New Zealand Doctor
Rata Aotearoa
22 April 2020
Every fortnight
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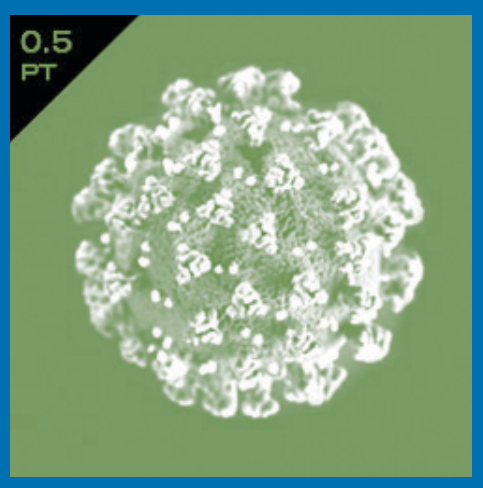
# Coping with COVID-19

**We have collated three of our recent Practice articles into one easy-to-find and access "Coping with COVID-19" course. This ELearning module aims to help you to provide patient care throughout the COVID-19 outbreak. It includes information on using virtual technology, elder care and keeping yourself safe, as well as earning you some CME credits along the way. This course is made up of three parts:**




1. **The first time you work from home using virtual technology to provide patient care:** In this article, GP Jo Scott-Jones prepares you to be able to work from home, should your patients still need to see you.

2. **Keeping yourself safe from COVID-19: Exactly how hygienic are you at work?:** Occupational health expert David McBride discusses the hazards of COVID-19 for healthcare workers and the roles of personal protective equipment and hand hygiene in managing this risk.

3. **Caring for older patients during the COVID-19 shutdown and beyond:** Professor of general practice Ngaire Kerse prefers the term shutdown to lockdown for describing current restrictions on human contact, travel and business. Here, she discusses the care of older patients during time.

**Any issues please contact Tyler Brady on 09 488 4286 or elearning@thehealthmedia.co.nz**

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**Lucy O'Hagan**
Bracing for existential fog

**Maximum protection**
Cromwell GP's DIY PPE

**Ngaire Kerse**
Caring for your older patients

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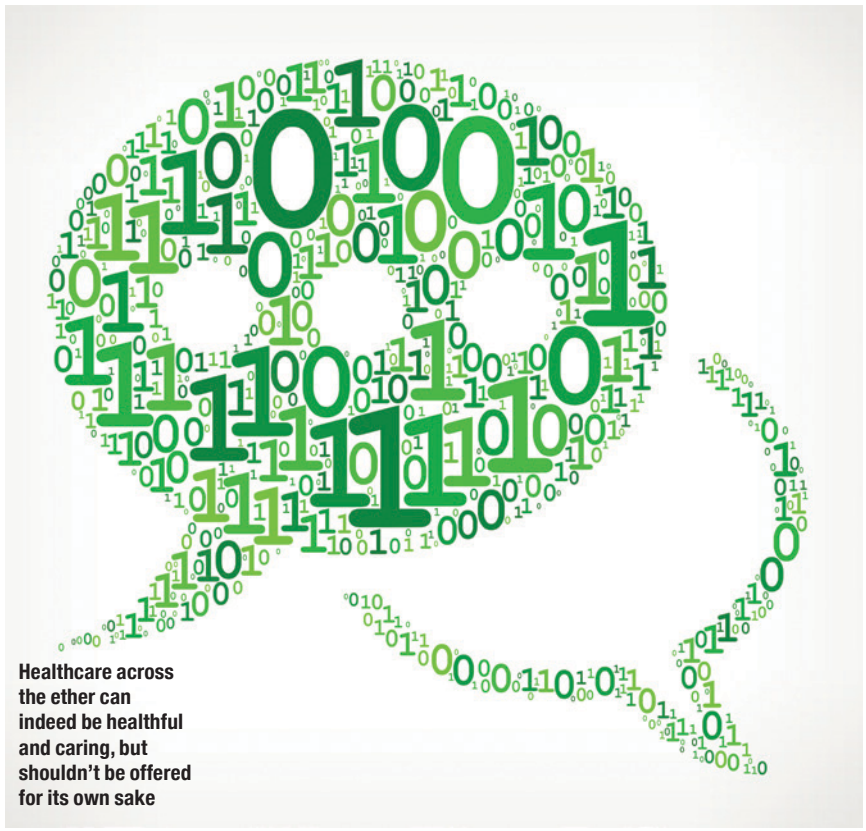
# Disruption in a time of COVID-19

Barbara Fountain



Healthcare across the ether can indeed be healthful and caring, but shouldn't be offered for its own sake

Bubaone

Odd things happen at the best of times. But a pandemic lockdown, it has to be said, produces a special degree of oddness. Kiwis take to queueing at two-metre intervals; the health minister takes a decidedly misguided family outing and gets demoted; the director-general of health is serenaded and gains his own fan club.

Along with the odd comes opportunity.

As GPs have grasped the virtual care nettle, others have looked at the opportunities arising from a locked-in population seeking virtual services. Health services the world over are being bombarded with new technologies and apps to help battle the pandemic. Hardly a day goes by when we don't receive news of a new product aimed at making some aspect of the health service easier. I struggle to see how they could ever find a logical place in a coherent health system; they will likely just further fragment it.

Into the fray come the owners of the start-up virtual general practice service Tend, James and Cecilia Robinson, the people behind the successful meal delivery business My Food Bag.

They're not grasping at an opportunity; they've been working on "Project XYZ" for the last year. They had planned to launch later this year, but COVID-19 brought that forward, so there is a bit of "now or never" about the move.

Together with My Food Bag colleague and former Telecom chief executive Theresa Gattung and Medicines New Zealand chair and former Counties Manukau DHB chair Lee Mathias, the Robinsons plan to deliver general practice services to smartphones.

Essentially, they're looking to serve up what Babylon Health does in the UK – GP at Hand. They're here to turn general practice on its head. Problem is, something has beat them to it – COVID-19.

I don't believe disruption is a bad thing per se. The virus has done wonders in terms of showing what years of railing by general practice leaders and health bureaucrats failed to do, that face-to-face consultations need no longer be the norm. Technology is here to help.

The virus changes everything. Funding models will be reshaped, along with models of care, and general practice is already working on what the new models will look like.

It's as if the sector has been given the opportunity to redesign on the run, driven by itself, without need of a new report and another set of recommendations.

The new normal should enable equity issues to rise to the fore – new models can place a premium on access for Māori and Pasifika to services designed by them.

Tend's narrative is that New Zealanders want easier and more affordable access to their GP (or, one hopes, a nurse practitioner). Smartphone access is definitely easier, though not always appropriate. As to affordability, the Tend folk don't go into details of charges but are considering opening some physical premises, enrolling patients and contracting for capitation funding. I doubt their population will qualify them for Very Low Cost Access, so copayments are on the cards.

Tend is not the first business to see there's money to be made in offering convenience in general practice care. But people in the sector know the margins are tight, particularly if you are caring for your enrolled population as is expected under the capitation contract and not just providing episodic care.

Babylon Health sought out, and is doing well out of, healthy and cheap-to-treat people. And, facing politically unpalatable lengthy GP waiting times, the NHS bought into Babylon's promise of providing a GP in the pocket. But for practices left with unwell and complex patients, Babylon has been extremely disruptive.

The fact Tend is home-grown does not make the potential disruption any less damaging. New Zealand's health system is small. The ripples of disruption spread wide.

Arising out of the current multifaceted response to COVID-19 we need a new normal of true integration within primary care and with the wider sector, aged care included.

Homecare Medical, the suppliers of Healthline, have shown how technology can work in concert with general practice through its after-hours nurse triage service, used by many of the country's practices.

Practices themselves are exploring how they can improve their use of technology.

Health administrators should be looking to protect the primary care sector into which they already invest over $1.3 billion a year, and should not be encouraging further fragmentation.

Any newcomers wanting a slice of Vote Health need to be prepared to work on improving poor health outcomes. Neither the health system nor patients need virtual white knights galloping into town to disrupt services just because they can. They risk doing more harm than good. ■

*editor@nzdoctor.co.nz*

**It's as if the sector has been given the opportunity to redesign on the run, driven by itself, without need of a new report and another set of recommendations**

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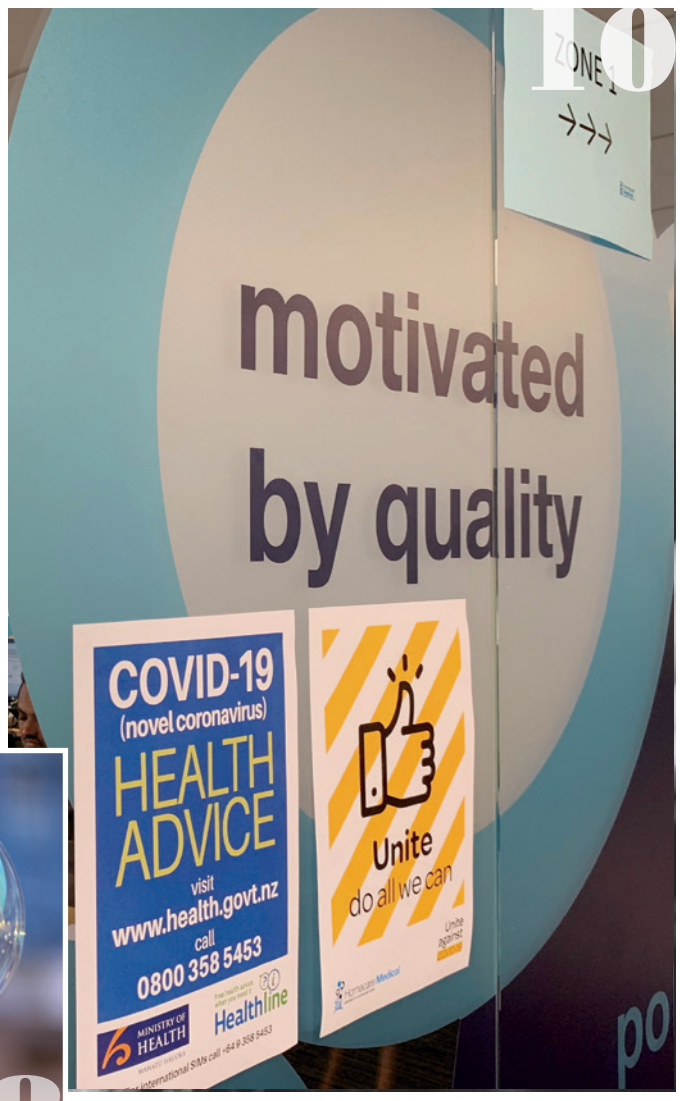



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## Clinical QUIZ

### Gain CPD credits reading *New Zealand Doctor*

Time spent reading the 'How to Treat' and 'Practice' sections of *New Zealand Doctor* is an approved "individually planned learning" activity recognised by the RNZCGP for continuing professional development (CPD) purposes. Time can be claimed on a basis of 1 credit per learning hour, to a maximum of 0.25 credits per article for Practice articles and a maximum of 1 credit for the How to Treat article. An RNZCGP Learning Reflection Form or, for some articles, quiz-based assessments, can be found online at ELearning **(www.nzdoctor.co.nz)**. *Happy reading,*
*Barbara Fountain*

The Royal New Zealand College of General Practitioners
Endorsed CPD Activity

**ELDER HEALTH**

1. The mortality rate from COVID-19 is around 5 per cent for those aged 80 and older. True/False?
2. Older people in residential care should get out of bed and mobilise during the COVID-19 pandemic. True/False?
3. Treatment for those severely affected by COVID-19 is with low-flow oxygen. True/False?

**PHARMACOTHERAPY**

1. Onset of gout occurs at an earlier age in Māori than non-Māori. True/False?
2. Serum urate levels can decrease during an acute flare of gout. True/False?
3. NSAIDs are associated with a dose-related 20–50 per cent increase in cardiovascular risk. True/False?
4. Allopurinol cannot be commenced during an acute flare of gout. True/False?

**SPORTS MEDICINE**

1. Spondylolysis predominantly affects the L4 vertebra. True/False?
2. Spondylolysis often causes neurological symptoms, such as pins and needles. True/False?
3. Four-view radiographs are preferred for imaging and diagnosis of spondylolysis. True/False?
4. Unilateral, early stress fractures to the pars interarticularis usually heal with conservative measures. True/False?

**FIRST TIME:**

1. Nationwide, face-to-face consultations have reduced by about 50 per cent since the COVID-19 lockdown began. True/False?
2. People using Healthline for general health enquiries are now presenting with higher acuity problems. True/False?
3. Consultations should currently be performed in the car park as much as possible. True/False?

**Answers on page 19**

# PHOs use funding streams to aid practices hit by lockdown; warning on wage subsidy

**Fiona Cassie**

PHOs around the country are taking different approaches to financially supporting practices hit by the drop in practice cash flow resulting from the Alert Level 4 lockdown.

Wellington's Tū Ora Compass Health has prepaid a number of government funding streams to practices up until the end of June, says chief executive Martin Hefford.

These payments include Care Plus (long-term conditions) funding, Services to Improve Access (SIA) funding and the usually outcomes-based, System Level Measures funding.

Pinnacle chief executive Helen Parker says it has told practices it will pay out 100 per cent of the quarterly SLM funding regardless of whether practices achieve the SLM quality targets.

ProCare has paid in advance 100 per cent of SLM funding to practices for the latest quarter to help them through the lockdown, says ProCare's chief financial officer Tony Wai.

It has also used flexible funding reserves to pay in advance Care Plus and SIA funding and is encouraging practices to use it to actively contact at-risk and vulnerable patients.

The small Canterbury PHO, Waitaha Primary Health, is taking a "business as usual" approach to paying SIA and Care Plus funding but has paid in advance 66 per cent of its SLM funding to practices up until the end of June, says chief executive Bill Eschenbach.

Practices around the country have received their share of the $10 million-a-week lockdown relief package, first negotiated at an urgent meeting with DHB and Ministry of Health leaders on Sunday 29 March.

But with the end of the Alert Level 4 lockdown on the horizon, practices are unsure how long the patient downturn or the funding package, which has not been formally announced, will last.

Some PHOs are paying funding streams like Care Plus and performance funding to practices upfront and early to support them financially during the COVID-19 crisis

The first fortnightly payout was distributed to reflect cash flow losses during the lockdown at a rate of $2.34 per week per urban practice patient and $2.47 per week per rural practice patient.

At the start of April, practices received an initial $15 million from the Government's overall $500 million COVID-19 health services package. This was to cover out-of-pocket COVID-19 costs prior to the lockdown, and also included targeted funding for equity and high-needs patients.

Grant Thornton business adviser Pam Newlove says it is too early to tell whether the relief package would ensure practices no longer met the wage subsidy threshold of a 30 per cent decline in income. Ms Newlove advises practices who have applied for and received the subsidy to "park" it and be ready to pay it back. But she also advises them not to pay it back too quickly, as there is uncertainty over how much general practice income will improve with the shift to Alert Level 3. ■

*fcassie@nzdoctor.co.nz*

**How is your PHO handling funding through the COVID-19 crisis?**
Contact Fiona Cassie, fcassie@nzdoctor.co.nz if you would like to discuss.

# Pharmac tweaks special authority rules and looks for further changes amid COVID-19's threat

**Simon Maude**

COVID-19's impact on drug dispensing and monitoring has had a positive side effect, a former Pharmac clinical leader says.

Porirua GP and former Pharmac deputy medical director primary care Bryan Betty says a webpage the agency has launched to drum up drug-funding change suggestions during the COVID-19 crisis is welcome news.

The *COVID-19: Suggestions for funding changes* page summarises "recurring themes in suggestions" received from health-sector stakeholders, as well as Pharmac's responses. It comes as a way to manage medication use during the COVID-19 pandemic.

**Pharmac had to be responsive in the context of the present situation; there's been a huge amount of feedback to them through the system around problems with special authorities**

Pharmac has tweaked some special authority rules to ensure they don't hinder appropriate prescribing and dispensing of funded drugs.

Broadening discussion over needed measures beyond Pharmac's formal channels and systems is a welcome move, Dr Betty says.

"Pharmac had to be responsive in the context of the present situation; there's been a huge amount of feedback to them through the system around problems with special authorities."

As the COVID-19 crisis drags on, Dr Betty anticipates Pharmac will become aware of a "whole lot of anomalies" via its webpage.

Late last month, Pharmac announced special authority strictures, covering a swathe of funded drugs and some devices, would be relaxed until it's practical to reinstate them.

Many restrictions, including on cancer drugs, insulin pumps and patient testing, have been modified to allow for the fact physical distancing and Alert Level 4 rules make it difficult or impossible for patients and clinicians to meet them.

The monthly prescribing of some restricted medicines, for example, natalizumab (Tysabri) for patients with multiple sclerosis, has been expanded to three monthly.

*Pharmac's COVID-19: Information for prescribers* page lists a host of further changes on the way:

- removing fixed timeline requirements for hospital-administered medicines
- removing or reducing requirements for specific testing or scanning only performed in hospitals or by laboratories that are limited by COVID-19 circumstances
- increasing access to some preventive treatments
- changing requirements for applications normally made only by certain types of specialists, so that any practitioner can make them.


GP and former Pharmac deputy medical director primary care Bryan Betty welcomes the agency's broader problem-solving approach


Pharmac director of operations Lisa Williams was non-committal on whether the new approach would last beyond the pandemic

Pharmac director of operations Lisa Williams says the changes are designed to provide "reassurance and comfort" to patients they will continue to receive uninterrupted treatment. Normal rules will be reinstated once the situation allows, Ms Williams says.

Dr Betty says long-standing special authority rules, in place to ensure patient safety and prevent misuse of drugs, should, of course, be reinstated. But he hopes Pharmac initiatives like the COVID-19 suggestion/response page can be made permanent.

In her email response to *New Zealand Doctor*, Ms Williams did not answer whether the agency could continue this measure. Instead, she made reference to Pharmac's application tracker webpages. ■

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**To read Pharmac's *COVID-19: Suggestions for funding changes*, head to https://tinyurl.com/Pharmac-Suggestions**

### New medical director for Pharmac

Pharmac has finally appointed a new medical director to replace John Wyeth, the last permanent holder of the role who left in March 2019. Shirley Crawshaw has previous experience as a senior official at the Ministry of Health. She trained as a GP in the UK and worked in various consultant posts in communicable diseases and clinical governance. She came to New Zealand in 2014, taking up a job as medical officer of health in Northland and then later acting deputy director of public health at the ministry. She has also worked at ARPHS and latterly at ESR during the measles outbreak last year. According to a media release from Pharmac, it is expected Dr Crawshaw will take up the role in mid-June, depending on the international travel situation.


David Clark

# Mountain-biking health minister unlikely to retain role after pandemic

**Martin Johnston**

Our mountain-biking health minister may have patched the puncture, but he looks certain to crash permanently off his sole remaining portfolio once New Zealand's COVID-19 crisis settles sufficiently.

David Clark's punishment by prime minister Jacinda Ardern and his dose of self-flagellation – over lockdown looseness that risked undermining the Government's pandemic demand for personal sacrifice – have staunched the political blood loss. For now.

