

# GP Voice

YOUR NEWS, YOUR VIEWS, YOUR VOICES

2024 Workforce survey

GP access and  
surviving lung cancer

Revolutionising  
IBD care

ADHD advocacy:

What the College is doing



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

November 2024



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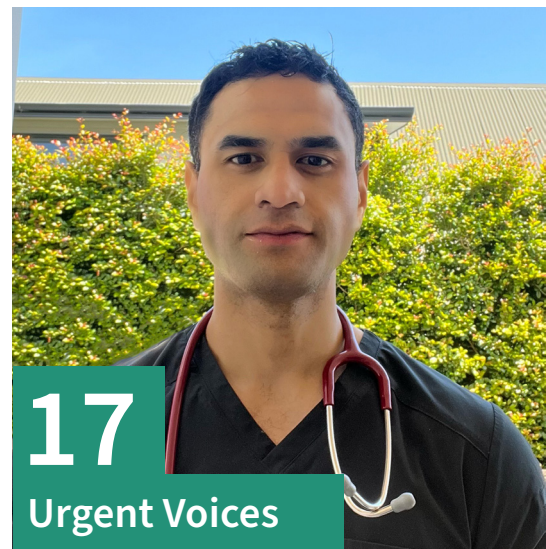
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# Editorial

Dr Luke Bradford

**Kia ora koutou,**

**T**he College's 2024 Workforce Survey has been open for almost two weeks, and it's great to see that over 720 of you have already taken the time to complete it.

The survey gives us the opportunity to compare your responses to the findings from the 2022 Workforce Survey and see what has changed. Your responses also give us a first-hand and up-to-date view of the current primary care landscape in general practice and rural hospital medicine. It gives us a gauge on how you're feeling, what's important to you, as well as more information about how you're working – who makes up your team, where are you working, are you training/teaching or undertaking clinical governance and much more.

The survey also has questions focusing on specific areas of interest such as the gender pay gap, so we can collate data in these areas and explore further.

While we know what the major challenges are that we're facing, we want to hear your unique perspectives and lived experiences. This will allow us to present an accurate picture of the state of general practice and primary care across the country to the Minister and sector officials. This data and the stories that we tell can also raise public awareness and call for their support to help us as we push for change.

Like many of you, College President Sam Murton and I have been following the increasing amount of media coverage on the primary care workforce shortages.

Reading the stories has been disheartening to say the least. And while we agree that these stories about the realities of our work and workforce need to be told, we also believe it is important to change the narrative and focus on the positives; the things we can change and the solutions that could bring some support as well as help to grow our primary care workforce to meet the challenges of today and in the future.

Together, Sam and I penned [this editorial for the NZ Herald](#) which did both these things.

By not backing down from our advocacy about changing the current funding model, which we all know is no longer fit for purpose, we have highlighted some solutions that could be implemented in the short term. This would provide primary care with some relief. It would also show us that the Government is listening and showing their commitment towards creating a sustainable and future-focused primary care workforce.



**Dr Luke Bradford**

Medical Director | Mātanga Hauora

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**This data and the stories that we tell can also raise public awareness and call for their support to help us as we push for change.**



You can also help us with our advocacy efforts by taking some time to have your say and completing the Workforce Survey before Sunday 24 November. The more insights and data we have from across the workforce, the stronger our case for change.

Enjoy this month's issue,



## Goodfellow Unit podcast: **Melanoma**

Dr Susan Seifried is a general and endoscopic surgeon based at Nelson Marlborough Hospital. In this podcast, Susan discusses the 'Quality Statements to Guide Melanoma Diagnosis and Treatment in New Zealand' developed by the National Melanoma Working Group (NMWG) and MelNet.

The key take-home messages of this podcast are:

- Prevention education is key – sun-smart behaviour
- Early detection – be observant of your patients and learn to use a dermatoscope
- An excisional biopsy with 2mm margins and a primary closure is the gold standard
- Refer on before doing wide local excisions if it's past stage 1b or if you're unsure
- Use the quality statements found through MelNet.



[Listen to the podcast](#)



# Editorial

The Member engagement survey – you completed, we listened

**Rachael Dippie**

## Tēnā koutou katoa

Understanding members' views of the College, what's important and where we can improve, is vitally important. I'm a firm believer of a customer-centric culture where understanding our customers (i.e. our members) and their needs and expectations leads to smarter business planning and design.

In August we conducted a member engagement survey. As this was the first survey of its kind in a while, it was a shallow dive into some of the functional areas of the College, seeking feedback and thoughts to help us identify areas for improvement to add to our workplans.

This is what we heard:

- Members value the functions of the College, but there are some areas where they would like to see more effort placed – mainly in the areas of attracting more GPs and rural hospital doctors to the profession, facilitating the training of GPs and rural hospital doctors and advocating for better health care outcomes with Government and agencies.
- Not surprisingly, it was clear that members have time and capacity constraints for engaging with the College's communication channels. We are under way reviewing how we can ensure that the most important information is most prominent across all our channels.
- Over a third of members have engaged in a faculty or chapter event in the past 12 months. More research is required to identify any barriers for engagement.
- Over 80% of Fellows find our CPD programme Te Whanake easy to use.
- While the majority of members found contacting the College by phone or email easy, we know there are improvements we can make in this area which we are currently implementing.
- Awareness varies considerably across the various benefits available to members. And we can see that usage also varies. We've swung into action by relaunching the College app and have added a new supplier Samsung, who are offering significant discounts. You can view the full list of [member benefits](#) on our website.

Thank you to the 1,130 members who completed the survey and shared their views openly to aid our work planning. The survey will be a regular annual fixture to ensure we continue to seek feedback and support you as effectively as we can.



**Rachael Dippie**

Head of Membership

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**Thank you to the  
1,130 members who  
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views openly to aid  
our work planning.**



To end, and to ensure our database is up to date, can I please remind you to regularly check that your contact details and faculty and any chapter involvement is up to date on the member dashboard – you can log in to it from the [website](#) and then click on ‘edit details’. If you have trouble accessing your details, give us a call on 0800 965 999 or email [membership@rnzcgp.org.nz](mailto:membership@rnzcgp.org.nz).

Hei konā mai

Rachael Dippie

## We'd like your feedback

Help us improve the reading experience of GP Voice by completing the short survey at the link below.

[Submit your feedback](#)

### Goodfellow Unit podcast: **Herpes Zoster Ophthalmicus**

Rachael Niederer is a senior medical ophthalmologist at Greenlane Clinical Centre, the RANZCO College Representative for Auckland Ophthalmology trainees and a senior lecturer at the University of Auckland.

In this podcast Rachael answers some of the common questions surrounding Herpes Zoster Ophthalmicus (HZO) also known as shingles. The key take-home messages of this podcast are:

- Early detection is vital to starting antivirals
- HZO is a common disease among older adults (60+)
- Vaccination is a key preventative therapy and readily available
- Complications can be devastating and carry high risk of vision loss.



[Listen to the podcast](#)



# Month in review

The College is a strong, constant advocate for general practice and rural hospital medicine. We use our voices and experiences to inform Government, politicians, other sector organisations, the media and 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 from October.

## 2024 Workforce Survey

The College's biennial Workforce Survey went live on Friday 25 October and is open for members to complete until Sunday 24 November. The survey data gives us up-to-date demographics of the workforce and important insights that are used in the College's ongoing advocacy work. [Please see the Workforce Survey story on page 8](#) for more information.

## Collaborative Aotearoa workshops

Medical Director Dr Luke Bradford participated in three workshops discussing how to update and enhance the Health Care Home model. Considering changes over the last 15 years, and upcoming advancements and pressures, the group want to ensure that the toolkit is updated with useful modules and improvements for general practice.

