

NOTES:



**New Zealand Primary Health Care,
General Practice & Rural Health
Research Symposium**

1-3rd September 2023

**El Rancho Holiday Park at Waikanae
58 Weggery Drive Waikanae**

Organised by

**Department of Primary Health Care & General Practice
University of Otago Wellington**

Contact
HOD Lynn McBain
Lynn.mcbain@otaog.ac.nz



Thank you to the Goodfellow Unit for sponsorship of student registrations.

Arrive from 3pm to check into Elm Complex.

Friday 1 September

5:30pm Meet from 5:30pm for a pre-dinner drink – Elm Dining

6:00pm Dinner 6pm Sharp - Elm Dining

Session 1 7pm-9pm Elm Hall

7:00-7:20pm	Welcome / Intro / Housekeeping
7:20-7:40pm	Experiences of living with migraine disease in Aotearoa NZ, a survey <i>Sue Garrett</i>
7:40-8:00pm	We need to talk about polypharmacy: a qualitative study of medication reviews with older adults <i>Jo Hilder</i>
8:00-8:20pm	Empagliflozin and Necrotising Fasciitis of the Perineum (Fournier's Gangrene). Potential risk factors in New Zealand adverse reaction reports. <i>Ruth Savage</i>
8:20-8:50pm	Using Pilot and Feasibility RCT Methods: Team Approach to Polypharmacy Evaluation and Reduction (TAPER) <i>Dee Mangin</i> Research Capacity Support Resource - Demo <i>Dee Mangin</i>

Break for refreshments**25th Anniversary of Research Weekends - please bring your memories.****Facilitator -** Tony Dowell**Saturday 2 September****Breakfast from 7:30am** Elm Dining**Session 2 8:30am – 10:20am Elm Hall**

8:30-8:40am	Intro / Housekeeping
8:40-9:00am	Fat bias and weight stigma in primary care <i>Angela Ballantyne</i>
9:00-9:20am	Drivers of access to cardiovascular healthcare for rural Indigenous Peoples: A Scoping Review <i>Taria Tane</i>

NOTES:

NOTES:

9:20-9:30am	Whānau and workforce wellbeing – the parent who is also a General practitioner within Aotearoa a qualitative study. <i>Emily Cavana</i> [10 minutes]
9:30-9:40am	Hinaki method of consultation communication – a dissection of the double diamond model <i>Tanya Quinn</i> [10 minutes]
9:40-10:00am	A rapid review of ethical issues experienced by rural doctors <i>Samantha Menzes</i>
10:00-10:20am	Primary care call for change - Enabling rural primary care providers in Tai Tokerau to deliver equitable health services to Māori <i>Jess Morgan-French</i>

10:20 - 10:50 am Morning tea + make plans for afternoon

Session 3 10:50am – 12:45pm Elm Hall

10:50-11:10am	Ethnic Chinese experiences of mental health services in Aotearoa New Zealand – progress thus far and next steps <i>Denzel Chung</i>
11:10-11:30am	Managing medicines-related continuity of care: the general practice prescriber perspective in New Zealand <i>Julie Wells</i>
11:30-11:50am	Range of physical functions assessed by existing knee performance-based and self-reported outcome measures: a scoping review <i>Andres Pierobon</i>
11:50-12:10pm	Does the quality of sleep, nutrition, oral health and social connectedness matter when it comes to functional status? <i>Ngairé Kerse</i>
12:10-12:20pm	The Māori Women's Experience of Sexual Healthcare <i>Chelsea Harris</i> [10 minutes]
12:20-12:40pm	The 'All in 4 IPE study': Practice architectures in interprofessional health professions education. An international multi-site research study <i>Eileen McKinlay</i>
12:40-12:45pm	Wrap up of the morning

Lunch at 12:45pm Elm Dining

Afternoon activities

Dinner 6:30pm Long Beach Tavern - 40 Tutere Street, Waikanae

Sunday 3 September**Breakfast from 7:30am** Elm Dining**Session 4 8:30am - 10:20am** Elm Hall

8:30-8:40 am	Intro / Housekeeping
8:40-9:00am	A scoping review on the use of routinely collected primary care data in research (1990-2022) <i>Sharon Leitch</i>
9:00-9:20am	Research Prioritisation Setting for the Primary Care Research Network <i>Jing Ru Li</i>
9:20-9:40am	Multimorbidity patterns and risk of long-term care admissions in community-dwelling older adults <i>Ruth Teh</i>
9:40-10:00am	Brown Buttabean Motivation in the media: relationship between the media representations of a community organisation and its self-representation <i>Felicity Goodyear-Smith</i>
10:00-10:20am	Do General Practice facilities measure up to guidance for big bodied patients? An exploratory study <i>Lesley Gray & Eileen McKinlay</i>

10:20 - 10:50am Morning tea**Session 5 10:50am - 12:45pm** Elm Hall

10:50-11:10am	Improving the Effectiveness of External Management Consultants in Healthcare: A Modified Delphi Study in the New Zealand Health System <i>Adeel Akmal</i>
11:10-11:30am	Ergot, Madness and Being Female <i>Katherine Hall</i>
11:30-11:50am	Generative artificial intelligence in primary care: benefits, risks and ethically appropriate use <i>Rochelle Style & Angela Ballantyne</i>
11:50-12:10pm	Family views on the acceptability and use of public health and social measures to reduce transmission of respiratory disease: A qualitative scoping study <i>Amanda Sexton & Maria Stubbe</i>
12:10-12:30pm	Evaluation of the Health Sector Immunisation Education, Training and Clinical Support Programme during the New Zealand COVID-19 pandemic – methodology and overview <i>Tony Dowell</i>
12:30-12:45pm	Wrap up + award presentation

Lunch at 12:45pm Elm Dining

Clean up and departure.

Evaluation of the Health Sector Immunisation Education, Training and Clinical Support Programme during the New Zealand COVID-19 pandemic – methodology and overviewAnthony Dowell¹tony.dowell@otago.ac.nz(co-authors listed in alphabetical order) Susan Bibby¹, Marama Cole¹, Abigail Dunlop¹, Jo Hilder¹, Gayl Humphrey², Larisa Karteleva², Kunal Kumar³, Azim O'Shea², Mayor Pokino², Amanda Sexton¹, Maria Stubbe¹, Penny Zipfel³¹ Dept of Primary Health Care and General Practice, University of Otago Wellington² The National Institute for Health Innovation, University of Auckland³ The Immunisation Advisory Centre**Background**

The introduction and roll-out of the COVID-19 vaccine was one of the most important and complex initiatives undertaken by health sectors world wide. In New Zealand the Education, Training and Clinical Support to the health sector of the immunisation programme was undertaken by the Immunisation Advisory Centre (IMAC). This presentation describes the methodology and main outcomes of an evaluation of the New Zealand programme.

