MCNZ Chair Andrew Connolly clarifies what the council hopes to achieve by changing doctors’ recertification requirements.

**Workforce Survey: Just how ‘techie’ are we?**
We release the third instalment of the College’s 2016 workforce survey which looks at members’ use of technology.

**Patient portals for young people**
Our new guide helps GPs manage portal access to children and young peoples’ medical information.

**2017 College Conference update**
Preparation is ramping up. Keynote speakers include the Chair of the UK National Institute for Health and Care Excellence.

**Advocating for members on proposed recertification**
The College has made its submission to the Medical Council on its proposed changes to recertification.
CONTENTS

Lots happening with your rural colleagues – p4
Highlights in the rural health space include the College’s first Rural Research Day, the announcement that Otago and Auckland universities are proposing a new national School of Rural Health, five new Fellows join the Division of Rural Hospital Medicine, and we release a guide for GPs - On-call, Off-site and After-hours Safety.

EDITORIAL

1 College President Dr Tim Malloy discusses the College’s response to the Medical Council’s proposed changes to recertification. While some change is inevitable, he believes the College will continue to do what it does best – setting the standards in general practice in New Zealand.

1 College Chief Executive Helen Morgan-Banda talks about the latest workforce survey results which look at members’ use of technology. She notes the uptake in patient portal use and encourages members to check out the College’s latest resource – Child and Adolescent Health: Patient Portals, Health Information and Disclosure.

RURAL

4 Rural update

FEATURES

11 What you need to know about immunisation

13 Advanced care planning – conversations for GPs and their patients

15 The latest Journal of Primary Health Care

16 Clinicians’ challenge

COLLEGE NEWS

2 Advocating for College members on proposed recertification

3 MCNZ response to College

7 Workforce survey report on technology

8 New patient portal resource
Maintaining skills and learning new ones

Forty four years ago, your College was established to “encourage, foster and maintain the highest possible standards for medical care within the scope of general practice, in order to reduce health inequalities and achieve improved health for all New Zealanders”.

We are indebted to the founders of our independent New Zealand medical college for giving us a purpose that has stood the test of time and is also a wonderful blend of pragmatism and aspiration.

It is that pragmatic approach to general practice that came through loud and clear in your feedback to the Medical Council of New Zealand (MCNZ)’s proposed changes to continuing professional development (CPD) programmes for all New Zealand-registered doctors.

Overall, you told us that you support the general principle and purpose of CPD programmes and their role in helping doctors to maintain their skills and learn new ones.

But you were not keen on changes that were difficult to comply with as a general practitioner (in comparison to hospital-based doctors) and changes that would increase the time and cost you would need to spend in CPD administration and compliance.

The compliance burden is a topic that has come to the forefront in other discussions with members, including at the National Advisory Council and at the Board table.

We are very aware of the increasing number of activities being asked of general practitioners; it all adds up and takes time away from caring for your patients.

Having received the College’s submission, the Medical Council asked for the opportunity to speak directly to our Board. As a consequence, Medical Council Chair Andrew Connolly attended our April Board meeting and spoke in detail about the council’s intentions for CPD. We found his presentation useful and we are pleased to be able to share with you (overleaf) a letter Mr Connolly has prepared for members.

Some change is always inevitable, but with the strong College purpose to guide us, we will continue doing what we do best – setting the standards for general practice in New Zealand.

Tim Malloy, President

Fax to the future

Recently the College released the third report from its 2016 Workforce Survey on technology.

GPs’ use of technology in their practice is a new area of enquiry for the College.

Even in the past two years, the numbers of mobile health and telehealth options available to GPs and patients have multiplied like bacteria in a warm petri dish.

So of all the different technologies available to general practice, we were curious about how GPs are using technology, how often are they using it, and what risks and benefits they have found in doing so.

The findings are heartening.

Notably, technology is being used extensively to exchange information with other health professionals and patients. There is also a reasonable uptake of patient portals – and the feedback received from those who use these was quite positive.

Speaking of patient portals, I encourage you to read our new guide on patient portals (Child and Adolescent Health: Patient Portals, Health Information and Disclosure), which is also featured in this issue.

It provides an excellent discussion around the tricky area of child and adolescent consent (when can minors refuse to let their parents have access to their medical records through the patient portal?) and gives clear guidance about how to have this potentially difficult conversation with young patients and their parents or guardians.

Of course, some concerns were raised about the use of technology, and as you would expect, these concerns generally related to safety, privacy and time. Few people expressed any concern in relation to the technology being new and unfamiliar.

However, coming from a sector that still uses fax machines to send prescriptions to pharmacies there will be curly questions from time to time.

The good news is that the College is already working on answering many of those questions for you.

As a priority project, the College is focusing on national quality standards and the training for GPs when using technology to deliver new models of care such as e-consults.

The resources will be released as they are ready, but in the meantime if you have any questions or suggestions about technology resources, please email policy@rnzcgp.org.nz.

Helen Morgan-Banda, Chief Executive
Advocating for College members on proposed recertification

College members (mema) will be aware of the changes to recertification recently proposed by the Medical Council of New Zealand (the Council).

In March 2017, the College collected feedback from over 350 members on the Council’s proposed changes and made a submission to the Council based on members’ views and feedback from the College’s National Advisory Council and Education Advisory Group.

The College thanks all members who provided this invaluable feedback.

The Council proposed new requirements and standards for the accreditation of medical colleges, saying that continuing professional development (CPD) “is more effective when it is linked to baseline performance and when it addresses an individual doctor’s learning needs.”

