GP Voice

YOUR NEWS, YOUR VIEWS, YOUR VOICES

Your voice matters
The 2024 Workforce Survey

Cerebral Palsy in your practice

Recognising a MS relapse
A relapse management guide

Quality counts:
The PMAANZ conference

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

October 2024

In this issue

News from the College

Views of our Members

Voices of the Sector

Faculty spotlight

Your Work Counts

Online health portals

Editorial

Dr Samantha Murton

Dr Samantha Murton
President | Te Tumu Whakarae

Kia ora koutou

It's been a busy month of discussions with the College Board, General Practice Leaders' Forum (GPLF), the Practice Managers and Administrators Association of New Zealand (PMAANZ) Conference, and the Royal New Zealand College of Urgent Care Bootcamp.

All these forums end up discussing various aspects of the extreme pressure we are currently under. However, many of them also are about discussing solutions which are integrally entwined.

At the GPLF meeting we started a discussion with the commissioning team from Te Whatu Ora to develop a combined viewpoint on the general practice team, after hours care and telehealth. The first part of the discussion was on the general practice team. Jointly we agreed that:

- General practice is a team 'sport'
- We need to grow all the professions
- Continuity of care is essential (and cost effective)
- A broad range of skills is needed (generalism is key)
- The community you serve influences the team make up
- There needs to be clinical governance
- We need to integrate services
- We need to develop:
  - A permissive environment
  - Ways of getting and giving feedback
  - Data gathering and reporting that is not onerous and supports ongoing change.

Further discussions will occur from now to the end of the year and will include our urgent care colleagues as part of the afterhours solutions.

I also had the opportunity to attend the annual PMAANZ conference in Tāmaki Makaurau Auckland to present on why quality matters in what we do and how it is essential to have quality places that all professions can train in. We cannot grow the general practice team if we do not recognise that this takes work. We must invest appropriately in all the services that are growing the general practice team.

Investing in practices that are involved in developing teams will take a shift in how we champion and recognise training in general practice. The College is working on this as part of the changes required to support the General Practitioner and Rural Hospital Medicine registrars and give them equivalency with their colleagues.

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Later this month you'll be receiving a link to complete the 2024 Workforce Survey and I really encourage you all to set aside some time to work through it. While the overarching challenges we are facing are the same, our experiences at an individual, practice and regional level are different. This is the information we need to have and share with the Minister and other sector stakeholders when we are at the table discussing capitation, funding, our model of care and the future of the workforce.

We carry out the survey every two years. We are interested to see what has changed over that time and get an up-to-date record of how you and your practices are doing and how you're working. We have a particular focus with this survey on GP teams, gender pay differences and telehealth delivery.

If you've joined the College as a registrar on the GP or RHM training programmes in the last two years or are a member who hasn't completed the survey previously, please do take 15 minutes to have your say and make your voices heard. Your voices do matter, and this is our biggest source of information with the findings referenced across the sector.

We also use 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.

We do important work and need to ensure our workforce is sustainable now and into the future. Having this data is how we can push for the necessary changes and highlight the vital role we play in the healthcare system.

Enjoy this month's issue,

College president Sam with Hilary Morrish Allen, practice manager of Pihanga Health.

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Editorial

Toby Beaglehole

Kia ora koutou

Alongside the editorial that alternates between Sam and Luke each month, we're beginning a College focused editorial to give us the opportunity to highlight the work the College team is undertaking to support the membership and our wider GP and rural hospital medicine workforce.

A recent highlight has been sending out acceptance letters to applicants to start on the General Practice Education Programme (GPEP) in 2025. While we may not quite manage to build on the record of the 232 registrars who started this year, I am still encouraged by these medical graduates who have chosen to join us and the difference they will make to their patients and communities.

Our GPEP and DRHM trainees are the next generation of the workforce and along with the training and education, it is important that they learn from you, our current workforce. Having your support and guidance and the opportunity to learn from your experiences is invaluable.

Advocating for the membership – current and future – is always top of mind for the College, the Board, Sam, Luke and myself in every discussion we have. We don't shy away from the fact that we have a workforce who has reached its tipping point, and we do look at how we can push for change by offering future focused solutions to address the challenges.

Another way you can help us in our advocacy efforts is to complete the 2024 Workforce Survey when it is sent out later this month. Your voices are crucial and provide us with much of the data that helps us to meaningfully advocate for you. The more information we have, the more influential we can be. The survey will be open for a month and take around 20 minutes to complete so I hope you can set aside some time to complete it. You'll start to see more information about the survey in the coming weeks.

Carrying on the theme of advocacy, I was able to join Sam, Luke and Kerryn at the WONCA Asia Pacific conference in Singapore at the end of August. I thoroughly enjoyed immersing myself in a wide variety of conference sessions and taking advantage of the networking opportunities.

The challenges that the international primary care workforce is facing sounded all too similar to what we are seeing in Aotearoa, but the context for those challenges was often quite different in different countries. Having time to discuss the different approaches, advocacy efforts and solutions was both intriguing and beneficial and we'll be looking to how we can adapt these to suit our local context.

Another success from WONCA was hearing Luke present the Your Work Counts project to the delegates. They were very interested in why we developed the

Toby Beaglehole
Chief Executive

> "We don't shy away from the fact that we have a workforce who has reached its tipping point, and we do look at how we can push for change by offering future focused solutions to address the challenges.

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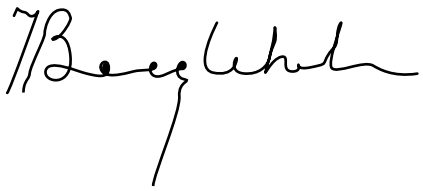
project, the methodology and results – with delegates from five countries immediately reaching out for further information, including our Australian GP neighbours. You can read more about this on page 21.

I hope you enjoy this month's issue of GP Voice and look forward to sharing the occasional thought in future.

Toby



We'd like your feedback

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

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Month in review

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

General Practice Leaders' Forum (GPLF) meeting

College President, Dr Sam Murton is the GPLF Chair

A discussion was held with Te Whatu Ora's Commissioning team to develop a combined viewpoint on the general practice team, after hours care and telehealth. The first part focused on the general practice team and discussions will continue throughout the year and include our urgent care colleagues. You can read more about what we agreed on in the President's editorial at the start of this issue.

Practice Managers and Administrators Association of New Zealand (PMAANZ) conference

The College has a Memorandum of Understanding with PMAANZ in recognition of the important role practice managers and administrators play in supporting our members and the wider general practice team. The College had a strong presence at the conference as both exhibitors and presenters in the programme.

College President Dr Sam Murton attended the conference in Tāmaki Makaurau Auckland and presented a plenary on 'Why Quality Matters' while the College's Quality Programmes team undertook an interactive workshop on "Demystifying Quality" to which 60 delegates registered to attend.

Sam also announced the first winner of our Cornerstone modules promotion at the conference. Read more about the PMAANZ conference on page 16.

