RNZCGP DIGEST

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

THE ROYAL NEW ZEALAND COLLEGE OF GENERAL PRACTITIONERS

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IN THIS ISSUE

Welcome to the RNZCGP digest. The digest contains a selection of recent New Zealand and overseas journal articles and other publications that might be of interest to general practice and to those working in the primary care sector. Some of the articles are available in full at the links provided. Others require an online subscription.

Health workforce

Approved CME activity
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What motivates doctors to leave the UK NHS for a 'life in the sun' in New Zealand; and, once there, why don't they stay?

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Authors: Gauld R, Horsburgh S.

This research probes the motives of UK-trained doctors who have migrated to New Zealand (NZ), their experiences in NZ and reasons for leaving the UK. The authors present findings of a 2014 survey of UK-born or UK-trained doctors working in NZ. They say that the UK–NZ case is important because the proportion of international medical graduates (IMGs) in NZ is high (44% in 2014), and around half of NZ's IMGs hail from the UK. Furthermore, recruiting UK graduates into NZ is not a sustainable solution. A year after registration, only 53% of UK doctors remain in NZ, dropping to 30% after two years, and 20% after eight years.

The survey found that 'Quality of life (or that of my family)' was an 'important' or 'highly important' factor for moving to NZ for 96% of respondents; 87% indicated more attractive working conditions and 72% said it was the availability of career opportunities. Notably, 65% indicated a 'desire to leave the UK NHS', with one-third indicating that this was 'highly important'. Younger doctors and GPs were more inclined to rate quality of life as an important motivator. Compared to their peers, GPs were less likely to be motivated by 'training and development goals'.

Overall the respondents were relatively content once they arrived in NZ, with 90% being satisfied with their workload, work colleagues and community life. Eighty percent agreed that 'The New Zealand health system is easier to work in compared to the UK system', although GPs were less likely to agree with this statement than hospital specialists and registrars. Twenty-nine percent of respondents indicated that they were considering a move away from NZ, and the motivation for 76% of this group was a 'desire to return to a country (eg UK) where I had previously worked/lived'. However, 55% indicated that the availability of career opportunities elsewhere was a motivating factor. The authors conclude that UK doctors usually seek work in NZ with initial plans to take up longer residence, but many find the 'pull' of home and family reduces the length of their stay.

Reference: Human Resources for Health (2015) 13:75 doi 10.1186/s12960-015-0069-4

Health workforce

Lost to the NHS: a mixed methods study of why GPs leave practice early in England

Authors: Doran N, Fox F, Rodham K, et al.

The majority of GPs leaving the UK primary care workforce are aged under 60, with 45.5% of the GP leavers aged under 50. This study relied on both a survey and interviews to investigate GPs' motivations for leaving in the early stages of their careers. Participants were GPs aged less than 50 years who had left the English Medical Performers List between 2009 and 2014. Of the 143 survey respondents, 21 were interviewed. The reasons for GPs leaving the workforce early were cumulative and multi-factorial. Many perceived that the extent and rapidity of organisational changes to the NHS (which has led to an increase in day-to-day administrative tasks and overall workload) had fundamentally changed the doctor–patient relationship – the very hallmark of general practice.

GPs felt that the lack of time with patients had compromised both their ability to practise patient-centred continuity of care and their professional autonomy and values. This resulted in diminished job satisfaction. In addition, the combined pressures of increasing patient demand and the negative portrayal by media left many feeling unsupported and vulnerable to burnout and ill health, and, ultimately, led to their decision to leave general practice. The authors conclude that to improve retention of GPs, the NHS needs to minimise the pace of administrative change and to reduce the amount of time GPs spend on work that is not face-to-face patient care.

Reference: Br J Gen Pract. 2016 Feb; 66(43):e128–35. doi: 10.3399/bjgp16X683425

Health care systems

Primary care physicians in 10 countries report challenges caring for patients with complex health needs

Authors: Osborn R, Moulds D, Schneider EC, et al.