## Access to Language Assistance Services in general practice

Dr Bradford has written to the Director-General of Health to address the lack of access to Language Assistance Services (LAS) within general practice and to highlight why this is a risk for the workforce and for patients. The Ministry of Business, Innovation and Employment (MBIE) have a policy that states those accessing government provided or funded services should have the right to access LAS. General practice and the patients cared for in our practices fall under this remit. [Read the letter here.](#)

## ADHD work

Dr Bradford attended meetings with the ADHD Consensus Group to further discuss the renewal criteria. You can read more about this on [page 19.](#)

## Meeting with University Otago researchers on former refugees' experiences of general practice

Dr Molly George and Dr Pauline Norris discussed and sought advice on disseminating the findings from the research 'Former Refugees' Experiences of Healthcare and medicines in Southern New Zealand: A summary of two projects' to understand how to effect change for access to health care, and what could be done to improve the experience of refugees visiting GPs.



## Hauora Taiwhenua

The College met with Marie Daly to discuss the Rural General Practice survey, the College's 2024 Workforce Survey and potential for working together on a paper once the College results are published.

## October submissions

- **Ministry of Health** – [Proposal to increase the period of supply limit from 3 to 12 months](#)
- **Pharmac** – [Proposal to fund medicines for lung cancer, breast cancer, for Chronic Obstructive Pulmonary Disease \(COPD\), and for the prevention of RSV](#)
- **Pharmac** – [Proposal to fund lisdexamfetamine for the treatment of ADHD](#)
- **Pharmac** – [Proposal to remove the renewal criteria for stimulant treatments](#)
- **Parliament Health Select Committee** – [Vaping Bill](#)
- **MOH** – Hauora Māori Strategy 2025
- **NZ Transport Agency** – [Medical Aspects of Fitness to Drive](#)

## Goodfellow Unit podcast: Diabetes Technology

Ryan Paul is an endocrinologist at Te Whatu Ora Waikato and is an Associate Professor of Medicine at the University of Waikato. He is also an honorary Senior Lecturer at the University of Auckland and a Clinical Associate of the Maurice Wilkins Centre.

In this podcast, Ryan discusses continuous glucose monitors and automated insulin delivery devices (aka insulin pumps). The key take-home messages of this podcast are:

- Great if all eligible whānau could have a script and special authority done for CGM
- Technical support and troubleshooting for patients are provided by manufacturers
- This is a big incentive for those who may have previously given up on insulin pumps
- Primary care has an important role in referring people to secondary care
- Talk to your local diabetes service about education programmes.



[Listen to the podcast](#)





# 2024 Workforce Survey

Your voice matters

The College's 2024 Workforce Survey has been live since 25 October, and at the time of publishing, over 720 members have completed it. Thank you to those who have taken the time to have their say – and if you haven't yet, you still have time!

## Your voice matters – have your say today

We are lucky to have such a diverse group of people who make up our 6,000-strong College membership. Alongside the faculties, which all members belong to based on regional location, we have our rural hospital medicine peers, Te Akoranga a Māui, and our Pasifika, Registrar and Rural GP chapters.

Dr Alvin Mitikulena, Chair of the Pasifika Chapter says, "Pasifika GPs make up less than 3 percent of the total GP workforce in New Zealand, and so not surprisingly Pasifika people's health is generally poorer compared to most.

"It is absolutely vital that the College captures the views of its Pasifika members through its Workforce Survey to better understand both the workforce and cultural pressures that may impact GPs of Pasifika heritage. Through this information, the College can improve pathways of learning and support for Pasifika GPs, resulting in a more robust and resilient GP workforce contributing to improving health outcomes for all New Zealanders into the future."

## How we use your responses to advocate for change

The insights from these surveys and the stories we tell with the data are referenced widely throughout the health sector and in the media.

The previous Workforce Surveys carried out in 2020 and 2022 had a major focus on the impact of the COVID-19 pandemic and post-pandemic 'new normal' and how that contributed to our membership's declining wellbeing and increased burnout rates over these years.

The burnout data is still referenced and at the time did show an accurate picture of how the pandemic truly impacted our workforce.

The survey findings also showcased the value of the workforce, highlighting how general practice teams across the country were proactive, became the 'masters of pivot' and were able to show how nimble, adaptable and solution-focused they were, doing what needed to be done to continue providing care to those who needed it.

In 2022 the Government did agree to a number of proposals that were put forward by the College to address some of the barriers to doctors choosing general practice as their vocation. The Workforce Survey data helped by

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The insights from these surveys and the stories we tell with the data are referenced widely throughout the health sector and in the media.



showcasing our value and the need to urgently increase our homegrown GP workforce, as we are no longer able to rely on as many overseas-trained doctors moving here.

### The proposals:

1. Committing to fund an increase of registrars training in GPEP year 1 to 300 per annum
2. Providing first-year GPEP registrars with pay parity with medical registrars training in hospital-based specialties
3. Providing a funding allowance for general practices hosting community-based attachments for PGY1 and 2 doctors
4. Increasing funded teaching time in GPEP from one and a half to four hours a week.

These changes came into effect from 2023 but were too late to influence the numbers starting in GPEP for that year. However, this year in 2024 we had the biggest cohort of registrars starting in GPEP – 232 of them benefited from the College's advocacy and push for change. This will ensure the future sustainability of our workforce.

## About the Workforce Survey

The 2024 Workforce Survey will be open for members to complete until **Sunday 24 November** and should take about 20 minutes.

If you are unable to complete the survey in one sitting, there is the option to save it and come back to it at a later date. Click the 'save your progress' button at the bottom of the survey screen. **It is important that you save the new link provided before you exit the survey so your responses to date are saved.** You can access the survey again from any device using the **new link** provided.

If you forget to save the new link, unfortunately you will be sent back to the beginning of the survey and none of your previous responses will be saved.

As a thank you for your time, all GP and RHM members who complete the survey will go into the draw to win one of two \$500 **Prezzy® Cards**. Dual members (who answer the most questions covering both RHM and general practice) will go into their own draw to win one \$500 **Prezzy® Cards**.

Any queries about the Workforce Survey can be sent to [workforce@rnzcgp.org.nz](mailto:workforce@rnzcgp.org.nz)

**Figure 1**



### Workforce Survey

< Return to survey

#### Save your response for later

Saved! Your submission can be restored using this link (click to copy):

<https://app.converlens.com/rnzcgp/workforce-survey/workforce-survey-pilot-2024?page=2?edit=sbm30dc11a73c67e4deec8d46code=f1d23edd67ff494f6ee4c690>

< Return to survey

**Figure 1:** A screenshot of the new link you will be given so you can continue the survey later. Remember to copy and paste the new link somewhere safe.



# Quality in Practice: Pihanga Health

Our first Cornerstone promotion winner

Congratulations to Pihanga Health for being the first winner of the College's promotion for completing the Cornerstone CQI module! College President Dr Samantha Murton presented the \$700 Amtech voucher to practice manager Hilary MorrishAllen at the PMAANZ Conference.

We caught up with Hilary to find out about their experience completing the Cornerstone CQI module, why they did it and what they learnt from it.

## A little bit about Pihanga Health

Pihanga Health is a not-for-profit primary care charity located in the remote rural area at the southern end of Lake Taupō. As a Very Low Cost Access (VLCA) practice they provide first-line health care for their community. They serve approximately 4,800 registered patients with 59% identifying as Māori and 41% from other ethnic backgrounds. About 80% of their patients are classified as Quintile 4 or 5.

Hilary says, "We're honoured to carry the name Pihanga, a treasured taonga of Ngāti Tūwharetoa and Ngāti Tūrangitukua."

## What motivated your practice to complete the Cornerstone CQI module?

As a committed teaching practice, completing the Cornerstone CQI module was a requirement for us. However, its focus on continuous improvement aligned perfectly with our established practices.

## What did you have to do to gain the Cornerstone CQI module accreditation?

Cases of Strep A are high in our community. In 2022, we conducted an audit of our adherence to the [New Zealand Guidelines for Rheumatic Fever](#) and found that our compliance was lacking.

This prompted us to enhance patient outcomes for those with potential Strep A through early detection and effective treatment with the aim of reducing the risk of rheumatic fever. We recognised our previous management of potential Strep A cases often led to delayed treatment or overprescription of antibiotics, and adherence to antibiotic regimens was inconsistent. To address this, we included improved antibiotic stewardship as a secondary aim of our project.

