam Coast treating soldiers injured in combat and taught the Harlem students surgical skills.

When Logan returned to New Zealand, he locumed in the Porirua area for GPs who were vastly overworked. He describes the GP service (at that time) as "not much better than Harlem in terms of coverage." He decided Porirua East was a good place to work and use what he had learnt in his training in Harlem. He set up practice at the Waitangirua Health Centre in 1976. He went on to become one of the earliest general practice teachers in 1980.

Influence on general practice as a specialty

In 1993, Logan was a member of the College Medical Education Committee and was asked to chair the new GPTP Management Board. This was a critical period for postgraduate training and a tight budget had been set to fund

> "I knew before I went into medical school that I wanted to be a GP.

training for 50 registrars for only 11 months, with no plans to roll over funding for subsequent years. Under the Medical Practitioners Act 1968, general practice was not defined as a specialty but as a discipline. The government argued this as a reason for not granting future funding.

In early 1994, Logan, joined by Dr Tessa Turnbull and Dr Jonathon Simon, met with the Minister of Health and advocated for the continuation of the College undertaking general practice training and pointed out that other specialities were currently funded by the Crown Health Enterprises and did not need to reapply each year for funding like the GPTP was required to do.

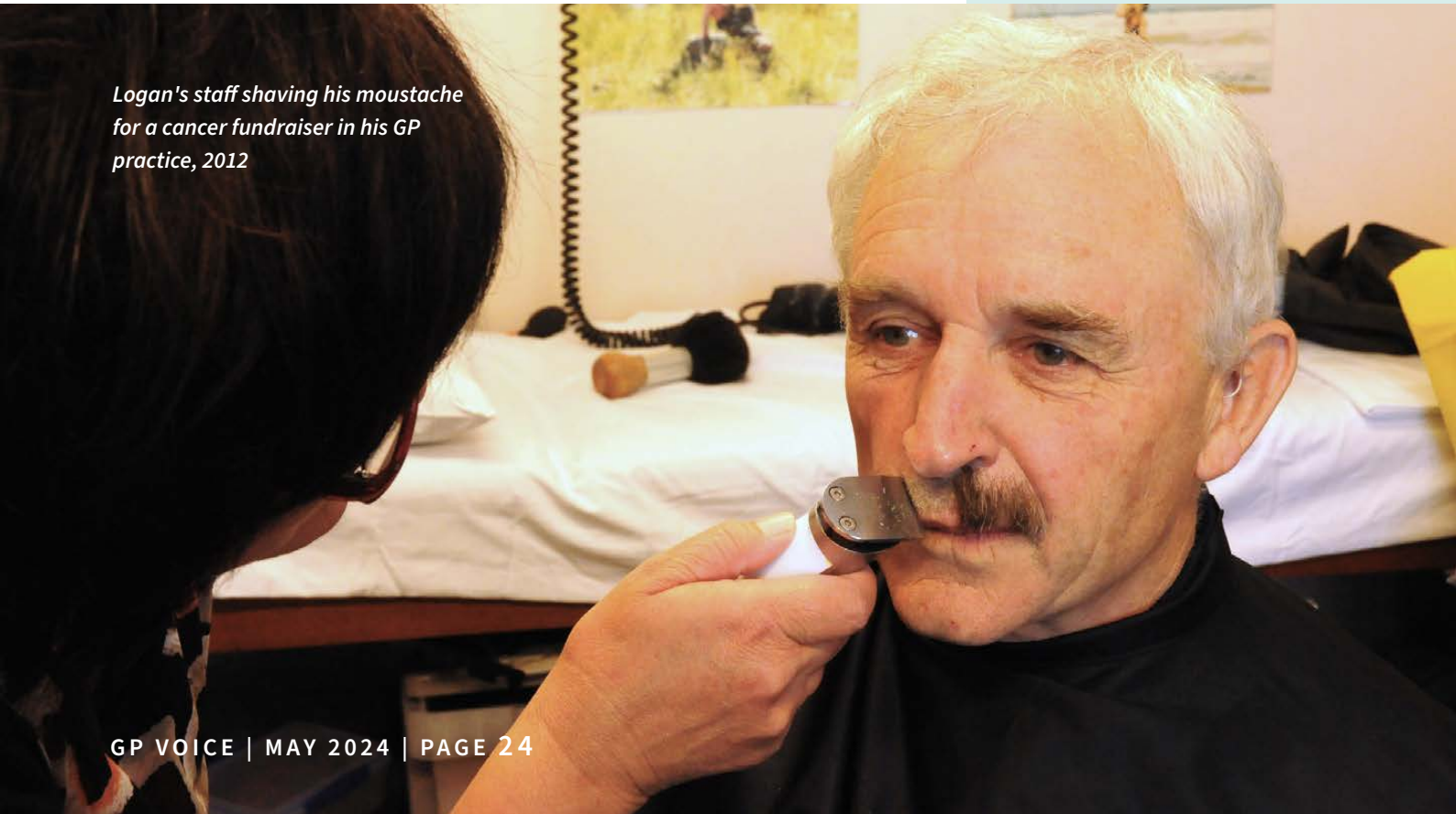
In April, Logan met with the Associate Health Minister and by June another round of funding was announced for 50 registers for 1995. From 1996, general practice would be considered for funding from the newly set up Clinical Training Agency (CTA). The College was required to design a new programme to fit the criteria of the new funding process, which would reach back as far as the early undergraduate years.

