GP Voice

YOUR NEWS, YOUR VIEWS, YOUR VOICES

Quality in Practice at Aspiring Medical Centre

A CQI initiative: Reducing or delaying Type 2 Diabetes

Diagnosing acute rheumatic fever

Helping veterans get the most from a consultation

GP24:

Changing the climate for the better

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

September 2024

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Editorial

Dr Samantha Murton

Kia ora koutou

GP Voice is turning one! It's been 12 months since the College revamped the monthly member newsletter and it is now full of College news, your voices and voices from across the health sector. I hope you've been enjoying the content over the year.

Even though last month's issue was dedicated to GP24, there was so much to share that we've got more updates on some of the panel and concurrent sessions, including the presentation from our very own Censor-in-Chief Dr Kerryn Lum who spoke about the challenges that introverted GPs can face and how to support them during GPEP.

As this goes to print, Luke, Toby, Kerryn and I will have just returned from the WONCA APR conference in Singapore where there were GPs and family doctors from the Asia Pacific region and around the world in attendance. I always find it refreshing to go to a conference where you are with like-minded people even if they are from a completely different country from you. We speak the same medical language and face the same challenges. It is also an opportunity to share what we are doing and to hear how others are tackling the issues they face. We'll no doubt be taking some of the ideas and seeing how we can adapt them to suit our local context.

It was also great to see Luke's Your Work Count project getting some international promotion as he presented to the conference delegates. There was a lot of interest and questions about the results and methodology.

On page 7, you'll be able to read more about the 2024 Workforce Survey that the College will be sending out shortly. This is our biennial survey that we use to capture demographics of the workforce and important insights into how our GPs and rural hospital doctors are feeling. We had a great response rate for the 2022 survey, 72 percent of you completed it, which was great, but I'm keen to beat that for this year.

This data is essential for not only our College advocacy work but we also share it with officials and decision makers including the Minister and the media regularly use the findings.

Please look out for the survey and make time to complete it. There'll be more information coming out over the next couple of weeks about it too.

If you have any stories or news that you'd like to share with your colleagues, please chat to the editorial team to get a spot in an upcoming issue. Email them on communications@rnzcgp.org.nz

Enjoy this month's issue,

Dr Samantha Murton
President | Te Tumu Whakarae

Submit your feedback

Month in review

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

Business case on GPEP training

A business case on transitioning training into a fully functioning three-year programme has been worked up with a College team, registrar representatives and the Board. This has been presented to the Minister and Health New Zealand and we are waiting on approval to go ahead with this transition and work through it with registrars, the membership and practices. Watch this space.

WONCA APR Conference – Singapore

Attended by College President Dr Sam Murton, Medical Director Dr Luke Bradford, Censor-in-Chief Dr Kerryn Lum and College CE Toby Beaglehole. Dr Bradford presented his Your Work Counts research, Dr Murton attended the Asia Pacific Region Council meetings and presented her own research "Art in the art of medicine".

National Quality Forum – complaints management systems and processes

Dr Bradford is a member of the National Quality Forum which has been established by the Te Tāhū Hauora | Health Quality and Safety Commission. His membership recognises the critical role of the College in setting quality standards for general practice and monitoring compliance through the Foundation Standard certification process. This month, the College gave forum members information on the complaints management systems and processes expected to be in place by general practices as part of their Foundation Standard certification. This was in response to the forum discussion on complaints management and processes in place across the health system.

Health Select Committee – Therapeutics Products Act Repeal Bill

Dr Murton and Dr Bradford spoke in front of the Health Select Committee about this Bill. The key message of the College's submission was that the wholesale repeal of the Therapeutic Products Act will dismiss 15 years of work by experts in the field, put us back under a 45-year old Act that does not reflect current medical options or prescribing practices and create a financial burden on the Government that it currently cannot afford.

Submit your feedback

Pharmac

Quarterly conversation with particular interest in ADHD SA criteria, access to MHT and other medicines with supply issues, upcoming Pharmac consultations and CMG supply. We touched base also on the improved remuneration package advocated for by the College, and agreed to by Pharmac, for specialist GPs sitting on their advisory groups.

PSAAP

The College is a member of the System Level Measures advisory group focusing on implementation of the agreed two-year immunisation target for the year.

MSK Advisory Group

Sign-off of the new MSK triage process for orthopaedic referrals to be rolled out nationally as well as involvement in ongoing sector communications.

General Practice Leaders Forum

(Sam is the current chair)

Working with Te Whatu Ora team on various topics, including:

- General practice interdisciplinary teams
- General practice and urgent/afterhours care
- Use of telehealth and digital enablers to supplement general practice.

College submissions:

1. MoH – Review of the End-of-Life Choice Act
2. Parliament – Therapeutic Products Act Repeal Bill
3. HDC – Review of the Act and Code
4. Pharmac – Oestradiol supply
5. Melnet – skin cancer screening guidelines

We'd love your feedback

Help us improve the reading experience of GP Voice by completing the short survey at the link below

Submit your feedback

Representatives on external committees

Dr Luke Bradford, Medical Director

Throughout the membership there is a lot of expertise and knowledge, and we know that many members sit on external committees or groups providing guidance, advice and a general practice or rural hospital medicine perspective.

You might have applied for these roles through the College or directly with the agency or organisation, and it might be a paid role or on a voluntary basis.

The College believes having our voice heard as often as possible is incredibly important and a great way to advocate for and influence change at a regional, national or international level. However, we want to ensure there are proper systems in place to ensure easy and accessible two-way communication and a systematic view of the issues facing the sector and our workforce.

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MedicinesComplete supports organisations minimise medication errors with easy access to essential guidance, including information on prescribing, interactions, adverse effects, and administration.

Find out more

The Royal Pharmaceutical Society's Knowledge Business

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We want to make it easy for you to contact the College ahead of your meetings to see what our position is on a topic or ask for guidance, and we'd like to be able to contact you to see what has been discussed at your committee, if you need any support from the College or would like to collaborate on College advocacy work, i.e. providing feedback on a submission.

The other part of why we're doing this work is to advocate for fair remuneration on these committees that you are providing your time and expertise to. We know that the current way for calculating fees using a points-based system can start at between $35 and $45 an hour.

If you are giving up your time or a clinical day, then the amount you are being reimbursed needs to be enough to cover your day away from work or the cost of a locum to cover your patient load.

On behalf of the College, I have asked other external agencies about what their remuneration benchmark is for those sitting on their committees and I have written letters to advocate for more realistic remuneration.

This would benefit them too, as more of our workforce are likely to put their hands up to join these external committees if they know they are being remunerated fairly for their time.

In the first instance, I'd ask any member who is sitting on an external committee – be it College appointed or not – to fill out this form and pass on some details about the committee/s that you sit on. We will add this information to a database that we can refer to and keep updated over the year.

> “…the amount you are being reimbursed needs to be enough to cover your day away from work or the cost of a locum to cover your patient load.

Goodfellow Unit podcast: **Perimenopause management**

Dr Anna Fenton is currently the clinical leader for the Te Whatu Ora Waitaha Bone Density Service and works in private practice as a gynaecological endocrinologist.

In this podcast, Anna discusses optimising perimenopause management.

The key take-home messages of this podcast are:

- **symptoms of menopause may precede the onset of period changes**
- **mood changes can occur early and be significant for 25% of women**
- **menopausal symptoms can be subtle and misinterpreted as cardiological or rheumatological problems**
- **the combined oral contraceptive pill can be an effective option for women who require contraception and symptoms management**
- **standard progestogen doses used in the POP do not confer endometrial protection when used with estrogen and there is scanty data using higher doses of desogestrel.**

Listen to the podcast

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2024 Workforce Survey coming soon

The College's biennial survey is carried out to gain demographics of the current workforce, as well as important insights into how specialist GPs and rural hospital doctors across the motu feel about their work, their place in the sector and their own health and wellbeing.

The 2024 Workforce Survey will be sent out to the entire membership shortly and College President Dr Samantha Murton is encouraging everyone to make time to complete it. The survey will be open for a month and take 10-15 minutes to complete. There is the option to save your progress and return later to finish it.

For the 2022 survey, we had a high completion rate of 70 percent of the membership (3,488 respondents) and we are looking to build on that in 2024.

This year the questions will be grouped into the following themes:

- Training
- Technology and tools
- 'Team GP'
- Models of care
- Positives and wellbeing
- Workforce

"Having a robust set of data from the frontline means we can present an accurate picture of our circumstances, challenges and experiences directly to officials and decision-makers, including the Minister of Health. The data also emphasises the key role we play in the health care of all New Zealanders every single day," says Dr Murton.

The College also uses the data externally in the media to raise public awareness about the importance of the specialist GP and rural hospital medicine workforce and how the changes we are advocating for will benefit the health outcomes of our patients and communities.

The survey will be emailed out to all members – from registrars through to Fellows across general practice and the Division of Rural Hospital Medicine.

Collating and analysing all this valuable data takes time. The College is working towards having the findings ready to launch by the second quarter of 2025.

You'll start to see and hear more about the survey from now on, and we'll keep members informed about when you'll receive it in your inboxes.

Thank you in advance for your engagement and participation.

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Fund your research

Apply for research funding through the College

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).

You do not have to be a member of the College or a doctor to apply for funding, but the research topic must be relevant to the workforce, so members and people working within a general practice are encouraged to apply.

The final round of funding applications in 2024 are being accepted until 24 September

Funding rounds and deadlines are advertised on the College website, in *NZ Doctor* and in our weekly member newsletter, *ePulse*. Information on the funding rounds is also shared with external research groups and organisations who pass on the information to their networks and encourage people to submit an application.

In the past, REC has funded research on diabetes management and primary care, rural placements of health professionals, the impact of Health and Disability Commission complaints and whether New Zealand's health care system provides equitable access to ADHD medications.