Fitness to drive webinar with NZ Transport Agency Waka Kotahi

Medical Director Dr Luke Bradford hosted a webinar with the NZ Transport Agency Waka Kotahi to discuss the proposed changes to the medical aspects of fitness to drive guidelines. The presenters from NZ Transport Agency Waka Kotahi were Kim Hawe (Manager, Driver Safety) and Mark Pugin (Principal Advisor from the NZTA Safe Drivers team). We had over 100 members attend the webinar. Watch the recording of the webinar.

Your Work Counts

Luke and members of the College's Policy Advocacy and Insights team are working on a paper on the Your Work Counts project for the Journal of Primary

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Health Care (JPHC) as well as an ethics application to broaden the utilisation study to other practices.

Healing, learning and improving from harm: National adverse events policy 2023

This month the College Quality Programmes staff facilitated a presentation to the PHO Quality Improvement Group in collaboration with staff from Te Tāhū Hauora – Health Quality & Safety Commission. The main outcome of this work is to ensure our members and practices are well supported and enabled to transition from the 2017 to the 2023 policy.

Medical Director meetings

Luke has met with ACC, MPS and MCNZ to discuss amongst other things, payment for sensitive claim consults, note requests, supervision of IMGs in general practice and complaint management across agencies.

He has had meetings with the screening advisory group, participated in Collaborative Aotearoa's Model of Care workshops and been involved in ongoing development of the new SLM program as well as PSAAP discussions on this via the contracted provider caucus.

College submissions:

1. Ministry of Health – Review of the End-of-Life Choice Act
2. Parliament – Land Transport (Drug Driving) Amendment Bill

Goodfellow Unit podcast: **Low carb diets**

Dr Marcus Hawkins is a GP who is a passionate advocate of dietary interventions to optimise health in primary care. Caryn Zinn is a New Zealand Registered Dietitian, has a PhD from AUT and is an Associate Professor at AUT.

In this podcast, Marcus and Caryn discuss therapeutic low-carbohydrate dietary interventions to optimise health in primary care.

The key take-home messages of this podcast are:

- Have an open mind
- Carb reduction is safe, efficacious and should be considered for anyone with insulin resistance
- Encourage your patients to be curious
- Parameters will improve (lipid profiles, weight, blood pressure, etc.)

Listen to the podcast

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Closure of after-hours GP services on the West Coast:

The College's response

Timely and accessible health care should be attainable for all New Zealanders, irrespective of where they live.

In a media release, College President Dr Sam Murton and Division of Rural Hospital Medicine Chair Dr Andrew Laurenson said that the story revealing plans to close all after hours GP services on the West Coast is extremely concerning for both patients and the health professionals who will take on the additional patient care.

Dr Laurenson said, "underfunding to the point of insolvency of services such as GP after-hours clinics, especially in an area so geographically dispersed as the West Coast, will do nothing to help us achieve a thriving and sustainable rural health workforce.

"The expectation for private rural businesses to fund the shortfalls in emergency care from their own pockets is not a sustainable solution.

This sentiment was echoed by Dr Murton who said, "primary care delivers 23 million contacts with patients every year and is the most cost-effective part of the health service. Chronic underfunding puts this essential service in jeopardy, and we cannot continue to rely on the goodwill of the primary care workforce to keep up this pace. The health and potentially the lives of New Zealanders are being put at risk due to a lack of access to primary health care services."

Read the full media statement.

> "The expectation for private rural businesses to fund the shortfalls in emergency care from their own pockets is not a sustainable solution.

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Your voice matters:

The 2024 Workforce Survey

The College's biennial Workforce Survey will be landing in your inboxes later this month.

The data gathered from the survey is invaluable for highlighting and promoting the value of the workforce as well as identifying (or reinforcing) the areas of general practice and rural hospital medicine that need attention.

Your responses provide first-hand data insights for the Government, key health sector agencies and the public to tap into and help make informed decisions for the future. We use the data regularly in our advocacy, media and policy work and share the results widely across the sector.

The challenges facing general practice and rural hospital medicine are complicated but they are not impossible to fix. Having these results to hand allows us to speak out, advocate and push for immediate and longer-term action that will make a significant difference to the health of New Zealanders and wellbeing of our workforce.

It's also useful to see how the responses have changed over the two years since the previous survey was conducted to help guide the College's mahi.

We have all seen the coverage in the media recently about primary care with many members also sharing their perspectives. Having up-to-date data about the positive aspects of the job, the challenges, and solutions, and analysing how it differs across demographics, regions and other factors such as hours worked per week is incredibly useful allowing us to target and tailor our messaging where required.

Why does your voice matter?

We are lucky to have such a diverse group who make up our over 6,000 strong College membership. Alongside the faculties that all members belong to, we have our rural hospital medicine peers, Te Akoranga a Māui, and our Pasifika, Registrar and Rural GP chapters.

Registrar chapter co-Chairs Dr Darren O'Gorman and Dr Vaaiga Autagavaia say that "*Registrars are the future of the general practice workforce. Our perspectives on current workforce challenges are critical to developing sustainable working conditions in the long term. Due to our freshness to current working conditions, we have unique insights that may otherwise be missed.*

"The Workforce Survey is important as it documents your working life as you experience it and gives evidence of the conditions registrars are faced with every day. In supporting this survey, you give the College the information it needs to advocate for better working conditions in the future."

> "Registrars are the future of the general practice workforce. Our perspectives on current workforce challenges are critical to developing sustainable working conditions in the long term.

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College President Dr Sam Murton says, “General practice and rural hospital medicine are rewarding careers. We are highly empathetic people who want to do the best for our patients and communities. But this needs to be a job that we can do safely and without sacrificing our wellbeing.

“Having data to back up our calls for action is crucial when we are at the table discussing the future of the workforce, capitation, funding, models of care, training or any other aspect that impacts the way we work.”

Please keep an eye out for more information about the survey over the coming weeks, and the link for you to access the survey later this month.

Read the results from the 2022 Workforce Survey.

Goodfellow Unit podcast: **Chronic kidney disease**

Elizabeth Stallworthy is a nephrologist at Auckland City Hospital. Her interests include kidney supportive care and conservative management of chronic kidney disease (CKD), metabolic management of kidney stones, haemodialysis and teaching communication skills to health care professionals.

In this podcast, Liz discusses screening at-risk individuals, the use of appropriate tests and ongoing monitoring of CKD in the New Zealand context.

The key take-home messages of this podcast are:

- CKD is common, affecting more than 1 in 10 adults in New Zealand.
- The vast majority of CKD is asymptomatic, so we have to be proactive to identify it.
- CKD is associated with significant morbidity and mortality from vascular disease as well as kidney failure itself.
- We can prevent or delay vascular disease and kidney disease with medical management to improve health outcomes for our patients.
- Patients will need education and support to understand what kidney disease is, why it is a problem and what the benefit of treatment is to motivate them to take treatment.
- Doing better at identifying and treating CKD early has the potential to address some of the inequity in health outcomes between ethnic groups in New Zealand.

Listen to the podcast

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Spotlight on the Southland Faculty

The Southland Faculty was established around 10 years ago, encompassing a vast geographical area with a dedicated and enthusiastic group of members from the region. A standout event is the annual CME weekend, set to take place in Te Anau once again this year. It's a well-received event, featuring a variety of local specialists and GPs who provide updates on a wide array of topics. The CME conference runs from Saturday morning to Sunday afternoon, offering not only valuable CME content but also plenty of opportunity for collegiality and catching up with friends old and new. In past years, the event has been hosted in Te Anau, Borland Lodge in Fiordland and Stewart Island, allowing members to explore the remarkable locales within Southland and delivering in-person CME to rural GPs.