There was general disquiet amongst College members about perceived changes in the direction, or actual changes to recertification, with some members holding strong views. The College is conscious that CPD requirements impact on all Fellows, and meeting them can be particularly challenging for Fellows, who generally meet any requirements in their own time and at their own cost.

In the submission, the College expressed concerns that extra compliance burdens may drive already burnt-out GPs into early retirement (the College’s 2016 workforce survey showed that 22 percent of GPs feel burnt-out) and that a major change to the programme could be the tipping point for the current critical workforce shortages in general practice.

The College asked the Council to consider any changes in the context of a general practice workforce that is ageing, and experiencing increasing compliance costs (eg achieving health (hauora) targets, PHO reporting and meeting practice accreditation requirements) in terms of time and money.

Other concerns raised in the submission included:

- The Council’s proposal goes considerably beyond a principle-based approach with requirements presented in a prescriptive manner.
- The paucity of supporting evidence in the consultation document for the proposed requirement.
- The general practice context is significantly different from that of other medical specialties, which are more procedural-focused and/or based in a hospital context. Some elements of the proposal, if applied prescriptively, would not fit well in the general practice context.
- The level of resourcing (financial, workforce and time) that would be required to implement the proposal in its entirety.
- The language of the document and the specific measures suggested seemed to favour quantitative measures, which are not easy to capture in general practice and are not widely available at the national level.
- The Council’s proposal to mandate specific requirements as doctors’ age. The College has an important role in enabling and supporting older doctors (rata) who wish to stay in practice, but beyond providing general guidance, the College is not convinced that individual career planning is an appropriate component of a recertification programme.
- The College’s experience of the value of the multisource feedback tool is to identify outliers; not in providing data which will better inform members’ professional development planning.

Read the full submission.

MCNZ’s response to College concerns

Having received the College’s submission, MCNZ Chair Andrew Connolly approached the College and offered to meet with its Board to clarify the Council’s plans and respond to the issues we raised.

As a result, Mr Connolly (accompanied by CEO Philip Pigou and Strategic Programme Manager Joan Crawford) attended our April Board meeting and spoke about the Council’s vision for recertification.

To address some of the main concerns raised by members, Mr Connolly asked for the opportunity to communicate directly with you – you will find this communication overleaf.
Dear Colleagues

As many of you are aware the Medical Council of New Zealand (Council) has recently consulted on important changes to Recertification for Vocationally-registered doctors. This has generated much feedback and commentary. We received the RNZCGP submission which is very detailed and rightly outlines many of the concerns members of the College have expressed. Council recently met with the Board and CE of the College to discuss the Recertification consultation in detail. What has been clear from a number of submissions is that some confusion exists about Council’s intent. The meeting with the College was an opportunity to clarify these areas of concern. This article summarizes much of the discussion.

Recertification is a term used in the Health Practitioners Competence Assurance Act 2003 (the legislation that regulates doctors and other health practitioners). Essentially it is a strengthened CPD process. Council recently adopted a principles-based approach to Recertification. These principles include being profession-led and evidence-based. To be very clear: Recertification is designed to be “therapeutic” for each doctor and is NOT a diagnostic tool for the Council. The Medical Council relies on a number of processes to identify competence or conduct concerns. Recertification is not one of them. With respect to Recertification and the individual doctor, Council is only interested in the outcome – that is, the doctor has successfully completed the College CPD programme.

For most doctors, the changes we are consulting on will mean little if any difference to what each of us does now. Council sets the over-arching principles for any CPD programme and accredits the College - this includes accreditation of the CPD programme. The College sets the content of the programme, mapped broadly to the principles. The College is the “subject expert” for General Practice and therefore rightly needs to set the content of the programme. Council will challenge all Colleges to assess the “value” a particular activity accrues, but the content remains the domain of the College. Indeed, the College Board members closely involved in your existing CPD programme believe little if any change will be required. We have attached some key words such as “Professional Development Plan” to activity many peer groups already undertake. We do expect all doctors to reflect on aspects of their practice – for instance perhaps discussing your BPAC prescribing report with a peer may highlight areas where you feel some reading would be beneficial. We are likely to insist all colleges have a practice visit as an option for all Fellows – if it is compulsory or not will be up to each College Board to decide. These activities all have evidence to support their value.

Perhaps the most contentious aspect of the debate has been around older doctors. Again, to be clear, Council is not introducing examinations or mandatory processes for older doctors. Nor are we introducing mandatory retirement or mandatory places of practice to avoid isolation and so on. We are, however, looking at the issues of safe practice and aging. This is something all responsible doctors (and regulators) should be interested in. We know cognitive decline affects doctors at the same rate as it does the rest of the population, and we know retirement brings added stressors. We are suggesting that as we all get closer to retirement we plan for it. In my field of General Surgery, I need in the next few years, to consider if I should remain on the after-hours roster. There is good evidence my decision making at 2am may well be different to 2pm as I get older. This does not mean I should not be a surgeon, but it does mean my colleagues and I should think over these issues well in advance. This is perhaps even more important for those in sole or remote practices as the implications of change may be much harder to address.

I am heartened by the volume of responses Council has received on this important consultation. We will need time to consider all the feedback and to look at our next steps. I hope the information above reassures you that Council is not planning radical changes; indeed, we are mainly formalising and strengthening existing College programmes with little real change needed by each individual doctor given the strength of your existing College CPD structures. I reiterate, this process is about aiding each of us to maintain our competence. I firmly believe it is not adding significantly to my work as a busy doctor; but it is adding to the confidence the public can have of my competence.

Andrew Connolly
Chair, MCNZ
Rural health update

The past two months have seen a lot of activities with our rural members. Here’s a quick wrap up of the highlights.

