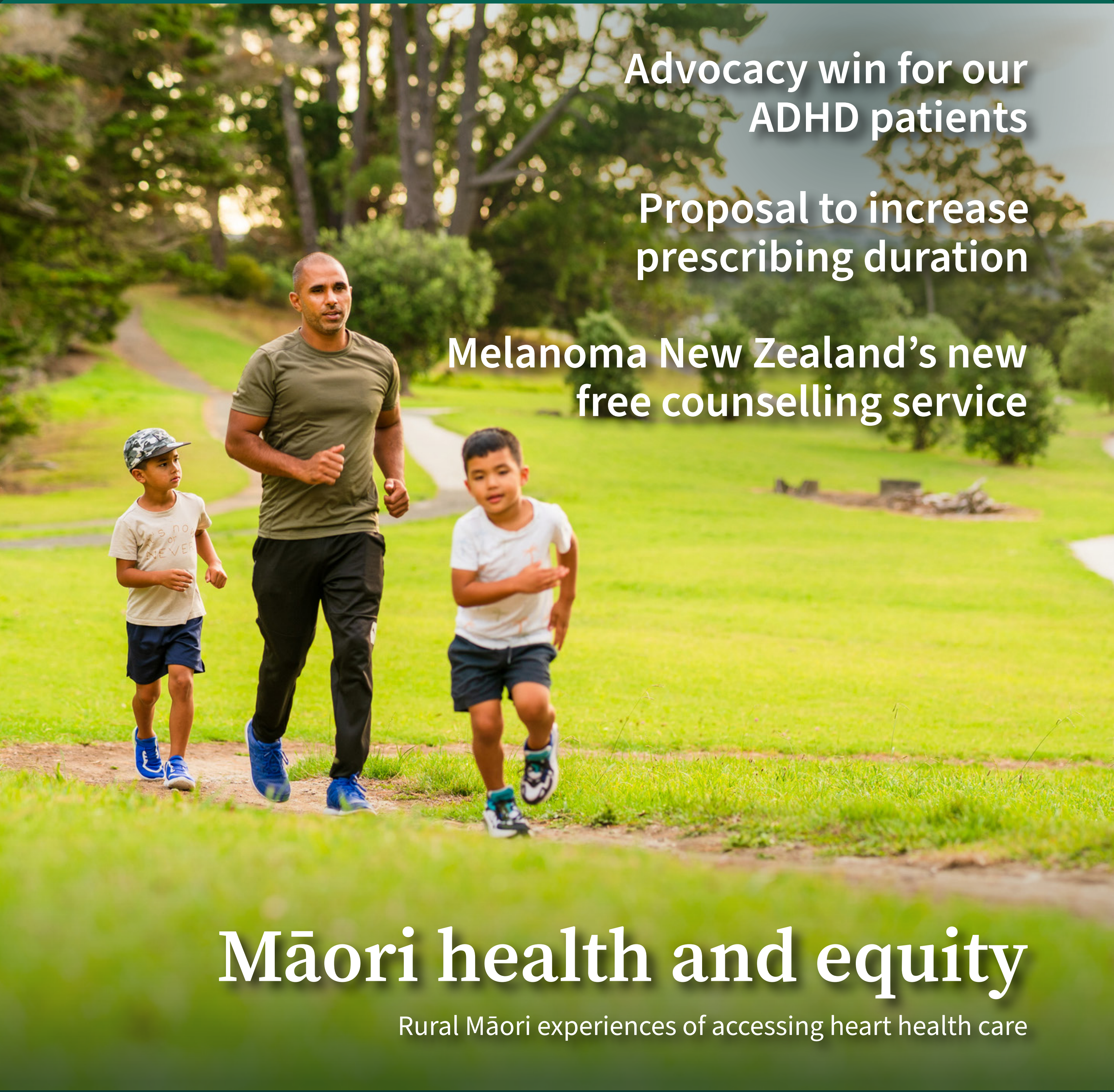
GP Voice

YOUR NEWS, YOUR VIEWS, YOUR VOICES



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

December 2024

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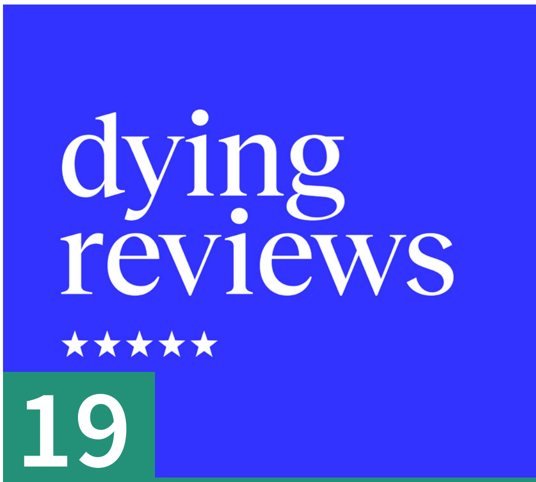


Editorial

Dr Samantha Murton

Welcome to the final issue of GP Voice for 2024.

Firstly, I'd like to say a big thank you to the 1,372 members who took the time to complete the Workforce Survey. This is the biggest source of data collection we do as a College looking into our workforce, and we use it frequently to reinforce our calls for action and highlight the crucial role we play in improving the health of New Zealanders and within the sector.

Work has already begun on analysing your responses and collating the data that will form the basis of our findings and reports. We are looking forward to having the findings ready to share with you in early 2025.

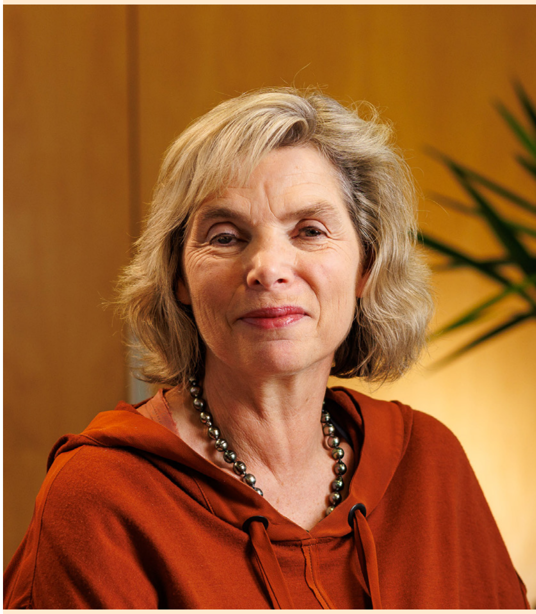
With this being the last issue of the year, I thought I'd share some highlights from 2024.

The College conference is always a highlight for me and a time to connect and engage with new and familiar faces. This year's conference marking the 50th anniversary of the College was even more enjoyable with all the 70s touches incorporated into the programme, the stand and the 50th anniversary conference dinner. Getting our rules changed at the AGM to better reflect our Te Tiriti o Waitangi commitment was also very gratifying from my perspective. As a College, we are leading the way in this area and should be proud of ourselves. My role as chair of the Council of Medical Colleges has also enabled all Colleges to work together on cultural safety training in all vocational programmes. I would suggest that we are a world leader in this area too. I highly recommend you read our media statement calling for the Government to drop the Principles of the Treaty of Waitangi Bill.

We don't often see all the College activity that goes on and the incremental changes that make a difference for members day to day. The College's work on ADHD medications has been exemplary and the changes that have recently been announced will make a huge difference to patients as well as our own clinical practice.

I hope all of you have downloaded the College app and looked at all the discounts available – especially for any DIY projects over the summer. There are many great discounts for you to take advantage of as a College member. Download the app by searching 'RNZCGP' on either Google Play or the App Store.

The Medical Council reaccreditation review was a lot of hard work and landed well with only a small number of changes needing to be made, many of which are under way. I would like to thank the Registrar Chapter for helping us put forward a proposal for changes to GPEP that will make our programme genuinely three years with no cost to the trainee. Watch this space!



