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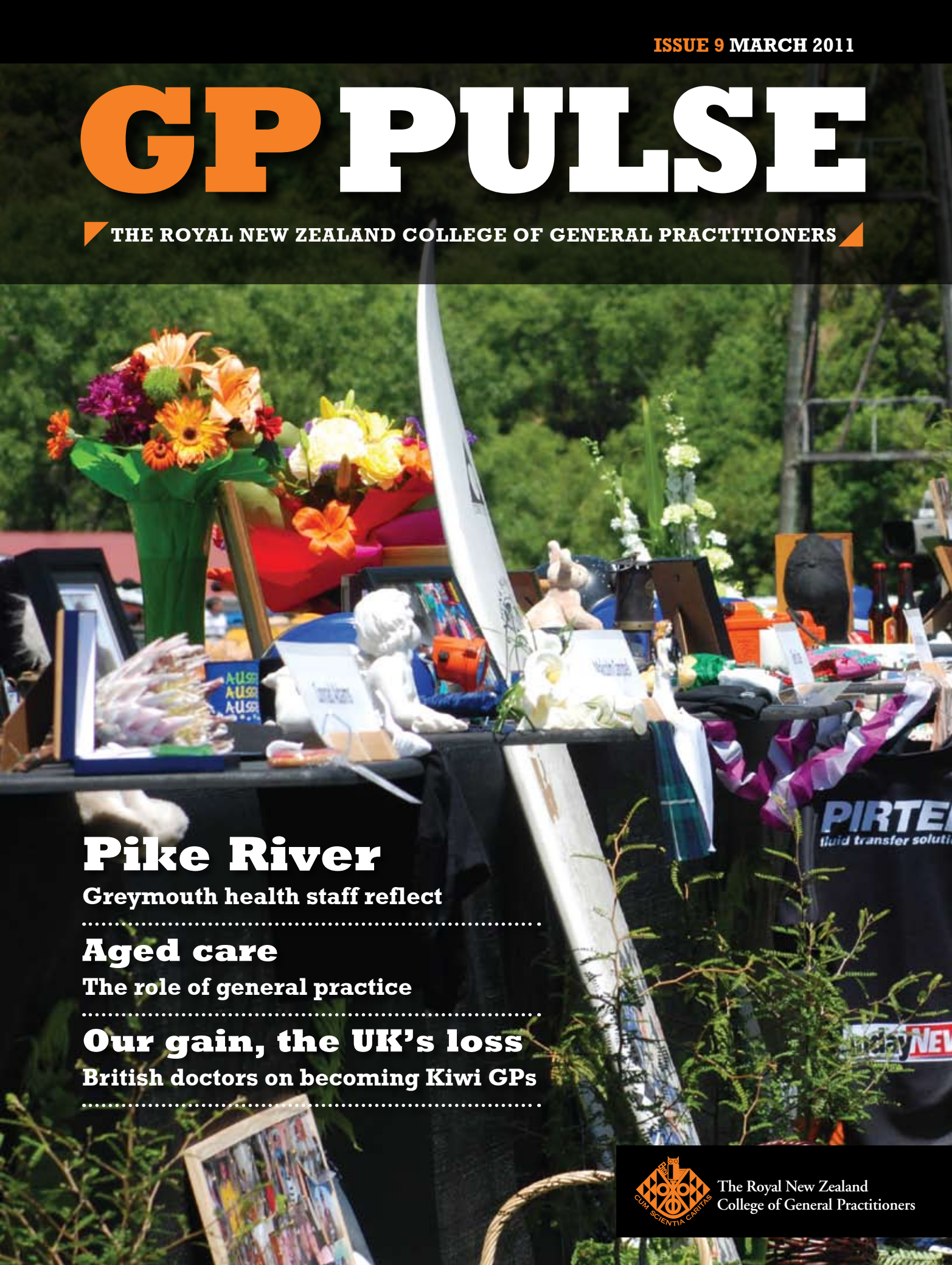
GP PULSE

THE ROYAL NEW ZEALAND COLLEGE OF GENERAL PRACTITIONERS



Pike River

Greymouth health staff reflect

Aged care

The role of general practice

Our gain, the UK's loss

British doctors on becoming Kiwi GPs

The Royal New Zealand College of General Practitioners

The Royal New Zealand
College of General Practitioners

RNZCGP Annual Quality Symposium 2011

Save these dates: 20 & 21 May 2011

Museum of New Zealand—Te Papa Tongarewa
Oceania Room

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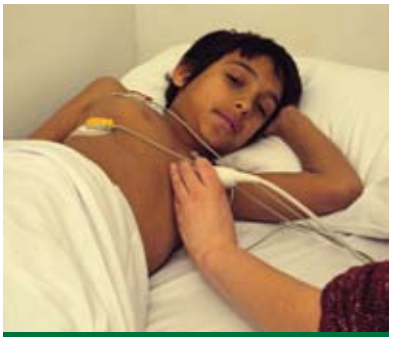

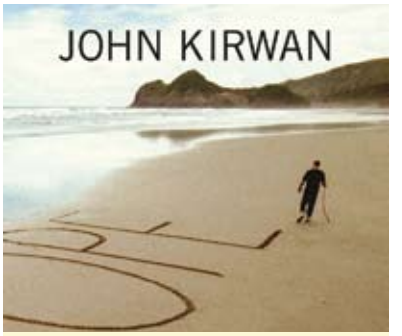

EDITORIAL

PARTNERSHIP

COLLEGE

RURAL

EDUCATION

CPD

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POLICY

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MEMBER SUPPORT

Cover picture: Tables at the Pike River Memorial Service, courtesy of the Greymouth Star.

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Looking to the future

Karen Thomas
Chief Executive, RNZCGP

It has been said that the only two things we can be sure of in life are taxes and death. While from time to time, we might attempt to vary our association with the former, we can't escape the eventual arrival of the latter.

We all hope we will live to a ripe old age, but recently we've been hearing what a burden we are all going to be on our children, their children and the health system in general if we do.

Care of the elderly, and in particular care at the end of life, are topics we must discuss and debate as health professionals and as a society. We have some major issues to address and resolve.

Surprisingly, about half of all people who die of old age live in a residential care home at the time of their death. And half of all public money spent on our health care is spent in the last six months of our life. With ever-increasing concern about the money needed to fund the retirement and old age health needs of the baby boomers, we have some challenging funding and resourcing issues to face.

Professor Ngaire Kerse has contributed a major article on residential care and the role of general practice in that sector. While noting the importance of a partnership approach in providing quality care to residents, Professor Kerse urges us to debate the future shape of such services, what developments and improvements we need to see and who is going to pay for them.

At a recent Council of Medical Colleges' meeting, members discussed the need for the medical profession to help generate debate in the wider community on such end-of-life issues, including what some economists are calling 'ethical rationalisation' or, in other words, rationing.

GPs, with their intimate knowledge of, and relationships with, patients throughout their lives must feature strongly in this debate—helping to shape it at the very least, but ideally to lead it. Now is the time to step up in terms of clinical and professional leadership and represent the interests of our older patients both today and in years to come. I am sure it will be an interesting and robust debate.

On a sadder note, when events occur like the explosion at the Pike River coal mine and the 22 February earthquake in Christchurch which occurred just as we went to press, we are reminded that life doesn't always go according to plan and we don't always get our 'three score years and 10'.

In this issue, we publish accounts from some of our West Coast members and their colleagues. Tragedies like this tear at the very heart of a community and people are affected both personally and professionally for months, if not years thereafter. The fabric of day-to-day lives is irrevocably changed.

In the months that follow, I want our West Coast and Canterbury members, their colleagues, families, and all those affected by the tragedies to know that they have the very best wishes and support of the College behind them.

Arohanui and kia kaha.

Partnerships in residential care for older people

Ngaire Kerse PhD, FRNZCGP, MBChB

Professor, General Practice and Primary Health Care, The University of Auckland

Introduction

Currently 33,000 people work in residential care supporting 33,786 residential care beds (usually quite full, so that's close to the estimated number of people actually in care). This seems a small number overall, but the sector consumes an alarming proportion of health and welfare dollars and everyone is worried about what will happen when they get old. "Be nice to your children; they will choose your nursing home," is perhaps not as compelling as the suggestion that about half of all people dying in old age use a residential care facility immediately before death. The Aged Residential Care review was commissioned and has recently been released, providing the opportunity to reflect on the place of general practice within the aged-care sector.

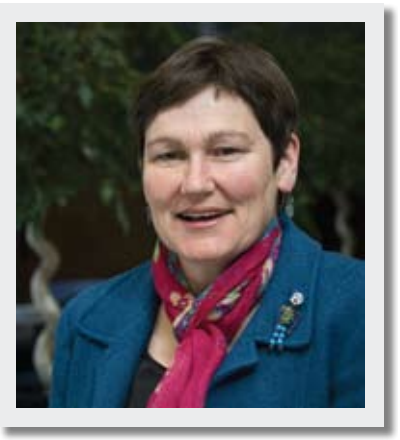
The review emphasised the efficiency and market aspects of the residential care industry rather than the quality care issues. The survey of facilities was probably answered by the larger facilities rather than the small owner-operated facilities, and the needs for advanced nursing and allied health workforce were not being considered. The briefing book for the focus groups makes good reading (Appendix F of the report)* and outlines more of the evidence base for quality improvements in care. It is poignant that the words "quality of care" are absent from the 15 recommendations and that there is only one care-related recommendation—"Recommendation Ten: Develop appropriate service models that support care delivery to unique clientele in differing locations."

General practice in the mix

General practitioners, in the main, provide the medical services to residential care. This is, of course, in partnership with:

(a) the staff and owners of the facilities;
(b) the DHBs who provide the contracts to the facilities and additional secondary services for the residents as needed (this is quite variable around New Zealand);
(c) WINZ who provide the subsidies for those who are eligible (about 60–70% of all residents, the rest pay out of pocket);
(d) other providers who manage to get into the facility, such as physiotherapists and dietitians (either publicly or privately funded); and
(e) the residents' families who are arguably more influential here than in community contexts.

Complexity challenges GPs who negotiate care for the resident, manage crises, staff, families, hospital registrars and community psychiatrists while keeping the quality of life of the resident to the fore. GPs don't have much control over how things are done in residential care and the contracts for providing medical services vary markedly with a mix of facility payments (per visit, and or capitated), DHB capitated funding for those enrolled through PHOs and sometimes



the old GMS payment. Out-of-hours care is costly and only about 60% of Auckland facilities have "the usual GP" providing 24-hour cover for residents.[2] After-hours continuity increases quality, reduces costs and probably decreases admission to hospital. GPs in general find the continuity and person-related rewards of working in residential care satisfying and, with appropriate systems, processes and facility policy supporting quality care, have a reasonably good time in this part of their work (anecdotal evidence from 20 years of practice and conversations with colleagues). Recommendation Fourteen calls for innovation in increasing participation in residential care. GPs will be expert and should be asked to contribute to developments related to this recommendation.

Over the past two decades the level of dependency and complexity of medical and social needs of people in residential

* Declaration: The author was part of the expert advisory group for this review and contributed to the writing of the briefing book. The author was not able to directly influence or contribute to the recommendations of the report.

A bedroom, hall and street frontage of aged residential care facilities in Auckland

The Aged Residential Care review (ARC review)

The Aged Residential Care review provides "a comprehensive stock-take of the current range and location of aged-care facilities across the spectrum of dependency care. It identifies the growth of supply and investment required in rest home, dementia and hospital care facilities and services to meet projected demand".[1] The review was conducted by an accounting firm with expert and advisory panels and comprises four main sections summarised (very briefly) here with the main findings:

- A survey of current costs and estimate of return on investment (60% of beds covered by responses, 360 respondents of a total of over 700 facilities);
  - Findings: current financial return does not support building new capacity and replacing ageing stock. Half of current facilities are over 20 years old.

- Facility demand and supply, baseline projections with consideration of population demographics and utilisation changes due to increased home and community care and current age and stage of facilities;
  - 12 to 20,000 additional residents will need residential care by 2026, an increase of 78 to 110% in the currently available beds.

- Workforce demand and supply, baseline profiles with potential productivity gains (i.e. changing roles and increasing efficiency) and projections of demand based on existing available workforce and projections;
  - Grow slowly next five years then 50 to 75% growth in workforce needed by 2026 (on a full-time equivalent basis).

- Four models of care were considered: improvement in the current approach, an enhancement of professional services in the community, an individualised funding approach and the development of low income community housing for the elderly;
  - These were not mutually exclusive but could be considered along a continuum of care.

Recommendations from the review basically emphasised the need for greater public awareness of the potential for rapid expansion of the residential care sector (and resulting funding issues), and care needs for older people in general (requirements for health sector reform). The report calls for policy change to stimulate investment in the sector, particularly in dementia services because of the current low rate of return. Preserving current capacity and examining regional and urban/rural variation in efficiency, further analysis by DHB and overall economic tactics to stimulate growth are called for. Recommendations for piloting options for enhanced professional services in the community and residential care workforce enhancement with training, technology and flexibility are balanced by calls for evaluation of a managed bed policy.

care has increased remarkably[3] even though the population percentage of people in care has not gone up.[2] There will undoubtedly be a need for more time, more expertise, more partnerships and more support over the next two decades and beyond (by then we —the current GP workforce—will be receiving rather than delivering services). Involvement of GPs directly in the management of facilities through advisory boards and clinical review processes may be needed to ensure that quality increases in this complex environment. As GPs are business owners, many GPs may have considerable experience balancing profitability with patient care. Perhaps this equips GPs to contribute to debate and influence thinking on, "Recommendation Nine: Consider options to influence the market's rate of return expectations." Facilitating this will be challenging in the complex funding environment.

that could become part of existing residential care facilities. With increased medical input, these could provide a reasonable alternative to acute hospitals for sick older people and a better stepping stone back to usual residence or recovery. Acute hospitals (AT&R wards exempted) remain unwilling and inept partners in caring for acutely unwell older people, particularly if they have dementia. Maintaining continuity of primary care providers will be important in avoiding unnecessary investigations and diagnostic confusion during transitions in care. Rethinking how this works for general practice, increasing flexibility for GPs and an increased team approach with nursing and nurse practitioner input may enhance care and reduce hospitalisations. GPs have extensive experience working with patients at all stages of life and inherent knowledge and skills in working with families, and must be kept in the conversation about

creased conversations about dementia. Ongoing upskilling about the dementias (Alzheimer's, vascular, Lewy body, frontotemporal etc.), BPSD (Behavioural and Psychological Symptoms of Dementia), drugs and non-pharmacological management will be a priority to meet the growing need and should be embraced by PHOs, DHBs and training programmes. For people with dementia in residential care, diversional therapy to maintain productive activities, educating staff about BPSD (and dementia in general), and maintaining physical activity safely are priorities overlooked by the report.

Summary

General practice has an essential place in residential care and must be included in developments in response to the ARC review. Now is the time for community debate and PHO-level develop-

It is poignant that the words "quality of care" are absent from the 15 recommendations and that there is only one care-related recommendation—"Recommendation Ten: Develop appropriate service models that support care delivery to unique clientele in differing locations."