Another anticipated annual event is the AGM. For 2024, the faculty enjoyed a delicious dinner at Invercargill's new Langlands Hotel, where they also listened to local GPs discuss the application of AI in Primary Care.

There are several collaborative CME evenings held throughout the year, with several speakers from both secondary and primary care. These events are well attended, the most recent one held in August, had a medical focus with a range of topics covering respiratory medicine, an update on travel medicine, geriatrics and the CEO of one of our local Māori health NGOs speaking about the services they provide to the region. Over 40 attended this event with drinks and nibbles provided, it was a great chance to catch up with colleagues.

The faculty also provides funding for access to online CME through sponsorship of the Goodfellow Unit podcasts and the Otago Faculty for ZOOM access to their regular CME.

The faculty supports local registrars by sponsoring GPEP events during the year including the mid-Winter Christmas quiz. This is a fun event for GPEP registrars, teachers and medical educators, with a medical twist to some of the questions!

“The faculty also provides funding for access to online CME, through sponsorship of the Goodfellow Unit podcasts and the Otago Faculty for ZOOM access to their regular CME.

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The Southland Faculty exec currently comprises of nine members.

Left to Right: *Dr Jacqui Walker, Dr Tabitha Luecker, Dr Dayna More, Dr Amy Rosario, Dr Andy Shute and Dr Kirsten Taplin.*

Absent: *Dr Rachel Greenwood, Dr Callum Fowler, Dr Sophie Sharpe.*

So if you are in the Southland Faculty, make sure to head along to their next event and connect with your colleagues!

Quality in Practice: Gain Health Centre

A Cornerstone CQI module case study

Gain Health Centre is Upper Hutt's smallest practice working to provide patients with the best care possible in a very challenging environment. They have four GPs who are supported by three nurses, a clinical pharmacist, a primary care practice assistant and six administration staff including the practice manager.

They pride themselves on providing excellent all-around general practice care including a skin clinic and minor surgery, and a women's clinic including IUCDs and menopause consultations. Their nursing team provides a range of skills including punch biopsies, smears, immunisations, cannulating, long term condition management along with many other skills.

We caught up with Dr Imogen Robertson Owner/Clinical Director at Gain Health Centre to find out about their experiences of the Cornerstone CQI module, why they did it and what they learnt from it.

What motivated your practice to complete the Cornerstone CQI module?

We wanted to make sure that patients with congestive heart failure (CHF) were being offered iron studies blood tests regularly. We had no process for this and some patients were falling through the gaps and not receiving iron infusions.

We wanted to see if there were inequities in our iron management of those patients with CHF and if so improve those outcomes. We also wanted to improve patient health outcomes, decrease hospital admissions and give better symptom control to generally improve quality of life.

What did you have to do to gain the Cornerstone CQI module accreditation?

We decided on this project as it was a well-defined question and touched on equity, while also involving all clinical staff. Our project leads met with a CQI assessor early in the process before the full plan was developed. This made it easier to incorporate aspects that would be required for the write up.

We pulled a report of CHF patients to understand if they had had an iron studies blood test in the last six months and added recalls if they hadn't. We presented the first data at a full staff meeting which was great as it fuelled the enthusiasm to improve, and discussion helped formulate a standardised process going forward for management of iron deficiency at Gain Health Centre. A second report was run six months later.

“

We decided on this project as it was a well-defined question and touched on equity, while also involving all clinical staff.

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The write up of our project was in a PowerPoint document and our assessor was very responsive to questions and helping with the format.

What were the results of your CQI initiative?

We redesigned a six-monthly recall system for patients with CHF to create a consistent standardised process. We also implemented a structured process for CHF patients follow up to include iron levels advised as per BPAC guidelines and Health Pathways, with iron infusions administered at the practice where necessary.

Initial results (out of 42 patients):

- Eight patients met the criteria for iron infusion
- Four patients had infusions in the previous six months
- 15 patients (36%) had existing recalls set for the next iron studies
- Six monthly recalls with prompts for ideal iron levels added to the remaining 27 patients (64%).

Iron studies blood tests in the last six months in Māori and Pasifika with CHF were 40% and 50% respectively, and in the second query it increased to 100%. So, we've made a significant improvement. European and other ethnicities have not quite reached our target of 80%.

This project has highlighted for us that there are continual improvements regarding updating recalls.

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What is different for your team because of doing this work?

Keeping staff on board was key to keeping the project on track. Whenever the audit of numbers of patients who had had iron studies in the last six months was run, we found errors and processes to update and communicate to staff.

The project was great because it brought the clinical team together to look at a topic, that has had variations in practice, and now we have a consistent approach leading to a higher quality of care and staff satisfaction.

Unfortunately, two patients died over the project duration due to the natural history of the condition, and all staff gained a greater understanding of the delicate balance of care for those with CHF, and the need for increased vigilance with this population.

Our key take home messages were:

- There is a need for clear written notes so no matter which GP was filing the results, the low iron levels that may look normal for other patients were not missed.
- Blood test challenges: Patients who were in hospital unknown to the practice and therefore missing routine tests, home visits not requested when needed, patients not going for blood tests. They are difficult to resolve but as a primary care provider we continue to keep trying.

The team really enjoyed the CQI process and would like to do it again in the future. We loved getting the results for our patients and it was a much more manageable task than expected!

> “The patient is feeling better after having an iron infusion. She has been able to do more things since.

Quality counts: The PMAANZ Conference

The College's Quality Programmes team alongside College President Dr Sam Murton attended the annual Practice Managers and Administrators Association of New Zealand (PMAANZ) conference in Tāmaki Makaurau Auckland from 13 – 14 September. The College holds a memorandum of understanding with PMAANZ, and this conference has always been an important one for the College to attend.

Over the two day conference both the College Quality Programmes team and Sam presented on two very important topics. Sam's presentation focused on why quality matters. She shared that across the country 1,000 general practices deliver health care to 4.9+ million enrolled patients. We deliver 23 million patient contacts a year, which equates to 400,000 a week and 80,000 a day, so we need to do it well!

Sam also talked about how the quality standards in general practice have been developed over many years. It has been the work of many people to get to where we are, and if the College did not set the standard for health services in general practice, someone else would. However, she stated that fundamentally it is about holding ourselves accountable and to a high standard of care, which is important in our role as healthcare professionals and something that the College takes seriously.

The Quality Programmes Team (L to R): *Sandy Bhawan, Heidi Bubendorfer, Carrie Hetherington and Lucy Wass*

> We deliver 23 million patient contacts a year, which equates to 400,000 a week and 80,000 a day, so we need to do it well!

Submit your feedback

The College Quality Programmes team consisting of Sandy Bhawan, Heidi Bubendorfer, Carrie Hetherington and Lucy Wass presented on demystifying quality. They had over 60 attendees come to their workshop which was a successful turnout and a real team effort. They focused on the quality programmes that the College offers including a case study about Lyttleton Health Centre, interactive activities focused on Foundation Standard and encouragement for all the attendees to continue on their quality journeys.

