



**Primary Health Care and General Practice
Research Weekend, 15 – 17 September 2017
Peppers Parehua, Martinborough**

Programme & Abstracts



SESSIONS

Saturday, 16 September 2017

08:30 - 10:00 Session 1 **Terrace Room**

ORAL PRESENTATIONS x 4

Title	Presenters
Metaphoric Language in Cognitive Behaviour Therapy	Fiona Mathieson
The doctor by-pass project	Bruce Arroll
Does prior receipt of HPV vaccination decrease the risk of adverse pregnancy and perinatal outcomes?	Anna Howe
Walking A Fine Line (Carefully): An Exploration of Beliefs about Knee Pain in People with Osteoarthritis	Ben Darlow, Ben Hudson & Eileen McKinlay

10:30 - 11:30 Session 2 **Terrace Room**

ORAL PRESENTATIONS x 3

Title	Presenters
Quality of life after prostate cancer treatment	Ross Lawrenson
Community Pharmacists' Perception of their Role in Primary Mental Health Care	Mary Wong
Research versus Relationships: Discussion of viewpoints from qualitative interviews of GPs and Acupuncturists	Kate Roberts

11:45 - 12:30 Session 3 **Terrace Room**

PECHA KUCHA PRESENTATIONS x 4

Title	Presenters
The immune status of child bearing age in a Sydney General Practice	Fiona Millard
Measuring the Quality of Māori Health Providers	Kyle Eggleton
lbgaine treatment for opioid dependence: Results from a New Zealand 12-month post-treatment follow up study	Geoff Noller
Continuity of Care – Why does it matter? To whom and when?	Olivia Currie

Sunday, 17 September 2017

09:00 - 10:15

Session 1

Terrace Room

ORAL PRESENTATIONS x 3

Title	Presenters
Delivering Better Care for People with Severe COPD in the Southern Region (HRC Partnership Grant with Southern DHB)	Kathryn McAuley
Surgeons' informing for informed consent: The 'return home'	Isobel Ross
Diabetes stories: what can we learn from patient experiences of communication with health providers?	Maria Stubbe

10:30 - 11:30

Session 2

Terrace Room

ORAL PRESENTATIONS x 3

Title	Presenters
Ideas to action: the emergence national rural health research network	Georgina Richardson
The ethics of using clinical data for research: consent, control and transparency	Angela Ballantyne
'When you're 85, then I'll call you old': Age and identity in health care interactions	Jo Hilder

11:30 - 12:15

Session 3

Terrace Room

PECHA KUCHA PRESENTATIONS x 3

Title	Presenters
Post-settlement refugee-like migrants and refugees, a comparative primary care health analysis.	Jonathan Kennedy & Serena Moran
Introducing health humanities into the medical curriculum: charting our steps	Eileen McKinlay & Lynn McBain
Did Alexander the Great die from Guillain-Barre Syndrome?	Katherine Hall

ABSTRACTS

Title: **Metaphoric Language in Cognitive Behaviour Therapy**

Author(s) and department affiliation (underline presenter(s) name):

Fiona Mathieson (UOW DPHC&GP), Dr Maria Stubbe (UOW DPHC&GP), Dr Jennifer Jordan (UOC Psych Med), Dr Paul Merrick (Massey University Albany School of Psychology)

Aims/background/methods:

Metaphoric language is a rich source of meaning in psychotherapy. There is increasing discussion of the use of metaphor as a way of enhancing cognitive behaviour therapy (CBT) (Butler, Fennell and Hackmann, 2008; Kuyken, Padesky & Dudley, 2009; Newman 2015), but with little empirical basis. This study investigates the effect of training therapists to attend to client metaphors and bringing them into CBT conceptualisations. We also examined whether working metaphorically suits some clients and therapists more than others.

Twelve experienced CBT therapists attended two half-day workshops held a fortnight apart, where they were trained to attend to and develop central client metaphors for their problems and incorporate these into shared case conceptualisations. The effect of the training was evaluated using before and after video-recorded role-played CBT sessions, with graduate clinical psychology students acting as 'clients'. The 'clients' rated the sessions in terms of helpfulness and alliance using the Session Rating Scale, (an alliance measure) and the Working Alliance Inventory-short form (a second alliance measure) . The sessions were rated by a blind external rater using the revised Cognitive Therapy Scale (Blackburn et al, 2001) and the Collaborative Case Conceptualization Rating Scale (Padesky, Kuyken & Dudley, 2011). Therapists and clients all completed the Language Preference Report, a measure of preference for metaphoric language (Yarbrough, 1991).

