GP Voice

YOUR NEWS, YOUR VIEWS, YOUR VOICES

Your prescribing matters
Asthma and the climate crisis

Rural hospital medicine
A day in the life of a rural hospital doctor

Blood pressure
New patient resources from the Heart Foundation

Climate action in practice
Sustainability tips for general practices

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

JUNE 2024

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News from the College

Views of our Fellows

Voices of the Sector

Editorial

Dr Samantha Murton

Dr Samantha Murton
President | Te Tumu Whakarae

Kia ora koutou,

With the release of the College's updated **Climate change, health and general practice in Aotearoa New Zealand and the Pacific** position statement recently, we've decided to put a climate change slant on this month's issue.

As New Zealand's largest medical college, we want to be seen stepping up and taking a leadership role in raising awareness of the current and future effects of climate change and its impact on health and equity.

We also want to do what we can to support our Pacific neighbours as they navigate their own unique climate-related health concerns related to their geographical, resource and infrastructure vulnerabilities.

Working on the frontline of community health care and having the relationships we do with our patients means we are likely to be the first to detect any changes to disease profiles, identify new illnesses or trends, or get a first-hand look at how the effects of climate change are impacting our patients' mental, physical and emotional health.

So what can we do?

There are long-term projects of raising awareness, being involved in adaptation planning in our communities and coordinating with the relevant local and regional service providers.

But every little bit does make a difference. How can you and your practice teams make changes to reduce the impact of climate change for you, your patients and community?

One way is to promote healthy climate-friendly lifestyle choices and/or medications where appropriate that contribute to improving the sustainability of health care; for example, switching from prescribing metered-dose inhalers (MDI) to dry powder inhalers (DPI) instead.

The carbon emissions associated with one MDI are equivalent to driving a petrol car 290kms, and approximately 100,000 MDIs are dispensed each month. The carbon emissions from DPIs are less than 10% of those associated with MDIs. In a recent conversation with a new patient, when I informed her of these statistics, she mentioned she worked in climate action and was interested in making the change.

Small changes include switching to LED lightbulbs, using paper from sustainable sources, not using paper at all, installing a bike rack for patients and staff to cycle into the practice, and simple things like turning off lights, electrical appliances and computer screens overnight.

Read more on our website, along with our Greening general practice toolkit for ways to make more environmentally responsible changes.

I hope you saw my message a couple of weeks ago for World Family Doctor Day and that you took a moment to remember the value you bring to the workforce and the sector and the impact you have on the lives of your patients.

We truly do make a difference every day and it's one of the reasons I am proud to represent specialists in general practice and rural hospital medicine.

Enjoy this month's issue,

College advocacy work: A month in review

The College is a strong, constant advocate for general practice and rural hospital medicine and we use our voices and experiences to inform Government, politicians, other sector organisations, the media and the public about the importance of the work we do and the value we add to the sector and our communities. Here is a snapshot of the advocacy work in May.

ADHD Parliamentary hui

This was the culmination of two years of work by the ADHD Working Group led by ADHD NZ resulting in political support and broad sector consensus to both remove the Special Authority renewal criteria for stimulants and work to change the prescribing and diagnosing gazette for ADHD to include vocationally trained GPs.

Pharmac and Medsafe

Discussion around coordination of resource support for continuous glucose monitor (CGM) introduction and educational support for practices as well as the practicalities of ADHD changes.

RuralFest

A parliamentary day focusing on the incredible service delivery of our rural members and the work done with insufficient workforce numbers or remuneration, and the securing of political will from the coalition government to support rural health further.

Firearms engagement group

The work programme to fully establish all elements of the Firearms Safety Authority – Te Tari Pūreke, including the Registry, is progressing well. The focus of the work is on safety through positive relationships, good communication and support. The Authority is working with communities in an educative way rather than a punitive one. The Coalition government has signalled a legislation change to establish a separate entity from the Police but has not yet determined where this will sit.

Oranga Tamariki

Detective Inspector Craig Rawlinson took the working group, convened to progress recommendations of the Karen Poutasi Report on children in care, through the findings of the Police investigation into the death of Malachi Subecz. The report highlighted an entire system failure and missed opportunities which could have been prevented if decisions were not made in isolation and information shared.

Our advocacy work in May:

- ADHD Parliamentary hui
- Pharmac and Medsafe
- RuralFest
- Firearms engagement group
- Oranga Tamariki
- Commonwealth Fund – International Health Policy (IHP) Survey – 2025
- Capitation technical advisory group
- Musculoskeletal (MSK) community pathway Chair
- PHO Services Agreement Amendment Protocol (PSAAP)
- General Practice Leaders' Forum (GPLF) meeting
- Primary care sector meeting with MOH
- Skin cancer primary prevention and early detection strategy
- New Zealand Women in Medicine conference

College President Dr Sam Murton said, "I listened to the report which was hard going but reminded me that we have opportunities at times to intervene and we should be willing to take them up. It could be as simple as expecting to do a check-up on any new children coming into the practice and particularly those in care."

Commonwealth Fund – International Health Policy (IHP) Survey 2025

The College is an active partner organisation for the 2025 IHP Survey. During April and May we have worked on the cross-country themes' development phase.

Capitation technical advisory group

Medical Director Dr Luke Bradford is sitting as a clinical advisor on this group with Sapere and Health New Zealand | Te Whatu Ora. Your Work Counts project data is being used.

Musculoskeletal (MSK) community pathway Chair

Dr Bradford is now sitting as Chair of this group working on the MSK pathway for patients nationally, including referral pathways, cortisone injections, allied health input and preoperative optimisation.

PHO Services Agreement Amendment Protocol (PSAAP)

The College is a contracted provider representative at PSAAP meetings for those practices who nominated the College.

General Practice Leaders' Forum (GPLF) meeting

The GPLF chaired by College President Dr Sam Murton held an online meeting to discuss their areas of work, as well as meeting with Minister Reti. GPLF collectively supported the sustainability of general practice document put out by GPNZ and also wrote to Dame Karen Poutasi regarding the Health Status report that had negative framing of primary care.

Primary care sector meeting with MOH

This is a broad group of participants and this month's topics for discussion were Meso-level organisation workshops, clinical leadership and the primary care policy programme.

Skin cancer primary prevention and early detection strategy

Dr Murton attended a workshop to discuss the updating of this document with MelNet. This document has been regularly updated over the years as skin cancer management changes and the College has been integrally involved in this work.