How to apply

All the information you need, including the application form can be found on the College website, along with the funding round dates and previous research topics that have received funding.

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 and FAQs.

Applications should reflect one (or more) of the below domains:

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

Successful applicants are also encouraged to submit their final papers to the *Journal of Primary Health Care* (JPHC) and submit an abstract to the annual College conference to share their research with members.

“

The final round of funding applications in 2024 are being accepted until 24 September.

Submit your feedback

Quality in Practice at Aspiring Medical Centre

A CQI Initiative: Reducing or delaying Type 2 Diabetes

By Vivienne Petrie, Operations Manager and Lynda Davis Clinical Nurse Manager at Aspiring Medical Centre

Aspiring Medical Centre is a privately owned rural general practice in Wānaka. We are a team of experienced health professionals who offer a wide range of health services, from general medical care to specialised services.

With the nearest hospital over an hour away, we're well-equipped to manage the challenges of a rural health setting, including providing quality acute and emergency care. We pride ourselves on providing excellent health care to the Wānaka community and our regions visitors.

Wānaka is a tourist destination, and our population dramatically increases over the peak summer and winter periods. Winter brings the ski season and summer the holiday makers, international and New Zealand tourists.

The practice continues to grow with the increase in population to the Wānaka region across all age brackets.

What motivated your practice to complete the Cornerstone CQI module?

Aspiring Medical is a College teaching practice. We teach upcoming GPs and it's a requirement that we hold Cornerstone CQI. We also felt that completing this module gave the practice an opportunity to continuously improve the quality of services we provide.

Tell us about your CQI initiative

Our aim and CQI project overview was to identify those at risk of developing Type 2 diabetes including Māori and Pasifika people who already have pre-diabetes and are below the age of 70 years, to try and reduce or delay their risk by:

- Involving the whole team within the practice (including the wellbeing team), the patient (and their families/whānau/carers) who may have associated cardiovascular risk factors; for example: smoking, elevated blood pressure and or elevated cholesterol. We empower this target group and their family or whānau with lifestyle interventions, continuity of care and ongoing support if required.
- Encouraging the person to nominate their provider of choice, so that continuity of care can be achieved in partnership with both the doctor and the person.

"With the nearest hospital over an hour away, we're well-equipped to manage the challenges of a rural health setting, including providing quality acute and emergency care.

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- Offering either evidence-based lifestyle medicine support sessions either in a group or private setting at an agreed interval (for example, weekly or fortnightly) and reviewing process or individual sessions with a nurse and or their Doctor and or involving the wellbeing team (at no cost to the patient). Lifestyle medicine can assist the prevention, management and reversal of chronic and lifestyle-related diseases. It is centred around optimal nutrition, increased physical activity, improved sleep, reducing smoking/alcohol and improving wellbeing and connectedness. The evidence shows making changes in these areas dramatically improves health and can treat, prevent or reduce disease and ill health. Lifestyle medicine plays a key role in conditions such as pre-diabetes.
- Offering the right service to meet the needs of the person and if they decline lifestyle medicine intervention, enabling them to access alternative support. For example, fully funded sessions with the wellbeing team for education and ongoing follow up.
- Ensuring that our CQI project is reflective of Health New Zealand Te Whatu Ora's pre-diabetes and self-management advice.
- Ensuring all clinicians follow the HealthPathways: pre-diabetes pathway for best practice and continuity of care (see report definitions and references for the pathway).
- Improving routine screening for diabetes for all our registered patients, using the dashboard to highlight if they aren't up to date with screening and to be able then to identify those at risk, providing equitable care to all patients. To assist these patients to learn more about pre-diabetes and prevent the progression to diabetes and the associated long-term side effects.
- Empowering these patients to be responsible for their own health care and checking their symptoms and recalls.

> "With the nearest hospital over an hour away, we're well-equipped to manage the challenges of a rural health setting, including providing quality acute and emergency care.

Goodfellow Unit podcast: **Concussion guidelines**

College Fellow Dr Stephen Kara is a sport and exercise physician at Axis Sports Medicine in Auckland. He has a background in general practice prior to transferring into sports medicine.

In this podcast, Stephen discusses the newly introduced New Zealand 2024 concussion guidelines, including recognising diverse signs and symptoms. The recovery phase is detailed, encompassing rest, reintroduction and clearance, featuring a graduated return protocol.

The key take home messages of this podcast are:

- **recognise and remove early**
- **early controlled physical and cognitive loading is key to early recovery**
- **use BIST to risk stratify your patient and refer early if required**
- **most patients recover inside three months**
- **concussion recognition and the appropriate return to play is everyone's responsibility, not just a medical problem.**

Listen to the podcast

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

Our initial observation highlighted a large number of patients that had a classification of pre-diabetes did not have a nominated health care provider. To improve continuity of care, the patient should have a nominated provider of their choice to be involved with their care. We explored why continuity of care benefits the patient.

Our CQI nurse team systematically went through the list of 180 patients (not just our target group) and contacted each person, discussed the benefits of having a nominated provider and in partnership with the patient a nominated GP was confirmed on their patient file.

Seven were unable to be contacted by a GP and they have an alert on their patient file to address this at their next consultation.

We checked that the classification of pre-diabetes was entered correctly on the patient's file and that the associated recalls for monitoring were accurate and up to date. Recall for one year to check HbA1c unless otherwise specified by GP or plan of care (Initial HbA1c should be repeated after three months of lifestyle change and thereafter at 6 to 12-month intervals).

What is different for your team after completing this work?

By creating and sustaining a process that becomes 'business as usual,' our clinicians are more involved with their patients working towards improved outcomes.

We've implemented the following changes:

- Three-monthly audits of our registered patients with prediabetes as a classification (from Thalamus) are being completed by our nurses. The audit:
  - ensures the patient has nominated GP. If they don't, we check our patient portal and offer it.
  - reviews blood test recall for HbA1c. If the yearly GP appointment is due, we co-ordinate that.

"By creating and sustaining a process that becomes 'business as usual,' our clinicians are more involved with their patients working towards improved outcomes.

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  - reviews any deterioration of HbA1c levels and offers lifestyle support sessions.
  - ensures all clinicians are following HealthPathways for guidance on the patient's shared management plan.
- We have a three-monthly meeting with [the College's] CQI team, continue using the PDSA cycle for quality improvement and update the clinical team on data results.
- The new patient enrolment process has been updated. For any patient enrolling into the practice with a prediabetes classification, administration staff create a task for the LTC nurse who will (as per Healthpathways):
  - arrange GP and nurse appointments working towards nominating a GP for continuity of care within partnership with the person, lifestyle education etc.
  - ensure correct classification is entered on patient management system.
  - manage any identified complications and risk factors.
  - check last HbA1c result and organise repeat if required.
  - set up blood test monitoring and annual GP recalls.
  - offer and encourage use of Manage My Health (our patient portal) for everyone that enrols, so that they can access their open record files and test results.

What is different for the patients?

- The majority of patients now have a nominated provider
- Reduced patient pre-diabetes blood test results to normal values by 7%
- Reduced patient blood glucose levels in the prediabetic range by 8%
- Overall improvement in patient engagement
- Updated diabetes screening recalls achieving 100%

Overall, the feedback from patients involved in the CQI module was extremely positive and they appreciated the level of care and their involvement with their health journey.

Complete either the Continuous Quality Improvement or Equity module as part of **your Cornerstone accreditation for a chance to win one of five $700 Amtech Medical vouchers for your practice.**

To find out more about the Cornerstone Modules go to:
rnzcgp.org.nz/running-a-practice

Promotion ends March 2025

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FPM

Faculty of Pain Medicine
ANZCA

2024 FPM SPRING MEETING

Collegial intelligence in pain medicine

18-20 October 2024
Pullman Auckland, New Zealand

Join us for the annual Faculty of Pain Medicine (FPM) Spring Meeting.

Pain medicine's greatest strength is the ability to interact with multiple specialty and subspecialty services. We have an array of specialist speakers who will share their expertise and address pertinent challenges and opportunities to expand our practice. We hope, by working and sharing our experience, we keep you updated in the constantly challenging and vital area of pain medicine care.

We're excited to announce a special one day and one and a half day rate for general practitioners. Please visit the meeting website to check out the program, further information and to register.

Visit the ANZCA website

SCAN HERE TO FIND OUT MORE

#painSM24

Quality Assessor spotlight

An interview with Celia Tymons

Celia Tymons is a College - endorsed assessor for both the Continuous Quality Improvement (CQI) module and Foundation Standard, and a contractor to GPDocs. Celia also runs a sheep farm in the foothills of the Torlesse ranges near Sheffield so of course we wanted to learn more about her life!

What inspired you to run a sheep farm and what does a typical day on the farm look like for you?

It starts far too early, ends very late and there's just too much included during the day. However, lambing season (mid-August to end of September for me) is my favourite time of year.

I have a near pure Texel flock and I've been around sheep for most of my life. By ensuring that my sheep are all friendly, it allows me to know them individually and understand their needs. At lambing time this pays off as I can see that they're starting labour even before they've worked it out themselves. I have to do a lot of midwifery during lambing and it can be pretty intense at times.

Fun fact: Sheep will always go into labour just as you have to leave to go somewhere or as soon as you sit down to eat/rest/do something not sheep related.

Can you share more about your goal to become more self-sufficient?

I like to grow food. I produce meat from the fields, I grow fruit and vegetables in the garden, and have a young orchard full of beautiful fruit trees. Serving meals that have been 100% home grown and homemade is a pretty special feeling and one I'd recommend to everyone.

The garden is a labour of love. The beds are all built from available materials and upcycled tractor tyres filled with horse poo and contain a thriving worm population. The soil is beautiful. I have a relatively short growing season with frosts starting and lasting longer than on the Canterbury plains, but I've developed lots of tricks to grow great fruit and veggies over the years.

