RNZCGP DIGEST

THE ROYAL NEW ZEALAND COLLEGE OF GENERAL PRACTITIONERS

The Royal New Zealand College of General Practitioners

ISSUE 2 | APRIL 2015

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. Click on any of the bullet points below to go to a section of interest.

## TOPICS IN THIS ISSUE



**Approved CME activity**
Click **here** for details.

## Quality improvement

FREE

### Improving quality in general practice

**Authors:** de Silva D, Bamber J.

An evidence scan was commissioned for the National Summit on Quality in General Practice, which was held by the UK Royal College of General Practitioners in July 2014. It explored the topic of quality, including what the public considers is important in good quality general practice, and interventions to improve the quality of general practice.

The report found no single definition of quality in general practice, noting that it would depend on what the information is used for. Frameworks on quality in health care frequently focus on patient experience, clinical effectiveness, and safety, but it is questionable whether these three domains are the most important for general practice.

For patients, 'good quality general practice' included:

- GPs, nurses and receptionists having good interpersonal skills
- easy access to care, including convenient appointments with a familiar GP
- being involved in the care process, including decision-making and being supported to self-manage.

Technical skills and safety were less often mentioned as key components of quality.

Interventions shown to improve quality in general practice included:

- **At the patient level:** improving access, increasing the duration of consultations, seeing the same GP over time, patient education, patient access to records, gaining patient feedback, and using technology and other support tools.
- **At the practitioner level:** training in quality improvement methods, interprofessional learning, audit and feedback, educational outreach visits, improvement collaboratives, decision support tools, nurse-led services, and increased staffing levels.
- **At the practice/system level:** providing a wider range of services, quality improvement projects, telehealth, clinical audit, significant event analysis, electronic tools, and improving data collection and error reporting.

**Reference:** The UK Health Foundation, November 2014.

## Clinical issues

### Population health perspective on high users of health care: role of family physicians

FREE

**Authors:** Stone C, Rosell L, Goel V.

This Canadian commentary explores the relationship between high users of health care and population health, and how family physicians address non-clinical issues. The authors argue that family physicians need to go beyond clinics and hospitals to address the social determinants of health (SDOHs). SDOHs predispose patients to becoming high users and affect the patient trajectory of the high-user group.

The authors believe that addressing SDOHs will delay or prevent patient transition into the high-user group, and ensure better health outcomes for those in that group. At a system level, health programmes could better coordinate high-user care and help family physicians to address SDOHs of high users. For example, by finding adequate housing, encouraging group support for those with psychological illnesses, and contacting patients daily for medication reminders.

Identifying and characterising patients' needs may entail obtaining demographic data such as income, neighbourhood, social support, education, and immigration status during patient encounters. This information can be used to develop care plans that address SDOHs for high users. The authors conclude that all family physicians should better understand and address social gradients. This may produce economic efficiencies as a result of high-quality health delivery and avoidance of hospitalisation.

**Reference:** Can Fam Physician. 2014;60(9):781–83.

## Clinical issues

### Should doctors record their patients' income?

**Authors:** Moscrop A, MacPherson P.

The link between lower income and poorer health is well established. In this British article, the authors argue that recording patients' income in primary care benefits both individuals and the population. They state that, in most circumstances, household (rather than individual) income is the most useful data for GPs to record. GPs could then offer health and lifestyle advice suited to an individual's budget, identify patients for whom health care–related costs may challenge compliance, and ensure patients are accessing community resources. Furthermore, linking household income to health care data would enable researchers to better recognise income-associated variation in accessing health care, health care experience, and health outcomes. This would permit better informed and more effective corrective interventions.

However, household income alone might not provide a complete picture of an individual's available resources. Thus, the authors suggest including both poverty screening and income enquiry in a consultation. They conclude that the discomfort in diagnosing poverty is a poor reason for not recognising the evolving role of general practice and for avoiding the extent of health inequities in Britain.

**Reference:** Br J Gen Pract. 2014;64(627)e672-e674;DOI: 10.3399/bjgp14X682009.

## Clinical issues

### New Zealand is far behind Australia in offering weight-loss surgery

**Authors:** Kelly S, Flint R.

In this editorial, two New Zealand bariatric surgeons state that bariatric surgery remains the most capable strategy for inducing robust and long-term weight loss. They argue that, with the overall rate of obesity rising by one percent each year, New Zealand will become the fattest nation on earth within five years.

The authors explain that patients can expect an average of 50 to 70 percent excess body weight loss with bariatric surgery, which is maintained over several years. A total of 889 operations were undertaken by nine major bariatric surgical groups in New Zealand for the year ending February 2014. These were evenly distributed between the public and private sectors. The authors calculate a rate of 0.4 percent procedures per year for those who are morbidly obese in New Zealand. This is much lower that the rate of 1.4 percent in Australia.

