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# GP PULSE

THE ROYAL NEW ZEALAND COLLEGE OF GENERAL PRACTITIONERS

## The Strength of Hokianga

Inspirational Marae Kaupapa

## Conference 2010

Anna Maze's rousing address

## Kiwi Doctors Abroad

Valerie Archer on Kapuna

The Royal New Zealand College of General Practitioners

# CONTENTS









*Cover picture Te Kaiwaha Marae, South Hokianga, courtesy of Hauora Hokianga.*


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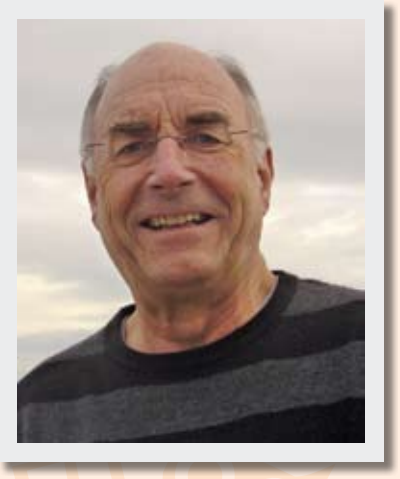
EDITORIAL

# Doing the right thing at the wrong time

**Tony Townsend**
*RNZCGP Deputy President*



On Thursday September 3 and Friday September 4, 550 GPs, practice nurses and other medical stakeholders gathered in the Garden City of Christchurch for the Royal New Zealand College of General Practitioners Annual Scientific Conference. Our theme was 'Doing The Right Thing'. Dr Iona Heath (President, UK College of General Practitioners) was the first keynote speaker, Dr Anna Maze presented the Peter Anyon address and Dr Jeff Shortt was the College Orator. There were many interesting concurrent presentations, including John McMenamin's on stopping alcohol abuse and Hamish Osbourne's on prescribing exercise. I spent Friday morning honing my minor surgery skills. We socialised with colleagues and friends enjoying Cantabrian hospitality. We went to bed on Friday looking forward to a further day and a half of conference.

Then, as we all now know, Christchurch was rudely jolted awake at 4.35 am on Saturday, forcing us all to congregate under the cold but starry sky. Even before the shaking had stopped, hotel staff were bringing out extra bathrobes and towels to ward off the cold. Everyone looked after each other. Emergency services raced into action.

Within hours, Pegasus Health was following their after-hours clinics disaster management plan. Extra doctors, nurses and admin staff turned up to help out. Despite stress (many having personally sustained substantial property damage) and fatigue, doctors, nurses, pharmacists and their admin staff are continuing to provide the care that is required. When I talked with one GP who worked on the Saturday he said that, although the injuries sustained were mostly relatively minor, the patients were seriously frightened.

Christchurch hospital was intact and coped but electives were pulled back as a precaution. Similarly, primary care infrastructure had survived well in terms of buildings and IT function, with only one inner city practice reported as closed. While the enormity of the impact on Canterbury's general infrastruc-

ture is becoming clearer, the psychological and psychosocial impact on people in the community will continue to evolve over the next few weeks. The latest issue of the *Journal of Primary Health Care*, published shortly before the conference, included a guest editorial titled 'Are we ready for the big one?' in which the authors urged us to train a cadre of primary health care personnel to deliver CBT for trauma so that NZ is well prepared for the effects of any major disaster. Timely advice.

National support is important. GPNZ has compiled a register of GPs, practice nurses, practice managers and community pharmacists from other parts of New Zealand prepared to offer short term relief. The local earthquake incident control centre for general practice and community pharmacy is based at Pegasus Health, whose staff are coordinating requests from general practice and community pharmacy for

**We went to bed on Friday looking forward to a further day and a half of conference.**

**Then, as we all now know, Christchurch was rudely jolted awake at 4.35 am on Saturday**

a relief workforce. Both organisations are working along side Canterbury DHB and a Ministry of Health led 'national health coordination centre' (NHCC) to coordinate workforce relief. This type of support will be essential to help our

*Quake photo by Chris Fawcett, Chief Censor, Professional Practice*

Canterbury colleagues continue to care for their patients who are facing ongoing challenges.

Cantabrian health care professionals will also be personally affected by the quake and the aftershocks. They face the same issues and concerns as those they live along side. Self care will be important and involves developing effective strategies for managing stress, remaining positive and ensuring support from peers, friends and family. A resource on self care is available to College members electronically on the website. It is important for all of us to keep doing the right thing, for ourselves as well as for our communities!

# Peter Anyon Address

**Anna Maze**

*General Practitioner, Christchurch*

Anna Maze, GPEP1 Registrar 2009, was invited to give the Peter Anyon Address at this years conference.

*Anna with husband Mike and their children Pippa (left) and Eliza*

Sometimes when you are asked to do something a bit daunting you set to it with a slight panic and find your mind casting around in a slightly desperate way. If you force yourself to be a bit dispassionate for a moment, it can be interesting to see what random thoughts you dredge up. For me it was two long ago memories of general practice, long pre-dating any GPEP registrar days.

The first was as a very hurried and busy six-year-old, just come in from doing some very important gum-booted business on the farm. I was just in time for mum to wash mud from my face and hands and to get into my 'going to town' clothes as we headed in to see the doctor. Most likely it was for a family-full of ailments, but my particular issue was a stubborn wart on my foot. Alas for my poor mum, a six-year-old in a hurry (particularly this one) might take a few short cuts, like for instance being too busy to put on socks while wearing my sheep-poo filled gumboots, and certainly too busy to wash my feet after that initial oversight. So out came the warted foot, displaying a whole lot more than a skin lesion. My poor mum's face must have gone as red as my foot was black. Fortunately, the GP was a non-judgmental type who had a good laugh, and even the good grace to still look at the wart. I'm sure he'd be pleased to hear that I now keep two passably clean feet. Fewer gumboots and more socks helps I guess.

My other significant general practice memory is as a 15-year-old, going to the GP about a sore throat or something similar. She asked me what my plans for the future were and I mentioned that I'd thought about doing medicine. She said to me that should I choose general practice, I'd need to be comfortable with uncertainty. Now, I'm sure I nodded as if I knew exactly what she meant but in fact I had no idea. But it has always been a comment that has stayed with me, despite the fact that by rights it should have gone the way of all other things that I don't have the foggiest idea about and slipped right out of my head. It has been really gratifying to gradually understand what she meant by that comment 17 years ago and slowly become more comfortable with that uncertainty that she was talking about.

So if I was to sum up those two memories into key points of:

- firstly, be professional, respect and see your patients as a whole, while keeping a sense of humour close at hand and
- secondly, work at being comfortable with uncertainty.

I think I'd come out with my two basic principles of general practice. And two key components of the GPEP1 course I'm happy to say. You could also argue that they are two key points of difference from hospital

medicine. Certainly it felt blindingly different to me when I left the hospital house surgeon life after 18 months to do my three months rural GP attachment with Ron Janes in Wairoa. In retrospect, I had probably become a bit disillusioned with medicine but all that was to change. The lights came on. This is what I wanted to do. I felt this certainty despite the palm-drenching feeling of having a patient sitting opposite me in a chair, talking to me and then expecting an on-the-spot, coherent and presumably wise response. This wasn't a delirious octogenarian, on the ED gurney, passively submitting to my prodding of her abdomen and then uncomplaining while I retired to the sanctuary of the doctors desk to synthesise what I had found and reference a text to confirm that this was an appropriate management plan. Now I had to work out what was going on when more often than not I had absolutely no idea.

Then ideally I should still allow this patient to have a degree of confidence in me and my ability to heal them, which was already on shakey ground given I was a third of their age and a bit sweaty and would certainly be blown out of the water if I went and looked at Murtagh just now.

And finally I had to try to keep to time when some kind of weird time warp/black hole effect seemed to turn 20 minutes into three.

On the bright side it was absolutely WONDERFUL not to have a pager.

More on the bright side, there seemed to be tricks to this GP business, like admitting when you weren't sure, and getting them back for a follow up, and actually using the intervening time to sort out the likely diagnosis, or at least a reasonable attempted solution.

And it seemed, given time, most people did actually get better.

More so, some of these problems weren't just the kind of flesh and bone and body problems that had kept me so busy as a house surgeon in Gisborne. They were often relationship problems, despair, child custody battles, and broken hearts that sometimes I could help with what I saw as a bit of a fraudulent pseudo-official letter from me 'pretending' to be a GP, and sometimes couldn't be helped except by being listened to. I found this to be an incredible honour, that a stranger would trust me with these tales and that sometimes they even seemed a little buoyed as they left my room.

Ron was a terrific mentor through these three months, someone who had a great method and high standards clinically and who was aware of and interested in the patient's perspective and story and understanding of their health. This felt quite a huge shift from hospital medicine.

My next major training ground for general practice was a bit unorthodox. Despite this, it certainly taught me a huge amount about the value of seeing the bigger picture than just the immediate problem with which the patient presents, and also had me working in more clinical uncertainty than anywhere I have worked before or since.

I'll also take this chance to get up on my soap box and make a little political point. Currently there is a move in medical politics to speed up junior doctors' transit into vocational training. While I can see the intended purpose of this in trying to reduce the damaging locum industry amongst RMOs, I worry that it might pressure people out of taking anything but the fast track after qualification. This spot was very far off the fast or conventional track but I'm sure that I'm a far better doctor because of it and I'd hate other young doctors to miss out on the opportunity to try something similar.

**Many GPs will tell you that it is the variety of their workload and the unpredictability of any given day that keeps their work satisfying. Well the average day at St Francis had that in spades**

My husband Mike and I set off on a year's contract at St Francis Hospital, a 350 bed hospital in rural Zambia. We were two of anywhere between five and 20 doctors and worked in the medical and paediatric service there. Fortunately, obs and surgery were covered by others which was great, as my sense of adventure falls short of requiring me to be let loose with a scalpel.

HIV, TB, Malaria and malnutrition made up our daily patient workload. We'd prepared ourselves a little for this by doing the Tropical Medicine and Hygiene diploma in London prior to going to Zambia but it was still a very steep learning curve.

Many GPs will tell you that it is the variety of their workload and the unpredictability of any given day that keeps their work satisfying. Well the average day at St Francis had that in spades. From doing a therapeutic LP, to preventing imminent coning in a patient with cryptococcal meningitis, to then unravelling a vague presentation of abdo pain into its true underlying

emotional pain of infertility in a society where children count for everything, to then retrieving the file of one of the nurses from the locked confidential box to treat them for the HIV, that prior to the introduction of ARV treatment had been killing about 10 staff members every year. We certainly covered a lot in a day!

**We had enough basic diagnostic tools to generally have a reasonable idea of what was going on in the straightforward cases. But there were so many cases that were far from straightforward**

We had enough basic diagnostic tools to generally have a reasonable idea of what was going on in the straightforward cases. But there were so many cases that were far from straightforward. The patients would present late with serious problems, so often the stakes were extremely high. We had no choice but to do our best, have a go with what we had available and read up hard on those tricky cases to try and shift all that clinical greyness into a bit more of a black or white hue. It was incredibly satisfying to use common sense, clinical judgment, and by the end of our year there, experience, to come up with management that most often gave successful outcomes.