I've also got solar panels and a large battery system at my house, which significantly assists the mains power supply. I'm not off grid, but my power bill is always very low. It all helps the bigger picture, both environmentally and financially. I have to drive a lot to get anywhere, so reducing my carbon footprint in my food consumption and in my energy use is a way to help offset the impact of travel.

Submit your feedback

How do you manage to balance your responsibilities on the farm, with your family, the school and assessing?

I strongly agree with the view that it takes a village to raise a child. As a result I've been on the Darfield Primary School Board for nearly nine years. I'm nearing the end of this journey as my daughter will be finishing primary school at the end of 2024 and is joining her older brother at high school next year.

I feel I've done my dash now so won't stand for a fourth term. I've been the presiding member for six years and have seen changes in the education system that parallel a lot of the issues and redirection of focus that the health sector is experiencing. Helping make the school the best it can be fits in well with the idea of aiming for quality in general practice.

I'm self-employed now, contracting to GPDocs and to each practice for assessments. Without this flexibility I would not be able to function and be the good solo parent that I try to be. Both my kids are very sporty, and I'm their PA, taxi, support crew and best fan. One moment I'm at a dance competition, the next a mountain bike race, athletics meet, pony club rally or a netball/rugby/football game. I wouldn't change this for the world and I feel lucky to have this in so many ways.

The other sacrifice I make is not much down time for 'me' and probably not enough sleep. My late-night emails are always a bit of a giveaway to my busy schedule. I figure life won't always be this busy and none of it is a rehearsal. Life is short and I want it to be full and have meaning. I do have to try to manage the workload sensibly though and have several strategies to succeed e.g. only one Foundation assessment a month, host backpackers to help on the farm, have a very organised calendar and most importantly ensure I am part of a great 'village'.

What do you find the most fulfilling about travelling across the country to complete assessments?

I love a long list of Met's in a Smartsheet. Seeing a practice go from an empty Smartsheet to one filled with confirmation of achievement is a satisfying thing. Seriously though, travelling to a practice to see the reality of what a bunch of words in a Smartsheet actually looks like in real life is the best bit.

Meeting the people behind the words, evidence and info, seeing them in their workplace and getting to understand how the practice works is truly a privilege. Being an Assessor allows you to see behind the scenes and it never grows old; you always learn something new, and it's great to connect with the practice team at assessment time.

Looking ahead, are there any new projects or aspirations you're excited about?

I'd like to see general practice funded appropriately, find New Zealand pandemic free again and have a health sector workforce who are appreciated better.

In the meantime, I'll keep living my best life by mixing it up with work, farm, school and the kids.

Submit your feedback

MIND THIS

HDC to the rescue

Dr Peter Moodie

Mrs A was known to be at high risk for liver cancer following a diagnosis of primary biliary cholangitis in 2011 and was regularly followed up by a public hospital gastroenterology department.

In May 2017 the gastroenterologist organised six-monthly ultrasound examinations with a clinic follow-up after each ultrasound. In November 2018 she was also referred for an MRI which did not show any malignancy, but the report suggested a follow-up MRI in a year's time.

Her last ultrasound was in April 2019, and although she was subsequently seen at the same hospital for other conditions, there appears to have been no recognition that her ultrasounds were overdue.

In November 2022, Mrs A was referred to ED with symptoms of nausea, fatigue and back pain. A CT scan showed that she had advanced liver cancer and she was given palliative care until her death.

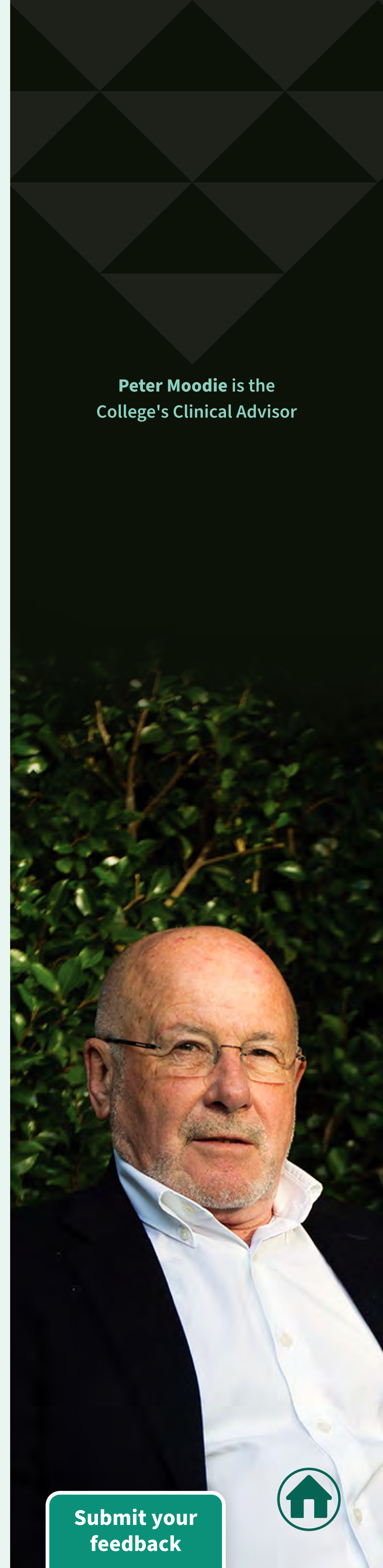
What went wrong?

The gastroenterologist stated that his last appointment with Mrs A was in Feb 2019 not specifically for risk of liver cancer; however, he explained to her that the MRI from November 2018 did not show any cancer, but a further MRI would "likely be required in 12 months' time."

The gastroenterologist further noted, that with subsequent admissions after the Feb 2019 consult, under other specialists "they did not consider whether Mrs A was due for liver follow-up or request additional scans." It is unclear whether this was a criticism of his colleagues but we can be reassured that Health New Zealand | Te Whatu Ora (TWO) in their review advised "that during these presentations there was no concern about her liver."

The lack of regular follow up appears to have coincided with the implementation of a new electronic Radiology referral system which curiously was designed to NOT accept repeat or recurring requests, including liver surveillance ultrasound scans. TWO argued that this was a safety and efficiency measure. All staff were made aware of this change; however, it was agreed that a specialist nurse managing a surveillance programme could have delegated authority to order a scan on behalf of a clinician.

Following on as a result of these changes Mrs A fell out of the surveillance programme possibly because of timing of the software change, possibly because the gastroenterologist didn't order another test, or because the specialist nurse forgot to arrange it. The error was further compounded by outpatient reception staff omitting to arrange a follow-up appointment for Mrs A in 2019.



Peter Moodie is the College's Clinical Advisor

TWO added another dimension to the story by trying to blame Mrs A's general practitioner for not identifying that the ultrasound scan was overdue!

The justifications

It always seems strange to me that TWO acts on behalf of public hospital secondary care clinicians rather than them having to defend themselves. The result is often that the "system" and/or "overstretched resources" are found to be the problem rather than individual failings.

In this case the failings were described by TWO as "multifactorial" notwithstanding that a number of people did not do their job properly. Along with this, some badly designed software was implemented without checking to see if it was fit for purpose.

The involvement of TWO creates even more confusion when they try to blame Mrs A's general practitioner for the hospital's failed systems. Pleasingly the Health and Disability Commissioner (HDC) was not impressed with this attempt and firmly stated that the general practitioner was not responsible for other's failings.

Lessons learned

One of the recommendations the hospital has made is that the general practitioner should be more involved in such surveillance programs so that they can act as a "safety net", but if this is to happen:

- There needs to be a genuine peer to peer handover, which means a Senior Medical Officer talking to and obtaining agreement from the general practitioner. This is a job that should not be delegated to junior staff.
- The general practice needs to have direct access to the investigative procedure. This should not be a "Please Sir, you forgot to order a test for my patient" but rather an ability to efficiently take control.
- If a hospital is not capable of managing a particular service and wants general practice to take responsibility for it, they should ask TWO to provide funding for that service. Why would you do someone else's work and not be paid for it?

Finally, congratulations to the HDC for not buying into the suggestion that a general practitioner should shoulder some of the blame.

"

The involvement of TWO creates even more confusion when they try to blame Mrs A's general practitioner for the hospital's failed systems.

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

Make your voice heard

Submit your article to the Editorial team:

communications@rnzcgp.org.nz

Submit your feedback

GP24: The quiet GP

A summary of Dr Kerryn Lum's GP24 presentation

When Jamie in the College's Communications team attended Kerryn Lum's session titled 'the quiet GP' at GP24, she was wondering what it was all about. Was it about GPs with soft voices? GPs that don't talk very much? Or introverted GPs?

Her last guess was the right one; Kerryn had prepared a thought-provoking presentation on the challenges introverts face and how we could help them during the GPEP training programme.

Some interesting points

- The introvert is a plug-in electric vehicle; when the battery is low, they need to go home and quietly recharge. The extrovert is the hybrid electric vehicle that recharges as it is out and about interacting. To the observer, they both look the same.
- Being an introvert doesn't mean you are shy. Introverts can engage quite easily, but when they become depleted, they need to withdraw.
- Introversion isn't a personality disorder, it's not something that needs fixing. No one should ever force themselves to be an extrovert.
- Interestingly introverts often choose people-facing careers.
- Thinking about meetings, do we send agendas out far enough ahead so the introverts have time to gather their thoughts? Often when they do have an idea it's a really great one.

Applying these thoughts to the General Practice Education Programme

Kerryn tied some of these thoughts back to the General Practice Education Programme for consideration.

- **Written exams:** Everyone gets a year to prepare
- **Clinical exams:** They are quick and you have to think on your feet, but you do get five minutes' reading time before you go into the room with the actor and examiner.
- **Fellowship assessment:** Potentially an area where there is room to improve – we could look at giving the registrar the opportunity to call a 'timeout' to recharge.