Dr Samantha Murton
President | Te Tumu Whakarae

> "The College team's work on ADHD medications has been exemplary and the changes that have recently been announced will make a huge difference.

I'd like to acknowledge the Board, Toby, Luke and the whole College team for their work over the year. There are many moving parts that go on behind the scenes, and the commitment and dedication to the College and the members is great to see.

To you, the members, thank you again for all your work over the year too. It's been another year of uncertainty and frustration, but there have been wins and successes that you have played a part in – whether that be from your participation in the Your Work Counts project, your feedback for College submissions, advocacy, training our future workforce or for turning up each day to provide care to those in your communities. It all makes a difference to our work in improving health outcomes for New Zealanders.

The College office will be closed from Saturday 21 December and will re-open on Monday 6 January 2025, so please contact the College team with any questions or requests you have before then.

Enjoy this month's issue and all the best for the holiday season.

SAM

Goodfellow Unit podcast: **Maternal mental health**

Dr Mathanki Vivekananda graduated from Auckland Medical school in 2013 and has worked in Rotorua, Kenya and Wellington where she completed further training in psychiatry. She now works as a GP in Tauranga. Mathanki has a strong passion for mental health and is thrilled to be a board member for PADA (Perinatal Anxiety and Depression Aotearoa).

In this podcast Mathanki discusses postnatal depression and other mental health conditions. The key take-home messages of this podcast are:

- Screen for maternal mental health during the first 12 months of postnatal period
- Follow up with Edinburgh PDS if needed
- Investigate clinician resources and community support services.

Listen to the podcast

Submit your feedback

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 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 from November.

2024 Workforce Survey

The 2024 Workforce Survey closed on Sunday 24 November. The survey was completed by 1,372 of members. The data will now be collated and analysed, with findings shared in early 2025. Thank you for taking the time to have your say.

Advocacy win: Decision to fund lisdexamfetamine and remove renewal criteria for stimulant treatment

From 1 December 2024 Pharmac will now fund lisdexamfetamine for the treatment of ADHD and remove the renewal criteria for stimulant treatments – methylphenidate, dexamfetamine and modafinil used in the treatment of ADHD and narcolepsy.

Read the College's submission to Pharmac. See more information in the article on page 8 of this issue.

Advocacy win: Audiology referring directly to ENT

Dr Luke Bradford has been working with the New Zealand Society of Otolaryngology Head and Neck Surgery (NZSOHNS) to agree on a process for audiology referrals going directly to ENT rather than via GPs.

At the NZSOHNS AGM it was agreed that:

- NZSOHNS supports the direct to department referral from audiologists for asymmetric sensorineural hearing loss.
- Due to a lack of gold standard audiometric criteria, NZSOHNS supports the use of existing department referral criteria.
- For departments seeking audiometric referral criteria guidance it is reasonable to use a rule of 30, whereby significant threshold differences of 30 dBHL at a single frequency or 15 dBHL at two adjacent frequencies or 10 dBHL at three adjacent frequencies constitute a significant asymmetry.
- Patients under 75 years with the above audiometric criteria should be considered for direct to department referral. Patients over 80 years with the above criteria but no red flags* do not need to be referred for imaging. Patients between 75 and 80 years with no red flags* should continue to be referred to their GP via existing pathways for medical review and consideration of referral for imaging, but imaging is not obliged.

- Patients with asymmetric non-pulsatile tinnitus should be reviewed with audiometry and only referred for imaging if they meet the audiometric criteria above. It is recommended they have repeat audiometry in 6–12 months to check for an evolving audiometric asymmetry.

*Red flags = facial dysaesthesia (sensation changes), unusual balance or coordination issues, unusual headaches, or facial weakness.

ACC

Dr Luke Bradford met with the ACC team on GP specialist recognition in Cost of Treatment Regulations (COTR). Dr Bradford argued that there needs to be transparency, recognition and fairness. ACC took this on board and are exploring options internally with the Ministry of Business, Innovation and Employment (MBIE) and the Minister to address our concerns and recognise general practice training as the optimum to ensure good primary care delivery.