Results/observations/conclusions:

There were significant improvements in both client and external ratings of alliance post-training. Therapist and client Language Preference Report scores were compared to alliance ratings, providing some pointers regarding therapist and client suitability for working in this way.

While further research is needed, it appears that metaphoric language is a rich source of meaning that clinicians can usefully draw on in CBT. It may prove to be an important process variable in CBT, with potential to assist client engagement.

Title: **The doctor by-pass project**

Author(s):

Giles, S, Arroll B, Cavanagh E, Moananu A, Dayal D, Dalbeth N, Fishman T.

Aims/background/methods:

AIM: To determine the proportion of patients with inadequately controlled gout in a clinic and to see how many of them wished to participate in an up-titration project. There was an additional concern that there were some patients who had difficulty in getting time off or accessing the clinic.

METHODS: A computer search was conducted in Greenstone Family Clinic (Auckland New Zealand) to find patients with gout that was well or poorly controlled. Those in the latter group were invited to be part of a project to have the up-titration of their urate lowering drugs done at local pharmacies. The plan was for the clinic to contact the relevant patients and invited them to collect

their prescription (written by a doctor at the clinic) at two local pharmacies. The pharmacies were provided with uric acid testing machines to facilitate up-titration of their gout medication according to the blood levels of the patient's uric acid.

RESULTS: 232 patients were eligible for assessment of their gout control. 71 (31%) were considered to be possibly poorly controlled. Of this 71, 27 agreed to participate in the up-titration study and 25 declined. Of the 25 who declined only 8 people stated that getting time off work was a reason for not being involved in the project.

CONCLUSIONS: This project found that 27 (12% 27/232) out of 71 potentially eligible patients would consider being part of a project whereby they could bypass their GP and laboratory and get their medication up-titrated at a local pharmacy. This represents a significant proportion of patients at the clinic who can get their gout under better control.

Funding RNZCGP summer student fund

Title: **Does prior receipt of HPV vaccination decrease the risk of adverse pregnancy and perinatal outcomes?**

Author(s) and department affiliation (underline presenter(s) name):

Nikki Turner¹, Anna Howe¹, Bev Lawton², Par Sparen³, Julia Brotherton⁴

¹ Department of General Practice and Primary Healthcare, University of Auckland

² Department of Obstetrics and Gynaecology, University of Otago

³ Karolinska Institutet

⁴ University of Melbourne

Aims/background/methods:

Preterm birth and intrauterine growth retardation (IUGR) are major causes of morbidity and mortality globally. An early New Zealand (NZ) retrospective cohort study of 36,000 females offered vaccination against human papillomavirus (HPV) prior to pregnancy, indicated an important and significant reduction in preterm birth (10% reduction) and IUGR (20% reduction) amongst vaccinated women after adjusting for potential confounding factors. Preterm birth alone affects 11% of births (14.5 million pregnancies per year) and contributes to a million deaths. This observed preventive effect has biological plausibility, given the known increased risk of preterm birth amongst women with untreated cervical intraepithelial neoplasia (a direct consequence of HPV infection) and studies indicating the presence of HPV in the placenta of women who have experienced preeclampsia and preterm birth. HPV appears to have significant effects in pregnancy and therefore prior vaccination has the potential to dramatically reduce maternal and neonatal outcomes.

Results/observations/conclusions:

We aim to test the hypothesis that HPV vaccination can prevent important adverse pregnancy and perinatal outcomes, by analysis of high-quality population-based data from cohorts across three countries with national HPV vaccination programmes. Outcomes of interest include IUGR, preterm delivery, premature rupture of the membranes, hospitalised spontaneous abortion, eclampsia and preeclampsia, perinatal death including stillbirth, and Apgar scores. We will use anonymised linked data from different governmental administrative sources from NZ, Australia, and Sweden. Data elements will include information about immunisation (exposure factor), hospitalisation, demographic, pregnancy, foetal and neonatal outcomes.

Title: **Walking A Fine Line (Carefully): An Exploration of Beliefs about Knee Pain in People with Osteoarthritis**

Author(s) and department affiliation (underline presenter(s) name):

Dr Ben Darlow, Department of Primary Health Care and General Practice, University of Otago, Wellington.

Dr Ben Hudson, Department General Practice, University of Otago, Christchurch.

Associate Professor Eileen McKinlay, Department of Primary Health Care and General Practice, University of Otago, Wellington.

Mely Brown, Department of Primary Health Care and General Practice, University of Otago, Wellington.