Take home points

- It's a continuum; it is part of who we are
- Not something to be fixed
- Does not mean you cannot be a great leader
- Introverts need to prioritise protecting their boundaries
- Learn to recognise introvert strengths.

Useful resources

The life story of an introvert, Steve Liew

Ted Talk: The power of introverts, Susan Cain

Quiet girl in a noisy world, Debbie Tung

Introvert Power, Laurie Helgoe

Quiet, Susan Cain

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GP24: Rural clinician wellbeing

A summary of Dr Robin Chan's presentation

"I'd like to start by congratulating you on your choice of plenary session today" is how Dr Robin Chan started her presentation 'defining rural clinician wellbeing' at *GP24: Conference for General Practice* on Saturday 27 July 2024. The crowd chuckled away.

Robin grew up in a very small village in the central highlands of Papua New Guinea and says rural and remote is part of her formative experience. She moved to Australia and went through medical school on a military scholarship.

Her first seven years of clinical experience were as an army doctor and included deployments to the Middle East and Afghanistan. Robin got out of the army in 2011 after attaining her GP Fellowship and went on to work for the Royal Flying Doctor Service.

"I was mostly responsible for giving primary care to remote, disadvantaged Aboriginal communities.

In 2019 she moved to Taupō for a better work–life balance just in time for the COVID-19 pandemic.

"I've come to realise, if you're going to be in rural and remote health, sh*ts going to happen and I had to find a way to make sure I could keep showing up and keep doing the mahi."

At the end of 2022 when 70% of Robin's colleagues resigned, she wondered how she could keep going and not leave like her colleagues. "I had to pull out all the tools in the shed," she said.

"I put a lot of thought into how I could continue doing this mahi and how I can support my colleagues in rural health for the benefit of the communities that we all know and love."

Robin says she went on a "lifestyle bender" listening to inspirational podcasts, ice baths, going plant based. The list goes on.

And what did Robin learn? She said it wasn't nothing, but it wasn't the main thing.

Robin went to the doctor's health conference in Adelaide and met Dr Tait Shanfelt, Chief Wellness Officer for Stanford Health, who introduced her to a screening tool called the wellbeing index.

What Robin liked about the wellbeing index was that it was short and could be done in a few minutes, it is validated specifically for health care workers. There are nine simple questions and you score points based on your answers.

"
What Robin liked about the wellbeing index was that it was short and could be done in a few minutes, it is validated specifically for healthcare workers.

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The tool is an effective way to get base of staff wellbeing indexes. They also asked some questions to find a thematic basis to how the organisation could improve things.

The top three priorities for doctors were:

- Recognition and appreciation
- Engaged leadership
- Workforce.

The top three priorities for nurses were:

- Rostering
- Workforce
- Recognition and appreciation equal with social connection.

There are legislative requirements for workplaces to be safe and it might be that an approach to workplace wellbeing is that we ask our organisations to measure workplace wellbeing as a KPI. And then take some responsibility to identify and act on those risks.

Robin's organisation did this and in terms of distress by occupation they found that nurses showed significantly higher rates of distress compared to doctors. This was useful because it helped them to direct their efforts to those professionals that needed it most.

They had two nurses become 'wellbeing champions' who learnt from the feedback and got some great initiatives up and running (donated almost exclusively by the local community).

"This was useful because it helped them to direct their efforts to those professionals that needed it most.

Dr Robin Chan at *GP24: Conference for General Practice*

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Diagnosing acute rheumatic fever

Dr Barnett Bond

This case study comes to you from the series "Flat White Short Case Studies." They are based on real cases where New Zealand GPs have missed this particular diagnosis. Would you have missed this diagnosis?

Tane is an 8-year-old child of mixed Scottish, Māori and Polynesian heritage. He has mild asthma that is well-controlled with medication. He presented to his primary care provider with seven days of abdominal pain and a rash on his trunk, upper arms and his heel. He had loss of appetite and fatigue for three weeks. Mom has four other children aged 12, 10, 5 and 2 years old and it was a challenge for her to get to your surgery today, but she made the effort because she is very concerned.

Based on the history, the following questions and physical examination steps could help you make the diagnosis:

- Check his face and palms for signs of the same rash
- Ask if the rash is itchy or painful
- Ask if he has had a sore throat in the past few weeks, which got better
- Ask if he has muscle aches/joint pain either now or recently
- Ask if he has diarrhoea
- Listen to his heart and lungs with your stethoscope.

Differential diagnosis

An eight-year-old boy with this history could have a number of possible conditions. At this stage the following are a short list of differential diagnoses:

- Mesenteric adenitis
- Acute rheumatic fever
- Intestinal parasites with allergic skin manifestation
- Gallbladder disease
- Abdominal pain of childhood NOS
- Diabetes mellitus
- Viral/mycoplasma infection
- Leukaemia.

Discussion

Gallbladder disease is not unknown in overweight children as young as eight, but it is exceedingly rare. Mesenteric adenitis is uncommon also but presents with abdominal pain, usually in the right lower quadrant. Abdominal ultrasound is very useful in both conditions if either was top of your differential diagnosis list. Tane told his GP that the rash was not itchy, that he could not recall a sore throat in the last few weeks and that he did not have diarrhoea nor an itchy anus. Fatty foods did not make the abdominal pain worse. When the GP asked a direct question about muscle or joint aches he admitted to having aching joints this morning and he then remembered that last week he had a very sore swollen

Table 1: Tane's initial workup

Patient information
Aged 8 years
Height: 123cm
Weight: 30kg
BMI: 19.8 (94th percentile)
Personal and family medical history
History of mild asthma; no other health issues
No sore throat, no ear pain, no pain elsewhere, appetite diminished
Current medications: salbutamol MDI prn and Fluticasone 125
MDI
Consumes more than three sweetened beverages daily
No allergies
Completed full course of childhood vaccinations
No family history of note
Physical exam
Tenderness in upper abdomen and perhaps the right lower quadrant as well
Rash (see photo) in upper abdomen and on the heel
Temp = 37.4 C
Respiratory rate 18/minute
Pulse 78 / min and regular
No cervical nor inguinal adenopathy
ENT exam normal
Limbs = nad
Lungs clear to auscultation – no wheeze. PF not done
Heart sound dual – no murmurs
Laboratory evaluations
None at this stage

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right knee and it was painful to walk but after a couple of days it got better. He said he had forgotten about this. When his GP re-examined him, there was no rash on the face nor on the palms nor soles. It was hard to be sure, but the rash looked a bit like erythema marginatum.

At this stage the following could have been appropriate to help make the diagnosis:

- Throat swab
- Skin scraping of the rash for fungal culture
- CBC, ASOT and anti-DNase
- LFTs (Liver function tests)
- Stools for parasites? Mid-stream urine for dipstix then culture and sensitivities
- Abdominal ultrasound
- HbA1c

Discussion

Acute rheumatic fever (ARF) is the important "Not To Miss" diagnosis at this stage because of the very serious sequel of **rheumatic heart disease (RHD)**. If the rash was associated with intestinal parasites or with allergic skin manifestation, it should have been itchy. The abdominal pain associated with gallbladder disease is more typically in the RUQ and aggravated by fatty foods, and one could reasonably expect RUQ tenderness. The features of:

1. a rash
2. a sore joint which resolved, and
3. a fever which is less than 38°C, should have directed the GP's attention away from mesenteric adenitis as a cause of his abdominal pain.

While this child may have had one of the other conditions, there were some pointers that should have made the GP place ARF at the top of the list and either eliminate or confirm it before turning his attention to other differentials. These were the clues:

- An elevated respiratory rate and heart rate. This could be the first sign of heart failure from carditis.
- A rash that looked like erythema marginatum. Only 10% of cases of acute rheumatic fever have this rash. Erythema Marginatum never appears on the face, nor the palms, nor the soles. It is typically found on the trunk and limbs.
- The child has both Māori and Pacific ancestors; 99% of cases of ARF in New Zealand are in Māori/Pacific people between the ages of 4 and 30 years (82% between 4 years and 15 years).
- A good history of recording their housing environment i.e. overcrowding and any family history of rheumatic fever also will give some risk factors for ARF.
- Tane recalled a sore swollen joint which got better. This is a serious red flag for ARF. Many children who have a missed diagnosis of ARF have told the doctor(s) that they have or have had a sore swollen joint. These missed cases have been worked up for an orthopaedic joint condition (trauma, arthritis, septic arthritis) and ARF was not considered.
- Although a sore throat is a common feature of GAS throat infections, not all children recall having had a sore throat recently even when they have had one. ARF typically starts five weeks after a GAS throat infection.

"99% of cases of ARF in New Zealand are in Māori/Pacific people between the ages of 4 and 30 years. (82% between 4 years and 15 years).

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If you even remotely suspect acute rheumatic fever, and you should in all Māori/Pacific persons between the ages of 4 and 15 years (even up to 30 years) who have now, or had recently, any one of the following:

- a sore throat
- a swollen painful joint(s)
- a rash that could be erythema marginatum
- abdominal pain
- weeks of malaise
- even slight dyspnoea or tachypnoea
- chorea

Both a throat swab and a blood test for inflammatory markers and strep serology/anti-DNase should be done that day.

The GP in this case listened to heart and lungs and heard no murmurs. An echocardiogram can detect carditis at a much earlier stage than can a stethoscope. If you suspect ARF, send the child to your local hospital's emergency department stating a concern it may be rheumatic fever with request for an urgent "echo". If the throat swab reports GAS or the ASOT and anti-DNase B is elevated, then you must treat asap for ARF.

Check your regional HealthPathways page or the National Heart Foundation for more information about the correct treatment for a child with ARF and for how long treatment should continue.

