



## IN THIS ISSUE

### Health workforce

- Primary care specialty career choice among Canadian medical students

### Education

- Evaluation of general practice house officer attachments in Counties Manukau: Insights and benefits

### Clinical issues

- Effect of comorbidities and medications on frequency of primary care visits among older patients

### Cross-cultural care

- Young people have their say: What makes a youth-friendly general practice?

### Health technology

- Text messaging between clinicians and patients – Hve we got thngs unda cntrl?

### Health care systems

- The heroism of incremental care

### Professional practice and development


- Principles of family medicine and general practice – defining the five core values of the specialty

### Quality improvement

- Standing order use in general practice: the views of medicine, nursing and pharmacy stakeholder organisations
- Responding to the needs of patients with multimorbidity: A vision for general practice

Welcome to the RNZCGP digest. The digest contains a selection of recent New Zealand and overseas journal articles and other publications that might be of interest to general practice and to those working in the primary care sector. Some of the articles are available in full at the links provided. Others require an online subscription.

## Health workforce

 **Approved CME activity**  
Click [here](#) for details.



FREE

### Primary care specialty career choice among Canadian medical students

**Authors:** Osborn HA, Glicksman JT, Brandt MG, et al.

Following a literature review, researchers identified factors found to be important to medical career choice and developed a questionnaire with the goal of comprehensively assessing the various influences on specialty choice.

The survey encompassed demographic, geographic, financial and personal characteristics, followed by specialty preferences. It also asked the students to score the relevance of 40 potential career- and training-related factors that might influence their career choice. Family medicine and paediatrics were selected as specialties representing consultant front-line primary care providers (compared to non-front-line specialties).

Three hundred and twenty-three questionnaire responses (59% response rate; N=548) from the 2008–2011 graduating classes of a Canadian medical school were included in the analysis (respondents not indicating their specialty preference were excluded).

Responses were dichotomised into positive and negative influences (no influence responses excluded) and those interested in primary care or front-line specialties were

compared with those whose preference was a non-front-line speciality.

Researchers looked specifically at 15 of the career- and training-related factors selected a priori as being of potential relevance to the choice of a career in family medicine or paediatrics. Eight (out of 15) career- and training-related factors were found to positively influence students' career choice of family medicine or paediatrics compared with other specialties, and these fell into three general categories: work–life balance, physician–patient relationships, and the duration of the residency programme. Conversely, students pursuing non-front-line specialties prioritised developing a specific expertise, maintaining a procedure-focused practice, seeing immediate results of their actions, potentially earning a high income, and having a perceived status among their colleagues. Of these, researchers identified perceived status and remuneration as potential areas of intervention. They suggest slowly changing the perceived medical hierarchy through increasing exposure of students to primary care mentors. They also suggest that increasing exposure to the wide spectrum of practice models and resultant variation in remuneration may reduce the misperception that family physicians are underpaid.

Although the study involved a small sample size from a single institution and an un-piloted survey, researchers expected the findings to be meaningful and able to be extrapolated to other Canadian universities.

**Reference:** Can Fam Physician. 2017;63:e107-13

## Education



FREE

### Evaluation of general practice house officer attachments in Counties Manukau: Insights and benefits

**Authors:** Le Comte L, Hayward B, Hughes D, et al.

Despite international evidence demonstrating benefits of house officer (HO) attachments in general practice, there is little research into how HOs are used during their placements. In particular, there is a paucity of New Zealand evidence from patients, HOs themselves, and non-GP staff in general practice. This study aimed to help fill these gaps by evaluating the value of four HO general practice attachments in Counties Manukau and describing how HO placements are being used in these general practices.

The evaluation occurred during three attachment runs commencing February, May and August 2015 with three to four HOs placed in general practice per run. Each attachment lasted for three months and most involved a postgraduate year 2 HO. The evaluation included interviews with supervising GPs, primary health organisation (PHO) staff, and HOs, focus groups of practice staff, and patient surveys. A total of four practices were involved. Seven HOs were invited to be interviewed following their attachment, one declined. Full sets of data were not gathered for all attachments.

All involved in the HO attachments viewed the programme positively. HOs stated that their placement in general practice increased their confidence with patient examinations and making clinical decisions. HOs and practice staff felt that HOs brought up-to-date or current knowledge to their attachment. Practices also reported that having the HOs helped increase staff morale. HOs generally did not have full caseloads and had flexibility regarding consultation length.