It was also lovely to engage with the stream of people who came to the College stand, there were lots of smiling faces and questions. The Quality Programmes team also appreciated being able to engage with people face to face who they usually communicate with via phone or email.

The College team have also launched a Quality Programmes case study booklet, showcasing the experience of practices who have undertaken the Cornerstone continuous quality improvement and equity modules. You can read it on our **website.**

Overall, it was a successful conference attendance by the College to reinforce why quality matters in general practice.

Goodfellow Unit podcast: **Tongue Tie (Ankyloglossia)**

Dr Abby Baskett works as a paediatric emergency specialist at Starship Children's Emergency Department and in private practice through Milk & Honey Paediatrics in Auckland.

In this podcast, Abby discusses tongue tie (ankyloglossia) and its impact on breastfeeding. It also covers the prevalence, definitions, assessment tools and management options including the intricate details of the frenotomy procedure.

The key take-home messages of this podcast are:

- Not all tongue ties need dividing
- Assess the whole issue (feeding/other adjustments)
- If referring, refer to someone who can offer broader support.

Listen to the podcast

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Learn the format and get feedback

The 2024 mock exams

Every year during August and September the mock clinical and written examinations are held across the motu for GPEP year 1 registrars. The mock exams allow our registrars to familiarise themselves with the structure of the exams in a supportive environment and receive feedback on areas where they may need to focus on when preparing for the real exams that are held later in the year.

This year we had 250 GPEP registrars sit the mock clinical exam and 251 registrars sit the mock written exam in regions right across the motu.

For the clinical mock, registrars have the opportunity to do three clinical examination cases and receive feedback from the educators and their peers after each case. While the mock written exam is a formative assessment completed online during the registrars' regional seminar day, the real exam is a traditional written exam with registrars putting pen to paper.

"Running these mocks exams means registrars know exactly how the real ones will be run and what is expected of them later in the year. We hope it can reduce some of the stress that naturally comes with exam time," says Stefanie Joe, Manager GPEP1 delivery at the College.

Our Lead Medical Educators, Medical Educators and GPEP1 teachers play an important role in this process running the exams and providing invaluable feedback to the registrars.

There is also a contingent of College staff involved in this process, both in the lead up to and on the days of the exams. The entire GPEP1 team plus members of the Advanced Registrars team are tasked with setting up for the clinical exams at each venue, facilitating on the day to ensure everything runs smoothly which involves making sure the registrars are in the right place at the right time, timekeeping, troubleshooting and being available to answer any questions.

Preparation is key and a lot of logistics and planning go into making sure everyone involved is well prepared and equipped with the resources they will need on the day.

Well done to all the GPEP year 1 registrars who sat the mock exams this year, we hope it helps you in your preparation for the final exams later this year!

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MIND THIS

Nitrofurantoin prescribing practices

Dr Peter Moodie

In 2019 Mr A, who was tetraplegic (from an accident some years before) died from pulmonary fibrosis, which is a rare but well documented complication of the long term use of nitrofurantoin. The complaint to the HDC was that Mr A and his wife should have been made aware of this risk so that they could have made an informed decision about the treatment.

Medsafe have issued two warnings about the long term (greater than 6 months) use of the drug in 2002 and 2012.

Because of his tetraplegia, Mr A had a neurogenic bladder and was prone to recurrent urinary tract infections. In 2017 he was seen by a rehabilitation specialist and given a two-month trial of nitrofurantoin. The treatment worked and for the next 28 months, Mr A was prescribed the medication regularly, mainly by his general practitioner Dr C but also by a urology registrar Dr D.

The rehabilitation specialist who saw him in 2017 stated that he was aware of the risk and informed Mr A and his wife. However, they did not document this conversation and Mr A's wife denied that she had been warned. The Commissioner stated that on balance she felt that they had not been warned.

Dr D and Dr C along with the dispensing pharmacist all stated that they were unaware of the risk and unfortunately this is a classic case of *"not knowing what you don't know."* Not withstanding this knowledge gap, the Commissioner considered that they **should have known.**

Rather than trying to apportion blame for this sad case it is worthwhile looking at how this could have been avoided:

- We all have a responsibility to review the possible long-term risks associated with a medication which is normally used for only a few days. This is particularly relevant in general practice where a doctor would have very few patients on such a treatment.
- The rehabilitation specialist who said they were aware of the risk could have put that into their consultation letter to the GP.
- Pharmacies could be required to put a warning label on the bottle of any long-term prescription for nitrofurantoin. This could also trigger a discussion with the prescriber to ensure that they were aware of the issue.
- One proposal from a pharmacist was that after six months, prescriptions for nitrofurantoin should be subject to a Special Authority restriction. Apart from the paperwork, it would be impossible to set up such an authority.

Peter Moodie is the College's Clinical Advisor

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- It would be wise for all practices to run a query on their own PMS databases to identify any patients currently on long term nitrofurantoin.

This case raises two further questions: the first is whether it is practical to record in the case notes that all possible side effects of a drug have been discussed; and secondly; whether there are other drug reactions like this one for other medicines that we are not aware of.

> “Rather than trying to apportion blame for this sad case it is worthwhile looking at how this could have been avoided.

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

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Your Work Counts goes international

At the WONCA APR 2024 conference in Singapore, Medical Director Dr Luke Bradford shared the aims, results and next steps of the Your Work Counts project to delegates.

He explained how the College is using this data to advocate and push for change in New Zealand's general practice and primary care workforce. He shared how the workforce shortages have meant specialist GPs in New Zealand are having to take on more work and work longer hours, as well as identifying how much time is being spent on key tasks so we can highlight the unrecognised and often unremunerated work that is required to look after a primary care patient load.

Dr Bradford says, "the challenges we are facing in New Zealand are also being experienced by our international peers and it's very clear that we should be taking any opportunity to join forces to apply pressure to our respective Governments and health sector officials. When tens of millions of patients worldwide are being impacted by the total lack of investment into primary care and general practice, the calls for action can't get much more urgent."

Dr Bradford also encouraged the delegates to run their own version of the Your Work Counts project which would provide robust data to be used within their own advocacy work.

Medical Director Dr Luke Bradford sharing his Your Work Counts presentation at the WONCA APR 2024.

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Not surprisingly, the presentation was well received and the project was described as a unique initiative.

After the conference, delegates from five countries across the Asia-Pacific region reached out for more information about the project and our methodology. We'll be keeping in contact with them and offering support where we can.

Our peers over the ditch from The Royal Australian College of General Practitioners have also expressed an interest in learning more about the project and delving deeper into our results from the two diary studies.

If we are to have a sustainable and well-resourced general practice and primary care workforce, appropriate investment needs to be made so that complex and comprehensive, timely and affordable care can be given to patients and communities – right around the world.