He had admitted, in a media release on 7 April, that on the first weekend of the national lockdown he drove his family about 20km north of their home in Dunedin for a walk at Doctor's Point beach.

"In the interest of full disclosure, since the lockdown began I have also driven my family to a walking track approximately 2km from our house for a walk and gone for occasional runs, all of which were local and within the rules, and one bike ride ..."

It was the mountain-bike ride, also during the lockdown, that brought it all to light, after a witness told a reporter. He had driven to a park about 2km from his home for the ride on what he said wasn't a challenging track.

**Under normal circumstances I would sack the minister of health. What he did was wrong and there are no excuses**

He offered to resign, but Ms Ardern refused. Instead, she flung him down the cabinet rankings and stripped him of his associate finance minister role.

"Under normal circumstances," she said in a media release, "I would sack the minister of health. What he did was wrong and there are no excuses."

She said the pandemic was her priority and the country could not afford the disruption of replacing him.

The affair attracted international attention, featuring, for example, in *The Guardian*, the BBC and CNN.

NZMA chair Kate Baddock was unwilling to criticise Dr Clark, saying his beach trip was "the kind of decision probably many of us thought about making in the early days of the lockdown".

And National Party health spokesman Michael Woodhouse said in a text message he had "nothing to add" to what had been said. "This is a matter for the prime minister and she has acted as she saw fit". ■

*mjohnston@nzdoctor.co.nz*

# New virtual world for GP care robs digital service Tend of novelty factor

Fiona Cassie examines a new player in primary care in the changed context since the arrival of COVID-19

My Food Bag founders James and Cecilia Robinson, chief executives of new online primary health service Tend, chief product officer Josh Robb and director of medical and health services Mataroria Lyndon

Helen Parker

Martin Hefford

The success of general practice in adapting to virtual consultations in the COVID-19 pandemic may have robbed a new competitor of its market advantage

Tend, a home-grown digital service with an ambit similar to UK's Babylon Health, has at its helm My Food Bag founders Cecilia and James Robinson.

On its board are ex-Telecom chief executive and fellow My Food Bag director Theresa Gattung and Medicines New Zealand chair and former Counties Manukau DHB chair Lee Mathias.

The service was to have launched later this year, but the Robinsons announced earlier this month they are hiring doctors and nurses with the aim of fast-tracking their "digital first", app-based health service to launch around July.

Co-chief executive Mrs Robinson says Tend will focus first on enrolling patients and gaining a capitation contract in Auckland. It wants to either purchase an existing general practice or develop a physical clinic to support the seven-day-a-week 7am to 9pm virtual service, she says.

She cites commercial sensitivity when asked to name the PHOs the company has approached or those that have approached the company since it announced the launch, but says Tend seeks a PHO of "progressive thinkers" that wants to provide more options to better serve patients.

General practice leaders doubt Tend will find the general practice market the easy mark it might have been six months ago.

Tend will be entering a "new world" market, where the pandemic prompted general practices to switch to virtual consultations in just two days, says interim chair of new general practice ownership group GenPro, Tim Malloy.

"The concept that we would simply remain as we used to be, having lived through these changes, under a pandemic emergency seems most unlikely," Dr Malloy says.

"So I suspect that this will be a difficult environment [in which] to be bringing new players into the system."

He says safety was behind the switch to more video and phone consults and e-prescribing, but the funding model needs to change to ensure the evolving virtual consult model is sustainable.

Tū Ora Compass chief executive Martin Hefford told a Health Care Home Collaborative webinar this month that conditions were now right for national virtual GP services to compete with traditional general practice.

"By the end of the lockdown, patients will be socialised to use virtual care and GPs will be used to doing it as well," Mr Hefford said mid this month.

He also pointed out the crisis has created a pool of under-occupied GP associates potentially available for virtual work, and competition to employ them could be global.

"So we need a superior local offering to maintain continuity of care and local clinical ownership of practices."

Asked by *New Zealand Doctor* specifically about Tend's likely impact, and how practices should respond, he said: "Practices have already responded beautifully by making virtual healthcare available to their patients."

At Pinnacle Midlands Health Network, which coped with Waikato DHB's aborted entry into the virtual general practice market with US app SmartHealth, chief executive Helen Parker says the proposed service is likely to appeal to people wanting quick, convenient, episodic care.

Ms Parker says the strength of general practice is its ability to provide convenient and responsive virtual care, plus access to a wider interdisciplinary team model of care in a variety of community settings.

**Tend will be entering a "new world" market where the pandemic prompted general practices to switch to virtual consults in just two days**

"We know some practices have been slow to develop a virtual care service, but these last couple of weeks has probably shifted this on significantly, and we will be supporting our practices to continue this alongside their much wider comprehensive primary care service than Tend, at first glance, would seem to provide."

Tend does not have a GP near the top of its management structure, but former Ministry of Health primary care manager Andy Inder is on its team, and public health doctor Mataroria Lyndon (Ngāti Hine, Ngāti Whatua, Waikato me Ngāti Hau), equity lead for Northland's PHO Mahitahi Hauora, is director of medical and health services.

Asked to elaborate on how Tend will support equity, Mrs Robinson says an example is Tend's aim to individualise and target health promotion information and screening reminders for patients based on their age, gender and clinical history.

A fact-finding trip to Europe did not include a meeting with Babylon Health: "There are much more interesting and much more patient-oriented models out there than Babylon," she says.

Scandinavian providers are of greater interest. One of the largest is Swedish digital health provider KRY, founded in 2014; in the past six months, it has opened three physical clinics in Sweden. It is also operating in Norway and Germany, and moved into the UK in 2018.

In response to a question about digital health providers being seen to "cherry-pick" younger, healthier people, Mrs Robinson says she thinks that has not empirically proven to be true.

She says most digital healthcare providers overseas only started with a digital platform, but Tend has chosen a mixed model of digital healthcare options and physical clinics and to place a "big focus" on its care team.

"So I don't think cherry-picking is going to be an issue when it comes to Tend."

Tend will help "democratise" health services by giving patients the ability to have more control over their medical history and their medical planning.

To date, feedback from the sector, including the Ministry of Health, has been overwhelmingly positive, Mrs Robinson says.

COVID-19 prompted the company to fast-track its app and software development and service launch, to "help take some of the pressure off the health system", including some regions of the country where practices have closed books. She expects to employ doctors and nurses who have lost their jobs with the downturn in general practice consults.

Mrs Robinson is confident Tend will have both a PHO and a capitation contract by the time it launches but, because of the difficulty progressing real-estate conversations during the lockdown, was uncertain about the clinic.

The company has 20 staff, including software and app developers and three clinicians. It is aiming to have a dozen doctors and nurses available to deliver virtual consultations by the launch in July. ■

*fcassie@nzdoctor.co.nz*

# DISPATCHES

## NEWS IN BRIEF

### ‘Open for business’ is college catchcry

The RNZCGP has reminded member GPs of the need to assure patients they will be cared for safely, should they need to attend a practice for an in-person consultation in the virtual health COVID-19 era. “Open for business” promotional materials for use on emails, newsletters, and websites have been made downloadable on the college website. A series of frequently asked questions and answers for patients is also available. The last campaign to the general public was 2017’s “GP – heart of the community”.


**Australian academics will research bushfires’ physiological and mental health effects**

### Bushfires affect body, mind and community

The Australian Government is funding research into the physiological impacts of prolonged bushfire smoke exposure and the mental health impacts of bushfires on communities. Nine research projects will receive A$5 million, including work with Australia’s first responders to the 2019/20 bushfires on their ongoing mental health and wellbeing. The effectiveness of measures used to reduce exposure to smoke hazards will also be studied, the Department of Health says in a media release.

### Christchurch GP next NZMA GP Council chair

Christchurch GP Vanessa Weenink will next month replace Auckland GP Jan White as chair of the NZMA GP Council. Dr Weenink is the managing partner in her practice, Papanui Medical Centre, and is studying for a diploma in public health. She is also a member of the Pegasus Health Membership Ltd board and the Pegasus Health (Charitable) Ltd board (the board of the PHO and wider Pegasus network). Every second year, the council elects a new chair who takes over the role at the NZMA annual general meeting, but arrangements are not yet finalised for the imminent transfer because of the uncertainty caused by the COVID-19 emergency. The meeting was to be held on 19 May.

### Nursing shortage heads towards 6 million

The number of nurses increased by 4.7 million between 2013 and 2018, but the global shortfall is 5.9 million, mainly in Africa, South East Asia and the eastern Mediterranean, says a report from WHO in association with the International Council of Nurses and global campaign Nursing Now. Countries experiencing shortages need to increase graduates by on average 8 per cent a year, and improve nurse employment and job retention, says *The State of the World’s Nursing 2020*. This boost to the workforce would cost each country US$10 per head of population per year.

### Easier to become vaccinator

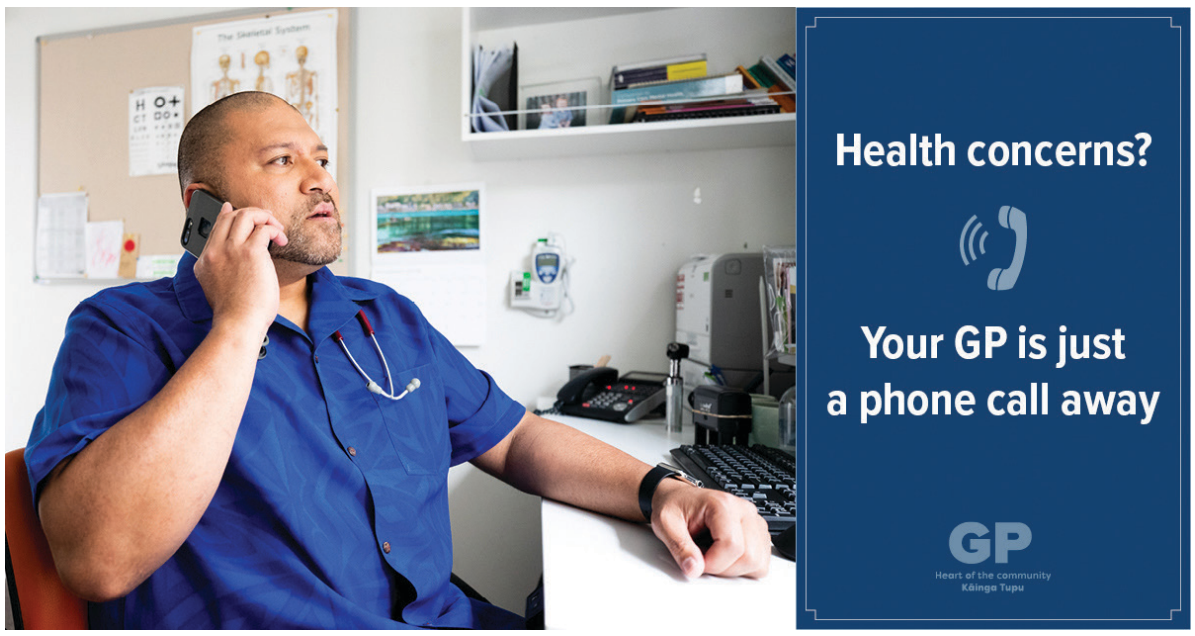
A wide range of health workers can now be accredited to offer influenza, MMR and any potential COVID-19 vaccinations by completing a free online course with changes announced by the Ministry of Health making it easier to get vaccinator accreditation. A new influenza, MMR and pandemic vaccinator training course has been developed and will be available free on the Immunisation Advisory Centre website to any healthcare professional with a current Annual Practising Certificate. The course will also be available to appropriate health science students registered with a professional body, Well Child Tamariki Ora nurses, Māori and Pacific health providers, school-registered nurses, pharmacists not already vaccinating, enrolled nurses, retired health professionals, third-year student nurses and fourth-year student doctors.

### Meanwhile, Ebola has not gone away

Ebola persists in the Democratic Republic of the Congo, where more than 2200 lives have been lost and 3400 infections confirmed since August 2018. WHO says a new case of the viral disease was confirmed earlier this month in the city of Beni. The organisation has hundreds of staff helping the Government-led response to the disease, which has an average case fatality rate of about 50 per cent. The Centers for Disease Control (US) says outbreaks in west Africa have cost US$4.3 billion.

### Metered inhaler can go generic, says FDA

The US FDA gave drug-maker Dipla Ltd the go-ahead to make the first generic of the metered-dose albuterol sulfate inhaler (Ventolin in New Zealand). Indications are treatment or prevention of bronchospasm in patients over four years old with reversible obstructive airway disease, and prevention of exercise-induced bronchospasm in this group. Demand has risen during the coronavirus pandemic, the agency says.




**RNZCGP downloadable imagery promotes the importance of patients visiting their medical centre when necessary**

### Indoor shooters at risk from lead

Firearms-related lead poisonings are highlighted by University of Otago, Wellington, senior research fellow Marie Russell, who seeks tougher regulations on indoor firing ranges. Eighty-eight firearms-related lead poisonings were reported between 2014 and 2018, but most gun users are never tested for lead exposure, Dr Russell says. The Arms Legislation Bill should require regional public health to inspect indoor ranges, she says in a media release. Using lead ammunition, casting lead bullets or reloading bullets with lead can expose shooters to risk.

**Public health academic Marie Russell says lead risks justify tougher regulations for indoor firing ranges**

### Rethink urged on CPR in pandemic

Because CPR has little benefit to patients, and potentially significant harm to staff, it is justifiable for staff to not carry it out on a hospitalised COVID-19 patient if they don’t have enhanced personal protection, say authors of an article in the *British Medical Journal* (2020;369, online 6 April). Intubated and ventilated COVID-19 patients have poor survival rates and a poor chance of success with cardiopulmonary resuscitation. The article points to a “moral imperative” to identify COVID-19 patients who are deteriorating, and support them with intubation and ventilation, or discuss honestly, with them and family, the prognosis should a cardiac arrest occur.

### WHO catches up data and strategy

WHO reports about 40 per cent of COVID-19 cases experience mild disease; 40 per cent, moderate; 15 per cent, severe; and 5 per cent, critical disease. The crude clinical case fatality rate is now over 3 per cent, rising to 15 per cent or higher in patients aged over 80. Morbidity is also very high, says the agency in its latest strategy update. Underlying health conditions of the cardiovascular, respiratory and immune systems increase the risk of severe illness and death. *COVID strategy update 13 April 2020* can be found at nzdoctor.co.nz in The Vault under ‘Document Archive’.

### First-of-its-kind drug trial in GP patients

General practices are taking part in the UK’s first national, non-hospital, clinical trial involving COVID-19. Practices using IT firm TPP’s electronic health record are being asked to recruit 3000 high-risk patients. The aim is to test medicines that might reduce the duration and severity of COVID-19 illness. The first drug to be tested is hydroxychloroquine, says the RCGP in a media release. The trial is led by the college’s General Practitioners Research and Surveillance Centre at the University of Oxford.

### Merest hint of BCG’s potential in COVID-19

Countries routinely using the Bacille Calmette-Guérin (BCG) vaccine in neonates have reported fewer COVID-19 cases, according to three papers yet to be peer-reviewed. WHO referred to, but did not cite, this work in a media release suggesting the likelihood of bias, for example, from differences in demographics and disease burden, testing rates and pandemic stage. WHO awaits outcomes of two clinical trials of the BCG vaccination in healthcare workers caring for patients with COVID-19, and does not recommend BCG vaccination for prevention of COVID-19.

### Hospitals, but not as we know them

China’s COVID-19 shelter hospitals, converted rapidly at massive scale from sports and exhibition centres, numbered 16 with 13,000 beds. Running costs were low because of a low health worker-to-patient ratio, all patients having a primary diagnosis of mild-to-moderate COVID-19 disease. The hospitals’ essential functions were: isolation; triage; basic medical care, including antiviral, antipyretic and antibiotic medication, oxygen supplementation and intravenous fluids, and mental health counselling; frequent monitoring and rapid referral; and emotional support and community activities. Many countries and communities could boost their response to pandemics by embracing this approach, say authors in an analysis in *The Lancet* (online 3 April).

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References: 1. Ramesh H, et al. Pancreatology 2013: 13(2):133-139. 2. Lindkvist B. World J Gastroenterol. 2013;19(42):7258-66. 3. Lohr, et al. United European Gastroenterology Journal. 2017; Vol. 5(2):153–199. 4. Dumasy V, et al. Am J Gastroenterol. 2004;99(7):1350-4. CREON® (Pancreatin). Modified release capsules. General Sales (10,000 Ph.Eur. units) and Prescription Medicine (25,000 Ph.Eur. units) Indications: For treatment of conditions associated with pancreatic exocrine insufficiency (PEI), such as: cystic fibrosis (CF), chronic pancreatitis, post-pancreatectomy, postgastrointestinal bypass surgery, ductal obstruction of the pancreas or common bile duct. Contraindications: Hypersensitivity to porcine protein or to any of the excipients. Precautions: Fibrosing colonopathy, pregnancy, lactation. Adverse Effects: Abdominal pain, nausea, vomiting, constipation, diarrhoea, abdominal distension, rash, pruritus, urticaria. Dosage & Administration: The dose required depends on the severity of disease and the composition of food. It is recommended to take the enzymes during or immediately after each meal or snack. Always ensure adequate hydration of patients to avoid constipation. The capsules should be swallowed intact however when swallowing of capsules is difficult, the capsules may be opened and the minimicrospheres added to acidic soft food such as apple sauce, yoghurt or fruit juice with pH < 5.5, or taken with liquid such as fruit juice with pH < 5.5, e.g. apple, orange or pineapple juice. Rinse mouth out afterwards to ensure no product is retained in the mouth. Treatment of adult patients with PEI associated with non-CF conditions – Required dose for meals: 25,000 to 80,000 lipase units; Snacks: half of meal dose. Refer to data sheet for dose titration considerations. Treatment of paediatric and adult patients with CF - Children < 4 years: Starting dose of 1,000 lipase units/kg bodyweight per meal; Patients ≥ 4 years: Starting dose of 500 lipase units/kg bodyweight per meal. For CF patients, maximum dose of 4,000 lipase units/gram dietary fat intake. Creon® is a fully funded medicine. Before recommending this medicine please refer to the full datasheet available from www.medsafe.govt.nz. Creon® is a registered trademark of BGP Products Operations GmbH, Germany, a Mylan company. Mylan New Zealand Ltd, Auckland.TAPS DA1927FR-125.

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# John Elliott a gentleman doctor in the 'finest tradition' of general practice

**PRIMARY STARS**

Martin Johnston meets the GP who blew away the judges of the New Zealand Primary Healthcare Awards | He Tohu Mauri Ora

Medtech GP of the Year winner John Elliott at Kumeu Village Medical Centre has an old-style sense of duty and calling

When John Elliott learned he was up for the GP of the Year Award, he was in North Shore Hospital after suffering a heart attack.

It was a small one, he says, and he has two stents in his heart arteries to show for it.

For many people of his age – he's now 65 – a heart attack necessitating angioplasty would shout "take a breather".