Conference presentations

During November, Dr Luke Bradford participated in two panel discussions. At the Pasifika Medical Association (PMA) Conference 2024 in Ōtautahi Christchurch he spoke about the role of the College and how we are working to grow the workforce. At the ASMS 36th Annual Conference in Te Whanganui-a-Tara Wellington he spoke about the importance of continuity of care.

National Quality Forum

This is a quarterly meeting of the clinical and quality leads from MoH, HNZ, HQSC, Cancer Control Agency, Pharmac and others responsible for oversight and governance of the clinical safety and quality of the system. The College is primary care's representative and Dr Luke Bradford attends on your behalf.

Te Manawa Taki Clinical Leads Forum

Dr Luke Bradford attended and presented on the College's role in ensuring teaching is recognised and resourced for specialist GPs who teach medical students, house officers, registrars and the MDT.

November submissions

Here are the recent College submissions:

- Pharmac – Proposal to fund β-hCG low sensitivity urine test kits
- Ministry of Health – Hauora Māori Strategy

If you are looking for other submissions, make sure you check out the revised submissions page on our website.

Submit your feedback

Advocacy win for our ADHD patients

Dr Luke Bradford, Medical Director

Over the past year or so a lot of work has gone on behind the scenes with members and other organisations to advocate for changes that would make a significant difference for clinicians and for our patients who have been diagnosed with ADHD.

As of the beginning of this month, Pharmac has begun to fund lisdexamfetamine for the treatment of ADHD and remove the renewal criteria for stimulant treatments – methylphenidate, dexamfetamine and modafinil used in the treatment of ADHD and narcolepsy.

The College supported the removal of the renewal criteria, and this is a positive outcome for patients in continuing access to medicines and treatment. It supports continuity of care and will relieve the bureaucratic burden on GPs having to chase Special Authority (SA) reviews.

Moving forward, the College will work with education providers to ensure there are resources around dose titration and formulation changes which will allow members to upskill and feel confident in this skill. Below are some resources for members who are interested in upskilling in this area:

goodfellowunit.org/podcast/adhd-assessment-and-diagnosis

goodfellowunit.org/podcast/adhd-management

goodfellowunit.org/podcast/adult-adhd

goodfellowunit.org/events-and-webinars/primary-care-management-adhd

Read the College's submission to Pharmac. Thank you to all the members who provided feedback for this submission.

Submit your feedback

2024 Workforce Survey

Thank you and next steps

The 2024 Workforce Survey closed on Sunday 1 December. Thank you to the 1,372 members who completed the survey to share your perspectives and feedback about the sector, the workforce and your place in it.

The College's Policy, Advocacy and Insights team will now collate and analyse all your responses and feedback. We're looking forward to having the findings ready to share with you all early in the new year.

With our Workforce Survey being done every two years, the data and findings from our 2022 survey findings are still being regularly referenced. The importance of getting responses from our members from every corner of the motu means we have a current and accurate view of our members, the workforce and the work you are doing now in 2024. It also means we can compare findings from previous years to see what has changed or stayed the same and compare your feedback and answers.

The open text box asking about what you love about being a GP/rural hospital doctor will also be incorporated into our ongoing promotion to medical students, graduates and PGY1/2 doctors to showcase the rewarding nature of the job as we push to grow our workforce.

The Workforce Survey is the College's biggest source of workforce data and is referred to extensively throughout the health sector to further understand what and where the challenges lie within the sector as well as providing the data to back up the College's calls for action through its policy and advocacy work.

The findings are used regularly to tell your stories in the media to raise public awareness of the work you do as specialist GPs and rural hospital doctors, and the crucial nature of your roles in improving health outcomes for all New Zealanders.

We look forward to sharing the findings of the survey with you in the new year and getting more of an understanding of what it is like to be working on the frontline of community medicine in New Zealand in 2024.

> “
> The findings are used regularly to tell your stories in the media to raise public awareness of the work you do as specialist GPs and rural hospital doctors...

Submit your feedback

Proposal to increase prescribing duration

Dr Luke Bradford, Medical Director

In October the Ministry of Health consulted on a proposal to increase the period of supply limit from three to 12 months.