Rural Research Day

The inaugural Rural Research Day was held in Wellington (Te Whanganui a Tara) at the end of March. This was a precursor to the National Rural Health Conference. Organised by the College’s Rural GP Chapter, the event was facilitated by College Fellow and rural advocate Greville Wood. The morning session reflected on the current state of rural health research and the reasons behind this. There was some discussion on what constitutes ‘rural research’ – was it research on rurality and workforce issues? Should it focus on the differences between rural and urban issues? Or was it research that was conducted in a rural setting?

The answer was probably ‘yes’ to all of these, and so the conversation moved to resourcing and capacity for rural research. Those who have conducted rural research were thanked for the time and effort they put into this much needed resource.

During the afternoon, attendees heard from several speakers on a wide variety of topics – from equitable access to GPs, to medical students’ self-reflected wellbeing; from motivational interviewing to plant-based diets; and from gout to chest pain diagnostics.

Despite the foggy weather which interrupted travel plans for several attendees, the day was generally hailed as a great success. Those who were unable to attend, but wish to see the sessions are able to view them via this site.

If you enter your College ID number you will also accumulate CPD credits for watching them.

New rural training models

You may have heard the news that Otago and Auckland universities are developing a proposal for a new national School of Rural Health. The College had been asked by the universities for its input and advice on their proposal and, having considered the plan, the College has offered its support for the concept.

We have also been liaising with Waikato University who with the Waikato DHB are proposing the establishment of a post-graduate entry medical school at Waikato University. Its aim is to increase our rural GP workforce by recruiting students from rural areas and focusing much of the training in rural communities.

“Like most developed countries, New Zealand has been facing chronic shortages of rural doctors and other rural medical health professionals for some time,” says College President Dr Tim Malloy.

“To have a sustainable rural workforce we need to increase the number of New Zealand medical graduates choosing general practice from 30 percent to 50 percent. And to achieve this there needs to be system changes, including training in new ways, as is being proposed, to ensure rural communities have equitable access to health services,” he says.

The College has always said that it supports medical training programmes that are equitable for applicants, students and graduates.

National Rural Health Conference

It was nice to see so many College members and Division of Rural Hospital Medicine colleagues at the recent National Rural Health Conference in Wellington (Te Whanganui a Tara). As well as attending sessions, several of our members delivered presentations. For example, College present Dr Tim Malloy participated in a PRIME panel discussion and also spoke about the challenges of having two careers - farming and medicine; Garry Nixon spoke about unknown unknowns in New Zealand rural health; Buzz Burrell spoke about getting the most out of student placements; and Peter Moodie spoke about the sustainability and equity of general practice – to name but a few.

One of the presentations, delivered by College Fellow Dr Kati Blattner, Cook Islands Ministry of Health Dr Nini Wynn, and rural registrar Dr Joel Pirini, reviewed the work the College has done in collaboration with the Cook Islands
Government to build capacity of its medical workforce. If you missed this presentation, you can read more about this in the latest issue of the Journal of Primary Health Care.

New resource for members

Visitors to the College conference stand at the National Rural Health Conference were some of the first to see the College’s new On-call, Off-site and After-hours Safety resource. This guide aims to provide GPs with practical options to minimise the risks they may face when working late or away from their practice. The guide is a members-only resource and can be accessed from your College Dashboard.

Working alone - whether it be in the practice after hours, when visiting a patient (tūroro) in their home, or at the site of car crash as part of on-call duty - always carries additional risks. In these situations, the ‘normal’ risks of abusive, intimidating, threatening, or violent behaviour becomes more concerning. This is of particular relevance to rural and small community practices where home visits and after-hours care can occur in more isolated locations.

The care provided by GPs when working on-call, off-site, and after-hours is invaluable to the patients who need it. This guide aims to provide GPs and practices with options that may be reasonably practicable to employ to minimise and eliminate the risks they face.

The guide outlines policies and practices that GP clinics (whare haumanu) could institute to maximise staff safety, such as: including hazard notices on patient files in the Patient Management System, setting up security arrangements with other local service providers, and having ‘check-in’ procedures.

Additionally, a comprehensive list is included for GPs on what to consider before, during and after visiting a patient off-site. The list covers assessing and minimising risks, what you are wearing and carrying, safe parking practices, approaching the residence or scene, entering a home, remaining situationally aware, documenting and reporting incidents, and debriefing with colleagues.

While managing violent patients and difficult situations is part of medical teaching, the guide also provides a refresher on what can be done to prevent violence, and in the event of an attack.

Case studies and personal stories are included throughout to highlight the realities of on-call, off-site and after-hours work – particularly rurally – and to provide real life examples of risk management.

Peter Snow Memorial Award

The 2017 Peter Snow Memorial Award has been presented to Kaikōura GPs Dr Chris Henry and Dr Andrea Judd for their “Innovations to patient management under difficult circumstances” following last year’s 7.8 magnitude Kaikōura earthquake.

In accepting the award, the Kaikōura-based GPs paid tribute to the efforts of their wider teams, as well as the various other community and emergency groups involved in the quake aftermath.

Dr Henry was in Kaikōura at the time the quake struck and Dr Judd was in Christchurch (Ōtautahi) when she heard the news.

“Once I realised the extent of the quake I rang St John and said I needed to get up there [to Kaikōura] in one of their helicopters and they obliged. It was an unreal scene when I arrived and something akin to a war zone,” she said.

“The new Kaikōura medical facility is the health hub in Kaikōura and there was very much a focus on that facility to provide health care as well as a reasonable amount of the social support needed. There were daily and constant interactions between the district council, civil defence, St John, district nursing and teams from Canterbury,” said Dr Judd.