But the north-west Auckland doctor, who took out the Medtech GP of the Year accolade in February at the inaugural New Zealand Primary Healthcare Awards | He Tohu Mauri Ora, seems deaf to that. Perhaps that's due to a combination of medical inheritance, leadership and an old-style sense of duty and calling.

Dr Elliott is a medical pure-bred.

It started with his grandfather, Sir James Elliott. Born in Ireland, he became the first house surgeon at Wellington District Hospital. A chairman and president of the New Zealand Branch of the British Medical Association, he was influential as editor of the *New Zealand Medical Journal* from 1911 to 1933.

His three sons became medical practitioners, including Sir Randal Elliott, John Elliott's father.

Sir Randal (1923–2010), an ophthalmologist, was chairman and president of the New Zealand Medical Association.

With this distinguished lineage, which to John Elliott was both an inspiration and slightly daunting, medicine was the only career he ever seriously considered.

After he stopped wanting to be a fire-engine driver at about age three, "it never occurred to me I would be anything else", he says.

He was a trainee intern and house surgeon at Wellington Hospital, began specialist training, then won a scholarship to Rhodesia (now Zimbabwe).

On returning to New Zealand, he worked in general practice, first as a locum, later setting up a practice in Palmerston North and, for the past 20 years, at the Kumeu Village Medical Centre in Auckland's north west.

"A bit by default", he never pursued vocational registration in general practice, which he now regrets.

But he has no regrets about his vocation.

"When I stood down from neurology, a lot of people thought I was mad. I haven't regretted the decision. I have thoroughly enjoyed general practice. It's extremely challenging on occasions, but I can't think of me ever being anything else."

Dr Elliott, tall and possessing a kindly yet precise manner, seems almost to fizz with excitement for his work.

His medical commitments are broad. They extend far beyond the Kumeu practice's patients to on-call duties to the north and west, community hospice patients, complex mental-health patients, and a list of health organisations he leads, including the Auckland-Waitematā Rural Health Alliance, a St John area committee, and a ProCare educational group.

The on-call work contributes to what Dr Elliott calls "the tyranny of distance", which he thinks makes rural medicine unattractive to many doctors. He notes 11 doctors have left the Westgate-Helensville area in the past three years and just three have arrived.

He recalls last year one on-call Saturday on which he drove back and forth across West Rodney, the territory his practice shares with two others after hours. He saw patients in the Kumeu clinic and one in their own home at Muriwai, helped someone who fell at Bethells Beach and attended following two deaths, one of which was at Kaipara South Head. "I did 305 kilometres in one day."

But he says rural practice also places GPs in a respected position in the community. As a medical student put it, accompanying him was "like touring with royalty".

**Younger GPs will look at the way many of us work and think we are mad. Well, it's called service to the community**

Kumeu Village Medical GP and shareholder William Ferguson describes Dr Elliott as compassionate, with impeccable clinical standards, and highly respected and greatly loved by his patients.

He has a "work ethic and dedication to the job that stands in the finest tradition of New Zealand general practice", wrote Dr Ferguson in nominating his colleague for the award. And he has "an unswerving sense of duty and support for his colleagues, such as when problems of availability arise with the after-hours call roster".

"Such a 'life-calling' level of dedication is becoming a rarity among health professionals and, for many of us, 'lifestyle' increasingly dictates the scope of the job that we are prepared to take on."

Dr Elliott is proud of his rural alliance work, which has resulted in many improvements for patients and health workers. One is the enhanced urgent and after-hours service on Waiheke Island, which involved extra funding from the Auckland DHB.

In support of his award nomination, Waiheke GP Rebecca Potts wrote, "He listened to the GPs on Waiheke and understood our concerns about the sustainability and safety of the [previous] service.

"He…dedicated a lot of time and energy to us on Waiheke, resulting in a very positive improvement in services for patients."

Dr Elliott's heart attack came as a great shock as he had had no symptoms. Everyone around him told him to slow down.

"Well, yeah. I'm trying to," he says with little conviction. It has been suggested he could just "not give a damn" any more.

"That's never going to happen. It's just not me, nor is it the average GP, a dedicated, hard-working group of people. And I don't think New Zealand will realise what it's had here until most of us are gone."

He recognises that in many older GPs the lifestyle/work balance is "deplorable".

"Therefore, younger GPs will look at the way many of us work and think we are mad. Well, it's called service to the community. But actually, there isn't an easy answer to it. One of the real elephants in the room is how short of people we are.

"Really the only solution you can see to the manpower troubles currently in the next 10 years is for people, the average GP, who looks very like me, male or female, to actually work into their 70s, or possibly even their early 80s.

"And you start saying, are there patient safety issues for all of us when we are getting much older? Of course there are, but there isn't an easy solution," Dr Elliott says. ■

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# Inventive South Island GP gears up to the max to protect his tiny practice

**Fiona Cassie**

A Cromwell solo GP improvised his own face shield, and says his practice team wears PPE in all consultations with patients.

Greg White, of Cromwell Family Practice, wore his own homemade shield until a neighbour offered him one over the back fence which had been bought from a hardware store.

Dr White now awaits delivery of "mark III", a face shield ordered from the organisation ShieldsUp.

"I'm a solo GP with just a nurse and receptionist – so we're small, we can't afford even one person sick," he says.

"So we've decided we will wear PPE (personal protective equipment) for all face-to-face consultations – even for car-park flu shots." And they have added face shields to the standard kit.

He made the decision after reading research on infection protection rates. He concluded shields are superior to the Ministry of Health-recommended safety goggles or glasses.

"Half of us wear glasses and safety goggles or safety glasses, [and] either you can't see, or they fog up, or they don't go over your glasses and it's uncomfortable," he says.

Staff find shields give a clearer field of vision, and they can keep them on for longer without getting hot and uncomfortable.

**Staff find shields give a clearer field of vision, and they can keep them on for longer without getting hot and uncomfortable**

Dr White says the practice team had felt reassured by Southern DHB's advice that they wouldn't need shields, "but it's become glaringly obvious to the entire world that healthcare workers are incredibly vulnerable".

"I have asthma: I can't afford for my lungs to be attacked any more."

Finding the PPE and guidelines for primary care did not include shields, Dr White experimented with a laminator and created a shield using a plastic lamination pouch that went hard after being heated.

Then a neighbour he chatted to across the driveway offered him a hardware-store variety still in the original plastic wrapping.

His third version is on the way after he got in touch with the volunteer collective ShieldsUp, which produces face shields.

The collective's website says it has delivered hundreds of washable and reusable shields across the country on a first-come, first-served basis.

Some of the collective's 200-plus volunteers use home-based 3D printers to print the shield's headband frame, or laser-cut visors from PVC or PET plastic.

Dr White says he has also sourced his own plastic aprons as the gowns supplied were easy to rip and staff were having to tape up holes.

"We're basically improvising our own PPE gear – which is fine, as I know the DHB are conserving their stock."

A typical day at Cromwell Family Practice now sees only a handful of phone-triaged patients coming through the practice door for blood tests, dressings or a physical assessment, says Dr White.

Otherwise, the day is made up of between five and 10 short video consultations using Doxy.me or phone. "It's probably about half our usual workload," he says. ■

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Cromwell GP Greg White improvised his own face shield

# To listen and soothe – important GP roles during COVID crisis

Southern correspondent Fiona Cassie talks to Christchurch GP Jeremy Baker about helping patients with the emotional side of lockdown; and doing the same for yourselves

Christchurch GP Jeremy Baker

photo: Etienne Boulanger on Unsplash

Soothing and listening to people can reduce the risk of acute stress disorders in situations like the COVID-19 pandemic

Listening, soothing and keeping a relationship with vulnerable patients struggling in the lockdown is an important role for GPs and nurses, believes Christchurch GP Jeremy Baker.

Mental health is a special interest of the experienced GP and GP-registrar educator who is also currently involved in delivering a mental health coaching programme.

Dr Baker says the lockdown has seen many patients with existing mental health issues, or those anxious that their health condition or age makes them particularly vulnerable to COVID-19, without their usual support systems and contacts.

"Even if we're not counsellors I think the least we as GPs and nurses can take on board, is how to soothe and how to listen."

He says general practice staff need to put themselves in their patients' shoes, particularly those who are alone.

"They are much more in their own thoughts and their own emotions. And all the self-doubt that comes into that.

"If you look at trauma studies, the ability for someone to have their concerns heard and empathised with does prevent matters leading on to acute stress disorders and post-traumatic stress disorder (PTSD).

"If we soothe and listen…that's getting somewhere."

Dr Baker believes it also may be helpful to draw on some tips for the lockdown he has discussed with counsellors, including the four Ps from Christchurch colleague Richard Black of Strength to Strength Counselling.

**Prepare**: have a sense of preparedness about what you are doing with your day including fitting exercise into your daily routine. But also be prepared to break-up the routine so you don't get trapped into negative thinking.

If feeling powerless, try to instil some **peace**: you may have a sense of powerlessness about what you now can't do. Try and seek peace in the face of this powerlessness.

**Prayer,** contemplation or mindfulness may also help. Remind yourself that everyone is in the same boat and the lockdown will bring better health to the country.

Dr Baker says his own variation on the "Ps" also draws on cognitive behavioural therapy (CBT) and acceptance and commitment therapy (ACT).

His first p is **pause**. "Pause your thinking rather than thinking in a rush or thinking negatively." The second p is for **prayer**, contemplation or mindfulness. The last p is for **pronouncing** a positiveness about what you will do next.

"It's called self-agency – pronouncing something that you will do next even if you feel negative, down or despondent." He says this can give people a sense of re-empowerment so rather than just "pausing, praying and pronouncing" you start to have a sense of your ability to overcome. ■

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## Calming distress in challenging times

So all we have is the phone (or maybe Zoom or WhatsApp) to connect with someone. How can we help others at a distance?

Listening, empathising and soothing are really good just in their own right. They have been shown to help prevent later-onset PTSD.

Here also is a map (a mnemonic) of where to go next as we try to find out how people are doing inside themselves. It's called **REST**.

REST stands for resting from being anxious, and from trying to solve everything right now. It means getting more comfortable not being in control of things.

It means stopping fears and frights triggering into anxiety. It gives room for other people to be present in the distress. It means having faith.

**R – Relationships** with other people are really, really important.

Watch our words. Remember to be gentle. Remember to forgive. Try not to aim our anger or frustration, etc directly at people.

**E – Executive function** means keeping a sense that we still have the capability and strength to do something. We are not totally hopeless. Even if we can't change big things, we can change small things – and we should practise doing that.

**S – Soothing** is important. We can learn to self-soothe. This helps to keep pressure (which is okay) from turning to stress. When we're "in the valley" we need to guard against the negative thoughts building up in our minds.

**T – Truth-finding** and holding onto truth become very important in stressful times. Truth is a compass to keep us oriented and moving forward in life. We often have to find truth and develop our personal meanings about truth in times of reflection – on the "mountain-top". We travel to the mountain-top to find calm and clarity.

*Jeremy Baker*

**Wellbeing resources for COVID-19** All Right? – Allright.org.nz; Mental Health Foundation – mentalhealth.org.nz

# COVID-19 lines of communication:


Hundreds of staff, thousands of calls. Zahra Shahtahmasebi finds out how Homecare Medical fronted up to the need to expand New Zealand's health call lines to cope with COVID-19

Andrew Slater never expected his call centre staff would be delivering babies over the phone on a regular basis.

Mr Slater certainly didn't foresee he would be running around Auckland dairies on the hunt for Ajax Spray n' Wipe and hand sanitiser for the office.

Nor did he expect an IT system that would normally take five months to develop could be established in just seven days.

In the COVID-19 pandemic, the chief executive of Homecare Medical, the organisation that runs Healthline, has found the extraordinary has become ordinary.

"To give some context, normally we would deliver a baby 'over the phone' or deal with someone with severe chest pain probably once a year but, in the last week, the number of those presenting to the service has been alarming."

This is because, says Kristin Good, Homecare Medical's clinical lead for primary health, New Zealanders under Alert Level 4 lockdown have been reluctant to reach out to their GPs for healthcare as they normally would.

"So, as a result, they're presenting to Healthline much later and are much sicker than usual," Dr Good says. "It's added a new layer of complexity."

Homecare Medical runs the National Telehealth Service, including Healthline, the free mental health line 1737 and the general practice after-hours nurse triage service. COVID-19 has forced a rapid transformation in the past two months.

Staff were already partially prepared. Hard lessons had been learned last year from major health emergencies: the terror attacks in Christchurch, the measles outbreak, and the Whakaari/White Island eruption.

"This enabled us to establish and strengthen our relationships within the health sector," Mr Slater says.

But, in many ways, COVID-19 has been totally unique, he says. "The increased public need, and for such a sustained length of time, as well as the multicultural dimension…Dealing with international travellers, the Chinese community, our Māori and Pasifika communities, our elderly population…it has affected all communities, all of Aotearoa, in different ways.

"The service has never experienced anything of this magnitude before."

**Blueprints for the future have arisen from this innovative thinking. The health system over the last month has done some extraordinary things**

Equity initiatives are of high priority, Mr Slater says. The service is working with New Zealand's Māori, Pasifika and deaf communities, in particular, towards ensuring they get timely, relevant health advice.

Dr Good and Mr Slater say they are immensely proud of the way their staff have risen to the challenges presented by COVID-19.

The organisation began taking action in late January, and a dedicated public phone service was made available 24/7 for COVID-19 related health advice and information by 7 February.

Three days later, 34 Mandarin-speaking health advisers had been recruited and trained.

Staff numbers were rapidly increased, from 126 manning the phones at Healthline at the end of January to 426 by the end of March.

When Mr Slater and Dr Good spoke with *New Zealand Doctor* in mid-April, the number had increased to 500-plus clinical and non-clinical staff delivering the service.

Many are working from home, but some staff are still working in Healthline's contact centres, where they are practising physical distancing, says Mr Slater.

The number of contact centres has increased from three to eight – five in Auckland, two in Wellington, and one in Christchurch. There are also five smaller regional hubs.

Mr Slater says credit needs to be given to the staff who worked closely with telecommunications provider Spark to implement a five-month IT programme in just one week.

"Our infrastructure has got six times bigger. We were developing and deploying virtual desktops, an intranet, so people are able to get the information they need and several phone lines.

"Every staff member needed to have all the right tools, a desk, a computer and they had to be inducted.

"We also had to build robust security and privacy frameworks, especially to allow staff to be able to work from home…to make sure nothing was compromised."

The biggest challenges in facing COVID-19 so far have been the ones Mr Slater least expected.

All parts of the organisation have been affected by the virus, he says.

He never predicted global and national supply chain problems that would make it hard to increase server capacity and obtain equipment.

"Normally, we would be able to get

# The extraordinary becomes ordinary

Andrew Slater has been at the helm of Homecare Medical during a transition no one foresaw would be necessary

Clinical director Kirstin Good is proud of Healthline staff as they cope with the heightened degree of alarm from the public

## Homecare Medical's pedigree

Homecare Medical Ltd, the supplier of Healthline, is owned by two of the country's biggest PHOs – ProCare in Auckland and Pegasus Health in Christchurch. It is in charge of running New Zealand's National Telehealth Service, of which Healthline is but one component.

The National Telehealth Service model was developed in November 2015, and is co-funded by the Ministry of Health, ACC, the Health Promotion Agency, the Ministry of Social Development and the Department of Corrections.

Homecare Medical holds a 10-year contract worth $257 million awarded in June 2015 to run all the Government's free 24/7 digital telehealth services, which are offered across seven different channels including voice, webchat and text.

It receives government funding in the annual Budget. Funding for the current COVID-19 response is through the Ministry of Health's $20 million-spending package announced on 17 March.

Both non-clinical and clinical staff, such as registered nurses, psychologists, paramedics, doctors and emergency triage nurses, staff the phones, and the number of staff required has been massively upscaled to cope with demand during the virus pandemic.

Homecare Medical is governed by a board of directors: former National cabinet minister Roger Sowry (chair), Pegasus Health chief executive Vince Barry, ProCare chief executive Steve Boomert, general manager for Australia and New Zealand of IT company Certus Lee Eglinton, Christchurch GP and chair of Homecare Medical Clinical Governance Committee Hillary Gray, head of Te Runanga o Ngāti Ruanui Debbie Ngarewa-Packer (Ngāti Ruanui, Ngā Ruahine, Ngā Rauru) and chartered accountant James Sclater. The organisation is led by chief executive Andrew Slater.

According to its website, the following is a full list of services provided by Homecare Medical :

- Healthline, 0800 611 116
- Poisons Advice, 0800 POISON (0800 764 766)
- 1737 Need to Talk? Text or call 1737
- Depression Helpline, 0800 111 757 or text 4202
- Depression.org.nz
- Quitline, 0800 778 778
- The Diver Emergency Service Hotline, 0800 4 DES 111 (0800 4337 111)
- Live Kidney Donation, 0800 LIVE DONOR (0800 5483 3666)
- Alcohol Drug Helpline, 0800 787 797, or text 8681
- The Lowdown for young people feeling stuck or anxious or depressed
- RecoveRing for offenders who want support with alcohol or drug use, 0800 678 789
- Puāwaitanga for individual phone and online counselling
- The national sexual harm helpline, Safe to talk, 0800 044 334 and text 4334
- Gambling Helpline, 0800 654 655 or text 8006
- Immunisations Advice, 0800 IMMUNE (0800 466 863)
- Kupe, a website and tool for information on prostate cancer
- Ambulance Secondary Triage for low acuity calls to 111
- Early Mental Health Response for those in social and psychological distress who call 111
- Elder Abuse Response Service, 0800 EA NOT OK (0800 32 668 65)

hundreds of headsets at the drop of a hat. I never thought they'd become as rare as a hen's tooth.

"We can normally order Ajax Spray n' Wipe and hand sanitiser for our offices…I never did foresee a world where we'd be running around small dairies in Auckland hunting for them."

Healthline also ran into trouble with the phone lines on 23 March, when it seemed every New Zealander was calling everyone they knew as the lockdown was announced.

The organisation has also had to prioritise its work and staff.

With bowel screening all but stopped, teams working on that programme have joined the COVID-19 team.

Mr Slater says, since Easter, the aim has been to increase the capacity for the 1737 service, as the number of calls is edging up.

For Dr Good, her main challenge has been trying to manage the ever-changing COVID-19 disease case definition and maintaining a quick flow of information to staff.

"Sometimes we've had just 10 minutes' warning before needing to respond to the public. But we've met this challenge head on…

"Everything is constantly changing, but we've risen to the occasion, and demonstrated our value by coming up with innovative solutions."

Public health units across the country have been swamped, so Healthline jumped on board, helping out with the likes of welfare checks for those in self-isolation and their close contacts.

"We've had to step up and provide those services; I wouldn't have imagined us doing this three months ago."

The huge demand from the public for non-clinical information saw Healthline quickly engage with both Plunket and House of Travel to redeploy some of their staff.

"There were about 200 House of Travel call centre staff who had no need to respond to travel requests any more, so we trained them, as well as Plunket nurses."

A recruitment process that would normally be done in six months was condensed to about three days, resulting in 200 staff able to provide callers with non-clinical information while under the clinical supervision of the nurses.

Mr Slater says staff did an outstanding job, not only building rapport with callers but also satisfying their needs, which freed up clinicians for clinical triage.