Dr Bronwyn Thompson, Department Orthopaedic Surgery & Musculoskeletal Medicine, University of Otago, Christchurch.

Associate Professor Haxby Abbott, Department of Surgical Sciences, Dunedin School of Medicine.

Dr Rebecca Grainger, Department of Medicine, University of Otago, Wellington.

Aims/background/methods:

AIMS: Explore the beliefs of New Zealanders living with knee osteoarthritis (OA) to understand their concepts of the disease and how these beliefs influence their preferred management strategies, activity participation, and quality of life.

METHODS Semi-structured qualitative interviews were conducted with thirteen participants who had been diagnosed with knee OA by a health professional. Participants were purposively recruited through primary care, secondary care and community advertisements. Interviews were audio-recorded and transcribed verbatim. Data were independently analysed by two researchers using Interpretive Description and verified by a third researcher. Data were collected and analysed concurrently. Recruitment continued until theme saturation was achieved.

Results/observations/conclusions:

RESULTS: Participants explained their OA using a biomechanical model, describing progressive structural deterioration due to joint wear and tear that was associated with ageing. They considered these changes resulted in bone grinding on bone and pain. These beliefs were reinforced by what participants saw, heard, and felt from their joint, and explanations from health professionals, particularly in relation to x-rays. This model heavily influenced beliefs about OA, its management and impact. Participants expected an inevitable progressive decline in joint condition with inevitable increase in pain and decrease in function that would ultimately require joint replacement surgery. This concept, combined with health professionals playing down OA's importance, limited exploration of other management options. Participants acknowledged benefits of physical activity for other tissues around the knee (such as muscles) and for other aspects of health but thought activity also accelerated joint damage. Consequently, participants reported carefully balancing activity benefits against the risk of further joint damage and were uncertain about these decisions.

CONCLUSION: The belief that joint use wears out articular cartilage is widely held and can be perpetuated by messages from health professionals. This belief results in a cautious approach to activity and limits participation in meaningful activities.

Title: **Quality of life after prostate cancer treatment**

Author(s) and department affiliation (underline presenter(s) name):

Ross Lawrenson and Tania Blackmore, University of Waikato

Aims/background/methods:

Prostate cancer is the most commonly diagnosed male cancer in New Zealand, and 3% of men over age 40 have had a previous diagnosis of prostate cancer. We were interested in the supportive care needs of men with prostate cancer in the Waikato and

Bay of Plenty region who had given consent to be part of the Midland Prostate Cancer Register. 197 men who were diagnosed in 2014/2015 were sent a postal survey designed to capture post treatment information such as level of continuing GP involvement, psychological needs, advanced care planning and quality of life using the Extended Prostate Cancer Index (EPIC26) Quality of Life Tool.

Results/observations/conclusions:

128/197 (65%) of surveys were returned. Analysis showed that 74% of respondents had seen their GP in the previous 3 months, but only 55% considered that their GP was involved in ongoing prostate cancer treatment. Only 8% of men had thought of future planning with an advance care plan. There was small evidence of a need for some psychological support to help respondents cope with ongoing symptoms that impact on daily quality of life, with 5% of men indicating that they would like to see a psychologist or counsellor. Although this number was low, 20% of men made additional comments relating to anxiety and depression following treatment. Results of the EPIC26 showed that generally, quality of life for men with prostate cancer appeared to be good, with 58% and 78% reporting no overall problems with urinary and bowel symptoms respectively, although 62% reported some continuing problem with sexual function. These data suggest that while many men reported no problems and a return to life as normal, there is still some ongoing need for support. We believe GP's could be more involved in the ongoing management of men with prostate cancer.

Title: **Community Pharmacists' Perception of their Role in Primary Mental Health Care**

Author(s) and department affiliation (underline presenter(s) name):

Mary Wong, Eileen McKinlay, Caroline Morris

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

Background: Rates of mental health issues continue to rise in New Zealand, particularly for Māori and Pacific peoples. There is an increased focus on primary mental health care by the Ministry of Health in order to improve access and outcomes for those with mental health issues. Community pharmacists as a group of professionals can contribute towards this goal. Their role has changed from primarily a supply function to providing clinical pharmacy services including drug information and assisting in medicine management to improve patient outcomes. These increased roles are well documented for patients with physical conditions such as diabetes and cardiovascular disease, but not yet for those with mental health conditions.

Aim: To explore community pharmacists' perceptions of their role in primary mental health care. In particular to identify the services that community pharmacists provide for those with mental health issues and also the barriers and facilitators to providing this care.