Method

The evaluation aim was to appreciate and record positive success, and identify potential challenges and opportunities at an early stage and work with stakeholders to enable innovative solutions to be generated (Hindsight to Foresight).

The evaluation used a previously developed methodology and evidence base derived from complexity and implementation science and appreciative inquiry (CIS-A).

Methods included analysis of routinely collected workforce data, call data from a help line, surveys, focus groups and interviews with vaccinators, vaccinees and key stakeholders. There was also direct observation of vaccination sites and settings.

Results

The evaluation was able to assess the overall success and contribution of the IMAC programme to the immunisation rollout. Regular assessment and feedback enabled support of positive features of activity and provide information about challenges with the opportunity for early course correction.

There were specific areas where external evaluation was especially helpful, the focus on important and concise "Toolkit messages for the day" approach and the focus on equity being two examples.

Conclusion

We recommend that using a similar multi perspective approach is of value in evaluation of complex health sector initiatives.

Family views on the acceptability and use of public health and social measures to reduce transmission of respiratory disease: A qualitative scoping study

Amanda Sexton,¹ Maria Stubbe¹, Sue Bibby¹
mandy.sexton@otago.ac.nz

¹ University of Otago, Wellington

Background

Covid-19 has led to worldwide behaviour change, in particular Non-Pharmaceutical Interventions (NPIs) to reduce disease spread. This exploratory study investigated the acceptability to New Zealanders of these measures in 2023 and beyond.

Method

We conducted 22 in-depth interviews with a purposively selected diverse sample of households from the SHIVERS WellKiwis Study. Interviews explored acceptability of NPIs during the Covid-19 pandemic, currently, and into the future for respiratory diseases. Transcribed interviews were analysed thematically using NVivo software.

Results

All households reported positively engaging with mandated NPIs early in the pandemic. NPIs used in the home varied between and within households, and with time and diagnosis. Influenza was perceived as milder than Covid-19, despite many reporting themselves more unwell with influenza. Within the home, most used fewer NPIs for influenza, but stayed home to reduce disease spread. Many households saw schools as drivers of transmission, expressed frustration at seeing sick children at school, often struggled to identify when how sick was 'too sick,' and faced barriers to keeping children home. Appetite for future lockdowns was low: if necessary, transparent decision making is paramount. Key strategies to contribute to household decision making around NPI use were awareness of local epidemiology, strong health messaging, and workplace support.

Conclusion

Engagement with NPIs appeared linked to perceptions of disease severity. Enhanced local surveillance, strong public health messaging, greater access to sick leave, increased measures in schools to reduce transmission, and access to multi-viral RATs were identified as ways to support households to reduce respiratory disease transmission.

Acknowledgements

The authors would like to thank the following for their support: Prof Tony Dowell¹, Dr Sue Huang², Ruth Seeds², A.Prof Nayyereh Aminisani², Prof Nikki Turner³, Prof Cass Byrnes³

¹ University of Otago, Wellington, ² Institute of Environmental Science and Research, ³ University of Auckland

Contents

Experiences of living with migraine disease in Aotearoa NZ, a survey	8
Sue Garrett	
We need to talk about polypharmacy: a qualitative study of medication reviews with older adults	9
Jo Hilder	
Empagliflozin and Necrotising Fasciitis of the Perineum (Fournier's Gangrene) - Potential risk factors in New Zealand adverse reaction reports.....	10
Ruth L. Savage	
Using Pilot and Feasibility RCT Methods: Team Approach to Polypharmacy Evaluation and Reduction (TAPER).....	11
Dee Mangin	
Fat bias and weight stigma in primary care	12
Angela Ballantyne	
Drivers of access to cardiovascular healthcare for rural Indigenous Peoples: A Scoping Review	13
Taria Tane	
PROPOSAL: Whānau and workforce wellbeing – the parent who is also a General Practitioner within Aotearoa, a qualitative study	14
Emily Cavana	
PROPOSAL: Hinaki method of consultation communication – a dissection of the double diamond model.....	15
Tanya Quin	
A rapid review of ethical issues experienced by rural doctors.....	16
Samantha Menezes	
Primary care call for change - Enabling rural primary care providers in Tai Tokerau to deliver equitable health services to Māori	17
Jess Morgan-French	

Ethnic Chinese experiences of mental health services in Aotearoa New Zealand – progress thus far and next steps	18
Denzel W.K. Chung	
Managing medicines-related continuity of care: the general practice prescriber perspective in New Zealand	19
Julie Wells	
Range of physical functions assessed by existing knee performance-based and self-reported outcome measures: a scoping review.....	20
Andrés Pierobon	
Does the quality of sleep, nutrition, oral health and social connectedness matter when it comes to functional status?.....	21
Ngaire Kerse	
The Māori Women's Experience of Sexual Healthcare.....	22
Chelsea Harris	
The 'All in 4 IPE study': Practice architectures in interprofessional health professions education. An international multi-site research study.....	23
Eileen McKinlay	
A scoping review on the use of routinely collected primary care data in research (1990-2022)	24
Sharon Leitch	
Research prioritisation setting for the Primary Care Research Network.....	25
Jing-Ru Li	
Multimorbidity patterns and risk of long-term care admissions in community-dwelling older adults	26
Ruth Teh	
Brown Buttabean Motivation in the media: relationship between the media representations of a community organisation and its self- representation.....	27
Felicity Goodyear-Smith	

Generative artificial intelligence in primary care: benefits, risks and ethically appropriate use

Angela Ballantyne¹, Rochelle Style²

angela.ballantyne@otago.ac.nz

¹ University of Otago, Wellington

² Independent Researcher, Wellington

Background

Generative Artificial Intelligence (GAI) includes large language models such as ChatGPT, Bard and Bing. These tools have potential clinical applications. However, the Privacy Commissioner, MBIE and WHO have taken a conservative approach to their current use. Te Whatu Ora has not yet issued guidance on the use of GAI. Here we consider the specific risks in the context of the delivery of primary healthcare services in Aotearoa New Zealand.

Method

This paper uses ethical and legal analysis to assess the current risks of using GAI in primary care and the future potential benefits; we consider requirements on health providers under the Code of Health and Disability Consumers' Rights and the Health Information Privacy Code.