This article reports the findings of the 2015 Commonwealth Fund study of primary care physicians in 10 countries, looking particularly at their ability to care for high-needs patients. Overall, NZ is shown in a good light. NZ had the second highest proportion of GPs (32%; n=503) who considered that the quality of care provided to patients throughout the health system had improved in the last three years. The majority (52%) considered quality of care had remained about the same, and only 16% (the second-lowest proportion) considered that care had become worse. Fifty-seven percent considered that the system worked well, and that only minor changes were needed, compared with 22% in the UK and 16% in the US. Twenty-four percent of NZ respondents found the job very or extremely stressful, compared to 59% in the UK.

Eighty-one percent of NZ respondents said that they were well prepared to manage care of patients with multiple chronic conditions, but this fell to 62% for patients needing palliative care, 41% for patients with dementia (lowest ranked country), 24% for patients with severe mental health problems and 20% for patients with substance-related issues. Of the NZ respondents, 83% said their practice used nurses or case managers from within the practice to monitor and manage care for patients with chronic conditions, second only to the UK on 87%. NZ also ranked comparatively well on measures of communication and care coordination where a patient is seen by a specialist, or in an emergency department, or discharged from hospital.

Reference: Health Aff December 2015; 34(12):2104–2112. doi:10.1377/hlthaff.2015.1018

Clinical issues

Antibiotic prescribing and patient satisfaction in primary care in England: cross-sectional analysis of national patient survey data and prescribing data

Authors: Ashworth M, White P, Jongsma H, et al.

Given the growing concerns about antibiotic-resistant bacteria, there have been attempts to limit antibiotic use in general practice. The aim of this study was to determine the relationship between antibiotic prescribing in general practice and patient satisfaction.

The study analysed data from the General Practice Patient Survey (GPPS) in 2012 (2.7 million questionnaires in England; 982,999 responses), the national Quality and Outcomes Framework dataset for England 2011–2012 (8164 general practices), and general practice and demographic characteristics. Measures of antibiotic prescribing volumes were obtained for each practice in England during 2012–2013. The role of antibiotic prescribing volume was identified as a determinant of GPPS scores and adjusted for demographic and practice factors.

The final dataset consisted of 7800 (95.5%) practices. A total of 33.7 million antibiotic prescriptions were issued to a registered population of 53.8 million patients. The study found that antibiotic prescribing was a significant determinant of patient experience, as elicited by the GPPS, both for satisfaction with the GP and, to a lesser extent, for satisfaction with the general practice. The authors conclude that patients have lower levels of satisfaction if they are registered at practices that prescribe fewer antibiotics. Thus, there may be a trade-off between the wish to nurture the doctor–patient relationship and antibiotic stewardship.

Reference: Br J Gen Pract. 2016 Jan; 66(642):e40–60. doi: 10.3399/bjgp15X688105

Clinical issues

Unrecognised bipolar disorder among UK primary care patients prescribed antidepressants

Authors: Hughes T, Cardno A, West R, et al.

This observational study reviewed patients aged 16–40 years who had been prescribed antidepressant medication across 21 practices in West Yorkshire. The study aimed to determine the prevalence of unrecognised bipolar disorder among those with depressive or anxiety disorders.

Of 2433 patients identified from primary care data, 236 participated in a diagnostic interview and completed a screening questionnaire and rating scales of symptoms and quality of life. The prevalence of unrecognised bipolar disorder in the study population was 7.3%. Adjusting for differences between the sample and a national database gave a prevalence of 10%. Those with unrecognised bipolar disorder tended to be younger and reported more severe lifetime depression.

The researchers also assessed the effectiveness of the Mood Disorder Questionnaire (MDQ), a screening test comprising 13 items asking about symptoms. The researchers found the predictive value of the MDQ was poor, but said that it is quick and easy to use and might be useful in augmenting non-standardised questioning. The researchers recommended that GPs review life histories for evidence of unrecognised bipolar disorder when seeing patients with depression or anxiety disorder, particularly younger patients and those not doing well.