New Zealand Women in Medicine conference

Dr Murton spoke on a workforce panel presentation on the topic of "Is it terminal? Tackling the workforce crisis in Aotearoa."

Climate change in Aotearoa New Zealand and the Pacific

Updated College position statement

The College has updated its *Climate change, health and general practice in Aotearoa New Zealand and the Pacific* position statement, which was first published in 2016.

The College is proactively taking a principled, active and practical lead on an issue that is globally the biggest health and health equity threat, that will significantly affect New Zealand, and that at the same time is a significant opportunity to improve health, health equity and the resilience of general practice.

Measures to improve our housing stock (so they are warm, dry and mould-free), diet, exercise, lived environment and pollution levels will improve health and help address climate change. The cost of these measures will be offset by savings from reduced demand for health services and increases in productivity from a healthier population.

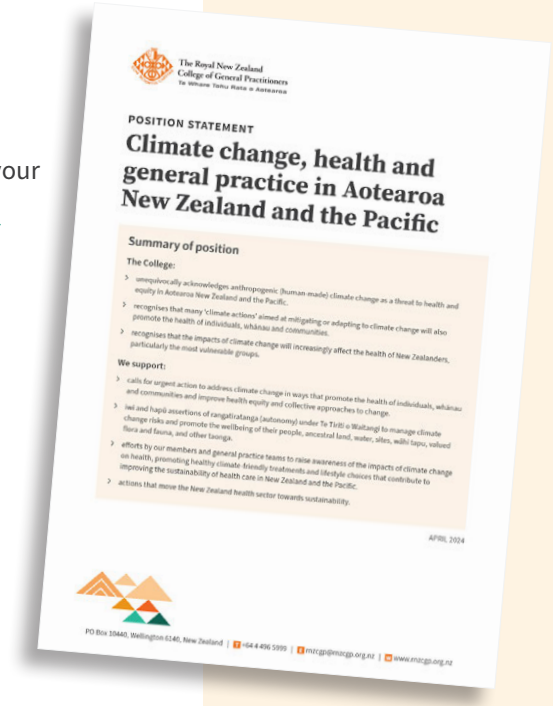
The College supports the efforts of our members and wider general practice teams to raise awareness of the impact of climate change on health, promote climate-friendly treatments and lifestyle choices (where possible and clinically appropriate to do so) that contribute to improving the sustainability of health care in Aotearoa and the Pacific.

We also support the call for urgent action to address climate change in ways that promote the health of individuals, whānau and communities, and improve health equity and collective approaches to change.

Read the position statement on our website.

Throughout this issue, we've got sector and expert opinions on a range of climate related topics and trends that we hope you and your patients will find informative – from **how one practice is tackling climate change** to **respiratory physician Dr Johnnie Walker highlighting the impact your prescribing can have**.

> "The College supports the efforts of our members and wider general practice teams to raise awareness of the impact of climate change on health, promote climate-friendly treatments and lifestyle choices...


The Royal New Zealand College of General Practitioners
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POSITION STATEMENT

Climate change, health and general practice in Aotearoa New Zealand and the Pacific

Summary of position

The College:

- unequivocally acknowledges anthropogenic (human-made) climate change as a threat to health and equity in Aotearoa New Zealand and the Pacific.
- recognises that many 'climate actions' aimed at mitigating or adapting to climate change will also promote the health of individuals, whānau and communities.
- recognises that the impacts of climate change will increasingly affect the health of New Zealanders, particularly the most vulnerable groups.

We support:

- calls for urgent action to address climate change in ways that promote the health of individuals, whānau and communities and improve health equity and collective approaches to change.
- iwi and hapū assertions of rangatiratanga (autonomy) under Te Tiriti o Waitangi to manage climate change risks and promote the wellbeing of their people, ancestral land, water, sites, wāhi tapu, valued flora and fauna, and other taonga.
- efforts by our members and general practice teams to raise awareness of the impacts of climate change on health, promoting healthy climate-friendly treatments and lifestyle choices that contribute to improving the sustainability of health care in New Zealand and the Pacific.
- actions that move the New Zealand health sector towards sustainability.

APRIL 2024

PO Box 10440, Wellington 6140, New Zealand | +64 4 496 5999 | mrcgp@nzcgp.org.nz | www.nzcgp.org.nz

Quality in practice: Gate Pa Medical Centre

Lorraine Anderson
Practice Manager

Gate Pa Medical is a family-orientated medical centre that has been offering general practice services to around 3,000 patients for approximately 30 years. Situated in a lower socioeconomic area of Gate Pa in Tauranga, it has a high-needs population of close to 50 percent.

Its long-standing mission statement has been to 'provide quality accessible whānau care', and it has tried to foster and maintain strong links with our community through Focus Groups and our kaiāwhina.

We consider ourselves to be an innovative practice and because of our size we're very adaptable. There are strong lines of communication within the practice team made up of four GPs (two FTE), two practice nurses, a receptionist, a practice manager who has a strong relationship with a large number of patients, a part-time health improvement practitioner, clinical pharmacist and kaiāwhina.

Continuous Quality Improvement (CQI) is something we do all the time, but projects are not always documented. The CQI module is something we undertook to maintain our teaching practice status.

We were aware of the very poor statistics in uptake of Faecal Immunochemical Testing (FIT) in Māori and Pasifika populations in other areas of the country, as the Bay of Plenty was one of the last regions to roll out the National Bowel Screening Programme.

We built a project around personalising the programme and by using our relationships or whanaungatanga with patients to see if we could achieve higher uptake rates over a six-month period.

This involved change methodology involving the entire project, with adaptation using CQI principles to address several factors, including postage issues, health literacy issues and cultural concerns. CQI was used also to ensure that input was completed in a cost-efficient way.

The results at the end of the six-month project showed markedly improved statistics with:

- 75 percent of Pasifika patients (39% national) participating in the programme
- 74.5 percent of our Māori patients (49% national) participating in the programme.

These results have continued to improve following completion of the module.

> "We achieved far better results after we had our first positive result who went on to have a colonoscopy. They had two adenomas removed within 10 days of the result being received. Being able to share a patient's positive story with others acted as a huge spur.

We found that although there was a cost to the practice, it was moderate, and we concluded the learnings could be implemented more widely if funding for general practice was obtained, with the likely result of a much more equitable and cost-efficient system for National Bowel screening.

This project reinforced the importance of whanaungatanga to our team, with many of our patients who had already tossed the kit into the rubbish after it had arrived unsolicited and unexplained in the post going on to complete the testing.