Results

Beneficial clinical use might include entering identifiable patient information as a prompt, producing health information products for patients, drafting patient notes or discharge summaries, patient diagnosis or to inform/guide patient care and treatment. Ethical and legal risks associated with the use of GAI include the risk of hallucinations, errors and falsification of data; breaches of patient data privacy; amplified misinformation; biased output increasing health inequity and threats to data sovereignty.

Conclusion

Generative AI tools have not been validated as safe and effective for use in health; nor have the risks and benefits been adequately evaluated in the Aotearoa New Zealand health context. Providers have ethical, legal and professional obligations to provide services of an appropriate standard and health providers remain accountable for harm arising from the use of GAI. A precautionary approach is warranted until there is clearer guidance on use of GAI in the Aotearoa New Zealand health context.

Ergot, Madness and Being Female

Katherine Hall¹

Katherine.hall@otago.ac.nz

¹ Dunedin School of Medicine, University of Otago, Dunedin

Studying medical history gives insight into the present and how we can better treat our future patients. Here, I will discuss the use (and abuse) of ergot alkaloids through history. These compounds have been known since ancient times to induce abortions, speed up prolonged labour and control postpartum haemorrhage. They remain, in synthetic form, an indispensable part of resuscitation protocols for the latter. However these compounds are also highly hallucinogenic, especially causing hallucinations related to flying. In this ongoing research, I look at the history of the use of ergot in obstetrics and its relationship to ideas about postpartum psychosis, femininity and madness. For example, the imagery of women and flying in Ancient Greek literature (Medea, Harpies etc) may relate to the experience of women 'flying' whilst 'under the influence' of these compounds, and how this may have vicariously influenced the men who witnessed these events to promote such imagery in their literary works. Such ideas can hold powerful sway over medical beliefs about sanity and femaleness through the ages. I conclude with some comments on contemporary use of ergot alkaloids and its relationship to modern ideas about postpartum psychosis, being female and being considered sane.

Do General Practice facilities measure up to guidance for big bodied patients? An exploratory study..... 28
Lesley Gray, Eileen McKinlay

Improving the Effectiveness of External Management Consultants in Healthcare: A Modified Delphi Study in the New Zealand Health System..... 29
Adeel Akmal

Ergot, Madness and Being Female 30
Katherine Hall

Generative artificial intelligence in primary care: benefits, risks and ethically appropriate use 31
Rochelle Style

Family views on the acceptability and use of public health and social measures to reduce transmission of respiratory disease: A qualitative scoping study..... 32
Amanda Sexton

Evaluation of the Health Sector Immunisation Education, Training and Clinical Support Programme during the New Zealand COVID-19 pandemic – methodology and overview..... 33
Anthony Dowell

Experiences of living with migraine disease in Aotearoa NZ, a survey

Sue Garrett¹, Fiona Imlach²

sue.garrett@otago.ac.nz

¹ University of Otago, Wellington

² Migraine Foundation Aotearoa New Zealand

Background

Migraine disease affects around 1 in 7 people worldwide, causing significant disability and reduced productivity. However, there is a dearth of research on migraine in Aotearoa. In September 2022, Migraine Foundation Aotearoa New Zealand, a charity founded to raise awareness of migraine, undertook an online survey of people with migraine, promoted through social media and stakeholder networks. The survey included questions about the burden of disease, impact on daily life (including work), utilisation, access and experience of health services and the use of acute and preventative treatments.

Method

Survey responses were exported into Microsoft Excel for cleaning, collation and analysis. Response frequencies were tabulated for all quantitative survey items, with number and percentages calculated. Free text comments (short statements or several sentences) were analysed using template analysis. (King, 2012) Responses to each question in the survey were initially coded separately, but with overlap between codes across the questions, the second stage of coding involved creating themes across questions.

Results

The survey was completed by 579 people, with 530 responses meeting the criteria to be included in analysis. 82% of respondents were female, with the majority being in the 25-to-54-year age range. Findings will be presented on the impact of migraine and utilisation, access and experience in primary healthcare services.

Conclusion

The impact of migraine is underestimated, particularly on people's ability to work and complete everyday tasks. Most migraineurs are cared for in primary care where prescribing is often sub-optimal.

Improving the Effectiveness of External Management Consultants in Healthcare: A Modified Delphi Study in the New Zealand Health System

Adeel Akmal¹ Nataliya Podgorodnichenko² Tim Stokes¹ Robin Gauld¹

Adeel.akmal@otago.ac.nz

¹ Centre for Health Systems and Technology, University of Otago, Dunedin

² Doctor of Business Administration Department, University of Otago, Dunedin

Background

The health sector is increasingly relying on external management consultants (EMCs) to provide various services that a health organisation (HO) is unable to perform or deliver itself. Research has highlighted this ongoing reliance on EMCs to be questionable in terms of value for money. Using an activity theory lens, this study explored EMC-HO interactions to seek an understanding of the practice-level features that impact the outcomes of an EMC-driven project in HOs.

Method

Using a modified Delphi method, over 60 professionals in EMCs and the NZ health system were interviewed multiple times, and their perspectives were compared.

Results

This research provides a rich understanding of the concerns fundamental to EMCs and HOs, and applies activity theory lens to highlight strategies to improve EMCs' effectiveness in the health sector. Our results highlight that among many issues, short-term contracts, poor accountability and evaluation of EMCs, and a lack of internal human resource capabilities in HOs are the major themes that result in the ineffective and unsustainable improvements delivered by EMCs.

Conclusion

Using a multiple stakeholder perspective, this research examines the perspectives of the HOs and EMCs to identify concerns fundamental to EMCs and HOs, and highlight strategies to improve EMCs' effectiveness in health sector.

Do General Practice facilities measure up to guidance for big bodied patients? An exploratory study

Lesley Gray¹, Eileen McKinlay², Sonya Morgan¹, George Parker³.

lesley.gray@otago.ac.nz; Eileen.mckinlay@otago.ac.nz

¹ University of Otago, Wellington

² University of Otago, Dunedin

³ Victoria University of Wellington

Background

Big bodied people (BBP) are described as those who weigh 150kg or more, have a body mass of 40kg/m² or more or who have large physical dimensions, a lack of mobility or other conditions that make moving and handling challenging (Accident Corporation Company, 2011). The 2021 New Zealand (NZ) health survey reported that 5.9% of adults were identified as having a body mass of ≥ 40 , with Māori (13%), Pasifika (24.5%) and those living in high deprivation areas (11.9%) being disproportionately represented (Ministry of Health, 2021). In this study we set out to explore how general practice facilities performed against available building/health care facility standards to accommodate BBP. We received some funding from the Royal New Zealand College of General Practitioners and a small grant from the University of Otago, Wellington.