Many things struck us when we came home after that year away, from the serenity that road rules can create when followed, to being paralysed with indecision as to which crackers to buy when suddenly faced with 30 or so to choose from. Medically, back as RMOs in the hospital system, it was the reluctance of clinicians to rest easy

*Mothers and children on the paediatrics ward*

with their clinical judgment that this diagnosis was the most likely cause of this presentation and the need to exclude other obscure diagnoses with expensive investigations before inevitably going back to treat for the first diagnosis anyway. Obviously there are a lot of other influences at play here, not least the medico-legal aspect, which exists here and is conspicuously absent in Zambia. In fact there's nothing like working somewhere where formal patient rights are so few to make you appreciate what a safeguard they are when they exist. However, there's no denying that they do impact both positively and negatively on the way medicine is practised here.

If I was to be permitted a little bit of poetic license here, it would be possible to draw some parallels between my time in Zambia and working in general practice. Clearly there's a whole lot more greyness to work within when there are no crisp black and white CT images to refer to. Time and access restrictions have you relying much less on investigations in day to day decision-making, unless clinical judgment nudges you towards accessing those services. In both settings we use time, and treatment with review, which in fact are the resources often in such short supply to our hospital colleagues

However, the lack of resources or extra care facilities made the decision-making superficially much easier in Zambia—how can you angst over not referring a patient when there's nowhere to refer them to? That's an important distinction from general practice here, and in fact I am so extremely happy for the public of NZ, that I am not as good as it gets in terms of their more advanced health care needs. Having resources to access for those patients who need them is a first world privilege, even if they are always being harassed for not being up to scratch. It's deciding for whom you need to access these services that makes GP work so challenging,


*Mike heading in to give out some goodies to the paediatrics ward kids on Christmas day*

As well as this exposure to large amounts of clinical uncertainty, my time in Zambia also gave me a reference point to how important communication and seeing the bigger patient perspective are, When I started my GPEPI year we had a very interesting presentation from Brett Mann about communication and the 'double diamond' model of consulting, where, to paraphrase we work with the patient to first gather information with open

*Anna painting up the new HIV paediatric clinic room*

**We could talk until we were blue in the face about taking this or that medicine but if we'd not met that patient's own understanding of what was going on, then they'd likely not be following your advice**

then progressively more closed questions, eventually reaching a diagnosis with which both parties are comfortable, and then repeat the process to plan a management and follow-up plan. I've always tended to be a bit sceptical about models like this but this one immediately resonated loud and clear with me, simply because it was exactly what I had been unable to do in my work in Zambia. Partly this was time restraints—our HIV outreach clinics had been known to see 150 often fairly sick patients in a day, finishing off by car headlight well into the evening. But even that aside, there were language barriers and cultural concepts of health and illness of which we were barely able to scratch the surface. We could talk until we were blue in the face about taking this or that medicine but if we'd not met that patient's own understanding of what was going on, then they'd likely not be following your advice—just as would be the case here in NZ too.

I do have to make an important qualification to this. In terms of compliance with anti HIV medication, Zambian and other sub-saharan patients are outstanding. They have had too long watching their contemporaries die terrible deaths and count themselves too lucky to have access to these medications to be anything but precise with their treatment.

Generally these communication subtleties didn't matter too much. We were too busy, the patients so grateful, gracious and full of good humour and dignity even often in the face of great sorrow. But for the final three months there we became so busy, sharing the ward, clinic and call work that had healthily occupied 12 doctors between just three of us. That was when I learnt

*Dinah, one of the translators, painting up the new HIV paediatric clinic room*

*Mike with a Zambian elephant*

my final lesson that I have taken with me from my year there. When the patient's stories really stop mattering to me, when I'm getting frustrated with the patient that they are not getting better with the completely reasonable treatment that I gave them last time, and when I can't laugh off frustrations and then work a way around them, I'll know that its time for a break. It was certainly not a feeling that either of us had experienced before, but it's a very useful memory to tuck away in reference should we ever burnout again. To be honest though, right now, my main burnout threat comes in the shape of a one-month-old daughter and her very energetic two-year-old sister, with my GPEP2 time on hold for now.

Dealing with the realities of uncertainty in general practice certainly isn't made straightforward by referencing it all back to my time overseas—there are too many basic differences for it to be as easy as that and I'm sure it will continue to be something that stretches and challenges me throughout my career.

**Hopefully, keeping myself balanced, finding humour in my work and working at really hearing where my patients are coming from will keep me grounded**

Tackling it head on through my time with Les Toop and his team of Pegasus Clinical Educators has given me a taste of how best to arm yourself in clinical practice. In fact it seems to me that for Les, this clinical greyness is what he loves best about general practice! I haven't got to that point yet, but hopefully, keeping myself balanced, finding humour in my work and working at really hearing where my patients are coming from will keep me grounded enough to deal with the ongoing challenge of clinically grey stuff. And as far as our plans for the future go, we spend a lot of time making plans for more stints in Zambia. Pippa and Eliza might not know it yet, but they are going to love it there too. They certainly have a lot of people there waiting to meet them both and we can't wait to get back.

# Confessions of a maverick

Campbell Murdoch

*General Practitioner, West Otago*

**Campbell Murdoch, along with eight other RNZCGP Fellows, was awarded Distinguished Fellowship at this year's Conference.**

In 1992, just before I left the Chair of General Practice in Dunedin to go to the United Arab Emirates, I was interviewed by the *Otago Daily Times*. The headline for the article was 'Maverick off to greener pastures.' Wikipedia tells me that maverick is a term for an animal that does not carry a brand. The term derived from Samuel Maverick, who was notorious for not branding his cattle and refers to 'Someone who exhibits great independence in thought and action.' I'll wear that badge with pride!

I started my career in general practice in Kirkintilloch, Glasgow, Scotland on the first of August 1968, just two years after I graduated from the University of Glasgow medical school. My career change from surgical trainee to being 'just a GP' wasn't idealistic. Annie and I had just got married. We were barely surviving on her salary and my 80 pounds a month and had already demonstrated our fertility. A friend told me of an opportunity in his general practice. It was better money that I could ever make if I had stayed in hospital so I decided to jump off the specialist ladder and find myself in the real world. I often reflect what life might have held if I had continued to be a surgeon. I reckon it would have been very boring, repeatedly cutting flesh, standing around all day, having to work in hospitals.

The great thing about general practice was the ability to order your own life, to live and work in the community, to be with your family, and to get to know, love and treat real and mainly uncomplicated people. So for the first nine years of our married life we lived in a small town where I was 'the doctor' to about three thousand people. In addition I was a deacon in the local Baptist Church, a regular lay preacher, and opened a youth centre for troubled youth. I also kept goal for the University graduate soccer XI called Westerlands and we won a medal in the Scottish Amateur League Fifth Division Championship.

Increasingly I became involved in teaching and through an amusing set of circumstances I found the time to do research. I had applied for a job as a Visiting Practitioner in a local hospital for intellectually disabled women, and assumed that, to do the job, I would need to take time off the practice. When I turned up for my first session, the Matron asked 'What are you doing here, doctor? Dr Irving only came when we called.' Having already arranged to take two half days off a week, I decided to do research. The hospital had a large number of adults with Down's Syndrome, so a three year study led to a doctoral thesis. At the same time the University of Glasgow was expanding its teaching in the community and I was asked to take students regularly from the paediatrics rotation. It was a time of great academic excitement in the new discipline of general practice. I got hooked and at the age of 34 decided to apply for an academic position.

In Dundee I was the first Senior Lecturer working with Professor Jimmy Knox, who was one of the original founding four Professors of General Practice in Scotland (1970). As it was believed academics should work in real general practice and my role was to develop a city practice as the Medical School Teaching Practice. I inherited an inner-city practice run by a GP for 30 years from his own house. I believe that the academic basis of general practice is about how we best look after individual persons, families and communities and this was my emphasis in teaching and research. We developed 'The Living Anatomy Club' where patients from the practice and students met to discuss basic science topics. I was funded to develop the Down's Family Project, which involved families with Down's children and their doctors in longitudinal research. I also got involved in another PhD study with the Professor of Pathology as supervisor in a funded project which looked at the relationship between the *in vivo* morbidity and mortality of the elders in the practice and the *in vitro* behaviour of their lymphocytes in the laboratory. All exciting stuff and not yet finished because three of the patients (of 405) are still alive 31 years later.

**The great thing about general practice was the ability to order your own life, to live and work in the community, to be with your family, and to get to know, love and treat real and mainly uncomplicated people**

In 1982 I was invited to apply for the Chair of General Practice which had been established in Dunedin using the generous bequest of Dr Elaine Gurr. In 1983, Annie and I and our four children aged 6–15 set off on the great New Zealand adventure. Just before we left, I was giving a paper at a RCGP conference in Glasgow and one of the other papers was on an outbreak of myalgic

encephalomyelitis (ME) in a community in the West of Scotland. When we arrived in Dunedin, the first hotly discussed community health issue that presented itself was 'Tapanui Flu' described by Dr Peter Snow and colleagues in West Otago. I was asked whether or not I believed it was a 'real illness'. Dr Keith McLeod, a feisty neurologist in Dunedin Hospital, went round all the clinical Heads of Departments asking them what they were going to do about the problem. My view then was that it was, and that one of the purposes of a Chair in General Practice was to research such genuine community issues.

I came to the opinion that ME/CFS was a physical disorder initiated by a viral infection and proceeding to an immune disorder. Twenty-seven years on it is difficult to understand all the hype. Public meetings in Dunedin, Gore, Christchurch, Wellington and Auckland attracted hundreds of people. The press and media ran hot with the topic and I was always 'Brave heart,' unafraid of being interviewed. I am afraid this did not go down well with the conservative medical profession in New Zealand who didn't think that 'Morning Report' was the appropriate teaching platform for a Professor.

understanding of their problem. Some very early and important research has now been confirmed in other parts of the world. The recent discovery of a new retrovirus called XMRV (Xenotropic murine leukaemia virus-related virus) in a large percentage of ME/CFS patients in the US has given hope that a contention made by me in a paper in 1987 'that an as yet unknown retrovirus could be the initiator of the illness,' might come to pass. However my main aim was to stand by those who had an unexplained illness, to bear witness to their disability and their bravery, and it is here that the doctor who wishes to do research on his or her own patients becomes terribly conflicted. Many times I was told that I cared for these people so much that I was incapable of being objective.