Although there was only a short timeframe for such a significant consultation, we had an unprecedented level of response from members with over 120 emails, raising critical concerns for patients, specialist GPs and practices alike.

The College's Policy, Advocacy and Insights team and I reviewed all your feedback, which formed the basis of the College's submission.

Based on the feedback from members, the College's submission did not support the proposed amendment to increase the period of supply limit (prescribing duration) from three to 12 months. The submission supported a six-month prescribing duration as a safer and more appropriate option.

We outlined what occurs with a repeat prescription and highlighted that our concern is that practices will need to find ways to ensure these essential patient-safety steps occur – but in doing so it will lead to increased and more non-remunerated, non-contact work, further stressing the system.

However, we noted that the proposal is at clinician discretion and that some medications and some patients could be suited to a longer prescription length, and a number of members did advocate for this; hence the College's support for a six-month prescription length.

Thank you to the many members who provided feedback to support the College's submission on this important topic. A wide range of views were submitted, and it was important for us to ensure everyone's voice was heard and represented. We will keep you updated with any response from the Ministry or changes that come from this consultation.

You can read the submission on our website.

> "We outlined what occurs with a repeat prescription and highlighted that our concern is that practices will need to find ways to ensure these essential patient-safety steps occur...

Submit your feedback

MIND THIS

A missed pregnancy

Dr Peter Moodie

On 1 June 2021 Ms A, whose second child had been born three months previously, had a long-acting reversible contraceptive (LARC) inserted by Dr B. On 23 September 2021, Ms A realised that she was pregnant, and a subsequent ultrasound identified that she had probably conceived some 13 days before the LARC insertion. Ms A was distraught about finding herself pregnant so soon after her recent delivery, but a termination was not possible because an ultrasound in October showed the gestational age of the foetus to be over 21 weeks. She laid a complaint with the HDC.

The background

Ms A contacted her medical centre on 26 May requesting a LARC as she was familiar with this type of contraception. A phone consultation was arranged with her usual doctor (Dr C) for the next day; however, Dr C was unable to contact her. Realising that there was some urgency, Dr C:

- sent Ms A a text message informing her that she could combine the LARC insertion with a cervical smear (which was obviously due) and her baby's three-month immunisation
- sent information about Jadelle (LARC) insertion via Manage my Health
- suggested that, because of time constraints, Dr B should carry out these procedures; Dr B was a registrar but well conversant with LARC insertion
- arranged for a practice nurse to ring Ms A and confirm that she was fully breastfeeding, and if she was, she should be offered an iodine supplement, but if she wasn't then to offer her condoms. Ms A apparently declined the offer of the condoms but there was no evidence that she was offered iodine.

The LARC insertion

Dr B's case notes record that they obtained informed consent, discussed side effects and provided an opportunity for Ms A to ask questions. The computer records showed that a consent form had been generated, but there wasn't a scanned copy of the signed consent form. The (unsigned) consent form specifically stated that the patient had a pregnancy test done at the consultation and that she had been given a further test to self-administer some weeks later. Ms A stated that she did not have a pregnancy test done.

With the passage of time, Dr B could not recall the actual consultation and could not explain why there was no signed consent form uploaded onto the computer. Dr B did, however, say that they could not see why they wouldn't have followed their normal procedures for a LARC insertion, including checking for an unintended pregnancy. Dr B did, however, note that Faculty of Sexual and Reproductive Health (FSRH) criteria stated that if the baby was fully breastfed, was less than six months old and the woman was amenorrhoeic (LAM test), a pregnancy test was not required.

Peter Moodie is the College's Clinical Advisor

The Commissioner was critical that there was no documented discussion about the risk of pregnancy nor was there a signed consent form.

The Commissioner considered four different scenarios, including the possibility that Dr B did assume that Ms A was fully breastfeeding and had relied on the prior actions of Dr C. However, on the balance of probabilities, she concluded that the risk of pregnancy was not discussed, no pregnancy test performed, and no advice given on post-insertion risks. Dr B was found to be in breach of the Code.