Challenges included variation in the level of knowledge and experience of HOs, leading to some practices scaling back the level of responsibility given to them. Supervisors felt that it took four to six weeks to orientate HOs, and three months for them to be fully up and running. (A proposed orientation framework is provided within the article). Supervisors raised concerns regarding the quality and safety of patient care due to the impact of HOs working after-hours shifts at Middlemore Hospital following work at the practice.

The study is limited in its generalisability by the small number of HOs and practices participating in general practice attachments for HOs and the small geographic area covered.

**Reference:** J Prim Health Care. 2016;8(4):288–294. doi:10.1071/HC16001

## Clinical issues



FREE

### Effect of comorbidities and medications on frequency of primary care visits among older patients

**Authors:** Hu T, Dattani ND, Cox KA, et al.

This was a retrospective chart review of patients registered with the Sunnybrook Academic Family Health team to ascertain if comorbidities and high-risk medications affect the frequency of family physician visits among older patients.

Patients aged 65 years and older were selected if they were among the 5% who visited their doctor most frequently (median 11 visits) or the 5% who visited their doctor the least frequently (median 0 visits) in a year (N=265).

A retrospective chart analysis of the past 12 months was conducted, the number of medications patients were taking was recorded, and an age-adjusted Charlson comorbidity index score calculated for each patient. Researchers also used the 2012 Beers criteria, and the Anticholinergic Risk Scale to identify and score high-risk medications. Data was anonymised before statistical analysis.

Researchers found that women were twice as likely as men to visit frequently (OR=2.2,  $p=0.03$ ), which is consistent with other studies and possibly explained by gender-differentiated attitudes towards seeking care.

Patients aged older than 85 were also found to be more likely to visit frequently than those 85 and younger (OR=5.35;  $p=0.001$ ). Researchers attributed this to the increased comorbidities, resultant increased medication use, and consequent increased need for monitoring.

## Clinical issues

High medication use was another factor found to be associated with higher visit frequency (OR=1.49;  $p<0.001$ ), as may be expected with polypharmacy.

Interestingly, neither high-risk medications nor a high age-adjusted Charlson comorbidity index score were found to be predictors of high-frequency of visits.

Researchers identified several limitations of the study, including an inability to check that all patients in the relatively small sample were still being seen at the family practice during the time frame. This research may contribute to predicting who may benefit from early support and to policy that promotes access to health care services.

**Reference:** Can Fam Physician. 2017;63(1):45–50.

## Cross-cultural care



### Young people have their say: What makes a youth-friendly general practice?

**Authors:** Laura Turner, Leah Spencer, Jack Strugnell, et al.

This research is based on a survey of 155 16–18-year-old students at a single high school in rural Tasmania, which looked at barriers and enablers to young people receiving care.

Of the survey participants, 98.4% reported that GPs were their usual health care providers. Eighty percent reported that it would be 'really useful' to see the same GP at each consultation, and 85.2% stated that it would be 'helpful' or 'very helpful' to see a GP without a parent present.

The most commonly reported barriers to young people accessing health care were 'hoping the problem would go away by itself' (64.5%), difficulties obtaining an appointment at a convenient time (56.1%), and not feeling comfortable seeing a GP (40%).

Almost two-thirds of respondents (64.5%) deemed it 'really important' to discuss issues of mental health, drugs and alcohol, and sexual health with a GP, and a further 32.3% deemed it 'somewhat helpful'.

Over 90% identified the following to be 'really important' qualities in a GP: listening skills (97.4%), easy to talk to (94.8%), makes young people feel comfortable (92.9%), and non-judgmental attitude (92.3%). The age of the GP was not a concern for the majority (56.8%) of participants.

In terms of practice qualities, nearly all (98.1%) of participants stated that it would be 'somewhat' or 'very' helpful if reception staff were able to identify a youth-friendly GP. The availability of after-school appointments was also identified as a high priority.

While the findings of this study may not be generalisable because survey participants were limited to one site, they may provide some guidance to practices looking to improve access to young people.

**Reference:** Aust Fam Physician. 2017;46(1):70–74.

## Health technology



### Text messaging between clinicians and patients – Hve we got thngs unda cntrl?

FREE

**Authors:** Muller MD, Moyes SA, Fulcher ML.

This study aimed to assess clinicians' attitudes and behaviours towards text messaging (texting) with patients. An anonymous, online survey was distributed to GPs and physiotherapists in New Zealand, and to Sports Medicine Fellows (SMFs) and Sports Medicine Registrars (SMRs) in New Zealand and Australia.