In order to do research you have to ask questions and simply asking can cause a lot of heartache. The most difficult question for patients with ME/CFS was whether this was a psychiatric disorder albeit minor. We asked that question in a large case/control study published in 1989, studying 58 people with chronic fatigue syndrome (CFS) 81 with chronic

**I am sure there were many wise commentators in NZ general practice who wished that the country's only Professor of General Practice would conduct himself with academic gravitas and not be the fool who rushed in where angels feared to tread**

I am sure there were many wise commentators in NZ general practice who wished that the country's only Professor of General Practice would conduct himself with academic gravitas and not be the fool who rushed in where angels feared to tread. Perhaps that was where the maverick reputation came from. Thousands of people with ME/CFS were grateful for the top level support and

pain syndrome (CPS) and 104 apparently healthy controls. We found that there was an excess of depressive illness in the CFS group, but all the groups, even the so-called normals, were very mixed in their psychological makeup. There was an overlap between CFS and CPS and, like all good research the study provided more questions than answers. This conclusion is a common one from a

*Campbell and Annie go west*

generalist perspective, that it all depends how you look at things. Our view of the world is of our own patients, seen through the skewed perspective of their GP. Those who believe in the 'myth of objectivity' and who dominate research thinking and funding try to seek truths from the ivory tower perspective. One of my insights into the treatment of GPs by the academic world was to examine proposals for doctorates which had been submitted to Deans of Medicine over the years in Dunedin. Most had scrawled over them 'Not suitable for an MD' in red ink. This led us to propose the new Master of General Practice degree in 1990. This and other academic endeavours such as the development of College Research Units has demonstrated that generalists looking after particular and, often peculiar, populations have much to contribute to the academic world.

In 1992 I left New Zealand for another pioneering academic position in the United Arab Emirates. A sign of good management is that the organisation doesn't miss you when you leave. Murray Tilyard, a GP registrar when I arrived, became the second Dunedin Professor when I left. The UAE University gave me the opportunity to build a strong Department of Family Medicine and, at that time, there were more full-time NZ academics in our discipline than there

were in NZ—Tony Townsend and Nick Glasgow to name but two! There we had internships in Family Medicine and started a new Residency programme which was the most popular in the Medical School. We then went to Malaysia where I was involved in yet another new but short-lived Medical School.

In 1998, Annie and I were back in New Zealand. The great thing about being a GP is that there is always work and so I found myself in Winton as a full-time procedural rural generalist. It was also a time of clinical rehabilitation. As a Professor of General Practice I had always claimed that I had kept my clinical skills, but a few weeks in Winton proved that this was a delusion. The doctor who is seeing 30 patients a day, delivering babies and doing emergency call in a local population develops knowledge and skills which are unique and irreplaceable in the health care mission of a country. The problem was, and still is, that no one wants to fund that system of care. Therefore, after time no one wants to work in that system. In a study of invoices in the Winton practice I found that we did obstetrics for $5 an hour, after hours for $11.43 an hour and office practice for $251.81 an hour. The business plan arising from these observations favours city practice and devastates rural practice.

After three years there, we had gone from having five participating GPs to two. So when I was contacted by the Goldfields Division of General Practice in Kalgoorlie to see if I would be interested in setting up the Rural Clinical School in the University of Western Australia, I accepted the challenge and the rest, as they say is history.

Australia, unlike New Zealand, has responded to the challenge of the proper funding rural and remote medicine. Western Australia has half the population of New Zealand and now produces about 330 medical students per year. One in four of these students (75) do a year long immersion course in one of twelve rural and remote sites. The two Medical Schools send their students to the same Rural Clinical School. We have appointed 30–40 academic staff, mainly but not exclusively rural generalists, and we give students a clinical education that is recognised to be equivalent to that delivered by tertiary hospitals, to the extent that 42% of medical students apply for a place. I have always claimed, like a true maverick, that I could do great things if only 'they' would give me the funding, so it is a matter of some pride to me that this was achieved in a few short years. Of course I would never have been able to do this had I not been supported by Annie, who has yet again been prepared to travel with me on this incredible journey. One of the most important honours to us was the creation of the Campbell and Annie Murdoch Prize for Rural and Remote Medicine at the University of Western Australia, and I am so glad that her place has been recognised.

**I have always claimed, like a true maverick, that I could do great things if only 'they' would give me the funding, so it is a matter of some pride to me that this was achieved in a few short years**


*Campbell Murdoch in his new practice*

And now I am a PGY 44 rural general practitioner in West Otago, albeit part-time and working 7/10. Why am I there? Because there was no one else. The best minds in New Zealand academic medicine have produced a situation where no one wants to work in rural areas. My colleagues are nurse practitioners and they lead and I support. When I arrived in New Zealand in 1983, 60% of the deliveries in Queen Mary Maternity Hospital were done by GP obstetricians. Now are there any GP obstetricians? Will there be any rural generalists left in 2037? By that time I'll be 95 but I venture to suggest that few of them will be medically trained.

The following eight Distinguished Fellowships were also conferred at Conference in September. At least one of these new Distinguished Fellows will write/be profiled each issue of *GP Pulse*.

- Dr Tana Gail Fishman,
- Dr Jonathan Edward Mark Fox,
- Dr Janet Seymour Frater,
- Dr Steven Lillis,
- Dr Stephen Paul McCormack,
- Dr Garry Harold Nixon,
- Professor Leslie John Toop,
- Dr John Terence Wellingham.

## RECENT TAX DEVELOPMENTS

# Is your practice at risk of Inland Revenue scrutiny?

Chris Leatham and Owen Gibson

*Chris Leatham*

*Owen Gibson*

It is sometimes said that 'Big Brother' is watching. This has never been more true for many GPs as it is right now.

Recent tax developments in the New Zealand Courts have serious implications for individuals who provide professional services through company or trust structures, as many GPs and other professionals do. If you answer 'yes' to any of the questions below, your practice may be at risk of Inland Revenue scrutiny:

- *Do you operate your practice through a company or trust?*—Companies and trusts are taxed at a lower rate than many individuals, so can give a tax advantage.
- *Are your family members and/or family trust the shareholders of the company or the beneficiaries of the trust?*—This may suggest you or your family are benefiting from the income, even though it is not being taxed at your higher rate.
- *Is the income of the company or trust generated largely from services provided by you personally?*—This may suggest the tax should be paid by you personally.
- *Are you paid a salary by the company or trust that could be considered to be below market value?*—This may suggest you are contriving a reduced tax bill.

By way of background to this issue, the Court of Appeal recently issued its judgment in the case of *Commissioner of Inland Revenue v Penny and Hooper*. Messrs Penny and Hooper are orthopaedic surgeons who operated their practices through companies owned by family trusts. As sole directors of the companies, Penny and Hooper set their own salaries, which were significantly lower than the income they had previously earned as sole practitioners. The remaining income was taxed at the lower company and trustee tax rates of 33% as opposed to the higher personal tax rate of 39%.

The Court concluded that these arrangements were tax avoidance because they allowed Penny and Hooper to take advantage of the lower company and trust tax rates by paying artificially low salaries while retaining the control and benefit of the company's income. The Court concluded that income substantially generated by a taxpayer's personal exertion should be taxable in the hands of that individual and not taxable (at the lower rate) to the company employing them. The Court's decision is the latest in a string of tax avoidance cases that have been won by Inland Revenue.

**It may be timely for GPs to review their tax affairs now, to avoid unwanted tax liabilities**

Many professionals such as GPs, doctors, dentists—and of course tax advisors—have cried foul at the controversial Penny and Hooper decision. However, Inland Revenue seems determined to cash-in on its winning streak.

Shortly after the latest Court decision, Inland Revenue announced that it will continue to investigate arrangements similar to those of Penny and Hooper, noting that it will generally focus on the most serious and artificial cases. This is of particular relevance to many GPs who may have similar structures and tax arrangements as Penny and Hooper.

It may be timely for GPs to review their tax affairs now, to avoid unwanted tax liabilities, interest and penalties at a later date. If in doubt, they should consider taking advice to help keep 'Big Brother' at arm's length.

*Chris Leatham and Owen Gibson are partners in PricewaterhouseCoopers. They are available for a confidential discussion and initial 'health check' of your practice structure and can be contacted at:*

*chris.j.leatham@nz.pwc.com; telephone 04 462 7304*

*owen.d.gibson@nz.pwc.com; telephone 04 462 7230*

# Diabetes integrated model of care

| | | PRIMARY & COMMUNITY CARE<br>3 MONTHLY CHECK | | SECONDARY CARE<br>PRIMARY CARE REFERRAL (2) |
|---|---|---|---|---|
| **DIABETES MELLITUS** | → | Diet | → | Diabetes Clinic |
| Hyperglycaemia | | Exercise | | |
| | | Weight loss medication | → | Bariatric surgery |
| | | Oral Hypoglycaemics | | |
| | | Insulin | | |
| **COMPLICATIONS** | | | | |
| **1 Microvascular** | | | | |
| *Eyes* | → | Retinal Photoscreening | → | Ophthalmology |
| Retinopathy, Maculopathy | | 2 yearly—minimum | | |
| *Kidneys* | → | Blood, Urine testing | → | Nephrology |
| Microalbuminuria | | 3–6 monthly—minimum | | |
| Macroalbuminuria | | Smoking—Cessation (1) | | |
| End Stage Renal Disease | | Blood Pressure—ACEI | | |
| *Nerves* | → | Foot check and education | → | Podiatry (3) |
| Peripheral neuropathy | | 1 yearly—minimum | | Neurology |
| —Sensory, Motor | | | | |
| Autonomic neuropathy | | | | |
| —Gastroparesis, Impotence, Postural hypotension | | | | |
| **2 Macrovascular—due to accelerated atherosclerosis** | | | | |
| *Ischaemic Heart Disease* | I | | → | Cardiology |
| Angina | I | | | |
| Myocardial infarct | I | | | |
| | I | **treat other major risk factors** | | |
| *Cerebrovascular Disease* | I | Smoking—Cessation (1) | → | Stroke team |
| Stroke | I | Blood Pressure—Antihypertensives | | |
| TIA | I | Cholesterol—Statin | | |
| | I | Clotting—Aspirin (4) | | |
| | I | | | |
| *Peripheral Vascular Disease* | I | | → | Vascular team |
| Claudication | I | | | |
| Arterial ulcer | I | | | |
| **3 Increase Risk of Respiratory Tract Infections** | | | | |
| Influenza | → | Influenza immunisation | | |
| | | 1 yearly | | |

**4 Other Selected Complications—not specifically treated at 3 monthly check**

- Depression
- Recurrent Urinary tract infections
- Skin infections e.g. Boils, Cellulitis

**COLOUR CODING—PRIMARY ROLES**

General Practitioner

Diabetic Nurse Educator and/or Practice Nurse and/or Community Health Worker

Dietician

Exercise facilitator

Retinal Photoscreening

**EXPLANATORY NOTES**

1. 'The 'Diabetes Integrated Model of Care' is a practical and simplistic overview of Diabetes Mellitus, as it may assign specific roles to primary care workers. In reality, tasks may have shared responsibility with multiple therapeutic options possible e.g. SMOKING CESSATION

   ***Responsibility:***

   - General Practitioner
   - Practice Nurse
   - Community Health Worker

   ***Therapeutics:***

   - Counselling
   - Nicotine Replacement Therapy (NRT)
     - Quit card
     - Prescription
   - Pharmacological Management
     - Bupropion
     - Nortriptyline
     - Varenicline

2. Referral from Primary to Secondary Care follows National and/or Regional Guidelines.

3. Podiatry services may also be provided within a Primary Care or Community setting.

4. Clear benefit of Aspirin in the Primary Prevention of Major Cardiovascular Events in people with Diabetes remains unproven—*BPAC December 2009*

*This article is co-authored by Dr Kevin Gabriel (College Fellow) and Dr Ajith Dissanayke (Diabetologist at Middlemore Hospital), and peer reviewed by Professor Bruce Arroll. The article is an original piece of work and is copyrighted as such.*

# The Strength of Hokianga

In March 2010, a small group of rural doctors gathered at Te Kaiwaha Marae at Waiwhatawhata in South Hokianga for a three day stay. This was the residential workshop for the University of Otago GENX 725: Communication in Rural Hospital Medicine paper, which forms part of the academic component of the Rural Hospital medicine training programme. Hone Taimona and Marara Rogers (hosts Te Taumata, Hauora Hokianga), Carl Marais (Rural Hospital MOSS), and Emily Gill (Rural Hospital Registrar) give their personal views from the residential for *GP Pulse*.