These changes meant that medical schools would no longer have to show general practice to their graduates as if it were something new. This is an ongoing issue with today's medical students where there is insufficient general practice taught to undergraduate students. "Inside the medical school itself, certainly in my day, there was very little exposure to family medicine," says Logan.

> "Inside the medical school itself, certainly in my day, there was very little exposure to family medicine.

Becoming a medical educator

Logan's motivation and drive to become a teacher was knowing that he had decided early on that he wanted to become a GP. "A lot of medical students go through medical school and don't quite know where they want to go. And they'll meet someone who is inspirational, like a haematologist or a paediatrician, and that can turn their direction towards that speciality."



Logan's staff shaving his moustache for a cancer fundraiser in his GP practice, 2012

Logan is well-known for his work mentoring family doctors in the Postgraduate GP Training Scheme. Being a teacher was very much what he wanted to do, which he never regarded as an add-on. He really enjoyed that one-to-one teaching. “This was the best place to be a teacher because the trainees were advanced; they were postgraduate. It was one on one. It was the best place to be for teaching; it was more mentoring.” The College had set the assessment process separate from the teaching, which meant that the teacher didn’t have to be an assessor, “because as soon as you’re an assessor, you alter the teacher–pupil relationship. A true mentor doesn’t assess and write reports on someone and score them. The way that the College had set it out, those of us that hosted registrars didn’t have to judge or assess them and that made it a much better mentoring process. It’s one of the strengths of the programme. I hope it’s still going on!”

When he graduated and was a young doctor he got involved with the Clinical School in Wellington, where he would send out fourth-year medical students to sit in with GPs for a week to see what the job was like. This was outside of the College training where he was asked to place students at practices throughout New Zealand in parts of the country such as New Plymouth or Kaiapoi – wherever he could find a GP in another town willing to host a student for a week. That went well for quite a few years. “I had a bunch of really helpful GPs around the country who took the fourth-year students. That was my start until the general practice training programme was up and running.”

When Logan went through the fledging GP training programme in 1975 it was in its second year of existence. He was a registrar at Hutt Hospital for six months with Dr Peter Anyon. He described him as an inspirational person and worked at his medical centre in his practice in Lower Hutt for six months. In 1978 Logan received a fellowship to train in Miami to observe their teaching techniques. Eleven New Zealand GPs were sent over in total, rotated one at a time. Logan was the second GP to be sent over on the programme, and he came back with insights into formal education processes. “This stimulated the general practice training programme quite a lot in New Zealand.”

Later life

He was awarded a Queen’s Service Medal in 2013 for this work and made a Distinguished Fellow of the College on 16 July 2008. He worked tirelessly as a family GP for 43 years, caring for thousands of patients and delivering over 1000 babies before midwives took over in 1990.