Who gets rheumatic fever?

ARF usually affects children aged 5–15 years. Most cases of ARF currently occur in developing countries. Worldwide there is an estimated 470,000 new cases of ARF annually (60% of whom eventually develop rheumatic heart disease). In most developed countries ARF is now rare, with a few notable exceptions; the highest documented rates of ARF in the world are in Māori and Pacific people in New Zealand, Aboriginal Australians and those in Pacific Island nations.

Rheumatic fever is associated with poverty, overcrowding and poor sanitation facilities. It is suspected that there are genes that make some families more susceptible to the disease.

Figure 1: The global burden of RHD

Image courtesy of R. Seth, Telethon Kids Institute, Perth, Australia
Carapetis, J. R. et al. (2015) Acute rheumatic fever and rheumatic heart disease Nat. Rev. Dis. Primers doi:10.1038/nrdp.2015.84

"...the highest documented rates of ARF in the world are in Māori and Pacific people in New Zealand, Aboriginal Australians and those in Pacific Island nations.

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What are the clinical features of acute rheumatic fever?

Symptoms of ARF generally develop several weeks after an episode of streptococcal pharyngitis. However, many patients do not recall having a sore throat. Non-specific symptoms include:

- Fever
- Chest pain
- Abdominal pain – not that often

Arthralgia joint pain/s, migratory joint pain or monoarthritis is the most common presentation (up to 75% of ARF cases); however, ARF causes a variety of more specific clinical features:

- Polyarthralgia (minor criteria) and or arthritis (major criteria) Polyarthritis (multiple inflamed joints)/monoarthritis — most common ARF presentation and often ankles, knees, elbows, wrists. Arthralgia/Arthritis and arthralgia can migrate from one joint to another
- Carditis (inflammation of the heart) – This involves the heart valves, heart muscle and membrane surrounding the heart. May not be heard on auscultation. Echocardiogram is needed
- Sydenham chorea – This is a disorder of the nervous system characterised by personality changes, muscle weakness and involuntary movements
- Subcutaneous nodules – Rare.

Final thoughts

- Jones Criteria – use the link to the Jones Criteria for Diagnosis of Rheumatic Fever (medscape.com). Ask your nurse to run the quiz on any Māori or Pacific person aged 5–30 who has now or had in the last few weeks a sore throat or a sore joint or a fever and a rash
- First line treatment and second line treatment of ARF
- How does penicillin work in severing the link between the streptococcal throat infection and the organ-damaging autoimmune response?
- Why do some patients need to take lifelong monthly penicillin by injection?

For more information check your regional HealthPathways page or the National Heart Foundation website. Alternatively you can email Dr Barnett Bond at barnettb@adhb.govt.nz.

“Symptoms of ARF generally develop several weeks after an episode of streptococcal pharyngitis. However, many patients do not recall having a sore throat.

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GP24: Rural health panel

On the final day of GP24, we were lucky to have four knowledgeable members share their stories and experiences on our rural health–focused panel.

The theme was 'Rural health: The challenges of today are the opportunities for tomorrow' and the panellists were asked to discuss solutions and future directions for rural health in Aotearoa New Zealand.

Our panellists were:

- Dr Fiona Bolden, Chair of Hauora Taiwhenua Rural Health Network
- Dr Garry Nixon, Director of the University of Otago's Centre for Rural Health
- Dr Andrew Laurenson, Chair of the Division of Rural Hospital Medicine
- Dr Alex McLeod, Dual Fellow and GP at Coromandel Family Health Centre

Dr Bolden opened the panel session by sharing Hauora Taiwhenua's 2024 '**Rural Health New Zealand snapshot**', which is Aotearoa's first study of this kind. The statistics were sobering and showed the inequities faced by these people when it comes to accessing health care.

Close to 900,000 people live rurally in New Zealand, and there is a strong correlation between rurality, ethnicity and social deprivation – leading to a negative impact on rural health outcomes:

- Significantly higher mortality rates from preventable causes.
- Alarmingly higher rates of suicide, particularly for males.
- Twice as many people living in social and economic deprivation, particularly in more remote areas.
- Much lower educational qualifications (NCEA and tertiary level).
- Far fewer families have access to mobile phones and internet in their homes.
- Very low vaccination rates to prevent disease. The more remote, the worse the rates.
- Far fewer rural people accessing hospital care, despite their poorer health.
- Many of these statistics are worse for Māori living in rural areas.

When it comes to creating a home-grown workforce, we see that the rate of rural origin students who enrol into medical school is less than half of that of urban-based students.

Dr Bolden ended by saying that the Government must recognise the correlation between the health of our rural communities and the health of our nation and economy. Investment must be made here if we are to see a reversal in health inequities outlined in the Rural Health snapshot.

Dr Alex McLeod is a GP in Coromandel Town and a Dual Fellow of the College. He spoke about a solution of having rural leaders – those working in rural health – having the freedom and trust to do what needs to be done in their communities and for their rural patients. The status quo isn't working so how can we work

“...the Government must recognise the correlation between the health of our rural communities and the health of our nation and economy. Investment must be made here if we are to see a reversal in health inequities outlined in the Rural Health snapshot.

From left: Dr Fiona Bolden, Julian Wilcox, Dr Alex McLeod, Dr Andrew Laurenson and Dr Garry Nixon

differently to ensure we have a thriving and sustainable rural workforce and truly make a difference to health outcomes.

Dr Andrew Laurenson, who recently took over the role of Chair of the Division of Rural Hospital Medicine, spoke about his experiences working in Greymouth, a very dispersed part of Aotearoa (the equivalent distance between Auckland and Wellington) and what innovations they've come up with to ensure their community can access the care they need.

An example included an in-patient medicine service that's run by the rural hospital medicine graduates, which has received positive feedback from the community and nurses.

Dr Garry Nixon, who spends half his time as a rural GP and the other half as an academic, spoke about growing up rurally and then basing his career in rural New Zealand. He said he understands his patients better as he also grew up rurally and knows the positives and the challenges that come with that lifestyle.

He spoke about Dr Pat Farry as being a champion of general practice who playing an integral part in the development of the RHM training programme. Farry understood that although general practice and rural hospital medicine have different ways of working, both are very generalist roles and shouldn't be siloed.

At the end of the panel, moderator Julian Wilcox asked each panellist about what brought them joy in their roles.

Dr Laurenson said being pushed to the limit of our knowledge, and the people and teams he works with who makes his job possible.

Dr Bolden said she loves her job and the continuity of care and relationships she has with her patients. She said it is a privilege to hear their stories and be a part of the health journey.

Dr McLeod said knowing that if he is called out to attend an emergency, he knows his team have his back. Everyone is on the same waka and trying to make the system better.

Finally, Dr Nixon said it is the best job in medicine. He loves the community and the people and gets enjoyment from teaching and working with the next generation coming through.

“ Dr McLeod said knowing that if he is called out to attend an emergency, he knows his team have his back. Everyone is on the same waka and trying to make the system better.

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GP 24: Changing the climate for the better

By Simon Wright

Principal Insights Advisor, The Royal New Zealand College of General Practitioners

General practitioners are quietly changing the climate for the better and contributing to the health and equity outcomes we all strive for.

This message was highlighted during the panel session titled "How to Future Proof Patients' Health, Our Practices and Primary Care from the Effects of Climate Change" at the GP24 conference. A substantial amount of work is already underway, both locally and internationally, to tackle the health challenges posed by climate change

If you're uncertain about the potential impacts of climate change in Aotearoa New Zealand, Vicktoria Blake, Principal Advisor for Climate Risk and Adaptation at Te Whatu Ora, outlined three plausible future climate scenarios. These scenarios were developed with input from a range of stakeholders across the health care sectors, including general practice and primary care. While two of the scenarios present significant challenges, the 'Ambitious & Orderly' scenario offers a pathway to a world that is healthier, more sustainable and more socially inclusive by addressing the determinants of health, equity and climate change.

	Scenario 1 (>3°C aligned)	Scenario 2	Scenario 3 (1.5°C aligned)
	Hot House World	Delayed & Disorderly	Ambitious & Orderly
SSP Scenario:	SSP – 7.0	SSP2 – 4.5	SSP1 – 1.9
Temp. (2050):	2.1°C	2.0°C	1.6°C
Temp. (2100):	3.6°C	2.7°C	1.4°C
CCC Scenario:	Current policies	Headwinds	Tailwinds
Summary:	With resurgent nationalism around the world, policies shift over time to become increasingly oriented towards domestic and regional priorities. There is declining public investment in health and education, with countries focusing on achieving their own energy, water and food securty at the expense of international cooperation.	The world follows a path in which social, economic, and technological trends do not shift markedly from current patterns. While global ambition and rhetoric are high, the implementation of climate action is variable across countries.	The world shifts towards a more sustainable and socially inclusive path, which respects environmental boundaries human health and wellbeing. With growing recognition that climate change is causing a global health emergency, emissions decline globally from 2025 to 2050 through the implementation of ambitious and coordinated climate action across countries.

To gain insights into a te ao Māori perspective on climate change, Dr Rāwiri Tinirau, the Director or Te Atawhai o Te Ao and Chair of the Rānana Māori Committee, alongside 11-year-old Manaaki Hogg discussed the significance of

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Te Awa Tupua (Whanganui River Claims Settlement) Act 2017. This legislation, which declares Te Awa Tupua a legal person, includes a set of kawa/values that describe the essence of Te Awa Tupua as:

a. *Ko te Awa te mātāpuna o te ora:* the River is the source of spiritual and physical sustenance
b. *E rere kau mai i te Awa nui mai i te Kahui Maunga ki Tangaroa:* the great River flows from the mountains to the sea
c. *Ko au te Awa, ko te Awa ko au:* I am the River and the River is me
d. *Ngā manga iti, ngā manga nui e honohono kau ana, ka tupu hei Awa Tupua:* the small and large streams that flow into one another form one River.