**Marara Rogers and Hone Taimona**

As hosts to the medical practitioners on their journey our obligation to prepare them for this experience began long before they arrived: teaching them at least three waiata, sent as a sound bite via email, the appropriate dress for the day, the process they would undertake etc. We are aware that the experience of Marae based learning can be extremely daunting for non-Maori and non-New Zealanders, and as responsible hosts wanted to ensure everyone was comfortable before they arrived. The Marae is a place of learning for both hosts and visitors. Our local kaumatua shared their gems of wisdom, and we the hosts received so much more from the students—things such as the varied cultures they come from, sharing their life stories and genealogy; the use of modern technology. Once upon a time the Marae had no telephone, then there was a telephone and electricity, today, we have mobiles and iPods and these were used to its full extent with one of the students using waiata (songs) from his iPod to support his korero (story).

The Marae is a safe place for debate and discussion especially in regard to death and dying, and the reality of living with the dead every day (wairua). It's just the way we are as Maori. This learning environment of the Marae adds value to the practice of clinical practitioners where a deeper intimate understanding of the culture of Maori, is sensed, is felt; and one is moved. It is hoped that the clinical scene practitioner's face in a ward with a bed, four walls, and a Maori patient now has another dimension, the dimension of wairua which comes with the patient and fills the room.

**We are aware that the experience of Marae based learning can be extremely daunting for non-Maori and non-New Zealanders, and as responsible hosts wanted to ensure everyone was comfortable before they arrived. The Marae is a place of learning for both hosts and visitors**

No reira, tena koutou, tena koutou, tena koutou katoa.

**Carl Marais**

If someone told me 10 years ago when I arrived in New Zealand that I'd be spending a week with 15 other doctors on a Marae, sleeping rough on little mattresses and listening to the guy next to me snoring to his heart's content I would have laughed. Getting a chance to relive those uncomfortable camping days of my youth in South Africa would have seemed daunting.

I arrived from South Africa aware and sure in my perspective that the only people who ever had disparities in health care were us, it was our domain, as if we had a sole right to feel aggrieved at what it felt like to live under an apartheid government. I was wrong, I read the Treaty of Waitangi, absorbed it all, but somehow it slipped from mind until that week. Working as predominantly a rural locum doctor I never got a sense of the communities I cared for. The Marae experience changed all of that for good. In South Africa foreigners were never welcomed for the mere experiences they brought, our initial history was of white immigrants arriving to bolster our white supremacy, black African immigrants arriving as refugees from the neighbouring war torn countries. This was the first time I'd ever been welcomed, from the smiling singing walk up the steps of the Marae, to the gentle openness of the people that told their life stories. It reminded one of how it must have felt centuries ago when men and women sat at the feet of that matua, the oral tradition of bringing tales to life. Everyone removing their shoes and leaving the shackles of their self-importance and status outside.

This was oneness, a common goal, from the sharing of food, to the quiet nights listening to Hone's soothing voice lulling us off to sleep, in the dark one could still barely see the beautiful carvings on the wall. I could wax lyrical about the Hokianga, the warmth and the quiet dignity of the people that make up its shores, the soul-searching life stories we had to tell at midnight, the sense of how privileged we were to have knowledge imparted by so many wise people.

One of the speakers said something I found profound, she suggested that to ensure the inequities of the past are wiped out, all health care professionals should go the extra-mile to ensure that Maori and other previously disadvantaged patients be cared for even more diligently than before. I suggest that other colleagues try to incorporate a period of the Marae experience. Maybe then, and only then, could we ensure that we have no more disparities in health care, and that all our grandparents live to the fullness of their years.

*Carl Marais, a South African trained doctor, has been in NZ for 10 years working as a Rural Hospital MOSS (Medical Officer of Special Scale), mainly in central North Island at Thames and Tokoroa Hospitals. He enrolled in this paper for personal interest, but has since applied to the experiential pathway process for Rural Hospital Medicine.*

*Countryside around Te Kaiwaha Marae*

**Emily Gill**

Most of us attending the Te Kaiwaha Marae residential course had foreign accents.

I consoled myself that I'd been born here, thanks to parents who planned my birth during a sabbatical in Auckland. Subsequently, I lived in California with periodic sabbatical years in France and Japan. The kiwi connection was maintained through my GP uncle (Dr Paul Corwin) and his family. After graduating from Otago (2003), I received an excellent generalist foundation in Nelson Hospital. I fell in love with rural medicine, and first experienced a Maori community during my PGY3 rural GP attachment in Kawhia, Waikato. However, before committing to rural NZ, I worked for MSF (Medicins Sans Frontiers) in West Africa where medicine was both rural and multicultural. Last year, I completed GPEP1 in Canterbury (Akaroa, Kaikoura) and gained acceptance into the Rural Hospital Medicine registrar training scheme.

*A time for reflection*

As a dual GPEP-RHM trainee, I was exempt from the communication paper requirement of the RHM program, but I was allowed to attend the Marae-based residential component. Both GPEP1 and the RHM registrar programme focus on Maori health in the context of communication, though the content goes beyond consultation-skills. GPEP1 provides great classroom education about the context of Maori Health and I'd been privileged to spend time on the Maketu Marae in Kawhia but I had never experienced the process of living on a Marae. The course was an opportunity to integrate a visceral understanding of Maori health into my training. As Dr Nicholls articulated in the March edition of *GP Pulse*, reducing gaps in health inequities requires cross-cultural understanding, which will likely improve rates of smoking cessation, weight loss and therapeutic interventions to name a few inequities.

**The Marae is a safe place for debate and discussion especially in regard to death and dying, and the reality of living with the dead every day (wairua). It's just the way we are as Maori**

The Hokianga is a stunning setting to experience a rural Maori community. We strolled to the beach from the Marae and explored the nearby Kauri forest. The people of the Marae reiterated that we were to make ourselves at home, though contending with communal sleeping, eating and shared bathrooms was not part of most of our home experience. Our days were filled with korero from both our hosts and invited guests. Topics included the Treaty of Waitangi, palliative care, self care, breaking bad news, etc. What struck

me most were discussions of spirituality and its relation to health, a topic largely absent from secular medical training. We were a captive audience with no escape from conversations that went beyond the boundaries of traditional medical dialogue. Indeed, one evening we all shared a personal korero about our own lives. Inevitably, conversations became personal. What better way to remind us that our profession is about caring for others going through deeply personal experiences.

The Maori traditions value kineasthetic and face-to-face relationships. Through the process of Marae protocol and the reality of communal living, the RHM residential course provides protected time for a blend of academic discussion and potential personal transformation. A natural part of such open discussion was occasional disagreement. However, we all agreed the food was excellent!

*Emily Gill is a Rural Hospital Medicine Registrar, doing a Dual Fellowship with General Practice. She is currently based in Rotorua completing a hospital based run in internal medicine.*

*Te Kaiwaha Marae*

## RESUSCITATION:

# From the Coroner

**Cathy Webber**

*RNZCGP Principal Advisor Medico-Legal*

The Coroner has recently brought to our attention the issues involved in the death of a 10-year-old boy, presenting to a GP working alone at a general practice during after-hours. The parents phoned ahead and brought the boy in with a recent history of fitting. The GP attempted oropharyngeal intubation (which became occluded by vomit), and the insertion of an endotracheal tube, with no success. He called for ambulance assistance which arrived, followed soon after by a paramedic. The boy was subsequently found to have a cardiac condition—long QT syndrome.

The Coroner recognised that the GP dealt competently with an unexpected medical emergency of an unconscious vomiting child with a compromised airway, seeking appropriate emergency assistance. And that 'although aspects of the resuscitation were not ideal', the GP met the minimum standards of resuscitation expected in accordance with appropriate professional standards.

With such a tragic outcome it is useful to reflect on the issues raised, particularly in relation to resuscitation skills required of a Fellow of the RNZCGP. GP resuscitation skills at level 5 do not deal with IV line access or intubation, as were required in this case. We do not address the clinical issues of long QT syndrome in this article.

The expert cardiologist/electrophysiologist for the Coroner advised it is 'essential that all health care practices, particularly rural ones, should have [automatic] external defibrillators (AED).' He also noted that:

- awareness of, and vigilance for, symptoms of inherited cardiac conditions by GPs is important.
- AEDs are as effective in children as in adults and there should be no hesitation to use them in sudden, unheralded, pulseless collapse.
- early defibrillation from direct current cardioversion provides the best chance for improving survival in these cases.
- cardiac arrhythmias cause a significant proportion (approximately 15%) of cardiac arrests in otherwise fit, healthy young people.[1]

**Endotracheal intubation is a skill that requires frequent practice and there are arguments that in the wrong hands it can cause more damage than good**

The New Zealand Resuscitation Council (NZRC) has guidelines for paediatric and adult cardiac arrest.[2] There will be new guidelines announced at the end of this year, once the worldwide recommendations from the International Liaison Council for Resuscitation (ILOR) have been made public. Following their publication we will revisit this issue.

Endotracheal intubation is a skill that requires frequent practice and there are arguments that in the wrong hands it can cause more damage than good.[3,4,5,6,7] Like endotracheal intubation IV access also needs regular practice and is less likely to occur in the urban setting. Neither the Level 5 nor Level 7 NZRC courses provide specific practice in IV access.

The advent of AEDs has revolutionised defibrillation. They are designed for lay people to use so can be potentially used by anyone in general practice. While cardiac arrests are not common events in general practice, the public has an expectation that general practitioners would have the ability to manage a cardiac arrest. Over 60% of adult cardiac arrests are due to a shockable rhythm. Immediate defibrillation gives the best chance of survival.[8,9,10]

### RNZCGP standards

The College's training programme (General Practice Education Programme—GPEP) requires registrars to train to Level 7. However, the Maintenance of Professional Standards Programme (MOPS) for the 2011–2013 triennium requires Fellows to train to a minimum of Level 5. This is consistent with PRIME that requires training to level 5.

The MOPS programme encourages GPs to train to an appropriate level for the area they live in and provides more credits for the attainment of level 7.

The College standard for general practice, *Aiming for Excellence* (2009), requires practices to have a significant event management system to address serious or potentially serious practice problems (Indicator E.12.3). The College has developed a resource to help practices meet this indicator: *Significant Event Management*.

*Aiming for Excellence* (2009) also requires rural practices to have a manual defibrillator and/or AED (Indicator B.5.1).

*Aiming for Excellence* is currently being reviewed and is considering including the need for a regular resuscitation drill for practices, as well as ensuring all resuscitation gear is in working order and in one location (and transportable where applicable).