The wider aged-care sector needs to be considered in calls for reducing unnecessary hospitalisations (mentioned as potential leverage in shifting funding from acute to residential care). The ARC review was able to show that "high needs home support clients use substantially more secondary services than either low needs clients, as would be expected, or residents of aged residential care", not surprising as high-needs clients are cared for at home now and many secondary services don't visit residential care. Integrated multidisciplinary teams and step-down or intermediate care community places (that can provide nursing care) are examples of some of the changing models of care

new models of care and in response to Recommendation 10 (service models for unique clientele). They are experts on unique clients and deliver patient-centred care. PHOs have to embrace aged residential care in projects over the next decade, with the input/leadership of their GPs.

Dementia

Dementia care is an area that polarises health professionals and, by the looks of the report, is in need of attention to maintain the industry prerogative to provide it. For those who love it, more is on the way. The advent of public funding for anti-dementia drugs has in-

ments to ensure that quality of care is maintained and improved throughout the projected expansion of the residential aged care sector.

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A woman of our times: Distinguished Fellowship recognises a lifetime of generous contribution

Auckland GP Medical Educator **Janet Frater** became a Distinguished Fellow of the College in 2010. Her citation for Distinguished Fellowship reads: "Janet Frater studied medicine at The University of Auckland and was awarded the Douglas Robb prize for being the top student in her final year. As a general practitioner in Auckland for many years, she has managed to balance clinical work and family life with a generous and growing contribution to the work of the College. As well as serving on the Board of the Auckland Faculty and being a Primex examiner for many years, she has been a seminar facilitator and, since 2008, a medical educator with responsibility for the seminar programme of GPEP1 in Auckland. Janet has also done work for the Medical Council as a mentoring coordinator, competence reviewer and educational supervisor. She has been medical advisor to Interserve with an interest in the health of aid and mission workers. Colleagues of Janet find her always enthusiastic, supportive, well-organised and displaying great wisdom and insight." After 30 years in her Balmoral practice, Janet talks about some of the things that have inspired her and keep her energetic.

Life is full of lessons and, as GP teachers, we try to encourage reflection and life story as part of our learning at the beginning of the year. So this is a bit of my life story.

When I left school there seemed to be three main options for women who were in the academic classes. One was teaching, but I always felt sorry for teachers standing up in front of a class of pupils who did not always want to learn or behave, so that option was definitely out. Another was going to business college, but business and office management really did not interest me. The final option was nursing and, as I liked the idea of helping people and enjoyed biology, I decided this was the best of the three. An irony is that I am now a GP teacher and stand up in front of a class on Wednesday seminar days. I also own a business and part of our building.

When I decided to do nursing there was no degree course and, as I wanted to go to university, I started a BSc at Auckland. It was Professor John Morton, my zoology teacher, who was the person who changed the course of my life. I was doing well in his subject and he asked me what I was thinking of doing. When I said nursing, he asked if I had considered medicine as there was now a medical school in Auckland and he thought I would be capable of doing the course. So I learned never to underestimate the power of mentoring. A comment from a wise person can be life-changing.

I went to Auckland Medical School after my two years of a BSc and had to start another six years of study. There were 12 women in our class of 60 and we became a supportive, close-knit group over the years. It has been good to see more women doing medicine in recent times, but I hope that as a profession we will not lose a gender balance.

In my final year I did an elective in a mission hospital in Tansen, Nepal. This was a great experience as I had always loved mountains and tramping and I would go out to mountain villages with the community health nurses. I saw lots of advanced disease and I always remember the awful supracondylar fractures in boys who had fallen out of trees which they climbed when cutting leaves to feed the family buffalo. One little boy said, 'jolly good cheer' whenever we did a ward round. His father had been a Gurkha soldier with the British Army. This elective fuelled an interest in aid and mission work and I became a medical advisor to Interserve. It also opened my eyes as to what happens when people do not have access to medical care. It was a great moment when I was able to return to Nepal in 1997 with my family. My daughter said to me: "Mum if you had stayed in Nepal you would be dead now", as she had read the average age of death for adults was 45 and I was older than that.

After my elective, I went to the UK with the idea of working there for a while, but instead I got married to Jim and took a year off medicine. These were two of the best things I ever did. Jim shared a love of the outdoors and tramping with me and is an accountant who has been invaluable in dealing with GST, tax and those business issues I prefer to delegate. The year off was a great opportunity for travel and avoiding one-in-two on-call rosters in Britain. We tented through Bulgaria, Romania

Self-care—no cell phone coverage or Internet here!

and Hungary when it was still under communist rule and spent a day with an Indian colleague in South Africa which helped us understand what it was like to live under apartheid. I have also travelled a lot in Asia and all this has opened my eyes to different cultures and added to my understanding when I talk to our overseas-trained registrars about their countries of origin.

On return to New Zealand, I completed three house surgeon years and a Dip Obs. I had decided general practice was what I wanted to do and entered the Auckland GP training scheme. One of my runs was with Dr Ritchie Gilmour at Henderson—an inspirational teacher who had done a counselling course in order to better help his patients. He took his registrar back home for a leisurely lunch each day, so I learned a lot about the family life of a GP as well as the latest healthy food from his wife Myra. I then did Primex when the examiner doctors were also acting the patient. It was a bit hard to imagine a grey-haired male doctor playing a young woman with multiple sclerosis. The next case, a male patient who drank too much alcohol and was impotent, was easier. The use of actors has certainly been a great help in communication skills training and exams.

I joined my present practice, Balmoral Doctors, 30 years ago and have worked with very supportive colleagues. However, it has been a challenge to juggle work and three children. One of my more interesting jobs was to go to the Women's Periodic Detention on Saturday mornings. This was run by a wonderful woman who wanted a GP to help sort out some of the health issues of the women there. When I had no babysitter, I would take my baby and found this was very helpful in breaking down barriers. I really appreciated the support I got from the College in those years of part-time work and preparing for part two of my GP training. I hope we can continue to value and support our part-time workforce and retain flexibility. Having children certainly helped my understanding of patients' problems. I was very sympathetic to young mothers whose babies would not sleep, and later on, to parents who were not able to sleep as they waited up for teenagers to come home.

In more recent years, I have become interested in mentoring and doctors' health. I was asked by the Medical Council to mentor doctors and then run their mentoring programme. Some had got into difficulties with drugs and alcohol. Part of the reason for their addiction was the need to relieve the stress of work pressure. I had had to learn to set boundaries myself, as a couple of times I had recognised I was getting burnt out. I now have supervision and encourage all GPs to get a mentor or supervision as we deal with some very

When I said nursing, he asked if I had considered medicine as there was now a medical school in Auckland and he thought I would be capable of doing the course. So I learned to never underestimate the power of mentoring. A comment from a wise person can be life-changing.

stressful issues and the time pressure can be relentless.

My main area of life-learning at present seems to be related to older people's health. I have elderly parents and when you have been in one practice a long time your patients grow old with you. Some are now in their late 80s and 90s. So I have been thinking a lot about another inspirational teacher, Dr Kingsley Mortimer, who left anatomy teaching to study psychogeriatrics and was concerned about the quality of care of older patients. The 15-minute appointments become impossible when dealing with multiple, chronic problems and several layers of cardigans and vests. I am grateful to have been able to move to 20-minute appointments. Even then, I feel I miss out on some amazing stories because of time pressure. I recently found out one of my older patients has two adopted children, and it was moving to discuss her feelings about adoption. I also went to the funeral of my oldest patient recently, and learned she had been a keen gardener and loved fishing. I realised how little I really knew about her and wished I had known more, as those are two of my hobbies as well.

Three things I enjoy: mountains, travel and general practice

So what are my hopes for myself and general practice in 2011? I still need to work on time management and make sure I can listen to my patients' stories so I can care for them better. I have to be careful with reaccreditation, business plans, bureaucracy and paperwork, so that I don't lose the energy I need to care and advocate for the disadvantaged in our society. I would like to give back some of what I received from my inspirational teachers and help our younger doctors find the joy of general practice as we try to replenish our GP workforce.

Continuity of care: a core value or outdated dogma?

Steven Lillis

Chair, Education Advisory Group, RNZCGP

Culture is a word mostly associated with ethnic norms of belief and behaviour. It is also a very useful term to describe what is accepted and expected in a professional group such as general practitioners. The term 'continuity of care' is enmeshed in the folklore and language of general practice as a cultural icon. Like most cultural icons, the concept is widely-used and seldom examined as to the value it gives to general practice. Indeed, many descriptions of general practice will incorporate continuity of care as a defining principle.

Changing work environments provide a pressing need to re-examine basic assumptions about what we do and why we do it and continuity of care should not be spared this process. Changing work environments will require us to think and act differently about the models of medical care that we use. A purely business model would hold that work should be undertaken by the person who can competently complete the task with the least investment in training. Administrative tasks should not be undertaken by a nurse if a receptionist can compe-

tently complete the task, and a general practitioner should not be following up patients if a nurse can competently do this. The alternative view—that the general practitioner should undertake work such as follow-up to build relationships with patients—starts to look somewhat lame in an environment of increasing resource constraint and the significant difficulties that some sectors of the population have in even getting to see a general practitioner.

The definition of a general practitioner as one who successfully works in a low-technology, high-uncertainty environment is also useful here. I personally believe this concept is what is behind research showing how decreasing cost and increasing effectiveness of care are proportional to the numbers of general practitioners in a medical system, but are inversely proportional to the number of specialists. A low-technology and high-uncertainty environment requires many of the concepts that are traditionally associated with continuity of care, particularly knowledge of the patient assisting to accurately interpret limited clinical information.

Steven in action in the Goat Alpine Adventure Run in the Central North Island in 2010

Unpackaging the multiple meanings behind continuity of care may allow us to better understand our own and external perspectives. A useful method of doing this is to look at three different components: continuity of information, continuity of relationship and continuity of location. Diabetes is the disease par excellence where continuity of information is of critical import. Any general practitioner should be able to recognise and interpret clinical parameters and apply guideline information as to the next steps in clinical intervention. We, as clinicians, are interchangeable, whereas the information kept on computer systems is highly individualistic. Caring for the elderly is a circumstance where continuity of locality is important. They may have difficulty in getting to any other practice due to transport difficulties. Continuity of relationship becomes important for those with depression, severe and life-threatening physical illness or other occasions where one's search for meaning requires the input of a wise and empathic other. We, as clinicians, are not interchangeable.

The wider community of general practitioners needs to understand and respect how others may view and understand continuity of care as much as we need to educate other health practitioners about our views. We also need to relinquish simplistic notions of what it is and replace them with models of care that provide us with a way forward in the environments of the future. I would suggest that continuity of relationship, of information and of location are separate entities that should not be incorporated into a single concept, but should stand alone as being independent of each other and useful to patient care in very different circumstances. The consequence is being both true to our values and being able to work cooperatively with others.

What does continuity mean for the patient in rural or remote centres?

Professor Campbell Murdoch

Medical Director, West Otago Health Ltd

For the past six months, **Campbell Murdoch** has been employed as the sole GP in West Otago, working with a team of rural specialist nurses. He commutes from Dunedin, spending three days a week there. He assumes that the fact that he, a 68-year-old professor, was the only applicant for the job means that rural medicine in New Zealand has "a wee bit of a problem!"

I have had the privilege of being 'the doctor' in eight practices and five different countries over the past 42 years. In most of these locations, the most important question patients wanted to ask when I introduced myself as yet another strange doctor was, "Are you going to be here the next time I come back?" The motive for the question was whether it was worthwhile to reveal their secrets to someone who was never going to be what John Berger* called "the clerk of their records." In these widely differing geographical locations and cultures, 'the doctor' was recognised as the repository of a special kind of personal knowledge which meant that you didn't have to start at square one each time. The introduction to Berger's book talks about landscapes as "less a setting for the life of its inhabitants than a curtain behind which their struggles, achievements and accidents take place." The doctor and other personal carers are, in that special sense, invited behind the curtain.

It has become fashionable to say that these days have ended, but they asked the same question when I came to Tapanui in August 2010, and they continue to ask how things are going and whether I am likely to stay. Particularly to the older folks, it is also important that I wear the mantle of Peter Snow rather than the succession of 20 to 30 short-term aspirants or locums who have dealt with their medical problems since he retired after 30 years of practice in West Otago. It helps that I am recognised as someone who knew Peter; even better that I was his friend and fellow researcher. The story seems to go that locums are OK as a short-term substitute or in an emergency, but that Kiwi patients still require their primary care professionals to provide continuity of care.

Patients wanted to ask … "Are you going to be here the next time I come back?"

Rural medical practice is now in a state of permanent crisis because of the lack of medical specialists who can take on this role. Urban generalism can cope with a succession of part-time shift workers because the increasingly feminised workforce tends to congregate in our larger centres. People can choose to come when their doctors are there and they provide a great service. The problem seems to be worldwide that specialist generalists are not generally living in rural areas, and are not being attracted by the rural lifestyle.

Steven Lillis (previous page) rightly pointed to the three different components of continuity of care—continuity of information, continuity of relationship and continuity of location. It is the latter which is giving us the great headache in

* Berger J. A fortunate man: The story of a country doctor. 1967.

New Zealand. Continuity of information can now be relatively easily provided by good medical records backed up by information technology, although the quality of inputs still leaves much to be desired, and the application to everyday practice is a problem. Continuity of location comes before that of relationships, because if you do not stay in a place, you cannot meet and know its inhabitants. The economy of our country is highly dependent on the earnings of those who live and work in rural areas in agriculture, fishing, mining and tourism, and yet the number of doctors who work permanently in rural areas and who make primary care their life's work has declined. The emphasis on expertise rather than continuity has brought the locum and the fly-in fly-out (FIFO) doctor to our rural communities. I venture to suggest that locums are more of a problem than an answer.

Rural nurse specialist Gina Mills reviews the elderly

So is there a future and can we plan for it? Let's forget all the long-term and totally impractical ideas like revamping postgraduate training and emphasising generalism—we simply cannot afford to wait for all that. This is a delivery problem. Just like Fonterra has tankers crisscrossing our rural areas to pick up the milk, we need a service that delivers medical care to the rural community. Believe me, DHBs have not the slightest desire or ability to do this and most PHOs have not the slightest intention of doing so. Experienced rural doctors and nurses and local health trusts have most to offer. The bulk of the professionals will be rural nurse practitioners simply because they are in greater supply in rural areas. A few medical practitioners may survive, but only as advisors to these teams. Will continuity survive? Well, at least people will have continuity of relationship and place and their records will be in good hands—their own.

Evening in West Otago—landscapes are "less a setting for the life of its inhabitants than a curtain behind which their struggles, achievements and accidents take place"

Pike River—a personal perspective

Greymouth GP **Greville Wood** writes about how his community is surviving unthinkable tragedy.

November 19, 2010—a lovely, sunny Friday afternoon; at 3:44pm an explosion ripped through the mine at Pike River.

The emergency response was immediate: by 5:30pm a control centre was established at the Grey Base Hospital; by 6pm senior Accident and Emergency specialists from Christchurch, with senior nurses and flight staff were already at Grey Base Hospital. The hospital had been readied to receive the influx of casualties that were expected, and we all waited. Emergency rescue crews and ambulance staff were on-site at the mine. All the GP practices in town offered free services to those affected by the disaster. Mobilisation of the psychological support services was initiated.