Logan was diagnosed with multiple myeloma in 2021, two years after he retired. Sadly, this cancer of the bone marrow is currently incurable, and he has the most aggressive form. Initially he was treated with a triple-drug regime partially funded by Pharmac and achieved an amazing three years of remission, but the myeloma returned in November 2023.

If you would like to contribute towards his treatment costs, his friends and family have set up a **Givealittle page to help fund his ongoing treatment** via the donations they receive.

> “A lot of medical students go through medical school and don’t quite know where they want to go. And they’ll meet someone who is inspirational, like a haematologist or a paediatrician, and that can turn their direction towards that speciality.

Perspectives of health providers in rural Māori and Pasifika communities during the COVID-19 vaccination rollout

Katharina Blattner

Associate Professor, Rural Section, Department of General Practice and Rural Health, University of Otago

This study was part of a wider project. A parallel quantitative study* showed lower rural COVID-19 vaccination rates: at the end of that study period, age standardised rates were 12% lower in remote communities than in larger cities, for both Māori and non-Māori. Most of the rural–urban difference was the result of low vaccination rates among younger rural people (less than 45 years of age). While the rollout appeared relatively uniform in urban areas, this wasn't the case in rural areas where large differences were seen, at times between neighbouring rural communities, and especially for Māori. Despite it being a national programme, local health service factors played a major role in determining the success or otherwise of the vaccination rollout, especially for underserved rural communities.

Our research team (which included experienced rural, Māori and Pasifika researchers) thus wanted to gain insights into local health service factors that contributed to this disparity – what went on in rural health services in Māori and Pasifika communities during the vaccination rollout? Were there lessons to be learned?

We did this by interviewing health care providers in four rural areas across New Zealand to explore the perspectives of those on the ground in rural health services during the pandemic response.

What we found

What we found were numerous challenges but also resilience and innovation. In the planning of the centrally imposed vaccination rollout the rural context had not been considered and multiple logistical challenges were encountered. Recognition that central vaccination policies and procedures were failing their communities spurred rural health providers (NGOs, GP clinics, Māori and Pasifika health providers) to tailor the vaccination rollout to their local context.

> “We found numerous challenges but also resilience and innovation.

* Liepins T, Davie G, Miller R, Whitehead J, De Graaf B, Clay L, Crengle S, Nixon G. Rural-urban variation in COVID-19 vaccination uptake in Aotearoa New Zealand: Examining the national roll-out. Epidemiol Infect. 2024 Jan 4;152:e7. doi: 10.1017/S0950268823001978..

They were able to better factor in their geography, community characteristics, cultural safety, the workflow of smaller health provider teams and limited internet connectivity amongst other things.

The study puts a spotlight on the features and strengths of rural health services – in whakawhanaungatanga; knowing their people and their locality, through established networks and trusted relationships. In this way they were able to tailor services to their geographical and cultural context, taking ownership of the rollout.

The importance of the study:

- The study shows that with adequate central resourcing (as provided during the COVID-19 pandemic), rural services are flexible and can pivot quickly to meet rapidly changing health care needs within their communities, including upskilling and maximising the opportunities offered by the unregulated, but community-engaged, workforce.
- It highlights the importance of both 'geographical' and 'cultural acceptability' when considering the rural context.
- The study emphasises rural places are not miniature cities: the smaller and more remote the community, the more important it is that health services are integrated, requiring bundled rather than fragmented administrative and regulatory frameworks and resources.
- It highlights the need for rural health providers serving under-represented communities like the growing rural Pasifika population to have sustained health programme funding.
- Successful rural vaccine rollouts should not be built on specific immunisation programmes, but rather on strong, resilient rural health services.

Conclusions

1. More sustainable and resilient local rural health services that are geographically tailored, culturally appropriate, and locally driven can deliver routine care and are adequately prepared to respond to emergencies.
2. More equitable outcomes will result from services that are more responsive, flexible and innovative.
3. However, this will require an alternative funding and commissioning process for rural health services to the current predominant model that is based on siloed programmes and funding.