Journal
OF PRIMARY HEALTH CARE

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

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

Trending articles:

1. Patient perceptions of barriers to attending annual diabetes review and foot assessment in general practice: a qualitative study
2. Cultural safety in paramedic practice: experiences of Māori and their whānau who have received acute pre-hospital care for cardiac symptoms from paramedics
3. Exploring the role of physician associates in Aotearoa New Zealand primary health care
4. Attention deficit and hyperactivity disorder and use of psychostimulants in Aotearoa, New Zealand: exploring the treatment gap
5. The impact of nurse prescribing on health care delivery for patients with diabetes: a rapid review

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Hyperthyroidism: A surgeon's perspective

By Dr Francis Hall

Hyperthyroidism refers to the condition where the thyroid gland makes too much thyroid hormone. Thyrotoxicosis refers to the condition where there is too much thyroid hormone from any cause.

The symptoms of hyperthyroidism include: preference for cold, increased appetite, weight loss, excessive sweating, anxiety, palpitations and tiredness. Wayne's index rates the symptoms and signs of hyperthyroidism and is accurate at making a clinical diagnosis of hyperthyroidism.[1]

Hyperthyroidism causes

There are three causes of hyperthyroidism:

1. Graves' disease
2. Autonomous functioning thyroid nodule AFTN (autonomous hot nodule)
3. Toxic multinodular goitre (toxic MNG).

In hyperthyroidism the TSH is suppressed and the fT4 level is elevated.

Graves' disease is an autoimmune disease. There are elevated levels of TSH receptor antibodies. It typically affects middle-aged (40–60-year-old) females but can occur at any age and also occurs in men. It is the most common cause of hyperthyroidism. The eyes are involved in one third of patients and the skin (pretibial myxoedema) is rarely involved. Eye involvement includes proptosis, extraocular muscle involvement leading to diplopia and optic nerve involvement leading to blindness.

Toxic MNG is usually seen in a long-standing goitre that slowly over time starts to secrete excessive thyroid hormone. It is usually proceeded by compensated hyperthyroidism (suppressed TSH and normal fT4 levels).

Traditionally a radionucleotide thyroid scan is requested to differentiate between the causes of hyperthyroidism. In Graves' disease there is diffuse homogenous uptake of the isotope. In an autonomous hot nodule there is localised uptake of the isotope by the nodule with no uptake in the rest of the thyroid gland. In toxic MNG there is heterogenous uptake of the isotope.

An ultrasound scan can frequently differentiate between Graves' disease, autonomous functioning thyroid nodule and toxic MNG. In Graves' disease we see a homogenous mild to moderately enlarged thyroid gland with a markedly increased blood flow (thyroid inferno). In AFTN we see a thyroid nodule in the setting of a low TSH and elevated fT4. In toxic MNG we see an enlarged multinodular thyroid gland in the setting of a low TSH and elevated fT4.

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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Hyperthyroidism treatment options

There are three main treatment options for hyperthyroidism:

1. Anti-thyroid medication. Carbimazole is the most commonly used medication (initially up to 60mg per day, then reduced slowly down to 10mg per day). Many doctors request liver function tests and a full blood count as a baseline because carbimazole may cause liver dysfunction and agranulocytosis. Patients should be informed to report immediately any fever, mouth ulcers or sore throat so that urgent repeat FBC and liver function tests can be performed. Carbimazole is contraindicated in the first trimester of pregnancy. Over 50% of patients develop recurrent hyperthyroidism after stopping carbimazole.
2. Radioactive iodine (RAI). RAI takes about six months to work. Following RAI, about 25% of patients develop recurrent hyperthyroidism. RAI may exacerbate eye disease in Graves' disease. RAI is not particularly effective in large toxic multinodular goitres. Pregnancy should be avoided for 6–12 months after RAI. RAI may cause chronic sialadenitis.
3. Surgery. Surgery is very effective in Graves' disease, autonomous hot nodules and toxic multinodular goitre. Total thyroidectomy is recommended for both Graves' disease and toxic MNG. Hemithyroidectomy is recommended for an autonomous functioning thyroid nodule. Surgery facilitates the treatment of Graves' eye disease. It is important that the hyperthyroidism is controlled with antithyroid medication prior to surgery to help prevent a thyrotoxic storm. Potential complications of surgery include injury to the recurrent laryngeal nerve and hypocalcaemia.

Finally, radiofrequency ablation (RFA) is an acceptable treatment for an autonomous hot nodule. It is a scarless procedure performed under local anaesthetic and ultrasound guidance.

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

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2. Campbell K, Doogue M. Evaluating and managing patients with thyrotoxicosis. Aust. Fam. Physician. 2012; 41(8): 564-572.
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A quiet revolution:

Climate change and asthma

By Dr Rob Burrell

Back in July we introduced the idea of a quiet revolution in the clinical management of asthma. We desperately need that revolution because the asthma treatments some of us were taught in the 1980s, 1990s and 2000s are no longer fit for purpose, and the drug delivery systems from those days are even less so. In particular, we are talking about the salbutamol inhaler.

Salbutamol inhalers use propellants that are potent greenhouse gases

Salbutamol was invented and marketed as Ventolin in the 1960s. The original propellants were chlorofluorocarbons (CFCs), but by the 1980s CFCs came with a bad rap. They were destroying the ozone layer.

For the last 30+ years, generic and branded salbutamol inhalers have proudly stated their CFC-free status. But the manufacturers have not really moved with the times and almost all metered-dose inhalers (MDIs) use propellants that are extremely potent greenhouse gases. The propellants don't damage the ozone layer, but they most certainly are not good for the planet.

The propellant in an MDI is so potent that the carbon footprint of just one inhaler is ~28kg CO_2 eq. That is about the same as driving a petrol car for 300km. (The carbon footprint of a dry powder inhaler (DPI) is up to 1kg CO_2 eq.) If we want to bring down the carbon intensity of health care and to reduce our environmental footprint, we need to rapidly move away from MDIs. The most prescribed MDI in Aotearoa by a country mile is salbutamol.

SMART therapies for asthma care

Twenty-first century asthma care is not about prescribing large numbers of blue inhalers. It has become much SMARTer, and prevention and combination therapies are driving better control. SMART therapies in DPI formulations are the backbone of the Asthma and Respiratory Foundation Guidelines for adults and adolescents. Better prevention and treatment are the pathway to better equity, reduced health costs and reduced illness burden.

How are we tracking?

Our quiet revolution – better therapies, better management, DPI whenever possible – is something we can audit, a pathway we can track. So how are we doing?

We have access to some useful data on medicines that are community dispensed and Pharmac funded. Combining that information with embodied carbon estimates of the various inhalers and their propellants gives us

About the author

Dr Rob Burrell mixes his anaesthesia job at Middlemore Hospital with his clinical lead role in Te Whatu Ora's Sustainability team.