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We're honoured  
to carry the name  
Pihanga, a treasured  
taonga of Ngāti  
Tūwharetoa and  
Ngāti Tūrangitukua.



In our remote setting, we saw the benefits of point-of-care testing for patient access and care. We successfully raised funds to purchase an Abbott ID NOW™ Strep A 2 machine for identifying strep throat, which we hoped would transform our approach to Strep A presentations.

Before fully implementing this testing method, we conducted a year of dual testing – using both point-of-care tests and standard laboratory GAS tests – followed by a retrospective audit of the results. Our findings showed a 30.7% positive rate with the point-of-care test compared to 23.2% from the laboratory tests, with no negative point-of-care tests yielding positive laboratory results. This evidence gave us confidence that the point-of-care test was safe, accurate and suitable for guiding antibiotic prescribing in our high-risk rural population.

During the same period, we found that 100% of positive cases (both point-of-care and laboratory confirmed) received antibiotics at their initial consultation with 95% of prescriptions dispensed. This increased confidence in our point-of-care testing, which led to a 33.2% reduction in antibiotic prescriptions overall while ensuring the right patients received treatment, thereby enhancing antimicrobial stewardship.

### **What did you have to do or think about differently as you worked through the CQI module?**

Currently, the New Zealand Rheumatic Fever guidelines do not recommend point-of-care testing for GAS pharyngitis due to a lack of local studies, although international guidelines support its use. We had to embrace the idea that thorough, data-driven research could lead to better treatment pathways for our patient population. Initially risk averse, we prioritised patient safety, but as we collected and analysed more data we grew more confident in our approach. External peer review and objective validation of our results were also crucial.

We learned the importance of a thorough design process. Collecting accurate data from the beginning was essential, and we needed to plan our analysis in advance to ensure we gathered the right information.

Taking a whole-practice approach to tackle this clinical issue allowed us to leverage the skills of our entire team – from data collection to analysis, documentation, review and patient communication.

### **What is different for your team because of doing this work?**

Our focus on managing patients with sore throats has sharpened significantly. Now when a patient visits another clinician with a sore throat and doesn't get tested, we question why.

This experience has shown us we can effectively address major issues, and we feel more confident using data to support our hypotheses and actions. We are better at recognising when we talk about perceptions as if they are facts, prompting us to refer to data for confirmation. This shift has inspired several other projects aimed at challenging our assumptions through data.

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We are better at recognising when we talk about perceptions as if they are facts, prompting us to refer to data for confirmation.





## What is different for your patients?

Our patients now experience a significantly improved care pathway. Our responses are quicker and more targeted, and we provide better support and education to our patients and their whānau. The skills and confidence we gained from this extensive project have strengthened our overall approach to continuous improvement activities, ultimately benefiting our patients through enhanced services and care.

*College president Sam with Hilary MorrishAllen, practice manager of Pihanga Health.*



**The Quality Programmes team are running a promotion until the end of March 2025.**

Complete either the Continuous Quality Improvement (CQI) or Equity module accreditation for a chance to win one of five \$700 Amtech Medical vouchers for your practice. Winners will be drawn in September, October and November 2024, and February and March 2025. If you have any questions about this promotion, please email the [Quality Programmes team](#).

[Find out more about the CQI and/or Equity module today.](#)



# PMAANZ Conference

## ‘Demystifying Quality’ workshop

The College Quality Programmes team consisting of Sandy Bhawan, Heidi Bubendorfer, Carrie Hetherington and Lucy Wass ‘flew the College flag’ at the PMAANZ conference in September.

During the two-day conference, they ran an interactive workshop on ‘Demystifying Quality’ which was attended by over 60 delegates who were either practice managers, nurses or administrators.

“It was a successful turnout and a real team effort,” said Sandy, Manager Quality Programmes.

The workshop focused on the Foundation Standard, one of the College’s Quality Programmes and included an activity where attendees were split into five groups to discuss the five domains of the Foundation Standard. The Foundation Standard combines all the legislative and clinical requirements needed for general practices to deliver safe, equitable and quality care.

It was launched in April 2020, so the workshop was a good opportunity to check in on what was working well and what could be done better and to identify what was challenging.

Below is a summary of the feedback from the workshop delegates.

### Domain 1: Tūrora | Patients

The indicators in this domain focus on the Code of Health and Disability Services Consumers’ Rights, the Privacy Act 2020 and the Health Information Privacy Code, application of the principles of Te Tiriti o Waitangi and the practice’s responsiveness to diversity.

The comments about this domain were largely positive. Attendees said it works well and is straightforward. Comments for improvements included more onsite training in the key areas for practice teams and more resources.

[View this domain](#)

### Domain 2: Manaaki haumanu | Clinical care

The focus of this domain is on best practice clinical care including continuity of care, emergency response, immunisations, screening processes, clinical governance and valuing patient experience.

This group understood the importance of the clinical care domain, but meeting the requirements of this domain was the most challenging as it required



time from clinical and administrative staff. The group suggested further simplification to the requirements and the introduction of incentives such as CPD points to encourage the engagement of clinicians with this domain.

[View this domain](#)

### Domain 3: Whakahau rongōā | Medicines management

The focus of this domain is on medicines management, including prescribing patients' medications and controlled drugs management in accordance with New Zealand legislation.

Feedback from this group indicated that this domain was clear and concise and that the challenges were minimal. Areas of improvement included more training for practice staff.

[View this domain](#)

### Domain 4: Taputapu | Medical equipment and resources

The focus of this domain is on ensuring medical equipment and materials essential for delivering comprehensive care, including resuscitation and delivery of all procedures, is available and in date.

The group found this domain easy to follow – the resources provided were simple and requirements were clear.

[View this domain](#)

### Domain 5: Whare haumanu | The practice

The final domain's focus is on assessing the compliance of practices with relevant legislation and New Zealand standards to ensure the safe delivery of health care services.

The group recognised this domain was necessary and needs to be part of Foundation Standard due to the legislative requirements. They appreciated the consolidation of the requirements as it made it easier to track and comply with. There was a suggestion for improving the guidance on emergency planning and business continuity.

[View this domain](#)

Overall, the attendees indicated high levels of satisfaction with the domains of the Foundation Standard and the need for it. They appreciated the opportunity to provide feedback to the team. The College will continue their engagement on the Foundation Standard as a way of continuous improvement for ensuring quality and patient safety in general practice.

If you have any questions about the Quality Programmes, please email [quality@rnzcgp.org.nz](mailto:quality@rnzcgp.org.nz)

All general practices in Aotearoa New Zealand are required to complete the Foundation Standard to receive Government funding and be recertified against the Standard every three years. All teaching practices must also be Foundation Standard certified for the duration of the GPEP registrars' hosting/employment and have either completed or be working towards completing the Equity and CQI modules for Cornerstone accreditation.



## MIND THIS

# A delayed diagnosis of urinary retention and prostate cancer

Dr Peter Moodie

## The HDC case

In April 2021 Mr B, a man in his 70s, presented to Dr C with atypical joint pains and a six-month history of lower urinary tract symptoms (LUTS). Mr B had a history of heart disease, and the urinary symptoms were described as polyuria at night. Dr C checked him out for signs of heart failure, but the primary focus was on the joint pains for which Dr C referred him to a rheumatologist. There is no further reference to this referral.

Mr B was seen in September 2021, again with joint pains and polyuria both in the day and at night, but with no hesitancy nor dysuria. Mr B was prescribed doxazosin (presumably for prostatic symptoms) and bloods were taken. These showed a moderate reduction in renal function and the patient was informed. There was no attempt to arrange for a PSA nor a urine test.

Mr B was seen again because of prostatism in November when it was noted that the doxazosin may have helped, and he was checked out for a possible urinary infection. At this consultation Dr C noted that they had overlooked recording that they had done a rectal examination at the previous consultation; Dr C did, however, incorrectly state that they had done this some “two weeks ago”.

There was a further consultation in December where his doxazosin was doubled.