Reference: Br J Gen Pract. 2016 Feb;66(643):e71–7. doi: 10.3399/bjgp16X683437

Rural practice

"Sorry, I'm not a dentist": perspectives of rural GPs on oral health in the bush

Authors: Barnett T, Hoang H, Stuart J, et al.

Australians who live in rural areas have poorer oral health than city residents, and the availability of dental care services in rural areas is inadequate. The researchers examined how oral health problems are managed by rural GPs through face-to-face, semi-structured interviews with 30 GPs from rural Queensland, Tasmania and South Australia between October 2013 and October 2014.

The GPs reported seeing between one and 20 patients of various ages with oral health problems each month (mean 12 per month for each community). The problems included toothache, abscesses, oral infections, dentures and trauma. Most study participants provided prescriptions for antibiotics and short-term pain relief, and advised patients to see a dentist. Eighteen of the GPs were confident within their scope of practice about providing oral health care advice and treatment. Some said that they were not always confident and they lacked training in this area. Participants expressed concern that some patients would not visit a dentist as advised, and return to the GP with more severe problems requiring hospitalisation.

The GPs recognised potential ways to provide better care to their patients with oral health problems that included: additional training on topics such as 'major trauma interventions' and practical skills, alternative business models for delivering dental services to public and private patients, and teledentistry to connect GPs with dentists. The authors conclude by suggesting various approaches to improve rural oral health – building GPs' capacity to better assist patients with oral health problems, focusing on preventive dental care, improving visiting dental services, and establishing more effective referral and communication pathways between dentists and GPs.

Reference: Med J Aust. 2016 Jan 18;204(1):26e1. doi: 10.5694/mja15.00740

Comment: The article suggests including resources from the the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine in the induction process for GPs working in more isolated practice settings. The RACGP resources on dental health and clinical guidelines on oral hygiene can be found **here**.

Professional practice and development

The importance of being different (Inaugural Dr Ian McWhinney Lecture)

Author: Kidd M.

Dr Kidd's commentary is based on the lecture he gave at Western University in London, Ontario, on 23 September 2015. Dr Kidd outlines his perspective on the following nine principles of family medicine from Dr Ian McWhinney's textbook (*Textbook of Family Medicine*). The principles state that physicians:

1. are committed to the person rather than to a particular body of knowledge, group of diseases, or special technique.
2. seek to understand the context of the illness.
3. see every contact with their patients as an opportunity for prevention of disease or promotion of health.
4. view their practice as a 'population at risk'.
5. see themselves as part of a community-wide network of supportive and health care agencies.
6. should ideally be part of the same community as their patients.
7. see patients in their home surroundings.
8. attach importance to the subjective aspects of medicine.
9. are managers of resources.

Dr Kidd then speaks of the importance of expanding the commitment to educating and training family doctors, high-quality care, and primary care research where WONCA (World Organization of Family Doctors) does not yet have a presence. He highlights the doctor–patient relationship as a key feature of family medicine using the Cuban system as an example (ie patients have free access to their primary health care doctor and nurse team). The possible diversification of family medicine careers is then touched on, as well as the treatment of patients as complex organisms rather than a biological machine.

Dr Kidd also discusses the challenges of rural medicine using an equity lens, and the rural doctor stereotype of the 'rugged male'. The recruitment and retention of rural doctors is a challenge internationally. For instance, China aims to recruit up to 400,000 GPs in the next seven years to meet population needs, especially the 800 million living in rural areas. This is in line with an increasing global understanding of the value of having a solid primary care foundation. His final message is on the importance of family physicians participating in advocacy and speaking up for what is right. The lecture concludes with a quote from Dr McWhinney: "the importance of [family doctors] being different is that we can lead the way".

Reference: CFP December 2015; 61(12):1033–1038

Models of care

Should patients pay to see the GP?

Authors: Jones D, Loader N.