Method: A qualitative study involving semi-structured, face-to-face, audio-recorded interviews with 15 practising community pharmacists, including a mix of gender, ethnicity, age and geographic location. Transcripts coded and analysed using a thematic approach.

Results: Analysis of the first 8 interviews indicates community pharmacists believe that they have an important role in providing mental health care. Preliminary emerging themes include:

Important relationships with both patients and other health professionals

Beliefs about the pharmacists role in mental health services

Discussion: Community pharmacists hold a range of views about their role in providing care for those with primary mental health issues. Some describe providing counselling, self-management support as well as the traditional role of providing advice on medicines particularly when starting or stopping medicines for mental health conditions. They all endorse the importance of the long-term relationships community pharmacists hold with patients and other health professionals.

Title: **Research versus Relationships: Discussion of viewpoints from qualitative interviews of GPs and Acupuncturists**

Author(s) and department affiliation (underline presenter(s) name):

ROBERTS, Kate, Department of General Practice and Primary Health Care University of Otago

Aim: This qualitative study conducted as part of a larger mixed methods PhD project investigates current and potential models of communication and collaboration between New Zealand based General Practitioners and Acupuncturists.

Methods: 27 semi structured interviews were conducted between June-September 2016 The raw data (interview transcripts) were entered into the NVivo data management program which allowed for a systematic process of identifying and coding data in order to identify themes.

The primary objective of this data collection and analysis was to provide a viewpoint from both acupuncturists and general practitioners in New Zealand on their experiences and perceptions of communication and collaboration between the two groups, with a particular focus the care of mental health patients.

Results: Key themes emerged from the raw data regarding the role of research when defining scope of practice and how research informed practice. These at times conflicted in an additional theme which emerged regarding the relationship between research and evidence in assessment of competency. These two themes will be explored in this presentation.

Conclusions: The findings of the qualitative interviews of 27 practitioners will be discussed with specific emphasis on the role of research in regards to self-identity relationship building across disciplines. This is done with the view for encouraging discussion of strategies to continue to develop ways to enhance communication and collaboration strategies across disciplines.

Title: **The immune status of women of child bearing age in a Sydney General Practice**

Author(s) and department affiliation (underline presenter(s) name):

Dr Su-Yin Yeong, GP Synergy, Sydney

Dr Fiona Millard: University of Notre Dame, Sydney

Background: Best practice for women preparing for pregnancy includes protection against rubella infection and other vaccine preventable illnesses. In New Zealand and Australia, women and their GPs may assume that standard immunisation programs will provide adequate levels of immunity. There are no published studies of the immune status in women of childbearing age attending their GP.

Aims: To describe the immune status of women of childbearing age attending a general practice in Sydney and document the adequacy of rubella immunity at first antenatal visit.

Method: This is an epidemiological study using de-identified data extracted from the files of women of childbearing age (16 to 44 years) attending a Sydney general practice during 2016. Women who had attended the practice only once and those who were never or no longer planning pregnancies were excluded. Data were entered in SPSS software for analysis. Ethics consent was obtained from the University of Notre Dame HREC.

Results: During 2016, 1871 women in this age group attended the practice of whom 70% met inclusion criteria. Only 30% of the women were born in Australia, most arriving in Australia in their 20s from Korea, China, India and the Philippines. Rubella immunity was documented in 44% of the sample of whom 42% were tested when already pregnant. Rubella immunity was adequate (>30 IU/mL) in 60% of the sample, 31% had inadequate (<30 IU/mL) and 9% no immunity. Alarmingly, 3% of pregnant women had no rubella immunity and there was no significant difference between those born in Australia or overseas ($p=0.55$).

Conclusion: Immunity levels in women of childbearing age may be inadequate to protect the foetus during pregnancy. Women born in Australia were just as much at risk as those born overseas.

Title: **Measuring the Quality of Māori Health Providers**

Author(s) and department affiliation (underline presenter(s) name):

Kyle Eggleton, Te Kupenga Hauora Māori and Department of General Practice and Primary Health Care, The University of Auckland

Aims/background/methods:

The aim of my presentation is to outline the methodological approach of my PhD and present findings from my literature review. My PhD is entitled Measuring the Quality of Māori Health Providers: A Self Reflection and Critique of Tauwiwi Paradigms. As implied from the title the PhD explores the concept of quality primary health care from Te Ao Māori worldview as well as reflecting on my own identity and position as Tauwiwi within a Kaupapa Māori project.