They conclude that New Zealand should reflect on its use of effective weight-loss strategies, and that health authorities need to seriously address the impediments to access publicly funded bariatric surgery.

**Comment:** We note Professor Boyd Swinburn's comment that funding more operations should not come at the expense of programmes aimed at preventing obesity (Radio New Zealand News, 30 January 2015). The Policy Team's brief **Tackling the growing obesity epidemic: a general practice perspective** looks at the wider context of managing obesity.

**Reference:** N Z Med J. 2015;128(1408):10–12.

## Clinical issues

### Primary care's 2014 lessons: the research changing practice

FREE

**Author:** Brookes L

In this Medscape article, the author highlights research that is likely to change clinical practice or have significant implications for primary care. Taking a US focus, the article sets out the top 10 take-away messages for primary care, based on recommendations from Medscape's experts across specialties. The article includes publications considered important on each subject. The 10 areas are:

- LDL cholesterol: lower is better
- Vitamin D and mortality: supplementation with vitamin $D_3$ reduces risk
- Cardiovascular risks with testosterone: Europe's word that risk is weak and inconclusive
- A new era in hepatitis C virus: cure with serious cost
- Clinical trial data confirms efficacy of pneumococcal 13-valent vaccine in older adults
- Aspirin for primary prevention: the debate continues
- Mammography: growing evidence for cutting back
- Calls for action against antimicrobial resistance
- The human microbiome: enthusiasm for what can be achieved may be premature
- More nutrition education is needed in medical training.

**Reference:** Medscape Family Medicine, December 2014.

## Cross-cultural care

### Health literacy: health professionals' understandings and their perceptions of barriers that Indigenous patients encounter

FREE

**Authors:** Lambert M, Luke J, Downey B, et al.

One definition of health literacy used in New Zealand is: 'the ability to obtain, process, and understand basic health information and services to make appropriate health decisions'. It implies that health care providers and the health system play a major role in assisting people to build knowledge and skills about their health. This study explores the experiences of health professionals working with patients with cardiovascular disease who take medications to prevent future events. Four Indigenous health care services (in New Zealand, Canada and Australia) were studied.

The researchers found that health professionals' ideas about health literacy varied and were associated with their perceptions of the barriers (a combination of cultural, social, and systemic barriers) that their patients faced when attempting to build health literacy skills. The study suggests that, in general, health professionals have a limited understanding of health literacy and of the consequences of low health literacy for their Indigenous patients. This lack of understanding and the perceived barriers to improving health literacy limit the ability of health professionals to improve their Indigenous patients' health literacy skills. It may also limit patients' capacity to improve their understanding of illnesses and instructions on how to manage their health conditions.

**Reference:** BMC Health Services Research. 2014;14:614.

## Models of care

### Organizational aspects of primary care related to avoidable hospitalization: a systematic review

**Authors:** van Loenen T, van den Berg MJ, Westert GP, et al.

In this systematic review, the authors investigated the characteristics of primary care organisation that influence avoidable hospitalisation for chronic ambulatory care sensitive conditions (ACSCs) such as diabetes, asthma and hypertension. The review included 49 publications between 1997 and 2013. Twenty-two primary care factors that influence avoidable hospitalisation for chronic ACSCs were found covering four areas: system-level characteristics; accessibility; structural and organisational characteristics; and organisation of the care process.

The authors found that avoidable hospitalisations were reduced by strong primary care in terms of an adequate supply of doctors and long-term doctor–patient relationships. The findings suggest that strengthening primary care might prevent potentially avoidable hospitalisations. This was more important than how the actual primary care delivery was organised (e.g. disease management programmes, practice type, size, specific services and IT services).

**Reference:** Fam Pract. 2014;31(5):502-516;doi:10.1093/fampra/cmu053.

## Models of care


### An inquiry into patient centred care in the 21st century: implications for general practice and primary care

**Author:** The Royal College of General Practitioners

In June 2014, the RCGP commissioned an independent panel to lead an inquiry into patient-centred care in the 21st century. The inquiry aimed to identify cost-effective solutions to the challenges of rising levels of multi-morbidity. The authors argue that clinicians must work with patients in a different way, provide personalised care, and empower patients to play an active role in managing their health. The report also calls for a shift in the delivery of general practice, so that practices come together as federations/networks and work with other services to deliver coordinated and proactive care in the community.