These kawa can be used as a framework for exploring climate issues and guiding decision-making. For example, they invite us to consider the impacts of climate change on the physical and spiritual health of the river and the people, and how the community will be nourished and sustained if the river is compromised.

Another panel member, Dr Kiyomi Kitagawa, a New Plymouth GP, shared her **practice's sustainability journey**. Carefirst has taken significant steps such as installing solar panels, diverting 55 percent of their waste, changing prescribing practices to reduce emissions (e.g. dry-powder asthma inhalers instead of metered-dose inhalers), supporting a community garden and achieving Toitū Carbon Reduce certification with plans for becoming carbon zero in the not too distant future. For more details, refer to Kiyomi's article in the June 2024 issue of GP Voice.

Associate Professor Karen Flegg, President of WONCA, emphasised the often overlooked fact that the health care sector is a significant emitter of environmental pollution that adversely affects health and is responsible for 5.2% of global greenhouse gas emissions. Given this, WONCA is advocating for a just and equitable transition through international bodies, including the World Health Organization and the Lancet commisssion on Sustainable Health Care. WONCA has also produced practical resources, such as **a guide for sustainable conferences** and one-minute videos on climate-related issues such as **mental health**, **novel diseases** and the **global health care sector**. Karen encouraged College members to consider joining WONCA's **Working Party on Planetary Health** and adopting **Professor Enrique Barros's 'One Minute for the Planet' strategy during consultations**.

> "...the health care sector is a significant emitter of environmental pollution that adversely affect health and is responsible for 5.2% of global greenhouse gas emissions.

Associate Professor Karen Flegg

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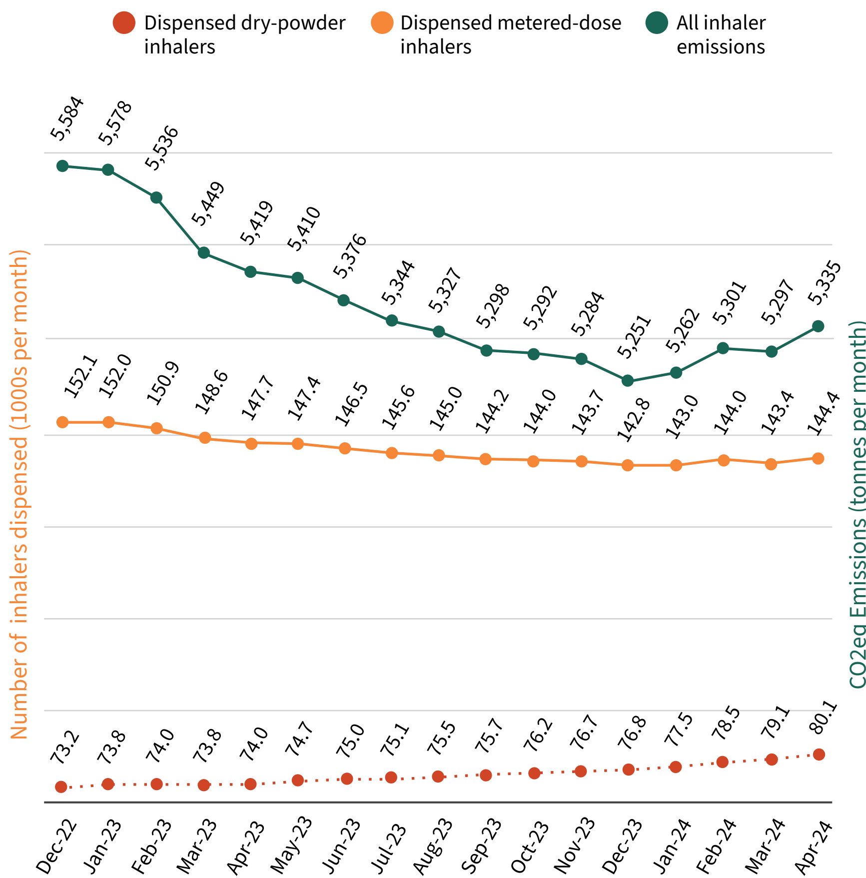
Here in Aotearoa, your 'one-minute-for-the-planet' discussion could focus on asthma inhalers. Many patients are surprised to learn that the greenhouse gas emissions from a single metered-dose inhaler are equivalent to a 290-kilometre car journey. With this knowledge, many patients may be willing to switch to a low-carbon dry-powder inhaler if it is clinically appropriate.

As Figure 1 illustrates, progress is being made in reducing emissions from inhalers. Overall, greenhouse gas emissions are trending downward as metered-dose inhaler dispensing decreases and dry-powder inhaler use rises. To further improve outcomes, consider reviewing the cases of patients who use more than three short-acting beta-agonist (SABA) metered-dose inhalers per year and sharing a 'one-minute-for-the-planet' story to help switching when appropriate.

Figure 1: Averaged inhaler dispensing and emissions



> "Many patients are surprised to learn that the greenhouse gas emissions from a single metered-dose inhaler are equivalent to a 290-kilometre car journey.

From left: Dr Kiyomi Kitagawa, Vicktoria Blake, Dr Rāwiri Tinirau, Manaaki Hogg, Julian Wilcox and A/Prof Karen Flegg

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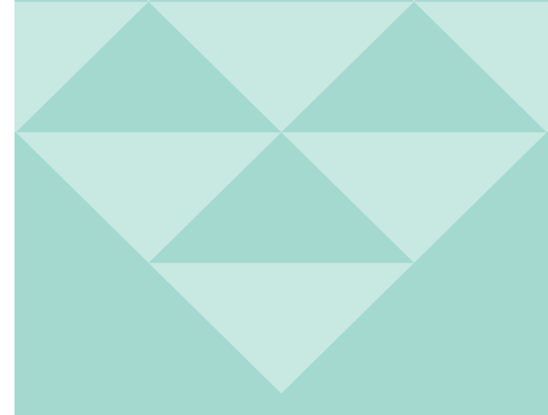

Helping veterans get the most from a consultation

By Phil Bilbrough

Projects and Communications Team Leader at Veterans' Affairs

From September, a Veterans' Affairs poster will go up in many GP practices around New Zealand. The poster aims to reach veterans in surgery waiting rooms and encourage them to tell their GP that they have served.

At Veterans' Affairs we would like the patient–GP relationship to begin well and sometimes ex-service people (in particular ones who have just left service) aren't used to the public health system and might be uncomfortable establishing a relationship with a civilian GP.

If the veteran has qualifying operational service, that is they may have been deployed to a qualifying military operation, they're entitled to support from Veterans' Affairs if they have a condition that was likely to be caused by their service. You can find out more about qualifying service here on our website.

We would like younger eligible veterans to establish a good relationship with their GP for both their wellbeing and to help them when they need to access support from Veterans' Affairs.

Some of the younger former service people don't see themselves as veterans. To them the word 'veteran' means someone older, someone from an earlier generation or conflict, and they don't identify with those people. For this reason the posters ask, "Have you served?"

Our website also has tips about how to work with Veterans – click here to see them.

These are the posters that will go up in surgeries in September.

If you would like to know more about these posters or about working with veterans, please email va.communications@nzdf.mil.nz.

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Six FAQs about goitres

Dr Francis Hall

The "why me?" question

A. A goitre is simply an enlarged thyroid and may be due to:

1. Benign thyroid enlargement (the most common cause)
2. Thyroid cancer (papillary, follicular, medullary, anaplastic, lymphoma...)
3. Inflammatory thyroid disease (Hashimoto's thyroiditis, Graves' disease...)

Benign thyroid enlargement, commonly just called goitre, may be classified as:

1. Endemic due to iodine deficiency, extremely common in certain parts of the world, or
2. Non-endemic not due to iodine deficiency, most common cause in New Zealand.

Other risk factors for benign goitre include:

1. Female gender. Goitre is more common in females than males. Goitre is also associated with parity especially in iodine deficient areas.
2. Genetic factors. It is estimated that genetic factors may account for up to 40% of the risk for developing a goitre.
3. Smoking. The effect of smoking on goitre is most evident in areas with iodine deficiency. Smoking is associated with goitre and multiple thyroid nodules.
4. Diabetes. Goitre is more common in diabetics and there is some evidence that metformin may lower the incidence of goitre in diabetics.
5. Other. Cassava and soya beans, Selenium deficiency. Most of this effect is in areas of known iodine deficiency. Nitrates. Polychlorinated biphenyls.

When should a goitre be removed?

A. A goitre should be removed when:

1. It is causing significant compressive symptoms (dysphagia, shortness of breath, shortness of breath on exertion, shortness of breath lying down, pressure feeling in the neck).
2. The patient is hyperthyroid (low TSH, high fT4) or developing hyperthyroidism (compensated hyperthyroidism: low TSH, normal fT4). It is essential to control hyperthyroidism with medication prior to surgery to prevent a thyroid storm.
3. There are red flags (rapid growth of the thyroid (anaplastic thyroid cancer, lymphoma), lymphadenopathy, hoarse voice due to vocal cord palsy, positive Pemberton's sign).
4. When FNA of any suspicious nodules is concerning. (See article in GP Voice June 2024). Note, there is little point performing a FNA if the patient is going to have surgery anyway.

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

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Is total thyroidectomy the only operation recommended for goitre?

A. No, but most patients with a goitre requiring surgery undergo total thyroidectomy because both thyroid lobes are involved. If the goitre only involves one thyroid lobe, then hemithyroidectomy is the appropriate operation to perform. If hemithyroidectomy is performed the patient does not need thyroxine after surgery and there is no risk of hypocalcaemia.

Do all patients with large goitres need surgery?

A. Surgery is not indicated in patients with a large goitre if they are asymptomatic, euthyroid and there are no red flags (see above).