Method

This exploratory study utilised a qualitative mixed methods design. Direct observation, physical measurements of the main practice areas and interviews with key staff were undertaken in three diverse NZ general practices. Findings were compared to existing Guidelines or Standards for healthcare of BBP.

Results and Discussion

The analysis identified environmental features in each of the three general practices which did not meet the Standards or Guidelines and where accessibility, inclusivity, and comfort for BBP could be improved. In particular: examination beds, suitable seating and diagnostic equipment. Staff interviewed were not aware of how the general practice environment impacted on health care access and experience of BBP.

We need to talk about polypharmacy: a qualitative study of medication reviews with older adults

Jo Hilder¹, Lynn McBain¹, Maria Stubbe¹, Jeannine Stairmand², Caroline Morris¹, Abby Dunlop¹

jo.hilder@otago.ac.nz

¹ University of Otago Wellington (Dept of Primary Health Care & General Practice)

² University of Otago Wellington (Te Rōpū Rangahau Hauora a Eru Pōmare)

Background

Many older adults are on multiple medications, with multimorbidity and polypharmacy more common among Māori and Pacific ethnic groups and evidence of inequities for these groups. Reviewing medications as patients age is important and may result in additions, deprescribing or other changes. Communication around this may be challenging and there is little research on this or educational resources for patients or clinicians on this aspect of the process.

Method

A qualitative approach focused on videorecordings of invited medication reviews in primary care with older adults on 4 or more medications, aiming for equal numbers of Māori, Pasifika (55 years and over) and 'other' (65 years and over) patients. An online survey of general practices and two focus groups with older adults fed into pamphlet resources to support the medication reviews. Descriptive and thematic analyses of the data sets were conducted and integrated.

Results

Video recordings were collected on six sites, with 17 patients (7 Māori, 4 Pasifika) and 8 clinicians. Effective medication reviews need sufficient time (and funding), and practicalities such as patients bringing medications. Effective communication rests on whakawhanaungatanga and trust, use of visual resources, an explicitly expressed clear agenda, and patient centred interaction where patients can contribute their agenda, perspectives, experience and knowledge about their medications and ask questions. The pamphlet resources were well-received and have been reworked and disseminated.

Conclusion

Medication reviews with older adults on multiple medications can be optimised by simple practical measures, a focus on effective communication, and use of patient and clinician resources.

Empagliflozin and Necrotising Fasciitis of the Perineum (Fournier's Gangrene) - Potential risk factors in New Zealand adverse reaction reports

Ruth L. Savage^{1,2}
ruth.savage@otago.ac.nz

¹ Dept of General Practice, University of Otago, Christchurch

² New Zealand Pharmacovigilance Centre, Health Sciences Division, University of Otago

Background

In New Zealand (NZ), empagliflozin funding has been approved since 2021 for Type 2 Diabetes Mellitus with increased accessibility for Maori and Pacific peoples and others at high risk of cardiorenal complications. It is now widely prescribed in general practice. Unexpectedly, given its rarity, eleven reports of Fournier's gangrene (FG) with empagliflozin were submitted to the New Zealand Pharmacovigilance Centre (NZPhvC) up to May 2023.

Method

A qualitative review of FG/empagliflozin reports in the NZPhvC database. An overview of similar reports in VigiBase, the WHO Programme for International Drug Monitoring database. Usage data from the NZ Pharmaceutical Data web tool.

Results

Up to 25 May 2023, 112 reports for empagliflozin or empagliflozin/metformin were submitted to the NZPhvC, eighty-one in 2021 with approximately 55,000 patients exposed. Males and females were represented equally. Almost half of the reports were for people of European ethnicity (48%), then Maori (25%), Pacific Peoples (18%) and Asian (7%). Pharmacists submitted 40 reports, then GPs (25) and nurses (22). Eleven reports described FG. Males accounted for 82% (9) and Pacific peoples 45% (5) in contrast to the overall reporting pattern. The number of VigiBase reports for empagliflozin and FG was statistically disproportionate (481 observed, one expected). Males were over-represented in these reports.

Discussion and Conclusion

NZ and international data suggest that male gender is an unrecognised risk factor for FG, a life-threatening condition, with empagliflozin. NZ data suggests that Pacific peoples may also be at increased risk. Further information is needed to examine these hypotheses.

Brown Buttabeen Motivation in the media: relationship between the media representations of a community organisation and its self-representation

Felicity Goodyear-Smith¹, Sandra Smith², Karen Fernandez², Fa'asisila Savila³, Dave Letele⁴, Fuatino Laban⁴, Warwick Bagg⁵, Boyd Swinburn⁶, Truely Harding⁵
F.goodyear-smith@auckland.ac.nz

¹ Department of General Practice & Primary Health Care, University of Auckland

² School of Business, University of Auckland, Auckland

³ Pacific Health, University of Auckland, Auckland

⁴ BBM, Manukau, Auckland

⁵ Department of Medicine, University of Auckland, Auckland

⁶ Department of Epidemiology and Biostatistics, University of Auckland, Auckland

Background

Brown Buttabeen Motivation (BBM) is a community-led initiative to combat obesity among Māori and Pasifika, extending to other activities focused on reducing health and well-being inequities such as foodbanks and vaccination drive. Leader Dave Letele has always maintained a strong media presence.

Aim

To examine how to BBM is portrayed in the news media, relative to its own narratives - whether, and how, mainstream news media reporting mirrors the actual development of BBM's activities: reflecting, converging, or diverging from the organisation's representations of itself.

Method

Guided by Fa'afaletu, Fonofale and Te Whare Tapa Whā approaches. Mixed method analysis of all traditional media data 2018-2020 (pre-COVID-19) and 2020-2021. Content analysis of text content using Leximancer software produced concept maps and .CSV files with comparison of two periods and mapping to BBM's activity timeline. This was followed by a 'deep-dive' using researcher-generated search terms to gain insight into how these were used/not used or how they changed over time.

Results

Key themes in concept maps for two periods show evolution of organisation towards more holistic approach to community needs. Media accurately maps BBM's own narrative although minor gaps.