Results/observations/conclusions:

The existing literature of quality measures used in primary care strongly suggests that these measures do not capture concepts of quality from a Te Ao Māori worldview. There is some evidence to suggest that quality measures may further marginalise structurally disempowered people. While Kaupapa Māori is the meta-theory that underpins my research the other theoretical framework that I am using is Gaventa's Power and Powerlessness theory. Gaventa's theory holds that three dimensions of power exist that promotes quiescence. By utilising strategies aimed at confronting each of these dimensions it is possible to move from a position of quiescence to action. My research project therefore has a participatory action approach. I am using an instrumental case study design in which the case in question is a Tai Tokerau based Māori health provider. Data is drawn from archival documents, hui interviews, individual interviews, observations and autoethnographical reflections.

Title: **Ibogaine treatment for opioid dependence: Results from a New Zealand 12-month post-treatment follow up study**

Author(s) and department affiliation: Geoff Noller (Dept. General Practice and Rural Health, Dunedin School of Medicine, Otago University); Chris Frampton (Dept. of Psychological Medicine, University of Otago, Christchurch); Berra Yazar-Klosinski, (Clinical Research, Multidisciplinary Association of Psychedelic Studies, Santa Cruz, CA, USA)

Aims/background/methods: Background:

The psychoactive indole alkaloid ibogaine has been associated with encouraging treatment outcomes for opioid dependence. The legal status of ibogaine in New Zealand provides a unique opportunity to evaluate durability of treatment outcomes. *Objective:* To examine longitudinal treatment effects over a 12-month period among individuals receiving legal ibogaine treatment for opioid dependence. *Method:* This observational study measured addiction severity as the primary outcome in 14 participants (50% female) over 12 months post-treatment using the *Addiction Severity Index-Lite (ASI-Lite)* following a single ibogaine treatment by either of two treatment providers. Secondary effects on depression were assessed via the *Beck Depression Inventory-II (BDI-II)*. The *Subjective Opioid Withdrawal Scale (SOWS)* was collected before and immediately after treatment to measure opioid withdrawal symptoms.

Results/observations/conclusions:

Results: Nonparametric comparisons via Friedman Test between baseline and 12-month follow-up for participants completing all interviews (n = 8) showed a significant reduction for the ASI-Lite drug use (p = 0.002) composite score. Reductions in BDI-II scores from baseline to 12-month follow-up were also significant (p < 0.001). Significant reductions in SOWS scores for all participants (n = 14) were also observed acutely after treatment (p = 0.015). Patients with partial data (n = 4) also showed reductions in ASI-Lite drug use scores and family/social status problems. One patient enrolled in the study died during treatment. Conclusion: A single ibogaine treatment reduced opioid withdrawal symptoms and achieved opioid cessation or sustained reduced use in dependent individuals as measured over 12 months. Ibogaine's legal availability in New Zealand may offer improved outcomes where legislation supports treatment providers to work closely with other health professionals.

Title: **What do GPs care about when it comes to pharmacoepidemiology?**

Author(s) and department affiliation (underline presenter(s) name):

Dr. Olivia Currie¹ Prof. Dr. Dee Mangin¹ Dr. Jonathan Williman (biostatistician)²

1. Department of General Practice, Christchurch School of Medicine
2. Department of Public Health, Christchurch School of Medicine

Aims/background/methods:

Aim: A research weekend discussion to establish research questions of interest to general practitioners with regards to pharmacoepidemiology and analyses of large electronic prescription database.

Background: There is an increasing trend to analyse electronic health records in recent decades with recent focus in pharmacoepidemiology. With proven methodology and advancement of statistical software, we can analyse the likelihood of New Zealanders prescribed statins, anti-hypertensives and antipsychotics in receiving their first prescription of metformin between 2005 and 2011.

Method: A longitudinal cohort study identifying first incident rates, hazard ratio, double-sided multivariable analysis of routinely collected data from a complete national primary care electronic prescription database in New Zealand. Cohort characteristics and persistence with medication within cohort were also calculated.

Results/observations/conclusions:

Summary of results will be presented from 3 publications (one published in 2013, and two in final draft at time of this application)

Needing advice and feedback where to from here, especially to find out research questions that will be of interest to general practitioners. Discussion may occur at free time.

Title: **Delivering Better Care for People with Severe COPD in the Southern Region (HRC Partnership Grant with Southern DHB)**

Author(s) and department affiliation (underline presenter(s) name): Kathryn McAuley, Emma Tumilty, Fiona Doolan-Noble, Tim Stokes

Aims/background/methods:

This research aims to improve the healthcare of people with severe COPD (Chronic Obstructive Pulmonary Disease) across the Southern DHB region. This study comprised of three sub-studies. The first was a case note review of all patients admitted to southern hospitals with severe COPD; the second and third were interviews with both patients and stakeholders. This presentation will discuss the preliminary findings from the patient interviews which were conducted using a semi-structured approach with 23 patients (and some of their whānau). These were aimed at identifying the barriers and enablers to the provision of high quality, person-centred, and integrated care for COPD.