At the same time, Victim Support teams were mobilised and an Air New Zealand Crisis Management Team member was allocated to every family affected. The mental health services of the West Coast DHB and PHO were mobilised and additional psychologist support was flown in to assist the town to cope. This support included written material which was made available to the public as we grappled with what had happened.

The local churches and their ministers, and the Red Cross opened up their facilities as places of gathering, tea, talk and respite. Church services and chapels of contemplation were used by the community to come together as groups or individuals to seek comfort. The Salvation Army established a centre for counselling those affected and the PHO clinical psychologists were available all day in their offices.

The wait was terrible as we clung to hope that a rescue was possible—although all the signs pointed to the worst possible outcome for the miners. The trapped miners were from all walks of life in Greymouth and everyone personally knew a family who had a relative trapped.

The support from around the country was overwhelming. This support sustained us: we did not feel alone. The support we received was kind and generous beyond belief. A local GP practice was sent morning tea from a colleague in the North Island. GPs offered and then came to help. As a GP community, we were reeling from having lost four GPs in July (three had left the area and one was ill). This extra support was wonderful.

As it turned out, we did not need to manage a mass casualty event, but the years of planning for such an event proved fruitful; we were able to mobilise resources as planned and we were ready. The provision of psychological support for the community was a collective effort. Those needing support were often older members of the community who had been through the Strongman Mine Disaster of 1967, when 19 miners were lost. The memories of that event came flooding back to them.

How do we cope with so much tragedy, when so many are affected around us?

Crowds at the Pike River Memorial Service; photo courtesy of the Greymouth Star

We all support each other: family, friends, workmates, colleagues, other communities in the area, the country and internationally. It is only when you come together as a community that you can survive. Many bonds had been forged with Christchurch during the earthquake and the reciprocity between the regions of help given and received was heartfelt and evident.

The town moved from hope (albeit slim) to despair and then acceptance of the grim reality of friends and loved ones lost forever. The memorial service held at the Omoto Racecourse was sorely needed by us all. As a community, we needed to stand together and mourn with the families. This service, and the personal funerals held by the families since then, have been essential in helping us all bring some closure to the tragedy.

On 5 February, the Warriors played the Newcastle Knights in a Rugby League Memorial match. League is the miners' game. The grandstand was reserved for the families and all those who had helped in November: the Police, the ambulance services, the mines rescue, the chefs from the Tai Poutini Polytechnic who kept making food for the affected families and workers for two weeks; they were celebrated and the families supported. What an event—6,000 (there are only 12–14,000 in the greater community) were there in solidarity.

Life has gone on, tears have been shed, hearts are aching, our arms have been around each other, and how much we have appreciated and been overwhelmed by the support from around the country and internationally, you will never know. Thank you to all who prayed, baked, sent messages, raised funds for the families, visited and skyped; all these things—both great and small—have been appreciated and cherished.

Marie West, *Practice Manager at the Greymouth High Street Medical Centre*

At approximately 4:50pm on November 19, 2010, the practice phone rang. Nothing new in that; however the gut-wrenching noise that came from one of our practice nurses (Kath Monk) that afternoon will live with us forever. Her husband had just told her that their son was in the mine. During the weekend, staff rallied around their colleague/friend covering her shifts for the first week—we all believed the trapped men would be out soon. How wrong we were. I had started as practice manager only one week before this tragedy and what I found was an already very fragile team due to recent events within the practice. My concern was how this would impact not only on Kath, but the entire team. As I drove into Greymouth from Hokitika on Monday morning, I felt an overwhelming sense of grief: I started early to reschedule the first few appointments to enable the team to gather, share their feelings, shed a private tear and say a prayer for all those involved. We accepted the offers from NZ Locums for additional GP cover, from nurses who had made themselves available during the Christchurch earthquake and who were contacted once again, and from other GPs around the country who came and worked with us. We can never thank those individuals enough for coming into our community and sharing our grief, but, more importantly, making us laugh—thanks must go to the West Coast DHB. For Kath, the ultimate professional, this meant she didn't have to worry about work; for me it meant being able to give other staff leave—some who were volunteers during the initial period—knowing that our road ahead would be a long one. The impact on the community hasn't yet reached its full extent. The ramifications of the loss of high wages coming into a small community, redundancies, contractors and local businesses being owed large sums of money are the tip of the iceberg. Already we are seeing increased stress, anxiety, alcohol use and violence; it is our belief that many families will have thought, "let's get through Christmas". A lot of physical, psychological and financial resources were quickly made available to the immediate families and the wider community. However, this need will continue for some months yet. Quickly I realised that I had come into a supportive team and that became increasingly evident. In the following weeks, a staff member's husband suffered a CVA and another staff member's father had an MI requiring stents, but somehow we have survived.

Brian Weston, *Retired GP, Greymouth*

I'm not seeing patients anymore, so I don't have direct contact with the families affected, but I know many of them and I can begin to understand the grief they're going through. I know that many of them are very unhappy with the events still unfolding and with the police.

Everyone down here knows someone who is still in that mine. I went to the memorial service and, even though I was hundreds of metres from the stage and could only see what was happening on the big screens they had erected, it was incredibly moving.

From the heart: Lance O'Sullivan on general practice and fighting rheumatic fever in the Far North

GP Pulse visited **Lance O'Sullivan** at his Kaitaia practice, Te Hauora o te Hiku o te Ika, to find out about his involvement in a recent project to test Far North kids for rheumatic fever, and about his passion for general practice and life as part of the Kaitaia community.

The rheumatic fever project was the brainchild of Northland DHB Medical Officer of Health Jonathan Jarman and paediatrician Roger Tuck. Lance's role was getting community buy-in, and he describes himself as humbled and flattered that his name was the one that came up when they asked how to ensure support for the project amongst local people.

"But," says Lance, "I've been in Kaitaia for five years and I've worked hard at building that profile and standing, and I'm immensely proud that I have that reputation as the person to go to: 'If Lance O'Sullivan buys into it you'll get the community behind it,'. My endorsement and promotion of this project helped ensure good participation—the consent rate was very high in an area where that isn't typical and where people can be suspicious of research that they haven't got control over.

"That trust from the community is so valuable and it's a big responsibility—you have to make sure you use it for the right things and maintain it by ensuring local ownership and understanding. I could lose that trust: if I was to abuse it by getting people involved with something unethical, they'd chew me up."

Lance at work in his Kaitaia clinic

Born and raised in white, suburban Auckland with what he describes as "the usual identity issues," Lance has whakapapa through his grandmother to Te Rarawa. He found on coming to Kaitaia that he was welcomed as a long-lost son. "When I came up here and people said 'you're ours' and I'm working for them, I find that immensely satisfying."

Lance was involved in the launch of the rheumatic fever project and believes it is especially important that he be involved in ongoing care and follow-up, to ensure continuity of care for the 13 kids who the project helped diagnose with rheumatic heart disease. "The implications of the project for these kids are huge—they would almost certainly have had repeated bouts resulting in heart damage and heart valve operations in their 20s."

The project has changed Lance's own practice and helped to educate health practitioners locally: "Pharmacists and GPs in other practices are far more aware of the high rheumatic fever rates in the local population and are more focused on correct sore throat man-

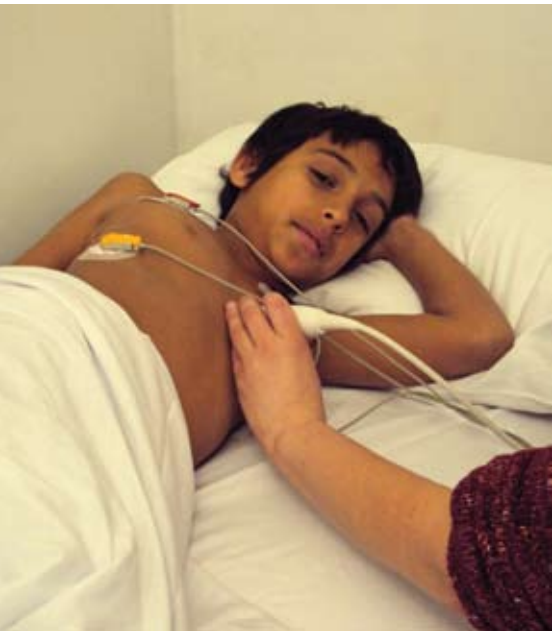
agement. It's something we all learn about at med school, but it can be a long time between drinks for people, and it's also important to ensure the locums regularly passing through are aware of it. People in the community here are more aware of the risks, and people at higher levels are also taking notice." Lance is pleased that the project has helped raise the profile of rheumatic fever work on the radar of the Ministry of Health, for example.

Through his role in the project, Lance has developed an interest in rheumatic fever and is now on the Heart Foundation's Rheumatic Fever Steering Group. This group aims to coordinate efforts politically, clinically and socially to reduce rheumatic fever rates in New Zealand. "The goal is get everyone working together to reduce rates of rheumatic fever for Maori and Pacific Island kids, so that they are the same as those for the general population by 2020."

The current figures are staggering: 2.5 per 100,000 for non-Maori and Pacific versus 50–250 per 100,000, and Lance describes these figures, which have stayed the same for the past 10 years, as literally "heartbreaking". He concedes that the figures do sometimes frustrate him but "You could pick any one of a dozen conditions where it's unfair; as a Maori practitioner lots of things are unfair. If I let them all get on top of me, I'd resign and go and be a farmer because that's something else I'd like to do. We do have this conversation now and then in our Northland rheumatic fever group about how frustrating it is—we get told that there's no more funding and that we just have to be smarter about how we use the resources we do get. That's just crap. How can funders tell us that when this is a preventable condition that is killing our children at up to 200 times the rate of other people's children? I think that's unacceptable. It's a preventable condition, and with

Northland DHB public health nurse Sally Wagener, NDHB clinical director of child services and paediatrician Dr Roger Tuck and Helen Herbert from Ngati Hine Health Trust

Northland DHB public health nurses talk to school students before their scans



10-year-old Caiden Murray during an echocardiogram scan

some resources and with some effort it is something we could be crowing about in 10 years' time and saying it's almost eliminated."

Lance's energy and enthusiasm for his work, life, multi-sport and community are seemingly boundless. You get the sense there are few boundaries between the personal and professional in Lance's life, and that's how he likes it. He's a role model in this community and a powerful and very deliberate advocate for keeping fit and healthy. He arrives wheeling his bike and showing off his fancy new racing tyres and he's off to do a half ironman this weekend. Local paper *The Northland Age* reports that Lance recently laid down a 'Wednesday wero' to the community—"where we get together for a ride, swim, run or other event every Wednesday. I'm proposing we start with a mountain of a challenge and ride from town to the top of the Mangamuka Gorge and back. This is an approximately 50km ride, with, of course, a rather imposing climb at the turnaround."

It's not surprising to discover that Lance completed a Rotary-sponsored fundraising ride up Mont Ventoux in Provence (well-known to fans of the Tour de France and "steeper than the Mangamukas") to raise money for picture dictionaries for the local kids who had their hearts scanned for the rheumatic fever project. He was challenged to complete the ride in less than three hours and 45 minutes with an additional $10 on offer for every minute faster.

Lance's healthy lifestyle is an inspiration, but it also throws into stark relief many of the challenges that the Kaitaia population faces.

"If I had my way, I'd put masses more funding into primary health and curb whatever else we're spending it on. Someone needs to make a hard call on the massive amount of funding we commit to cancer surgery and comorbid conditions; people who have lifestyle factors that preclude them from having a good long-term outcome.

"The real difficulty for me as a Maori is I completely agree that we should invest more in prevention, but until all the inequalities are gone, it will be my people who miss out when those tough calls get made. I represent a community that has high rates of poverty and smoking and all the related illnesses … it's a real tough one, because more of my people will be the ones dying of heart disease, end-stage renal failure and cancer because we're saying, 'sorry … you're a non-compliant smoker … no surgery, no dialysis.' I tell my students that I have a great respect for statistics, and I use them to illustrate things all the time, but as a GP working in a community, those numbers represent real faces and people lost to families in this community and to those diseases."

"It's a preventable condition, and with some resources and with some effort it is something we could be crowing about in 10 years' time and saying it's almost eliminated."

Lance with wife Tracy and son Conor at their recent half ironman (called ironmaori) in Napier

Despite the huge challenges, Lance seems unlikely to get demoralised any time soon and it's easy to see why his enthusiasm is so compelling. "I have students who come up here and I know I change their minds about general practice—general practice is where it's at to change the health of your community. I love it and it's where the battle will be won or lost. It's a great lifestyle up here and I show them that it's enjoyable and sustainable. I've created a niche for myself as a rural general practitioner and I do some emergency medicine and MOSS work to keep things varied. I cycle 15kms in to work each day. I love my role in the community, I have a really good income, and my wife and my family [Lance and his wife have seven kids—aged one through to 17] love it up here too."

Who is joining our GP workforce?

John Pearson

Education Development Officer, RNZCGP

One of the more interesting tasks each year is to identify just who has decided to enter general practice. Where do they come from? What background experience do they bring to general practice? What age and at what stage of their career are they? How different are they to the 'community of practice' that will welcome them and share their educational journey? Are there enough of them to replace those Fellows who are retiring each year? It is to answer these questions that some basic participation statistics are extracted from the application forms. Results from 2011 are below.

In 2007, 25 nationalities were represented in our Stage One General Practice Education Programme. In 2011, only 14 nationalities will be represented. However, the age and stage of training of new registrars is still as diverse as ever, as are the varied backgrounds of the 2011 intake. There are younger registrars (several born in 1985 for example), and an increasing percentage of New Zealand graduates (60% up from 49% in 2007). Overall, 66% are female (64% in 2007), with 75% of all registrars under 30 being female (78% in 2007).

Figure 1 showing the age profile of GP registrars in 2011 and the number of New Zealand Graduates (NZG) and International Medical Graduates (IMG) can be compared with the profile of 2007 GP registrars in Figure 2. In 2007 there were 176 'registrars' (77 CTA-funded registrars and 99 seminar attenders). Figures for the 2011 graph are drawn from applicant data (152) and do not include late applicants.

In 2007, the older IMG group were generally self-funded registrars who attended the weekly seminars only. Many were already working full-time in general practice. A number had also come to New Zealand on two-year work permits with provisional registration from the Medical Council. To gain general registration (and New Zealand residency) they needed to undertake the training programme.