It was only in 2023 that Pae Ora legislation mandated a first ever National Rural Health Strategy. Study findings concur with the Strategy emphasising the need for health policies and planning to be designed and adequately funded to meet the specific needs of rural communities rather than expecting rural health providers to fit into urban-centric funding and service delivery approaches. Culturally safe models should be prioritised to ensure the needs of rural Māori and rural Pasifika people (as well as other priority groups) are addressed and met.

Read more about the research study in the *Journal of Primary Health Care*:

He Aroka Urutā. Rural health provider perspectives of the COVID-19 vaccination rollout in rural Aotearoa New Zealand with a focus on Māori and Pasifika communities: a qualitative study†

† Blattner K, Clay L, Keenan R, Taafaki J, Crengle S, Nixon G, et al. He Aroka Urutā. Rural health provider perspectives of the COVID-19 vaccination rollout in rural Aotearoa New Zealand with a focus on Māori and Pasifika communities: a qualitative study. Journal of Primary Health Care. 2024. https://www.publish.csiro.au/hc/HC23171

PlunketLine: 30 years of 24/7 nationwide support for parents and caregivers

Stephanie Baird
Senior Communications Advisor, Whānau Āwhina Plunket

PlunketLine celebrated a significant milestone in April, as the much-loved free-to-call telehealth service turned 30 years old.

Day, night and in the wee hours of the morning, PlunketLine registered nurses are available to talk to anyone who has questions or concerns about caring for pēpi and tamariki under-five. Parents and caregivers can call them free 24/7 and don't need to be enrolled with Whānau Āwhina Plunket.

Chief executive Fiona Kingsford says there have been around 2.5 million calls to PlunketLine since the telehealth service started – around 300 calls a day.

"As any parent or caregiver knows, there is nothing worse when you're up in the middle of the night with an unsettled child. You're sleep deprived and you're unsure if they are unwell or just uncomfortable.

"Our PlunketLine nurses are available to listen, give advice and reassurance on what to do. They offer support on anything related to caring for under-fives, such as sleep, breastfeeding, toileting, child behaviour and development concerns and caregiver mental health support too."

Collaborative triage

In addition, PlunketLine partners with Whakarongorau Aotearoa | New Zealand Telehealth Services to manage sick and symptomatic calls for under-fives, utilising Healthline's clinical decision support tool to help with that triage. Healthline nurses and paramedics are also able to support PlunketLine callers overnight or at busy times.

PlunketLine nurses handled 42,661 sick and symptomatic calls in the last financial year. Outcomes as follows:

- 111: 1%
- Attend A&M: 36%
- Attend ED: 7%
- GP on call: 1%
- See GP: 32%
- Self-care advice: 22%

Whakarongorau CEO Glynis Sandland says, "Whakarongorau is pleased to partner with Plunket to provide free, clinically robust telehealth services that help ensure that everyone in Aotearoa has an opportunity for wellness."

> "Around 850 specialist sleep support sessions have been done since it started last year.

Porirua-based specialist general practitioner and Chair of General Practice New Zealand Dr Bryan Betty says, "It's really valuable for parents and caregivers to be able to call PlunketLine nurses day and night for advice on everything related to caring for under-fives.

"Those first five years are critical to healthy development and overall wellbeing, and early intervention is key. Telehealth is an important part of our integrated primary and community care landscape, and I value the role that PlunketLine play alongside general practice in setting our tamariki up for their healthiest futures."

Digital evolution

PlunketLine has seen a lot of digital innovation during the past 30 years. What started as an after-hours telephone-based service in Wellington now offers one-on-one video calls with breastfeeding lactation specialists as well as online face-to-face sleep support.

Martinborough-based Trish Higginson is one of PlunketLine's registered nurses providing a listening ear on the end of the line. As well as answering all calls related to raising under-fives, she's part of the team offering online face-to-face specialist sleep support.

Sleep, or a lack of it, is one of the top reasons people call PlunketLine. Around 850 specialist sleep support sessions have been done since it started last year.

"It's so important for caregivers to look after themselves and reach out for support. If you're not feeling your best, it's really tough to care for a little one."