Results/observations/conclusions:

Preliminary interrogation of these interviews has resulted in the emergence of several key themes. The patient's journey can be characterised by their experiences of COPD and their experiences with the health system, and the various positive and negative aspects that have arisen from their contact with a wide-range of health professionals. Of particular importance is the patient's shrinking world coupled with a strong sense of loss living with COPD – their increasingly limited physical mobility impacts significantly on their social and emotional wellbeing. Those patients interviewed made an immense effort to retain a sense of self and to carry on with their lives. The precariousness of their situation was also highlighted, and this was intrinsically related to the effectiveness of their coping and self-management strategies. The burden on whānau and the patient's corresponding feelings of burden were another key facet to emerge from the analysis.

Title: **Surgeons' informing for informed consent: The 'return home'**

Author(s) and department affiliation (underline presenter(s) name):

Isobel Ross, Maria Stubbe, Kevin Dew
Primary Care and General Practice, University of Otago, Wellington

Information is a pre-requisite of surgical informed consent or shared decision-making. However, 'doing informing' is not an easy matter. Surgeons face competing constraints when providing information. These include, on the one hand, a legal requirement for disclosure of information to 'the reasonable patient standard' and on the other, an ethical obligation to ensure substantive understanding by patients of that information. Health literacy among patients and the complexity of the information to be

imparted both vary, thus increasing the difficulty of the surgeon's task. Furthermore, interactional norms mean that patients (much like story recipients) normally confine themselves to brief vocal responses and/or head nods while an informing is in progress. While these brief patient turns may *claim* understanding (of what a surgeon is telling them), both *demonstrations* of understanding (or misunderstanding) and requests for clarification demand longer patient conversational turns. My research employs Conversation Analysis to examine the detail of informing sequences in video-recorded surgical consultations. A phenomenon observed in a minority of these is the so-called 'return home', a repetition of words and/or actions that 'launch' a particular stretch of informing. The 'return home' provides an interactional opportunity for more expansive patient turns, but in my data, is often absent. Surgeons could intentionally exploit this as a device to facilitate breaking up long tracts of information into more manageable chunks.

Title: **Diabetes stories: what can we learn from patient experiences of communication with health providers?**

Author(s) and department affiliation (underline presenter(s) name):

Maria Stubbe (Presenter)

Co-authors: Lindsay Macdonald, Rachel Tester and Tony Dowell

Aims/background/methods:

This paper explores how a diverse group of New Zealanders living with diabetes describe their communication with health professionals from the point of diagnosis along their journey to becoming 'self-managing' service users. The data comes from a maximum diversity sample of 27 video-recorded narrative interviews which have been transcribed and analysed using an inductive thematic methodology.

Results/observations/conclusions:

The people we talked to often mentioned experiencing high levels of stress around the time of diagnosis, along with negative feelings like guilt, shame or feeling overwhelmed. Some also reported ongoing issues with anxiety and depression. They often had remarkably clear memories of what was said and how they felt when they received the diagnosis, and reflected freely on the nature of their health consultations at that time and subsequently, and the extent to which they felt clinicians did or didn't understand and take account of their lived reality. Experiences of communication with health providers varied, and there were also shifts in perspective over time as people adjusted to their changed lifestyles. However, some clear 'messages' for health professionals emerged, including the importance of fostering resilience and mental wellbeing by being non-judgmental, respecting patients' right and ability to make their own informed choices, and acknowledging their individual preferences and the social and cultural contexts of their lives.

Title: **Ideas to action: the emergence national rural health research network**

Author(s) and department affiliation (underline presenter(s) name):

Fiona Doolan-Noble, Department of General Practice and Rural Health, Dunedin School of Medicine, University of Otago
Georgina Richardson, Department of General Practice and Rural Health, Dunedin School of Medicine, University of Otago

Aims/background/methods:

It is no secret that the 620,000 people living in rural and remote Aotearoa New Zealand have overall poorer health and wellbeing compared to the urban population and yet rural people are the driving force behind our nation's primary industries. Large gaps

exist in our understanding of this group and available, current New Zealand research is limited. At the same time, rural people and health professionals have resources, skills, and insights that can underpin research projects that are meaningful for rural health.