In January 2022, Mr B was seen by another doctor (Dr D) with elbow pain and nocturia. He was prescribed frusemide. He was then seen again by Dr C who noted that (unsurprisingly) the frequency had become worse and so he stopped the frusemide. He was also again investigated for a possible urinary tract infection. The consultation also covered his joint pains, and he was prescribed prednisone and a further rheumatology referral was arranged.

On 4 March 2022 Mr B saw another doctor (Dr F) at the practice who arranged for bloods, including a PSA as well as an ultrasound of his bladder; however, despite two reminders on 5 and 20 March, the blood tests were not done. It appears that the prostate ultrasound was finally reordered on 28 March and carried out the next day.

Meanwhile on 24 March following the referral by Dr C in February, Mr B was seen by a rheumatologist who elicited that he had signs of prostatism, post-urinary dribble, low volume stream nocturia, daytime frequency and clinical signs of urinary retention. They also elicited that Mr B had a family history of prostate cancer. A blood test ordered by him showed a PSA of 240mcg/L.

Peter Moodie is the  
College's Clinical Advisor





At this point the actual order of events becomes confusing, but on 28 March Mr B complained to the practice nurse that he had had a terrible night with frequency, and he thought there was a “blockage”. Dr C saw him and thought his symptoms were consistent with a UTI. Dr C did not appear to be aware of the rheumatology opinion at that time. Dr C did not palpate Mr B’s abdomen. Dr C did however arrange for an urgent ultrasound which showed gross retention of urine, and when catheterised the next day by Dr C, drained a litre of urine. A subsequent urology referral showed that he had a carcinoma of the prostate with metastases.

### The HDC findings

Dr C was found to be in breach of the HDC Code because they:

- failed to discuss PSA testing with Mr B from September 2021 onwards
- did not arrange for a urine test in September
- did not palpate the patient’s abdomen on 28 March 2022
- retrospectively documented their DRE findings in November.

Most clinicians would agree that it would be wise to consider the possibility of urinary retention in a patient with chronic LUTS and examine his abdomen, and indeed consider the possibility of prostate cancer. The lesson is that when a patient is continuing to present with similar symptoms, it is critical to review the initial diagnosis. Further, when other doctors see a patient with those same symptoms, it is important to look at the problem with fresh eyes rather than follow the previous doctor’s provisional diagnosis.

Realistically it is likely that a PSA result would not have altered the outcome; but curiously there was no specific criticism of the delay in diagnosing the chronic urinary retention other than to note that on 28 March Dr C did not examine his abdomen.

### Commissioner comments

In this case the Commissioner has effectively decreed that a PSA test must be done or at least discussed when LUTS in a male is identified; however, there is no formal link to guideline groups.

There were a number of other criticisms and suggestions for improvement, but no other breaches of the Code were identified.

There was however one criticism of the practice’s management of test results. The Commissioner’s view was that, in addition to the two reminders sent to Mr B about the blood tests ordered on 4 March, the practice should have followed these up with a phone call. This is a high bar, and if this were to become a required standard of care some practices might grind to a halt.

If this level of follow-up is to be a requirement for primary care, then the same rules **MUST** apply to hospital outpatients, particularly for those who do not attend appointments or follow instructions. If a hospital refuses to do this on the grounds of a lack of resources, then the same excuse **MUST** also apply to primary care.

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The lesson is that when a patient is continuing to present with similar symptoms, it is critical to review the initial diagnosis.



# Urgent voices

Speaking up for vulnerable communities in health care

**Dr Francis Katoa FRNZCGP**

When I reflect on my childhood, I think of prayer, living rooms filled with hymns, family meals and laughter. I also remember the struggles we faced during those times. The feelings of helplessness watching family members suffer were profound – there was something deeply heartbreaking about wanting nothing more than to comfort and protect your loved ones but not knowing how. I vividly remember my mother’s silent prayers and tears, her hopes for our family’s healing amidst fears that seeking medical help would lead to cultural misunderstandings, leaving us feeling judged and powerless.

Now as a doctor, the most rewarding aspect of my work is seeing the anxiety patients bring transform into relief and comfort. By listening, drawing on my own experiences and truly connecting with them, I reassure them that they are not alone. These experiences fuel my dedication to ensuring my patients never face the same exclusion and helplessness that my family once felt.

Like many Pasifika families, the systemic barriers my family faced growing up now risk being amplified by current policy changes – changes that prioritise universalism and equality over equity. These policies threaten to undo the progress we have made and further marginalise our community. We will not accept this silently; we will respond with determined resolve.

The notion of equality – treating everyone the same – sounds fair, but it actually ignores the distinct challenges faced by marginalised communities. Such policies often exacerbate disparities by overlooking our unique cultural, social and economic contexts.

According to the latest data, Pasifika peoples in New Zealand have an unemployment rate of 9.3% compared to 3.6% for the general population (Stats NZ, 2023). Educational attainment also continues to lag behind, with only 60% of Pasifika students achieving NCEA Level 3 compared to 78% of the total student population (Education Counts, 2023).

Health outcomes are equally concerning. Pasifika peoples are three times more likely to be diagnosed with diabetes compared to other ethnic groups and rates of hospitalisations for heart disease are disproportionately higher (Ministry of Health, 2023). Life expectancy for Pasifika peoples remains significantly lower – around 75.5 years compared to 81.5 years for the general New Zealand population (Ministry of Health, 2023). These statistics make it clear: culturally competent health care that acknowledges and actively works to bridge these gaps is urgently needed.



Dr Francis Katoa

“

The notion of equality – treating everyone the same – sounds fair, but it actually ignores the distinct challenges faced by marginalised communities.



The current Government's measures to reduce national debt have disproportionately impacted vulnerable communities, including Pasifika families. Cuts to mental health support, housing assistance and community health programmes directly harm those most in need. Reduced investment in education exacerbates disparities, curtailing opportunities for future generations. Additionally, budget cuts in health care have left culturally competent care underfunded, abandoning patients without the support they need.

Critics might argue that equity-based solutions could foster societal division or lead to preferential treatment. However, equity is not about special treatment; it's about levelling the playing field by addressing unique barriers to ensure everyone has the opportunity to succeed. Without focused interventions, so-called equality-based policies perpetuate systemic inequalities, hindering marginalised communities from thriving. Addressing the specific challenges faced by minority groups like the Pasifika community through equity-based approaches ensures that everyone can prosper, ultimately benefiting all of society.

True empowerment extends beyond mere access to resources; it involves claiming the authority to lead our families, communities and institutions. Imagine a health care system designed with and for Pasifika, where cultural competence is foundational. Despite overwhelming evidence that culturally tailored health care improves outcomes, the current administration continues to overlook this, reinforcing existing inequalities and neglecting the voices of those already marginalised. Pasifika-led health initiatives have consistently shown improved engagement and better management of chronic diseases, highlighting the importance of self-determination in policymaking.

We cannot afford to wait for the next election to see change. The systemic barriers of the past persist today, and the Government's one-size-fits-all approach only worsens these inequalities. We must leverage our collective strength, advocate passionately and refuse to be overlooked. If the Government continues to ignore the evidence, we will make our presence and demands impossible to ignore.

This moment is pivotal for our communities. We cannot let broad, universal policies go unchallenged. Our lived experiences uniquely position us to advocate for solutions that genuinely serve our people. By standing together, we ensure our voices are heard and acted upon. We must advocate for policy changes that prioritise the wellbeing of our communities over fiscal austerity that disproportionately harms the vulnerable.

This commitment stems from seeing my own family members' silent tears and prayers, and from witnessing similar scenes in my consult room daily. It's for every parent silently praying for a health care system that understands their unique cultural challenges. It's for the young boy I once was, and for every child like him, watching their family struggle with physical and mental health issues, feeling powerless and wishing for someone to help. The time of being passive observers has ended; now is the time to come together to think of solutions.