Calls relating to maternal mental health increased rapidly during the height of the COVID-19 pandemic. The latest data shows they remain high – up 70 percent from the onset of the pandemic.

"Sometimes people need someone who they can talk to and figure things out. Having someone to listen and navigate where to go to for support can make all the difference. Sometimes our nurses will call the GP or other support services on mum's behalf – take the load off, make it easier to access the support they need," says Nurse Trish.

About PlunketLine

- Call PlunketLine on 0800 933 922 for free 24/7 parenting and child health support.
- Calls are also free from mobile phones, and the caller doesn't need to be a Plunket client to use PlunketLine.
- Calls are answered by Plunket nurses, who can give advice and can speak other language.
- PlunketLine also offers free online specialist video support with breastfeeding and sleep.
- PlunketLine nurses are located across the country in main centres as well as rural areas such as Alexandra, Martinborough, Whitianga and Haruru in the Far North.

JPHC debate series: AI technology in primary care

The *Journal of Primary Health Care* (JPHC) has reintroduced their back-to-back series, which aims to stimulate debate on various topics, with professionals presenting their opposing views on a clinical, ethical or political issue.

In the recent issue, College Medical Director Dr Luke Bradford and Chester Holt-Quick, CEO of Kekeno Tech, a software development group passionate about the health care industry took sides to debate the topic: **Primary care clinicians should proactively take up the latest AI-based technology**.

A summary of both positions is outlined below.

The YES side

By Chester Holt-Quick

Holt-Quick asks that clinicians be open-minded and not disengaged when it comes to technology and recognise the potential benefits that it can, in many forms, bring to the workplace.

Primary care clinicians should see AI as an opportunity to build and gain knowledge and skills while feeling empowered to use the software in a way that best suits the needs of their patients, workload and business models.

Looking at the growth and the speed at which AI is already being used worldwide implies that more people and organisations will turn to these types of technology, incorporating it into their day-to-day business.

The amount of data that primary care clinicians deal with every day is rising, both with more consultations and more patients presenting with multiple health concerns. Processing this data, whether that be test results, referrals or patient notes, is an important part of the job and needs to be done in a timely manner. This is an area where AI software can assist by organising, analysing and providing relevant information to clinicians. Holt-Quick suggests that using such technology is the only way to fully harness such data.

As with any technology, time needs to be taken to ensure users are confident navigating it and have the necessary support and guidance to ensure they reap the benefits, while being aware of how to manage any risks or issues that may arise. As time goes on, using this technology in a real-world setting (i.e. in a practice with real patient data) will be the true test of how it can make a difference to clinicians' workloads or streamline processes within a practice to free up valuable time that could be used elsewhere.

“

Holt-Quick asks that clinicians be open-minded and not disengaged when it comes to technology and recognise the potential benefits that it can, in many forms, bring to the workplace.

Clinicians who proactively take up AI will ultimately become subject matter experts, sharing their knowledge about how to identify and manage risks, and provide leadership and first-hand experiences through participation in pilot studies.

Holt-Quick suggests AI-based technology must form an essential part of Continuing Medical Education (CME) for primary care clinicians, which means it should also be included in undergraduate medical curricula. He also notes the emergence of new medical journals in this domain that are already available.

Read the full 'yes' response.

The NO side

By Dr Luke Bradford

Dr Bradford acknowledged the growth in uptake of AI use across many sectors and organisations, and the positive transformations that these technologies have shown. However, when it comes to using AI in general practice, a cautious approach is suggested before incorporating it into business as usual.

With the style of health care provided in primary care often called community-based care, and GPs being family doctors, these roles carry the undertone of being very people-centric. Primary care clinicians act as a liaison between patients, whānau, community and services. These relationships take time to build and would be hard to replicate through technology.

Ensuring patients' health is not compromised and risks around consent and data sovereignty are mitigated also needs to be addressed. There is a big difference between a patient's health record being available to other relevant, national health professionals and services and being accessible to AI software developers and being used for research or commercial purposes.

Cost must also come into the decision-making process. On one hand AI use might be seen as an effective way to reduce some financial overheads. On the other hand, financial implications may also extend to why one AI programme is chosen over another.