"Blueprints for the future have arisen from this innovative thinking. The health system over the last month has done some extraordinary things."

In essence, though, the National Telehealth Service is doing what it was designed to do, says Mr Slater.

Co-designed with the Ministry of Health in 2014 and 2015, it was built with the idea it would be able to scale up and adapt rapidly in health emergencies.

"We've just had to roll up our sleeves and get stuck in."

Conversations with international counterparts in Australia, the UK, the US and Canada have provided lessons these countries learned in the fight against COVID-19, says Mr Slater.

"One of the things I've been most proud of has been the way we've managed to keep an eye on our clinical quality and safety."

Complaints are fewer than normal: 84 complaints were received in March from 191,995 contacts.

The majority of complaints were from callers experiencing long wait times.

In the last week of February, call volumes to Healthline surged, particularly around peak news times and in the evening.

By 31 March, the daily number of calls managed by staff each day increased from 1445 to 12,763, with wait times peaking at one hour 52 minutes in the middle of the month.

This is where Mr Slater apologises, saying the service let New Zealanders down.

"The demand was hitting us faster than anticipated, but we've managed to bring it down week on week."

Wait times have reduced dramatically: the median is now 20 seconds for clinical triage calls, and less than 10 for non-clinical.

However, with the unpredictability of call volume patterns and many calls – whether related to COVID-19 or not – becoming increasingly complex and requiring more time, longer waits on occasion can be expected.

It hasn't all been complaints; people have complimented the service and acknowledged the pressure and complexity of the work as well as the time taken, thoroughness and compassion received from Healthline staff.

**Everything is constantly changing, but we've risen to the occasion and demonstrated our value... with innovative solutions**

Life has certainly not been easy for call centre staff.

"Many of them may have partners who have lost jobs and are having to work from home while educating their children, or having to get to work using limited public transport. COVID-19 has impacted everybody and our staff are not exempt from adversity."

Still, the team has to provide assurance while dealing with unprecedented levels of health anxiety and fear, as well as keep up with the best and most recent advice, such as the current number of available community-based assessment centres.

"And sometimes they'll get people who have been given a response they don't want – [people] can become quite evil as humans when this happens, which is to be expected, so they've being dealing with that too."

In some cases, Mr Slater has personally called a few of these "evil humans" to ask them for some understanding and compassion.

All in all, though, he says he has found it interesting to see the public's need and desire for good and consistent information.

Dr Good is proud of the way Healthline staff have dealt with this heightened degree of alarm from the public.

"They've managed to provide appropriate responses and an empathetic ear while being extremely busy," she says.

About 10 per cent of the calls received have been from GPs and primary healthcare professionals.

The service has worked with the RNZCGP and other organisations so the common themes can be covered in resources they provide.

Despite the challenges, the COVID-19 experience has been rewarding: it has provided the service with a huge opportunity to support primary care and public health services.

Dr Good says she has enjoyed seeing relationships strengthened as well as new ones being formed.

"I'm very optimistic that we'll take some positive things out of this. I would like to acknowledge the stellar effort of all of the staff on the front line."

Mr Slater says it is because of these strong relationships with organisations like Plunket, St John, Spark, Atlantis Health and the college that the service has been able to respond in the way it has.

"I just want to say thank you to the health system and our services, and to all of those who provided us with feedback to allow us to make a bigger impact."

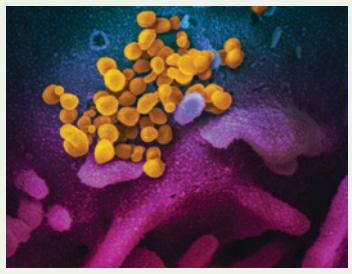
So, what will Healthline and the National Telehealth Service look like post lockdown?

"You know," says Mr Slater, "I've not had two minutes to think about the future.

"I just hope that we take on board all of the great things that have come about from this response and use them in our new normal." ■

*zshahtahmasebi@nzdoctor.co.nz*

## Coronavirus Update



### Key dates

- **29 December 2019** – China reports pneumonia cases of unknown cause
- **7 January** – China isolates a novel coronavirus, at first called 2019-nCoV and later SARS-CoV-2
- **13 January** – First lab-confirmed case of COVID-19 outside China identified, in Thailand
- **30 January** – WHO declares the epidemic a global health emergency
- **3 February** – New Zealand temporarily bans entry of foreigners from or via mainland China. Homecoming New Zealanders exempt but must self-isolate
- **28 February** – New Zealand's first confirmed case reported to Ministry of Health
- **28 February** – Entry ban on foreigners from/via China extended to Iran. Returning New Zealanders exempt but must self-isolate
- **16 March** – All passengers arriving in New Zealand, except those arriving from 17 Pacific Island countries/territories, must self-isolate
- **16 March** – Government bans non-essential outdoor gatherings of 500-plus people; schools and universities exempt
- **17 March** – Government announces $500 million in funding for health services to combat the disease, as part of $12.1 billion COVID-19 economic package
- **20 March** – Border closed to most foreigners
- **21 March** – Alert Level system announced. New Zealand is at Level 2 – "Reduce"
- **24 March** – Total confirmed/probable cases: 155
- **25 March** – Alert Level 4 – "Eliminate". Stay-at-home order, most businesses close or work from home
- **29 March** – First New Zealand death
- **6 April** – Downward trend of new cases begins
- **10 April** – Second death
- **19 April** – Deaths total: 12
Combined confirmed/probable case total: 1431
Recovered cases: 912

### By the numbers

**Confirmed cases as at 19 April:**

- 2,241,359 worldwide
- 695,353 in the United States
- 191,726 in Spain
- 175,925 in Italy

**Deaths as at 19 April:**

- 152,551 worldwide
- 32,427 in the United States
- 23,227 in Italy
- 20,043 in Spain

# Bracing for the existential fog ahead as what was safe feels like an illusion

**JUST WONDERING**

In the uneasy reflection time created by the COVID-19 lockdown, Lucy O'Hagan finds a lesson for the middle classes

It's hard to see where we are heading once the worst of the pandemic is over

I want to be doing better than I am. After all, there's a pandemic, and I'm a doctor.

I'd like to be more like Ashley Bloomfield, calm and rational. But in the first week of the COVID-19 lockdown, I became irritable – not at work, but at home.

And I would hear harsh sounds coming out of my mouth, and they would flow in slow motion across the space between my partner and me. I'd wonder: what is that sound, where did it come from?

It's the squeezing tension, I'm sure.

The study of graphs, and the specificity and sensitivity of tests, and appropriate use of personal protective equipment – all this keeps me in the Dr Ashley realm, and I can make decisions.

But then I get glued to my phone reading horror stories of the dead in Italy, see the photo essays of heaving hospitals and refrigerated trucks bound for morgues.

I'm a doctor, so I manage that; trauma and crisis are in my lifeblood.

It is later, perhaps while walking around the block past the teddy bears in windows, in cars, under teddy-sized tarpaulins with their picnic gear, that I feel my chest is full of tears. Teddies don't normally get to me.

It's the fear, I'm sure.

I am a realist. What if it was me, that 2 per cent?

I'm okay sitting at my kitchen table doing telephone consults in my socks. The patients are great, they tell me stories of spending lockdown singing, or drawing, or weaving, or playing games. The quietness has settled them. And, indeed, there is a queer peace in it, that empty diary.

It's the unnerving future, I'm sure.

I always manage a crisis by going to the worst-case scenario and working out how I would deal with it, then anything less than the worst will be okay. It worked with PPE. I imagined being a GP doing home visits to elderly patients dying of the virus, unable to get a hospital bed. But at that stage, we all had PPE anxiety, it was unsettling. My partner bought the last box of gloves in the local Countdown and found the last plastic face visor in town.

And I felt better, ready for the worst.

**We will all have to ask whether we are prepared to sacrifice a few older people to keep our economy and our lifestyle going. It's brutal, and I say no**

But this week I have developed a gnawing dyspepsia.

It's the existential fog ahead, I'm sure.

What was secure feels flawed. What was safe feels like an illusion.

The realist in me can't make a picture of the future worst-case scenario, let alone a plan. What will our world be like in one month, six months, a year, two years?

I fantasise about the best scenario, that we are all back to business as usual, flying around the world, living the middle-class dream, by Christmas. I must be kidding myself. House values will drop, my retirement fund will crumble, my tenant will probably lose her job, my kids might, I might. And I'm one of the lucky ones. I am not a practice owner struggling to keep my business afloat, or a young GP with a mortgage and no work.

I want that other life back. That life where I have reaped middle-class, first-world privilege. That life of consumption, and stuff, more and more stuff filling our homes, and those endless plane rides chewing up the ozone layer. I want that life back, but I don't. It seems grotesque from here.

It's a question of morality, I'm sure.

It always was, but now I see clearly the inequities, the advantage I still have.

We will all have to ask whether we are prepared to sacrifice a few older people to keep our economy and our lifestyle going. It's brutal, and I say no. I would rather give up greed.

It helps to forgive myself for being rattled.

It helps to put my hands in the soil.

It helps to laugh.

It helps to not go there.

It helps to talk with other doctors, to share ideas on Facebook.

It helps to put away the phone for hours on end.

I'm sure it helps to pray, if that is your thing.

It helps to just stay in the moment I am in, and be still.

I am warm and fed. I have a job, a home. Even if absolutely squeezed financially, I can find extra to share, I can employ others who don't have work, I can reduce the rent, the patients can pay less.

I want to cling on, but it's a time to let go. I want to protect what I have, but it's a time to share it. We are all in this together.

It's a time to ask, "What type of human being do I want to be?"

And in some way that feels better. ■

*Lucy O'Hagan is a Dunedin GP*

# Journo Alan Perrott on submitting to COVID-19 testing

**STUFF WE LIKE**

Our reporter makes an eye-watering 'donation' to the cause of defeating COVID-19

It wasn't so much the length of the stick being pushed up my nose as the tweak she gave it at the end.

"This might make your eyes water."

"What…?" The accuracy of her prediction at least boosts my confidence in the science underpinning the COVID-19 test. I'll take the result, whenever it arrives, as gospel.

(The result was negative and the common cold as boring as ever.)

The day I tested, almost 3000 others went through the same drill.

I'd been crook for several days and, after a little coaxing, agreed to call my GP for a chat. If it had been a few days earlier, it would have been a very brief chat indeed – I have no travel history, no contact with anyone who has travelled, and am not part of an at-risk group – but the testing definition had changed yet again, and so my headache, sore throat and knackered-ness now pass muster.

St Lukes on Auckland's city fringe is my nearest community-based assessment centre, but my GP said some referrals had been turned away for reasons unknown. So I was steered north over the harbour bridge to the AUT Akoranga campus clinic. I hoped this meant a chance to have a motorway to myself. Sadly, the traffic flows were at least at Sunday evening levels. (As a boy I thought car-less days would mean empty streets. One day it'll happen, I just know it.)

I finally sight an ad hoc sign pointing me in the right direction, and pull up at a couple of road cones. A masked security guy silently hands me a COVID-19 information sheet and waves me on to the next stop.

This time, I'm met by (I assume) a nurse in a gown and face mask. She stops me from winding down my window, mimes me to turn off the engine, and asks me to press my (emailed) referral form against the window. She checks all the details, makes some notes on a piece of paper, and jams it under a window wiper. She then gets me to open my window a smidge, slips through two more pages of information, and waves me on.

I fall in behind two cars queuing for the two testing tents as another nurse approaches. Engine off and my referral is checked again, and another piece of paper is stuck under the other wiper. I'm there for about 10 minutes before I reach the front. Ahead are two more security guys and several nurses, three doing the admin in the queue and two working the tents.

I pull into my tent and out pops a nurse, this time in gown, mask and face shield. The paperwork is removed from my wipers and my details are confirmed a third time before we have my one conversation of the encounter. Her colleague's gown had ripped – "must have been a cheap one" – and we chat about the fashion failings of personal protective equipment.

This time, my window rolls down far enough for an arm to slide through, brandishing what seemed like a thin jousting stick. You're putting that where?

Thinking of my country, I lie back and watch as the hand holding the far end slowly impales my face and she relates her eye-watering advisory. "What…?" Then comes the tweak, or was it a twist? Either way, it's the first time I've felt a bottlebrush rotate against the back of my skull.

*New Zealand Doctor* reporter Alan Perrott joins the end of the queue at a community-based assessment centre on Auckland's North Shore

**It's the first time I've felt a bottlebrush rotate against the back of my skull**

Did I get a stamp, or a lolly, for being brave? No, it was sling your hook, there are more people coming.

Still, as I blink back the tears, a memory is triggered of another time when I'd felt part of something bigger.

It was the first Telethon and I'd handed my pocket money over to the Lions, so as I drove off I'm singing (badly): "Thank you very much for your kind donation, thank you very much, thank you very very very much!" ■

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**Important message:**
Due to the COVID-19 lockdown our physical offices are closed but staff continue to work from home

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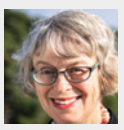

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THE HEALTH MEDIA

## Just Practising Malcolm Walker


# A few words from…Tegan Jones

Gisborne nurse Tegan Jones has been in primary healthcare since graduating five years ago – first in Cannon's Creek, Porirua, and for the past three years at Gisborne's De Lautour Medical. She has her sights set on becoming a nurse practitioner and started her master's degree this year

**Gisborne nurse Tegan Jones loves skateboarding, learning te reo, reading Haruki Murakami and savouring a glass of chenin blanc with a wedge of cheese**

**The best thing about my practice** is continuity of care and unremittingly beautiful team work.

**The worst thing about my practice** is our roof (inside joke) but no joke, everything else is wonderful.

**My greatest achievement is…** something I think about all the time – how grateful I am to have completed my bachelor's degree (BN). I failed pharmacology at the end of my second year at Massey University and felt totally deflated. I repeated the paper over summer school but was very anxious as I awaited my exam results. During this time, I organised a visit to the dean's office to explain that I wanted to take a "year off" the degree, I'd planned to work at the Island Bay Pharmacy. I feel so fortunate that she convinced me to stay, as I don't know if I would have returned otherwise. Thank you, Deb Leuchars!

**It might surprise other people** that I'm heavily tattooed and love skateboarding! I think people are surprised when nurses enjoy, or are associated with, anything that hints at social deviance or unconventionality in general. But I think it's important that our nursing workforce reflects our population – Gisborne is full of board riders and, as New Zealanders, we are among the most tattooed people in the world! In that sense maybe I'm not surprising at all?

**My favourite word** is "mauri". Its meanings include life principle, life force and vital essence. I consider the concepts of "mauri ora" and "mauri noho" in my personal and professional life every day.

**The trait I most dislike in myself** is how heavily self-critical I am and my fear of criticism from others. When I feel I've done something wrong I cry at the drop of a hat. I work on my resilience every day and I find reflective practice really helpful for this.

**The trait I most dislike in others** is entitlement. I'll leave it at that.

**I relax by** singing and listening to music, going for long drives up the East Cape, freedom camping with whānau and friends, baking bread and sweet treats, walking on and swimming at our beautiful beaches, and wrapping up with a good book and a mug of peppermint tea. I also enjoy a glass of chenin blanc and a big wedge of cheese.

**What keeps me awake at night?** Literally, the amount of coffee I've had to drink. Figuratively, I'd say climate change and the unremitting effects of colonisation on my whakapapa and that of my patients. This worries me more than COVID-19, although arguably COVID-19 is just another part of it all.

**My funniest moment as a practice nurse?** Auē, I think the funniest has to have been the time I was presented with a whole, perfectly formed, adult poo in an ice-cream container. I thought about how outrageously comical it would have been to be presented with such a thing if I was anyone other than a nurse – I had the giggles for hours.

**The three things I'd like to see changed about general practice?**
1) More continuity of care – I know this doesn't necessarily fit with the model of the health care home but I do know it has a huge influence on the level of trust that a patient places in their healthcare team, and this improves patient outcomes and patient engagement in self-care massively.
2) More innovation funding from PHOs. No one knows our communities better than us here at the proverbial "coalface", so give us the means to care for our whānau, their way.
3) Pay parity with the DHB for our incredibly knowledgeable and highly skilled primary healthcare nurses.
I am so thankful for all our medical colleagues and practice managers who have offered their support with our current Primary Health Care MECA negotiations (which are currently on hold in light of the COVID-19 pandemic response).

**My ideal dinner party guests** would be the most inspirational living women I know. A collection of leaders, nursing scholars, artists and writers – the honourable Jacinda Ardern, Helen Clark, Jill Clendon, Kim van Wissen, Rupi Kaur, Patti Smith, Tayi Tibble, Jessica Thompson Carr, Alexis Hepburn, Sam Rulz and Florence Welch. Some men for entertainment purposes too – Yo-Yo Ma playing the cello and Rod Stewart serenading. And readings by Diego Perez (aka Yung Pueblo) and Haruki Murakami.

**If I wasn't in my current job** I'd stick with nursing. I really love sexual health and working with young people in particular, so our local Family Planning or community clinic would be a great place for me. Outside of nursing, my dream job would be a florist – however, I have terrible allergies so it remains a dream!

**If I was stranded on a desert island** I'd take my partner Andre, a water filter, my record player and LPs, plus a stack of good books!

**On top of my bucket list:** Becoming a nurse practitioner and being fluent in te reo Māori are tied for first place. ■

MORE DOWN THE BACK
On page 22

With PMAANZ folk flat out with the COVID-19 response, we only have one bulletin down the back this issue and that is from the NZMA GP Council

▶NZMA GP Council chair **Jan White** urges GPs to support each other during the many challenges of COVID-19

# Healthy vibe created at battle-hardened Good Space Award-winning practice

PRIMARY STARS

▶**Fiona Cassie**

**Castlecliff Health team at the awards night: Leanne Sutter, Pom Johnson, Praveen Thadigiri, Grayson Cobb (The Health Media), Jane Dutton, Kylie Wagstaff, and Juliet Chapman. Kathryn McInnes (not pictured)**

**The "inspirational people" wall in the welcoming waiting room of Castlecliff Health which took out the Medispace Good Space Award at the New Zealand Primary Healthcare Awards**

**KEY POINTS**

- The two-year-old, $1.7 million Castlecliff Health building took out the Medispace Good Space Award at the New Zealand Primary Healthcare Awards | He Tohu Mauri Ora.
- The seven-member practice team has returned to being a Very Low Cost Access practice.
- GP Praveen Thadigiri and NP Pom Johnson are drawing on real-life experience in epidemics in India and Thailand for the practice's COVID-19 response.

The practice that battled to build its award-winning space is now rising to the battle of fighting COVID-19 in a lockdown.

Castlecliff Health took out the Medispace Good Space Award at the inaugural New Zealand Primary Healthcare Awards | He Tohu Mauri Ora, with the $1.7 million practice building it opened in February 2018 following a two-and-a-half year battle with red tape.

"Winning the award after all the battles we had is in some ways like a vindication that we were on the right track," says Castlecliff GP Praveen Thadigiri who bought the Very Low Cost Access practice in 2014.

"All of the fights were well worth it and to be acknowledged in the national arena is something completely different," Dr Thadigiri says.