**Learnings**

The College is currently scoping a Primary Care Incident Management System to support learning and improvement through information sharing about incidents that happen in primary care. Events like this would be developed into Case Studies and fed back to general practice teams to support national learning from incidents. Outcomes data will feed into the NZ Incident Management System which is also currently under development.

The improvements that the Primary Care Incident Management System can provide you and your team lies in the future.

What can general practice do now to help improve outcomes for patients?

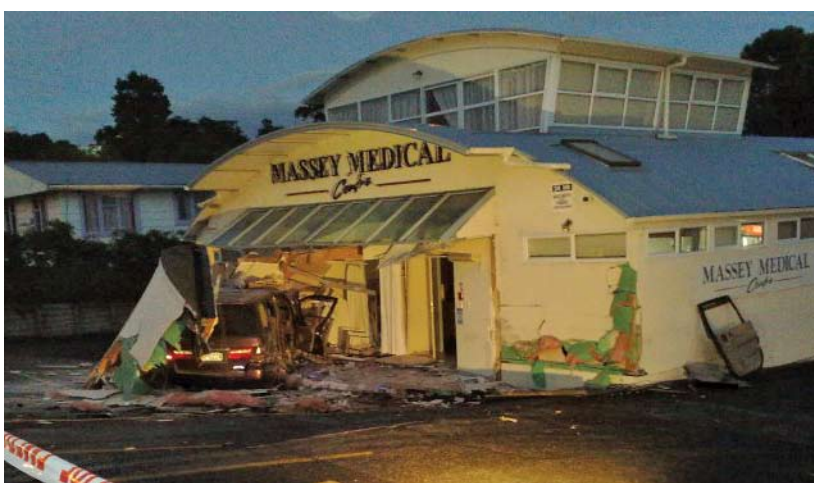
Intubation would not have saved this child's life, only successful defibrillation would have (and with the complication of the ongoing vomiting and hypoxia, successful defibrillation may not have saved his life). Being proficient at Level 7 NZRC may not have saved this child's life either, as it would be no guarantee of being able to intubate this child or others. As mentioned, it is difficult to remain competent unless you have the opportunity to practice these skills on a regular basis. The emphasis should be on developing excellent basic CPR skills for the general practice team until help is available, including rapid use of an AED.

You may wish to consider the need for a regular six monthly resuscitation drill for your practice, ensure all your resuscitation gear is in working order and in one location and, if you live in a rural area, consider whether you need to train to Level 7.

*References*


1. www.mja.com.au/public/issues/180_03_020204/doo10601_fm.html
2. NZRC: Management Plan for Childhood Collapse Level 4–7. 2006
3. Jabre P, Leroux B, Brohon S, Penet C, Lockey D, Adnet F, et al. A comparison of plastic single-use with metallic reusable laryngoscope blades for out-of-hospital tracheal intubation. Annals of Emergency Medicine. 2007 Sep;50(3):258–63.
4. Timmermann A, Russo SG, Eich C, Roessler M, Braun U, Rosenblatt WH, et al. The out-of-hospital esophageal and endobronchial intubations performed by emergency physicians. Anesthesia & Analgesia. 2007 Mar;104(3):619–23.
5. Wang HE, Abo BN, Lave JR, Yealy DM. How would minimum experience standards affect the distribution of out-of-hospital endotracheal intubations? Annals of Emergency Medicine. 2007 Sep;50(3):246–52.
6. Wang HE, Balasubramani GK, Cook LJ, Lave JR, Yealy DM. Out-of-hospital endotracheal intubation experience and patient outcomes. Annals of Emergency Medicine. 2010 Jun;55(6):527–37.e6.
7. Wang HE, Yealy DM. Out-of-hospital endotracheal intubation: where are we? Annals of Emergency Medicine. 2006 Jun;47(6):532–41.
8. Bury G, Headon M, Dixon M, Egan M. Cardiac arrest in Irish general practice: an observational study from 426 general practices. Resuscitation. 2009 Nov;80(11):1244–7.
9. Colquhoun MC. Defibrillation by general practitioners. Resuscitation. 2002 Feb;52(2):143–8.
10. Hudson L, Jacobs I. Defibrillators—their use in general practice. Aust Fam Physician. 2008 Jan–Feb;37(1–2):63–64


# Massey Medical Centre




*Massey Medical Centre, now offering a drive through service*

Early on the morning of April 23 the Massey Medical Centre Practice Manager was awoken and asked to attend the scene of a major accident at work. All thoughts that this was a hoax vanished when she arrived at the scene to see the flashing lights of fire engines and police cars.

A suspicious driver, followed by police, drove through a roundabout, across the middle of a car park and straight into the front of the medical centre. Two doctor's rooms were damaged and two nurse treatment rooms suffered severe damage. But with staff pitching in to clear up the rumble and return order to the centre, they were only closed for one day.

# 'Learnings not lynchings'

Cathy Webber
*RNZCGP Principal Advisor Medico-Legal*

Patient complaints, or notification of investigations, can be incredibly stressful. The Clinical Practice Group in the College monitors some medico-legal 'investigations,' (the Coroner, Health and Disability Commissioner (HDC), and Health Practitioners Disciplinary Tribunal), to ensure that the best interests of GPs and general practice are met. Occasionally we receive information from health insurance companies, ACC, Office of the Privacy Commissioner.

The College disseminates these learning's through College processes, including the General Practice Education Programme (GPEP), *Aiming for Excellence*, the CORNERSTONE Practice Accreditation Programme, and of course, *GP Pulse*.

Three major learning's in the past year are:

### Lesson one: Ensure your practice systems support continuity of care

The Palm's Clinic case emphasised the importance of systems supporting continuity of care, where multiple doctors provided episodic care but no single doctor took overall responsibility. The clinic worked as an accident and medical centre and general practice. It led to a number of practice system failures that had a very poor outcome for the patient.[1]

Continuity of care covers the importance of: keeping medical notes of sufficient quality that clinicians providing subsequent care have a clear understanding of the assessment and care plan; ensuring clinicians on subsequent visits refer to the previous notes (in this case the patient saw more than one GP); ensuring there are robust practice systems for incoming reports, results and patient follow up. The practice must ensure that all clinicians check their inboxes regularly, with timely filing and follow up of results, and that they delegate this responsibility to another practitioner if they are not able to perform the task (e.g. annual leave, days off, term of employment ending).

It is likely that the challenges to maintaining continuity of patient care on the provision of general practice will remain an issue for health professionals with the evolution of integrated family health centres, and Ron Paterson agrees:

> *I hope there will remain a central place for the individual doctor-patient relationship in the shiny new integrated family health centres. Fragmented care looms large in complaints about medical care, and I am convinced patients are best served by experiencing continuity of care from a regular GP who knows them well and coordinates their care.*[2]

### Lesson two: Ensure you know the limits of your professional boundaries

The GP circumcising a four-year-old boy under a local anaesthetic case emphasised the need to know and work within the limits of your professional boundaries.[3] The boy was distressed throughout the procedure, the GP was unable to stem the frenular artery bleeding so the boy was transferred by ambulance to hospital where he underwent a revision of the circumcision under general anaesthetic.

The College has begun discussions with the MCNZ on the issue of GPs performing office based procedures in general practice. We are keen for this issue to be practitioner led. But to be professionally led, GPs performing procedures need to ensure that they have adequate and appropriate training, experience, continuing professional development in the area, and maintain appropriate and adequate collegial relationships.

This expectation is contained within the RNZCGP training programme curriculum, which is organised into five domains of practice, including domain three 'professionalism'. This domain expects Fellows to be committed to the acquisition and maintenance of the range of professional competencies required of general practitioners. This includes recognising your own limitations, using a range of strategies to evaluate, maintain and advance own professional competence within the scope of general practice. Recognising when you should be in a collegial relationship is part of this.

### Lesson three: Incorporate these learnings into practice systems

It is important that you ensure these lessons are not just noted, but are incorporated into your practice systems. The College has a resource for practices that assists with this process: *Significant Event Management*.[4] Further assistance may be gleaned from the *NZMJ* articles on learning from medical incidents and complaints.[5,6]

By the time this is published Ron Paterson, the previous HDC (who coined the title for this article), will have moved on to the University of Auckland's Law Faculty as Professor of Health Law and Policy and may well have started writing his book on *The Good Doctor*. Despite what conclusions Ron may draw on how best to balance professionalism and regulation to ensure doctors are fit to practice in his book *The Good Doctor*, I agree with his motto 'Learning's not lynchings'.

*References*

1. HDC Opinion 08HDC06359, accessible at www.hdc.org.nz.
2. Window into the world of care gone awry. Ron Paterson. NZ Doctor. 24 March 2010.
3. HDC Opinion 08HDC00810, accessible at www.hdc.org.nz.
4. RNZCGP. Significant Event Management: A general practice guide. 2009.
5. Temelkovski S, Callaghan K. Opportunities to learn from medical incidents: a review of published reports from the HDC. NZMJ 14 May 2010;123(1314).
6. Paterson, R. Lessons from complaints: implications for medical education. NZMJ. 14 May 2010;123(1314).

# Older people driving safe

**Mark Pugin**
*New Zealand Transport Agencgy*

**Grey Power has asked the College to remind GPs about who they can refer their patients who require an assessment on fitness to drive to. Mark Pugin, team leader of the medical team at the New Zealand Transport Agency (NZTA), provided *GP Pulse* with this overview.**

Patients (from age 75, 80, 82, 84, 86, onwards) that want to renew their driver licence must supply an NZTA medical form (DL9) from their GP to the NZTA confirming that they are medically fit to drive.

Prior to December 2006, those aged 80 and older were required to pass a mandatory older driver practical test before their licence would be renewed. After December 2006, the practical driving test was optional; the GP had the discretion to recommend this as part of their assessment on fitness to drive.

There are around 2,500 older drivers renewing their licence each month. Each of these requires a DL9, and the doctor can refer for an On Road Safety Test (ORST), an Occupational Therapy Driving Assessment (OTDA), or any other assessment they deem necessary to establish fitness to drive (e.g. ophthalmologist, cardiologist, gerontologist).

There are two main options available to you as a GP:

1. For a driver aged 75 and older, that you consider is medically fit to drive (e.g. not at undue risk of loss of consciousness, and/or not significant cognitive issues), an ORST is available. An ORST can be used for a number of scenarios including: early cognitive decline, arthritic limitations, returning to driving after a fracture repair, concerns raised by family members regarding practical driving skills, etc. If you complete option '2 B' of the summary section on the back of the DL9, it will ensure that your patient is required to sit and pass an ORST before a licence will be issued. Your patient will need to take the DL9 to their local Driver Licensing Agent (e.g. Automobile Association, VTNZ, VINZ) to book a test. The test costs $41.00. If the licence holder fails the first test a repeat test is free.
2. For a driver of any age, where the medical condition may have an impact on their ability to safely control a motor vehicle, an OTDA should be used despite the extra cost. An OTDA is appropriate in cases of moderate to severe dementia or cognitive issues, post CVA (if it is suspected that there may still be significant deficits), post moderate to severe traumatic brain injury, etc., or where vehicle modifications may be needed to enable the person to drive safely. The assessment includes an initial off road assessment, testing things such as reaction times, hand eye co-ordination, memory, and planning skills. The occupational therapist will become aware of any significant impairment that may affect the driver's ability to safely control a motor vehicle before they proceed to an on road practical test. The average cost of this test is $450.00.