Conclusion

Letele's media presence and charisma meant he was often able to reshape media narratives to be more consistent with BBM's view, thereby acting as a positive influence on the communities he represented. BBM is a branded organization with different narrative strands mutable over time, and Letele can be viewed as a 'human' brand.

Multimorbidity patterns and risk of long-term care admissions in community-dwelling older adults

Ruth Teh¹, Ngaire Kerse¹, Dipan Ranchhod², Lynn McBain³

¹ School of Population Health, University of Auckland

² Tū Ora Compass Health, Wellington

³ General Practice, University of Otago, Wellington

Background

Multimorbidity, common among older adults, is a complex and challenging phenomenon affecting patients' quality of life, health outcomes, and health care utilization. This project aims to identify multimorbidity patterns and their impact on long-term care admissions in community-dwelling older adults.

Method

Multimorbidity was ascertained using primary care data from Tū Ora COMPASS Health, and aged residential care (ARC) admission determined from interRAI. Cluster analyses were completed to identify multimorbidity patterns by ethnicity, i.e., Māori, Pasifika, and nonMāori/non-Pasifika. For the latter group, analyses were also completed by age groups (<80 years and ≥80 years). Cox-regression models were used to examine the association between multimorbidity patterns and 5-year ARC admission.

Results

The sample comprises 45,178 adults aged 55+ for Māori (8%) and Pasifika (4%), and 65+ for Other (88%). The average age for Māori and Pasifika was 65.1y; the Other 74.1y. Three multimorbidity patterns were identified for Māori and Pasifika, respectively; four for NonM/nonP (<80 years and ≥80 years). All twelve conditions clustered differently in these samples. Māori in cluster-3 had three times higher risk of ARC admission than cluster-1 [aHR (95%CI): 2.96 (1.81-4.36)]. In the Pasifika sample, we did not observe an association between condition clusters and ARC admission risk. In the nM/nP<80y sample, those in cluster-4 had five and half times higher risk of ARC admission (5.48, 4.68-6.41) than cluster-1; a similar association was observed in nM/nP≥80y in cluster-4 when compared to cluster-1 (4.08, 3.67-4.53).

Conclusion

Complex clusters were associated with an increased risk of five-year ARC admission. The clustering patterns of conditions are helpful for a more strategic approach to manage multimorbidity better in older adults in primary care settings.

Using Pilot and Feasibility RCT Methods: Team Approach to Polypharmacy Evaluation and Reduction (TAPER)

Dee Mangin

Dee.mangin@otago.ac.nz

University of Otago, Christchurch

Background

Large RCTs in primary care can be challenging to fund and implement. Piloting can assist with these challenges. Emerging pilot and feasibility study methodology and reporting requirements are useful for GP trials. This presentation will outline, as an example this approach, a very recently published pilot and feasibility study for a larger RCT.

Method

Design: Pilot and feasibility study RCT.

We randomized consenting patients ≥ 70 years old on ≥ 5 long-term medications into intervention or control groups. We collected demographic information and research outcome measures at baseline and 6 months. We assessed four categories of feasibility outcomes: process, resource, management, and scientific. The intervention group received TAPER (team approach to polypharmacy evaluation and reduction), a clinical pathway for reducing polypharmacy using “pause and monitor” drug holiday approach. TAPER integrates patients' goals, priorities, and preferences with an evidence-based “machine screen” and teamwork between patient, pharmacist and GP. The control group were a “wait list” control.

Results

All 9 criteria for feasibility were met across the 4 feasibility outcome domains. Of 85 patients screened for eligibility, 39 eligible patients were recruited and randomized. Withdrawals (2) and losses to follow-up (3) were small and evenly distributed. Areas for intervention and research process improvement were identified. Outcome measures mostly performed well and appeared suitable for assessing change in a larger RCT. We also explored the mapping between patients' goals and priorities and recommendations.

Conclusion

Results indicate that TAPER as a clinical pathway is feasible to implement in a primary care team setting and in an RCT framework. Outcome trends suggest effectiveness. This provided the basis for successful funding and implementation of a large-scale RCT.

Fat bias and weight stigma in primary care

Angela Ballantyne¹, Lesley Gray¹, Denise Steers¹

angela.ballantyne@otago.ac.nz

¹ University of Otago, Wellington

In this paper we argue that promoting diets for the purpose of weight loss is ineffective, stigmatising, and harmful. Testimony from patients suggests there is no way to engage in medical screening of weight in a manner that is non-stigmatizing. This is in part due to the pervasive cultural bias against fatness and the repeated trauma and stress fat people experience due to fat-related stigma, discrimination and oppression. The methodology for this paper is ethical and conceptual analysis using a feminist bioethics and critical theory approach (a philosophical approach that considers the social, historical, and ideological forces which maintain social norms). The current guidelines for Clinical Guidelines for Weight Management in New Zealand Adults 2017 are out-of-date; they do not acknowledge medicalised fat phobia or weight stigma; despite significant evidence that fat phobic attitudes of health providers is a significant cause of fat patients delaying or avoiding medical care and inaccurate diagnosis leading to avoidable morbidity and mortality. Further, Medicine's commitment to dieting for weight loss is influenced by social ideals about temperance and self-control; and efforts to counsel dietary weight loss aims to reform fat peoples' perceived character flaws – laziness, dishonesty, lack of discipline. Diets are ineffective in achieving sustained weight loss and often result in weight cycling and long term weight gain. Promoting dietary-induced weight loss thus breaches non-maleficence, damages the therapeutic relationship, and creates a barrier for higher weight people to access medical care.

Research prioritisation setting for the Primary Care Research Network

Jing-Ru Li¹, Sharon Leitch¹

jingru.li@otago.ac.nz

¹ Department of General Practice and Rural Health, Dunedin

Background

A large amount of primary health care (PHC) data is collected every day. However, New Zealand lacks the infrastructure to readily access and use PHC data for research. The Southern Primary Care Research Network (PCRN) aims to facilitate the use of routinely PHC data for research promoting health equity. This project aims to explore stakeholders' perceptions of the most important questions in PHC to shape the research agenda for the PCRN to ensure research undertaken is fit-for-purpose.

Method

The Delphi method will be used in this study to rank and iteratively reviewed the proposed research questions, then weighted for project feasibility, relevance and for likelihood of improving health equity using the Hanlon Process of Prioritisation. PHC clinicians working in Southern NZ and PHC academics in NZ are eligible participants. So far, we have finished the first round of Delphi process.