A total of 322 clinicians completed the survey, which included 78 GPs. GPs and physiotherapists recorded the least uneasiness towards texting (32% of GPs, 31% of physiotherapists, 58% of SMRs, 71% of SMFs;  $p < 0.0001$ ) and were more likely to find texting useful for patient communication (76% of GPs, 73% of physiotherapists, 48% of SMRs, 33% of SMFs;  $p < 0.0001$ ). Most clinicians identified issues with accuracy when texting (eg texting wrong persons) and thought that texting patients is a privacy concern.

Of the GPs surveyed, 12% felt pressured into texting patients, 26% were likely to discuss patient symptoms and signs via texts, 75% were likely to discuss imaging or laboratory results, and 61% were likely to discuss management plans. Additionally, 79% of GPs sought consent before texting patients; only 9% were likely to discuss medical information with third parties via texts. Seventy-five percent of GPs allowed others to access their phones, while only 31% locked their mobile phones; 80% of GPs preferred to use a work

computer programme for texting rather than their personal or work mobile phone (34%).

The authors conclude that frequent texting occurs between clinicians and patients with potential risks to the privacy, accuracy and security of medical information. They argue that texting is not as accurate as face-to-face or phone communication and highlight the importance of obtaining patient consent before texting and considering texts as professional communications that should be fully recorded in patient records. They indicate that there is a need for further research and the development of readily available, best practice guidelines.

**Reference:** J Prim Health Care, Dec 2016

**Comment:** We note that using a personal mobile device for text messaging is inherently insecure. However, texting via the practice management system (PMS) is more secure and reduces the risk of privacy breaches.

## Health care systems



### The heroism of incremental care

FREE

**Author:** Gawande A.

In this essay for *The New Yorker*, Atul Gawande discusses the benefits of incremental action in medicine, as opposed to one-off 'heroic' interventions. He writes that he was drawn to medicine by its aura of heroism – by the chance to charge in and solve a dangerous problem. He became a surgeon, which seemed to him "the real work of saving lives. Surgery was a definitive intervention at a critical moment in a person's life, with a clear, calculable, frequently transformative outcome."

In contrast, primary care, Gawande states, seemed to him "squishy and uncertain". Gawande states that his views began to change as he viewed the evidence for the benefits of primary care. This convinced him that primary care does a lot of good for people, "...maybe even more good, in the long run, than I will as a surgeon". But he was still left wondering, "...what, exactly, is the primary-care physician's skill?"

The essay follows Gawande as he visits a number of primary care practices and talks to a range of primary care practitioners in the US. Initially his essay postulates that it may be the breadth of knowledge of primary care workers that makes them so effective, but he eventually concludes that their true strengths lie in their familiarity with their patients, the trust they develop with them, and their cautious and empirical approach which allows them to take a long-term view.

## Health care systems

He writes that medicine has evolved away from the 'rescue' approach of the post-war period and towards the 'incremental' approach long taken by primary care. Science has discovered the long-term health significance of high blood pressure, diabetes and other conditions, and with increasing amounts of data on our health, this trend towards incrementalism will accelerate. But, he cautions, "Our health-care system is not designed for this future" ... "We devote vast resources to intensive, one-off procedures, while starving the kind of steady, intimate care that often helps people more." He writes that the difference in the resources that are available to him as a surgeon and those that are available to his incrementalist colleagues is 'immoral'. He concludes that the health system needs to change. "We can give up an antiquated set of priorities and shift our focus from rescue medicine to lifelong incremental care. Or we can leave millions of people to suffer and die from conditions that, increasingly, can be predicted and managed. This isn't a bloodless policy choice; it's a medical emergency."

**Reference:** New Yorker. 2017 Jan 23.

## Professional practice and development



FREE

### Principles of family medicine and general practice – defining the five core values of the speciality

**Author:** Hashim M.J.

This paper reviews the literature relating to the evolution of the values of general practice and aims to identify a universal set of core values for primary care doctors worldwide.

The author identifies five core values that define the speciality of general practice. These are: **compassionate care** – a caring attitude towards patients and their families shown as kindness and a desire to help; **generalist approach** – a perspective on the whole person and the context of illness, including family, culture and society; **continuity of relationship** – the interpersonal bond of trust and respect between family physicians and patients and their families that develops over the life course; **reflective mindfulness** – doctors' awareness of their thoughts and emotions manifested as a sense of presence and attentiveness towards self and others; and **lifelong learning** – a commitment to personal and professional development by participating in learning activities and practice-based research that leads to better patient outcomes.

The author concludes that each principle is an essential attribute of the speciality and, therefore, carries weight in teaching and practice. He also suggests ways that these principles can be implemented or operationalised.