**This is why we cannot remain silent.**

## References

1. **Unemployment Rate: Stats NZ.** (2023). **Labour Market Statistics.** Retrieved from [stats.govt.nz](https://stats.govt.nz)
2. **Educational Attainment: Education Counts.** (2023). **NCEA Achievement Data.** Retrieved from [educationcounts.govt.nz](https://educationcounts.govt.nz)
3. **Diabetes and Heart Disease Rates: Ministry of Health, New Zealand.** (2023). **Health and Independence Report.** Retrieved from [health.govt.nz](https://health.govt.nz)
4. **Life Expectancy: Ministry of Health, New Zealand.** (2023). **Life Expectancy and Mortality Statistics.** Retrieved from [health.govt.nz](https://health.govt.nz)



# ADHD advocacy

What the College is doing

**Dr Luke Bradford, Medical Director**

Over the past few months there's been a steady increase of coverage about ADHD – particularly about the impact that under-diagnosis and/or poor management can have on employment, welfare, mental health and corrections as people with ADHD reach adulthood.

The New Zealand Drug Foundation has recently released a report, [Neurodivergence and substance use](#), that shows a failure to adequately diagnose and treat ADHD is likely leading to significant drug harm, including from alcohol and nicotine.

NZ Drug Foundation Executive Director Sarah Helm says, “Making ADHD diagnosis and treatment more accessible would avoid significant amounts of harm and save the health system money.”

This report showed that youth with ADHD who received appropriate and timely pharmacotherapy had an 85% reduction in risk for developing a substance use disorder (SUD) compared to those not receiving treatment.

The [College has contributed](#) to the Pharmac proposals to fund lisdexamfetamine for ADHD and to remove the renewal criteria for stimulant treatments which will make a significant difference for clinicians and for people with ADHD.

The College will also be contributing to the consultation on the change of Gazette to include GP Fellows. The considerations around this relate to Special Interest work and longer non-funded appointments which means the user pays.

There is a need for guidelines around treatment and diagnosis, and the College is looking into how we can adopt the Australian guidelines and adapt them to suit our environment.

We are working with education providers like the Goodfellow Unit to ensure members have access to appropriate resources and training. There is also a peer group of College members who have a special interest in ADHD who meet regularly, and the College is working alongside them to progress work in this area.

On any given day, we as GPs manage many complex and varied conditions with our patients, and we are knowledgeable about when we need to refer a patient to another specialist or service where required for additional support or advice. As vocationally trained specialists we don't require supervision to offer ADHD consultations; however, members should ensure they undertake the appropriate upskilling and education if they are planning to offer this service.

“

There is a need for guidelines around treatment and diagnosis, and the College is looking into how we can adopt the Australian guidelines and adapt them to suit our environment.





If you have any feedback or queries on the College's involvement in this ADHD space, please feel free to contact me on [luke.bradford@rnzcgp.org.nz](mailto:luke.bradford@rnzcgp.org.nz) or either [Dr Antonia Arlidge](#) who is part of the ADHD peer group, or [Dr Sophie-Lee Mace](#), Chair of the national ADHD GP group.

Finally, thank you to the many members who have reached out with their support and offers to assist in this process.

Read more: [ADHD: Clear link between ADHD and harmful drug use, new report confirms](#)



# 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.

For between issue reading, [visit the 'online early' section](#).

### Trending articles:

1. [Cultural safety in paramedic practice: experiences of Māori and their whānau who have received acute pre-hospital care for cardiac symptoms from paramedics](#)
2. [The impact of nurse prescribing on health care delivery for patients with diabetes: a rapid review](#)
3. [Attention deficit and hyperactivity disorder and use of psychostimulants in Aotearoa, New Zealand: exploring the treatment gap](#)
4. [Exploring the role of physician associates in Aotearoa New Zealand primary health care](#)
5. [Ethical assessment of virtual consultation services: scoping review and development of a practical ethical checklist](#)



# Perioperative pathways

Dr Neeta Haribhai, FRNZCGP



Dr Neeta Haribhai

As general practitioners working in a community-based setting we might not think much about what happens in hospital when we refer a patient for surgery. However, as an Auckland-based general practitioner with nearly 30 years' experience providing perioperative medicine services in a hospital setting, I am passionate about this area.

I practise perioperative medicine as I believe a better informed and skilled general practitioner with knowledge of the whole surgical journey is of enormous value to the patient.

Perioperative medicine is a multidisciplinary medical service with the patient at the centre. As general practitioners, we have a role at the beginning of the patient's medical journey to optimise them for surgery and a role at the end when they are recovering.

Patients who are optimised for surgery have fewer postoperative complications, are discharged from hospital sooner and can save hospitals money. We can help them to prepare by assisting with smoking cessation, achieving a healthier weight, achieving target HbA1c and optimising blood pressure control prior to planned surgery.

Since complications arising after surgery are the third leading cause of death in the developed world, general practitioners can make a huge difference in this space. While our patients are having appointments in the hospital setting and preparing for surgery, they will continue to need us for their general health needs.

The Australian and New Zealand College of Anaesthetists (ANZCA) has long been working in this space to develop perioperative medicine in Australia and New Zealand. To this effect, it has been establishing a Chapter of Perioperative Medicine which recognises the multidisciplinary medical practitioners who perform perioperative medicine.

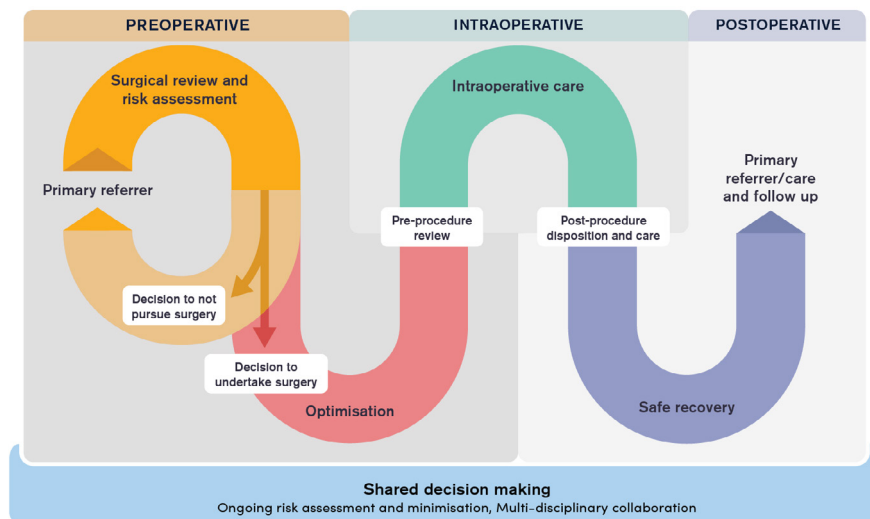
I have been working with ANZCA from the perspective of a New Zealand-based general practitioner and will be on two new committees that will be responsible for policy and advocacy as well as education.

ANZCA has recently extended the deadline for general practitioners practising in this field to become graduates of the Chapter of Perioperative Medicine (GChPOM) via its recognition pathway to 1 December 2024.

For those who haven't worked in perioperative medicine but are keen to learn, ANZCA has many good perioperative medicine resources such as the perioperative care framework, a document developed by a collaboration of stakeholder medical specialties that describes the optimised patient journey from beginning to end.



## From the contemplation of surgery to optimal outcome



ANZCA has developed a Course in Perioperative Medicine, which also confers its graduates with the GChPOM post nominals, and 2024 has been its inaugural year.

There is also a Perioperative Medicine Special Interest Group that is looking for further general practitioner members. Next month in Melbourne the special interest group is hosting a conference in Melbourne with the Perioperative Quality Initiative (POQI) and Summit III with the theme “Improve the quality, enhance the value, protect the future.”

The official launch of the chapter and a ceremony celebrating those who have been recognised as graduates will be held at the conference.

If you haven't already, I encourage you to consider perioperative medicine as part of your daily practice, and if you already practise perioperative medicine to apply to become a graduate via the recognition pathway.

It is important that perioperative medicine remains a multidisciplinary, cross-Tasman project that takes into account the unique perspectives of our specialty.

## Become a perioperative medicine graduate – 1 December deadline

GPs and rural hospital doctors with an interest in perioperative medicine have until 1 December to apply to become a graduate of ANZCA's Chapter of Perioperative Medicine via the [recognition pathway](#).