A proposal has recently received funding to establish a collaborative network of grassroots stakeholders and researchers to address these gaps both at the point of ideas - research generation and development - and the point of action - practical research translation and quality improvement. The initial requirement is for the network itself to be translated from an idea into action. This presentation explores activating New Zealand's first emerging inter-professional, inter-sectoral, inter-disciplinary research network. It explores the Network's strategies for bridging the research-practice-community divide, the lessons learned, and the foundations upon which it plans to achieve long-term, sustainable, community-responsive results.

Results/observations/conclusions:

People themselves are the greatest asset to rural health and rural health research. Community members, iwi and hapū, and professionals have a multitude of skills and insights that a research network can build on, facilitate, and develop to improve rural health and wellbeing. It is with the trust, passion, and visions of people themselves that the Network and its services can ultimately succeed in facilitating rural health research and quality improvement for the people it is purposed to serve.

Title: **The ethics of using clinical data for research: consent, control and transparency**

Author(s) and department affiliation (underline presenter(s) name):

Angela Ballantyne, Department of Primary Health Care & General Practice, University of Otago, Wellington

Background:

Research is vital to progress in healthcare; and research requires data. One potentially valuable and increasingly in-demand source of data is patients' clinical information.¹ Health data analytics involve repurposing, re-using, combining, sharing and linking data in new ways. 'Big data' refers to the storage and analysis of large, often complex, datasets. This typically involves novel combinations of datasets and real-time processing and application of the data. For example, researchers recently demonstrated that a self-taught artificial intelligence (AI) program was better at predicting heart attacks than doctors.² One vision for the future called 'learning health systems' pictures a continuous cycle where clinical service provision is driven by research, and research uses clinical data.³

Conclusions:

I argue that individual consent is becoming increasingly impractical as a tool for controlling the use of patients' health data. Yet, our research ethics framework (see NEAC Observational Research Guidelines P6.43) continues to focus primarily on consent. Options for centralized control and regulation of health information are also becoming problematic, given the complexity of the data ecosystem and that much health-related data is generated outside the health system (for example personalised fitbits). Rather than aiming to control the whole data ecosystem we need to identify critical points where we can influence practice. I propose that transparency is a core value of ethical data use and that this can support public engagement, researcher accountability and public benefit.

¹ The Academy of Medical Sciences. (2006) Personal data for public good: using health information in medical research. London: The Academy of Medical Sciences.

² Hutson M. 2017. Self-taught artificial intelligence beats doctors at predicting heart attacks. *Science* April 14. Available at: <http://www.sciencemag.org/news/2017/04/self-taught-artificial-intelligence-beats-doctors-predicting-heart-attacks> (accessed 29 May 2017); Mukherjee S. 2017. A.I. versus M.D. *The New Yorker*. Available at: <http://www.newyorker.com/magazine/2017/04/03/ai-versus-md> (accessed 29 May 2017).

³ Faden RR, Beauchamp TL, Kass NE. Learning health care systems and justice. *Hastings Cent Rep.* 2011; 41(4):3

Title: ***'When you're 85, then I'll call you old': Age and identity in health care interactions***

Author(s) and department affiliation (underline presenter(s) name):

Jo Hilder, Department of General Practice and Primary Health Care, University of Otago Wellington
Maria Stubbe, Department of General Practice and Primary Health Care, University of Otago Wellington
Ann Weatherall, Department of Psychology, Victoria University of Wellington

Aims/background/methods:

Background By mid-century, the number of older people in the world will exceed the young for the first time in human history. This demographic shift is likely to bring changes in both societal attitudes towards ageing and the old, and in clinical practice. Little is known about exactly how clinicians and patients in routine health encounters negotiate the various social meanings attached to age and ageing in this changing environment, or how these practices influence mutual understanding and health outcomes.

Aim This study investigates how health professionals and patients in NZ and the UK talk about age and ageing.

Methods Using existing video or audio recordings of primary care consultations from the New Zealand ARCH Corpus of Health Interactions and a similar UK database, we identify excerpts where age is explicitly mentioned and analyse the interaction using the tools of conversation analysis and membership categorisation. So far, 362 recorded consultations from the ARCH data set have been searched for explicit reference to age and an initial analysis conducted. Very preliminary observations from recently acquired UK data will be included if available in time.

Results/observations/conclusions:

Observations While mention of age in a medical context is frequently unproblematic and acknowledged by both parties as relevant to the clinical frame of reference, patients may identify with or resist explicit or inferred age categorisations in the talk. The possibility of interpreting age reference within an everyday frame is always present and can mean that mentioning age can be delicate and need to be negotiated. However, this very delicacy can be used as a resource of humour and affiliation.