We achieved far better results after we had our first positive result who went on to have a colonoscopy. They had two adenomas removed within 10 days of the result being received. Being able to share a patient's positive story with others acted as a huge spur.

Through our project we outlined the immense power of the relationship a general practice team has with their patients and began reconsidering other areas where with adequate reimbursement a GP practice could improve efficiencies in the wider health system through their relationships; for example, decreasing the high rate of failed hospital appointments for our high-needs patients, and improving screening and immunisation rates.

Find out more about the College's **Cornerstone CQI module**.

Journal OF PRIMARY HEALTH CARE

The *JPHC* is a peer-reviewed quarterly journal that is supported by the College. *JPHC* publishes original research that is relevant to New Zealand, Australia, and Pacific nations, with a strong focus on Māori and Pasifika health issues.

Members receive each issue direct to their inbox. For between-issue reading, **visit the 'online early' section**.

Trending articles:

1. **Exploring the role of physician associates in Aotearoa New Zealand primary health care**
2. **Patient perceptions of barriers to attending annual diabetes review and foot assessment in general practice: a qualitative study**
3. **Eating behaviour, body image, and mental health: updated estimates of adolescent health, well-being, and positive functioning in Aotearoa New Zealand**
4. **Attention deficit and hyperactivity disorder and use of psychostimulants in Aotearoa New Zealand: exploring the treatment gap**
5. **The impact of nurse prescribing on health care delivery for patients with diabetes: a rapid review**

Celebrating our newest Fellows at GP24

A highlight of our annual College conference is the Fellowship and Awards ceremony held on Saturday evening.

It is a time when whānau, friends and peers get to celebrate and acknowledge all the hard work of their loved ones and watch them walk across the stage to be formally congratulated by College President Dr Sam Murton.

Starting from med school, it takes between 11 and 14 years of education and learning to become a Fellow of the College and specialist GP (FRNZCGP) or a rural hospital doctor (FDRHMNZ), so it is an achievement worth celebrating.

When this issue is published, 174 members will already have been invited to attend the Fellowship and Awards ceremony, and we estimate a further 10–20 will also gain Fellowship and be invited to attend this year's ceremony.

This includes those who have completed the General Practice Education Programme (GPEP), the Rural Hospital Medicine Training Programme (RHMTP), and Dual Fellows – those who have chosen to study both general practice and rural hospital medicine.

To personalise the ceremony for our new Fellows we encourage whānau, friends, colleagues and College/Faculty members to show their support in whatever way, shape or form feels most appropriate when their loved one walks across the stage. At GP23 this included waiata, haka, cheering from kids and adults, and the presentation of leis.

“Starting from med school, it takes between 11 and 14 years of education and learning to become a Fellow of the College and a specialist GP or rural hospital doctor, so it is an achievement worth celebrating.

College Awards

At the Fellowship and Awards ceremony, we also celebrate the hard work and achievements of our members who are receiving a College award or Distinguished Fellowship of the College. These members are nominated

GP23 Fellowship and Awards ceremony celebrations

by their peers, and it shows the value that specialist GPs and rural hospital doctors bring to their community, their peers and the College.

The College awards consist of:

- Distinguished Fellowship
- President's Service Medal
- Community Service Medal
- Honorary Fellowship
- James Reid Award
- Eric Elder Medal
- Amjad Hamid Medal
- Humphrey Rainey Medal
- Peter Anyon Medal.

Read more about the awards.

Post-ceremony celebrations

Following the ceremony, there is an invitation-only celebration function for new Fellows and their families to attend. This is a family-friendly event with drinks, canapés, food and movies for the little ones, and music. The formal invitation to our new Fellows has all the information about the celebration, RSVP'ing and additional tickets.

We look forward to seeing you at GP24: the Conference for General Practice in Te Whanganui-a-Tara Wellington from 25 to 28 July.

To register and find out more **visit the conference website**.

> "A College award or Distinguished Fellowship of the College...shows the value that specialist GPs and rural hospital doctors bring to their community, their peers and to the College.

Climate action in practice

Dr Kiyomi Kitagawa
Carefirst Group GP and director/shareholder, New Plymouth

As health care professionals we are all aware of why action against climate change is important. It's the time and financial constraints within primary health care and the 'how' that often becomes the barrier and the topic of many heated debates. Many don't know where to start and often (understandably) put it in the too-hard basket before they've even begun.

At Carefirst, we understood that doing 'a bit here and there' wouldn't lead to any measurable change and would contradict that which we all work so hard on in our day to day. That is, the equitable health and wellbeing of our patients and the impacts of climate on those most at risk. As the whakataukī (proverb) goes, ka ora te whenua, ka ora te tangata – when the land is well, the people will be well. The connection between hauora and te taiao is so intertwined we must take notice.

Climate justice and climate action is an opportunity to reduce inequity, improve outcomes, build meaningful relationships in your communities and leave a better outlook for future generations. While we weren't sure we would be able to 'get it right', there was one thing we were all clear on: we wanted and needed to make a start.

We're a few years in now, and we're proud to say we've made some great progress. We've also learnt a few things that might help others on their own sustainability journey. Here is what we have learnt:

1. Make a commitment to systemic change

When implementing any long-term change in business, people want to see that those in leadership are on board with the changes and will set their teams up for success by supporting them to do the things that may be difficult.

“As the whakataukī goes, ka ora te whenua, ka ora te tangata – when the land is well, the people will be well. The connection between hauora and te taiao is so intertwined we must take notice.

Carefirst Westown Clinic

This was a driving force behind our decision to write our commitment to environmental sustainability into our values and strategic goals. It now guides our decision making at every level and makes it easier to take action.

2. Decide your key focus areas

Engage in open dialogue with colleagues, patients and governing bodies to raise awareness and garner support. Then use those discussions to decide what your short, medium and long-term sustainability goals are.

These might change over time and that's OK. It's good to have a place to start, and if there's one thing COVID has shown us, it's that we're an adaptable bunch. Pick the low-hanging fruit and then move on to the bigger things!

A big focus for us now is measuring our carbon emissions, and we have committed to **Toitū Envirocare's Carbon Reduce certification**. We have just received our Toitū audit and are officially on the Toitū Carbon Reduce Certification programme. We will now analyse our results and put plans in place to move to Net Carbon Zero. Beyond that we aim to be climate positive (negative emissions).