Successful applicants will be known as graduates of the Chapter of Perioperative Medicine (GChPOM) without having to complete the [ANZCA Course in Perioperative Medicine](#).

GPs play a crucial role in the patient's surgical journey, particularly at the beginning and the end, as can be seen in the [Perioperative Medicine Framework](#).

Please email [periop@anzca.edu.au](mailto:periop@anzca.edu.au) with any queries.

Submit your  
feedback



# GP access and surviving lung cancer

Characteristics and outcomes of lung cancer patients presenting through the emergency department.

**By Dr Ross Lawrenson FRCGP and FRNZCGP (Hon),  
Dr Rawiri Keenan FRNZCGP and Dr Chunhuan Lao (PhD)**

Surviving lung cancer in Aotearoa New Zealand could depend on whether you can access a GP – raising questions about equity in the country’s health system. Our new research examined the outcomes for patients who were diagnosed with lung cancer through their GP versus those who are diagnosed at the emergency department (ED).

Examining 2,400 lung cancer diagnoses in Waikato between 2011 and 2021, we found those who were diagnosed with lung cancer after ED visits tended to have later-stage disease and poorer outcomes compared to those diagnosed after a GP referral. We also found diagnosis after ED attendance was 27% higher for Māori than non-Māori and 22% higher for men than women.

## Health inequity and access to early cancer diagnosis

These results raise important questions about health inequity in Aotearoa New Zealand and highlight the need to ensure everyone is able to access an early cancer diagnosis. Currently half of all general practices have closed their books to new patients, leaving 290,000 patients unenrolled and reliant on ED for their health care. Some 80% of practices have closed their books to new patients at some point since 2019. For those who are enrolled in a practice, the wait times for appointments are often such that the only option is to go to the ED for help. This is especially true in rural areas where the hospital can become the default route to diagnosis.

Lung cancer is New Zealand’s single biggest cause of cancer deaths with over 1,800 per year. Some 80% of those who are diagnosed with lung cancer present with advanced disease and very poor prospects of survival. It’s also the cancer with the largest equity gap. While some of this disparity is due to differences in the rates of smoking among ethnic groups, we know delays in diagnosis and poorer access to surgery are also major influences on survival rates.

## The study results

Our study confirms earlier findings that those diagnosed through the ED are more likely to have advanced disease, more likely to have a more aggressive type of cancer (called small cell cancer) and have substantially poorer survival. The median survival for those who did not visit ED within 14 days prior to diagnosis was 13.6 months, while the median survival for those with one ED visit was just three months. That said, attending ED has some advantages.

“

Our study confirms earlier findings that those diagnosed through the ED are more likely to have advanced disease, more likely to have a more aggressive type of cancer (called small cell cancer) and have substantially poorer survival.





These include being seen by a doctor within a few hours, immediate access to X-rays and in our major hospitals access to the definitive diagnostic tool for a lung cancer – a computed tomography (CT) machine. Our study found 25% of cases went to the ED two or more times in the two weeks before their diagnosis. This was especially true for those going to one of the Waikato rural hospitals, where a second or third visit was more likely before being diagnosed.

It is clear New Zealand still has several barriers to primary care. This has led to an over-reliance on ED for diagnosing cancer, despite the long-running faster cancer treatment targets. Making general practice care more accessible is the most effective way of addressing the inequities in our lung cancer statistics. Currently, New Zealand has only 74 GPs per 100,000 people, compared to 110 in Australia. It is clear we need to substantially increase the number of GPs. This is a long-term project but needs to be a strategic goal for the health sector.

In the meantime, we need to make primary care more accessible by increasing patient subsidies and reducing the direct patient costs to see a doctor. At the same time, we need to better equip GPs with access to diagnostic facilities, including in our rural hospitals.

You can read more about the research in the New Zealand Medical Journal article below.

[Lawrenson R, Lao C, Nguyen H, Moosa L, Keenan R, Laking G, Wong J, Elwood M. Characteristics and outcomes of lung cancer patients presenting through the emergency department: a Waikato District Health Board study. N Z Med J. 2024 Sep 27;137\(1603\):14-24. doi: 10.26635/6965.6481.](#)

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# Understanding thyroiditis

By Dr Francis Hall

**T**hyroiditis refers to a group of conditions in which the thyroid is inflamed and may be classified in three different ways:

1. Clinical symptoms: Painless or painful
2. Onset: Chronic, subacute or acute
3. Aetiology.

Most forms of thyroiditis are painless. De Quervain's thyroiditis and acute suppurative thyroiditis are painful. Pain is a very helpful symptom in distinguishing between the different types of thyroiditis.

Most types of painless thyroiditis are autoimmune in nature. Hashimoto's thyroiditis, subacute thyroiditis and Graves' disease are all examples of thyroiditis with an autoimmune basis.

Chronic thyroiditis is Hashimoto's thyroiditis, subacute thyroiditis is either postpartum or De Quervain's, and acute thyroiditis is suppurative thyroiditis.

Many types of thyroiditis pass through four stages: thyrotoxicosis, euthyroid, hypothyroid and back to euthyroid. However, one or more of these stages may not occur. Thyrotoxicosis occurs when preformed thyroid hormones leak out into the circulation; therefore, antithyroid medication is not effective. Instead, beta blockers are used to control the symptoms of thyrotoxicosis. Graves' disease is due to stimulation of the thyroid by thyroid stimulating antibodies causing over production of thyroid hormones (hyperthyroidism).

Anti-thyroid medication (carbimazole) is therefore used to treat Graves' disease. If the decision is made to treat hypothyroidism it is treated with thyroxine at a dose of 1.6 microgram per kg per day. In elderly patients and patients with ischaemic heart disease thyroxine is started at a lower dose: 25 micrograms per day and titrated up every four to six weeks, depending on the results of blood tests (TSH and fT4).

## Hashimoto's thyroiditis (chronic lymphocytic thyroiditis)

Ninety-five percent of patients with Hashimoto's thyroiditis are women, and it commonly presents in the 30–50-year-old age group. It is the most common cause of hypothyroidism. Because about 50% of people with Hashimoto's thyroiditis eventually develop hypothyroidism, it is recommended to request annual thyroid function tests. Rarely, Hashimoto's can present with thyrotoxicosis – Hashitoxicosis. There is an increased incidence of lymphoma



**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.



of the thyroid in people with Hashimoto's. Most patients are thyroid antibody (thyroid peroxidase antibody) positive. Ultrasound scan shows an enlarged diffusely hypoechoic thyroid. Investigate any suspicious nodules with ultrasound-guided FNA. See the article on thyroid nodules in the [June issue of GP Voice](#) for more information.

### Subacute thyroiditis (Postpartum thyroiditis)

This usually occurs 3–12 months postpartum. Sometimes it occurs sporadically. It presents as a small painless thyroid and symptoms of thyrotoxicosis (tachycardia, heat intolerance, nervousness, weight loss). It typically goes through the four stages discussed above and approximately 30% develop permanent hypothyroidism. Treatment is as outlined above. It is very likely (70%) to occur in subsequent pregnancies.

### De Quervain's thyroiditis (subacute granulomatous thyroiditis)

De Quervain's presents with pain and tenderness of the thyroid. Patients usually also complain of pain on swallowing. Geographical and seasonal (summer and autumn) clustering of cases occurs. Many viruses including mumps, echovirus, EBV, influenza and adenovirus have been implicated. A markedly raised ESR and raised thyroglobulin level are seen. A normal ESR or a normal thyroglobulin level rules out the condition. It typically goes through the four stages discussed above and approximately 10% develop permanent hypothyroidism. Treatment is as outlined above. The pain usually responds to high-dose NSAIDs (ibuprofen up to 1800mg per day). If the pain is not controlled within four days, commence high-dose prednisone. Patients may need to be on prednisone for up to 4–6 weeks before weaning slowly off prednisone.