The inquiry calls on the Government, NHS England, and other stakeholders to work with patients and clinicians to:

- move away from tick-box clinical guidelines and performance indicators to an approach of tailored care, which rewards professionals for respecting patients' preferences;
- increase resources for primary and community-based care, and create a primary care 'transformation fund' to facilitate changes to health care delivery;
- introduce flexible commissioning and funding arrangements that break down barriers between providers (e.g. GPs and hospital-based doctors) and promote collaboration;
- implement NHS England's 'new deal for general practice', which builds on an easily accessible, local point of access; comprehensive services from a generalist doctor; continuity of care; and the registered patient list.

**Reference:** The Royal College of General Practitioners, November 2014.

## Professional practice and development


### National training survey 2014: bullying and undermining

**Author:** General Medical Council

The GMC uses national training surveys to capture data and ensure that medical education and training across the UK is adhering to, and delivering, the standards it expects. This particular survey analysed responses from 50 000 doctors in training about bullying and undermining. The results show that eight percent of the respondents had experienced bullying, and 13.6 percent had witnessed bullying. It suggests a reluctance to report bullying and undermining behaviour—both from fear of reprisals and from lack of faith that anything would be done. Notably, the general practice training programme scored relatively well (fourth out of 16 training programmes) in both indicators for overall supportive environment and (not) undermining.

The survey shows a link between the quality and effectiveness of training, and bullying. The GMC comments that a supportive and constructive environment is essential to promoting effective and successful training placements for doctors. Bullying may affect collaborative working and openness, stunt the development of doctors, and impact on patient safety. The GMC concludes that bullying must not be tolerated in the workplace, and must be openly discussed and tackled.

**Comment:** The GMC is working with postgraduate education providers to respond to feedback from doctors in training. It aims to develop a supportive culture that actively encourages doctors in training to feel confident in raising concerns at an earlier stage.

**Reference:** General Medical Council, November 2014.

## Medico-legal and ethical issues

### Physician, don't heal thyself: the perils of self prescribing

**Author:** Moberly T.

In many countries, self-prescribing is legal and commonplace, but regulators are increasingly taking a dim view of self-prescribing amongst doctors. Many countries have official guidance advising against doctors treating themselves, but have also continued to record cases of self-prescribing. As an example, the author notes that the Medical Council of New Zealand states that doctors should avoid prescribing for themselves, friends and family 'wherever possible', but that the Council reported several recent cases where inappropriate self- or family-prescribing has been an issue. In 2013, the General Medical Council strengthened its guidance and recommends against doctors prescribing for themselves or for friends and relatives. It also requires those doctors who self-prescribe to keep a clear record of their action and reasons for doing so.

Benzodiazepines, antibiotics and opiates are drugs often prescribed by those doctors who are referred to regulatory authorities. Cases are often first identified by pharmacists. The author concludes that the key role for regulatory authorities is to educate doctors about the dangers of self-prescribing.

**Comment:** See the MCNZ's **Statement on providing care to yourself and those close to you**

**Reference:** BMJ. 2014;349:g7401.

## Access to care

### The importance of measuring unmet healthcare needs

**Authors:** Gauld R, Raymont A, Bagshaw PF, et al.

Many countries undertake major restructuring of their health sector, but an objective assessment of the outcomes is rarely recorded. By way of example, the authors of this *NZMJ* Viewpoint explain that, in New Zealand, there was no formal, comprehensive review of the achievements and outcomes in the four years following radical health care restructuring in 1993. However, predicted outcomes of the market approach such as hospital profits and provider competition failed to appear. Positive outcomes (e.g. better organisation of general practice, improvements in Māori health organisation and the creation of PHARMAC) that were unforeseen had eventuated. In the absence of timely, broad-based objective data, ratings of the outcomes can range from superlative to dismal failure.

The authors point to conflicting reports (The King's Fund investigation report 2013, a *BMJ* editorial, and an *NZMJ* article) on Canterbury health care services as another recent example of the inadequacies in assessing overall effectiveness.

The authors propose that the performance of health care systems should be measured regularly, objectively and comprehensively by documenting unmet health care needs as perceived by representative segments of the population at formal interview. Representative interviews should be repeated regularly and cover all aspects of unmet health care needs, including dental, psychiatric, birth control and disability, as well as unmet general medical and surgical needs. Time-matched comparisons between different health care systems and longitudinal assessments within any one country may be a possibility.

**Reference:** N Z Med J. 2014;127(1404):63–6.

✓ 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.

**Please note:** A maximum of two hours can be claimed per digest. Total hours should be entered as CME credits on the MOPS page under 'CME reflected in PDP'. You do not need to return this form to the College, but will need to retain it should you be subject to a Medical Council of New Zealand audit.

We welcome your comments or suggestions. Please contact the RNZCGP'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.

PO Box 10440, The Terrace, Wellington 6134 | T +64 4 496 5999 | F +64 4 496 5997 | E rnzcgp@rnzcgp.org.nz | W www.rnzcgp.org.nz