"Often when Whanganui features on the news it is not for very positive reasons, especially health statistics, so I think it is refreshing both for a high-needs suburb like Castlecliff as well as for Whanganui in general," he says.

The judges commented on the colourful, spacious interior, good practice equipment, the excellent "inspirational people" wall in the waiting room and the "bonus" fenced-off pet corner on the site that allows the dog-loving team to bring their pets to work if they wish.

Dr Thadigiri says that two years after moving in he believes the space has created a very healthy vibe for the entire team and patients.

"I think we underestimate what a space can do for you – especially for your mind.

"One of the main comments we have from clients is how peaceful the place feels, and it doesn't feel like a place of sickness."

The trials of Dr Thadigiri and the part-owner nurse practitioner Jane Dutton to build the practice were shared with *New Zealand Doctor* readers in 2018.

The pair, who initially tried to purchase and renovate their former premises, struck barriers in finding suitable land to build on and then had their resource consent declined before community support helped them come through and build the 500sqm clinic in a commercially zoned area near Castlecliff.

The practice now has two nurse practitioners, with Pom Johnson joining the team in 2018, and most recently has taken on an enrolled nurse to bring the practice staff up to – one GP, two NPs, one registered nurse, one enrolled nurse, a practice manager and a medical receptionist.

The number of enrolled patients has slightly increased in the past two years to 2400, with about half of patients Māori and more than 80 per cent have high-needs.

The practice, which had given up its VLCA funding as commercially unsustainable, returned to being VLCA funded from the start of 2020, after securing its financial stability.

It promoted its dropped prices as a "New Year" gift to its patient community.

### COVID-19 hot on heels of win

But Castlecliff has hardly had time to celebrate its win before entering the new challenge of the COVID-19 crisis.

Dr Thadigiri has drawn on his joint Master's degree in international health (tropical medicine and disease control), done in conjunction with WHO, to respond to the pandemic.

He and Thai-born NP Pom Johnson also have drawn on real-life experience of working with epidemics in India and Thailand.

"We have, I dare say, enjoyed the stress of setting up and making sure we can deliver the services without fear and passing on the same messages to our clients."

Initially in the lockdown, Castlecliff was using the design and automatic doors to help lock-off parts of the practice, then it decided to keep the new building entirely sterile. With the luxury of space, it has set up two portable buildings on site – one in which flu vaccinations are carried out and the other for the daily handful of acute face-to-face consultations.

The practice has a person in personal protective equipment at the entrance to the practice car park to triage and direct people to the correct building, with the building entrances divided off by road barriers.

Dr Thadigiri also added web designer to his skill set, spending two nights early in the lockdown setting up the practice's first website so it could share information with patients about the video, phone and in-person consultations available. ■

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New Zealand PRIMARY HEALTHCARE AWARDS He Tohu Mauri Ora

# Gimme shelter: Building resilience for the other side

DEAR AUNT MASIE

**While the last month has been one of the most challenging in my professional career, it's also been fantastic to see how the practice team have responded. Can you share some ideas for how we could build on our team's response and their resilience, for when we come out the other side of the pandemic?**

***Grateful, Palmerston North***

**MAS healthy practice adviser Fiona Mines**

The COVID-19 pandemic has forced an enormous number of changes on the way we all live and work within a very short time.

It hasn't been easy and a full economic and social recovery may take years.

But for many individuals and workplaces, the lockdown also provides an opportunity to review the way they work and reassess their options for when things get back to some sort of normality.

General practice has been particularly impacted by the lockdown, and practices have had to adapt quickly to provide services in a different way, working to meet the expectations of patients under extraordinary circumstances.

These pressures can take their toll on practice staff and it's important to think about their resilience and wellbeing at times like these.

### The small things can make a difference

- ***Say thank you for a job well done, regularly***

As a practice owner or manager, one of the most effective things you can do to improve the wellbeing and resilience of your staff is to regularly show your appreciation for their work.

It sounds simple but it makes a huge difference – even if you only spend a few minutes at the start of team meetings, highlighting four or five positive things that have happened around the practice since the previous meeting.

And if a staff member isn't happy about their progress in a certain area, focus on the positive – remind them how much they have achieved, rather than commiserate over what they haven't.

- ***Think about what could be done differently next time, rather than who was at fault***

Of course, problems are going to crop up from time to time.

One approach to dealing with these situations is to try to depersonalise it.

Rather than apportioning blame to an individual, it is a good idea to step back and see whether the problem could be a fault in the systems and processes you have, or whether a similar problem in future could be avoided by tweaking your processes.

- ***Communicate often, and remember it's a two-way street***

It's also important to communicate well with your staff and regularly ask them how they're getting on and whether they need help with anything.

Hopefully, this will help your staff feel comfortable to speak up when things are getting difficult, allowing you to head off problems before they become insurmountable.

In return, you need to ensure your staff know what you expect of them. Provide clear position descriptions with expected outcomes, give them achievable goals and make sure they have the resources required to attain them.

**For many individuals and workplaces, the lockdown also provides an opportunity to review the way they work and reassess their options**

### Resilient staff take their lead from resilient managers

Good leadership is a key factor in building resilient teams. Team leaders and managers need to be strong and committed to getting the job done but also be open, honest and compassionate in their dealings with their teams.

When your practice is going through challenging times, it's important to remember that it's tough on everyone, and your staff will only be able to do their jobs well if they're feeling confident in themselves and the practice.

Ultimately, their mental health and wellbeing is something staff need to take responsibility for but a well-timed word or thoughtful gesture from their manager can do wonders.

At the very least, you need to be aware that your staff deal with stress in different ways and may need extra support at work. This may include directing them to the appropriate agencies where mental health support is available.

From a business perspective, your practice also needs to be set up in such a way to have the management structure and financial strength to survive setbacks. This can be achieved by thorough planning and risk assessment.

All practices should undertake a regular budgeting and planning process, have a business continuity plan and review insurances to make sure all contingencies are covered should the worst-case scenario eventuate. ■

*Fiona Mines is Healthy Practice Adviser at MAS*

**MAS staff are happy to answer any questions you have on practice issues and dilemmas.**
**Email business@mas.co.nz**

**WELLBEING RESOURCES FOR STAFF**

A good place to start is the MAS Wellbeing Portal, which we have launched in collaboration with Synergy Health to help our members get through these difficult times.

This online resource centre is free for members and their families, and it provides tools and simple, pragmatic advice about how to improve your physical health, along with your nutritional, mental, and financial wellbeing.

To find out more about the portal and how to register, visit mas.co.nz/mas-wellbeing-portal/.

It's also worth remembering that MAS offers its members three free counselling sessions through EAP Services, an independent counselling service. The counselling is available 24/7 and EAP Services can work with you remotely, if you would prefer not to go into one of their offices.

This service is completely free to members. All you need to do is mention you are with MAS, and EAP Services will invoice us directly. Your privacy is guaranteed – we do not receive any information about which members have used the service.

To make an appointment call EAP Services directly on 0800 327 669 or visit eapservices.co.nz


General practices are scrambling to find viable online payment options when charging for virtual consultations

# Making dollars and sense of patient copayments for virtual consults

**Simon Maude**

Patients have adjusted well to the virtual consultations that have become standard in the COVID-19 era, but copayments pose a problem, general practices say.

Since the RNZCGP advocated a virtual-first approach on 22 March and the country went into lockdown on 25 March, practices report they're undertaking few face-to-face appointments but a large number of telephone and video consults.

The concern is that fees won't fill the gap from lost in-person consultations, even with extra government funding.

General Practice New Zealand chair and Wellington GP Jeff Lowe says fears he raised in a 27 March letter to director-general of health Ashley Bloomfield have begun to materialise.

At Karori Medical Centre, where Dr Lowe is a partner, about 85 per cent of consultations are now teleconsults.

Post-consult, patients receive a text with the centre's internet banking details.

Compared with the same time last April, the centre has had a 50 per cent decline in consultations and a resulting loss in patient copayment cash flow, he says.

"We're hearing stories of [cash flow] drop offs of 80 per cent at other practices."

Dr Lowe says his patients have largely reacted positively to teleconsults, which cost the same as a face-to-face check-up but, for a variety of reasons, more patients have been slow to pay.

As revenue collection slows, Karori Medical and others are seeing bad debts and administration costs rise.

At south Waikato rural practice Putāruru-Tīrau Family Doctors, practice manager Trish Cole also says a decline in the number of procedures carried out is creating financial difficulties.

The community understands why people aren't allowed inside the practice, and have accepted the temporary situation, Ms Cole says.

People who can't use internet banking to pay for their consultations can still visit the practice. A staff member will take a mobile EFTPOS machine outside to take their payment, Ms Cole says.

Some practices take credit or debit card details over the phone, but this needs to be arranged with the EFTPOS provider and bank.

Dr Lowe's practice is investigating fee-charging, third-party e-commerce platforms, such as Stripe, to make it easier for patients to pay online.

Valentia Technologies, which runs the MyIndici patient portal, already uses Stripe, with copayments made via the portal.

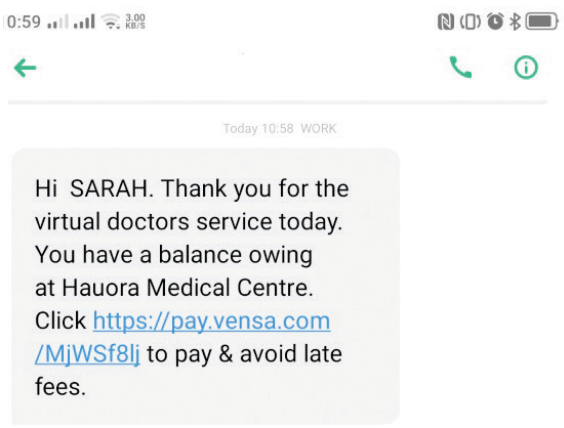
Valentia's technical services president Ahmed Javad, says patients logged in to their portal account can click on invoices, which then directs them to Stripe to make credit or debit card payments.

Patients pay a processing fee to Stripe, he says.

An in-video consult payment service is about to be introduced. This will mean patients will need only a smartphone, Dr Javad says.

New Zealand's largest patient portal provider, Medtech Global ManageMyHealth, also offers practices the option to run copayments via its portal, in much the same way as MyIndici.

Medtech Global chief architect Sanjeewa Samaraweera says ManageMyHealth uses payment processor Windcave, which charges practices 2.5 per cent per invoice for processing.




**Practices using VensaPay can send text messages to patients telling them how much their teleconsult cost, as this mock text shows**

### Real money for virtual consults

General practices can:

- set up internet banking
- take credit or debit card details over the phone, and/or
- use a third-party payment processor.

ManageMyHealth also charges practices a fee of 50 cents per transaction, Mr Samaraweera says.

Using the service requires practices to have an online merchant services account, which ManageMyHealth can facilitate.

Patients without credit or debit cards will soon be able to make bank-to-bank payments via the portal and Windcave, he says.

Meanwhile, virtual consult payment facilitator Vensa Health has lowered its cut for processing patient invoices, says chief executive Ahmad Jubbawey.

VensaPay, built on Vensa Health's widely used text-messaging service, TXT2Remind, was launched early last year, charging practices 15 per cent per patient invoice amount.

Recently, charges moved to a sliding scale. Practices now pay between 8.95 and 12.75 per cent, depending on the number of monthly invoices VensaPay processes.

Payment has also become an equity issue, because many patients don't have credit or debit cards, but do have smartphones, he says.

The service will eventually have bank-to-bank payment options for patients who don't have cards, Mr Jubbawey says.

The Health365 patient portal allows patients, when logged in, to view invoices and practice banking details. Health365 creator and GP Ashwin Patel says patients currently can't click through to make electronic payments.

Health365 had that capacity, but deactivated it two years ago because of low demand from patients.

Dr Patel says COVID-19 has forced practices and patients to make more use of online services, so Health365 may incorporate online payments once again. ■

*smaude@nzdoctor.co.nz*

# Welcome to the new feminism – where the aim is to really, really gross you out

Playing for laughs? UK researcher Zoe Strimpel takes a close look at in-your-face comedies starring women and sex, and finds a new take on a topic that has occupied feminists for centuries

The cast of BBC series *Fleabag*: Andrew Scott, Phoebe Waller-Bridge, Sian Clifford, and Brett Gelman, winners of the Outstanding Comedy Series award

Vaginas are so hot right now. If that sentence shocks you, then you've been out of the cultural loop. Thanks to a new wave of television and autobiographies by some very funny women, female privates have moved to the front and centre of popular entertainment.

Male bits, once the only game in town, are now chiefly of interest only as a sidebar to hilarious female riffs on misfiring, awkward and unsatisfactory sex, thanks to recent work by the likes of Lena Dunham, Britain's Phoebe Waller-Bridge (writer, actor and star of BBC series *Fleabag*), and now Amy Schumer, whose smash hit "femoir", *The Girl With the Lower Back Tattoo*, recently hit stores.

This is all part of a new movement – what I like to call "gross-out feminism".

It is gleeful, honest to a fault, and practised exclusively by women who long ago kissed goodbye to the capacity to be embarrassed. Its goal – apart from to make people laugh – is to provide a kind of shock therapy to those still harbouring the notion that women don't have bodily functions, trapped gas, or insubordinate periods. Or that women must either be thin or desperately wishing they were so.

Gross-out feminism works by normalising women through focusing on their bodies: traditionally, the first and final frontier of femininity. It violently pushes all remaining cats out of the bag. Women have smelly, sometimes even extremely malodorous vaginas – Schumer's smells like "chicken ramen"; "baby diaper" morning breath; explosive diarrhoea; acne.

They sometimes fart during sex.

You'd be right if you noticed that this type of feminism doesn't look like the iconic polemics of Shulamith Firestone, Naomi Wolf or Germaine Greer. It does not fit the sociological paradigm of Natasha Walter, Ariel Levy or Laurie Penny, all of whom have tackled a classic 20th century feminist subject – objectification – with political panache. And no, it's not related either to the brainy fiction of Erica Jong or Marilyn French.

But gross-out feminism owes much to these. The classic texts of feminism laid down the parameters of the various struggles women engage in on a daily basis. One of these was the battle to be taken as full humans, complete with an independent sexuality.

As far back as the 1790s, Mary Wollstonecraft raged against the reductive construction of doll-like femininity.

The new feminism builds on all this, but its toolbox is drawn not from an intellectual arena but rather from a peculiarly modern fascination with personal and especially sexual transparency. Honesty shall set us free: as sociologist Richard Sennett lamented, we moderns trade first and foremost in intimacies. But wrapped tightly in gut-busting hilarity, the relentless personal honesty of Schumer et al loses its potential for hollow narcissism and instead becomes powerful, adding vim to the traditional message to women to be strong and confident.

Schumer in particular paints an honest, if troubling picture of the impact of what Naomi Wolf so famously addressed in *The Beauty Myth*. Money, pain, time: a bewildering amount of these are required in order for most women to feel presentable, let alone attractive. Schumer nails this, but also admits to her own "beauty myth" victimhood.

Before a date she too waxes, straightens her hair, fasts, and tries to squeeze into Spanx so tight that they threaten to splice her guts in two. Schumer, then, is taking one for the team. She's performing her truth so that we can exorcise our demons. The intriguing implication is that she, like Dunham and Fey, is an everywoman as well as herself. "I am myself," in her words. "And I am all of you."

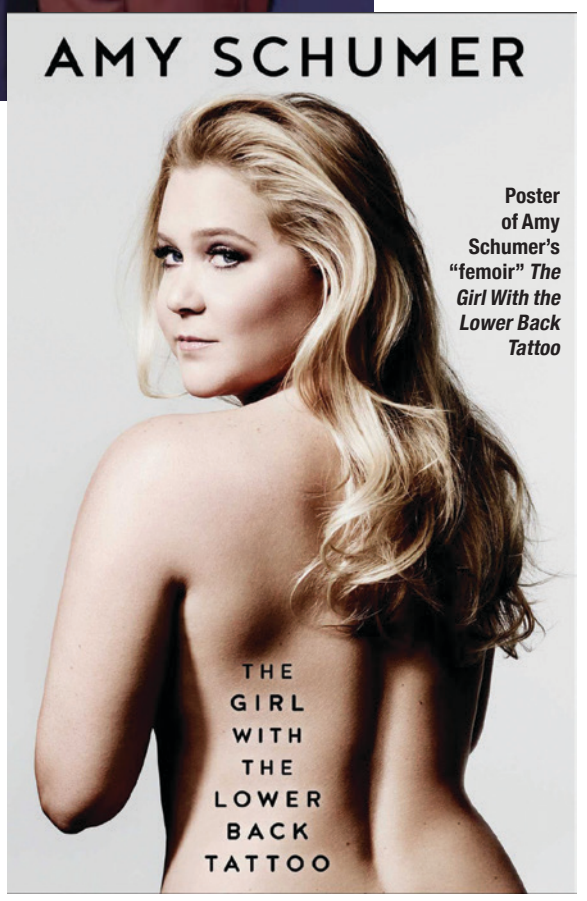
A new sisterhood.

Might this signal a reinvigoration of the idea of a universal "sisterhood" that since the 1970s has buckled under the weight of concerns about racial, ethnic and class difference? Perhaps so.

In her hit sitcom *Fleabag*, Phoebe Waller-Bridge does similar work to Schumer, if less autobiographical. She doesn't spend much time on her appearance, but when an attractive man calls in the middle of the night asking to come over, waking her up, she excruciatingly manufactures the appearance of having just come in from a night out. She throws off her pyjamas, pulls on her glad rags, a coat, and swigs some wine in preparation. She is soon speaking deadpan to the camera while being taken up the backside.

Lena Dunham at the 2012 Tribeca Film Festival premiere of *The Russian Winter*

[photo: David Shankbone]




Poster of Amy Schumer's "femoir" *The Girl With the Lower Back Tattoo*

**Schumer, then, is taking one for the team. She's performing her truth so that we can exorcise our demons**

**Waller-Bridge's genius is reading with jaded perfection the sexual proclivities of men half her intellect and beauty**

Her sexual honesty is eminently relatable to by millennials, and tinged with sadness. Waller-Bridge's genius is reading with jaded perfection the sexual proclivities of men half her intellect and beauty.

There are caveats, of course. Some might argue that bringing feminism back into the body merely reaffirms the idea that women are principally bodies rather than whole people. And putting sex front and centre emphasises a potentially one-dimensional representation of what it is to be human. Both of these objections are fair. But when it comes to mainstream, massively entertaining representations of women, gross-out feminism may finally be what has been missing all these years, showing once and for all that the "fair sex" is human in both body and spirit. Warts and all. ■

*Zoe Strimpel is a doctoral researcher in history at the University of Sussex, UK*

Mary Wollstonecraft raged against the reductive construction of doll-like femininity

# Waiting and watching and reading

**SPARE TIME**

Some tips from the *New Zealand Doctor* crew on what to read, watch or listen to during lockdown downtime

### Mutual agreement on comedies

Battling over the Netflix remote in our bubble reflects our different escapism needs. My husband and son are drawn to *Ozark*, *Narcos* and re-runs of *Breaking Bad*. Friends keep recommending the latest Scandi noir. But I keep lobbying for comedies that make me feel good about humanity.