All health professionals are working towards improved health equity – earlier prevention, better screening, diagnosis, treatment and management of conditions. AI has the potential to open more cost-effective access for priority and hard-to-reach populations, and in areas where workforce shortages are more pronounced – but the implications on, and the views of, the patients need to be at the centre of any decision making.

Dr Bradford highlights the importance of thinking about how we want our practices to run now and in the future. Sitting down as a team to discuss the pros and cons and whether these technologies will help or hinder the continuity of care, trust and whanaungatanga that has been built with patients and communities over time are the conversations that need to happen. As do conversations about how you will measure the success, impact or risk that introducing AI technology will have across your entire business.

Read the full 'no' response.

> "Dr Bradford acknowledged the growth in uptake of AI use across many sectors.... However, when it comes to using AI in general practice, a cautious approach is suggested before incorporating it into business as usual.

Highlights of the National Rural Health Conference 2024

Ashley Darbyshire
Hauora Taiwhenua Rural Health Network

The National Rural Health Conference (NRHC) 2024, held in Te Whanganui-a-Tara Wellington, brought together health care professionals, researchers and policymakers to discuss the challenges and opportunities in rural health. The conference, aptly themed "Kahikatea tū i te uru | Growing stronger, together", provided a platform for insightful discussions on all things rural health.

Endorsed by The Royal New Zealand College of General Practitioners and the College of Nurses Aotearoa NZ, the conference reflected the multidisciplinary nature of rural health care. The endorsement also highlighted the importance of continuous professional development in ensuring the delivery of high-quality care in rural settings.

The conference programme was packed with workshops and sessions that addressed the themes of equity, leadership, technology, resilient communities and growing the workforce. These themes were embedded throughout the conference, including the pre-conference day featuring a PRIME Workshop, Rural Hospital Medicine Registrar Day, and Rural Health Research and Education Day.

PRIME

The National PRIME Committee sought an update from the Health New Zealand Te Whatu Ora senior Rural Health team on the review of PRIME and after-hours services as part of the 'Unplanned Care review'. The PRIME day was a dynamic and engaging event that brought together 60 rural health enthusiasts.

> "The conference, aptly themed 'Kahikatea tū i te uru | Growing stronger, together', provided a platform for insightful discussions on all things rural health.

The day was kickstarted by Health New Zealand | Te Whatu Ora, with a focus on redesigning urgent, emergency and unscheduled care services in rural areas, placing PRIME at the heart of the discussions. Underscoring the crucial role of PRIME in rural health, it highlighted the importance of collaboration and integration in rural health care and emphasised the need for redesigning care services to better meet the needs of rural communities. The interactive 'on the ground PRIME call out scenarios' session offered a deeper understanding of the challenges and considerations in reimagining primary and urgent care services. The discussions from this workshop will contribute to the Terms of Reference, indicating a commitment to continuous improvement and evolution in the delivery of rural health care.

RHM registrar day

The Rural Hospital Medicine Registrar Day was a significant part of the National Rural Health Conference 2024 (see page 10 for the story around what it entailed). This day was exclusively for Rural Hospital Medicine Training Programme registrars, their educational facilitators, or anyone invited by the Division of Rural Hospital Medicine. It provided an excellent opportunity for these individuals to engage in focused discussions, share experiences and learn from each other.

Final thoughts

Clinical director of Rural Health for Hauora Taiwhenua Rural Health Network, Dr Jeremy Webber's highlights from the conference were the "strong presence of registrars and students, which really brought the passion and drive for rural to the fore" and the diversity of the presentations, which made the conference feel very inclusive of all rural health practitioners. His time at the conference helped him to feel a part of the collective and said there was "a large focus on positivity, particularly in light of the ongoing challenges of delivering rural health care."

The National Rural Health Conference 2024 was a resounding success. It not only provided a platform for learning and collaboration but also celebrated the achievements of those working tirelessly to improve rural health. The conference left attendees inspired and motivated to continue their work, with the shared goal of growing stronger, together.