Dr Henry said the medical centre was the very first emergency base until it was devolved...
and even afterwards it remained a key centre. As an unintended consequence it was about the only internet provider in the town that survived, so it was also a hub for all the businesses, who gathered at the health facility.

“We already had a community based team who arrived right after the quake. Admin staff for example just came in and collated extremely helpful data. We didn’t ask anyone to come in, they just turned up and got on with it in spite of the fact their own homes were in complete disarray,” said Dr Henry.

“The district nursing team knew most of the vulnerable members of the community and within minutes were able to check on them and get them out if necessary. Without that much discussion we just split up and said ‘right, you cover that patch, I’ll cover this patch’. You can’t do that if you don’t know the community well,” he said.

The pair also acknowledged the huge support from the network of rural doctors and nurses. “We were so confident in these people’s skills and they also practise medicine the same way we do.”

**About the award**

The Peter Snow Memorial Award was set up to honour the life and work of Dr Peter Snow who passed away in March 2006. Dr Snow was a rural general practitioner based in Tapanui. As well as caring for his patients, Peter was a Past-President of the College and was a member of the Otago Hospital Board and District Health Board. His work contributed to the identification of the chronic fatigue syndrome and he was influential in raising safety awareness on issues related to farming accidents. The 2017 award was presented during the recent National Rural Health Conference.

**New Fellows acknowledged**

We recently took the opportunity to acknowledge and welcome five new Fellows to the Division of Rural Hospital Medicine. After many years of training, we’d like to congratulate Rachel Green, Rachel Lynsky, Adele Pheasant, Jono Wills and Chris Hill for attaining their Fellowship.
Just how ‘techie’ are we?

The College’s third 2016 Workforce Survey report has recently been published. This report looks at members’ use of technology – in particular, their use of texts, email, patient portals, and skype/videoconferencing.

Strategic Policy Manager Michael Thorn explains what the survey results tell us.

“Overall we were pleased to find that GPs are embracing technology and are fairly confident using it,” says Michael.

“We looked at how these four types of technology were being used with respect to patient assessment and diagnosis, exchanging health information with patients, communicating with other health professionals, and for training and development purposes,” he says.

“It perhaps wasn’t a surprise that most respondents reported using these technologies to communicate with other health professionals - and to exchange health information with patients. However we had assumed that it would be fairly rare for GPs to use them for patient assessment and diagnosis – in fact, 40 percent of survey respondents had used one of the four technologies for this purpose.”

Michael says it was also reassuring to find that GPs take up of patient portals for patient consultations is fairly high.

“Almost half of GPs who participated in the survey said their practice makes portals available to their patients. Given portals are a fairly recent innovation, this is a clear signal GPs are embracing this new technology,” he says.

“What’s more, when we asked GPs about their concerns using these technologies, we found they were mostly concerned about safety and privacy issues – dealing with ‘new’ technology was not an issue.”

When asked specifically about patient portals, the majority of respondents whose practice offers this service acknowledged the portal had helped improve their service for patients.

Key findings:

- Almost as many GPs used technology to exchange information with patients (82 percent) as did to communicate with other health professionals (84 percent).
- 42 percent of respondents work in practices that made patient portals available to all (27 percent) or some (15 percent) of their patients.
- Patient portals are more likely to be available to patients in larger practices (more than 7,000 enrolled patients).
- Of the GPs working in practices where patient portals are available, 64 percent said their practice started using them within the last 12 months.
- Patient portals are most commonly used to exchange health information with patients (23 percent) as opposed to doing patient assessments and diagnosis (11 percent).

- Of those who use patient portals, 61 percent stated they felt confident using this technology for patient consultations (compared to seven percent who do not use portals).
- Younger GPs are more likely to use one or any of the four technologies we asked about to exchange health information with patients.
- 81 percent of GPs state the New Zealand e-Prescription Service is not currently available to them. Most GPs who have used the service, make limited use of it.

Of those whose practice made a patient portal available to all patients, 91 percent considered there had been an improvement in services for patients.
Patient portal access for young people

In 2015 the College produced a guide to help members introduce patient portals to their practice. Take up of this new technology has been steady. According to the Ministry of Health, as of January 2017, nearly 300,000 Kiwis from 445 general practices were using this new tool to access their health information and better manage their health care.

As more and more people request electronic access to their medical records, we realised that GPs could find themselves facing ethical dilemmas – particularly when the patient is a child or young person. While the laws relating to access of health information haven’t changed, the fact people now have easy, instant access to this data, can create expectations and generate interest in ways we haven’t seen before.

To help members understand their obligations, the College has developed a new resource Child and adolescent health: Patient portals, health information and disclosure that discusses relevant laws surrounding access to medical records and consent for treatment. We have also offered some suggested ways patient portals can be set up so they don’t breach patient privacy, but still give parents access to their child’s records if and when this is legally appropriate.

College Strategic Policy Manager Michael Thorn says the law is clear – unless withholding grounds apply, a young person has a right of access to their health information.

“Patient portals can make access easier and it is likely both a young person and their parent will share access to the information,” says Michael. “However, this situation can become tricky if a young person doesn’t want their parent to know or see certain health information.

“In general, if they are younger than 16 years, their doctor needs to make a decision on providing portal access to information on a case-by-case basis,” he says. “The GP will need to take into account the young person’s circumstances – including their level of maturity and understanding of the proposed treatment, the complexity of the information, the seriousness of their medical condition and their best interests.”

Complications can arise when a young person asks to limit their parents’ or guardians’ access to their medical records. The age of the patient, their level of competence, relationship with their parent or guardian, and other circumstances will need to be considered before a decision on access can be made.