What we can agree about in our household are the comedies *Lovesick*, *The Good Place* and *Schitt's Creek*. The first is about the trials of love in a group of mates in Glasgow, the second a crash course in philosophy and the third about a rich family thrown into adversity. Don't let these crude plot summaries put you off – they all have good heart and good laughs.

When it comes to books…I read anything and everything but during bouts of insomnia during the Canterbury earthquakes I found myself twice reading Gerald Durrell's *My Family and Other Animals*. Reading about scorpions, tortoises and Durrell's delightfully mad family in sun-drenched Corfu was the best of escapes.

*Fiona Cassie, Southern correspondent*

### Too tired for subtitles

If you're like me, you're too tired at the end of a long day to read subtitles, but you like that foreign TV takes risks and offers something different. Well dubbing is back, and it's not a joke any more. Netflix has loads of unique Scandinavian shows, and many of the actors record their own English dubbing, which helps make the performances more convincing.

Try *The Rain* if you like post-apocalyptic drama or *Ragnarok* if you're into fantasy drama, plus there are many excellent Nordic noir dramas to choose from, some of which have been remade in the UK and US (eg, *The Killing*).

You'll soon forget about the lips not matching the audio (although it's amazing how closely they do). If you'd rather brush up on your Norwegian, you can do that too by swapping to the subtitled version.

*Amy van der Loo, clinical editor*

### Rooting for the bad guy

Like *Breaking Bad* before it, *Ozark* makes you root for a bad guy because he seems so nice, has a lovely family, and because there are other bad guys who are far worse.

It follows Marty and Wendy Byrde, and their two children, as they relocate from Chicago to the picturesque Ozarks in Missouri. Everything they do is for their family, but that only gets them deeper and deeper into trouble with a Mexican drug cartel.

*Ozark* has a satisfying plot with clever twists, and Jason Bateman (if you can forget his role in 1987's *Teen Wolf Too*) and Laura Linney give outstanding performances as the seemingly normal protagonists – they are both charming yet absolutely ruthless. There are three seasons to watch on Netflix, and in my opinion, they just keep getting better.

*Amy van der Loo, clinical editor*

### Trawling through the classics

It's not like we need any excuse, but Alert Level 4 has given our household the chance to revisit some of our best-loved classics.

A bit of a David Jason reconnaissance has taken place if you will, with the likes of *Only Fools and Horses* and *Open All Hours* adding some much-needed humour and light-heartedness.

Derrick "Del Boy" Trotter will always have my heart with the way he seeks to find worth in (and sell) the items he acquires and still manages to outsmart any rival or enemy – particularly former classmate turned police officer Roy Slater (Jim Broadbent) who pops up in series three.

Another classic that has started back on TV again is the *Great British Bake Off* which aired on Prime on 7 April, starring Prue Leith, and Paul Hollywood as judges.

*Bake Off* has always been one of my favourite shows, wholesome with relatable contestants who have a remarkable level of creativity and talent, which I aspire to reach.

*Zahra Shahtahmasebi, reporter*

Reporter Simon Maude has been enjoying Steve Martin and Martin Short's comedy special on Netflix during the lockdown

### I love the house Martins

I didn't have the inclination, nor the money, to catch comedy doyens **Steve Martin** and **Martin Short**'s critically acclaimed *Now You See Them, Soon You Won't* when they toured here in in November.

So, under COVID-19 "house arrest", it was a pleasant surprise finding the actually unforgettable *Steve Martin and Martin Short: An Evening You Will Forget for the Rest of Your Life* comedy special on Netflix.

These extraordinarily funny men, one, a deceptively nice Canadian, the other a snow-white-haired banjo player, spend 80 minutes steadily roasting each other, biographically speaking.

Full of deliciously cutting twists and turns, ventriloquism, and of course some mighty fine banjo pickin', this duo's vaudeville-style comedy special is all class.

*Simon Maude, reporter*

### Insight into a Hasidic community

Satmar in Williamsburg, New York, is a Jewish orthodox dynasty, which is home to Jews who fled from Hungary. It is this community that newly married Esty flees, heading for Berlin where her estranged mother lives, but her husband Yanky and his nasty cousin Moishe are hard on her heels.

*Unorthodox*, on Netflix is loosely based on an autobiography by Deborah Feldman. The depiction of life in a Hasidic community is breathtaking, particularly its portrayal of life for women, whose heads are shaved on their wedding day, and whose sole job is to make babies. And check out the hairy hats those Satmar men wear!

*Ruth Brown, deputy editor*

### A sonnet a day

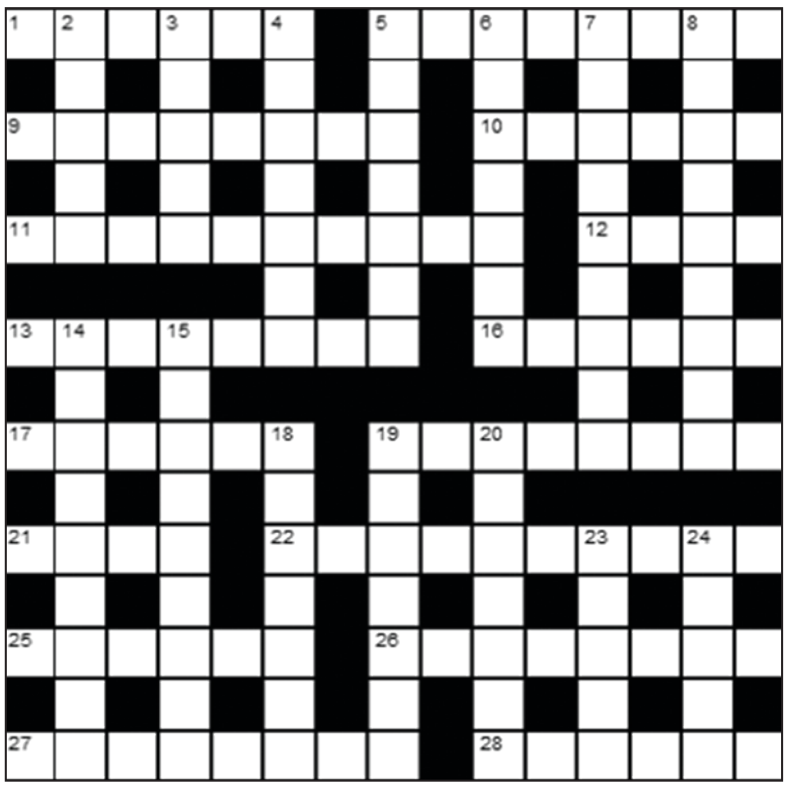
Sir Patrick Stewart treaded the boards as a Shakespearean actor well before he treaded the deck of the USS Enterprise as Captain Jean Luc Picard. His Shakespearean heritage rings out on his Instagram account (@sirpatstew). Back on 22 March, Sir Patrick recited Shakespeare's sonnet 116 – "Love is not love / Which alters when it alteration finds, / Or bends with the remover to remove." Such was the response from his followers, he is now reading a sonnet a day – making his way through all 154 of Shakespeare's 14-line verses. It's an easy way to experience a little of Shakespeare's brilliance. ■

*Barbara Fountain, editor*

# Bridgespotter's cryptic crossword with a clinical twist: No. 40

Double-definition clues in cryptic crosswords usually look simple, just two words, sometimes with a link word in between. All you have to do is find a word which is a simile for both words in the clue. However, sometimes one or both of the definitions are longer. There are 10 double-definition clues for you to solve in this crossword.

If you cannot get going, there is a kick-starter at the end of the clues. How did you go? Sixteen is good, 24 is excellent and 30 is perfect.



**Across**

1. Takes the mickey and downs grub (6)
5. Punishment could be everything from capital to period (8)
9. Rice dome concoction is pretty average (8)
10. Short sighted people dash my hopes in Yorkshire (6)
11. Centenarians with lengthy organs (4,6)
12. Could be a leap into form (4)
13. Spends and gets it back in allowances (8)
16. Unchanging evil becomes established (4,2)
17. Teddy joins battle as gets thin around the edges (6)
19. Appropriate flattering (8)
21. Opposed to beginnings of a new tourist influx (4)
22. Finding a solution for doing exercise (7,3)
25. Angry about smoking (6)
26. Battered petunias go belly up (8)
27. Little creatures coming back in air etc abundantly (8)
28. Mistakes made in terror scenario (6)

**Down**

2. Doctrine revealed in sacred order (5)
3. Throw party (5)
4. Caesar's lot (7)
5. Misrepresent the Queen's pointed poles (7)
6. Enemies in confusion lose interest and take second but remain enemies (7)
7. Natural, sustainable and green method for us and our environment (9)
8. Switzerland joy at an unproven therapy (9)
14. Hairy bird hunter, natural at jumping (9)
15. Scientist reports finding effervescent vesicle (9)
18. Make bet on Stately Lady (7)
19. Is a brat unfortunately but knows his beans (7)
20. Carpenter gets takeaway (7)
23. Dead one in Greece (5)
24. Speak to describe nonsense (5)

**The kick-starter: Punishment could be everything from capital to period (8)**

Long clues are often charades, which require you to build up the answer a bit at a time. Usually this means finding short similes or abbreviations which you carefully stick together.

However, that approach does not seem to work for this clue. Also, there are no words which could be anagram indicators or, indeed, an indicator of any kind.

Considering the warning above, that double-definition clues could be long, we'll see if we can find link words. There are three possibilities: "could be", "from" and "to".

Let's start with "could be". This would mean we are looking for a word that is a simile for both "punishment" and for "everything between capital and period".

**For answers: see page 23.**
**For an explanation of how the answers are found, see Crossword under Opinion at nzdoctor.co.nz or search for Bridgespotter**

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# Want to save the world? Save yourself first and beware of 'bubble busters'

**FIRST TIME**

GP Jo Scott-Jones discusses the effects of the COVID-19 lockdown on general practice and on patients, and gives some pointers on how you can help break the chain of transmission

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It is vital that general practice doesn't start bursting bubbles

When the RNZCGP, on 21 March, called for general practice to shift to virtual care, separate the well from the unwell, protect vulnerable staff and push preventive measures, such as the flu vaccine, it was partly in response to information from the Italian health authorities. This information suggested that health centres themselves are associated with community transmission of the SARS-CoV-2 virus.

On the same day, the country heard about different levels of community response, and we were told we were in Level 2. Two days later, we reached Level 3, and on 25 March, we moved into Level 4 – the countrywide lockdown which we are experiencing now. The regulations are having an impact on movement around the country.

Google analytics released data on 3 April that showed, across New Zealand, we have reduced visits to restaurants, cafés, shopping centres, and retail and recreation sites by 91 per cent compared with baseline. We have reduced our visits to supermarkets and pharmacies by 54 per cent, parks by 78 per cent, transit stations by 84 per cent, and workplaces by 59 per cent, while there has been an increase of 22 per cent in the "mobility trend" for places of residence (see link below).

## Impacts of lockdown on general practice

The impact of regulation on COVID-19 prevalence and incidence is tantalising but unclear at this point. We are seeing the rise in case numbers level off as this is written, but without widespread community testing, and with the rapidly changing case definition, it will be a few more days before we see what impact we are having on prevalence and community transmission.

The impact on general practice, however, is clear.

We have successfully reduced "foot traffic" by over 70 per cent, with some practices reporting a reduction from 120 face-to-face consultations a day to three or four. We have created systems to deal with patients with respiratory symptoms separately from those who don't have symptoms, we have shifted vulnerable staff to non-face-to-face roles, we have pushed flu vaccines out to car parks and rapidly provided access to the most vulnerable, to the point where stock is under pressure.

We have also seen a massive reduction in income from patient fees, activities that attract a "fee for service", medicals for insurance and immigration, minor surgery and from ACC. Government funding support has been welcomed, but confusing.

Practices are weighing up whether the wage subsidy scheme will support them better than the "capitation uplift" that has been provided. The complexity of how to figure out the balance of employer obligations, worker rights, and subsidies is causing sleepless nights to practice owners and practice managers across the country.

Organisations like the Medical Assurance Society have put together helpful resources for employers (https://bit.ly/2XdWyau), but no doubt accountants and financial advisers are working overtime providing guidance to small businesses across the country.

## Impacts on patients are emerging

Patients are deferring contact with health providers. Healthline reports that fewer people are using their service for general health enquiries, and when they are, they are presenting with higher acuity problems. Practices are reporting a worrying drop-off in consultations for people with long-term conditions, and stories are emerging of patients with poor outcomes that could have been prevented by earlier intervention.

The director-general of health Ashley Bloomfield and others are making public announcements to say that general practice is still open for business, and they are encouraging people to contact their GP for advice about non-COVID-19 concerns.

We certainly don't want people to put off asking questions about unexplained weight loss or moles that have turned purple and started bleeding, especially as many of us are picking that the shift to "virtual care first" will persist as we deal with the pandemic.

## The danger of bubble busting

The combination of economic strain on practices and the emotional pressure of seeing patients suffer from delayed access is creating a risk that more bubble-busting activities will happen in general practice. It is vital to the efforts we are making as a country that general practice maintains its part in breaking the chain of transmission.

Before arranging a face-to-face consultation, ask yourself:

**1.** Is there any way we can meet this need without having a face-to-face consultation?

**2.** Is the risk of transmission worth the benefit of seeing this patient, or can this consultation be deferred?

**3.** If this consultation cannot be deferred, how can we minimise the risk of transmission?

- Keep the patient out of the waiting room by consulting as much as possible in the car park.
- If you need to do something inside the building (eg, an intimate examination or a procedure that needs equipment, such as an excision), bring the patient directly into the clinical space, bypassing the waiting room.
- Try to maintain the physical distancing rules and keep interventions to less than 15 minutes, if possible.

**4.** What is the appropriate personal protective equipment needed in this encounter?

## Reducing risk of transmission

For anyone with respiratory symptoms, the advice is clear – droplet PPE should be worn by the provider (gown, gloves, eye protection, surgical mask), and the patient should wear a surgical mask.

The use of a mask and gloves when seeing patients who don't have respiratory symptoms is, at the time of writing, controversial. The received advice is that this is not necessary unless the prevalence in the community is thought to be high.

**The shift to "virtual care first" will persist as we deal with the pandemic**

### Key points

- The COVID-19 lockdown is significantly reducing face-to-face consultations.
- Bubble-busting activities may occur as practices face economic strain and emotional pressure.
- While it is important that patients don't defer needed care, GPs should minimise the risk of COVID-19 transmission by limiting patient contact and wearing personal protective equipment.

It is increasingly common for staff to wear masks and gloves when seeing all patients. As an ordinary surgical mask is most effective in stopping someone spread the virus to others, it makes sense for the patient to also wear a mask, just in case they have mild symptoms or are in the asymptomatic but contagious period of the disease.

Many general practices are shifting towards using "surgical scrubs" and encouraging staff to keep their home clothes separate from work clothes and to shower before mixing with their own whānau/bubble. They are also "cohorting" staff into teams to reduce the impact of transmission on staff availability.

What is clear is that now, more than ever, is a time to take heed of Greg Johnson's lyrics (https://bit.ly/34bEdMF): "First you save yourself. Then you save the world." ■

*Jo Scott-Jones is medical director for Pinnacle Midlands Health Network, has a GP practice in Ōpōtiki and works as a GP across the Midlands region*

**More Information**
**COVID-19 Community Mobility Reports**
**https://www.google.com/covid19/mobility/**

**PEARLS**

## HRT for women who have menopausal symptoms following surgery for epithelial ovarian cancer: Is it safe?

Practical Evidence About Real Life Situations

**Clinical question** How safe and effective is hormone replacement therapy for menopausal symptoms in women surgically treated for epithelial ovarian cancer?

**Bottom line** HRT may improve overall survival in women who have undergone surgery for EOC. However, this is based on low-certainty evidence and, therefore, should be interpreted with caution. We are very uncertain about the impact of HRT on progression-free survival and incidence of adverse events, such as breast cancer, transient ischaemic accident, cerebrovascular accident and myocardial infarction. Therefore, women and their doctors should make decisions based on individual priorities and symptoms.

**Caveat** None of the studies were blinded and 2 studies had high rates of discontinuation of therapy or loss to follow-up. One study was based in Europe and was multicentred, with the remaining 2 from China and South Africa.

**Context** Women who have undergone surgical treatment for EOC may develop menopausal symptoms due to immediate loss of ovarian function following surgery and chemotherapy. Women may experience vasomotor symptoms, sleep disturbance, difficulty concentrating, sexual dysfunction, vaginal symptoms and accelerated osteoporosis. Although HRT is the most effective treatment to relieve these symptoms, its safety has been questioned for women with EOC.

**Cochrane Systematic Review** Saeaib N et al. Hormone replacement therapy after surgery for epithelial ovarian cancer. Cochrane Database of Systematic Reviews 2020, Issue 1. Art. No.: CD012559. DOI: 10.1002/14651858.CD012559.pub2. This review contains 3 studies involving 370 participants.

*Pearls No. 651, April 2020, written by Vanessa Jordan*

*Cochrane Systematic Reviews for primary care practitioners – developed by the Cochrane Primary Care Field, New Zealand Branch of the Australasian Cochrane Centre at the department of general practice and primary health care, University of Auckland and funded by the Ministry of Health. Brian McAvoy is an honorary/adjunct professor of general practice at the universities of Auckland, Melbourne, Monash and Queensland. New Zealanders can access the Cochrane Library free via nz.cochrane.org*

# Caring for your older patients during the COVID-19 shutdown and beyond

**ELDER HEALTH**

Professor of general practice Ngaire Kerse prefers the term shutdown to lockdown for describing restrictions on human contact, travel and business. Here, she discusses the care of older patients during this challenging time

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I write from my desk at home and hope you all receive this in good health, safely. General practice has changed, with virtual consults, constant vigilance and communication challenges our new normal. How is this working for our older patients?

On the day of writing, we have over 1300 confirmed or probable cases of COVID-19. The numbers in our hospitals and intensive care units are small. The majority of those affected are young, but 95 people with the virus are age 70 or older, and there are four clusters centred around rest homes – in Auckland, Hamilton and Christchurch. By the time you read this, the situation will have changed.

Older patients are at increased risk of morbidity and mortality from COVID-19. The international experience reports a mortality rate of around 15 per cent for those aged 80 and older, compared with less than 1 per cent for those aged 30 and under. As such, prevention is by far the best approach.

Official advice for older people can be found on the Ministry of Health website (https://bit.ly/39pjBRT) and includes the recommendation for those under the age of 70 to practise a spirit of manaakitanga and run errands for older friends, family and neighbours. Many older people living at home started staying home before New Zealand moved to COVID-19 Alert Level 4 on 25 March and will stay home or maintain social distancing after the shutdown is lifted.

## What does staying at home mean?

One critical aspect of the shutdown is that it's a physical contact ban, not a social contact ban. Let's all give some thought as to how social relationships and contacts can be kept alive from a distance of two metres. I saw a lovely picture of a grandad and grandson playing noughts and crosses through a closed glass door, each taking their turn from their own side. There are also stories of people in their homes being visited through the window.