Lessons learned

- When there is a handover of responsibility from one clinician to another, the second doctor should take nothing for granted and must make sure that nothing has been missed.
- If a consent form for a surgical procedure is used, it must be read carefully by both the patient and the doctor, corrected if necessary and loaded into the computer system.
- If verbal consent is gained, then what is included in the consent process and relevant observations and investigations must be recorded in the notes.
- When an action is not recorded in the case notes, the Commissioner will usually take the view that the action did not occur. This will be particularly so if the patient denies that a particular action occurred.

An aside comment

It is not uncommon for the Commissioner to effectively create a protocol on how a particular event should be managed, and that is not necessarily a bad thing; however, the wider implications do need to be discussed by a responsible body.

This case is specifically about the risk of pregnancy preceding a LARC insertion, but a similar outcome could well have occurred with any hormonal contraception that might create amenorrhoea. Does this mean that for ANY initiation of hormonal contraception, two pregnancy tests should be done?

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> When there is a handover of responsibility from one clinician to another, the second doctor should take nothing for granted and must make sure that nothing has been missed.

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

Submit your feedback

Māori health and equity

Rural Māori experiences of accessing heart health care

Taria Tane (Te Roroa, Ngāpuhi), Doctoral candidate, School of Population Health, University of Auckland

Rural Māori experience inequities in heart health outcomes compared to rural non-Māori and urban Māori, with health care access being a significant contributor to these inequities. There is a wealth of research that focuses on Māori access to health care. However, the voice of rural Māori communities within the literature is limited.

As part of my doctoral project, I led a study to investigate the drivers of access to heart health care for rural Māori living in Te Tai Tokerau Northland with support from a supervisory team including GPs Kyle Eggleton and Matire Harwood, and public health physician Vanessa Selak.

Like many whānau Māori, heart health conditions are entrenched in my whānau, so this topic is close to home for me. I was born and raised in Tunatahi Dargaville and live in the rural village of Kaihū. I grew up in small towns scattered across Kaipara and Hokianga, spending my free time helping out on my Nana's farm or out on the beach gathering kaimoana (seafood) with my whānau. My childhood was the quintessential Kiwi upbringing. There is something incredibly special about calling Te Tai Tokerau Northland home – our humble communities, our resilience, our strong connection to our whenua (land) and each other. For me, embarking on this kaupapa was about doing something I believed could benefit my whānau, hapū and our local communities here in Te Tai Tokerau Northland.

Access to care has always been at the forefront of my mind working in the health care sector. Before studying full-time, I was a project manager working with various projects in primary care, secondary care and health research in Tāmaki Makaurau Auckland. This work exposed me to the complexities of our health care system. I moved back home to Dargaville as COVID-19 hit and then supported national and iwi/hapū-led COVID-19 responses, which opened my eyes to the unique challenges that rural Māori communities were facing.

In my experience, there seems to be a strong disconnect between what whānau aspire to and need when navigating the health care system and what they are experiencing. Exacerbating the problem is the impression that the needs and aspirations of rural whānau Māori are not heard or listened to. What is missing from health care decision-making is whānau voice, and I aimed to address that gap in my research.

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> ... embarking on this kaupapa was about doing something I believed could benefit my whānau, hapū and our local communities here in Te Tai Tokerau Northland.

In talking with some rural whānau Māori about access to heart health care, their key aspirations were:

1. to be able to access quality heart health care closer to home
2. for the health care system to value culturally safe care
3. for authentic patient–provider partnerships based on manaakitanga (respect, generosity, and support) and reciprocity
4. for the wider whānau to be considered in their heart health journey
5. to understand their heart health condition so they can make informed decisions
6. to live well so they can be there for their whānau and mokopuna.

We are often exposed to narratives that frame rural communities and rural health care provision as inferior or deficient. What resonated with me when talking to rural whānau Māori is the collective understanding held by rural communities and rural health care providers that they bring strengths and solutions to optimise heart health care delivery. Yes, there are many challenges and much work is needed to improve heart health care, but rural whānau Māori have the answers. Our first job should be to listen.