The College’s Medical Director, Dr Richard Medlicott, is one of eight eHealth Ambassadors who are available to help provide support and advice to GPs setting up patient portals. Richard says this new guide provides useful advice and suggestions for GPs, but it’s important to keep the practice manager and admin staff in the loop too.

“I’d also recommend talking to parents about their child’s legal rights to access and consent, when you set up their patient portal,” he says.

“If you’re setting up a shared portal account - where parents and their child can access the child’s health information - be sure to explain that access won’t always be a given. As children mature and gain a sufficient level of competence, they may have their parents’ access removed.

“Talking about this early removes the element of surprise, and helps families plan for this transition.”

The new resource, which was developed in conjunction with the Ministry of Health and the Privacy Commissioner, contains a number of scenarios which will help GPs navigate this potentially tricky territory. There is also a flowchart that will help GPs with their decision-making.

As there are several patient portal software options available, there is no ‘one size fits all’ solution. That said, the guide offers practical tips for setting up and managing access to patient records via the ManageMyHealth, Health 365, MyPractice and ConnectMed platforms. GPs may like to consider contacting their portal provider for specific advice.

Download your copy of Child and adolescent health: Patient portals, health information and disclosure
GP conference update

As preparations for the College’s 2017 conference reach full swing, we are constantly thinking of this year’s theme ‘Inspire. Invent. Intertwine. Working together we can do great things’. The College and the Otago Faculty are working hard to develop one of our most exciting programmes yet. And although it hasn’t yet been published, we thought we’d whet your appetite by sharing a couple of the programme highlights.

Professor David Haslam

This year we will be welcoming Professor David Haslam, Chair of the UK National Institute for Health and Care Excellence (NICE), as one of our key note speakers. NICE works independently of the UK government to improve outcomes for people using the NHS and other public health and social care services.

David’s career began as a general practitioner working in Ramsey, Cambridgeshire. He has since been an expert member of the NHS National Quality Board, and National Clinical Adviser to both the Care Quality Commission and the Healthcare Commission. He is the former Chair and President of the Royal College of General Practitioners.

As Chair of NICE David is responsible for looking after the organisation’s long term strategy, but he also personally feels that one of the biggest challenges facing the sector is multi-morbidity. There is clear evidence that there are more people in the UK living with two or more long-term conditions, than there are with one. This means health professionals must look at their shared decision making - when in the past, a lot of their work has dealt with just one long-term condition at a time. NICE is now trying to bring the different health services together to ensure the best care for patients.

At our conference, David will talk to attendees about the guidance, quality and equity that can be provided for patients (tūroro) as health care and social services become intertwined. He will explain how ‘working together’ will enable different health services to provide the best care for patients.

Workshop - Whole life health; evidence-based wellbeing for doctors

27 July 2017, Dunedin (as a pre-conference day)

A recent study in New Zealand showed that more than 50 percent of doctors (ngā rata) are experiencing symptoms of burnout, and more than half would not choose medicine as a career again. As a GP, knowing what you should do to avoid burnout, does not mean you will always do it.

On 27 July, as a pre-conference day in conjunction with MedWorld, the College will be running a one-day workshop focused on helping GPs manage their well-being over the course of their career. This day will cover whole life health and the wellbeing of our doctors.

In 2016 the College published a Self Care resource for members (ngā mema) which encourages them to consider their own wellbeing and take appropriate action when necessary. This workshop will extend on this, by providing practical sessions and advice.

This one day workshop will be presented by Dr Sam Hazeldine, who spent four years researching doctor stress and burnout and recently lobbied the World Medical Association to include a doctors’ own wellbeing in the declaration of Geneva. Sam will focus on some small but significant changes that doctors can make to improve their wellbeing. This includes discussing what he considers to be the ‘three areas of mastery’: wellbeing, finance and career. He will address each area with evidence-based methods to master them.

Registrations are now open!

Registrations for the 2017 GP Conference and Quality Symposium (including Dr Sam Hazeldine’s workshop) are now open. Go to www.generalpractice.org.nz to register now and receive early bird prices.

Register before 15 June and be in to win a Dunedin (Ōtepoti) experience!

The Conference will also provide an opportunity to expose medical students (ngā tauira rata) to general practice and encourage them to consider this as their chosen specialty. We will be offering special discounted prices to students, as well as the opportunity to talk directly to experienced GPs. See details of the special discounted student rates.
See you in Dunedin this July...

Early bird registration open. Be in to win a Dunedin package!

Quality Symposium
Thursday 27 July 2017
E-health: Technology is changing - are you?

Conference for General Practice
Friday 28 - Sunday 30 July 2017
Inspire, Invent, Intertwine: working together we can do great things.

Register NOW!
www.generalpractice.org.nz

28 - 30 July 2017
Conference for General Practice
27 July 2017 Quality Symposium

This is New Zealand’s only national GP conference that’s presented by GPs for GPs and the general practice team. Mix with your peers and decision makers in an environment focused on developing the profession with a strong clinical stream. CPD points automatically awarded for attendance.
Home and away immunisation update

The world of immunisation (tuku awhikiri) is complex and constantly changing. In this issue of GP Pulse we talk to two immunisation experts about what’s coming up for the New Zealand Immunisation Schedule, and the latest on travel vaccinations (rongoā āraimate).

Protection from diseases at home

Director of the Immunisation Advisory Centre (IMAC) Nikki Turner says technology and advances around vaccines (rongoā āraimate) are huge, and there are some specific changes of interest to GPs.