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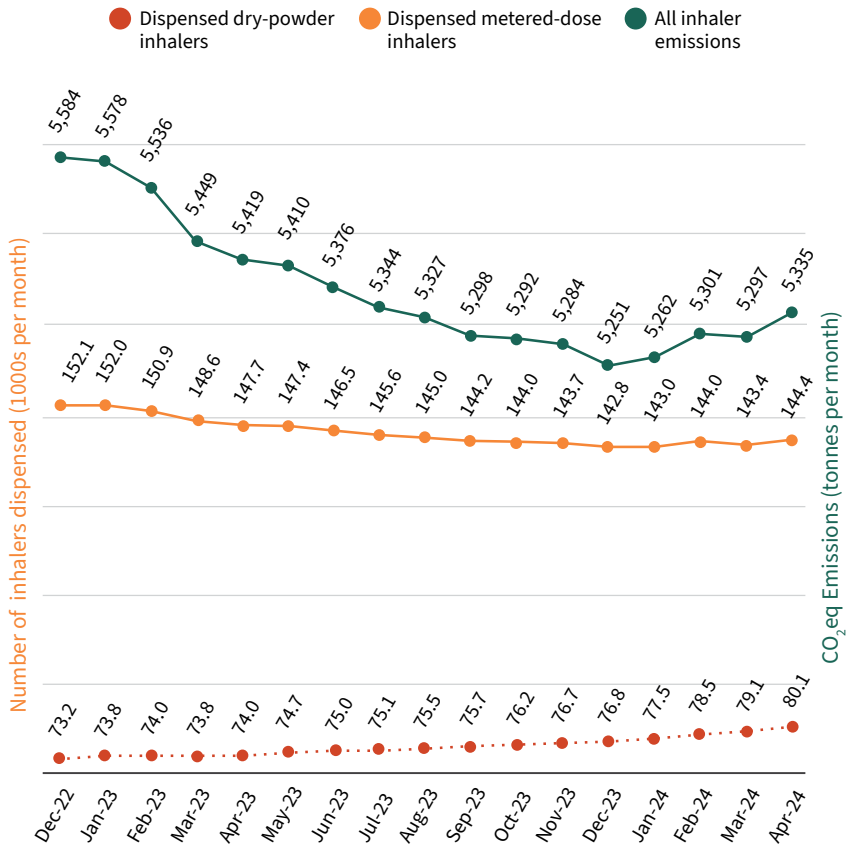
our graphs. There is an information lag because of pharmacy information processing, and we are looking at dispensing a surrogate marker for prescribing.

Figure 1: Averaged inhaler dispensing and emissions



In our **July article** we could see some healthy trends, with a nice steady rise in the dispensing of budesonide formoterol DPIs, "the preferred reliever treatment for intermittent mild, moderate and severe asthma." That is excellent news and we should be pleased.

What we are not seeing is a rapid and sustained decline in emissions because we are not seeing a rapid and sustained decline in Short-Acting Beta2 Agonist (SABA) MDI prescribing. Is that a function of a bad winter for asthma? Are patients making demands for salbutamol MDIs? Why are we not making more progress? The power to achieve this quiet revolution is in the hands of general practice, where 90% of the patient interactions occur, where the prescribing occurs and where the opportunities lie.

The next time you have a patient with asthma before you is the next moment to ask, "can we treat this illness better, with better management and better medicines?" Or even "Can we prescribe fewer SABA MDIs?"

Let's get rid of those greenhouse gas–laden blue inhalers where they don't add value. The potential for achieving this quiet revolution is huge. We are making change, but there is room for much more.

> "If we want to bring down the carbon intensity of health care and to reduce our environmental footprint, we need to rapidly move away from MDIs.

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Recognising a MS relapse:

A relapse management guide

Multiple Sclerosis (MS) is a long-term, progressive neurological disease. The cornerstone of any long-term condition is optimal and proactive management. Ongoing monitoring for treatment efficacy and signs of progression is important to minimise long-term disability in MS.

In an ideal world, all patients with MS would be closely monitored by specialist MS healthcare providers and have access to proactive and evidence-based treatment. Reality presents many challenges to this scenario, some of which can be overcome by promoting greater awareness to people with MS and their communities, and to the primary health care team who are often a person's first point of contact.

There is a spectrum of issues that a person with MS may present with, from straightforward infections to suspected relapse, to potentially serious complications from treatments. Most of which will need to be reviewed by their MS specialist, ideally within 10 days of the symptoms being noticed with the goal of making positive impacts through vigilance and proactive care (Giovannoni et al., 2016).

MS relapses need review and assessment

MS relapses or side effects from treatment do need review and assessment by their MS team. For a patient with MS presenting to primary care with new or worsening symptoms, their GP has an important role in timely and appropriate access to assessment and treatment. Suspect a relapse if someone presents with:

- New neurological symptoms **or**
- Worsening of old symptoms

that have persisted for more than 24 hours in the **absence of infection**.

Assess for infection, particularly respiratory and urinary infections. Consider checking bloods and urine sample (UTI can present atypically in MS) and treat as appropriate. Infection will often cause worsening of MS symptoms. Once the infection is treated MS symptoms often settle without further intervention (National Institute for Health and Care Excellence, 2022).

Clinical features of an MS relapse are highly variable and can present with single or multiple neurologic problems. Providing your clinical assessment findings to the MS clinician helps with decision-making and timeliness of specialist assessment and/or treatment. The goal of treatment of an MS relapse is to expedite recovery, there is currently no proven benefit to long-term disability or for reducing the risk of future relapses. Not all relapses will need treatment but assessment and documentation of neurologic changes are important (Olek, 2024).

“

Providing your clinical assessment findings to the MS clinician helps with decision-making and timeliness of specialist assessment and/or treatment.

Helpful things to remember:

- Assess for and treat infection
- Provide a good history and assessment to help MS clinicians with timely decision-making
- Not all relapses require treatment, but all suspected relapses should be reviewed by the MS team

Like managing any long-term condition, managing MS over a person's lifetime should focus on living well with MS. While access to highly effective treatment has improved quality of life, changes and complications can still occur and not everyone will be on long-term treatment. Either way, vigilance and proactive assessment and care can have significant positive impacts on MS disease trajectory.

Variability between regions can make access to MS teams challenging. Reach out to your local service for guidance and if this remains a challenge consider developing a pathway for your area.

ADHB guide

Contact MSNZ if you require guidance for developing a pathway: info@msnz org.nz.

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Submit your feedback

Managing and treating Cerebral Palsy in your practice

By Amy Hogan, Cerebral Palsy Society Researcher and Member Support Advisor
Melanie Louden,Cerebral Palsy Society Communications Manager

Every three days a baby is born in Aotearoa New Zealand with Cerebral Palsy – Hōkai Nukurangi*. It's a striking statistic.

Cerebral Palsy (CP) is the most common physical disability in childhood. People with the neurological condition don't grow out of it, so there are a large number of adults living with it. It affects the movement and posture of more than 10,000 New Zealanders.

The Cerebral Palsy Society of New Zealand is a charity that supports a number of those people and their whānau by providing information, advice and financial support. The Society also works in the advocacy and awareness space.

CP is caused by damage to the developing brain during pregnancy, shortly after birth, or up to the age of 2. It can result in different movement types and affect different parts of the body depending on where the brain injury is.

At least two-thirds of people with CP will have movement difficulties affecting one or both arms. Almost every daily activity – eating, writing and dressing – can be impacted.

These statistics help put the impact of CP into perspective:

- 1 in 3 is unable to walk
- 1 in 4 is unable to talk
- 3 in 4 experience pain
- 1 in 4 has epilepsy
- 1 in 4 has a behaviour disorder
- 1 in 2 has an intellectual impairment
- 1 in 10 has a severe vision impairment
- 1 in 4 has bladder control problems
- 1 in 5 has a sleep disorder
- 1 in 5 has saliva control problems.