3. Find support within your community

Once we knew where we wanted to go, we soon discovered there are plenty of organisations out there who are willing to help with the mahi. Whether it's your local hapū or iwi, district or regional council, your PHO, a sustainability NGO, or even a community garden, there's support to be found if you look for it.

A key support that we found at the start of our journey was our local council's **Resource Wise Business (RWB) Programme**. This is a free programme that audited our waste and provided tailored actions we could take to create long-term behavioural change to divert waste from the landfill.

4. Find champions in your team

Appointing champions within your staff who can work alongside leadership on your goals is a great way to drive staff engagement and help foster a culture of environmental responsibility. The key to this though is ensuring your champions are given the time and resources to do the work.

Our champion, Katherine (RN), was our liaison with the RWB team and worked closely with them on our waste reduction efforts. You can hear about it first-hand from Katherine in a case study video on the **Carefirst Sustainability page**.

5. Change your prescribing

Did you know it's estimated up to 60 percent of health care's carbon emission is in the medicines we prescribe? One big-ticket change is transitioning from pressurised metered-dose inhalers (pMDIs) to dry-powder inhalers (DPIs). The gas in a typical pMDI causes as much global warming as a car driven 290 kms. By making this switch, clinicians can significantly reduce their carbon footprint while simultaneously promoting optimal patient care.

> "We're a few years in now, and we're proud to say we've made some great progress.

We can also 'prescribe' social interventions to promote holistic wellbeing and environmental concerns. An innovative example of social prescribing in Taranaki is Kōia – mana kai, mana tangata (Gardening for wellbeing). This initiative encourages participation in community gardening with the support of health intervention practitioners and the local Green Prescription team. Participation boosts physical, spiritual, emotional and social wellbeing, by embedding positive behaviour change.

6. The best time to start is now

Avoid feeling overwhelmed by giving yourself some grace. You don't have to start big and you don't have to do it all at once. What's most important is that you start, because every little step you take adds up to significant change.

Why not take the first step today, and deep dive into these great resources:

- Zero Waste Taranaki
- RNZCGP – Greening General Practice
- RACGP – Reducing the carbon footprint of inhalers

> "You don't have to start big and you don't have to do it all at once... every little step you take adds up to significant change.

Carefirst Climate Champion Katherine auditing their practice waste

Carefirst Marfell Community Garden

MIND THIS

GP advice contradictions

Dr Peter Moodie

Peter Moodie is the College's Clinical Advisor

In March 2021 Mr A visited his GP, Dr B, with a history of exercise-induced chest pain over the previous five days. At the time of the consultation, he was pain free and an ECG showed no real abnormality; however, Dr B ordered bloods including a troponin T.

At 5pm that day Dr B was informed that the troponin T was 108ng/L. They immediately rang the patient and told him that he should ring 111 and ask to be transported to hospital urgently. Mr A was specifically told not to drive himself even if he was pain free as he was some 90 minutes from the hospital. They then rang and advised the hospital that Mr A should be expected, and an electronic referral was made.

Mr A rang 111 and explained that Dr B had been quite insistent that he "got an ambulance." The call handler explained that the doctor was "probably being a bit cautious" and asked him to ring back if they decided to drive themselves to hospital.

In the meantime, Mr A's condition was triaged as being "potentially serious but not life threatening" and a Fire First Response (FFR) team was dispatched and arrived at approximately 6pm. FFR teams are not equipped to transport seriously ill patients and unable to manage a deteriorating patient.

At 7.10pm an ambulance arrived carrying an intensive care paramedic and two emergency technicians. At this point things became very confusing. One officer said that the patient was assessed, and a 12-lead ECG was done, while another said the ECG was not done as it was not warranted. One said that they had read the doctor's referral letter, but Mr A explained that he didn't have one, and another stated that the troponin T was 30 when it was 108.

Mr and Mrs A complained that one of the officers was "rude" and suggested that they were likely to wait a long time in the ED. Finally, Mrs A drove Mr A to the hospital. He arrived at 9pm, some four hours after the initial 111 call. He was admitted to the CCU and diagnosed with a NSTEMI.

The complaint was initiated by Mrs A, and the St Johns ambulance service was found to be in breach of the HDC code, in part for ignoring the clear instructions of Dr B. St Johns carried out a review of the incident and found that its staff had clearly breached a number of ambulance service protocols, particularly with the lack of mandated documentation.

The learnings

Dr B was very clear in their communication to the patient and explained to him what they expected of the ambulance service. If Dr B hadn't been so firm, it is possible that Mr A could have suffered a severe, even fatal, event and the blame may have rested on the doctor for not explaining the seriousness of the situation.

It is heartening to see that the HDC placed a significant store on the expert opinion of the doctor.

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Funding for research

that benefits general practice

Did you know that the College funds research and education that benefits general practice, rural general practice and rural hospital medicine?

There are three funding rounds a year, and applications are reviewed by the Research and Education Committee (REC). **The second funding round for 2024 opened on 17 May, with applications accepted until 28 June.**

Chair of the Research and Education Committee (REC) Dr Stephan Lombard says, "If you have an area of interest or a research topic in mind that would benefit general practice and/or rural hospital medicine, I encourage you to apply for funding. Health research can provide us with incredibly important and innovative information about diseases or conditions, treatments, patterns of care, health care costs or workforce sustainability. Research findings can benefit both health care professionals and our patients alike."

"A benefit of REC funding is that applicants don't have to be a member of the College, or a doctor. The research just has to showcase benefits for our profession and the way we work, so please share this information with your colleagues, peers and health networks, and we look forward to receiving your applications."

Funding

Grants are typically between $5,000 and $20,000, although up to $40,000 can be awarded. Individual and group applications can be submitted. Read more in the application guidelines on the College website.

Research topic should reflect one (or more) of the below domains:

- Advancing Māori health
- Achieving health equity
- Enhancing the practice of primary care through scientific discovery
- Meeting the needs of rural general practice and/or rural hospital medicine.

Successful applicants are encouraged to submit their final papers to the *Journal of Primary Health Care* (JPHC) and submit an abstract to present at the annual College conference.

Apply for funding on our website.

Meet Dr Aimee Rondel: GP and embroiderist

Jamie Lamberton
Communications Advisor

Dr Aimee Rondel is a GP at Aurora Health Centre in Dunedin. Before specialising as a GP, her initial intention was to do maternal–foetal medicine or obstetrics and gynaecology (O&G). Following three years as a house surgeon, she just wanted out of the hospital for a bit.