When family live far away, this responsibility falls to the neighbourhood. Does everyone know their neighbours? It may be time to do just that – to make sure older neighbours have a way to inform others about their needs, that shopping and small tasks can be addressed, and that the casual conversations, from two metres away, can be had. Online and phone contact with loved ones is also possible and necessary.

Older people are resilient, have seen worse in some cases, and have life experience to share. They may have specific knowledge that is useful, so keep in touch, ask and involve.

## Maximise medical management

For those receiving services in the community, there is a ministry work stream for providers to identify those particularly at risk and to prioritise care. Social contacting and household services are not considered essential, so these have stopped. This is a necessary restriction to prevent the spread of COVID-19, but for those who were receiving care, the support worker may have been their only contact.

Maintaining physical activity is really important through this time, and any encouragement to your patients to maintain activity and cognitive challenge should be given. Walking, sit to stand exercises and balance-challenging exercises can and should continue. Exercise is good for the immune system and reduces the likelihood of chronic disease deterioration, and is good for mental health.

It is our job to come out the other side of this pandemic with healthy, functioning and content older people alongside us. We must maximise medical management and make sure they are as well as possible.

## Residential care

COVID-19 in residential care is difficult. The care home and retirement village providers were quick to institute "no non-essential visitor" policies. This is necessary and fits with the ministry's advice (https://bit.ly/2QUtpwJ). However, all efforts to manage comorbidities and maintain social contact with known people using virtual technology are imperative.

**Revisiting the advance care plan before the urgent time comes is really important**

Getting out of bed and mobilising are important to preserve function through the pandemic, even when staff shortages mandate changes to essential tasks. Family and whānau also need to keep in touch, but how to do this in these times of shutdown is challenging us all. Online contact needs to be at high volume with as large a screen as possible.

When COVID-19 involves staff and residents (so far, we have four rest home clusters with 10 or more cases each), the use of infection control processes, such as strict isolation and personal protective equipment, are needed. For the attending GP, make sure you know who will supply the gear. Swabs are needed and the community clinics will leave this to the GP and staff in the homes, or the local support teams from the DHB may be involved. Keep in mind that older people can find it frightening to see people in PPE; maybe write your name and role on the front if you are wearing it for a longish period.

Staff who have been in close contact with a person with COVID-19 will need to be isolated, and new staff may not know the residents. DHB support with ministry backup will be available – this is being organised as I write but may take some time to coordinate.

## Advance care planning

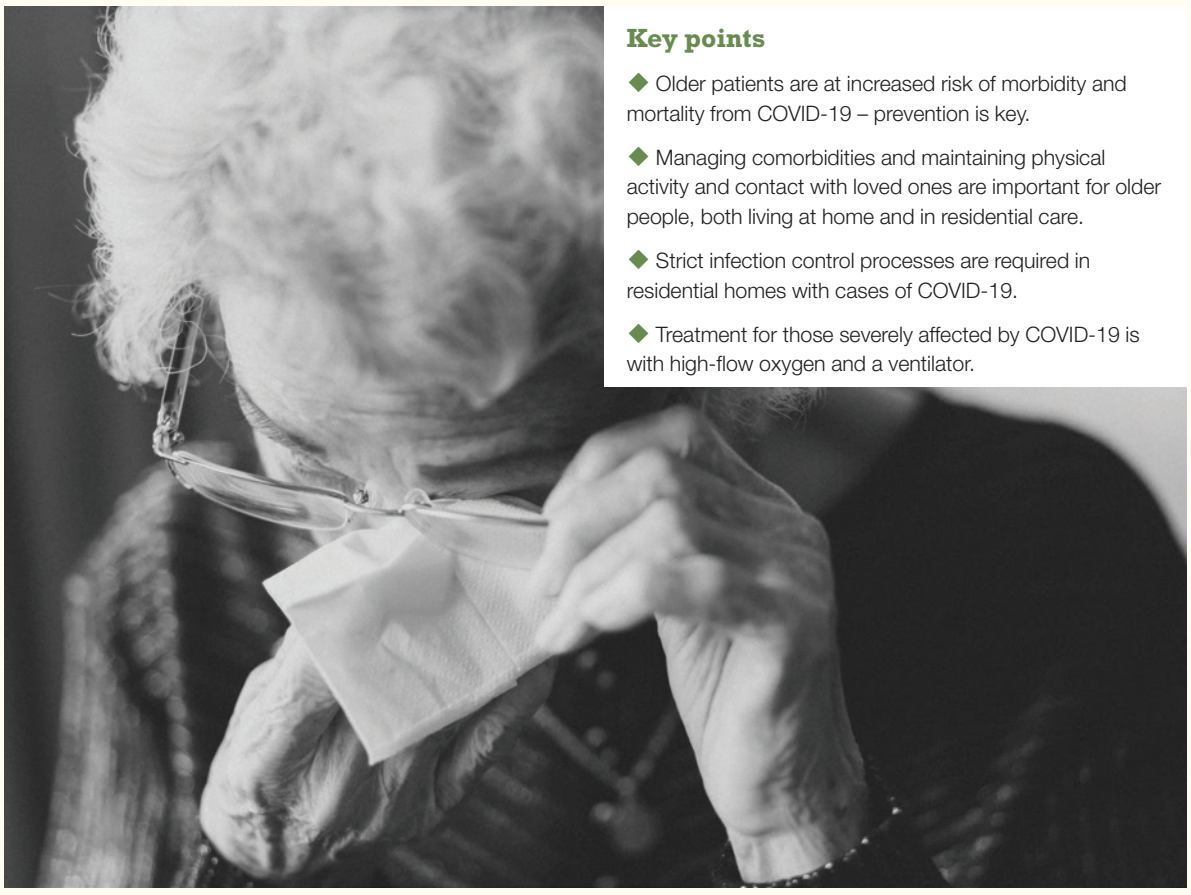
It never ceases to amaze me how older people can work out what's going on – please don't underestimate them in this situation. There will be many challenging decisions to make, and revisiting the advance care plan before the urgent time comes is really important. GPs, nurse practitioners, nurses and care staff are all there to support those with COVID-19 in the most compassionate way.

Remember, the older person needs people who know them, and being separated from their loved ones will be immensely hard. Excellent communication lines with loved ones are necessary, and these need time to be established. The time is now.

## Treatment and palliation

Outcomes from community-acquired pneumonia are the same whether residential care residents are transferred to acute hospitals or not. Presentation in older people is, as with other conditions, often non-specific for the initial period – a change in function, a "going off" – followed by fever and respiratory symptoms. When things do get worse, the treatment is high-flow oxygen and a ventilator; high-flow oxygen aerosolises, so the highest level of PPE is required.

Low-flow oxygen is not usually useful, so transfer or upskilling of care home staff may be needed. Care homes need to have isolation available as part of their response to delirium or deterioration, and you need to be aware that it could be COVID-19. Patients are hypoxic but not usually dyspnoeic, so palliation, if that is appropriate, may not be too difficult. The deterioration can be rapid. Clear decision making is needed within the team of doctors, nurses, family and DHB support.



Don't forget your older patients during these times of COVID-19

**Key points**

- Older patients are at increased risk of morbidity and mortality from COVID-19 – prevention is key.
- Managing comorbidities and maintaining physical activity and contact with loved ones are important for older people, both living at home and in residential care.
- Strict infection control processes are required in residential homes with cases of COVID-19.
- Treatment for those severely affected by COVID-19 is with high-flow oxygen and a ventilator.

## Look after your patients and yourself

During this time of COVID-19, many challenges are unfolding. Please remember your older patients, especially those in residential care. As with all areas of caring for older people, good communication, working with the family, and using your continuity and knowledge of the family are essential. It is also important to maintain excellent teamwork with the care home, hospital and available support lines.

Also, please look after yourself. Self-care can consist of time out, good food, regenerating activities (for me, that is sewing – masks this time), exercise and talking to friends and family. My next column will most probably be written from this desk, and so will the one after, so let's all get used to the new ways of doing things. Kia kaha. ■

*Ngaire Kerse is a professor of general practice and primary health care, and the Joyce Cook chair in Ageing Well, University of Auckland*

CLINICAL QUIZ ANSWERS

*(questions on page 3)*

**ELDER HEALTH**
**1. False. 2. True. 3. False.**

**PHARMACOTHERAPY**
**1. True. 2. True. 3. True. 4. False.**

**SPORTS MEDICINE**
**1. False. 2. False. 3. False. 4. True.**

**FIRST TIME:**
**1. False. 2. True. 3. True.**

## goodfellow gems #123

**"great COVID-19 short daily podcasts"**

The Australian Broadcasting Corporation has developed a podcast series,[1] each about 10 minutes in length with interesting angles on COVID-19, such as "Think coronavirus only kills the old? Think again".

Likewise, Radio New Zealand hosts a daily podcast on COVID-19.[2]

These will sustain your interest in the topic even when COVID-19 fatigue kicks in.

References: 1. https://ab.co/3ayNFMq (ABC *Coronacast* 2020). 2. https://bit.ly/3bH4Yes (RNZ *Coronavirus Podcast* 2020).

**Gems are chosen by the Goodfellow Unit director Bruce Arroll to be either practice-changing or practice-maintaining. The information is educational and not clinical advice. You can receive them electronically from www.goodfellowunit.org/gems**

# Avoid perpetuating inequities when managing gout in the setting of COVID-19

**PHARMACOTHERAPY**

Gout is the most common inflammatory arthritis in New Zealand, but medicines are available to manage and prevent it. This article presents the treatment options available and discusses how COVID-19 might affect prescribing decisions

**Leanne Te Karu and Linda Bryant**

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RNZCGP Endorsed CPD Activity

Avoiding kaimoana is culturally inappropriate to some people and may not be necessary if gout is well managed

**Key points**

- There is debate and a lack of clear evidence around the use of prednisone (immunosuppression) and NSAIDs (impact on renal and cardiovascular disease) during this COVID-19 pandemic.
- When introducing urate-lowering therapy, always begin with a "start low, go slow" approach and give gout flare prophylaxis/cover.
- Follow up with patients and continue to reinforce messages at every interaction – check for understanding.
- Treat cardiovascular risk in patients with gout.

It's 8:30 on Tuesday morning and Jack rings telephone triage with yet another gout flare, wanting more diclofenac. He says that he probably had the "wrong food". You note Jack has made multiple similar requests over the years, with requests becoming more frequent – three in the last six months.

Jack is a 39-year-old Māori man with prediabetes and a cardiovascular risk of 5 per cent, with his blood pressure averaging 144/88mmHg over the last year. His estimated glomerular filtration rate (eGFR) is 72ml/min/1.73m$^2$ and he has microalbuminuria. Although you have previously discussed his cardiovascular risk with him, Jack has not been keen to take any preventive medicines. His weight is 90kg.

A recent article indicated there is inequitable gout treatment in Aotearoa with variation in care for Māori and Pasifika, in whom gout occurs at an earlier age and with worse outcomes compared with non-Māori. In the setting of COVID-19, it is important that inequity gaps are not perpetuated and that a pro-equity approach is applied. Gout is a health condition that can be relatively easily managed to help prevent morbidity and premature mortality.

The ability to provide face-to-face consultation is limited with the current preferred delivery of virtual consults, but Jack has no device or data to enable this. The easy path would be to repeat the diclofenac and flick a script to the pharmacy. You decide to ring Jack so he does not pay for the call, and to revisit gout management with him.

## Talking to Jack

As for any health conversation, you start by unravelling Jack's thoughts, beliefs and experience of gout. Even before the COVID-19 lockdown, Jack's employers were becoming frustrated, and he risked losing his job as a labourer. He feels he simply needs larger supplies of diclofenac so he can start taking it before symptoms become debilitating.

In addition, Jack doesn't fully appreciate that while some foods may trigger gout, the actual *cause* is that he has an elevated serum urate level, and there is genetic variation in urate handling. The discussion of genetic differences between Māori and non-Māori provides a better understanding for Jack as to why allopurinol is the gold standard for treating the cause and reducing complications, such as bone deformity, renal disease, cardiovascular disease and tophi – and job loss and relationship problems. You impress upon him that *gout does not go away when the pain goes away*!

Some useful resources that help generate discussion with Jack are shown in Panel 1.

Because beliefs around food have become so entrenched in the general population, you state that focusing on food avoidance is unhelpful, and in the case of kaimoana (shellfish), it is culturally inappropriate to some. However, you discuss fructose with Jack and how ubiquitous it is. Fructose-containing fruit juice increases the risk of gout by 81 per cent, and sweetened soft drink increases risk by 85 per cent, compared with 49 per cent from 15–30g alcohol.[1,2] You add that by lowering his "uric acid" or serum urate level to below 0.36mmol/L, he may be able to enjoy kaimoana again.

Jack has heard of allopurinol and remembers that he has been provided with it previously, but it only made his gout worse. He heard through whānau that allopurinol can be "really bad at making gout worse", so he is not keen to try it again. A quick search shows you that Jack has been prescribed allopurinol twice before. On both occasions, he was not given "cover" (to prevent acute flares) and the starting dose was not matched with his renal function on a "start low, go slow" approach.

You recall that you have also tried getting Jack to come back between gout attacks to start allopurinol but, frustratingly, this has not worked. You establish that there were a few barriers for Jack – his hours of work, transport for getting to the practice, cost of the consult and the prescriptions, and how easy it is to get "gout pills" (usually diclofenac) from friends and whānau in the community. He has bought diclofenac from the pharmacy before, but these are not nearly as strong as the ones you can prescribe. He has also presented to the emergency department before, which mitigated some of the costs.

## Gout treatments and COVID-19

Jack's cardiovascular disease risk and microalbuminuria, suggesting endothelial dysfunction, mismanaged gout and prediabetes, don't mean he is at greater risk of becoming infected with COVID-19, but he may experience more severe sequelae if infected.

The acute treatment choices for gout are generally NSAIDs, prednisone or colchicine (Panel 2). You are aware that there have been internet discussions advising against the use of ibuprofen, but none of these are reputable and, beyond the normal cautions, there is nothing robust to validate this.

There is a dose-related 20 to 50 per cent increase in cardiovascular risk with NSAIDs, and they can be nephrotoxic. As Māori and Pasifika generally have a tendency for renal impairment and cardiovascular disease, your approach has been to use short courses of prednisone for first-line treatment of gout. Currently, you worry about prednisone's broad ability to be immunosuppressive. You know that you should not stop it for patients who use it regularly for other rheumatological conditions, but you wonder whether you should use it for gout during the COVID-19 pandemic.

This concern needs to be balanced with attack severity – the most effective treatment should be used, to avoid treatment failure and patients seeking medicines elsewhere, including secondary care. The principle of using the lowest effective dose for the shortest time, rather than "standard" dosing, becomes more crucial. For Jack, the cardiovascular and renal risks are more quantifiable at this time, rather than the unclear impact of prednisone and its immunosuppressive risks.

**A "normal" serum urate level during an attack does not exclude gout**

Colchicine has been used for millennia for acute treatment of gout, although the dosing has changed considerably in recent times, with fatalities occurring at doses high enough to induce diarrhoea. It is generally slower to provide relief and, as a result, less likely to be used as a first-line treatment.

Recruitment is underway, by the Montreal Heart Institute, for a phase III, multicentre, randomised controlled trial to evaluate the efficacy and safety of colchicine in adult patients diagnosed with COVID-19 (ClinicalTrials.gov: NCT04322682). This is to determine whether short-term treatment with colchicine reduces the rate of death and lung complications related to COVID-19 on the basis of its blood vessel anti-inflammatory properties. This sounds feasible in rationale, but in the absence of any results, no conclusions can be made.

*Continued on page 21*

**PANEL 1**
**Useful learning resources for patients with gout**

**Health Navigator** – www.healthnavigator.org.nz (search for gout)
**Gout Happy Feet** – https://bit.ly/2UuZNbC
**Arthritis New Zealand** – www.arthritis.org.nz/gout-arthritis
**Pharmac** – https://bit.ly/39pX3R2

**PANEL 2**
**Options for acute management of gout**

### NSAIDs

**Naproxen** – 750mg initially, followed by 500mg after eight hours, then reduce to 250mg every eight hours until attack has passed.[3]
**Diclofenac** – 75mg once or twice daily (use for no more than five days at the maximum dose).

### Adverse effects of NSAIDs are dose related

**Renal** – if eGFR is less than 60ml/min, limit the daily dose of diclofenac to 75mg, or naproxen to 1000mg. Be very careful and limit the dose if the patient is on an ACE inhibitor or angiotensin II receptor blocker as well as a diuretic.
**Cardiovascular** – check the patient's cardiovascular risk calculation and add 20 to 50 per cent (dose-related increase in risk with NSAIDs). It is strongly recommended *not* to give NSAIDs within 24 months of a myocardial infarction or acute coronary syndrome.

### Prednisone

Concerns surrounding immunosuppression and unknown risks with COVID-19 mean caution should be taken.

Dose depends on the severity of the gout attack and patient factors, such as size. By dosing at 0.5mg/kg and rounding off this calculation, the dose for Jack would be 40mg for three to five days, then 20mg for up to five days *if needed*.

Tapering the dose over 10 days can reduce the likelihood of a rebound flare, although tapering is not always necessary.

Blood glucose may rise, usually in the late afternoon, but this is transient.

### Colchicine (low dose)

Give 1mg stat, followed by 0.5mg one hour later. A further 0.5mg may be taken once or twice daily for two to three more days.[2]

For people less than 50kg or with a creatinine clearance less than 50ml/min, the maximum dosage is 1mg (two tablets) in 24 hours, and no more than 3mg (six tablets) over four days.

Once the maximum cumulative dosage is reached, colchicine should not be used again for at least three days.

The hazards of excessive colchicine need to be stressed to avoid the acute toxicity likely to result from the perception of "more is better".

The dosing approved by the New Zealand Formulary is 1mg (two tablets) immediately, then 0.5mg every six hours, to a maximum of 2.5mg (five tablets) on the first day, a maximum of 1.5mg (three tablets) on subsequent days, and no more than 6mg (12 tablets) in four days.3 Do not repeat the course within three days and use caution with cytochrome P450 3A4 inhibitors.