Many of these IMGs were also graduates from the bridging programme funded by the Ministry of Health. The bridging programme finished in 2006 and,

Figure 1 Age Profile GP Registrars 2011

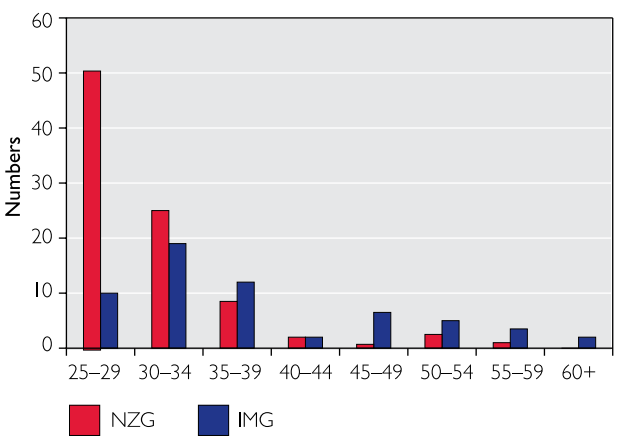
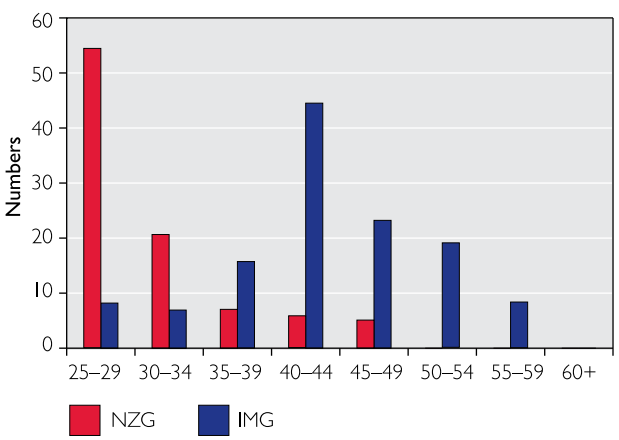


Figure 2 Age Profile GP Registrars 2007



since then, the number of older IMGs applying to train as registrars has decreased. Changes to New Zealand's immigration regulations are also a likely factor in the decline of older IMGs wanting to train as general practitioners.

As can be seen from the graphs, there has been a shift in the age range of IMGs. Formerly, many of these were in the middle age groups. In 2011, IMGs are younger and largely from the United Kingdom. Young female registrars are predominant in this group. Several UK GPs shed light on some reasons for UK registrars training in New Zealand (see right).

While there are similar numbers of New Zealand graduates entering general practice in 2011, 31 of them (20% of applicants) are 27 years old or younger. This is a doubling of numbers since 2007 (when there were 14 only in this age bracket). There has been a decrease in the numbers training part-time (down from 27% in 2010 to 13% in 2011). This may reflect the lower age of registrars and their life stage.

One of the striking diversities of general practice is the educational background of recent entrants onto the GP educational pathway. As usual, the majority of registrars are young and come straight out of hospitals. However, many of them have entered medical school on adult entry and have had another career. We will profile some of these doctors in future *GP Pulse* issues. As well, several registrars have had other careers in medicine and have now come into general practice. These are generally IMGs and include doctors with successful careers in, for example, cardiothoracic surgery, anaesthetics, paediatrics and internal medicine.

OUR GAIN—THE UK'S LOSS

It is not just New Zealanders who believe the grass is greener on the other side of the world. In 2011, we have 16 UK graduates on the programme. *GP Pulse* asked four of them why they came to New Zealand and joined the GP educational pathway.

MATT SLOAN (pictured in Otago) gives some insight into the 'pull' factor of New Zealand and some of the 'push' factors from the UK.

"Back in 2005, soon after I completed my pre-registration house officer year, the NHS was having financial problems which were causing much frustration to my senior colleagues (I did not think they would have any impact on my career). There were headlines in the newspapers and morale was low in the NHS—financial consultants were being brought in to help save budgets.

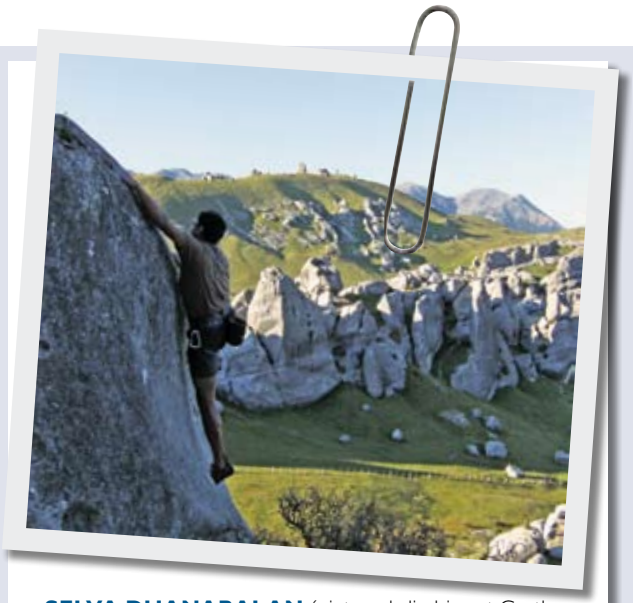
"Deficits were rising and jobs were being frozen and wards closed. I did not think this would affect my training as a newly-qualified doctor and had a good working relationship with my medical team. I had been offered a medical entry level training position and was advised that I could continue working as a senior house officer until my position was formally advertised and interviewed for. Within a few weeks, wards had been closed and the training position was given to another candidate, who was less than six months from being fully-qualified as a consultant.

"I decided to take a year out and work elsewhere. New Zealand looked an attractive place to visit and travel the world on the way there and back. This proved to be one of the best decisions in my life. I had excellent communication from Southland Hospital, and things could not have run smoother. Once my immigration visa was finalised, I booked my tickets and was on a plane three days later.

"My year taught me so much. I worked in a hospital with great morale and excellent senior medical support, and an RMO unit—not to mention the excellent work–life balance. I could never have imagined the outdoor activities (skiing, snowboarding, skydiving, surfing, mountain-biking and tramping) that I would be able to do.

"I chose to continue my training in New Zealand and applied for permanent residence.

"I have met many doctors from around the world and have been able to learn so much from my peers' global knowledge. Many doctors seem to come for a year's experience but so many want to stay. I believe this is because of the positive working/training environment and work–life balance and flexibility."



SELVA DHANABALAN (pictured climbing at Castle Hill) writes: "I think my story is probably reasonably representative of others in my position. I graduated in 2004 and worked in Dorset for two years in two different hospitals. At the time, the training for junior doctors was undergoing major changes. Overall, this forced us to decide on a committed career path two years' postgraduate, with significant career disadvantages if we took longer to decide. I, along with many others, felt the changes were almost entirely politically-driven, much to the detriment of our training and the calibre of doctors that training produced.

"In the two years I did work for the NHS, I felt overworked and undervalued for too many reasons to name. I felt that I was on the verge of falling into an endless rat-race where I didn't feel I'd have much say in what I ended up doing. I was considering a career outside of medicine.

"Working in New Zealand has restored my belief and passion in what I do. I have been able to work in many specialties in places all over New Zealand, taking my time to choose an appropriate career path, and in doing so to develop a breadth of experience that I could not have matched in the UK.

"I have been able to travel and to strike a much more sustainable work–life balance."

ROSS ANDERSON (pictured on the Tongariro Crossing) gave some general reasons why a doctor (or any Englishman!) would work and live in New Zealand and, specifically, train as a GP with the RNZCGP instead of entering the UK training scheme. He wrote: "I'd already spent 18 months working as an RMO in New Zealand before applying for GPEP1. I was keen to stay in New Zealand to train and live, in whichever speciality I chose. The reasons for training in New Zealand are multiple, but include:

- less dense population/crowding more personal space
- lack of traffic jams/congestion/long commutes to work
- wider scope of practice as a New Zealand GP than a UK GP where the most minor of ailments is referred to a hospital specialist
- 'can do' attitude of New Zealanders, as opposed to the unfortunately increasingly 'computer says no' attitude in the UK
- Good coffee!
- generally better weather

"Given a bit of time and thought, I could go on…"

SAM BARTHOLOMEW noted similar experiences: "I moved to New Zealand with my wife Nadia in November 2007, having completed 'F2' in the UK. As part of my F2, I had done four months' GP work and had considered this to be a potential future career. Moving and living abroad had always been on the agenda.

"The New Zealand health care system over the past three years has allowed me a great deal of flexibility in being able to locum in general practice and work in a variety of hospital positions in a supported manner. At the same time, I have felt independent in the decisions I have made regarding my career and my focus. I have not felt pressured into making an early career choice founded on a need to apply at a particular time for a training programme and I have been able to more fully explore where I feel most comfortable and happy practising medicine. This has enabled me to make a much more genuine and well-thought-through decision regarding becoming a GP.

"I feel lucky and privileged to have started a life and a career in New Zealand and to be able to call such an exciting country my home."

Succession planning and palliative care

Peter Fleischl

Medical Educator and GP Teacher, Taupo

Who is going to buy my practice when I retire? Will she/he be willing and prepared to carry on doing my palliative care work? Finding answers to these two questions helped propel me into teaching general practice. It has been a personal exercise in succession-planning, as much as a desire to up-skill the next generation of doctors.

Teaching fourth-year medical students represented an opportunity to market general practice as a stimulating way of life with immense variety and opportunity to have a great lifestyle and enjoyable family life. Then, after a few years, the university started requesting larger amounts of documentation to prove that their medical curriculum was being followed, not just my agenda. After some time spent studying educational theory, I started to see what they were on about, and how I could create a better learning environment for my students. In response, I have involved a variety of professionals with whom I work, who now join me in thinking that teaching medical students is an extremely valuable experience and a whole lot of fun.

Now, back to the two questions I started with. In answer to the first question, I am getting familiar with the type of doctor coming through the GPEP programme, which enables me to characterise who might replace me. John Pearson's article (page 17) provides some information about who will make up our future GP workforce.

The answer to the second question required a bit of investigation. To get the information I required, it was necessary to survey 414 GPEP2 registrars to find out what they thought of general practice palliative care, how confident they were in this field and what they thought of their palliative care training so far. By focusing on clinical training, practice behaviour and interprofessional collaboration I also tried to determine how well prepared they were to work in palliative care teams. Let's face it—you can't do comprehensive palliative care in general practice unless you are a team player.

I chose the online vehicle 'Surveygizmo' to deliver the survey. Quantitative data obtained was analysed using the application SPSS 15, and qualitative data was subject to a general inductive content analysis by three of the researchers and using NVivo 8 software.

Forty percent of the total of 414 GPEP2 registrars in 2009 responded to the online survey. The majority of respondents indicated that palliative care was an important part of the role of the general practitioner (Table 1).

Table 1. Importance of palliative care in role of general practitioner

Level of importance	Number	Percentage
Extremely important	113	77%
Moderately important	53	32%
Of little importance	2	1%

Total responses= 168

More than just succession-planning

Lack of structure to the palliative care component of training was identified as a problem by 43 respondents. Other identified themes included: supported early experiences, gaps in learning, and the importance of experience. Support during early learning experiences covered aspects of the doctor–patient relationship, time, supervisors' attitude and interest, relationship with the wider palliative care team, and educational

support. Well-supported early experiences were stated as giving the trainee confidence. Comparatively lower levels of confidence were identified in control of non-pain symptoms, syringe-driver management and bereavement care, while confidence in communication skills was rated highly.

Identified barriers to doing palliative care in general practice included family commitments (particularly childcare), part-time locum work, provision of young people's medical services, being a newcomer to the practice and having little interest.

Fifty-nine percent of the respondents reported feeling as if they "belonged" to a palliative care team. On rating the reasons why they did not attend palliative care multidisciplinary meetings, "lack of time" ranked highest. When asked which group of professionals they would prefer to attend an educational meeting in palliative care with, the favoured group was a "mixed professional" one.

The results of the survey suggest GPEP2 registrars view palliative care as an important part of the role of the general practitioner and want to receive more structured training in this discipline. Lack of case exposure, part-time employment, locum work, family commitments and lack of clinical support are identified as impediments to gaining experience in palliative care. Areas of relatively low confidence in practice include syringe driver issues and bereavement care. Measures of active involvement with palliative care teams were low. However, respondents value consultation with members of the palliative care team highly, based on differing perceived professional skills. Palliative medicine specialists are chosen by the majority of registrars as the palliative care educators of first choice. Collaborative interaction with palliative care teams was identified as a means of providing clinical exposure and support to GPEP2 registrars during the palliative care component of their GP training.

Failure to fully engage with all other members of the palliative care team in training and ongoing practice carries the risk of others taking over the role of the general practitioner in this area of practice. Remember the obstetrics experience?

Here is the challenge: Can the RNZCGP and all the stakeholders in palliative care come together and support young doctors in training to develop experience and facility in palliative care that the team-focused GP's patients of the future will need when they encounter their end-of-life illness? What do you think?

With good training and the support of those other members of the palliative care team, of course my replacement will practice good palliative care.

Learning groups

Sue Domanski

Advisor Education and Assessment, RNZCGP

2011 sees the establishment of formal learning groups for GPEP2 senior registrars to support them on their pathway to Fellowship.

Learning in small groups is the middle ground between lectures and self-directed learning. It involves interactive learning with the direction of the learning determined by the group's learning needs as a whole.

Based on feedback from past GPEP2 senior registrars, the establishment of learning groups was identified as a key factor within the General Practice Education Programme. This concept has been incorporated into a slightly revised GPEP2 programme for 2011. Each learning group will consist of a geographically-close group of approximately 10 senior registrars who will meet eight times a year. Meetings will be face-to-face, via teleconference, or Skype videoconferencing.

Medical educators

This year, all senior registrars entering GPEP2 will be placed into a learning group, which will be facilitated by a learning group medical educator, who will guide the group, supported by training scaffolds (learning resources), as they work towards vocational registration.

The scaffolds will provide some structure for the meetings and are available on OWL (the Online Web Learning platform). The focus of the scaffolds in GPEP2 is on the curriculum domains of Professionalism, Scholarship and the Context of General Practice.

Groups will be encouraged to make some meetings interprofessional by including other primary care health professionals. Group members will share responsibility for developing leadership skills, and encouraging self-directed and collaborative learning skills.

Learning group pilots

Throughout 2010, a number of small, pilot learning groups were set up to facilitate learning and the feedback was overwhelmingly positive. Two groups always met face-to-face, while a number of groups used teleconferencing.

The learning groups certainly appeared to provide a valuable opportunity for professional development:

> *"I know these are not intended to be peer review groups and neither are they Balint groups but, especially in retrospect, they were a real crossover—peer support and more formal academic discussion."*

The learning group served many purposes:

> *"Keeps you up-to-date with information, organised learning, stimulus for participation, exchange of experience, peer review, asking a friend."*

> *"With every kind of peer review or learning group, you get something to think about. It can be refresher of knowledge, plan to direct difficult consultation from [a] different perspective or just the fact that everyone can have a 'bad day at work'."*

> *"What I enjoyed was discussing cases and comparing ways of managing patients."*

Beyond 2011, as a result of the interest shown, all Fellows will have access to OWL and be able to tap into the same learning resources as registrars engaged in the training programmes

The learning group acted as a motivator:

> *"When one member was preparing for a final assessment visit, there was a sense of achievement which flowed through to the group and this gave motivational value for those less focused."*

When asked what difference the learning group made to their skills, knowledge and development, one senior registrar responded that it:

"Definitely helped address some issues that had never been present or touched on in GPEP1."

Another felt the "organised activities, the sense of belonging, established collegial connection, scientific venue, and protected time", made a difference.

The limitations of the learning groups identified by those taking part were time and geography:

"As in all things, finding a balance in life is very important and it sometimes feels that medicine takes one's life over."

"Limitations to a learning group, especially if you work in a rural setting, can be the travelling distance or just plain fatigue. If you had a busy day, and you have to travel another hour, you might reconsider attending."

Overall the pilot learning groups were an overwhelming success for those involved:

"…we had no shortage of expertise amongst ourselves…"

2011 and beyond

There has been an overwhelming response from Fellows wanting to share their knowledge and support senior registrars within GPEP2. This ensures a rich range of ideas, approaches to learning, and professional development, along with opportunities for senior registrars to develop a wide variety of skills, knowledge, values and attitudes required of a competent general practitioner.