"I decided to do GP training with the vague intention of going back after a few years to do O&G. However, I loved general practice and haven't wanted to do anything else. I enjoy my colleagues, patients, the continuity of care and the variety of presentations and challenges," says Aimee.

Medicine and thread converge

Outside of work though Aimee has an interesting hobby. She embroiders the human body; mostly women's reproductive organs.

"I started sewing when I was about eight. My mother showed me how to do cross stitch first, and then a woman at high school taught me stumpwork, which is a form of three-dimensional embroidery."

Aimee says she mostly sewed from pattern up until about five years ago when she was reflecting after a day of seeing patients, mostly with gynaecological problems.

"I was struck by the amount of shame my patients experienced and all the apologies they gave for what were routine exams… no one apologises when I have to look at their throat. So, I started sewing uteri with the idea to beautify the anatomy. I enjoyed making these and it snowballed into me stitching around 100 uteri. The idea was to depict a variety of experiences from stages of life and diseases to poking fun at medical terminology," Aimee said.

"My embroideries are completely entwined with my GP work. They are my way of reflecting on the challenges and joys of my job."

Aimee says she does this hobby for fun, but she's had some unexpected achievements along the way. In 2021 she ran an exhibition titled Dr Aimee Rondel and her Secret Gardens. That same year, she was featured in the *LA Times* article **See how health care workers make art to cope with COVID-19**.

When asked if she had any advice for members considering taking up a hobby while trying to juggle a busy GP workload, she said, "Ditch the housework, live in squalor and do fun things instead."

If you want to be featured in a future *GP Voice* article with your interesting hobby, please reach out to **communications@rnzcgp.org.nz**

"My embroideries… are my way of reflecting on the challenges and joys of my job.

A day in the life of a rural hospital doctor

Jamie Lamberton
Communications Advisor

Recently Dr Andrew Morgan, Chair of the Division of Rural Hospital Medicine ran a session for College staff on 'a day in the life of a rural hospital doctor.' I attended the session, and it was great to see so many staff there, engaged, and eager to learn about what a rural hospital doctor does daily. We thought we would share some of the key insights from the session with you, our readers.

Why Andrew specialised in rural hospital medicine

Andrew started off his career as a GP in New Plymouth and was looking for the next exciting step in his career. He got an opportunity to be a medical officer on the island of Niue.

When Andrew arrived in Niue with his New Zealand general practice training in tow, he was part of a team taking out appendixes, performing caesarean and forceps baby deliveries, and giving anaesthetics. When Andrew returned to New Zealand after two years in Niue, he worked in the emergency department, and everything rolled on from there.

Andrew said, "Rural hospital medicine is the greatest career, and I'm incredibly lucky to do it."

Rural hospitals

There are three levels (1–3) depending on the staffing levels and services available. Level 1 hospitals have slightly enhanced services to those that would be found in a GP practice. Level 2 hospitals can admit people and have services like X-ray and laboratory, and Level 3 hospitals build on Level 2 with sometimes approximately 50 beds and the opportunity to admit patients.

Rural hospital medicine scope

Similarly to general practice, Andrew explained that you really need to know a little about everything: pregnancy and obstetrics, paediatrics, strokes, pneumonia, palliative care and heart disease.

Andrew explained that admissions at rural hospitals are much like those at other hospitals. "We can diagnose and treat a heart attack, but for a more serious one, we'd transfer the patient to a cardiology suite sometimes via helicopter," Andrew explained.

Rural hospital doctors are great at doing procedures like chest drains, ultrasounds to look at gall bladders, and check heart and lung function. They also perform resuscitation often, so their scope cuts across emergency medicine as well.

> "Rural hospital medicine is the greatest career, and I'm incredibly lucky to do it.
>
> – Dr Andrew Morgan

They also provide palliative care. “When you think about end of life, people don’t want to be three hours’ drive from their home in pain, in a big hospital, so we’ve become very good at managing that.”

What skills do rural hospital doctors have?

Andrew explained the key skills that rural hospital doctors need to have include:

- knowing a little bit about a lot – you can’t choose what’s going to come through the door, just like in general practice
- being able to work through issues in a structured way
- being able to work in and lead a small team
- the ability to manage uncertainty and to know who to call for support
- resuscitation skills.

The Rural Hospital Medicine Training Programme

The Division of Rural Hospital Medicine (part of the College) runs the Rural Hospital Medicine Training Programme. It is a four-year full-time equivalent programme of study, but you can also do it part-time. The programme consists of multiple specialty runs, and you have the freedom to choose where and when you complete them.

The next round of applications will open in February 2025, for a start date of January 2026. **Find out more about the training programme, eligibility and application process.**

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> …the key skills that rural hospital doctors need to have include knowing a little bit about a lot – you can’t choose what’s going to come through the door, just like in general practice.

Our commitment to 700,000 Kiwis

Letitia Harding
Chief Executive of the Asthma and Respiratory Foundation NZ

As the CEO of the Asthma and Respiratory Foundation NZ, it is a privilege to lead a small yet dedicated team in our mission to support the 700,000 Kiwis affected by respiratory conditions.

At the heart of the Foundation lies a commitment to improving the quality of life for the 1 in 7 New Zealanders living with asthma, COPD and other respiratory conditions.

Our purpose is to lead respiratory health knowledge through research, education and advocacy, to reduce respiratory-related hospitalisations and improve respiratory health outcomes for all.

The Foundation works to achieve this through a combination of activities, including developing clinical best practices, encouraging self-management, improving health literacy, delivering education, advocating for tighter regulations around youth vaping and raising the national profile of respiratory disease in Aotearoa.

We are vocal advocates for those affected by respiratory conditions and our rangatahi who are battling to remain vape-free against the tobacco industry.

Advocacy and awareness matter

We tirelessly lobby for law changes and strive to raise awareness about issues that present lung harm with a crossover into heart health.

In representing individuals living with these conditions, we aim to evoke systemic change. Health literacy and empowerment of the patient are strong components of our mission. We also want to empower doctors, nurses and all other health care professionals with the knowledge and tools needed to deliver the best care to patients.

As part of that mission, we provide valuable resources and training opportunities to health care professionals, equipping them with the latest evidence-based guidelines and best practices.

Best practice guidelines

The Foundation – in close collaboration with its Scientific Advisory Board – has produced three sets of best practice guidelines for the treatment of respiratory conditions in New Zealand. These are:

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At the heart of the Foundation lies a commitment to improving the quality of life for the 1 in 7 New Zealanders living with asthma, COPD and other respiratory conditions.