# Consider spondylolysis in adolescent athletes presenting with low back pain

**SPORTS MEDICINE**

This article discusses the diagnosis and treatment of injuries to the weakest portion of the vertebra, the pars interarticularis

▶**Steve Targett**

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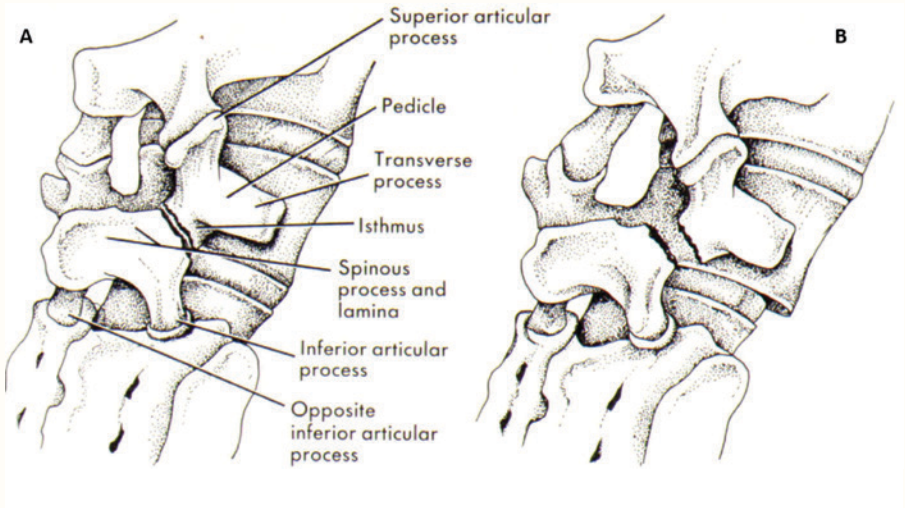
## Key points

- Consider spondylolysis if you see an adolescent athlete with extension-based low back pain, particularly one playing a sport requiring repetitive lumbar extension and rotation.
- It is reasonable to start treatment with an initial period of modified activity and to refer the patient to physiotherapy for a pain-free strengthening programme.
- If symptoms do not settle as expected, then imaging may be required and/or referral for further advice from someone with the relevant expertise.




SOURCE: Baig M, et al. *Cureus* 2018;10(4):e2456. CC BY 3.0

**On oblique views, the posterior elements of the lumbar vertebrae look like a Scottie dog. If spondylolysis is present, it often looks as if the dog has a collar around the neck (A). In spondylolisthesis, the fractured pars interarticularis separates (B)**

Low back pain is common in adolescent athletes. Spondylolysis is far more likely to be the cause of back pain in this age group (up to 47 per cent in one study) than in adults (5 per cent) and should be considered in the differential diagnosis.

Spondylolysis is a bony injury to the pars interarticularis of the lumbar vertebrae. It predominantly affects the L5 vertebra (91–95 per cent) with L4 next most commonly affected (5–23 per cent). If it is bilateral at the same level, a spondylolisthesis may occur (see figure).

In athletes, spondylolysis is usually due to repetitive loading, although it can occur quite quickly when there is a change in load (eg, changing technique or increasing the intensity of training sessions). The pars interarticularis is particularly loaded by extension, or extension with rotation, of the lumbar spine, which are common movements in sports such as cricket (fast bowling at back foot contact), tennis (serving), pole vaulting (take off), javelin throwing (end of wind up) and gymnastics (many activities).

### Diagnosis

Patients usually present with activity-related low back pain, which can be felt during activity and is usually felt after activity. Pain can be felt centrally or off to one or both sides and can radiate to the buttock or upper posterior thigh. It is usually provoked by activities causing lumbar extension with or without rotation.

The one-legged hyperextension test (standing the patient on one leg and extending the lumbar spine) is often quoted as an examination test for spondylolysis but, like many other named physical examination tests, has limited sensitivity and specificity. Neurological symptoms, such as pins and needles, weakness or sensory changes, are uncommon.

Imaging for spondylolysis starts with plain radiology and traditionally uses anteroposterior, lateral, and right and left oblique views. The oblique views reveal the typical "Scottie dog" appearance of sclerosis or a defect in the pars interarticularis (resembling a collar on the neck of the Scottie dog), while the lateral view can detect spondylolisthesis. However, studies suggest that the sensitivity of AP and lateral views alone (86 per cent) is no different to the traditional four-view approach, so to reduce irradiation of a particularly radiosensitive area, a two-view approach is preferred.

If x-rays are negative and further imaging is required, then MRI is the recommended modality as there is no radiation and it is sensitive for spondylolysis. CT is sometimes indicated to help with prognosis of a known spondylolysis by assessing the degree of bony healing or potential for healing – an old, wide sclerotic pars defect is unlikely to heal and may allow an earlier return to activity compared with an early fracture that you are attempting to heal (requires a more conservative approach to return to activity).

### Treatment

Treatment of a proven spondylolysis is initially conservative, with a period of rest from aggravating (painful) activities to allow bony healing (eight weeks). Cycling is often a safe activity. A programme of physiotherapy during this time is used to increase core strength and stretch hamstrings if they are tight.

**Physiotherapy is used to increase core strength and stretch hamstrings**

As is usual with athletes, it is preferable to call this a period of modified activity as compliance will likely be better than when told to rest or stop all activity. During this period of modified activity, other fitness work can be performed under the supervision of the physiotherapist to maintain cardiorespiratory fitness. The use of a brace is controversial but can be useful in the patient who cannot stay pain free with modified activity.

Unilateral, early pars stress fractures will usually heal with conservative measures, with the expected time to return to play being at least three months. Older pars defects, especially if bilateral, may go on to non-union with the formation of fibrous tissue in the bony defect, so it is important not to overlook this condition to avoid prolonged rehabilitation.

Surgical options are available, but not commonly required, and should only be considered after a trial of appropriate conservative treatment (six months or more). Fusion leads to loss of range of movement and can be an issue in active sportspeople. Direct fracture repair is another option, but the surgical method employed should be tailored to the individual athlete by an orthopaedic surgeon with a particular interest in spondylolysis in athletes. ■

*Steve Targett is a sports physician in Doha, Qatar*

*Continued from page 20*

### Starting Jack on prophylactic allopurinol

Having attempted to introduce allopurinol in the past, and being aware of the evidence that it can be commenced during an acute flare of gout, you contemplate this in light of the information you have gathered (Panel 3).

You really don't want to lose Jack's confidence and decide to treat him with naproxen acutely. As there is local funding available for short-term blister packaging (at $5 a pack, the cost would be an extra $15 for three months of blister packaging), you start allopurinol after two weeks at 100mg daily, titrating up by 100mg monthly, alongside prophylactic colchicine 0.5mg daily for three months.

The blister packaging will help manage the complexity of dose changes and the stopping and starting of medicines during the initiation of allopurinol.

Ordering a serum urate test during an acute flare can be inaccurate as levels can decrease – a "normal" serum urate level during an attack does not exclude gout. With Jack having an established diagnosis of gout, and with a priority of obtaining a serum urate level of less than 0.36mmol/L, you task yourself to measure his serum urate in three months.

In New Zealand, the mean dose to achieve a urate concentration of less than 0.36mmol/L is approximately 450mg, so you are confident that monthly testing for the initial allopurinol dose adjustment is not necessary, and it is difficult for Jack. The maximum allopurinol dose is 900mg.

For patients with severe gout (eg, those with tophi, chronic gouty arthritis or frequent attacks), the target serum urate level is 0.30mmol/L.

You are aware that Jack needs some encouragement, so you make a note to text him in a fortnight, and then monthly, to help him persist with the allopurinol introduction.

You are also aware that Jack has no ability to print out resources or access them on the internet, so you print some off and arrange to leave them in his mailbox, with instructions to wait a day before retrieving them.

Furthermore, you discuss with Jack that it is important to manage all cardiovascular risk appropriately, and this can be discussed the next time a face-to-face consultation is possible. ■

*Leanne Te Karu is a prescribing pharmacist working in primary care; Linda Bryant is a clinical advisor and prescribing pharmacist at Newtown Union Health Service and Porirua Union and Community Health Service, Wellington*

**PANEL 3**
**Notes on introducing allopurinol**

Dose and titration must be based on renal function to reduce the risk of allopurinol hypersensitivity syndrome and flare occurrence:

| eGFR (ml/min/1.73m2) | Starting dose | Titration |
|---|---|---|
| >60 | 100mg daily | increase by 100mg monthly |
| 30 to 60 | 50mg daily | increase by 50mg monthly |
| <30 | 50mg on alternate days | increase to 50mg daily in 4 weeks, then increase by 50mg 4-weekly |

**Cover** – prophylactic colchicine (0.5mg daily or twice daily) for the first three to six months of urate-lowering therapy is usually recommended. For people with tophi, this may need to be extended. The risk of a flare without colchicine prophylaxis is approximately 67 per cent; with colchicine it is about 20 per cent.

An NSAID may be used instead of colchicine for prophylaxis, but Māori and Pasifika have a propensity for renal impairment. Consider a proton pump inhibitor if covering with an NSAID. Low-dose prednisone (eg, 5mg daily) may also be used. Colchicine has less renal and cardiac toxicity, and may potentially be cardioprotective. Warn against diarrhoea and to cease taking colchicine if this occurs.

**Starting allopurinol during an acute flare** – prescribe acute therapy and ensure the patient completes the whole course rather than stopping when the pain is resolved. The Gout Happy Feet website recommends a 14-day course of prednisone. Sometimes there is no choice but to commence allopurinol when there is little time between critical periods.

**Notes on continuing allopurinol** – because allopurinol plus prophylactic colchicine, and sometimes the acute treatment, start at the same time, it is strongly recommended that *blister packaging* is used for at least the first three months, and preferably six months, as the regimen is complex.

Warn to stop taking allopurinol if a fever and/or rash occurs.

Ensure you tell the patient that treatment is lifelong. It is not stopped when the "target uric acid" concentration is achieved.

Once at the patient's target serum urate level, there is no need to reduce the dose if renal function deteriorates.

Monitor for flares, and confirm that the flare is gout rather than joint pain due to new-onset osteoarthritis.

References:
1. Choi HK, Curhan G. Soft drinks, fructose consumption, and the risk of gout in men: prospective cohort study. BMJ 2008;336(7639):309–12.
2. Dalbeth N, Merriman TR, Stamp LK. Gout. Lancet 2016;388(10,055): 2039–52.
3. New Zealand Formulary. NZF v93. www.nzf.org.nz (accessed 31 Mar 2020).

# We're all in this together: Forward marching towards a post-COVID world

NZMA GP COUNCIL

NZMA GP Council chair Jan White urges GPs to support each other during the many challenges of COVID-19

Jan White

The NZMA understands that we are all facing uncertainty and challenges with the trajectory and impact of the pandemic unclear, and it supports the Ministry of Health and the Government in the efforts they have made so far to meet the challenge of COVID-19. Nevertheless, we also understand our responsibility and we must continue to represent our members, remembering at this time that we are a pan-professional organisation.

While it has been gratifying to see general practices through necessity coming up with their own workarounds for PPE that was not readily available, to find ways to protect staff, as well as extra phone lines and extra staff to help with getting flu immunisations done and to answer phone calls, it has also taken its toll both financially and emotionally.

Many of our practices are truly struggling, unable to pay wages of staff and overheads in the situation we are in.

One cannot see this improving in the short term and the idea that practices may close is untenable but real. The consequences of such closures are obvious to us all.

On 28 March, we sent an email to our members asking for responses regarding the impact of COVID-19 on their business; the response was rapid with more than 100 responses in four hours. As a result, a meeting with the General Practice Leaders Forum, the ministry and DHB representatives was convened with urgency.

The outcome was, as you will all be aware, action on an immediate injection of $15 million into general practice with the ministry asking the Government for further weekly payments until the end of lockdown. There was acknowledgement of the potential further requirement of rural practices.

For the whole of the medical profession, the last weeks have presented a very steep learning curve, necessitating change even as we tried to continue business as usual. We as GPs have had to be agile and creative in our thinking and in our mode of delivery of healthcare.

Almost overnight, most GPs transitioned to 70 per cent or more of telehealth consults

Almost overnight, a transition to 70 per cent or more of teleheath consultations was made by most GPs.

This was an extraordinary effort to try and minimise community spread. Patients have been very understanding and grateful for changes they see being introduced to try to protect them, and there should be a sense of pride in how we have adapted so quickly to a situation that is ever changing.

Most of us have never faced the uncertainties and difficulties that previous generations had to in a world war, but in some aspects there are commonalities – we are all in this together and we have no certainty as to what tomorrow will bring.

**For the whole of the medical profession, the last weeks have presented a very steep learning curve, necessitating change even as we tried to continue business as usual**

NZMA has a benevolent fund founded in World War II by GPs who were unable to serve and who placed their house-call income into a fund to support returning doctors in need. This benevolent fund is still operational for those in need and more information can be found on the NZMA website.

We are not immune from the anxiety and mood disorders that sometimes afflict our patients, and so especially at this time with its added stressors, I would encourage us all to practise the advice that we give out on an almost daily basis.

We will make our way through this, but we will return to an altered post-COVID world.

We must do everything in our power to ensure that general practice survives so that we can continue providing the excellent care – of which we are rightly so proud.

We must look to each other to give and receive support.

Postscript: this article was written on 4 April. ■

*Jan White is chair of the NZMA GP Council and an Auckland GP*

**@ Information about the NZMA benevolent fund can be found at https://www.nzma.org.nz/members/nzma-benevolent-fund**

# Sitting in my bubble while COVID-19 tests nurses' resilience

An international chat group keeps Barbara Docherty informed of the desperate situation some British and American nurses find themselves on the front line

Lockdown week three. How am I doing, I ask myself. Well, my grey hair is more obvious at the roots. I seem to be snacking more. I have never watched so much Netflix. I have caught up with all my friends via Zoom or WhatsApp. My daily walks, now confined to "keeping it local", are much more boring than I'm used to, and when I say "hi" people seem afraid to talk.

My four-year-old granddaughter talks of bubbles and viruses and different bears in windows, and I wonder how much of this crazy situation she will remember when she's 21.

But I'm really enjoying my regular links with my international colleagues, most of whom are working incredibly hard to resist COVID-19 for themselves and their patients. We all check fairly regularly to see which of our countries' curves has flattened the most, that is to say not our personal curves but, well, you know what I mean.

I'm getting a much clearer picture as to what some of these nurses are doing and the conditions they are working under in their countries. While the majority on our Covid Chat Club are predominantly primary healthcare nurses, several have moved back to where they're needed most at this present time, in the hospital settings.

This includes Britain and the US. Without hesitation these nurses have donned the astronaut suits and gear and are learning quickly what PPE really means. But it is little short of amazing that, while I'm not talking about the third world but rather countries where money doesn't need to be restricted, the nurses' struggle to get the equipment they so rightly deserve; that is deadly serious.

More than 1200 healthcare workers in the US have used a private online document to share their stories of fighting the coronavirus pandemic on the front lines. The British nurses talked of hospital conditions being far worse than most people realise and the media talked only of the great work being done by doctors. The nurses know only too well if they speak out they could lose their jobs.

The private online document urges anyone who can contribute to tell the whole truth about the lack of equipment and the constant stories about being instructed to clean their masks and reuse them for several days, or told to cover their mouths with bandanas or coffee filters.

**The British nurses talked of hospital conditions being far worse than most people realised**

One contributor, a nurse in California, wrote: "We are being called to jeopardise our own health and safety to treat our community. It is disgusting. I wish more attention would be given to us on the front lines and the situation we face. We live in the richest country in the world and yet we don't have the tools to perform our job safely. This virus is terrifying."

We haven't had to experience any of this yet in New Zealand. But it still could happen if the second wave decides to swamp us. Already, nurses are saying they can't get all the right equipment, in spite of being told there is plenty available in the country. As if that isn't stressful enough our chat club identified that many nurses love their job but are scared to go to work because they are abused by others outside the hospital (think supermarkets) who believe they will spread the virus.

Everyone knows that nurses just keep on keeping on. Listening to all these stories made me feel quite removed from my nursing colleagues overseas. Have we dodged a bullet or is it yet to come and will we really be ready and prepared?

This virus is showing up some very strange differences and attitudes between countries. Panama decided to announce strict quarantine measures separating people by gender.

In some Colombian towns, people are allowed outside based on the last number of their national ID number.

The Belarusian president laughed off the suggestion that his country should try to stem the spread of the coronavirus, because he couldn't see the virus "flying around". But then he also cited drinking vodka and regular trips to the sauna as ways to ward off the virus.

The Malaysian Government women's ministry posted cartoons online telling wives to dress up, wear make-up and avoid nagging their husbands during the country's partial lockdown.

In Australia, you can still get takeaways, and more importantly, can go to the hairdresser.

Taiwan seems to be the shining example, but Sweden is the one to watch. Unlike its neighbours, its government hopes people will behave sensibly, and trusts them to do the right thing. Pubs and restaurants can still offer table service and many people are still socialising as normal. Nurses are relaxed for now but wary of a possible explosion in cases.*


***New Zealand Doctor* columnist Barbara Docherty in less stressful times at last year's Rotorua GP CME**

I feel guilty about not contributing. The best I can do is put my name down for anything that isn't front line. I am happy to do contact tracing or work for Healthline, but if I was of the right age would I be braver and go to the front line like some of my overseas friends?

I am absolutely unable to answer that with any degree of truth. I can simply salute those nurses who just go in daily and do their job under very unusual and seriously trying circumstances.

*Editor's note: As of late last week, Sweden had recorded over 1200 deaths

*Barbara Docherty is a primary healthcare nurse whose area of expertise is in behavioural health training and research into primary healthcare*

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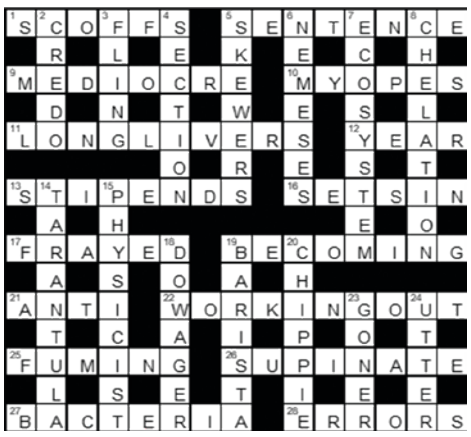

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**BRIDGESPOTTER'S CRYPTIC: ANSWERS**
**Questions are on page 17. To see full explanations of the cryptic clues and how the answers are reached, go to Opinion on nzdoctor.co.nz and click on Crossword or search for Bridgespotter**

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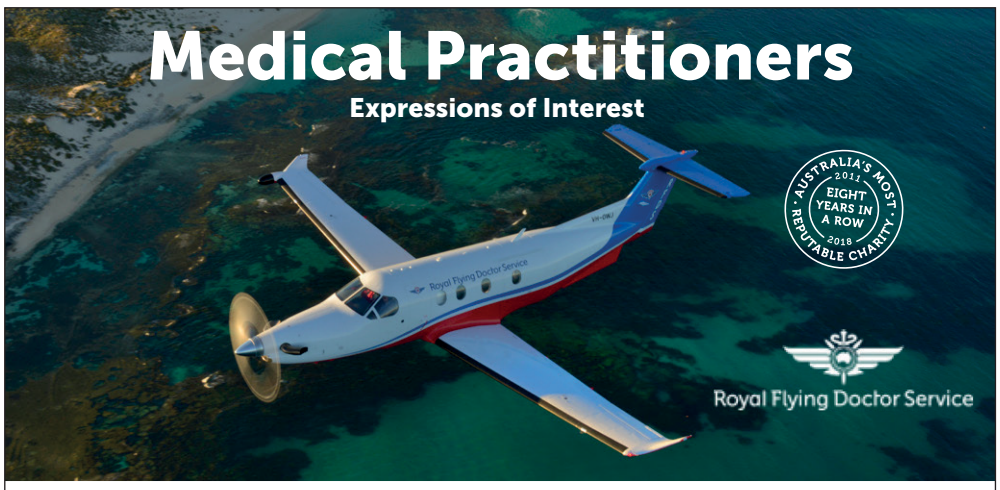


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