Results

Fifty-eight participants were recruited, including 16 PHC academics, 20 PHC clinicians and 22 people working as both PHC academics and clinicians. Participants have identified 13 areas and 46 categories of research questions. "Access", "health outcome", "quality of care", "funding", "equity", "rural health", and "Māori health" are the top categories of research questions. A strong interest is also indicated in questions regarding PHC clinicians' career and PHC workforce.

Conclusion

Establishing PCRN research priorities will strengthen future research success. Through widespread consultation with clinician and academic stakeholders, and future consultation with a patient panel and Māori kaitiaki research group, the PHC data will be optimised to address the health needs of all New Zealanders.

A scoping review on the use of routinely collected primary care data in research (1990-2022)

Sharon Leitch¹, Abigail Pigden¹, Gagan Gurung¹, Adibah Khan¹, Tim Stokes¹
sharon.leitch@otago.ac.nz

¹ University of Otago, Dunedin

Background

Primary care generates a substantial body of routinely collected data which can be a rich resource for research. This scoping review aims to explore how routinely collected primary care data is used for research to help understand its potential.

Method

English-language publications 1990-2022 describing research conducted using routinely collected data from primary health in high-income countries with similar health policies to NZ were included. Screening of major search engines yielded 3139 articles; 267 met the inclusion criteria.

Results

Most publications used general practice data (252/267, 94.4%). Health delivery, epidemiological, and medication-related research were the most common research areas. Health delivery studies (70/267, 26.2%) examined questions such as access to services, provision of care between providers, screening programmes, and different models of care. Epidemiological studies (66/267, 24.7%) investigated topics including disease prevalence, symptom patterns, and risk factors for specific conditions. Medication research (64/267, 24.0%) related to prescribing patterns, drug safety and pharmacovigilance. Clinical prediction studies used routinely collected data to model or predict specific conditions or disease severity (23/267, 8.6%). Social determinants of health studies investigated the effects of non-medical factors such as socioeconomic status, deprivation, or housing on health outcomes or service access (17/267, 7.1%). Intervention evaluation was the least common research type (8/267, 3.0%).

Conclusion

Routinely collected primary care data is rich research resource that has been widely used to evaluate health delivery, monitor health trends, and assess prescribing. The full potential of these data to be used for intervention studies is yet to be realised.

Drivers of access to cardiovascular healthcare for rural Indigenous Peoples: A Scoping Review

Taria Tane¹, Vanessa Selak¹, Kyle Eggleton¹, Matire Harwood¹
taria.tane@auckland.ac.nz

¹ University of Auckland, Auckland

Background

Māori are disproportionately represented in cardiovascular disease (CVD) prevalence, morbidity, and mortality rates, and are less likely to receive evidence-based CVD healthcare. Rural Māori experience additional barriers to treatment access, poorer health outcomes, and a more significant burden of CVD risk factors than Non-Māori and Māori living in urban areas. Literature exploring CVD treatment access for rural Indigenous Peoples is limited. Therefore, a scoping review was conducted.

Method

The review was underpinned by Kaupapa Māori Research methodology and was conducted utilising Arksey and O'Malley's (2005) methodological framework. A database search of MEDLINE (OVID), PubMed, Embase, SCOPUS, CINAHL Plus, Australia/New Zealand Reference Centre, and NZResearch.org was used to explore empirical research literature. A grey literature search was also conducted.

Results

A total of 21 publications were included in the final list. The literature was summarised using the Te Tiriti o Waitangi Framework Principles: Tino Rangatiratanga, Partnership, Active Protection, Equity, and Options.

Conclusion

The findings of this scoping review were consistent with other literature on access to healthcare for rural Indigenous Peoples. This review provides a new approach to summarising the literature by situating findings within a Te Tiriti o Waitangi Framework. By using equity-and-rights-based foundations to tackle inequities in CVD healthcare access, health systems may be better positioned to achieve equitable access to CVD healthcare for rural Indigenous Peoples.

PROPOSAL: Whānau and workforce wellbeing – the parent who is also a General Practitioner within Aotearoa, a qualitative study

Emily Cavana¹

Emily.cavana@otago.ac.nz

¹ University of Otago, Wellington

Background

Primary care, with general practice at its heart, is the backbone of the medical workforce in Aotearoa. General practice is facing looming retirements and reports of significant burnout rates in the remaining workforce. A significant stated motivator is “work-life balance” for junior doctors entering the general practice training programme. The training programme itself can be completed sooner than other medical training programmes and allows part time work, shorter patient facing days and has policies which acknowledge the benefits of being a caregiver. Thus, the training programme supports doctors who also want to grow a family.

The research could ask the questions – Is the GP training programme achieving work life balance with respect to having a family? How does this progress to the professional experience of parents who are vocationally trained doctors? How can the training and the profession itself be enhanced and optimised to benefit parents? The research could then inform both policies and practices regarding recruitment and retention of the general practice workforce within Aotearoa. It would add to the small body of work focusing on these issues within Australasia which has to date only been carried out in Australia.

Method

At this stage the method is envisaged as a 2-stage qualitative project including both focus groups and interviews with doctors and trainees with lived experience of parenting and working in primary care in Aotearoa.

The ‘All in 4 IPE study’: Practice architectures in interprofessional health professions education. An international multi-site research study

Eileen McKinlay¹, Sonya Morgan, Julie Myers, Linda Gulliver

eileen.mckinlay@otago.ac.nz

¹ University of Otago, Dunedin

Background

Globally, learning to collaborate across health professions is seen as crucial to ensure patient centred care, assure patient safety and meet the changing demands of health care. An international group of researchers from Sweden, Norway, Australia and New Zealand (NZ) will collaborate in this research. They will use a joint practice-oriented, theoretical framework with a multiple case ethnographic research design - one case in each country.

Overall, the study aims to (1) explore how health professional students interact in an Interprofessional Education (IPE) Programme investigating and recording their experience of interprofessional learning, and (2) Identify which aspects of IPE appear critical to its success across sites/contexts in the four countries.

This four year study is funded by the Swedish Research Council.

Methods

The NZ study will be undertaken in one of two 5-week rural IPE programmes. In this programme students live in shared accommodation and undertake clinical placements in their home-discipline and also interprofessional placements as well as taking part in other course activities.

Data will be gathered as follows:

- 1) Participant observation of students during clinical placements and other course learning, social activities, including in the communal areas of their shared living accommodation (observations totalling around 8 hours over a 5-week period).
- 2) Informal conversations with students, clinical placement health professionals and professional stakeholders.
- 3) Collection of some photos for context.
- 4) Formal interviews/groups with students, IPE programme staff, clinical placement tutors, community project stakeholders and possibly patients.