“The national immunisation schedule is changing this year. There is the extension of the HPV programme to boys and girls and the changing of HPV 4 to HPV 9. This adds broader cancer protection for men and women – not just protection against cervical cancer.”

She says the more we look, the more we are discovering how many cancers the HPV virus is implicated in.

“Extending the vaccine to boys and girls is an acknowledgement that this virus plays a much bigger part in cancers as an oncogene than we ever imagined.

“We are also getting varicella vaccine on the national schedule this year. There’s a compelling case for the effect varicella has in communities and the difference the vaccine makes.”

Nikki Turner says New Zealand is getting high immunisation coverage now and good disease control.

“However, historically our coverage was low and we are catching up. We’ve got older teenagers and young adults (taiohi) in the community who have not had their measles-containing vaccines and that leaves us at risk of importation and spread of measles.”

She says New Zealand’s anti-immunisation lobby has remained at around 2 to 4 percent of the population over the years, however, social media means messages can be spread further and more quickly.

“The social media networks can be very noisy, and sometimes that makes people panic. But New Zealand does so well because we have such highly educated frontline health professionals; we are very positive about our science. So there’s masses of social media myths flying around but we are managing it very well.

“I sit on the world committee on vaccinations to the World Health Organization, called the Strategic Advisory Group of Experts or SAGE. I’ve been able to talk to them about how New Zealand health care’s systematic approach and providers’ education creates sustained high immunisation coverage which supports a positive, confident community environment, including dealing with social media messages – so the New Zealand example is being used internationally.”

She says there are some important diseases we can protect against in the future.

“The shingles vaccine is one. It is already on the schedule in the UK and Australia.

“There is also a meningococcal B vaccine the UK has introduced and so whether that will eventually be introduced into the New Zealand vaccine schedule is up for consideration. While our meningococcal C rates are relatively low, we still also need to consider the advantage of adding C vaccines, or quadrivalent (A,C,Y,W135) to the New Zealand schedule for infants and teenagers, as is being done in many other Western countries.

“The other big diseases in need of better vaccines, which the international science community is putting a lot of effort into, are HIV, TB, and malaria, which are on the whole less relevant to New Zealand.”
Staying safe from disease while travelling

Kiwis are travelling in ever-increasing numbers and many are heading to countries that have required and recommended vaccination lists. As a GP you will likely be receiving more requests for pre-travel vaccinations and advice.

Jenny Visser is Senior Convenor of the Travel Medicine Programme at Otago University (Te Whare Wānanga o Ōtākou). She says the pre-travel consultation is a great opportunity to review a patient’s vaccination history and ensure they are up-to-date with all recommended routine vaccines.

“It can be helpful for GPs to think about the three ‘Rs’ – the recommended, the routine and the required.

“We saw someone recently who was really keen to get all her travel shots but she’d never been vaccinated. So our priority was getting her up-to-date with her tetanus, whooping cough, pertussis diphtheria and hepatitis B.”

Once that review is done you can discuss travel-specific vaccinations.

Jenny says in New Zealand, the vaccines recommended for travel most commonly are hepatitis A, typhoid, rabies, yellow fever, and Japanese encephalitis.

“With rabies, you need to consider what the benefits are of vaccinating someone before travel and what their risk of exposure is. For example, will they be able to get back to a main centre and access post exposure prophylaxis? That factors into your decision on whether they would benefit from pre-exposure or not.”

The yellow fever vaccine can only be prescribed by an approved yellow fever vaccinator.

“The Ministry of Health (Manatū Hauora) has an up-to-date list of yellow fever vaccinators on its website. You can also become an approved yellow fever vaccinator by following the process outlined.

“Yellow fever is a complex vaccine as the recommendations and countries change frequently, so it is good to check Annex 1 on the WHO site under the travel section as they have risks and requirements for each country. I recommend people to book with an approved vaccinator for a detailed consultation.

“Japanese encephalitis is a rare disease that only occurs in parts of Asia, and is not indicated for the average traveller. The only vaccine we have available in New Zealand is expensive and not licensed for children under 18 years of age – even though it is children who carry the burden of the disease.

“But if you had a family (whānau) doing a lot of rural travel or who were going to be living long term in an endemic area, that would be the group you would refer to a travel clinic to have a discussion with an expert.”

She says there is no one ‘source of truth’ when it comes to travel vaccinations, and recommends looking at multiple sources and making an informed decision that aligns with your practice.

“The New Zealand Immunisation Handbook only covers the routine vaccines, while the Australian Immunisation Handbook includes all the travel vaccines. A lot of GPs go to the CDC site, but the advice there can be quite conservative.

“Public Health UK’s NaTHNaC service is also a really good resource and more in line with our prescribing practices. You can also use the WHO website, but travel isn’t its main focus.”

She says, as well as consulting guidelines, GPs need to make a risk assessment to decide if a traveller is at a high enough risk for vaccines to be recommended.

“For instance, if you are visiting India, the guidelines will say there is a risk of hepatitis A, typhoid, Japanese encephalitis and rabies. But each traveller’s risk is very different. If you are going on a two-day visit to Delhi and staying in a 5-star hotel, I’m not going to vaccinate you against all those things.”

Short trips to urban areas with access to advanced medical care are lower risk than either long-term stays or visits to remote rural areas.

“There is no ‘destination X = vaccine list Y’ that works in all circumstances. It is up to the practitioner, in discussion with the traveller, to decide which vaccines will be beneficial. Different travellers also have different appetites for risk. You may meet a couple going on the same trip and one will want the full suite of vaccines, while the other is more relaxed.”

And just because we have a vaccine (rongoā āraimate) against a disease, doesn’t mean every traveller needs to have it.