What size does a thyroid need to be to cause compressive symptoms?

A. This is a tough question to answer with 100% certainty. Sometimes patients with a large goitre have no compressive symptoms while other patients with small goitres have compressive symptoms.

Eng et al. in his study of 99 patients who underwent thyroidectomy concluded, "Thyroid nodule size and lobe size appear to directly correlate with compressive symptoms."

From this paper it is inferred that compressive symptoms due to the thyroid enlargement are unlikely if the largest thyroid nodule is less than 1.5cm in diameter and the thyroid lobe is less than 5.7cm in size.

What does the term multinodular goitre mean?

A. The term multinodular goitre (MNG) is used by both radiologists and pathologists. When used by a radiologist to describe the ultrasound features of an enlarged goitre it should not be assumed that the goitre is definitely benign. In this context it is simply a descriptive term meaning that the thyroid is enlarged and contains multiple nodules. When used by a pathologist it means that the thyroid is enlarged, contains multiple nodules and there is no cancer. There are some thyroids that are termed multinodular goitre by radiologists which are in fact malignant.

In summary the word goitre simply means a large thyroid gland. What treatment the patient may need depends on the cause of the thyroid enlargement and any symptoms they may have.

If you have further questions about goitres that have not been answered here, please email **Dr Francis Hall:** francis@drfrancishall.co.nz

> "...most patients with a goitre requiring surgery undergo total thyroidectomy because both thyroid lobes are involved.

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Goodfellow Unit podcast: **Psychiatric aspects of Parkinson's**

Cheryl Buhay is a Fellow of the Royal Australian and New Zealand College of Psychiatrists. She currently works for Te Whatu Ora - Waitematā District's Specialist Mental Health Services as a Primary Care Liaison Psychiatrist, providing mental health support to GPs in the area.

In this podcast, Cheryl provides an update on Parkinson's disease and the psychiatric considerations that the primary care team need to be aware of.

The key take-home messages of this podcast are:

- Parkinson's Disease is a progressive neurological disorder that has high mental health comorbidity
- Be careful around medication management as these may exacerbate mental health issues
- With mental health presentations, exclude organic causes and review medication regime in case these are contributing
- Liaise with neurology and specialist mental health for management advice.

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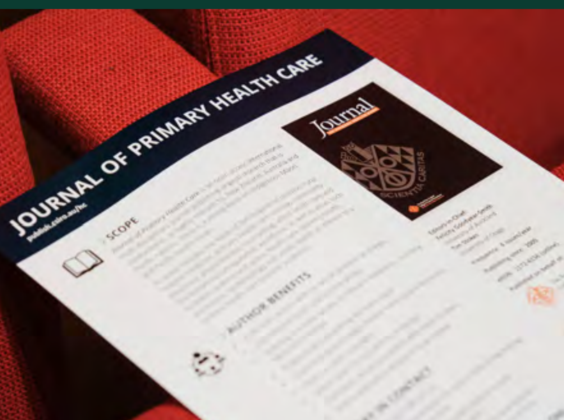

Journal
OF PRIMARY HEALTH CARE

The JPHC is a peer-reviewed quarterly journal that is supported by the College. JPHC publishes original research that is relevant to New Zealand, Australia, and Pacific nations, with a strong focus on Māori and Pasifika health issues.

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

Trending articles:

1. Patient perceptions of barriers to attending annual diabetes review and foot assessment in general practice: a qualitative study
2. Exploring the role of physician associates in Aotearoa New Zealand primary health care
3. He Aroka Uruta. 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
4. Advanced practice physiotherapists in primary health care: stakeholders' views of a new scope of practice
5. Unmet need for primary health care and subsequent inpatient hospitalisation in Aotearoa New Zealand. A cohort study

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Time matters in MS diagnosis and brain health

Multiple Sclerosis Society of New Zealand

Progressive neurological illness characterised by episodic deterioration has been observed and documented since the late 1300s. In the mid-19th century, multiple sclerosis (MS) was described as an identifiable entity based on its pathology (Murray, 2009). Since then, the process of diagnosing MS has evolved with a greater understanding of the pathology and advances in diagnostic tests available. The internationally recognised criteria for diagnosing MS currently used in Aotearoa New Zealand, the 2017, McDonald Criteria were first established in 2001. It has since undergone three revisions driven by the advancement of MRI technology, leading to earlier diagnosis (McNicholas et al., 2018).

Despite these advances, MS remains a complex and often lengthy diagnosis to reach, with time from first symptoms to diagnosis between 8 and 13 months in overseas studies (Rojas et al., 2021, Khodaie et al., 2024, Giovannoni et al., 2016). Dr Mason et al., 2015 found the average time between first symptoms to diagnosis in New Zealand was 4.8 years. Many factors contribute to this delay; one that is easier to modify is awareness. September 9 - 15 is MS awareness week and Multiple Sclerosis New Zealand's focus is 'Time Matters in MS'. By raising awareness of the early signs and symptoms and what to do next, we aim to reduce the average time from first symptoms to diagnosis.

'Brain health: time matters in multiple sclerosis', are evidence-based consensus recommendations which aim to improve diagnosis and management. Early management of MS reduces disease activity, in turn maximising neurological reserve, cognitive function and physical function over a person's lifetime. The goal is to improve timely access to a diagnosis and proactive disease management which will ultimately improve the lives of those with MS and their families (Giovannoni et al., 2016).

Often, people's first point of contact with new symptoms is to their GP. Early recognition of a possible MS presentation and referral to specialist services increases the access to early assessment and diagnosis creating the best chance to preserve brain and spinal cord tissue. MS brain health consensus standards recommend a patient is referred to a neurologist within 10 days of reporting symptoms to their health care provider (Giovannoni et al., 2016).

MS presents in various ways resembling a broad number of other conditions which should be considered. Fatigue, depression or dizziness alone would not routinely be considered an MS presentation. Neurological symptoms in the presence of infection or fever should be worked up for an infective cause and treated appropriately.

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Consider a referral to neurology if a person presents with any of the following symptoms:

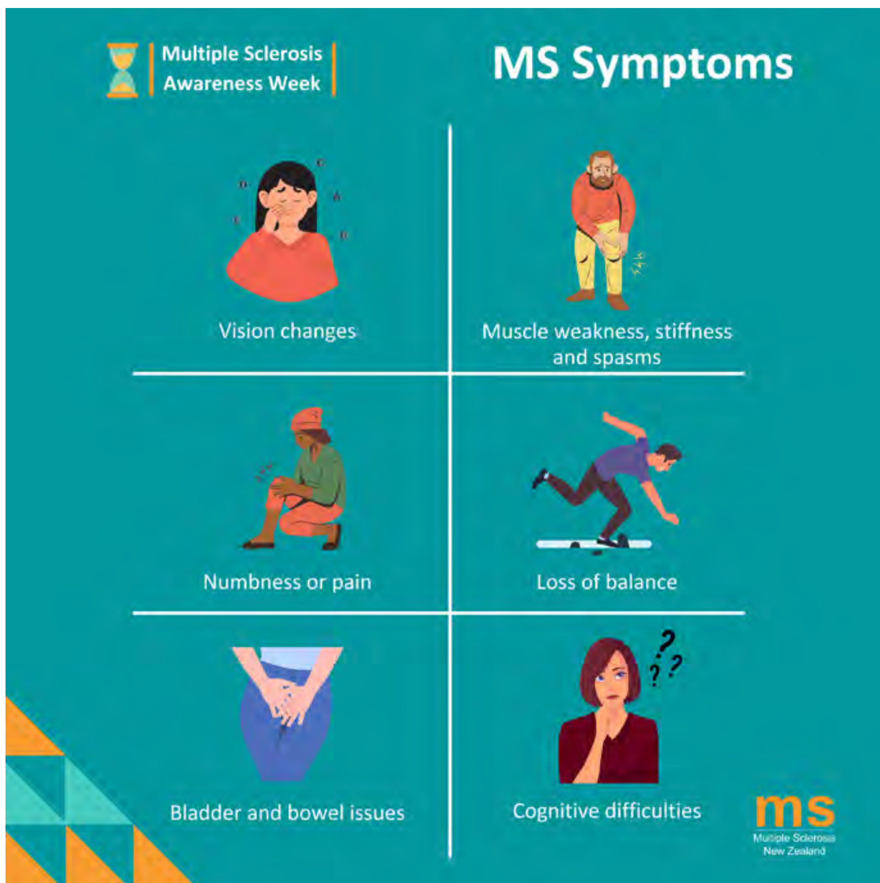
- Loss or change in vision with painful eye movement
- Sensory disturbance and/or weakness
- Progressive difficulties with balance and mobility that can otherwise not be explained.

Symptoms characteristically evolve over hours to days and can persist for weeks to months.

Referral for further evaluation and diagnosis should not be delayed if MS is suspected. It is important to provide clearly documented history and clinical assessment showing exclusion of alternate, more common diagnosis (National Institute for Health and Care Excellence, 2022, Olek & Howard, 2024).

Practical consensus guidelines can be found on UpToDate and NICE guidelines.

MS remains the leading cause of non-traumatic disability among young and middle-aged adults in many developed countries. Through the advancement of diagnostic testing and development of diagnostic criteria, times to diagnosis have dramatically reduced overall. Access to timely diagnosis and specialist care improves outcomes for patients, their families and the wider community. Significant benefits can be gained through early intervention. Primary care, where the finger is on the pulse, can make all the difference to achieve early diagnosis and intervention.



> “Through the advancement of diagnostic testing and development of diagnostic criteria, times to diagnosis have dramatically reduced overall...
> ... Significant benefits can be gained through early intervention.

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Screening outcomes since HPV go-live

On 12 September 2023, New Zealand introduced HPV primary screening as part of its National Cervical Screening Programme (NCSP), replacing cytology as the initial screening test for cervical cancer.