### Acute suppurative thyroiditis

Acute suppurative thyroiditis is uncommon. It is usually caused by Staph aureus or Strep spp. It is associated with either immunosuppression or fistula of the pyriform sinus. It presents with a systemically unwell patient with fever and a tender, enlarged thyroid lobe. The overlying skin may be erythematous. The ESR and CRP are elevated. Treatment is with antibiotics. There should be a low threshold to request an ultrasound, which may reveal an abscess. Any abscess should be drained surgically. Subsequent elective hemithyroidectomy plus or minus excision of any associated fistula may be required. Pharyngoscopy may reveal the opening a fistula in the pyriform fossa (third and fourth arch congenital branchial cleft fistula).

### Riedel's thyroiditis

Riedel's thyroiditis presents as a bony, hard thyroid mass. About one third of patients develop other areas of fibrosis, including sclerosing cholangitis, retroperitoneal fibrosis or orbital pseudotumour. Diagnosis is with a biopsy. Sometimes hemithyroidectomy is required to make the diagnosis. Treated as symptomatic or surgical depending on the severity of the symptoms and



the certainty of diagnosis. Excising the thyroid isthmus may be enough to relieve symptoms in some patients. Medical treatment with prednisone, mycophenolate or tamoxifen has been tried.

**Graves' disease** [See the October issue of GP Voice.](#)

## Drug-induced thyroiditis

Several drugs may induce thyroiditis. Amiodarone and lithium are probably the best-known drugs to induce thyroiditis. Other drugs that can induce thyroiditis include immune checkpoint inhibitors and tyrosine kinase inhibitors. Radiotherapy and RAI may also induce thyroiditis.

## Summary

Thyroiditis is best categorised by the presence or absence of pain. Pain from De Quervain's is treated with high-dose NSAIDs or prednisone. Some patients with thyroiditis develop permanent hypothyroidism. Surgery is reserved for patients with a thyroid abscess, symptoms from an enlarged thyroid or as definitive treatment of Graves' disease and some cases of drug-induced thyroiditis.

## References:

1. **Martinez Quintero B, Yazbeck C, Sweeney LB. Thyroiditis: Evaluation and Treatment. Am Fam Physician. 2021 Dec 1;104(6):609-617.**
2. **Lafontaine N, Learoyd D, Farrel S, Wong R. Suppurative thyroiditis: Systematic review and clinical guidance. Clin Endocrinol (Oxf). 2021 Aug;95(2):253-264.**
3. **Ragusa F, Fallahi P, Elia G, Gonnella D, Paparo SR, Giusti C, Churilov LP, Ferrari SM, Antonelli A. Hashimotos' thyroiditis: Epidemiology, pathogenesis, clinic and therapy. Best Pract Res Clin Endocrinol Metab. 2019 Dec;33(6):101367.**

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# Diabetes Action Month

## Busting diabetes myths and stigma

November is Diabetes Action Month when New Zealanders are encouraged to take action to support those living in Aotearoa with diabetes, raise awareness of one of our fastest-growing health conditions and share a greater understanding of what having diabetes actually means.

This year, the theme for the month is: ‘Don’t Sugar Coat Diabetes – Kaua e whakareka i te Mate huka’ which is all about busting myths and breaking down stigma. It’s also an opportunity to remind people to take the time to find out the signs and symptoms of diabetes and become aware of their own risk.

At Diabetes New Zealand, we hope that if we all:

- **get the facts:** learn the truth about diabetes | mate huka and dispel common myths,
- **get tested:** know the symptoms of Type 1 and Type 2 diabetes, find out our risk of developing Type 2 and encourage others to get tested, and
- **show more aroha:** find out how to support friends and whānau living with diabetes,

...then we will reduce judgement and stigma of people with diabetes.

Diabetes New Zealand is launching various initiatives throughout November to raise awareness and funds to support those living with diabetes. This includes a new diabetes health resource – a myth-busting guide to dispel common myths and provide accurate information about diabetes for everyone – as well as our ‘Know Your Risk’ quiz, new videos, social media content and a podcast, and our central fundraising event, Sneaker Friday.

We know from a recent survey that people with diabetes have been told things like: “only overweight people get diabetes” and “eating too much sugar causes diabetes,” which is not only hurtful but shows a real lack of understanding about what diabetes is.

We will be encouraging people to be brave and call out the misinformation they hear as well as getting informed about the symptoms of diabetes, including:

- thirst
- mood changes
- passing more urine
- getting infections frequently
- weight loss
- poor eyesight or blurred vision.
- extreme tiredness

World Diabetes Day also falls on 14 November, which focuses on wellbeing. Having access to the appropriate care and support – including for mental health – is crucial to enabling people to live well with diabetes. We have a dedicated ‘Diabetes Distress’ tool at Diabetes New Zealand that outlines some simple actions people can take if their diabetes is causing significant levels of distress in their daily lives.

To learn more about the initiatives from Diabetes New Zealand that will be running throughout Diabetes Action Month, please visit:

[www.diabetesactionmonth.org.nz](http://www.diabetesactionmonth.org.nz)

“

Having access to the appropriate care and support – including for mental health – is crucial to enabling people to live well with diabetes.





# Revolutionising IBD care

GPs invited to co-design world first mobile app

**By Crohn's Colitis Cure**

Digital solutions and access to quality data are transforming the management of chronic diseases like Inflammatory Bowel Disease (IBD). General practitioners in Aotearoa are invited to join a groundbreaking initiative to enhance IBD care through a world-first mobile app, now in its consultation and co-design phase.

Developed by Crohn's Colitis Cure (CCCure), this innovative app links patient-reported data with clinical data, enabling more accurate records, efficient consultations and personalised care journeys.

Supported by organisations such as Crohn's & Colitis New Zealand and international bodies like the Crohn's & Colitis Foundation (USA), the app addresses gaps in health care management and therapeutic innovation.

IBD affects millions of people globally and is increasingly diagnosed in younger individuals. New Zealand has one of the highest rates of IBD in the world; at least 20,000 people are currently estimated to be affected (one in every 227 people) – approximately the same as the number of people with Type 1 diabetes.<sup>1,2</sup>

This places GPs at the forefront of managing these young people with IBD over a longer period. Additionally, older people with IBD often have significant comorbidities, further complicating treatment. For GPs, particularly those in rural communities where access to specialist care is limited, the responsibility is even greater. The complexity of care, coupled with fragmented health care data, poses challenges for both GPs and people with IBD.

Professor Richard Gearry, a New Zealand gastroenterologist and CCCure Director, highlights the app's potential. "Addressing known IBD issues could potentially reduce avoidable morbidity, minimise time out of work and optimise care-related costs for people with IBD. For GPs, it could support increased efficiency in consultations and create more engaged, proactive, high-value care."

The CCCure app, expected to enter pilot testing in 2025, offers GPs up-to-date patient information while providing people with IBD a central platform to manage their health. Accessible via smartphones, tablets and web browsers, it integrates person-reported data with clinical records, streamlining communication and reducing reliance on GPs for routine tasks.



**Bill Petch**  
CEO of CCCure



**Prof. Richard Gearry**  
CCCure Director



Thanks to the linked data functionality, the app will be able to offer care plans that adjust in real-time based on individual symptom tracking, lifestyle data and clinical information like medication adherence and test results. This ensures patients receive personalised, actionable advice tailored to their current health status.

The app will continuously generate data-driven insights, such as symptom trends, treatment effectiveness, and the impact of lifestyle choices. People and their GPs will be empowered to quickly grasp what is working and what requires attention.

CCCure invites GPs to join the consultation process to ensure it meets the needs of people with IBD and health care professionals.

Bill Petch CEO of CCCure says, “Consultation with GPs is critical to improve engagement and care personalisation for people with IBD. No matter how good a country’s health system may be, some of the biggest issues for people with IBD and their clinicians are access to information and navigation of care. The more inaccurate or delayed the information, the less optimal the care journey and therefore the burden of disease remains or grows, as does the financial and time burden to all involved, including health systems and governments.”

With no cure for IBD, effective management tools are essential. This app could bridge gaps in care, especially in rural areas, improving access to health data and reducing strain on health care systems.

The creation of the app is supported and funded by the US-based Leona M and Harry B Helmsley Charitable Trust.

For more information or to participate in the consultation process visit [www.c-c-cure.org](http://www.c-c-cure.org) or contact [info@c-c-cure.org](mailto:info@c-c-cure.org).