1. The New Zealand COPD Guidelines 2021
2. The New Zealand Adolescent and Adult Asthma Guidelines 2020
3. The New Zealand Child Asthma Guidelines 2020.

These guidelines serve as a roadmap for health care professionals, offering clear recommendations for the diagnosis, management and treatment of respiratory conditions that affect many people in Aotearoa.

- Respiratory disease affects 700,000 people in New Zealand.
- It is the third leading cause of death in the country, behind heart attacks and strokes.
- It costs $7 billion annually.
- It is the cause of 1 in 11 hospital stays – that's 90,300 admissions.
- One-third of those hospital admissions are children – that's 27,200 children.
- Pacific peoples and Māori share the highest respiratory health burden.

Based on the latest research, our guidelines are designed to standardise care and treatment to improve patient outcomes.

As front-line health care providers, specialist GPs and rural hospital doctors play a pivotal role in implementing these guidelines.

By adhering to evidence-based guidelines, you can help ensure that your patients receive the highest standard of care, leading to better symptom control, reduced exacerbations and improved quality of life.

The Foundation also hosts the New Zealand Respiratory Conference every two years, with the next one set for 2025. The conference is always a valuable opportunity for knowledge sharing, learning and networking with other health care professionals, while gaining quality CPD hours.

This event features presentations from New Zealand's leading respiratory clinicians, researchers and health experts over a wide range of current topics, sharing the latest innovations, findings and advancements in respiratory medicine.

We understand that health care is a collaborative effort, and we are dedicated to supporting you, our front-line health care providers, in our journey to improving health outcomes for all New Zealanders. We always welcome your feedback.

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We are dedicated to supporting you, our front-line health care providers, in our journey to improving health outcomes for all New Zealanders.

Asthma and the climate crisis: Why your prescribing matters

Dr Johnnie Walker
Respiratory Physician, Bay of Plenty

Not only does the environment affect asthma, but our treatment of asthma affects the environment. Within the UK it is estimated that the NHS contributes around 4–5% of the UK's carbon footprint.[1] Of this, about 3% is caused by inhaler prescriptions.[2]

There are two main types of inhalers: Metered Dose Inhalers (MDIs) and Dry Powder Inhalers (DPIs). MDIs contain Hydrofluoralkanes (HFAs), which are used as an excipient containing the active ingredient. There are two main types of HFA used in MDIs, and these are imaginatively called HFA134a and HFA227.

The carbon footprint of these molecules is high

Just one cannister of HFA134a MDI containing the standard 120 metered doses, which will on average last a month, is the equivalent carbon footprint of driving a new car for about 300 km.[3] However, some MDI inhalers contain HFA227, which has about twice the carbon footprint of HFA134a.

Prescriptions of MDIs or DPIs is largely a matter of doctor, patient or local preference – for instance, in New Zealand and the UK about 70% of all inhalers prescribed are MDIs, whereas that figure is about 13% in Sweden.[3]

Ninety percent of the carbon footprint associated with MDI prescription is due to prescription of short-acting beta-agonist (SABA) inhalers,[2] and it is this which accounts for most of the carbon footprint.

Frequent use of a SABA inhaler is an indicator of poorly controlled asthma and should prompt review. Anything more than just three cannisters per year is associated with worse asthma outcomes, including death, hospitalisations, increased oral corticosteroid use and increased frequency of exacerbations.[4]

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Just one cannister of HFA134a MDI containing the standard 120 metered doses, which will on average last a month, is the equivalent carbon footprint of driving a new car for about 300 km.

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SMART or AIR therapy

It is for this reason that the 2020 Asthma and Respiratory Foundation NZ Adolescent and Adult Asthma Guidelines now strongly recommend SMART or AIR therapy as first-line treatment of asthma in anyone over the age of 12,[5] and states that SABA-only treatment is no longer recommended as long-term asthma treatment.

But now there is another reason to get patients off the blue inhaler and on to SMART/AIR therapy. SMART/AIR therapy can be administered using only DPI inhalers, which carry a fraction of the carbon footprint of MDI inhalers.

Since November 2023, bpac^{nz} have published the carbon footprint associated with inhaler prescribing data on the **He Ako Hiringa website**.[6] In 2019, about one fifth of all asthma patients in New Zealand – about 75,000 people – were inappropriately dispensed a blue inhaler only with no preventer.

According to bpac^{nz}, the use of salbutamol inhalers in poorly managed asthma (defined in this case as patients using over six SABA cannisters per year, or prescribed SABA only, without an ICS-based controller) is the carbon footprint equivalent of an astonishing 16,800 individual flights from Auckland to Hong Kong per year. Looked at another way, a UK-based study found that patients with poorly controlled asthma have 8x the excess carbon footprint of patients with well-controlled asthma – equivalent in the UK to the emissions from over 124,000 houses.[2]

This is the extent of the carbon footprint we can all help address by prescribing in line with the **2020 Asthma and Respiratory Foundation NZ Adolescent and Adult Asthma Guidelines**.

So, what can you do?

1. Ensure patients are on AIR or SMART therapy where possible.
2. Ensure that no one with asthma is prescribed a blue inhaler only.
3. Check inhaler technique regularly and offer DPI alternatives instead of MDIs if this does not adversely affect the patient's asthma control or personal choices. Many patients care about their carbon footprint and would wish to consider this information in their decision making.
4. If patients are using more than three SABAs per year, consider offering them a review.
5. Patients who remain poorly controlled – persistent high symptom burden, multiple SABA prescriptions, over two prednisone prescriptions per year, or any hospitalisation or ED attendance – despite optimal asthma management in the community should be considered for referral into local specialist services.

Hopefully by following these simple guidelines, we can all play our part in reducing our carbon footprint. We can all protect the natural beauty of Aotearoa New Zealand simply by managing asthma better.

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> SMART/AIR therapy can be administered using only DPI inhalers, which carry a fraction of the carbon footprint of MDI inhalers.

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Healthy homes assessment reduces avoidable hospitalisations

Housing plays a major role in people's health and wellbeing and their ability to live well. There is strong evidence nationally and internationally of improved health outcomes resulting from warmer, drier and healthier homes. He Whare Taonga, a healthy housing programme launched by Health New Zealand | Te Whatu Ora National Public Health Service in July 2023 services the Hutt Valley and Wellington region.