Learning groups will develop throughout 2011. Scaffolds will continue to be written. Medical educators will expand their professional skills facilitating learning groups, ensuring that senior registrars are supported, encouraged, and motivated to reach Fellowship.

Beyond 2011, as a result of the interest shown, all Fellows will have access to OWL and be able to tap into the same learning resources as registrars engaged in the training programmes.

The peer review group and the learning group—what's the difference?

Peer review groups are an important aspect of a health professional's development. The MCNZ requires that for recertification all medical practitioners must be involved in peer review.

A **peer review group** consists of a group of health professionals meeting on a regular basis to review clinical practice. The group can be at varying stages of their profession and bring different experiences and levels of expertise.

The **learning group** on the other hand is made up of a group of health professionals who are at a similar stage of their career.

"I guess the best thing about this type of peer review is that we are all on the same part of the journey together and it was good to learn more about the [Fellowship] process. I would recommend these meetings."

"Opportunity to share and learn from peers at the same level as me."

"It has been very useful to meet other GPEP2 registrars to discuss problems guided by an experienced GP."

'THE CALGARY–CAMBRIDGE FRAMEWORK':

The current approach to education in communication skills

Anna Gilmour

GP Medical Educator, Dunedin

It is widely-recognised that adequate doctor–patient communication is a key factor in achieving an optimal consultation outcome for both patients and doctors. Dunedin GP Medical Educator **Anna Gilmour** explains the benefits of the Calgary–Cambridge framework for communication skills.

Based on years of practical experience and evidence, Silverman and Kurtz developed the 'Calgary–Cambridge' framework for teaching and learning communication skills within the medical consultation. For those unfamiliar with the Calgary–Cambridge model, it may seem a bit daunting to introduce yet another model of the consultation when we may be better accustomed to some of the earlier models such as Roger Neighbour's '5 checkpoints' model[1] and McWhinney's 'Disease–illness' model.[2] Fortunately, the Calgary–Cambridge model includes much of what is already familiar to most of us. Its benefit is that it is evidence-based and presented in such a way as to be teacher and learner-friendly to use, as well as being adaptable and versatile. Most importantly, it purposefully integrates the traditional biomedical history (or 'content' of the consultation) with the patient perspective and the communication skills teaching (or 'process' of the consultation). Teaching both process and content in this way ensures that both are equally accepted and applicable to every medical consultation.[3]

The framework breaks the consultation into five key components—initiating the consultation, gathering information, physical examination, explanation and planning and closing the consultation. The framework also demonstrates the importance of 'building the relationship' and 'providing structure' throughout the consultation. Each of these basic building blocks can then be expanded on and analysed at a more detailed level. Although the guide comprises 71 skills in total, the basic frameworks provided make it seem a lot less overwhelming and able to be pitched to learners at a variety of levels.

Fortunately, the Calgary–Cambridge model includes much of what is already familiar to most of us. Its benefit is that it is evidence-based and presented in such a way as to be teacher and learner-friendly to use, as well as being adaptable and versatile

The 'gathering information' section contains the traditional biomedical content

and format such as the history of presenting complaint and review of systems, as well as emphasising the importance of the context of the presenting complaint and the patient perspective. The patient perspective can be understood through asking about the patient's ideas, concerns, expectations, feelings and effects on life in relation to the issue at hand. Throughout the resources available using the Calgary–Cambridge framework, there are numerous examples of ways of demonstrating the specific skills and ways of teaching these skills. The two books providing the most detail are *Skills for Communicating with Patients*[4] and *Teaching and Learning Communication Skills in Medicine*.[5]

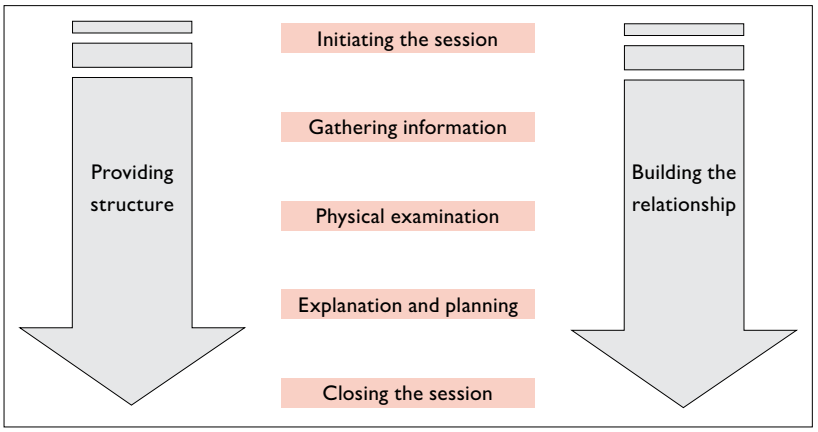
The framework is currently being used by more than 60% of medical schools in the United Kingdom. At Otago University, students are exposed to the

Calgary–Cambridge model from their entrance into medical school. At this level, the focus is mostly on initiating the consultation, gathering information and physical examination and as a student's knowledge base evolves, the subsequent years address in more detail the explanation and planning stages of the consultation.

Students are taught to evaluate their own video-recorded consultations with actors using the Calgary–Cambridge framework. This assists in fostering self-reflection from an early stage and demonstrates the usefulness of communication skills. They are also assessed using the framework as a marking tool in both formative and summative OSCE settings.

The Enhanced Calgary–Cambridge Guide to the Medical Interview

THE BASIC FRAMEWORK



Kurtz SM, Silverman JD, Benon J, Draper J. Marrying content and process in clinical method teaching: Enhancing the Calgary–Cambridge guides. Academic Medicine. 2003.

As a tutor for third-year clinical skills, I can see that the students have a head start with communication skills and a real appreciation of the benefit of learning these skills. From a teaching perspective, I have found it an easy framework to apply to a teaching scenario.

In contrast, the Calgary–Cambridge guides have been more difficult to introduce at a postgraduate level. As a medical educator for the first year of the GP registrar education programme (GPEP1), I have found that registrars do not always appreciate the value of learning communication skills. A content-driven approach, as many have been exposed to in their undergraduate teaching, can become ingrained. This makes it more difficult to try to incorporate the process aspects of the consultation. In GPEP1, we are lucky to have four specific learning resources (scaffolds) for communication skills, much of which has been adapted from the Calgary–Cambridge model.

The Communication 1 scaffold introduces the basic framework and the purpose and benefit of communication skills. The Communication 2 scaffold emphasises how to deal with conflict in the consultation and the importance of the role of empathy. Communication 3 teaches motivational interviewing and facilitating behaviour change in patients, and the Communication 4 scaffold deals with more complex consultations such as breaking bad news, the doctor as a patient, cross-cultural consultations, and consultations with adolescents.

Seminar days frequently involve video review to enable reflection on various aspects of the consultation. Role play enables registrars to practise their communication skills. Practice, practice and more practice is the key to developing good communication habits, with the aim of a more satisfying consultation process for both doctor and patient.

Actors trained as simulated patients provide valuable opportunities to tutor skills. Registrars generally grow to appreciate these sessions and request more. Some regions hold communication skills weekend workshops as well as consultation skills training in the seminar programme. In the practice setting, GP teachers demonstrate communication skills with registrars as well as using video and role play. Medical educators, teachers and registrars all have access to online learning resources.

It is very satisfying when a registrar experiences for themselves the benefits of applying these skills in practice. They tend to infect the group with their enthusiasm as the benefits become obvious and they can see how learning Calgary–Cambridge communication skills can help them to achieve their short- and long-term goals in general practice and beyond.

For more information and resources on the Calgary–Cambridge framework refer to www.skillscascade.com.

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Chronic Obstructive Pulmonary Disease (COPD) Integrated Model of Care

	PRIMARY and COMMUNITY CARE 3 MONTHLY CHECK	SECONDARY or SPECIALIST CARE PRIMARY CARE REFERRAL (4)
DIAGNOSIS		
COPD →	Spirometry (1) and CXR (2)	
MANAGEMENT—excludes acute exacerbations		
ALL PATIENTS →	Smoking cessation (3) Inhaler +/- Spacer technique Influenza immunisation	
	1 yearly	
	Pneumococcal immunisation	
	5 yearly	
	Spirometry	
	1 yearly	
	Diet	
	Exercise	
Early referral to specialist respiratory outpatient services may be indicated (5)		
MILD FEV1 60–80% predicted →	Short-acting beta agonist —PRN or REGULAR	
and/or	Ipratropium bromide —PRN or REGULAR	
MODERATE FEV1 40–60% predicted ***ADD*** →	Long-acting beta agonist—REGULAR (6) Tiotropium bromide—REGULAR (7) Inhaled corticosteroid—REGULAR (8)	→ Pulmonary rehabilitation (9)
SEVERE FEV1 <40% predicted		→ Oxygen service (10)
SELECTED COMORBIDITES—often requiring specialist input		
Lung cancer (11)		→ Respiratory clinic
Bronchiectasis (12)		→ Respiratory clinic Physiotherapy
Cor pulmonale (13)		→ Respiratory +/- cardiology clinic
Polycythemia (14)		→ Haematology clinic
Anxiety and depression (15)		→ Health psychologist Mental health team
End-stage COPD (16)		→ Palliative care

COLOUR CODING—PRIMARY ROLES

General practitioner

COPD nurse and/or practice nurse and/or community health worker

Dietician

Exercise facilitator

EXPLANATORY NOTES

(1a) Screening for COPD

- Consider COPD in all smokers and ex-smokers over the age of 35 years, with these symptoms: breathlessness, chest tightness, wheeze cough and sputum production.
- Fatigue, anorexia and weight loss occurs in advanced disease.
- Acute exacerbations can occur frequently in COPD.

(1b) Diagnosis of COPD

- Airflow limitation is not fully reversible when, after administration of bronchodilator medication, the ratio of FEV1 to forced vital capacity (FVC) is <70% and the FEV1 is <80% of the predicted value.

(1c) Classification of COPD severity

FACTOR	MILD	MODERATE	SEVERE
Spirometry —post-bronchodilator FEV1	60–80% predicted	40–59% predicted	<40% predicted
Functional assessment	Few symptoms No effect on daily activities Breathless on moderate exertion	Increasing dyspnoea Breathless on the flat Increasing limitation of daily activities	Dyspnoea on minimal exertion Daily activities severely curtailed
Complications	No	Exclude complications; consider sleep apnoea if there is pulmonary hypertension	Severe hypoxaemia (Pao2 45mmHg, or 6kPa) Pulmonary hypertension Heart failure Polycythaemia

www.copdx.org.au

(2) CXR

- May also be provided within primary or secondary care.
- All patients should be referred for a CXR on diagnosis of COPD, which may also exclude other causes of symptoms.

(3) The 'COPD Integrated Model of Care' is a practical and simplistic overview of COPD, 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

Therapeutics:

- Counselling by Quitline, primary or secondary care health professional
- Nicotine Replacement Therapy (NRT)
- Pharmacological management
  - Bupropion (Zyban)
  - Nortriptyline
  - Varenicline (Champix)

(4) Referral from primary to secondary care follows national and/or regional guidelines.

(5) Specialist referral

Confirmation of the diagnosis of COPD and differentiation from chronic asthma, other airway diseases or occupational exposures that may cause airway narrowing or hyper-responsiveness, or both, often requires specialised knowledge and investigations. Indications for which consultation with a respiratory medicine specialist may be considered are shown in the following instances:

REASON	PURPOSE
Diagnostic uncertainty and exclusion of asthma	Establish diagnosis and optimise treatment Check degree of reversibility of airflow obstruction
Unusual symptoms such as haemoptysis	Investigate cause including exclusion of malignancy
Rapid decline in FEV1	Optimise management
Bullous lung disease	Confirm diagnosis and refer to medical or surgical units for bullectomy
COPD <40 years of age	Establish diagnosis and exclude alpha1-antitrypsin deficiency
Frequent chest infections	Rule out co-existing bronchiectasis
Dysfunctional breathing	Establish diagnosis and refer for pharmacological and non-pharmacological management

www.copdx.org.au

(6) Long-acting beta-agonist (Oxis, Serevent)

- Stepwise management if patient still symptomatic after mild COPD management.
- May be used in addition to Tiotropium (see below). Consider especially in those who are not responding, intolerant or do not meet special authority requirements for Tiotropium.
  www.bpac.org.nz
- If frequent exacerbations, consider using combination LABA/ICS inhaler, e.g. Symbicort, Seretide (special authority required).
  www.pharmac.govt.nz

(7) Tiotropium bromide (Spiriva)

- Stepwise management if patient still symptomatic after mild COPD management.
- If using Tiotropium (long-acting anticholinergic) then Ipratropium bromide (short-acting anticholinergic) should be stopped.
- Currently Tiotropium is only available by special authority application, completed by a general practitioner or relevant specialist. Pharmac eligibility currently requires a FEV1 <60% predicted (other conditions apply).
- May be used in addition to LABA, if symptomatic and FEV1 <60% predicted.
- There is some evidence to suggest Tiotropium and LABA together may be superior to either monotherapy.
  Reference: Terzano C, et al. Rational timing of combination therapy with tiotropium and formoterol in moderate and severe COPD. Respiratory Medicine. 2008; 102(12): 701–7.

(8) Inhaled corticosteroids

- Inhaled glucocorticoids should be considered in patients with moderate or severe COPD with frequent exacerbations, e.g. two or more per year.
  www.copdx.org.au

(9) Pulmonary rehabilitation

- Pulmonary rehabilitation programmes involve patient assessment, exercise training, education, nutritional intervention and psycho-social support.
- Useful in addressing patient anxiety and depression.
- Proven to reduce hospitalisation and has been shown to be cost-effective.
- Improves overall quality of life.
  www.copdx.org.au

(10) Long-term oxygen therapy (LTOT)

- Assess the need for oxygen therapy in non-smokers with any of the following:
  - Very severe airflow obstruction (FEV1 less than 30% predicted)
  - COR pulmonale
  - Polycythaemia
  - Oxygen saturations less than or equal to 92% breathing air.

  www.nice.org.uk

(11) Lung cancer

- COPD patients are at high risk of primary lung malignancy. Hence, there should be a low threshold for specialist referral if there are any of these features:
  - Persistent haemoptysis in smokers or ex-smokers ≥40 years old
  - A CXR suggestive of lung cancer, including pleural effusion and slowly resolving consolidation
  - Systemic symptoms such as unexplained weight loss, anorexia and night sweats.

  Suspected Cancer in Primary Care: Ministry of Health – New Zealand Guidelines Group

(12) Bronchiectasis

- Between 20% and 30% of all COPD patients have bronchiectasis on CT scanning and in about 10% of patients this is significant.

  Reference: 10-minute consultation: Chronic obstructive pulmonary disease (COPD). Cedilla Publishing Ltd; 2008. p 57.
- Physiotherapy teaches people with excessive sputum how to use positive expiratory pressure masks and active cycle of breathing techniques.

  www.nice.org.uk

(13) Cor pulmonale

- Lung disease complicated by right ventricular failure.
- Consider in people who have peripheral edema, raised JVP, systolic parasternal haeve, loud pulmonary second heart sound.

  www.nice.org.uk

(14) Polycythaemia

- Secondary polycythaemia results from hypoxia due to severe COPD.
- If hyperviscosity symptoms or HCT >56%—consider venesection to HCT <52%.