General practices and other front-line health services (e.g. EDs, A&Ms) should be aware of the challenges of living with CP and be as prepared as possible to help patients of all ages who live with it. You can easily support patients with disabilities in a consultation with some pre-planning.

Practice accessibility

Ensure wheelchairs and mobility aides can fit into waiting and consultation rooms or make sure alternative rooms are available.

Before enrolling a patient or family with mobility needs, consider access options to ensure they can safely enter and exit all aspects of the facility.

The Cerebral Palsy Society is a charity, and we therefore seek funds from trusts and foundations, donors and through our annual national awareness campaign Be Green & Be Seen.

The campaign runs throughout October and coincides with World Cerebral Palsy Day on October 6. Green represents the international colour of Cerebral Palsy – Hōkai Nukurangi.

We ask our supporters to dress green for the day or come up with some creative green activities to fundraise for the Society.

You'll find all the information on their website.

*Hōkai Nukurangi is the te reo Māori term for Cerebral Palsy and translates to achieving what is important to you.

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Consider the whole experience of visiting the practice. Can people access the various rooms in the clinic, can they pay at the counter and park close by?

It's easier and cheaper to build accessibility into a new practice than it is to retrofit the adaptation.

New enrolment

Ask patients or their whānau what the general baseline for their health is. People with disabilities can have a different baseline compared to their non-disabled peers. Consider a double appointment for new patients.

Find out which communication methods new and existing patients prefer. People living with CP have a variety of communication methods or may rely on support people.

In the consultation

CP and neuromuscular disabilities can have cumulative effects on some aspects of health such as sleep, nutritional intake and comfort. Keep this in mind when considering pain management or digestive support.

Consider the best option when you conduct a full-body assessment of someone with a disability – is it best for the patient to be seated or lying down? Will you need additional support to achieve this?

When writing referrals

CP and neuromuscular disabilities can present a broad range of symptoms and experiences. When referring to a specialist, consider writing as many specifics as possible, e.g. transferring support, communication preferences or mobility aides.

For information about Cerebral Palsy visit their **website.**

> "Before enrolling a patient or family with mobility needs, consider access options to ensure they can safely enter and exit all aspects of the facility.

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Primary health care supporting early diagnosis for breast cancer

By Ah-Leen Rayner, Chief Executive at Breast Cancer Foundation NZ

Breast cancer in Aotearoa New Zealand

3,500 women are newly diagnosed with breast cancer every year. 55% of these are via the symptomatic pathway. Primary care is essential in driving early diagnosis – where breast cancer is more treatable and curable. Breast cancers that are stage 1 and 2 have a 92% survival rate at 10 years. However, late-stage diagnosis accounts for roughly 525 new diagnoses each year. This number hasn't moved in 10 years and primary health care can play a crucial role in helping move the needle towards more early diagnosis.

Education and awareness are powerful for patients

Primary care is critical to leading proactive education in the community, identifying patients at high-risk of developing breast cancer, and the assessment and management of patients who present with symptoms. Practices are also essential to ensure patients present to Breast Screening Aotearoa for screening.

However, there are gaps in action and awareness within the wider population. Currently, not everyone who is eligible for free screening is enrolled or up to date with mammograms. Since Covid-19 we have not hit Breast Screen Aotearoa's target of 70% coverage across the country. Additionally, younger women can – and do – get breast cancer and they are far more at risk of late-stage diagnosis, so more work needs to be done to ensure they have timely access to GP assessment.

October is Breast Cancer Awareness Month. Breast Cancer Foundation NZ is asking all women to know the normal look and feel of their breasts and to see a GP if they notice a change.

Throughout October, we are inviting you to reinforce this messaging in consultations with wāhine. We also recommend primary care offers every woman an annual wellness check, personalised education and assessment. We know this isn't always possible in the current system nor are you adequately funded to provide these services. Breast Cancer Foundation NZ supports the need for improvement in this area and stands behind your advocacy to improve funding.

How can Breast Cancer Foundation support primary care

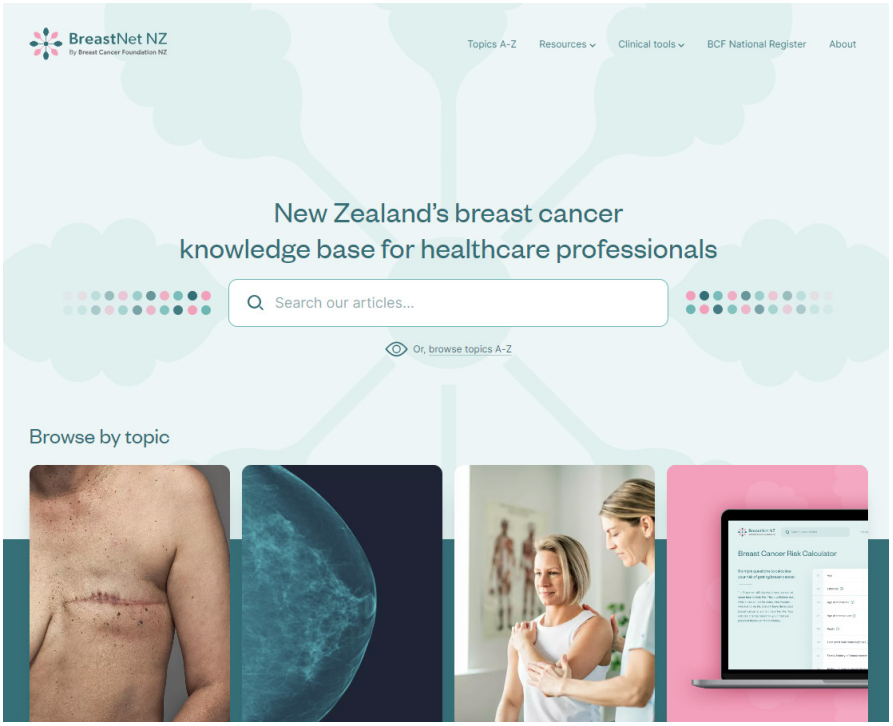
BCFNZ has been working to develop tools and resources to support the early detection of breast cancer.

- We have a clinical website designed for health professionals, **BreastNet NZ**. It contains information about early detection, referral pathways and genetic testing for suspected high-risk patients.
- We have developed a **breast cancer risk calculator** which helps underpin individual discussions with patients about their risk relative to the general population. The tool is unique in that it uses New Zealand-specific data. GPs have told us the tool is particularly helpful to reassure patients who are concerned but generally well.
- If a patient is unsure how to check their breasts, we have videos and instructions on our **website**. We explain breast awareness using the TLC method. **Touch**, **look**, get changes **checked**.
- Lastly, we have a telehealth service with a team of specialist breast nurses. If you are concerned about a particular patient, please direct them to us. They can call 0800 22 68773 (BC NURSE), during business hours Monday to Friday and it's a free service.

We can share the burden when it's related to breast cancer. You have a unique vantage point to see where the system isn't working, where there are gaps and what the barriers are. We would love to hear from you about these insights. This information is invaluable for us to advocate and consider our messaging to patients and wider community.

If you have any questions or you're happy to have a chat, please get in touch.