The NCSP reported that from 12 September 2023 to 31 May 2024 (approx. 8.5 months) they continued to see a steady increase in the number of wāhine and whānau with a cervix being screened.

There have been over 310,000 HPV primary screens completed since rollout and of those:

- 80.7% were self-tests.
- 18.9% of HPV primary screens done since rollout are in individuals who were unscreened or underscreened prior to 12 September 2023.
- HPV 16 or 18 was found in 2.1% of HPV primary screens.
- HPV Other was found in 8% of HPV primary screens.

In March this year, a good news story came out of the Goodfellow Symposium from an attendee:

"We have identified a treatable case of cervical cancer in an unscreened 68-year-old who had declined to have a smear."

This is a result of all the mahi being delivered by screen takers, regional coordination teams, primary care, labs, colposcopy and many others who work tirelessly to help eliminate cervical cancer in Aotearoa New Zealand.

September is Cervical Screening Month

The National Cervical Screening Programme will be highlighting cervical screening month throughout September.

A series of community activations and screening events will take place throughout the motu, focused on areas with lower cervical screening rates and reasonable population sizes. Events will include:

- at least 12 Te Wananga O Aotearoa campus events throughout the country.
- 10+ marae-based events (to support areas where there are no campuses).
- four Pacific community events.

Paid advertising will be increased throughout September and will include promotion of local events.

New resources will also be showcased and celebrated, including the addition of eight Pacific language translations and a new booklet sharing the screening journeys and encouragement from wāhine Māori.

“

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Our patients, our whānau:

Improving health outcomes in Māori communities through marae-based clinics

By Rebekah Crosswell

To the left of the majestic Hinerangi Marae sits a health clinic full of manaakitanga. Where the focus is hauora, from a Kaupapa-Māori point of view. Here, Western biomedical models are far from mind. On a clear, crisp day in Tūrangi, it was a hive of activity. Multiple cars were parked outside, with many people filtering through the hall. Warmth emanated throughout the building from the awhi provided by clinicians and the reciprocity from patients. The aroha and gratitude matched the sunshine that sat peering through the snow-covered mountains. In the corner was an area for a 'cuppa' and kai, with seating that looked like a great place to chat for the many who frequented the clinic.

As I walked further into the clinic, I saw cheerful clinicians collecting blood samples, measuring blood pressure and taking temperatures. They were smiling and laughing, chatting with their patients, their whānau. It is clear this is a tight-knit community, where the focus is on helping and contributing to the greater good. Those with a mistrust of the health system find a perfect fit here, with the down-to-earth and whānau-based treatment. Everyone who comes through these doors is greeted with whakawhānaungatanga. With staff exuding sincerity and positivity, you can't help but feel at ease. A typical day sees patients start wandering in at 7 o'clock – each one rushing for the envied first-place position in line. Though, if you must wait, you can happily chat with one of the many friends and whānau you are likely to meet. There is a strong sense of togetherness and unity, developed through commonalities in health, whānau and lived experiences.

The clinic is a gathering place, which feels like the ngākau (heart) of the community. Patients are familiar with the clinicians, who they know from their daily lives. Whether patients come in for a chat or a consultation, both are welcome. It wouldn't be unusual to witness multiple generations of whānau members visiting. Some clinicians have known whānau for years, even attending school with their patients' children or mokopuna, as is the case in small towns. The beauty of this is that conditions with a genetic component, such as diabetes or certain cancers, can be identified and discussed earlier. This enables the possibility of prevention before developing more serious illnesses and complications. Tamariki are also welcome. They may attend due to their own health or they may have been designated to keep their parents or grandparents company for the day. The happy sounds of children

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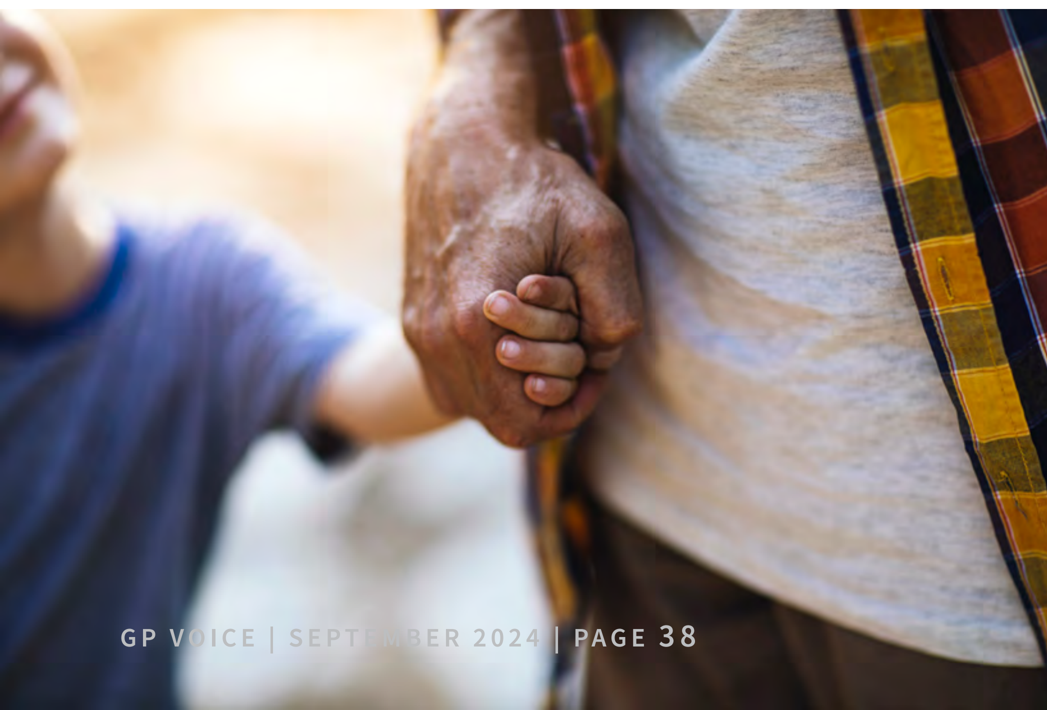
running through the hall, playing and laughing amongst themselves and one haphazardly playing an old piano rings through the hall. The innocence and happiness of tamariki is in stark contrast to the serious conditions the clinic sees daily.

There is no need for any pūtea here; all that is needed is a willingness to engage. Whilst the clinic is a fair distance from town, transport doesn't seem to be a barrier. Clinicians report some people walk to the clinic from home, or they collect them on their way to work themselves. Sometimes when they are not busy, some staff report they go for a drive to see if there is anyone on their way. Rigidly structured appointment times have no place in this clinic, and what each patient needs timewise, they will receive. Care plans are established for each patient, which may see them returning or referred to other services, such as secondary care. There is a compelling small-town feel to the clinic's marketing process, with one of the main methods being through advertisements on the local radio station and word of mouth, which isn't difficult in small communities. Others may know the clinician from previous clinics or are referred by friends or whānau.

A barrier for clinics such as this is its rural location, far from specialist clinics and central hospitals, such as Waikato or Rotorua. The local hospital must refer those with serious and critical conditions to one of the main centres. This is why identification, prevention and management of preventable diseases and chronic conditions in the community is so critical. What is essential for marae-based clinics such as this one is funding. Unfortunately, health care cannot be dissociated from the current economic and political landscape. However, what price can be placed on improved health outcomes for Māori? Imagine reducing rates of diseases where Māori are over-represented in statistics. Envision Māori living to the same age as their non-Māori counterparts, who have the privilege of enjoying another seven years with whānau[1]. Improvement in Māori health outcomes is an invaluable and achievable objective, as this clinic demonstrates. It has many success stories, such as motivating a patient who was resistant to medications to begin self-care and insulin. Another tāne who has kidney and heart failure and complications from diabetes, was able to overcome his aversion to the emergency department and Western medicine and now goes to the hospital when necessary.

> "This is why identification, prevention and management of preventable diseases and chronic conditions in the community is so critical.



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1. Statistics NZ, T.A. Growth in Life Expectancy Slows. 2021; Available from: www.stats.govt.nz/news/growth-in-life-expectancy-slows/#:~:text=Life%20expectancy%20at%20birth%20was,to%20live%20to%2084.4%20years.

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Before leaving, I talked to the Kaiwhakahaere (clinical lead), a registered nurse practitioner, whose passion for her mahi is unmistakable. Though she had worked a long day, she was happy to chat and welcome me. Full of energy and enthusiasm, she described the worthwhile nature of the clinic and the work undertaken, though humble in her own contribution. Her love for her work was infectious and her experience, wealth of knowledge and community connections were poured into all her patients. Her determination to deliver better health outcomes for Māori was evident in our conversation. The only thing stronger than her passion is the mana she possesses. Strong in her principles and formidable in her desire to challenge existing models and break down barriers. She explained that there were no 'health models' used here. There was not a one-size-fits-all approach, and we as health professionals and academics need to move away from treating individuals as if they can be neatly checked into boxes, labelled or judged. There is an obvious demand for an individualised approach tailored to each patient. Their care plans may not involve simply treating their physical conditions, but social and cultural aspects too. This mana wahine is a champion in her community, someone who provides the love and care that we would all want for our own whānau.

As I walk out of the clinic and back to my car, I reflect upon clinics such as this one, where the invaluable nature of having quality care at the community's doorstep cannot be understated. I can't help but think of the many whakataukī that I have learned throughout my childhood, which now come to mind. One in particular epitomises the health care provided at this clinic. "*Nā tō rourou, nā taku rourou ka ora ai te iwi.*" With your basket and my basket, the people will thrive. If clinicians combine the skills and knowledge that we already possess in our communities, through marae-based clinics such as this one, the health of our people will prosper.

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