  Reference: Guidelines for the diagnosis, investigation and management of polycythaemia/erthryocytosis. British Journal of Haematology. 2005; 130(2):174–95

(15) Anxiety and depression

- Frequently under-recognised and under-treated in COPD patients.
- Joint care by primary +/- secondary care health professionals utilising pharmacological and non-pharmacological strategies.

(16) End-stage COPD

- Determining prognosis in end-stage COPD is difficult, although guides to shortened survival include:
  - An FEV1 < 25% predicted
  - Weight loss (body mass index below 18)
  - Respiratory failure (Paco2 > 50mmHg, or 6.7 kPa)
  - Right heart failure.
- The goals of palliation are the elimination or attenuation of symptoms where the underlying cause remains irreversible or resistant to therapy.
- Opioids (usually morphine) and benzodiazepines (short-acting) may be used for dyspnoea.
- Issues for discussion could include Advanced Health Care Directives.

  www.copdx.org.au

This article is co-authored Dr Kevin Gabriel (College Fellow) and Dr Elaine Yap (Respiratory Physician, Middlemore Hospital and the NZ Respiratory and Sleep Institute) and peer-reviewed by Dr Fiona Horwood (Respiratory Physician, Middlemore Hospital).

Building a library for clinical measures

Julie Artus

ICML Project Manager

The Patients First programme (formerly known as qi4GP) supports the New Zealand primary health care sector in improving the quality of patient outcomes by obtaining a clearer focus on information.*

One of the key initiatives currently underway is to develop an integrated library of primary health care clinical measures in close collaboration with a group of sector representatives. The launch is planned for the end of this month.

The approach is similar in concept to work undertaken by the Information Centre of the English NHS—they have published a searchable resource of definitions for some 3000 measures currently in use in health and social care in England.† Our project involves building a library framework tailored to the New Zealand environment, enabled by a web-based repository and with an agreed standardised format for definition and presentation of clinical measures. Work also involves determining the appropriate governance arrangements to provide stewardship and support for the future direction of the library and oversight of agreed protocols for review, selection and development of new measures.

Operational project sponsor Andrew Stenson says: "In New Zealand, there is no easily accessible, reliable source of clinical measures that can be applied within primary health care. The lack of a standardised way of defining measures and the limited understanding of why and how they should be applied leads to duplication of effort and lack of clarity about whether users are comparing apples with apples, pears or oranges.

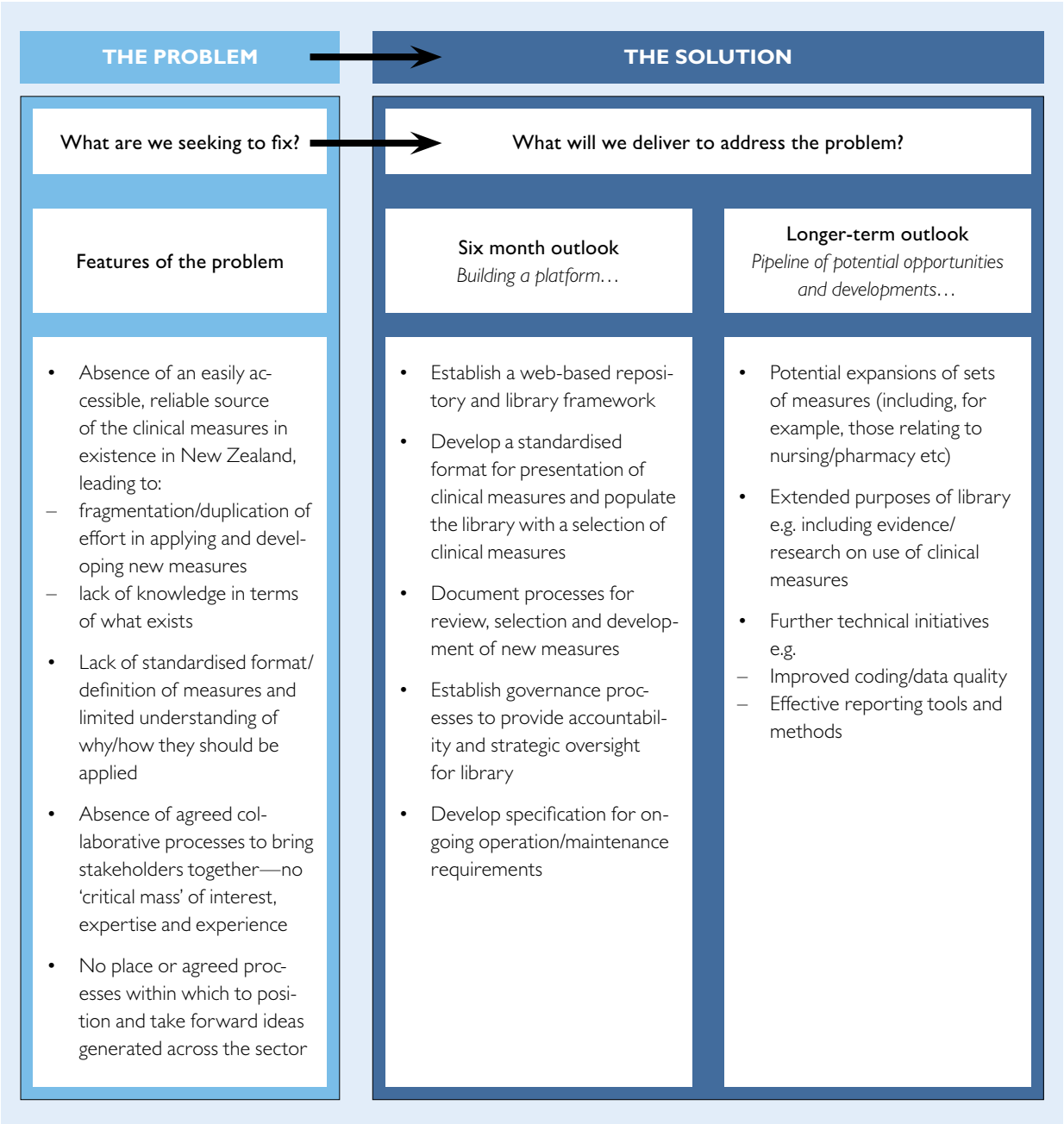
"Also, in bringing together stakeholders on a project with a strong practical focus, we seek to develop a critical mass of interest, expertise and experience and to provide a place from which to position and take forward ideas generated across the sector."

Our project involves building a library framework tailored to the New Zealand environment, enabled by a web-based repository and with an agreed standardised format for definition and presentation of clinical measures

As illustrated in the accompanying diagram, the establishment of the library is viewed as an opportunity to build a

* The Patients First programme (formerly known as qi4GP) is is co-sponsored by RNZCGP and General Practice New Zealand (GPNZ). It is funded via a primary health IT grant approved by the National Health IT Board. For further information about the programme and its constituent projects, contact the Programme Manager, Andrew Terris at andrew.terris@patientsfirst.org.nz.

† http://www.ic.nhs.uk/services/in-development/indicator-library



platform upon which to position future initiatives.

In the first instance, the library will be populated with a small selection of existing clinical measures (for example, the current PHO Performance Programme indicators and a set of new measures developed by the College in conjunction with the Wellington School of Medicine of the University of Otago).

Over time, we seek to expand the range and volume of information provided and potentially to consider options for extending the purpose of the library, for example to include discussion forums or evidence/research on the use of clinical measures.

If you have any questions regarding this project, or would like to receive updates on progress, please contact:
Julie Artus, ICML Project Manager
Email: jartus@srghealth.com

Aiming for Excellence 2011

Maureen Gillon

Principal Advisor Quality and Safety, RNZCGP

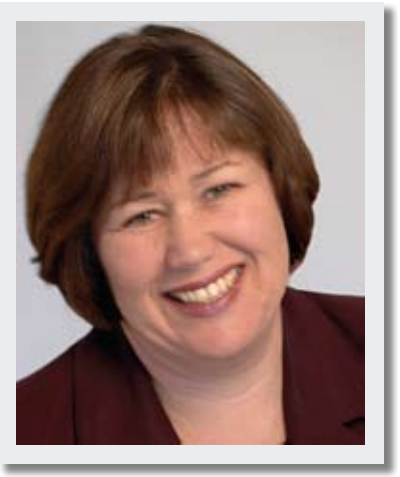
Aiming for Excellence is the foundation standard used by the CORNERSTONE General Practice Accreditation Programme and other College programmes. **Maureen Gillon** reports on a review of the 2009 standard, now nearing completion.

There has been steady progress toward completing *Aiming for Excellence* 2011. Interest from practices, CORNERSTONE assessors, networks, PHOs, various organisations and consumers have contributed advice to a small working group and larger Expert Advisory Group, both led by Dr Chris Fawcett, RNZCGP Chief Censor of CORNERSTONE and a GP.

Chris Fawcett notes there have been significant changes in the way general practices are organised in the current primary care environment since publication of the 2009 version of *Aiming for Excellence,* and this has required a rethink about the purpose and direction of the 2011 version. Growing complexity in general practices is evident as they are embedded in a variety of networks, and are more connected through new information systems. Combined with integration across primary, secondary and community settings, this activity is extending practice teams' capacity to improve delivery and clinical outcomes for patients.

One of the constant elements in primary care is change. Chris Fawcett notes that understanding the drivers and needs is important, and the impact of change in clinical practice is having measurable and positive effects on general practices and patients. To inform the rebuild, the Wellington School of Medicine undertook a review to understand any changes in the current quality landscape.[1] The College also sought feedback on the current version to understand the views of general practice teams and primary care. The consultation phase reinforced ownership of the document by its users, including people who use general practice services. Combining feedback from the review of the landscape and the consultation, the document reflects the blending of academic investigation with a pragmatic understanding of general practice. The exercise has been encouraging and useful to establish the rationale and inform direction in 2011 (Box 1).

An underlying principle during development has been to promote quality improvement and encourage critical thinking approaches to generate positive change for patients. The standards provide a foundation for practice teams to compare against a benchmark, reflect on their own practice and make changes to improve practice systems and processes. Chris Fawcett says this encourages practices to take a questioning and systematic approach to determine the effectiveness of care offered to patients.



The baseline provided by Aiming for Excellence is increasingly recognised by other organisations such as the Health and Disability Commissioner's Office. The Department of Corrections is the latest organisation to register its 20 practices in CORNERSTONE

Increasingly, there is greater understanding of the value of *Aiming for Excellence* and its role in guiding general practices, and the organisations that support them, to develop safe environments with robust systems and processes. Now that there are around 800 prac-

tices registered in the CORNERSTONE programme using *Aiming for Excellence*, it is even more important that the standard is 'fit for purpose' across a range of general practices.

Risk management is an essential element of a complex primary care environment. A major consideration for the rebuild was to update the double-star criteria[2] (identified as; external, legal, safety or those that pose a significant risk if not met) which sets out the minimum level of service patients can expect. A report[3] which provided advice on a comparison undertaken against any changes in legislation or regulation informed consideration by the development team.

The baseline provided by *Aiming for Excellence* is increasingly recognised by other organisations such as the Health and Disability Commissioner's Office. The Department of Corrections is the latest organisation to register its 20 practices in CORNERSTONE. It was important to first identify whether *Aiming for Excellence* 2011 would be applicable for use by prison practices. Maureen Gillon and Dr Judith Simpson visited the Wanganui prison practice with Debbie Gell, from Corrections, and their regional Clinical Quality Nurse. The visit confirmed the relevance and feasibility of the standard for developing their general practice systems. There are similar examples with Aviation and Defence Force practices using *Aiming for Excellence* to meet their requirements for CORNERSTONE accreditation.

Chris Fawcett notes that any measuring and counting must be closely associated with a critical understanding of standards and provide a pathway towards improvement. Furthermore, the review of the quality landscape[1] clearly identified a need for more resources to support clinical effectiveness activity by general practice clinicians. He believes the next step in the quality journey is to ensure that practice teams get value from being in the process by ensuring they enter into a continuous cycle of improvement and are provided with access to clinical modules that incorporate education, assessment and learning through cycles of improvement. This will provide clinical teams with a platform to set aspirational goals for improving patient care.

The review of the Quality Landscape found that there are exciting new initiatives occurring in general practice and clinical teams want to be able to showcase the work they do. They want greater emphasis on the patient journey and clinical activity. Fawcett says the combination of CORNERSTONE accreditation against the *Aiming for Excellence* standard and completion of clinical modules will enable practices to showcase and achieve recognition for their work to improve clinical effectiveness, or, as Professor Tony Dowell rightly notes, quality that makes your heart sing!

Aiming for Excellence Expert Advisory Group

Dr Chris Fawcett (Chair, Aiming for Excellence Expert Advisory Group), Dr Jane Burrell (Chair, Professional Practice Expert Advisory Group), Dr Jim Vause, Dr Tane Taylor, Dr Malcom Dyer, Dr Helen Rodenburg, Dr Jocelyn Tracey, Dr Keri Ratima, Dr Jane O'Hallahan, Jane Ayling, Kevin Rowlatt, Helen Bichan, Rosemary Gordon, Maureen Gillon, Waveney Grennell, Madhukar Mel Pande, Jeanette McKeogh

Box 1. General practice in 2011

New Zealand general practices are characterised by:*

- A person-centred approach
- Involving patients and their whānau in their care
- A culture of safety, accountability and continuous quality improvement
- Multi-disciplinary teams working together in networks of cooperation and support, providing both individual and population care for communities of patients
- Embracing new opportunities, including public health, screening, illness prevention, disease management and resource management
- Accepting greater accountability for health outcomes and best use of health resources
- Delivering clinical and management excellence in services, at all levels, to ensure optimum effectiveness and efficiency

* *Perera R, Morris C, Dowell T. Voyage to quality: Mapping the quality landscape. Report to The Royal New Zealand College of General Practitioners. Wellington, NZ: Primary Health Care Quality Research Unit, Wellington School of Medicine and Health Sciences, University of Otago; 2010.*

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CORNERSTONE accreditation … second time around

Sara Lewis

Business Manager, Coast to Coast Health Care

Coast to Coast Health Care (CTCHC) is a group of six clinics across the Rodney and lower Northland region employing a team of 60 people in an innovative teaching practice, where interprofessional collaboration is key to delivering seamless services with measurable outcomes for health improvement.

Having successfully completed CORNERSTONE in 2007, we were keen to build on the initial success and have continued to use *Aiming for Excellence* as a guide to our CQI (continuous quality improvement).

In preparation for re-accreditation, we established a core team plus a coordinator who reviewed the indicators and assigned work to the appropriate team member. By utilising a single coordinator the management team was able to continue with business as usual but could dedicate time, as required.

GDSL (the software from Geethal Data Systems Ltd) was new to us, but created an additional checking mechanism and proved really valuable when sending away policies and attachments for the assessors.

Our assessment on 8 December 2010 created apprehension and excitement, and the assessment team arriving an hour-and-a-half earlier than expected created some additional butterflies. Staff who were able to attended the pre and post-assessment meetings, and appreciated being interviewed in groups rather than as individuals.