Health New Zealand Team Leader for Communicable Disease and Housing in the Wellington region, Gail O'Leary, says He Whare Taonga focuses on enabling kaumātua/elderly, individuals and whānau to live in warm, dry and healthy homes, consequently enhancing their health and wellbeing and reducing the number of housing-related hospitalisations and GP visits.

"He Whare Taonga works with patients and/or whānau who have a housing-related health illness but do not meet the Healthy Homes Intervention eligibility criteria, which can be found on HealthPathways," said Mrs O'Leary.

"The service offers a free housing assessment by trained nurses with whānau in their home to identify and mitigate concerns within the home that affect the health of the patient/whānau.

"We discuss health and social concerns, offer education and tips on ventilating the home as well as developing a care plan to address housing and health concerns. This may involve providing housing items for the patient/whānau, such as bedding, heaters, mould kits, hygrometers and curtains. We engage with landlords and homeowners around heating, insulation and other housing upgrades as required," she said.

Patient case study

He Whare Taonga received a referral from a health provider for a person with a diagnosis of asthma, who was living in a cold, damp home, resulting in frequent GP presentations and increased medication use.

Public health nurses within the service visited the home of the person, and after gaining consent they undertook a housing assessment.

Due to the perceived cost of electricity, the person was using an unflued gas heater. Unflued gas heaters have been banned in many countries as they release many noxious gases plus 1L/hour of excess moisture into the air, causing dampness and mould. The person had also turned down the temperature of the hot water cylinder, risking Legionnaires' disease.

"He Whare Taonga focuses on enabling kaumātua/elderly, individuals and whānau to live in warm, dry and healthy homes, consequently enhancing their health and wellbeing and reducing the number of housing-related hospitalisations and GP visits.

The nurses had a long kōrero with the person and explained the risks of the unflued gas heater and reducing the temperature of the hot water cylinder. Using a hygrometer, the nurses were able to show the high humidity levels in the home from the unflued heater plus the cold temperatures in the home when not in use that were causing dampness and mould, exacerbating the impact on respiratory health.

The nurses provided an energy-efficient micathermic heater to replace the gas heater. With consent, the person was referred to local budgeting services to ensure they were receiving the correct benefit entitlement and support with energy costs. The nurses provided education on the importance of moisture control in the home, such as targeted ventilation times, drying clothes outside, and provided a Scoopy (window condensation squeegee) to clear and collect condensation from the windows.

The nurses liaised with health protection officers to provide education on the risk of Legionnaires' disease. They also advocated to the housing provider to provide a professional assessment of the hot water cylinder and the importance of it being at the correct temperature.

When the nurses undertook a follow-up visit, the difference in the air quality within the home was immediately apparent. The person had stopped using the gas heater and was regularly ventilating the home. The hygrometer showed healthy indoor temperatures were maintained at 20 degrees and humidity was at acceptable levels. The hot water cylinder had been turned up to maintain the correct temperature. The person reported their health had improved, resulting in better asthma control and fewer GP presentations.

More information can be found on the **Health New Zealand | Te Whatu Ora website**.

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> We discuss health and social concerns, offer education and tips on ventilating the home as well as developing a care plan to address housing and health concerns.

Do you have a story you'd like to share?

Make your voice heard

Submit your article to the Editorial team:
communications@rnzcgp.org.nz

World Family Doctor Day – It's all about you!

Since 2010, World Family Doctor Day (WFDD) has been held on 19 May. Started by WONCA, this day has become a significant occasion to highlight the vital role and contribution of family doctors/GPs and primary care teams in health care systems around the world and to acknowledge the crucial role you play in improving health outcomes for your patients and communities.

This year's theme for WFDD was '**Healthy People, Health Planet**' and the College chose this day to release its updated **Climate change, health and general practice in Aotearoa New Zealand and the Pacific** position statement to show the steps we are taking to reduce the carbon footprint within primary care in New Zealand.

In Aotearoa the health sector contributes 3–8 percent of New Zealand's greenhouse gas (GHG) emissions and is the largest emitter in the public sector. Now is the time for us to go further in acknowledging our role, identifying adaptation strategies and working together to reduce and minimise GHG emissions while continuing to provide high-quality care and health equity.

Working on the frontline of community medicine, GPs and rural hospital doctors have a first-hand view of the impact that climate change is having on the health of our patients.

In her WFDD message, College President Sam Murton said that the College supports the efforts of our members and wider general practice teams to raise awareness of the impact of climate change on health, promote climate-friendly treatments and lifestyle choices (where possible and clinically appropriate to do so) that contribute to improving the sustainability of health care in Aotearoa.

The College's advocacy efforts also play a key role in showcasing the value of specialist GPs and rural hospital doctors. Information and data collected from the **Workforce Surveys** and **Your Work Counts project**, as two examples, are being used to form evidence-based guidelines and solutions to acknowledge the value and efforts that GPs and rural hospital doctors put into caring for people throughout their lives.

You'll find more information highlighting the link between the health of our planet and the health of our patients throughout this climate change–focused issue.

Raising awareness of hypertension

Associate Professor Gerry Devlin
Medical Director of the Heart Foundation

Nearly one million New Zealanders aged 30–79 have hypertension, according to the World Health Organization's (WHO's) first ever Global Report on Hypertension. High blood pressure affects 1 in 3 adults, but many of those people don't know they have it. That's why it's been labelled the 'silent killer'.

Globally, high systolic blood pressure is the world's leading risk factor for mortality, particularly from heart disease and stroke. The WHO report reveals that it causes more deaths than any other behavioural, metabolic or environmental risk factor.

Furthermore, only around 1 in 4 New Zealanders with hypertension have it controlled. This presents a significant opportunity to save many more lives by better blood pressure control.

This year, the Heart Foundation is focusing on raising public awareness about blood pressure.

Resources for empowering your patients

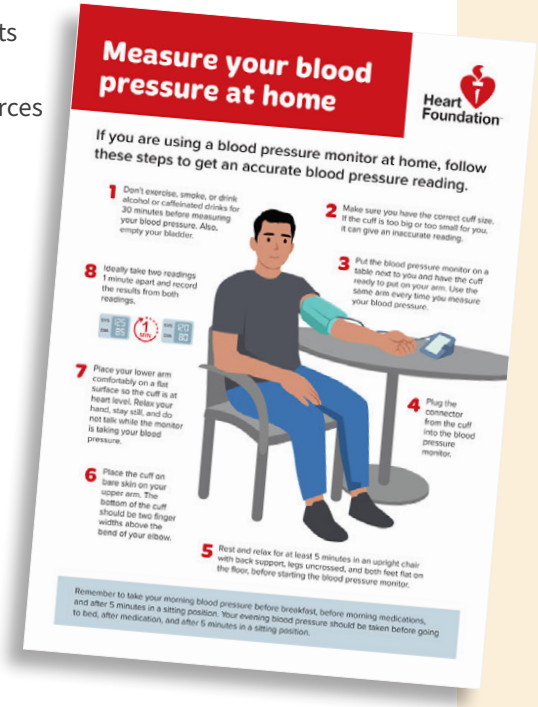
GPs, primary care nurses and community care nurses are an integral part of the solution to improving outcomes from hypertension. Early detection and effective treatment of hypertension are key to patients living well and reducing the associated risks of high blood pressure.