**Reference:** J Prim Health Care. 2016;8(4):283–287.

## Quality improvement



FREE

### Standing order use in general practice: the views of medicine, nursing and pharmacy stakeholder organisations

**Authors:** Taylor R, McKinlay E, Morris C.

Standing orders (SOs) are commonly used in general practice in New Zealand to improve patients' timely access to medicines. An SO is defined as a written instruction issued by a doctor that authorises a specific person (or class of people) who does not have prescribing rights to administer and/or supply specified medicines. This study explored the views of representatives from eight primary care stakeholder organisations, including nursing, medicine and pharmacy. Semi-structured, qualitative, face-to-face interviews were conducted in 2013/2014.

The researchers found that, overall, there was general agreement that SOs are a useful way to improve patient access to health care and to medicines. The use of SOs was believed to have considerable impact on workforce capacity and utilisation, eg supporting role extension and enhancing interdisciplinary collaboration. However, participants believed there was a lack of strategies for developing, implementing, auditing and reviewing SOs in general practice. There was no single place for GPs or practice nurses to obtain relevant information about implementing SOs. Some participants expressed concern that many practice nurses did not have the appropriate training or experience to diagnose and appropriately use an SO. There was a perception that GPs were unaware that they are required to assess or know about a nurse's competence to use an SO. Some participants felt that only a few quality assurance measures were in place.

## Quality improvement

The researchers conclude that there is a suboptimal understanding by key strategic professional stakeholder organisations of the use of SOs in general practice. They call for greater education and training on the development, implementation, use and audit of SOs, and a single organisation to provide advice on these issues.

**Reference:** J Prim Health Care. 2017;9(1):47–55. doi:10.1071/HC16023

**Comment:** We note the **Ministry of Health's Standing Order Guidelines** (referred to in the article) have since been updated. The document reflects the 2016 amendment to the Medicines (Standing Order) Regulations 2002, including the addition of nurse practitioners and optometrists as issuers of standing orders. It also outlines the roles and responsibilities of issuers of SOs and people working under SOs, and includes an SO template guide.



FREE

### Responding to the needs of patients with multimorbidity: A vision for general practice

**Author:** Royal College of General Practitioners.

This report reviews how effectively the current UK health system serves patients living with multiple long-term conditions, and explores the experiences of these patients. The report followed the Royal College of General Practitioners' analysis that revealed the number of people living with one or more serious, long-term condition in the UK will increase by nearly one million to 9.1 million by 2025.

The report highlights the existing barriers to improving the quality of care provided to patients, such as a lack of time and resources for GPs to deliver the care patients need, and the growing inadequacy of the standard 10-minute consultation. It notes that multimorbidity is one of the greatest challenges in twenty-first century health care, but research into patients

with multiple long-term conditions is only in its early stages. Most care is currently channelled towards single-disease conditions, resulting in patients receiving fragmented care. The current lack of a widely accepted definition of multimorbidity is acting as a barrier to consistent, holistic care for all patients.

The report makes a number of recommendations to overcome the barriers. It looks at innovative ways of working, such as longer consultation times for those who need them, collaborative care and support planning, and the role of multidisciplinary teams in caring for patients with complex needs. It also recommends improving communication between primary and secondary care sectors, particularly through improved IT systems; increasing exposure of delivering care to patients with multimorbidity in GP training; and developing improved decision-making tools.

**Reference:** RCGP. Responding to the needs of patients with multimorbidity: A vision for general practice. UK: Royal College of General Practitioners; 2016.

✓ Time spent reading the RNZCGP Digest has been approved for CME for The Royal New Zealand College of General Practitioners' General Practice Educational Programme (GPEP) Years 2 and 3 and Maintenance of Professional Standards (CPD/MOPS) provided that a Learning Reflection Form is completed. Please click [here](#) to download a CPD/MOPS Learning Reflection Form. One form per Digest is required.

**Please note:** A maximum of two hours can be claimed per digest. Total hours should be entered as CME credits on the MOPS page under 'CME – individually planned learning'. You do not need to return this form to the College, but will need to retain it should you be subject to a College audit. Alternatively you can upload the form at the point of making the online entry.



We welcome your comments or suggestions. Please contact the College's Policy Team at [policy@rnzcgp.org.nz](mailto:policy@rnzcgp.org.nz)

**The Royal New Zealand College of General Practitioners** is the professional body that provides training and ongoing professional development for general practitioners and rural hospital generalists, and sets standards for general practice.

PO Box 10440, The Terrace, Wellington 6134 | **T** +64 4 496 5999 | **F** +64 4 496 5997 | **E** [rnzcgp@rnzcgp.org.nz](mailto:rnzcgp@rnzcgp.org.nz) | **W** [www.rnzcgp.org.nz](http://www.rnzcgp.org.nz)