Having achieved CORNERSTONE, our motivation was to improve the standard we had set when assessed the first time

For us, the benefit of being part of the CORNERSTONE process is the development of a structure that enables continuous quality improvement, provides clarity to the whole team, supports our practice, and improves our ability to plan for the year ahead. Our patients benefit through more consistent practice, providing them with high quality services in an environment that is safe and informative and where they feel welcomed and supported.

Having achieved CORNERSTONE, our motivation was to improve the standard we had set when assessed the first time. CORNERSTONE is a continuous journey, and we believed that since Cycle 1, we had built on those foundations and continued to grow as an organisation. The second cycle has reinforced and acknowledged that development: staff appreciate guidelines and clarity surrounding their role and, as a practice, there is greater understanding through improved policies and procedures. CORNERSTONE instils a professional approach that supports our workforce to provide consistently high quality care to patients, who in turn are more satisfied with the outcome of their visit.

The outcome of our CORNERSTONE journey has been enhanced understanding of every area of the business, improved communication, and continual review of how we are working in an organisation that encourages and supports both staff and patient involvement.

The Coast to Coast Health Care team

Lessons from complaints—HDC investigation into missed colorectal cancer

Jeanette McKeogh

Senior Policy Advisor

The College recently received a Health and Disability Commissioner breach finding report on a general practitioner (Fellow of the College) who failed to diagnose colorectal cancer in his patient, who at the time was 66 years old.

The patient consulted the GP on a number of occasions between November 2007 and November 2008 with various complaints including tiredness, low energy levels, mild lower back pain, aching upper abdomen, shortness of breath, tightness in her lower chest, and a feeling of passing out.

The GP diagnosed the patient with iron deficiency anaemia in November 2007 and prescribed iron supplements. The patient's iron levels initially improved but dropped again between April and July 2008. The GP prescribed more iron supplements for the patient, but her health did not improve. There is no evidence that the GP carried out an abdominal or rectal examination on the patient, or ordered tests to investigate the cause of the patient's anaemia.

In November 2008 the patient sought a second opinion from another GP, who immediately identified a swollen liver and arranged for the patient to be investigated further with blood tests and a computerised tomography (CT) scan. The CT scan revealed a primary tumour in the patient's caecum and secondary cancer in her liver.

The major causes of iron deficiency anaemia are blood loss, poor absorption of iron, or inadequate intake of iron. In men and postmenopausal women with normal dietary intake of iron, iron deficiency anaemia is most commonly caused by gastrointestinal blood loss from certain types of cancer (oesophagus, stomach, colon), long-term use of aspirin or non-steroidal anti-inflammatory medication, peptic ulcer disease, or ulcers. Iron deficiency anaemia may also be caused by poor absorption of iron in the diet due to celiac disease, Crohn's disease, gastric bypass surgery, or taking antacids.

Therefore, examination of both the upper and lower gastrointestinal tract is an important part of the investigation of patients with such anaemia. In the absence of overt blood loss or any obvious cause, all patients with such anaemia should have upper gastrointestinal endoscopy, as well as a small bowel biopsy, and colonoscopy or barium enema to exclude gastrointestinal malignancy.

The GP treated the patient's symptoms of iron deficiency anaemia but did not undertake appropriate investigations to elucidate the cause of the anaemia. The GP should have carried out an abdominal and rectal examination on the patient, and requested laboratory tests (mid-stream urine sample to exclude renal blood loss, and faecal occult bloods to exclude blood loss from the bowel). The GP should also have referred the patient for a gastroscopy when the patient presented with upper gastrointestinal tract symptoms and anaemia.

The GP was found in breach of Right 4(1) and 4(4) of the Code of Health and Disability Services Code of Rights (the Code) for failing to appropriately investigate and manage the patient's iron deficiency anaemia. The GP also breached Rights 4(1) and 4(4) of the Code for failing to examine the patient's abdomen prior to diagnosing gastritis.

Record keeping

The report also comments on the GP's use of a 'hot key' function when recording his notes. This is a function available in most practice management systems that enables a word, phrase, or list to be inserted quickly, usually with the activation of one or two keys.

The GP in this case had used the 'hot key' function on several occasions throughout the notes to enter identical phrases (one phrase a total of nine times and another phrase a total of eight times). The GP was found in breach of Right 4(2) of the Code for failing to meet professional standards in terms of record-keeping.

While 'hot keys' are not uncommon in general practice, the content of clinical notes must accurately reflect the activity that took place during the consultation. The standard is contained in *Aiming for Excellence—An Assessment Tool for New Zealand General Practice*, 3rd edition, 2008, RNZCGP. Of relevance is indicator D.9.1–5 which states: "Consultation records relevant content of each patient contact with practice clinical staff, including consultations, home visits and telephone advice."

GP workforce project

Anne Davys

Policy Manager, RNZCGP

The Revision of General Practitioner Training project has now been underway for 10 months.

To recap: why is the review being undertaken?

The purpose of the project is to ensure that GP training prepares doctors for a role that is more flexible and multi-faceted, with closer links to local hospitals, and to prepare for emerging models of care with increased delivery of services outside hospital settings. With a growing elderly population, increasing co-morbidity and constant change in treatments and technology, we need to equip GPs to take on an increasingly complex role. We also know that we need to make the general practitioner role more attractive to ensure that we recruit more young doctors into this branch of medicine.

How is the review being run?

The review is being jointly managed by Health Workforce New Zealand, The Royal New Zealand College of General Practitioners and the Medical Council of New Zealand. The lead sponsors are Professor Gregor Coster (HWNZ), Dr Tana Fishman (RNZCGP) and Dr John Adams (MCNZ). Dr William Rainger, President of the College of Public Health Medicine has been appointed to project manage the process. A steering group of representatives from the three partner organisations meets monthly to oversee progress. Sector engagement and information has been gathered from GPEP educators, the RNZCGP Education Expert Advisory Group, the Division of Rural Hospital Medicine and a sector-wide reference group. An invitation to members for feedback has also been extended through the College website and these responses have been taken into account.

Key work in progress

The College is working with HWNZ to gain equivalence with other specialities' training in terms of benefits and, to that end, gaining support for greater benefits for the GPEP1 bursary for first year registrars.

The project team and associated working groups have also already started developing advanced competencies and related educational modules in areas of mental health and care of the elderly. This work is being developed in conjunction with both the College of Psychiatrists and the College of Physicians.

What happens next?

A discussion document on suggested changes to the current GPEP training programme will be released around April/May.

Matters to be considered within the discussion will likely include the relationship to general practice exposure in PGY2 as well as increasing links to the training opportunities within other specialties. A focus will also be on enhancing and better supporting GPEP2, and discussion around the proposed duration of the GPEP training programme. A second stream includes consideration of the augmentation/extension of the current Rural Hospital Medicine programme.

We will continue to keep you informed with various communications via the project partners' websites and print mail.

With a growing elderly population, increasing co-morbidity and constant change in treatments and technology, we need to equip GPs to take on an increasingly complex role

Contributing to general practice—beyond the consultation room

RNZCGP Policy Team

In response to requests for general practitioner input, the College has elected over 90 Fellows to represent our views on approximately 70 different groups. Committees range from cancer treatment steering groups to advisory groups on infectious diseases, with some of our reps active in more than one group. These general practitioners provide valuable and useful information for the College, fulfil important functions within the health sector, supporting service development and representing College positions. They are able to influence decisions effectively on the basis of general practice expertise and advice.

Improving the process we use to nominate College representatives is one of the areas on which the Policy Team has been focusing over the past six months. We have recently established an Ad Hoc Appointments Expert Advisory Group (EAG) which will assess applications and provide advice to the CEO regarding potential candidates. New representative roles are put into our weekly electronic newsletter *ePulse*, so remember to check your email every Tuesday if you are interested in finding out about new positions and possibly engaging in this very important work.

We would like to highlight the work that our representatives do on these committees and some of their experiences by regularly featuring a couple of their stories in each issue of *GP Pulse*. Dr Liz Harding (GP, Auckland) and Dr Jane Burrell (GP, Upper Hutt) have kindly contributed to this issue with some of their experiences.

The Professional Practice Expert Advisory Group (EAG) is an invaluable resource for the Policy Team. Our EAG members have a wide range of interests and experience and provide sound advice on policy issues, particularly topics with a clinical focus. They also provide input into our strategic direction when putting together our work plan for the upcoming year. **Dr Jane Burrell** is the Chair of the Professional Practice EAG, and here describes her experiences with work that GPs are involved in outside of the consultation room.

As doctors, we often focus on the patient's journey; I thought I would follow through the GP's journey—at least my journey to date.

When most of us start out in general practice, we are very focused on trying to be a good doctor. It is overwhelming the breadth of medicine we are expected to know, and my time was spent attending CME and practical skills sessions that helped to extend my knowledge. The focus was definitely on me as the GP and the patient—the consultation room.

After a few years, I developed a bit more confidence and was more comfortable with the one-on-one consultation, and wanted to have a better understanding of the health centre as a team and the management structure. I worked in the Mornington Health Centre at this time and learned a lot about teamwork amongst the GP directors, nurses and management team. I realised there was always far more going on behind the patient consult than just my input.

The next step along my journey was understanding the role of the PHO and how the practice, GPs and patients fitted into all of this. On shifting to Upper Hutt, I joined the Family Care PHO as the provider representative and my view of medicine

and the local community broadened again. I gained the understanding that the PHO not only had a fiscal responsibility, but that clinical governance was of equal importance.

The next step was a leap from local community involvement to join the Board of Quality, and currently the Expert Advisory Group for Professional Practice. This shift towards a national focus has broadened my understanding considerably. This was a chance to have a better understanding of what supports were in place to help make us better GPs; how the RNZCGP is helping us get our systems in order to reduce our clinical errors through *Aiming for Excellence*, and seeing the work being done to improve communication between the primary and secondary interface and between the allied professionals we work closely with, looking at ways of sharing great local initiatives throughout the country and learning from others when things don't go according to plan.

As Chair of the EAG for Professional Practice I have been included in a number of meetings with the senior management of the College, the Board, the College Council, Branch Advisory Bodies for the Medical Council, Performance Management Programme Advisory Board, Ministry of Health, Wellington School of Medicine… and the list goes on. It is amazing the amount of back-room work going on that I was initially oblivious to and that is helping and supporting general practice in New Zealand. I am in awe of many of the doctors who are members of the different committees and boards. They show such dedication, enthusiasm and expertise in so many areas. I feel totally inadequate at times, but I am definitely learning.

It is enlightening to see the bigger picture of general practice and to be able to have some input into where we are heading in the future. I strongly encourage anyone interested beyond the consultation room to work through the journey to broaden your understanding of general practice. I still enjoy my one-on-one consultation with patients but don't get bogged down in the same. I will always be looking to strengthen my medical knowledge, but I believe the journey I am on is helping me to be a more holistic GP within the community.

Dr Liz Harding is the GP Liaison Officer/ College representative on the New Zealand Mental Health Professional Group, and is also on the Clinical Ethical Advisory Groups for both the Auckland DHB and Waitemata DHB. Liz answered some burning questions in a mini-interview posed by the Policy Team.

Q: What have been your most positive or rewarding experiences working on the group(s) you are involved with?

A: The most rewarding experience has been the opportunity to develop a cohesive, mutually respectful and enjoyable relationship with a diverse group of people in the group, particularly those in the Clinical Ethical Advisory Group for the Auckland District Health Board, but also for the other groups I am involved in.

Initially, I was wary of members with other perspectives but I grew to value their own different experiences and areas of expertise. As an example, people working in the area of intensive care often have to make reasonably rapid life-and-death judgements, while my approach was more slow, gentle, wanting the best for everyone regardless of what resources existed. It took a while to find a balance where we could all help the clinician and patient in the best way possible. I have learned a lot.

It has been a real privilege to hear the concerns of clinicians about ethical issues to do with their patients, and be given the opportunity to struggle with the pros and cons of various courses of action. I have valued the input from the rest of the group and enjoyed stating my own opinion. It's good

to hear that our opinions are helping the clinicians manage their patients in a better way.

It was satisfying to be a bit involved in putting out 'Talking Therapies' with the NZ Mental Health Professional Liaison Group. We are currently organising a position statement on Adult Attention Deficit Disorder.

Q: Can you think of any funny moments you've encountered in your role?

A: Well, there was one embarrassing time. I'm not sure if I should tell you about it. I was working long hours and was very tired. We had an evening teleconference. Some friends came over, so I had to move to the telephone in the back bedroom and close all the doors for privacy. It was February and very hot and humid. Halfway through the meeting I was struggling to concentrate and keep my eyes open. Next thing I knew, all I heard was the beep, beep, beep of a hung-up call and it was an hour later. I had gone to sleep. The minutes have me involved until halfway through the meeting. I emailed the secretary and apologised profusely. She said she thought I'd gone a bit quiet, but she didn't think anyone had noticed. No one had spoken to me directly.

Q: What has been your favourite experience so far?

A: There are several: having clinicians write back to the ethical committee letting us know that we have helped them, or how we could improve our service, and how the patient has got on. Clinical Ethical meetings when we have a challenging ethical issue and we are working hard and well together to think through all of the options to best help the patient and clinician; and having a coffee with some of the members after the meeting—making friends.

Q: Would you like to offer any words of advice to GPs already involved in or taking up similar roles in the future?

A: At one stage I was involved in four medical committees, two peer groups and a Balint group. I work full-time as a GP locum and have teenage children. I am now GP Liaison for three committees and only go to one peer group. It's better not to spread myself so thinly. When I stop enjoying doing it, I'll hand it on to someone else.

BOOK REVIEW

All Blacks Don't Cry—A Story of Hope

by John Kirwan

Reviewer: David Codyre

Psychiatrist and Clinical Director, ProCare Primary Mental Health Programme

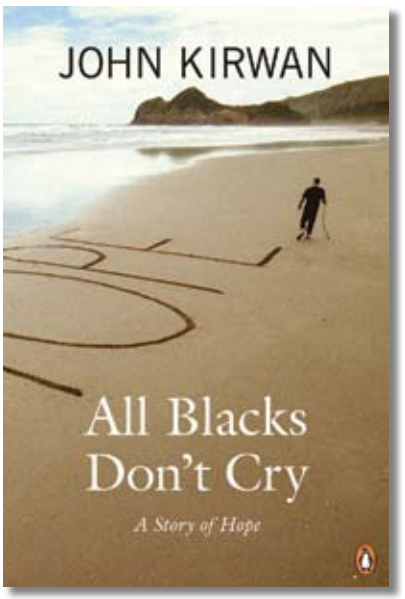
"Depression doesn't discriminate. It has no prejudice. I didn't choose depression, and when it came along I simply didn't believe it could be happening to me. I was in total denial. The day I accepted I had this illness was the day I started getting better."

All will be aware of John Kirwan's work fronting the National Depression Initiative (NDI—the public health campaign to increase depression awareness), and in particular the series of TV ads—the so-called 'JK ads'. I consider John to be a 'national treasure', for his courage in owning his illness experience so publicly. His story has resulted in increased numbers of people accessing effective treatment for their depression, and I have no doubt has saved lives. John's personal story, as distilled into those 'soundbites' has had universal appeal, in particular to men of all cultures. In phase 2 of the NDI, he fronts a highly effective online behaviour management tool for depression, 'The Journal'—I would encourage those of you who have not already done so, to have a look at this tool (www.depression.org.nz), and to include recommending it to patients into your routine management of depression.