This article provides opposing views on whether the NHS should introduce patient co-payments to help fund the health system. David Jones, a hospital registrar, argues that co-payments should be introduced. He notes that co-payments are the norm in other countries, are not unethical and in the UK they have already been introduced for prescriptions and dentistry. He suggests that co-payments may help to reduce the rate of missed appointments and encourage patients to self-manage or use other primary care services such as pharmacists. This would lead to greater service availability in general practice. To support his view that co-payments are unlikely to affect care-seeking behaviour or overall health, he cites evidence that rates of emergency department attendance in Australia are no higher than those in the UK, while life expectancy is similar. He suggests that effective triage and redirection to more hospital-based GPs could counter any increase in use of secondary care to avoid fees.

Nancy Loader, a GP partner, argues that co-payments should not be introduced. While acknowledging the problems faced by 'rich countries' with rising health care costs, she cites research associating strong primary care–led health systems that are free at the point of access with lower overall health care costs. She contends that co-payments increase health disparities to the extent that governments use expensive remedial actions to reduce them. Furthermore, co-payments interfere with initial access to care and deter preventive care, which results in greater health spending in secondary care. They have a detrimental effect on the doctor–patient relationship. Patients may collect multiple problems to discuss in a single consultation and pressure doctors to deal with them all at

Models of care

once. Patients may also defer attendance until very unwell, which increases the likelihood of hospital admission. She says that co-payments make no discernible difference to rates of non-attendance or rates of attendance of the worried well. Receptionists gain additional work collecting fees. She concludes that co-payments create a conflict of interest for GPs wanting to provide equitable care while protecting their income.

Reference: BMJ. 2016 Jan 6;352:h6800.

Public health

Beverage purchases from stores in Mexico under the excise tax on sugar sweetened beverages: observational study

Authors: Colchero MA, Popkin BM, Rivera JA, et al.

In January 2014, Mexico introduced a new excise tax on sugar sweetened beverages (SSB). The excise tax increased the cost to consumers of SSB by an average of 1 peso/L (approximately NZ$0.08/L). This study evaluated changes in the purchases of consumer beverages after the implementation of the excise tax. The researchers used scanned and recorded data on food purchases from a representative group of Mexican households in cities with more than 50,000 residents from January 2012 to December 2014.

The study found that the tax on SSB was associated with reductions in purchases of taxed beverages, and increases in purchases of untaxed beverages. Reductions in purchases of SSB became larger over time. Relative to pre-tax levels, purchases of SSB decreased by an average of 6% (-12mL/capita/day), and decreased at an increasing rate up to a 12% decline by December 2014. Reductions were higher among households with lower socioeconomic status, averaging a 9% decline during 2014 and up to a 17% decline by December 2014. Purchases of untaxed beverages were 4% higher over the same period, mainly driven by an increase in sales of bottled plain water.

The authors conclude that the short-term impact of the excise tax on SSB was moderate, but important. They comment that it will be critical to continue to monitor purchases to note whether the trend continues or stabilises, consumers substitute cheaper brands or untaxed foods and beverages for the taxed ones, or adjustments occur in the longer term.

Reference: BMJ 2016;352:h6704. doi.org/10.1136/bmj.h6704

Comment: SSB tax has not been included in the NZ Government's Childhood Obesity Plan, although it was recommended by the World Health Organization (WHO) Commission on Ending Childhood Obesity (ECHO). Recently, Sir Peter Gluckman, Chief Science Advisor to the Prime Minister and Co-Chair of the WHO ECHO, discussed the effects of tax and effective public health messaging on the findings in Mexico. His seminar, 'Childhood obesity: the challenge of policy development in areas of post-normal science' can be found **here**.

Time spent reading the RNZCGP Digest has been approved for CME for The Royal New Zealand College of General Practitioners (RNZCGP), General Practice Educational Programme GPEP Years 2 and 3, and Maintenance of Professional Standards (MOPS) purposes, provided that a Learning Reflection Form is completed. Please click **here** to download a CPD/MOPS Learning Reflection Form. One form per Digest is required.

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We welcome your comments or suggestions. Please contact the College's Policy Team at **policy@rnzcgp.org.nz**

The Royal New Zealand College of General Practitioners is the professional body that provides training and ongoing professional development for general practitioners and rural hospital generalists, and sets standards for general practice.

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