To support your conversations with patients about the importance of blood pressure management, we've developed new resources on home blood pressure monitoring.

We've created some handy guidance for patients using a blood pressure monitor at home. There are step-by-step instructions on how to take accurate blood pressure readings at home and an explanation of what the numbers mean.

See our:

- Illustrated 'how to' flyer
- Demonstration video
- Logbook for recording readings.



> "This year, the Heart Foundation is focusing on raising public awareness about blood pressure.

The printed resources are designed to be given to patients at the point of diagnosis, and you can order them in bulk from the Heart Foundation website.

For patients who prefer their information digitally, we've also got a new **blood pressure hub on our website** packed with useful information. Patients can learn more about managing their blood pressure and ways to lower it.

We also partnered with Kinetik Wellbeing to launch **My Blood Pressure** – a personal blood pressure web-based tool. The free online tool offers a simple way for patients to record their blood pressure readings online.

Taking steps together

Together we can raise awareness of the importance of people knowing and managing their blood pressure. If we all take action thousands of New Zealand lives can be saved.

To access our blood pressure resources and information for patients, **visit our website**.

> "Only around 1 in 4 New Zealanders with hypertension have it controlled. This presents a significant opportunity to save many more lives by better blood pressure control.

Managing patients with thyroid nodules: An increasingly common problem

Dr Francis Hall

Head of the Department of Otolaryngology Head and Neck Surgery at Counties Manukau DHB.

Thyroid nodules are very common and more common in women, with some estimates of palpable thyroid nodes occurring in 6% of the female population and 1.5% of the male population. Ultrasound detects thyroid nodules in 19–67% of the population with 5–10% being malignant.

Symptoms

Generally, the larger the thyroid nodule the more likely it is to cause compressive symptoms such as a pressure feeling, tightness or a lump in the neck. Thyroid nodules frequently cause no symptoms.

Nodules less than 2cm in size seldom cause symptoms.

If a nodule gets very large it may cause compression of the trachea resulting in shortness of breath on exertion and when lying down. Large thyroid nodules may also cause superior vena cava syndrome with restriction of venous drainage from the head and neck. This is most noticeable when the arms are raised in such activities as hanging out the washing. Patients may go red in the face when doing such activities (positive Pemberton's sign).

Ultrasound scans

A common scenario is a patient complains of a feeling of a lump in the neck, an ultrasound is requested, and this shows small thyroid nodules and a normal-size thyroid. In this situation, thyroidectomy is unlikely to cure the patient's symptoms.

An ultrasound scan of the thyroid and thyroid function tests should be requested on all patients with a suspected nodule in the thyroid gland. The majority of patients with a thyroid nodule are euthyroid.

If the patient is hyperthyroid (high fT4 and low TSH), then referral to an endocrinologist and/or starting the patient on carbimazole is appropriate.

Dr Francis Hall is Head of the Department of Otolaryngology Head and Neck Surgery at Counties Manukau DHB and has a private practice in Auckland. He is a New Zealand–trained ORL head and neck surgeon with extensive additional overseas training in head and neck surgery in Toronto, Sydney and Melbourne. He worked for five years as a head and neck/thyroid surgeon at Henry Ford Hospital in Detroit. He is an accomplished writer and presenter and loves to share his experiences with fellow specialists.

TIRADS classification system

Ultrasound is used to categorise thyroid nodules according to the TIRADS system. This system categorises nodules according to their composition (solid, cystic...), echogenicity (hypoechoic, isoechoic...), shape, margin and echogenic foci. Points are given for each of these characteristics, and recommendations are made depending on the size and TIRADS classification.

For example, fine-needle aspiration (FNA) is recommended for a 1.5cm TIRADS 4 nodule, while ultrasound surveillance is recommended for a 2cm TIRADS 3 nodule.

A 4cm TIRADS 2 nodule requires no follow-up. It is important to remember that these recommendations are for asymptomatic euthyroid patients.

The incidence of malignancy increases with a higher TIRADS classification as follows:

TIRADS	Description	Risk of malignancy
1	Benign	0.3%
2	Benign	1.5%
3	Mildly suspicious for malignancy	4.8%
4	Moderately suspicious for malignancy	9.1%
5	Highly suspicious for malignancy	35%

Basically, the size and TIRADS score determines which patients need an FNA and which patients need ultrasound surveillance.

Ultrasound-guided FNA (fine-needle aspiration)

It is recommended that fine-needle aspiration (FNA) of thyroid nodules is done under ultrasound guidance.

FNA cytology results are classified according to the Bethesda system as follows:

Bethesda	Description	Risk of malignancy
1	Non diagnostic	12%
2	Benign	2%
3	Atypia of undetermined significance (AUS)	16%
4	Follicular neoplasm	23%
5	Suspicious for malignancy	65%
6	Malignant	94%

Surgery recommendations

Patients with significant symptoms usually benefit from surgery, no matter what the TIRADS and Bethesda classification of the thyroid nodule are.

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Patients with significant symptoms usually benefit from surgery, no matter what the TIRADS and Bethesda classification of the thyroid nodule are.

For patients with no symptoms and thyroid nodules, treat along the following guidelines:

- **Bethesda 1:** Perform ultrasound-guided core needle biopsy and treat according to result.
- **Bethesda 2:** No treatment
- **Bethesda 3:** Consider surgery (especially if high TIRADS score)
- **Bethesda 4:** Strongly consider surgery
- **Bethesda 5:** Surgery
- **Bethesda 6:** Surgery.

RFA (Radiofrequency Ablation)

Patients with symptomatic Bethesda 2 nodes can also be treated with radiofrequency ablation of the nodule. This is a simple procedure done under ultrasound guidance and local anaesthesia. This is a scarless procedure that treats only the thyroid nodule.

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