Methods will be pilot tested in late 2023 and data collection will begin in 2024.

The Māori Women's Experience of Sexual Healthcare

Chelsea Harris¹, Ben Hudson¹

Chelsea.harris@otago.ac.nz

¹ University of Otago, Department of Primary Care and Clinical Simulation, Christchurch

Background

Sexual health should be considered an important aspect of health care. The implications of unintended pregnancy, sexually transmitted infections (STIs), and poor sexual well-being (in regard to sexual identity and expression) are many. It is therefore pivotal that health care providers are competent and confident providing well-rounded sexual health care, and that patients have access to the knowledge and means to protect their sexual well-being. It is also important that this health care is culturally acceptable, and accessible to all to reduce inequitable outcomes. There are significant inequities in sexual health outcomes for Māori, and so it is important to learn about their experiences of sexual healthcare, to identify areas of improvement to better equip Māori patients with the mātāuranga (knowledge) to feel empowered and able to make informed decisions about their sexual health.

Method

This study is a qualitative study in which twelve Māori women aged sixteen to 69 years of age are being interviewed to learn about: their experiences of sexual healthcare; their advice about how healthcare professionals could provide a better service to Māori wahine in regards to sexual healthcare; their perspective about what sexual wellbeing is; and how they learned what they know about sexual health, and how they access information. Once the interviews are completed, the interviews will undergo thematic analysis.

Results

Pending - currently six of the twelve interviews have been completed.

Conclusion

Pending.

PROPOSAL: Hinaki method of consultation communication – a dissection of the double diamond model

Tanya Quin¹

tanya.quin@auckland.ac.nz

¹ University of Auckland

Background

Communications skills for General Practice Education Programme Year 1 (GPEP 1) from the Royal New Zealand College of General Practitioners present a double diamond model fitting over the Calgary-Cambridge model of communication to help registrars visualise the structure of the consultation. It attempts to create a dynamic impression as the shape of each diamond may vary between consultations. This combined model still has limitations in reflecting the consultation, incorporating the communication skills taught in the curriculum, and understanding consultation flow.

Method

Teaching the GPEP registrars in 2022 the group and myself dissected the combined models of communication to include the various micro skills taught over the college curriculum and to reflect the actual consultation experience.

Results

This dissection created a teaching tool that is a dynamic reflection of the consultation. This has been shared with other GPs and registrars who have enjoyed the dissected model. It will be shared with other medical educators within the College teaching GPs for their thoughts. It has already been suggested that this model should be written up as a paper.

Conclusion

How do I start to write such a paper on this potential communication model?

A rapid review of ethical issues experienced by rural doctors

Kyle Eggleton¹, [Samantha Menezes](mailto:Samantha.Menezes@unimelb.edu.au)¹

k.eggleton@auckland.ac.nz

¹ Dept of General Practice & Primary Health Care, University of Auckland

Background

Despite the intersectionality of relationships in rural medicine the New Zealand Medical Council fails to mention the rural context in any of its guidelines. The intention of this study is to understand the literature on key ethical issues experienced by rural general practitioners that might inform the development of a New Zealand agenda of rural medical ethics

Method

A rapid review was undertaken of three databases using a variety of key words relating to rurality, ethics, professionalism and medicine. Inclusion criteria were research articles focussing on the experience of doctors working in a rural healthcare setting. Exclusion criteria were commentaries. The findings from the paper were synthesised and broad ethical categories created.

Results

12 studies were identified that met the inclusion and exclusion criteria. Synthesis of the data revealed five ethical issues that predominately arose from living and working within communities. These ethical issues related to juggling personal and professional lives, managing friendships with patients, managing loss of privacy and anonymity, assuring confidentiality, and practicing outside of comfort zones.

Conclusion

The majority of ethical issues arose from managing overlapping relationships. However, these overlapping relationships and roles are considered normal in rural settings. A tension is created between adhering to urban normative ethical guidelines and the reality of living in a rural environment. Professional ethical guidelines, such as those developed by the New Zealand Medical Council, do not account for this rural lived reality. Rural practitioners in New Zealand should be engaged with to progress a specific rural ethics agenda.

Does the quality of sleep, nutrition, oral health and social connectedness matter when it comes to functional status?

Khalid Abdul Jabbar¹, [Ngaire Kerse](mailto:Ngaire.Kerse@unimelb.edu.au)¹, Sue Lord², Silvia Del Din³, Ruth Teh¹

khalid.abdul-jabbar@auckland.ac.nz

¹ School of Population Health, Faculty of Medical & Health Sciences, University of Auckland

² School of Clinical Sciences, Auckland University of Technology

³ National Institute for Health and Care Research (NIHR) Newcastle Biomedical Research Centre (BRC), Newcastle University and The Newcastle upon Tyne Hospitals NHS Foundation Trust

Background

Information on how key health determinants (KHD), such as sleep, nutrition, oral health and social connectedness, interact with the relationship between physical activity (PA), sedentary behaviour (SB), and functional status (FS) is scarce.

Method

Seven days of accelerometry data from 53 community-dwelling older adults (79.8 ± 6.1 years, 71.7% females) were quantified using the AX6 sensor on the lower back. Volume, pattern and variability of gait, upright, sitting and lying bouts were extracted. Measures include: NEADL for FS, PSQI for sleep, SCREENII for nutritional risk, OHIP14 for oral health and UCLA 3-item for social-connectedness. Linear regression models investigated the direct association between FS (dependent variable) and PA and SB. The impact of KHD on the direct relationship between PA, SB, with FS was investigated by entering each KHD as an interaction and covariate term.

Results

FS was associated with total walk duration ($p = 0.008$), number of walking bouts ($p = 0.010$), number of steps ($p = 0.007$) and pattern of upright bouts ($p = 0.010$). Sedentary behaviour was not significantly associated with FS. Those who reported poorer nutrition ($\text{SCREENII} < 50$) had improved FS when they spent more time on their feet. Those more socially connected ($\text{UCLA} < 5$) had higher FS with greater number of daily walks. Neither the quality of sleep nor oral health affected the association between FS and PA, and SB.

Conclusion

Our findings suggest that the quality of nutrition and social connectedness may be key health determinants that could affect the relationship between physical activity and functional status.

Range of physical functions assessed by existing knee performance-based and self-reported outcome measures: a scoping review.