“I suspect there is over-prescribing of typhoid vaccine, for example. We know that for most travellers on short and medium length trips to the usual tourist destinations in Africa, South East Asia, South and Central America the risk of typhoid is extremely low. On the other hand, among all international travellers, travel to South Asia – India, Pakistan, Bangladesh and Nepal – does carry a significant risk.

She says for New Zealand travellers, travel to Pacific islands has also been shown to be a risk factor. For both South Asian and Pacific destinations, the risk is further increased if the traveller is visiting friends and relatives.

“Most experienced travel medicine practitioners would only routinely prescribe typhoid for long-term travellers in underdeveloped countries, or for short term travellers to South Asian destinations such as Nepal, especially if they were visiting friends and relatives.

“So again, it comes down to evaluating the specific risks and the access to care your patient (tūroro) will have on their trip.”
GPs urged to get patients talking about advance care planning

GPs may have more patients (ngā tūroro) raising with them the issue of advance care planning.

“Conversations that Count Day” happened in April, with various promotions encouraging people to think about, talk about and plan for their future and end-of-life care. For example, who they would like with them at the end, and what treatment (rongoā) they would or wouldn’t want. The theme for this year was ‘Get them talking’.

Auckland and Christchurch GP and College Board member, Dr Api Talemaitoga, says advance care planning is a complex issue and discussions about it can take time, especially for patients with low health literacy or English as a second language.

“We also need to ensure that discussions are culturally appropriate and recognise the patient’s background, and to use interpreters and other tools to ensure our patients have full understanding of the process.”

Dr Talemaitoga says GPs need to be aware that these days patients’ ‘significant others’ may vary in gender, culture, beliefs and sexual identity, and that there may be multiple significant others, including aiga and whānau.

“In some cases the advance care plan can take a while to finalise because cultural protocols and obligations (tikanga) need to be considered and patients may need to discuss their plan with their family and wider community.

“Above all, we must never lose sight of the fact that we are advocates for our patients, no matter what family dynamics come into play. This is about recognising our patients’ mana and empowering them to have a say about their final days.”

He says an advance care plan is an important aspect of helping people to take control of their own health (hauoranga).

“It helps patients to clarify their thinking about what’s important to them as they near the end of their life. ‘Sharing their plan with their family and health care team can make their treatment approach clearer and easier to follow, and support what matters to them. This is particularly important if a patient is no longer able to speak for themselves.”

The advance care planning website has a number of free resources to make advance care planning easier for GPs and their patients, including a downloadable ‘Advance care plan and guide’ for people to enter their information and save. Printed versions are also available.

Dr Talemaitoga says patients may ask their GPs for help to fill out the ‘When I am dying’ and ‘My treatment and care choices’ sections of the plan.

The face of this year’s Conversations that Count Day, Arthur Te Anini (Ngāti Whanaunga), says it’s a huge relief to have done his advance care plan and shared it with his whānau and health care team.

“If I reach the stage where I can’t speak and prolonging my life would be futile, I don’t want to be kept alive by having a feeding tube or being hooked up to machines.

“My advance care plan was an opportunity to say that to my medical team, while I could. I can still change it at any time, but it means I am free to enjoy my life.”

Arthur’s plan also says that if he is unable to speak for himself it’s important to him that he is “kept presentable – clean shaven, fingernails cut and wearing clean clothes.”

In September last year, all DHBs agreed to contribute to an advance care planning funding model for the current year. With that funding the Health Quality & Safety Commission is managing the advance care planning programme while it undergoes a comprehensive review that will decide its future direction. The need to recognise the extra time required for health professionals (mātanga hauora), including GPs, to have productive advance care planning conversations with their patients is included in the programme’s review.

The College recognises the value of ACP for patients, clinicians and families and is developing a Policy Brief that covers some of the challenges GPs experience in engaging with ACP.”

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The March issue of the Journal of Primary Health Care (JPHC) is online. In it you’ll find articles on a wide range of topics, including the use of standing orders, New Zealand’s outreach immunisation services, and doctor availability in Northland.

There are also papers on the role of community pharmacists, access to vasectomy services, and support for youth in relation to sexual health conversations.

The journal is rating well internationally. According to Scimago Journal & Country Rank’s assessment of nearly 30,000 international scientific journals, JPHC ranks in the top third of journals for impact.

Editor in chief, Honorary Fellow Susan Dovey, encourages all members to consider contributing to the journal.

“If you are working on a project where the findings will be beneficial to the wider primary health care sector, I would strongly encourage you to consider preparing a journal article,” says Susan.

“Not only is this valuable professional development, but it helps raise awareness of New Zealand’s primary health care issues amongst the international community,” she says.

“If you have an idea but don’t know where to start, go to the ‘Instructions for Authors’ page on the Journal’s website. This will tell you how to write everything from essays to research reports. We will work with you to make sure we publish something you can be proud of and that others will want to read.”
Clinicians’ Challenge 2017 now open

Entries have opened for the Clinicians’ Challenge 2017, a nationwide competition that seeks to harness innovation in the health (hauora) sector, and convert it into the best possible patient care. Doctors (nga rata) can demonstrate their vision and creativity by relating how they use – or would like to use – information and technology to revolutionise patient care.

A key focus for this year’s challenge is ‘disruptive innovation’, where an existing norm is replaced by a new development. An example of disruptive innovation is the smart phone-based retinal camera that was developed by the 2015 competition winner, Dr Hong Sheng Chiong.

The device features a high quality camera that attaches to a smart phone, allowing optometrists to perform eye exams for a low cost in any location. The innovation works alongside a free app that Dr Hong developed for health care practitioners to assess how well a patient (tūroro) can see.