Through exploiting the dual frames of reference, mentions of age can be used to accomplish two goals simultaneously – the clinical goal of communicating information and the interpersonal goal of relationship building.

Title: **Post-settlement refugee-like migrants and refugees, a comparative primary care health analysis.**

Author(s) and department affiliation (underline presenter(s) name):

Jonathan Kennedy; Senior Lecturer; Department of Primary Health Care and General Practice, University of Otago, Wellington
Serena Moran; Clinical Research Nurse; Department of Primary Health Care and General Practice, University of Otago, Wellington
Eileen McKinlay; Associate Professor; Department of Primary Health Care and General Practice, University of Otago, Wellington
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Aims/background/methods:

This research asks the question: Should refugee-like migrants be treated differently from refugees with respect to their post settlement health needs? Migrants to New Zealand with a refugee-like background are not recognised as a distinct group by legislation or health authorities. This contrasts with quota refugees who are recognised and who routinely receive orientation, health screening and settlement support. A Wellington primary care clinic has been systematically identifying refugee-like

migrants, providing health screening and linking with social work and secondary providers since 2011. The researchers will extract and analyse data from the clinic and from Ministry of Health datasets to compare characteristics and health needs of refugee-like migrants with those of refugees. All refugees and refugee-like migrants registering with the clinic from 2011 to 2015 are included in the research. The research has ethical approval from the University of Otago Human Ethics Committee, reference HD16/064, and is funded by a University of Otago Research Grant.

Results/observations/conclusions:

Work to date includes identification of the groups of refugees and refugee-like migrants at the primary care clinic. The researchers then determined health information available to answer the research question. Clinic data have been extracted for demographic characteristics, morbidity and health utilisation. Data from the Ministry of Health including emergency department attendance, outpatient visits, hospital admissions, immunisation records, maternity presentations and mortality have been requested. The researchers present the methods, challenges faced, and initial results for this project which is due to conclude at the end of 2017.

Title: **Introducing health humanities into the medical curriculum: charting our steps**

Author(s) and department affiliation (underline presenter(s) name):

Eileen McKinlay, Lynn McBain, Sinead Donnelly (CCDHB) Clare O'Leary & Brian Ensor (Mary Potter Hospice)

Background: There is a growing endorsement for the inclusion of the humanities or creative arts within medical education. Humanities are credited with developing innovation, perspective, observation, alternative views, humanism, professionalism and empathy. They challenge formulaic ways of thinking and acting and introduce and validate the importance of creative arts to sustain professional practice.

Methods: Over the last 5 years we have gradually introduced humanities into the medical curriculum. Since 2012 students have had the option to use creative work (vs an essay) to reflect on a visit to a patient at end-of-life 50% consistently choose this option and submit: photography, oils/watercolours, clay, poetry & narrative writing, music & vocals, jewellery, stitching collage and video. In 2015 we ran a successful optional writing workshop with Glenn Colquhoun facilitating. In 2017 a webpage has been established to display selected student creative arts re end-of-life and we now also share pieces of student-work within small group classes.

Observations: Students endorse the choice of creative work options and say it fosters their learning. There are a range of suitable topics in which the humanities can be incorporated: life stage (adolescence, old age); illness (multimorbidity, mental illness); human activity (giving birth, dying); procedures (cardiology, neurosurgery). Using creative work options for these topics are likely to bring diverse insights in contrast to essay writing or multi-choice questions. We encourage a staged introduction and making some compulsory rather than optional components so all students have the opportunity to explore creative arts methods of expression.

Title: **Did Alexander the Great die from Guillain-Barre Syndrome?**

Author(s) and department affiliation:

Dr Katherine Hall; Dept. of General Practice and Rural Health, Dunedin School of Medicine, University of Otago.

Aims/background/methods:

Theories about the cause for Alexander the Great's death generally centre on his symptoms of fever and abdominal pain, and have given rise to a wide variety of accounts for his demise ranging from typhoid fever to poisoning by white hellebore. What has received relatively scant attention, however, is the rather unusual symptom of 'ascending paralysis' mentioned in the accounts.

Results/observations/conclusions:

This paper argues a new theory for the cause of Alexander's death by analysing the possible causes of death via the most common diagnosis - Guillain-Barre Syndrome (GBS) - for this relatively rare symptom of ascending paralysis. In doing so, the balance of probability of the cause of his death swings towards an infective organism. Including the epidemiology of disease where he died, the most likely culprits will be discussed.