**After December 2006, the practical driving test was optional; the GP had the discretion to recommend this as part of their assessment on fitness to drive**

*I am happy to help you if you (or your patients) require any further assistance. The team is available on 0800 822 422 ext 8089 or dial me directly, 06 953 7024.*

## KIWI DOCTORS ABROAD:

# Papua New Guinea

We read a lot about young doctors leaving the country at the end of their training. We read less about the many wonderful young doctors leaving to provide great service in developing countries.

One such couple were Peter and Lin Calvert of Kapuna Hospital, Papua New Guinea (PNG). The Calverts left New Zealand in 1953, both completing a Diploma in Tropical Medicine in Sydney before going to a new mission hospital at Kapuna in 1954. More than half a century later, the family are still there serving the local community. Peter died in 1982, and Lin and her son Colin continued the work. Dr Valerie Archer FRNZCGP, who writes below, now works alongside her semi-retired mother Lin.

**Valerie Archer**

*General Practitioner, Kapuna Hospital, Papua New Guinea*

'Is there anywhere else in the world that I would rather be at this moment? Is there anything I would rather be doing right now at this moment?' I asked myself this question today as I took a few moments to gaze out from the house veranda over the muddy flooded garden, past the reeds in the muddy swamp to the muddy river beyond. Mud is a fact of life here in the vast delta of the Gulf of PNG where all the land for 100km lies at about one centimetre below sea level.

After 15 years as a Tauranga GP, I now work in a small mission hospital in the swamps of PNG. Kapuna hospital is run by an interdenominational agency called Gulf Christian Services. GCS manages two small hospitals (about 30 beds each—which is arbitrary as mostly there are no beds and people sleep on the floor) and a Community health worker (CHW) training school.

*Valerie starting her rounds at Kapuna Hospital*

The work is varied and never boring. The doctor can take on as much or as little as they want to do: You can open the abscess yourself, or you can teach a CHW to do it. You can suture the axe wound, or leave it for the staff to suture. You can attend every delivery or you can leave most of them for the midwife. You can learn to do tubal ligations and vasectomies, or you can refer them to the provincial hospital (except that most patients won't end up going as it is too far away). You can volunteer to take lectures for the training school or you can fix the electrical wiring in the operating theatre. You can go on patrol south to the coast or north to the mountains and see 40 sick people in a day who have never seen a doctor before, or you can stay home and write emails.

What is a Kiwi GP doing in the swamps of PNG anyway? Or put as a more direct question: What use could a GP volunteer possibly be in PNG, or for that matter any third world country? Surely to be of any use to the poor and needy you need to have some 'qualifications'. Perhaps be an ophthalmologist, or a fistula repair gynaecologist or a leprosy surgeon, or at the very least have ED training?

If you actually analyse the situation and what is expected of a doctor in any rural area, you will find that the average GP already has most of the skills required to be useful in a third world country and those he or she doesn't have can mostly be acquired 'on the job.'

Actually, in my opinion, it is willingness to learn on the job, which is probably the most important prerequisite to any overseas voluntary type work. Overseas assignments are always going to be different to what we are used to, so it is the ability to adapt and use some of our Kiwi ingenuity that makes the crucial difference. Other important factors are individual personal traits such as stickability, sense of humour, cultural adaptability (especially food) and a bit of Island time.

I have made a short list of the practical medical skills that I consider important for the swamp doctor. This needs only minor modification for bush mountain doctor, atoll lagoon doctor or wallaby grasslands doctor—all of which have positions vacant in PNG!

1. In a small hospital you need negotiating skills and a thick skin to deal with government bureaucracy. GPs have a fair idea how bureaucracy works, just multiply that by 10. Joy is when someone picks up the phone at the other end.
2. Knowledge of public health is a must. Most GPs have some idea of the importance of immunisations, family planning and preventive care—so this is a good start.

3. Administration. GPs all know the essentials of this and are already well suited to making the books balance when the outgoings are exceeding the incomings.
4. Teaching skills. In this third world country 90% of the health care is run by nurses. Some of them are expected to have the knowledge and the skills of a doctor when there is no doctor. So we take every opportunity to teach.
5. Surgical skills. most GPs have the essentials of these. If you can read English, have a few tools and have access to text books such as Emergency Surgery, you will eventually learn all you need to know. Remember that due to remoteness, most emergencies will die before they get to you.
6. Learn to pray: this is essential for getting yourself out of sticky situations.
7. Obstetrics. Most of us are pretty rusty here. My advice is if you are going to work in a remote place anywhere, stop off at a major hospital in any third world country and volunteer to work in the labour ward for a few weeks. Guarantee you will learn more obstetrics in three weeks than you would have learned in 10 years in NZ.
8. General medicine. All you need to remember is that whatever the symptoms, the diagnosis is always TUBERCULOSIS, unless proven otherwise. Easy. (Having said that people are people everywhere and they have the same concerns about their chronic arthritis, their fertility and their children crying.)
9. Tropical diseases. The nurses will tell you who have malaria, typhoid or amoeba and what to do for snake bite. Just don't be too proud to ask!
10. People skills. We know every GP has these or they wouldn't have patients! In PNG there is no medical protection society (in fact there is very little legal justice in any shape or form). People skills means that you handle your own complaints.

In PNG there is the ingrained belief that every illness is caused by sorcery or witchcraft. For the doctor this can be a good or bad thing. It is good in that rarely, except in a case of blatant negligence, will the doctor be blamed for any death or even for gross medical misadventure. But it is also very bad because as soon as one patient dies, you will have another patient, usually in the form of bush knife wounds or burns, who was the unfortunate person accused of the witchcraft that killed your first patient.

So in PNG, as I would imagine would be the case in a lot of poor countries, the doctor enjoys a place in society that is usually only occupied by God. What GP wouldn't enjoy the change of status? That is until a patient with a stab wound right through his abdomen is carried in on a bush stretcher and everyone looks to you because you are God? So it pays to remind everyone and yourself that you are not God.

Back to my original question, 'Is there anywhere else I would rather be, or anything I would rather be doing?' The answer is of course, I would much rather be lying on the beach enjoying a good book and eating ice cream. But if at age 70, I am going to have any regrets about the number of ice creams I ate, then I think that it is just as well to review these choices from time to time.

*Paediatrics admissions at Kapuna Hospital*

The answer to my question is 'No'. I am very happy here. If anyone would like to ever try their hands at 'Swamp Medicine', I am still a GP and still looking for locums.

Read more about the Calverts and Kapuna Hospital at www.kapuna.org.

*An aerial view of Kapuna beside it's only means of access, the Wame River*

# From chartered engineer to general practitioner

**Tim Wilson**

*General Practitioner, Dunedin*

People often ask 'How did a British engineer come to be a Kiwi general practitioner? Aren't these completely different jobs?' Well, yes, and no!

I originally trained as a computer scientist, and then worked as a software engineer for a variety of companies—from multinationals such as IBM, down to small firms the size of a rural general practice. I worked at the technical end of software engineering, with a side-line in quality management. In car terms, I might have been an expert on piston rings: undoubtedly vital, but not something you'd want to talk about at a party.

For several years I had been looking for ways to add interest to my job, and came up with the idea of an OE in New Zealand. My sister (a surgeon) had enjoyed her year here, and perhaps I was subliminally influenced by John Wyndham's *The Chrysalids*, a favourite childhood novel, in which 'Sealand' (a thinly disguised New Zealand) is home to an advanced and welcoming society.

While making arrangements and obtaining a visa, I finally found a fascinating IT job as technical director of a start-up company in Moldova (in the former USSR). I was very close to tearing up my ticket to Auckland, but the doggedness that was later useful in slogging through med school kept me to my original plan.

I was soon installed in a routine software engineering job in Auckland, working for a business I soon realised was doomed to bankruptcy. Having already loosened the social and geographical

*Tim and family*

anchors, I started to think that it was now time to change occupation too. I was attracted to medicine because:

- medicine offered interpersonal and social dimensions, in addition to intellectual and technical domains.
- I enjoyed the company of my sister's medical friends, whom I found an attractively vivacious bunch.
- I noticed that experience was a prized quality in medical practitioners, so senior staff were valued, not ripe for redundancy. This was important to me because my father had lost his job in his 40s, and never found another permanent professional job.

So I enrolled for med school! I was attracted to general practice from the start, not only by the challenging breadth of the specialty, but also by the opportunity to get to know patients and colleagues better than in large busy hospitals. I knew from my experience in computer companies that I preferred small organisations where individuals could make a difference without being hamstrung by bureaucracy. While at med school I met my wife, and our son Samuel was born in the TI year.

Although software engineering and medicine at first seem very differ-

ent, here are some ways I have found them similar:

- 'The joy of always learning, which springs from the non-repeating nature of the task. In one way or another, the problem is ever new, and its solver learns something: sometimes practical, sometimes theoretical, and sometimes both.'[1] Originally written about software engineering, this description applies equally to medicine.
- Most of the time, the job consists of investigating problems arising in a complex system (the patient or the computer). Sometimes these problems are found to arise from a focal pathology (MI, programming error), sometimes as an emergent behaviour with multiple causative factors (T2DM, erratic seize-ups) and sometimes due to the interaction of the system with the environment (poisoning, lost emails).
- There is a strong emphasis on achieving quality from the common unpromising starting point of fallible humans interacting with complex and partially understood systems. Simply being careful isn't enough to produce good results reliably.

**I noticed that experience was a prized quality in medical practitioners, so senior staff were valued, not ripe for redundancy. This was important to me because my father had lost his job in his 40s, and never found another permanent professional job**

I am currently focusing on my GP training (and the addition to our family due in September), but look forward to being able to use my IT background to help GPs obtain better outcomes for our patients.

If you would like to contact me, please email tim@wilsontribe.net.

*Reference*

1. Brookes F P. The Mythical Man-Month. Addison-Wesley 1995; 2nd Edition

# From the mean streets of Glasgow to the Kapiti Coast

**Kirsty Lennon**
*General Practitioner, Kapiti Coast*

Why did I give up a forward-thinking, developing, driven partnership on the West Coast of Scotland to start again in New Zealand? For a change of pace and a chance to enrich and further develop my general practice career, but it was the opportunity to redress my work/life balance, to give my kids more freedom and more of a childhood that clinched it.

When I graduated from Glasgow University I knew I wanted a career in general practice. I trained in a highly deprived area of Glasgow, with significant social, drug and general health problems. After years of locum experience I secured a partnership in Dumbarton, a commuter belt town that had thrived in the ship building era but now had socio-ecomonic problems and the health issues that go along with it. Although I am proud of the practice we developed over the next six years and my work with the local health board including the development of a primary mental health care service and a COPD service for house bound patients, this all seemed to come at a cost to my family life.

Dr Ruth Brown and Dr Robyn Crow have welcomed me into their practice, the Kapiti Coast and New Zealand. The patients have been both welcoming and understanding. It is a privilege to be part of patients lives and allowed into their thoughts and feelings. I will bring the skills I have developed previously to improve health and access to health on the Kapiti Coast but also to explore, engage in health care in New Zealand and take in all the country has to offer.