Contact us at **intouch@bcf.org.nz**



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Our message to women:

Know the normal look and feel of your breasts,

Touch and look regularly for changes,

See a GP to get changes checked.

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Preventing hospitalisations for the elderly:

The vital role of GPs and Rural Hospital Doctors in aged residential care

Aged Care Association NZ

New Zealand's aging population presents an escalating challenge with avoidable hospital admissions placing strain on the healthcare system. General practitioners (GPs) and rural hospital doctors both have roles to play in preventing unnecessary hospitalisations for elderly patients in Aged Residential Care (ARC) facilities.

Building strong partnerships with ARC facilities

It's crucial to recognise the importance of strong, collaborative relationships between ARC facilities, local GPs and hospitals. When these relationships work well, residents get the care they need on time and the pressure on our hospital's eases. The Aged Care Association's (ACA) member facilities have shown this in practice—where these partnerships exist the outcomes speak for themselves.

Take the example of a facility where one GP is responsible for all 30 residents. That GP knows the residents, their histories and trusts the nursing staff on the floor. With just two hours of GP time per week, hospital admissions are minimal and costly after-hours callouts are rare. As the facility owner said, "these partnerships make all the difference—minor issues are managed early and we avoid unnecessary hospital admissions."

But it's not always like this. We've heard what happens when primary care services are stretched too thin and communication breaks down. For example, residents waiting over three days for a GP response, only to end up in hospital for something that could have been handled inhouse. One member told us about a resident who spent ten hours in ED just to get antibiotics because their GP was unavailable for an urgent consultation. These situations are difficult for everyone involved and it's clear that with better coordination, we can improve outcomes.

Proactive GP engagement with ARC facilities is not a luxury—it's a necessity. The same applies to hospital doctors. Some of our members have voiced concerns about elderly patients being discharged from hospital too soon, simply because there's an RN at the ARC facility. But when there's no GP to monitor them, what happens next? These vulnerable people can end up back in the hospital because they were discharged too soon.

Research shows that strong therapeutic relationships between health professionals improve patient outcomes. We need a more coordinated approach and better communication between hospital staff, GPs and ARC facilities to reduce avoidable admissions.

"These partnerships make all the difference—minor issues are managed early and we avoid unnecessary hospital admissions.

Enhancing knowledge and awareness of elder care

In the earlier positive example, the owner of the facility said, “our GP has a real interest in older adult care. It shows in their respect for the residents and how they engage with their families.” This is the level of care we should expect everywhere. Specialised knowledge in managing chronic conditions, palliative care and multiple comorbidities is essential. Prioritising ongoing training while maintaining close communication with ARC staff can help identify issues earlier and facilitate interventions before they escalate into emergencies.

Leveraging technology to alleviate pressure

Alongside building strong relationships with ARC facilities, we should embrace technology to support GPs and rural doctors. Remote consultations and telehealth services, which rose during the COVID-19 pandemic, are game changers for rural areas where face-to-face visits can be tough. These tools help bridge geographical gaps, offer quick advice and ease the load on GP services.

Trials of these innovative tools are showing promising results. A pilot program at Uniting NSW.ACT with Augmented Reality (AR) Smart Glasses linked to remote specialists reduced medical response times by 75% and prevented nine hospitalisations in just four weeks. These advanced solutions could be particularly valuable in rural settings with limited access to specialised care. However, the effectiveness of these technologies depends on proper training, support, and infrastructure.

Adapting the healthcare system to meet changing needs

As our elderly population grows our healthcare system must adapt to their increasingly complex needs, and GPs and rural hospital doctors must be at the forefront of these changes. By building strong partnerships with ARC facilities, leveraging technology and enhancing their knowledge of elder care, healthcare professionals can make a significant impact on the wellbeing of elderly patients and reduce unnecessary hospitalisations.

It’s time for a collective effort to improve coordination, raise awareness and embrace innovative solutions to ensure our elderly receive the best possible care.

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Prioritising ongoing training while maintaining close communication with ARC staff can help identify issues earlier and facilitate interventions before they escalate into emergencies.

Online Health Portals getting a boost from DORA

By Laurence Zwimpfer MNZM, Operations Director for Digital Inclusion Alliance Aotearoa

Who is DORA, you might be asking? And what does DORA have to do with online health portals? If your medical practice is in Northland, Southland or Waikato, then you may already have met DORA.

DORA is a 39-year-old bus that travels around New Zealand helping people become more confident using their digital devices so that they can better manage their lives. From 2019 until 2022 our focus was on helping people become more digitally capable with online banking. This was prompted by the progressive withdrawal of cheques by all the banks as well as the closure of many branches. From the beginning of 2024 our focus has been online health portals.

Helping communities to use their online health portals

Late last year Dr Di Davis from Te Whatu Ora Northland invited us to collaborate with her in helping Northland communities engage with online health apps such as Manage My Health, Health365 and The Doctors which most GPs in Northland were using. Together with Dr Davis and local libraries, medical practices and other community organisations we planned a 5-week tour, commencing at Waitangi on 6 February 2024.

DORA travelled to 24 Northland communities with each visit being supported by local tutors. Altogether 17 tutors engaged with around 750 people; some wanted help with their online health app but many just wanted help in using their smartphone.

Word spread quickly, so we were soon on our way to Southland at the invitation of Rural Women, with visits to 13 communities from Invercargill to Te Anau. Returning to the North Island in May to join a mobile health display at Parliament and then start our Waikato regional tour as part of the Health and Wellbeing Hub at Mystery Creek Fieldays®. Since June we have visited 39 communities in the Waikato and Bay of Plenty regions, engaging with a further 1500 people. We are looking forward to visits in the Bay of Plenty, Rotorua, Wairarapa and Whanganui over the coming months.

Helping people use digital technologies to connect with their general practice

Our focus is on helping people use their digital technologies, mainly smartphones to connect to and use the online portal managed by their GP. When visiting the Waikato, we expanded our support to include the myindici 2.0 portal and since then we have discovered Vensa. No doubt we will discover other online platforms as we travel around New Zealand.

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Our focus is on helping people use their digital technologies mainly smartphones to connect to and use the online portal managed by their GP.

Before each visit we send explanatory letters to every medical practice with a promotional poster and flyers. For the most part we have found that practices welcome this support as they do not have the resources or the time to help patients with their digital technologies. Thank you to the 100 practices that have already supported a visit by DORA; we look forward to visiting the other 900 practices in the coming months (and years)!

Our Digital Inclusion Alliance is a not-for-profit charitable trust set up in 2017 to promote digital inclusion. We work with 350 active delivery partners (65% are public libraries) to provide digital inclusion programmes and support to their communities. One of our objectives is to encourage these partners to expand their support for online health apps, not only when DORA is visiting, but ongoing as part of their digital drop-in programmes.

We encourage all medical practices to find out who can provide this support in your community and refer patients as required. Let us know if we can help make these connections by contacting us on info@diaa.nz or 0800 463 422.

And just in case you are still wondering if DORA has any connection to Nickelodeon's famous Dora the Explorer, the answer is "no", much to the disappointment of some of our younger visitors. Our DORA is an acronym for Digital On Road Access.

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