### References:

1. **bpac<sup>nz</sup>. Inflammatory bowel disease – a focus on Crohn’s disease and ulcerative colitis [Internet].** bpac<sup>nz</sup>; 2021 Feb 1.  
Available from: <https://shorturl.at/OHSTE>
2. **Morton H, Coad J, Pedley KC, Irwin JR. Incidence of Inflammatory Bowel Disease in New Zealand Remains High, Findings in the Manawātū Region.** Dig Dis Sci. 2023 Nov;68(11):4230-4242. doi: 10.1007/s10620-023-08070-5. Epub 2023 Sep 2.  
Available from: <https://pubmed.ncbi.nlm.nih.gov/37659030/>



# #MedSafetyWeek 2024

[#MedSafetyweek](#) runs from 4 to 10 November 2024 to raise awareness of reporting adverse reactions to medicines. There are 92 organisations across 86 countries getting involved, including Medsafe and the RNZCGP in New Zealand.

This year we are focused on the prevention of adverse reactions through the safe use of medicines and reporting suspected adverse reactions when they occur.

## Reporting adverse reactions contributes to safety monitoring

Adverse reaction reports form an important part of pharmacovigilance in New Zealand. Your reports enable Medsafe to quickly identify and respond to emerging medicine safety issues. Reports are entered into a database that is used for detection of safety issues through review of individual cases and disproportionality analysis. Information from relevant cases is used to inform Medsafe's evaluations and actions on safety issues.

New Zealand has historically had a high rate of adverse reaction reporting and health care practitioners have played an important part in helping Medsafe identify medicines safety issues. General practitioners are in a good position to identify and report adverse reactions because of the trusted relationships they have with their patients.

An example is Fournier's gangrene associated with empagliflozin. A series of local reports in 2022 showed a high proportion of cases in Māori and Pacific peoples highlighting a need for further action. This prompted Medsafe and CARM to promote awareness of Fournier's gangrene among health care professionals in Prescriber Update articles. Medsafe also created an information leaflet for patients in English, te reo Māori and Samoan with information on recognition and prevention of Fournier's gangrene through careful hygiene measures.

## Prevention of adverse reactions

Adverse reactions are an inherent risk of treatment with medicines. However, the risk of some adverse reactions can be mitigated with careful prescribing, monitoring and patient education.

Some ways to prevent adverse reactions include the following:

- Identifying patient risk factors for adverse reactions by checking the warnings and precautions for the medicine and selecting treatments accordingly
- Checking for drug interactions including additive pharmacological effects (e.g. QT prolongation or anticholinergic burden)
- Educating patients on safe use of the medicine



- Educating patients to self-monitor for symptoms of serious adverse reactions and get medical attention early
- Reviewing and discontinuing medicines when they are no longer needed
- Identifying and documenting previous adverse reactions to avoid inadvertent re-exposure. When you report an adverse reaction, the Centre for Adverse Reactions Monitoring (CARM) can add an alert to the [Medical Warning System](#)
- Avoiding additional medicines to manage adverse reactions unless the medicine cannot be withdrawn or changed.

Check [medicine data sheets](#) and local guidelines for information on known adverse events, risk factors and recommended monitoring.

## How to report adverse reactions

Medsafe wants to hear when your patients have a reaction that might be connected to their medicines. You can make a report using the [Centre for Adverse Reactions Monitoring online reporting form](#). Some practice management software includes a reporting feature.

Anyone can submit a report. You don't need to be certain that the medicine caused the reaction – just suspicious. You should get consent from your patient before you make the report.

## What to report

There are only four requirements for a valid report, but the more information you can provide, the better. The essential pieces of information for a valid report are:

- one patient identifier (e.g. name, initials, gender, age)
- a suspect medicine
- an adverse reaction
- reporter details.

Additional information is valuable for Medsafe and CARM's investigation of safety concerns. Some examples of helpful details include:

- dates medicines were started and stopped
- concomitant medicines
- date of onset and clinical course of the adverse event
- results of investigations
- diagnosis
- medical history
- medicine dose and brand
- whether the reaction improved after stopping the medicine
- outcome of rechallenge.

## Getting involved with #MedSafetyWeek

During #MedSafetyWeek 2024 you can raise awareness of reporting suspected side effects by using the hashtag #MedSafetyWeek on social media and resharing posts from the Ministry of Health and RNZCGP.

You can also [subscribe to Medsafe safety communications and Prescriber Update](#).



# Understanding Tourette Syndrome

The critical role of early diagnosis by GPs

By Tourette's Association of New Zealand

**T**ourette Syndrome (TS) is a neurological condition characterised by involuntary movements and vocalisations or tics. Despite affecting 1% of the population, TS is often underdiagnosed, misunderstood or overlooked and sometimes dismissed as a behavioural issue. In New Zealand, TS is not always recognised as a disability, which can limit access to support services.

For GPs, especially in rural areas, early diagnosis is crucial for ensuring patients receive appropriate care.

## What is TS?

TS is diagnosed by the presence of both motor and vocal tics lasting more than a year. Tics vary in complexity from simple movements like blinking to more elaborate and often debilitating behaviours. Although coprolalia (the involuntary uttering of obscenities) is often associated with TS in popular culture, it occurs in only about 10% of cases.

TS frequently coexists with other conditions such as ADHD, OCD and anxiety. These comorbidities can obscure the diagnosis, making it vital for GPs to recognise the signs early.

## Challenges in diagnosis: GPs can diagnose TS

Patients with TS often suppress their tics during brief consultations, making diagnosis difficult. GPs should encourage families to record tics on video or keep a diary to track symptoms over time. This additional information can provide crucial insights that may not be evident during an appointment.

GPs can and should diagnose TS based on patient history and observations, as specialist referral isn't always necessary for diagnosis. Early identification is critical to ensuring appropriate treatment and support.

## Why is diagnosis important?

- 1. Clarity and understanding:** For many families, a diagnosis helps alleviate stress. Recognising TS as a neurological condition rather than a behavioural problem provides clarity.
- 2. Access to treatments:** While there's no cure for TS, several treatments can manage symptoms. Comprehensive Behavioural Intervention for Tics (CBIT) is an effective therapy, and medications may be prescribed in certain cases. Early diagnosis allows for timely intervention improving the patient's quality of life.





3. **Managing comorbidities:** Since TS often coexists with conditions like ADHD or OCD, a clear diagnosis enables holistic treatment, addressing both the tics and related issues.
4. **Government and financial support:** Although TS is not universally recognised as a disability in New Zealand, some financial support options exist. A diagnosis can help families navigate these services and advocate for the support they need.
5. **Educational and social support:** For children, a formal diagnosis can lead to access to individualised education plans (IEPs) and classroom accommodations. Early intervention helps prevent academic struggles and social isolation.

## What GPs can do

- **Encourage documentation:** Suggest patients or families document tics with video recordings or a diary to capture their severity and frequency. This helps paint a fuller picture, especially when symptoms are less noticeable in clinical settings.
- **Diagnose with confidence:** GPs can diagnose TS, especially if tics have been present for over a year. While referral to a specialist may be beneficial in complex cases, a GP diagnosis can set patients on the right treatment path without unnecessary delays.
- **Explore treatment options:** Based on the severity of symptoms, GPs can recommend behavioural therapies like Comprehensive Behavioural Intervention for Tics (CBIT), which is the mainstay of intervention. Pharmaceuticals are generally reserved for more severe cases, and their initiation is best done after specialist input.
- **Refer for further support:** GPs can direct patients to organisations like the Tourette's Association of New Zealand (TANZ) for additional support and guidance, including help navigating assistance programmes.

## Conclusion

Early diagnosis of TS allows GPs to play a critical role in improving patient outcomes. By recognising the signs of TS, encouraging documentation and ensuring timely access to treatments and support, health care providers can make a significant difference for patients and their families.

For more information on identifying Tourette Syndrome you can visit this [website](#) or you can contact the Tourette's Association of New Zealand on their website: [www.tourettes.org.nz/](http://www.tourettes.org.nz/).

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