*Kirsty Lennon near Kapiti Island*

# Peter John Van Dyk

## 16 NOVEMBER 1961–1 AUGUST 2010

**Bob Fearon**

*General Practitioner, Wellington*

Dr Peter John van Dyk MRNZCGP was born in Methven on 16 November 1961, the only boy in Ari and Joan van Dyk's family of four children. He grew up in Ashburton, attending Allerton Primary School and Ashburton College. He entered Otago Medical School in 1980 having gained preferential entry, exempt biology and chemistry. In his first year he studied anthropology, psychology, physics, mathematics and statistics. He graduated M.B.Ch.B. in December 1985 and commenced his first houseman year with a three month attachment in geriatrics at Wakari Hospital, followed by three month attachments in general surgery, cardiology and cardiothoracic surgery. In November 1986 he moved

to Wellington to work in accident and emergency and orthopaedics at Hutt Hospital, and general medicine at Kenepuru and Wellington Hospitals.

He met Stephanie in Christchurch in 1983, and they married in 1986. In 1988 they spent time travelling through Europe, and Peter spent several months working in London's Harold Wood Hospital's Accident and Emergency Department. Upon returning to New Zealand, he attained Diploma of Child Health and Diploma of Obstetrics. He then entered the College of GPs general practice registrar programme and spent one of his attachments at Newtown Medical Centre in Wellington. He eventually joined the practice and became a partner.

Peter had an ongoing interest in sport having played first-fifteen rugby at school, and was involved in umpiring and coaching his sons, Henry and George, in cricket and soccer. He was always interested in the Black Caps performance with regular updates through the working day. He held season tickets at the Westpac Stadium and would attend matches in all weathers. The most memorable game Peter attended was one that was difficult to remember—the Super 14 final between the Hurricanes and the Crusaders in the thick mist in Christchurch. Although the game was a disappointment, the flights there and back were memorable for the yellow and black food Peter provided, as despite the fact he was raised in Canterbury he was a staunch Hurricanes supporter.

His other passions were cooking, gardening, fishing and diving. These were self-complementary as Peter believed the best cooking required starting from scratch with the ingredients: and what better way than having vegetables from your own garden, catching fish or diving for shellfish yourself. Anyone who was fortunate enough to partake of one of Peter's culinary presentations never regretted accepting the invitation.

He collapsed and died when playing tennis with colleagues on 1 August 2010. The large attendance at Peter's funeral reflects the huge respect with which he was held in the community. He was a knowledgeable colleague and a caring doctor who will be remembered especially for his expertise and special empathy he had with the children he cared for. He will be sadly missed by all at Newtown Medical Centre—colleagues, staff and patients alike—for his enthusiasm, humour and compassion. Peter is survived by his wife Stephanie and three children Grace, Henry and George.

**The large attendance at Peter's funeral reflects the huge respect with which he was held in the community. He was a knowledgeable colleague and a caring doctor who will be remembered especially for his expertise and special empathy he had with the children he cared for. He will be sadly missed by all at Newtown Medical Centre—colleagues, staff and patients alike—for his enthusiasm, humour and compassion**

***GP Pulse* obituaries can be submitted to the Editor via the College address, RNZCGP, PO Box 10440, Wellington 6143, or to email communications@rnzcgp.org.nz. Photos are encouraged.**

# Henry Justin Bradshaw

## 7 APRIL 1964–28 MAY 2010

**Was a beloved partner, father, son, brother, friend and colleague.**

Akke de Grip

*General Practitioner, Tauranga*

Harry trained in the United Kingdom and visited New Zealand during his training, working in New Plymouth for a year in 1991. He then became a GP in the United Kingdom, only to return to New Zealand in 1997, one year after the birth of his son. He practised in Coromandel, then in Thames hospital, before moving to Tauranga where he worked in Bethlehem Medical Centre and finally at Accident and Healthcare, Tauranga.

He was a well respected and loved colleague, known for his gentleness and ability to deal with patients with challenging behaviour. He had a keen interest in his spiritual growth, meditation, and lived by his intuition; he was a powerful, yet gentle, example whom people turned to. He loved his creative endeavours including painting, sculpting, photography and woodwork. Of late he developed an interest in electronics and made a pair of astonishing speakers inside and out.

Harry died much too young and taken completely by surprise by a cholangiocarcinoma.

He fought the cancer valiantly with anything we could come up with. He maintained his spirit to the very end, putting his wish to learn and continue to grow from the experience above his physical comfort. What certainly grew was the love in and around him, exponentially, during those last months, as his body gradually faded away.

He was surrounded by family and close friends who all gathered to be with him during this time.

His love lives on within of us and in how he changed us, and continues to guide us. Still, we miss him.

**He was a well respected and loved colleague, known for his gentleness and ability to deal with patients with challenging behaviour. He had a keen interest in his spiritual growth, meditation, and lived by his intuition; he was a powerful yet gentle example whom people turned to**

# Laurence Allan Malcolm

## 8 NOVEMBER 1929–23 JUNE 2010

**George Salmond**

*General Practitioner, Wellington*

Many in the general practice community would have been saddened by the death of the public health and general practice researcher and health activist Professor Emeritus Laurence Allan Malcolm, an affiliate member of the College.

Malcolm grew up in Nelson. After achieving well academically at Nelson College he went to Otago University to study medicine. His early postgraduate years were spent in Blenheim and Christchurch hospitals.

Seventeen years as a general clinician, a health care planner, and a local health care organiser in the rural highlands of New Guinea equipped Malcolm with the knowledge, skills and experience that fuelled his ambition to engage in the planning and delivery of community based health care when he returned to New Zealand in 1974.

At that time formally structured health planning was just getting started in New Zealand. There was only limited appreciation of the contribution that could be made by the disciplined gathering of data, by analysis, and by the sharing and use of information in the allocation and use of health resources.

At the time the then Department of Health had a small operations research, later a management services and research, unit based in its Wellington head office. The unit was small with limited capability and capacity. Malcolm's recruitment to the unit added substantially to the range and quality of it's work. For personal reasons he wished to work in Christchurch where, with a small team of researchers and analysts, he set up a subsidiary health policy and planning unit.

From the outset Malcolm's ideas and concepts about community-based health care and the integration of community and hospital based services challenged conservative ways of thinking and established interests. This was some years before the World Health Organisation launched its global primary health care strategy at Alma Ata in 1978, and 25 years before a similar strategy was enacted in New Zealand.

Malcolm was an early champion of seeking ways to move the focus of health care delivery from hospital to community based settings, of strengthening general practice and of extending the range and scope of general practice based service delivery. He advocated service planning as a way of improving the integration of service delivery across different parts of the health sector.

Using research methods and evidence he demonstrated unfairness, injustice and inequalities in the way health resources were allocated and used to meet health needs within and between ethnically and geographically diverse populations in New Zealand.

He recognised that in a country like New Zealand with a slowly growing economy, an aging population, rising health care costs and increasing health and health care expectations, it would not be possible to sustain existing patterns of health care delivery. In future such care would simply not be affordable. This prompted his active interest in, and support, for service and workforce innovation and development, particularly in general practice and other primary health care settings.

From modest beginnings in Christchurch Malcolm broadened and deepened his information gathering and research activities as Professor of Public Health at the Wellington School of Medicine and later in private consultancy practice based in Christchurch.

Malcolm's thinking was always ahead of its time, not only in New Guinea but also in New Zealand. Lack of research resources and information limitations sometimes made it difficult for him to convincingly justify the ideas and concepts he sought to promote. Often challenging, and sometimes controversial, he was frequently a burr under the saddle of the health sector establishment. He was not only an academic researcher and a planner but also an activist who widely promoted his work and that of his colleagues. If he felt that he was on sound ground Malcolm was a difficult man to budge, regardless of the opposition ranged against him.

Malcolm pushed the margins. He was an explorer, a navigator and an innovator and as such he was not always right. He was a man of spirit and courage in the pursuit of those causes he had evidence for and in which he fervently believed. He will be sorely missed not only by his wife Lyn and family but also by research colleagues and friends in public health and general practice.

# Wonca in Cancun

**Tony Townsend**

*RNZCGP Deputy President*

Sounds like a title to an Edward Lear poem? At times, being there was like being in an Edward Lear poem. In the early 1970s Cancun Island was a 22.5 km sandspit and a small fishing village. The hotel zone was established in 1971 and this sandspit now boasts 140 hotels that accommodate about 4 million visitors a year who come for tourism, or partying, or both. The Wonca Conference was held in the Cancun Convention Centre in the Plaza Caracol. It comes to life at night with (mostly) young visitors enjoying their clubbing at *Hooters*, *G Spot* or *Too Mucking Fuch* or drinking at bars such as *Marguerita & Marijuana*.

The conference was held in the multi-level, many roomed Convention Centre with concurrent sessions indicated by electronic notice-boards. There was no enquiry desk for those like me, who wanted to ask questions. On the other hand there were no pharmaceutical trade stands or marketing displays. It can be done. Wonca Cancun 2010 nearly didn't happen. After the Mexicans won the vote H1N1 emerged, the global recession hit, Cancun was partly wiped out by a hurricane and then the eruption in Iceland resulted in many European delegates cancelling their travel.

So why go? My answer to that is to reflect on what there is to gain from attending an international conference of family doctors in an exotic location.

*Tony (centre) immersed in a sinkhole*

Sharing stories of family doctoring with people from all over the world is an exciting experience. We all learn from each other. In between presentations I talked to doctors from Denmark, Norway, Sweden, the UK, the US, the Middle East and, of course our Asia-Pacific neighbours.

I attended several of the keynote sessions including Jan De Maeseneer's presentation on the future of primary care. He presented his four part, interlocking jigsaw: Universal coverage—health equity, People-centred service delivery, Public policy reforms integrating personal and public health care and Leadership reforms ensuring contributions from family medicine. This all fits quite comfortably with what we are trying to achieve in New Zealand. Barbara Starfield once again presented the research basis for a primary care led health service.

However, highlights for me were sessions that I knew little about until I stumbled upon them. There was an interesting series of presentations and a workshop on MUS (medically unexplained symptoms). A special interest group has been formed to pursue this area of primary care but, as I discussed with my Danish neighbours, isn't MUS what general practice is really about? We are the experts at sorting out and managing medically unexplained symptoms. Why would we need to, as one presenter suggested, participate in a two year course on how to deal with these patients?

Then I was attracted to a session called The Wings of Life. This was a showing

of a beautiful documentary following the final years in the life of Spanish family doctor, Dr Carlos Cristos, as he lived with the effects of Multiple System Atrophy (MSA), a progressing, incapacitating and ultimately fatal neurodegenerative condition. The director of the documentary talked about making the film and the time that he shared with Carlos in the five years from age 47 until his death in 2008.

I, along with several of the 16 other NZ delegates, went to hear Ben Hudson (GP, Christchurch) talk about osteoporosis. The interesting issue for me was not about the management of osteoporosis, but how to explain risk to women or indeed to any patient in a way that is meaningful to them. Risk means something different for me than it does for you or for our patients. That is a challenge.

Another fascinating presentation was about using Dr Google. An excellent presentation about how best to use the Internet as a learning resource for both our patients and ourselves. How to sort out the real pearls from the imitation ones. Have a look at www.hon.ch.