As we look forward to the next National Rural Health Conference, 2–3 May 2025 in Ōtautahi Christchurch, we are reminded of the importance of these gatherings in driving change and innovation in rural health.

"

It not only provided a platform for learning and collaboration but also celebrated the achievements of those working tirelessly to improve rural health.

Book review: Doctor Eric Elder of Tuatapere by Lloyd Esler

Emma McCleary

Tuatapere, in Western Southland, is remote, verdant, bush-covered land. It's a town at the bottom of the South Island, butting up against the remote wilderness of Fiordland. To the south there is nothing much more than the wild icy winds from Antarctica that permanently mark the mighty macrocarpa trees.

This is rural life in its essence where community is everything because there are few other services or people close by to rely on. It's a place where it's not hard to imagine early timber milling settlers and colonial cottages, and it's in this remote, forested Southland area that Dr Eric Elder served his community.

Doctor Eric Elder's life, which is primarily also his work serving as a country GP in Tuatapere, is the subject of Lloyd Esler's recent book *Doctor Eric Elder of Tuatapere*. His work is a detailed memorial to a life of service, alongside great medical adventure stories, and community recollections that show what a magnificent contribution he made, through his medical training, to a community. A more sophisticated book might have edited the community recollections to be sharper and more succinct, but part of the charm of *Doctor Eric Elder* is that they are written verbatim. It's by allowing the locals to not keep on topic but cast a wide net for their memories of Dr Elder, that you see a truer reflection of life in New Zealand at the time.

For example, in a rural community where others didn't have a lot of money, the local GP appeared pretty cashed up, although not an easy mark after all.

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Alongside the stories you'd expect of Dr Elder's career, life and family are the ones you don't, which adds to the detail of this rich life.

Sometimes the local GP also played veterinarian, amputating a dog's leg, working on a cat that had skewered itself on a pitchfork on Christmas day and sewing up a dog in the middle of the night. No vet, no worries. "I didn't really take into consideration he wasn't a vet, says Les. "I saw Dr Elder as someone who would help no matter the circumstances." (page 66).

Dr Eric Elder is also a great marker of how high-trust life used to be, with people recalling – like it was reasonable and not weird at all – how Dr Elder

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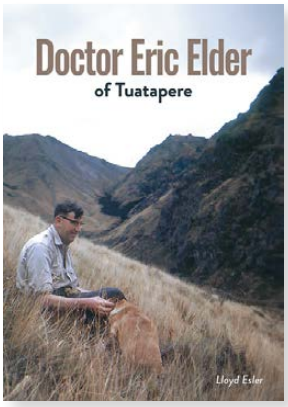
would visit them in the middle of the night, check up on sick patients and then be off again without waking the rest of the household. Many people in rural Southland probably still don't lock their doors. I'm also convinced that many GPs still don't sleep.

In addition to attending sawmilling accidents, delivering babies (the nearest hospital is over an hour away driving at 100km most of the way) and mopping up after car accidents, Dr Elder instigated the fledging GP training programme that is still how the College trains GPs today. Dr Elder had the vision for the scheme (detailed in another more lyrically titled book, *The amoeba, the snail, and the octopus*), that was built on a simple wish that graduates be prepared for general practice when the medical schools and hospital system had so clearly failed them. In 1972 Dr Elder was in the first group of 11 Southland GPs who took in registrars who would otherwise be doing their postgraduate years in hospitals, a doctor-to-doctor training system that still runs in a similar manner, albeit run by the College now, some 52 years later.

Signing up to become a specialist general practitioner, regardless of whether you're looking for just a job, is often signing up to give your life to service. There are many examples in the College's membership of that approach and Dr Eric Elder is here amongst them as kaumātua, trailblazer and foundation stone. His story is one of giving his life to his community and the difference one person can make through dedication to the craft of medical practice and ongoing relationships.

Each year the College awards the Dr Eric Elder medal to an outstanding rural GP who embodies the spirit and dedication of the man it was named for.



Dr Eric Elder of Tuatapere
By Lloyd Esler
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If you'd like to purchase a copy of the book, you can do this by emailing Lloyd directly: lloydesler@outlook.com

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