This book then, extends on from John's story as presented in the ads, and is a series of anecdotes regarding his battle with, and recovery from, depression, interspersed with brief vignettes from his family and friends (including many past All Blacks) regarding their experiences of him through this time. It is a very personal account, written with that rare combination of insight, wisdom, and humility. It is also written in a style that will make it easy for most people, particularly men, to identify with. It is an easy and enjoyable read, and as such is a welcome addition with a uniquely 'Kiwi' feel, to the range of books we can recommend to the many patients we see in primary care who are suffering from depression and anxiety.

John's many descriptions of the key learning and personal changes which have allowed his recovery will be an important source of hope and inspiration to others on their own journey of recovery

John's many descriptions of the key learning and personal changes which have allowed his recovery will be an important source of hope and inspiration to others on their own journey of recovery. He elegantly articulates through a variety of his anecdotes, the reality that while medication can be key to control of symptoms of this illness, recovery is most often about seeking (via professional help if necessary) to understand why depression has got you in its grip,



and making changes to get 'balance' into your life. "In some ways depression was a gift for me. So did I like it when I was in there? No. Am I a better person? Yes. At the other end of this experience you're going to be a whole lot better from a human point of view.'… 'It amazes me now that a lot of the things I used to perceive as weakness are actually strength. You know, if you can tell someone you love them; have the courage to cry; understand your emotions; for me those are real strengths."

I would recommend this book to anyone working in general practice as a rich source of insight into the experience of depression, and what it takes to recover. Its hopeful and inspiring message will also be of benefit to many of your patients.

BOOK REVIEW

Caught Between Sunshine and Shadow—Living with and managing bipolar affective disorder

Compiled by Georgie Tutt

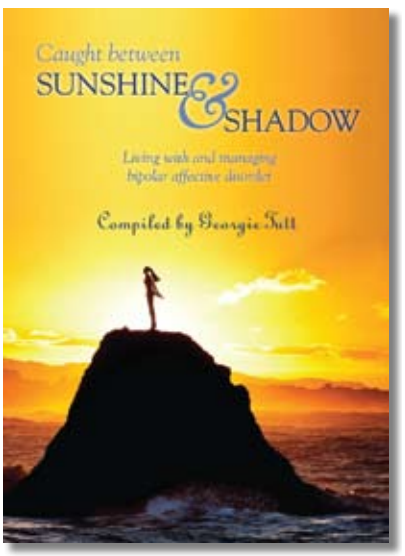
Reviewer: William Ferguson

GP, Kumeu

There is a lot to learn for both doctors and patients from this book. It consists of 37 well-edited personal accounts of the trials, tribulations and diverse paths to recovery from bipolar disorder (BPD). Scattered within these personal and anecdotal accounts of living with BPD are well-articulated gems of insight into the condition, and the difficulties in treating it. It is an engaging read and the images it creates are at times very vivid. "In our case leaving it for a day can be too long—the mania takes hold like a bush fire with a gale behind it." (Frans)

A recurring theme that struck me was the very early age of onset of symptoms reported in many of the accounts—often decades before a diagnosis was formally established. "The first evidence that I was depressed emerged when I was seven and wrote a letter to my mother that read, 'Dear Mummy, I don't know why I am always sad'," (Sharon) and, "I remember being seven and thinking of going to the back of our farm and not coming back. I didn't realise at the time that these were suicidal thoughts." (Carra)

Another theme was the typically long and convoluted path most sufferers had to follow in order to eventually find effective treatment. The GP's role was central to recovery in some of the stories. The take-home message for us as GPs is the importance of close and continuing follow-up until recovery is fully established, and avoiding the ubiquitous pitfall of using anti-depressants alone, when the true bipolar nature of the illness has not been recognised. The relief afforded by finally being given the correct diagnosis, and thus an understanding of the nature of the condition, was an almost universal theme.



The take-home message for us as GPs is the importance of close and continuing follow up until recovery is fully established, and avoiding the ubiquitous pitfall of using anti-depressants alone when the true bipolar nature of the illness has not been recognised

Some of the important messages we as doctors would often like to convey come best out of a patient's mouth: "If there is one thing I cannot stress enough in your quest to gain control over bipolar disorder, it is to make friends with your illness, the people who are there to support you and the medications you need to remain stable." (Sharon) This book will help many people.

Caught Between Sunshine and Shadow is available from the following website: **www.cbsas.co.nz**

HUMOUR

Out, damned spot!

Buzz Burrell

GP, Blenheim

There it was, taunting me. It stared at me with malignant pride, having sneaked on to my skin when my guard was down. My fingertip had become the ashamed and terminal owner of a new black spot.

'New or changing' are the two excuses for excision, or in my case pre-mortem amputation. I found the dermatoscope to confirm what I knew already, that the world's most aggressive malignant melanoma had moved in to claim first my finger tip, and subsequently via a series of increasingly violent mutilations, my body.

Medical training has its advantages. I knew beyond any doubt this was superficial spreading at the very least, and perhaps I should go straight to the oncologist. Less educated people would consider themselves paranoid, or hypochondriacal, but many thanks to DermNet, and complete objectivity, I was above this, and not a normal patient.

Although my symptom was real and genuine, the lesser mortal real hypochondriacs are a serious problem. According to TIME magazine, although they account for only about 6% of the patients who visit doctors every year, they cost at least $20 billion in wasted medical resources in the US alone. With internet user-guides, a user-pays environment, and health insurance, hypochondriasis is a handy phenomenon. That $20 billion has no doubt been nervously spent but gratefully received in the US, and I'm sure there are a few boats and overseas holidays funded by the New Zealand hypochondriacs we're not in a hurry to pay back.

But is the paranoid feeling that any symptom is a pre-terminal ticket of doom a new thing?

Charles Darwin maintained it was 'illness' that allowed him to work so hard and achieve so much. It was his sickness that kept the world at bay and required a rigid routine of rest and recuperation. His illness included the combination of palpitations, gastric upsets, headaches and general feelings of being "dull, old, spiritless and stupid". Maybe times have changed, but I challenge anybody to find a doctor who hasn't experienced all of these in any combination.

Charlotte Bronte claimed to have suffered a fit of hypochondria while teaching in West Yorkshire, aged 19. She fell into "a most dreadful doom", which she believed had little to do with the sickly and doomed family milieu in which she lived. She meant by 'hypochondria' a dismal combination of sorrow, worry and resignation that arose from the fact that she now had no time to write or to think. In real life, Bronte outlived her five siblings.

Both these famous introspectives timed the announcement of their illness well. Just a century earlier, I can only presume people were less likely to admit to ambiguous symptoms with the contemporary deterrent treatments. A late 17th century remedy book advises: "In hypochondriac disease, force the dark humour downwards with frequent enemas. Infuse mallow and marshmallow and other gentle herbs with seeds of dill and fennel and senna, and let this be taken with prunes often, or with fat broths".

The centuries have seen us mature into the complex and unpretentious. Although MRI, PET and PCR are readily available, our clinical acumen and simple remedies have been honed too. Take for example the man who walks into a doctor's office. He has a cucumber up his nose, a carrot in his left ear and a banana in his right ear.

"What's the matter with me?" he asks the doctor.

The doctor replies, "You're not eating properly."

A simplicity which brings me to my new collection of unwanted malignant melanocytes. Accepting the inevitability of a shortened life with one arm, I thought it might save time if I performed my own shave biopsy. I prepared the trolley with both hands, possibly for the last time, and anticipating a DIY ring block, I washed the cancerous digit with alcohol.

The result was embarrassing, and reassuring. Terminally hypochondriacal I may be, but I am in good company with Darwin, Bronte, and other famous sufferers such as Florence Nightingale, Marcel Proust, and Andy Warhol.

With diagnostic clarity, the spot washed off.

Wine, sensory evaluation and GPs: the aroma wheel

Ros Gellatly

GP, Blenheim

When you were training in medicine and now as you continue life-long learning, you build up your clinical acumen by a combination of acquiring knowledge that includes technical information, applying it in real cases, and then evaluating the outcome. If you want to do the same for your wine acumen, adopt the same approach.

Training courses are out there. Look for 'wine appreciation'. Do one with friends. For example, well-known wine writer and raconteur Bob Campbell runs excellent basic courses. Check with an Institute of Technology in a wine region or some of the larger wine retailers for another source for courses and 'tutored tastings'. Read any or all of the host of excellent books by authors such as Jancis Robinson (she used to sport very large red glasses—the visual kind not the drinking ones), Oz Clarke or Hugh Johnson. If you want to get technical and academic, try Bryce Rankin and Emil Peynaud.

Key skills are being able to describe and name what you taste, lock that in your memory for future comparison and retrieve it from your memory when needed.

A fun way to develop this is to set up an aroma wheel. You can do this at home.

- Get some fairly neutral white and red wines; ones that don't have strong smells of anything in particular, like a bulk-produced Riesling or Merlot.
- Get as many XL5 standard wine tasting glasses as you can and put some of the plain wines in them and leave one each of these unadulterated as a baseline.
- In the white wine glasses, add things that you'd find in whites: cut grass, chopped bits of red capsicum, lemon peel, mandarin, rose petals, for example. In the reds, add things like pencil shavings, green olive (chopped to release smell), violets, coconut, chocolate, vanilla.
- Get some cards, one for each glass. Write the name of the additive on one side.
- Put the cards on the glasses to make lids with the writing on the glass side (i.e. you have to turn the card over to read it).
- Then, without sneaking a look, swirl the glass, sniff the wine and name what it is you can smell as the extra component.

Have you ever had that experience where you smell something and you know what it is but you just can't put your finger on it? Well, this exercise is the antidote to that.

Have you ever had that experience where you smell something and you know what it is but you just can't put your finger on it? Well, this exercise is the antidote to that.

It's called an aroma wheel because many classifications group the smells in wine in similar categories and display them in a circle. So, *florals*, e.g. roses and violets; *fruits*, e.g. quince, pear, raspberry, prunes; *wood* (in which the wine is made or stored), e.g. vanilla, coconut, pencil shavings; and *mineral/earth* smells, e.g. flintiness, are grouped together. Smells from the way the wine was made and kept such as *volatile acidity* (nail polish remover), mousiness, wet socks, burned matches (sulphur) are another group. Some of these can be a bad thing.

Now, next time you have a glass of wine, remember the last column [*GP Pulse*, December 2010] and the skills you've honed with the aroma wheel. Describe what you see and smell, and have fun. But be careful about those jokes with OTT wine buffs and critics who claim they can tell from the 'nose' of the wine what side of the hill the grapes were grown on and which year and where and what grape, blah, blah, blah, blah… With practice you too will be making highly intelligent best guesses at what you're drinking and have great respect for the very experienced practitioners who are skilled at this. But, just like our specialist colleagues, even the best wine tasters can be fooled, so don't take any of this too seriously. As ever, it's all about pleasure and restraint.

Membership information

The College is proud to be your partner in professional practice. Everything we do is aimed at strengthening and supporting you in your practice. We aim to keep you informed about new developments, opportunities, risks and changes within the health sector, and we provide regular opportunities for you to have your say and contribute to the College's work with key stakeholders. As a College member, you have the opportunity to represent us on expert advisory panels in a range of health stakeholder organisations.

You will also receive a suite of free and discounted publications, resources and services to support you in your day-to-day work and professional development. The following information provides you with an overview of what you receive with your membership, as well as some essential information about member categories, faculties and subscription fees.

If you have any questions or would like more information, please don't hesitate to contact Linda Hartstonge, Member Services Coordinator, phone: 04 496 5969 or email: linda.hartstonge@rnzcgp.org.nz

We look forward to working with you to improve the health of all New Zealanders through equitable and high quality general practice.

Benefits

As a member, you have access to the College's personalised member-only area of the website (www.rnzcgp.org.nz), where you can update your membership details and access the following member benefits and services.

Clinical Resources
Free access to College clinical guidelines and resources (PDF format) such as: *Cultural Competence*, *Aiming for Excellence*, *Care of Older People* etc.

ePulse
Free College weekly e-newsletter with salient news items, information about consultations, education events, conferences, vacancies and more.

Classified Job Advertisements
A highly popular service—free classified advertising in ePulse and on the College website to help you find locums, GPs, buy/sell practices etc.

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

BMJ Learning
Free access to all 550 BMJ Learning modules, one of the world's most respected online learning services for GPs.

BMJ Learning offers a range of resources which deal with everyday issues in primary care, general practice and hospital medicine.

McGraw-Hill Medical Books
College members receive a 15% discount and free freight (within New Zealand) for orders from McGraw-Hill Medical Books. The McGraw-Hill catalogue is available on the College website.

Meltwater News
Free access to Meltwater News, an online media intelligence service providing you with current articles, issues and new information from around the globe to inform and support you as a general practitioner.

Journal OF PRIMARY HEALTH CARE

Free subscription to the College's peer-reviewed quarterly journal, designed to meet the information needs of NZ GPs, practice nurses and community pharmacists. The *JPHC* is indexed in the MEDLINE database and deposits published content in PubMed Central.

GP PULSE

Free subscription to *GP Pulse*, the College's current affairs quarterly magazine. *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.

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.

Education

Maintenance of Professional Standards Programme (MOPS)

As an RNZCGP or DRHMNZ Fellow you will receive free access to the RNZCGP Maintenance of Professional Standards Programme (MOPS) through the members-only area of the College website.

This programme helps you to maintain your registration within the vocational scope of general practice or rural hospital medicine by meeting part of the recertification requirements of the Medical Council of New Zealand (MCNZ) and your obligations under the Health Practitioners Competence Assurance Act (2003). The programme's aim is to simplify compliance and reduce your paperwork.

Continuing Professional Development Programme (CPD Online)

If you are an MCNZ general registrant you will receive free access to the Continuing Professional Development Programme (CPD Online) through the members-only area of the College website.

The purpose of this programme is to assist generally registered doctors who are working in general practice to meet the practising certificate (previously called Annual Practising Certificate, APC) requirements of the MCNZ.

Online Web Learning (OWL)

If you are a General Practice Education Programme Stage 1 (GPEP1) or Stage 2 (GPEP2) registrar, Rural Hospital Medicine Training Programme registrar or on the Primex Intensive Training Programme you will have access to Online Web Learning (OWL).

OWL provides access to training programmes, curriculum guidelines, professional development plans, e-Portfolio, workshop and 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.

RNZCGP Research & Education Charitable Trust (RECT)

The Research and Education Charitable Trust's goal is to foster research and education beneficial to general practitioners and their patients, and to continuously improve New Zealand's primary health care system. While the RECT Board awards grants based on criteria that may change from time to time, RECT has historically supported:

- younger researchers working in established GP or registrar practices
- working expenses related to research
- Summer studentships
- travel to conferences where the applicant is making a significant contribution to the conference and where the conference will likely contribute to the GP community.

The funding for grants comes directly from the research levy that each full member of the College pays as part of the annual subscription.

Support

RNZCGP Crisis Line (0800 RNZCGP/ 0800 769 247)

Free RNZCGP Crisis Line and confidential referral service for you to access the appropriate support and services you need in your time of need.

PLAYING THE ADVANTAGE

Tackling the wicked issues

The 2011 Conference 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