Andrés Pierobon¹, Will Taylor¹, Richard Siegert², Richelle Caya³, Pablo Policastro⁴, Santiago Soliño⁴, Federico Villalba⁴, Ben Darlow¹
andi.pierobon@postgrad.otago.ac.nz

¹ University of Otago, Wellington

² Auckland University of Technology, Auckland

³ University of Otago, Dunedin

⁴ University of Buenos Aires, Buenos Aires

Background

Measuring functional limitations arising from knee conditions is important for clinical practice and research. Current objective performance-based outcome measures (PBOMs) assess a narrow range of functions. Self-reported outcome measures (SROMs) include a greater number of functions, but the range and frequency of functions included in existing measures is unknown.

Aim

To identify the range and frequency of physical functions assessed in existing lower limb PBOMs and SROMs for people with anterior cruciate ligament (ACL) injuries, knee osteoarthritis (OA) and patellofemoral pain syndrome (PFPS).

Method

We conducted a scoping review of the literature. A comprehensive search strategy was performed in 4 databases. Title and abstract screening and full text review were carried out by two independent reviewers. Physical functions were extracted and coded according to the International Classification of Functioning, Disability and Health framework. Descriptive analysis was undertaken.

Results

After duplicate deletion, 4146 articles were screened. A total of 140 articles were included for data extraction. SROMs and PBOMs assessed a median of 10 and 1 physical functions, respectively. The three most frequently assessed physical functions were 'climbing stairs or hills', 'walking short distances' and 'arising to standing from sitting'. ACL and PFPS outcome measures evaluated more challenging physical functions than knee OA measures.

Conclusion and future research

The results of this study will inform physical function selection for a new tool being developed to measure physical performance in people with knee OA. Future steps will include seeking input from different stakeholders (consumers, researchers, clinicians) to construct a preliminary version of the tool that can be tested.

Primary care call for change - Enabling rural primary care providers in Tai Tokerau to deliver equitable health services to Māori

Jess Morgan-French

jess.morgan-french@gpnz.org.nz

Kerikeri, Bay of Islands

In Aotearoa (New Zealand), there is an opportunity to change rural primary care services to improve health outcomes for Māori. Both the Health and Disability System Review (Simpson, 2020) and the Waitangi Tribunal Hauora Report (Waitangi Tribunal, 2019) outlined the inequities Māori suffer due to a lack of appropriate system design and constitutional accountability. Specifically, rural Māori populations have received sub-optimal service due to being the minority group within Aotearoa (Waitangi Tribunal, 2019).

This appreciative inquiry research will be nested within Māori centred research methodologies positioned through a critical philosophical position. The research will seek solution-focused conclusions based on patient and provider experiences in rural primary care environments. This research will involve focus groups and individual interviews to understand rural primary care networks' positive work to enable equitable care for their communities.

Thematic analysis will develop, analyse, and interpret patterns across the qualitative data set. While current research identifies key themes and patterns to enabling equitable care in rural primary care, understanding how these enablers can be implemented to ensure an equitable outcome for Māori is crucial to achieving improved outcomes.

This research can potentially change how rural primary care is delivered through the discovery and advocacy of system fixes. This work intends to inform and make recommendations to Te Aka Whai Ora, Te Whatu Ora, Manatū Hauora, National Primary Care Clinical Leaders and Primary Care Network Support organisations for rural primary care service delivery and service commissioning.

Ethnic Chinese experiences of mental health services in Aotearoa New Zealand – progress thus far and next steps

Denzel W.K. Chung¹, Katherine H. Hall¹, Jing-Bao Nie², Chrys Jaye¹
chude049@student.otago.ac.nz

¹Dept. of General Practice and Rural Health, University of Otago, Dunedin

²Bioethics Centre, Dunedin School of Medicine, University of Otago, Dunedin

At the 2022 Colloquium, our team presented on exploring moderate Confucian familism as a potential avenue for promoting whānau involvement in mental health care in Aotearoa. This formed part of a wider PhD project which has been running since 2021, exploring ethnic Chinese experiences of mental health services in Aotearoa. This project seeks to encompass the perspectives of mental health service providers as well as ethnic Chinese former and current service users, to shed light on factors which could be impacting the utilisation of mental health services by ethnic Chinese in Aotearoa, as well as proposing steps which could be taken to improve the accessibility and cultural safety of mental health services for ethnic Chinese.

This presentation seeks to provide an update on progress that has been made on this project throughout 2023. Topics to be covered include the publication of a viewpoint article in the *New Zealand Medical Journal*, which explores in more detail the opportunities and challenges of integrating a moderate Confucian familist framework in Aotearoa's mental health system; as well as progress made regarding the recruitment of ethnic Chinese mental health service users from across Aotearoa, and the thematic analysis of data gathered from interviews of those participants. We also seek to outline next steps, including work towards further publications and presentations.

Managing medicines-related continuity of care: the general practice prescriber perspective in New Zealand

Julie Wells¹, Lesley Gray¹, Lynn McBain¹
cjwells@inspire.net.nz

¹ Dept of Primary Health Care & General Practice, University of Otago, Wellington

Background

Continuity of care is considered a fundamental aspect of good quality primary care. General practice prescribers play a key role in managing continuity of care and are largely accountable for optimising medicines-related health outcomes. Legislative changes have resulted in different health disciplines prescribing medicines for patients with chronic disease in the New Zealand general practice setting. Increasingly patients are prescribed medicines by more than one prescriber. There is a paucity of research investigating how different prescribers view their role in managing continuity of care from a medicine's perspective. A greater understanding of the views of clinicians directly involved in the prescribing process is vital to achieving safe, effective, and more equitable outcomes from medicines for New Zealanders.

Method

Qualitative, semi-structured in-depth interviews were undertaken with sixteen general practice prescribers (GPs, nurse prescribers, pharmacist prescribers) from eight North Island general practices. Interviews were transcribed verbatim and analysed thematically using an inductive approach.

Results

Three key themes were identified from data analysis including: (1) a patient-focused approach; (2) interdisciplinary teamwork; (3) optimising the medicine regimen.

Conclusion

Prescribers in this study identify the significance of three aspects of continuity of care (relational, informational and management). Good patient-prescriber relationships and ongoing interdisciplinary relationships, across all health settings, are considered essential to managing continuity of care and achieving good outcomes from medicines. However, challenges associated with increasing multimorbidity, time restraints and fragmentation of clinical records are experienced. There is a sense that managing medicines-related continuity of care is no longer solely the responsibility of general practitioners.