Wonca is not all about the learning, it is also about sharing. Workshops with the Asia-Pacific delegates were useful both for them (I believe) and for me. It is also about recognition. David Whittet was presented with a Wonca Foundation Award to help him with working with family doctors in Cambodia to improve family health care systems. Dr Karen Flegg, former CEO of the College, was announced as Editor, WONCA News.

*A Mayan pyramid at Chichen Itza*

**Sharing stories of family doctoring with people from all over the world is an exciting experience. We all learn from each other. In between presentations I talked to doctors from Denmark, Norway, Sweden, the UK, the US, the Middle East and, of course our Asia-Pacific neighbours.**

It is also about experiencing the culture. Between the World Council meeting and the start of the conference we managed to get away for a day to immerse ourselves in the Mayan culture. Chichen Itza is is a large pre-Columbian archaelogical site built by the Maya civilisation located a few hours drive from Cancun. With the help of an extremely knowledgable guide we had a great history lesson and, on the way back to Cancun, I managed to completely immerse myself in a natural sink hole.

I have, over several years, attended other Wonca conferences in London, Vancouver, New Orleans, Hong Kong and a European regional conference on Kos Island in Greece. They have all been different and worth attending and I seriously suggest that you start saving for 2013 in Prague.

# Wine, sensory evaluation and general practice

**Ros Gellatly**

*General Practitioner, Blenheim*

This is the first in a short series on wine appreciation and general practice.

I'm starting with some basics, so some of you may want to skip to the Guild of Sommeliers formal approach in a later article. Thrown in on the way are some anecdotes of personal experiences as an amateur but enthusiastic sensory evaluator.

This is the 'Why French Women Don't Get Fat' approach to wine. When you stop to notice, identify, name and savour what's in your glass you find less is more. It also enhances your time on earth because you won't waste time drinking bad wine once you get the hang of this, and it's good for the New Zealand economy because you'll be doing comparative tastings—so you'll have at least two bottles to compare (not that you drink them all then.) I'm surprised that setting up an aroma wheel and doing some combined practice education hasn't yet been incorporated into MOPS or CORNERSTONE! Oh, and then there's the wine and food matching to enjoy.

First off let's talk about physiology—this is a medical magazine after all. Most of us have different thresholds for tasting the many components in wine and the overall feel in the mouth is influenced by such things as the pH of the wine, the alcohol level, and the processing methods. Did you know there are people with far more than the regulation number of taste buds, called super tasters, for whom tasting may even become unpleasant? (Sometimes you can have too much of a good thing.)

That aside we all have the capacity to taste. One of my best experiences, whilst I was a weekend cellar door person at Forrest's, was introducing a lower North Island darts club group to wine tasting. This mixed group was doing the Marlborough wine trail for fun, possibly more intent on being a little intoxicated than anything else. However Forrest's have a wine tray with notes and the cellar door staff take visitors through the tasting process:

- Look at the wine to begin assessing and anticipating what's coming: age, varietal, clarity and so on.

**Now tasting is just like general practice really; the medical model of diagnosis, the PDSA cycle in a glass**

- Sniff and think about what you smell: flowers and fruit, wood, earth and stones, chemistry in action-some of it good and some much less desirable.

- Then the swirl, sip and the sucking-air-through-your-teeth thing and finally spitting out. This last bit is invariably accompanied by much laughter and embarrassment, cries of 'I couldn't do that' (meaning: 'How could I make all that noise, my mother taught me good table manners!', and 'I'll get wine everywhere down my trousers', and 'Spitting is disgusting') also 'What a waste!' (meaning: 'I'm just here for the booze').

Anyway some of the group had a go and realised they could do it too. As they worked their way through the six wines on the tray with the notes that told them what they might smell and taste in the wine, I could see the lights go on. This wine tasting lark isn't just for 'clever people… who talk loudly in restaurants.' It's interesting! Tasting side-by-side made the differences between varieties apparent, and suddenly the wine world was opening up for them. Two weeks later they were ordering cases.

Now tasting is just like general practice really; the medical model of diagnosis, the PDSA cycle in a glass. Greet the 'patient', make them comfortable (with a well-shaped tasting glass), and invite them to tell their story.

History: what's on the label. That's why it's harder if you're doing a blind tasting; no information to give you 90% of the answer before you do the physical.

Examination: what you see in the glass, what you smell and taste. All influenced by your knowledge and past experience against which you compare this 'case' to the standard expected and to your working diagnosis. 'This is a dark garnet, perfectly clear wine that smells of violets, dark cherries and pencil shavings (remember those?), and has fine tannins, with a long delicious aftertaste.' Most likely diagnosis: New World pinot noir.

Now the label may have given you all that, but in some cases you'll have an unpleasant surprise, as the poor 'patient' has a nasty case of cork taint.

Finally, the Management Plan. Treat this wine by drinking it with slow roasted duck breast with a wild mushroom ragout, and any number of good friends.

*Forrest Wines vineyard*

*Everything we do is aimed at strengthening and supporting you in your practice.*

## Website

Exciting times, the College launched a new upgraded website in September 2010.

The new website has a **Member only login** which gives you access to your personal membership details allowing you to update these at any time. The member login also gives you access to all the member benefits and services.

The website development is an ongoing project that will further enhance the services we can offer you. Watch this space as new website developments unfold!

## RNZCGP College Events

**Discounted registration** to attend College events such as the Annual Scientific Conference, Quality Symposium and Education Convention.

## Clinical Resources

**Free** access for members only to all College resources (PDF format) through the member login area on the RNZCGP website or you can request a hard copy, contact publications@rnzcgp.org.nz. Some hard copy publications have a small fee attached.

The College is currently in the process of updating old resources. These will be made available on the website as they are completed.

## Meltwater News

**Free** access to Meltwater News for members only. Meltwater News is an online media intelligence service providing you with current articles, issues and new information from around the globe to inform and help you as a general practitioner. You can access this service by logging into the member's only area on the RNZCGP website.

## BMJ Learning

**Free** access to all 500 BMJ Learning modules, one of the world's most respected online learning services for GPs. Working in conjunction with the *British Medical Journal*, BMJ Learning offers a range of learning resources which deal with everyday issues in primary care, general practice and hospital medicine.

To gain access to BMJ Learning, you will need a keycode. To get this code, send us an email to bmj@rnzcgp.org.nz. The email should contain your name, your College membership number and/or your NZ Medical Council number. Once we have received your email, we will send you the access code and instructions of how to join the BMJ Learning service.

## McGraw-Hill Medical Books

**15% discount and free freight** (within New Zealand) for orders from McGraw-Hill Medical Books. You can access the McGraw-Hill Medical Books catalogue through the member login area on the RNZCGP website.

## *ePulse*

You will receive the College's weekly e-newsletter, sent every Tuesday evening. *ePulse* carries salient news items, information about consultations, education events, conferences and vacancies.

## Classified Job Advertisements

**Free** classified advertising to help you find locums and GPs, published in *ePulse* for two weeks and on the RNZCGP website until we are advised the position is filled.

Non-members pay $300.00 per advertisement.

## *Journal of Primary Health Care (JPHC)*

You will receive **free** hard copies of the College's peer-reviewed quarterly journal (March, June, September and December), designed to meet the information needs of New Zealand general practitioners, practice nurses and community pharmacists plus other primary health care practitioners and the patients and communities we serve. A PDF version can be viewed on the RNZCGP website: www.rnzcgp.org.nz /journal-of-primary-health-care.

Non-members subscription cost is $100.00.

## *GP Pulse*

You will receive **free** hard copies of *GP Pulse*, the Colleges current affairs quarterly magazine. You can login to the member only area of the RNZCGP website to view the PDF versions online.

*GP Pulse* is the vehicle for you to have your say, either in response to something you've read, or as a request for a specific need you have identified. We welcome your comments on *GP Pulse* at gppulse@rnzcgp.org.nz.

Non-members subscription cost is $60.00.

All RNZCGP resources, including the *GP Pulse* and the *Journal of Primary Health Care (JPHC)*, are produced using paper sourced only from sustainable and legally harvested forests (FSC Certified). *GP Pulse* and the *JPHC* are mailed in compostable film wrap.

## Maintenance of Professional Standards Programme (MOPS)

If you are a RNZCGP or DRHMNZ Fellow you will get free access to the RNZCGP Maintenance of Professional Standards Programme (MOPS) through the member login area on the RNZCGP website.

This programme assists you to maintain your registration within the vocational cope of general practice or rural hospital medicine by meeting part of the recertification requirements of the Medical Council of New Zealand, and meet your obligations under the Health Practitioners Competency Assurance Act (2003). The programmes aim is to simplify your compliance and reduce your paper work.

## Continuing Professional Development Programme (CPD Online)

If you are a Medical Council of New Zealand (MCNZ) general registrant you will get access to the Continuing Professional Development Programme (CPD Online) through the member login area on the RNZCGP website.

The purpose of this programme is to assist generally registered doctors who are working in general practice to meet the practising certificate CPD requirements of the MCNZ.

The Royal New Zealand College of General Practitioners
CORNERSTONE™

## CORNERSTONE

CORNERSTONE General Practice Accreditation Programme is a programme within RNZCGP which accredits practices using the member-developed standard *Aiming for Excellence*.

CORNERSTONE is the vehicle to assure the delivery of a quality environment at your practice.

Please visit the RNZCGP website for more information or contact CORNERSTONE at cornerstone@rnzcgp.org.nz to find out how CORNERSTONE can help your practice.

### Support for general practice and general practitioners

- You will have the opportunity to participate in expert advisory panels in a range of health stakeholder organisations.
- You will be regularly updated through ePulse and on the RNZCGP website on changes and proposed changes within the health sector. You will have an opportunity to voice your views on any of these issues and to contribute to the College's work with key stakeholders.

## RNZCGP Helpline

Not sure where to turn when you are feeling stressed and not coping or wanting medico-legal advice? You can access the RNZCGP Helpline who will refer you to the appropriate support and services you need in your time of crisis.

**0800 RNZCGP (0800 769 247)**

## Online Web Learning (OWL)

Currently if you are a General Practice Education Programme Stage 1 (GPEP1) registrar, Rural Hospital Medicine Training Programme registrar or on the Primex Intensive Training Programme you will get access to Online Web Learning (OWL).

Launched in February 2010, OWL is the Online Web Learning platform developed for registrars and educators involved in the General Practice Education Programmes provided by the College.

From October 2010 General Practice Education Programme Stage 2 (GPEP2) will be supported via OWL.

During 2011 it is envisaged all College members undertaking professional development will have the opportunity to gain access to OWL and the e-portfolio tool.

OWL provides access to training programmes, curriculum guidelines, professional development plans, e-Portfolio, workshop & seminar details, a variety of quizzes and other resources, forms and documents, all required to undertake and complete registrar training and ongoing professional development.

OWL has interactive components and enables all users to participate in forums and surveys regionally and nationally.

# PLAYING THE ADVANTAGE

Tackling the wicked issues

**The 2011Conference for General Practice**

1 - 4 September 2011

The Langham Auckland

The Royal New Zealand College of General Practitioners

GENERAL PRACTICE NZ

*The Heart of Health Care Networks*