In an interview published on the oDoc Eye Care website, Dr Hong said that he was motivated by the real-life problems faced by ophthalmology, and the need to find solutions for doctors (ngā rata) and patients (tūroro). One of the key issues Dr Hong identified was a lack of access to the expensive equipment that is needed to perform eye exams.

“Cumulatively you’re talking about $37,000 worth of equipment just to do an eye examination.”

“Even in developed nations you don’t really get to see that equipment in health care centres and general practices.”

In creating a disruptive innovation, Dr Hong’s aim was not to create completely new equipment, as the process would likely cost millions of dollars to produce and distribute. Rather, he focused on using technology that was already available and creating a system to disrupt the pattern of low access to ophthalmic equipment. This is where Dr Hong got his inspiration to use smart phones as technological basis for his invention.

Do you have an innovative idea for using IT to improve health care today, or to transform tomorrow?

Enter the Clinicians’ Challenge and tell us about it!

ENTRIES CLOSE 16 JUNE 2017

The Clinicians’ Challenge is your chance to show us your vision and creativity, and how you are using information and technology to revolutionise patient care.

Winners receive $8000 and runners up $2000. They will be announced at the HiNZ awards lunch, 3 November 2017.

To enter and for more information, go to hinz.org.nz/page/CliniciansChallenge or moh.govt.nz

IMPROVE TODAY, TRANSFORM TOMORROW!
Clinicians’ Challenge 2017 | Call for entries

There are two categories.

NEW IDEA
Share your idea for a disruptive innovation for a digital system or application to deliver health services in new ways. The goal is to improve patient outcomes, improve workflows, bring efficiencies or support better integrated care.

ACTIVE PROJECT/DEVELOPMENT
Share an innovation for a system or application you are developing, or have already developed. It should improve the way you work, support better patient care, and deliver efficiencies and better integrated health services.

* Clinicians’ Challenge 2015 winner Dr Hong Sheng Chiong examining a patient with his retinal device, which attaches to a smartphone.
“We wanted to harness the power of mobile technology and utilise it in delivering standard health care.”

“There are more people around the world that have access to cellphones than toilets. That figure is predicted to get higher and higher.”

“Among health care professionals, 95 per cent of doctors own a smart phone as well.”

One of the inventions that Dr Hong created was a small 3D-printable device that fits on the top of a smartphone. The device feeds images to the phone’s screen during a front of eye examination, and allows the clinician to magnify images, see infection and other elements not visible to the naked eye. The device costs about $20 and takes only 30 minutes to create on a 3D printer. Traditional equipment can cost up to $15,000 and is not portable.

The second and more difficult challenge was to come up with a way to perform a retinal exam, which is an assessment of the back of the eye through the patient’s pupil. Dr Hong successfully developed an invention to replace the traditional ophthalmoscope – a device invented more than two hundred years ago. This second magnifying device can also be attached to a smartphone, and can record video or still images from the eye examination. The new device gives the clinician a forty degree view of the retina while conventional technology provides only a ten degree view.

“Using this device is like looking into a room through a big window, rather than through a key hole.”

Alongside the retinal examination camera, Dr Hong also created a multi-function app that allows health care practitioners to assess how well a patient (tūroro) can see. Using the free app, patients view a series of different sized letters on a smartphone screen, in a vision test similar to traditional wall charts.

“In about one minute, a clinician or nurse can check a patient’s vision in a very objective manner.”

Dr Hong is an advocate for an open-source medical community, and has made all aspects of his innovation available freely online.

“This innovation captured the potential to save on clinicians’ time, improving workforce performance and job satisfaction by reducing paperwork and improving quality of care in rural areas.”

By utilising mobile technology to increase access to ophthalmic care for vulnerable demographics, Dr Hong’s innovation captured the spirit and aims of the Clinicians’ Challenge.

Participants can enter the Clinician’s Challenge in two categories. They can either share a new idea for disruptive innovation for a digital system or application to deliver health systems in new ways. The goal is to improve patient outcomes, improve workflows, bring efficiencies or support better integrated care.

Alternatively, submissions can be made for an active project or development. Clinicians can share an innovation for a system or application they are developing, or have already developed. It should improve the way the clinician works, support better patient care, and deliver efficiencies and better integrated health services.

The winner in each category will receive a grant of $8,000, and runners up will receive $2,000. Entries can be submitted at www.hinz.org.nz until 16 June 2017. Winners will be announced at the HINZ awards lunch on 3 November 2017.

Dr Jo Scott-Jones, 2012 Clinicians’ Challenge winner

Ōpōtiki Fellow Dr Jo Scott-Jones won the 2012 Clinicians’ Award for his innovations to standing order use in general practice. Dr Scott-Jones has been a rural GP for 24 years, and is currently a College Board member.

Standing orders are legislatively permitted as a way to enable nurses to supply or administer drugs for routine and simple conditions. Dr Scott-Jones’ experience in rural general practice was that there has been a growing interest in using standing orders to bridge service gaps in areas where there are doctor shortages.

He submitted a proposal improving the effective delivery of healthcare in a rural environment that asked IT vendors to come up with a way to operationalise a national set of standing orders for primary care. The proposal focused on a evidence-based set of protocols and educational modules that would cross the divisions of primary and secondary care nationally.

This innovation captured the potential to save on clinicians’ time, improving workforce performance and job satisfaction by reducing paperwork and improving quality of care in rural areas.

New research has just been published regarding standing order use in general practice. Read it now in the latest issue of the Journal of Primary Health Care.