Read the full study in the Journal of Primary Health Care.

> “
> ... there are many challenges and much work needed to improve heart health care, but rural whānau Māori have the answers. Our first job should be to listen.

Goodfellow Unit podcast: **Menopause hormone therapy**

Dr Anna Fenton is currently the clinical leader for the Te Whatu Ora Waitaha Bone Density Service and works in private practice as a gynaecological endocrinologist. She is actively involved in postgraduate teaching and public education.

In this podcast Anna discusses some more complex cases of menopause hormone therapy (MHT) in perimenopausal women. The key take-home messages of this podcast are:

- MHT is the most effective option for managing perimenopausal and menopausal symptoms.
- MHT prevents bone loss although the effect is dose dependent.
- Transdermal estrogen based on observational data is safer than oral estrogen with respect to VTE risk.
- There is a window of opportunity with MHT use early in menopause to reduce the risk of coronary artery disease and all-cause mortality.
- Consider the entire medical history of the patient when prescribing MHT, and this includes considering the use of a progestogen in women with a history of complicated endometriosis.

Listen to the podcast

Submit your feedback

Molecular analysis of FNA samples of thyroid nodules

By Dr Francis Hall

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.

Thyroid nodules are very common. Approximately 50% of the population have thyroid nodules on ultrasound examination. Most thyroid nodules are benign while some are malignant. The incidence of thyroid cancer is 13 per 100,000 per year. About 1 in 100 people develop thyroid cancer over the course of their lifetime. It is three times more common in women.

To determine which thyroid nodules are cancerous, ultrasound and FNA cytology of suspicious thyroid nodules are the mainstay of investigation. Please see the article entitled "**How to manage a patient with a thyroid nodule**" in the June edition of *GP Voice*. About 10% of thyroid FNAs are reported as Bethesda 3 (atypia of undetermined significance) and a further 10% are reported as Bethesda 4 (follicular neoplasm), but only about 16–23% of these patients actually have thyroid cancer.[3] It is common practice, however, to offer patients with Bethesda 3 and 4 cytology surgery in the form of a diagnostic thyroid lobectomy. Although this approach detects and treats thyroid cancer in 16–23% of people in this category, 77–84% of people have an operation with little or no therapeutic benefit.

To help further determine which patients are more likely to have cancer, molecular analysis of FNA specimens can be performed. This involves testing the DNA and RNA of the cells obtained in the FNA specimens. These tests look specifically for mutations in genes associated with thyroid cancer. The prevalence of some of the common genetic mutations are listed below.

Papillary thyroid carcinoma: prevalence of genetic mutations

BRAF	45%
RAS	15%
RET/PTC	15%

Follicular carcinoma: prevalence of genetic mutations

RAS	40%
Pax8/PPARg	40%

In America, Thyroseq® and Affirma® are two of the common molecular tests looking at genetic mutations seen in thyroid cancers. Affirma® looks at 593 genes associated with thyroid cancer. Using Affirma® 2/3 of patients with Bethesda 3 and 4 nodules are reclassified as benign.

Thyroseq® looks at 112 genes associated with thyroid cancer. Similarly, Thyroseq® is able to stratify patients with Bethesda 3 and 4 nodules into low, intermediate and high risk of having thyroid cancer. Low risk patients can be observed. Thyroid lobectomy is recommended for intermediate risk patients and total thyroidectomy is recommended for high-risk patients with aggressive types of thyroid cancer.

	Affirma[4]	Thyroid Print[5]	Idylla ThyroidPrint[7]	Thyroseq[6]
sensitivity	97%	91%	92%	94%
specificity	88%	88%	82%	82%
negative predictive value	99%	95%	96%	97%
positive predictive value	65%	78%	66%	66%

It is important for the reader to realise that as the prevalence of a disease increases in a population, the positive predictive value increases and the negative predictive value decreases.

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It is important for the reader to realise that as the prevalence of a disease increases in a population, the positive predictive value increases and the negative predictive value decreases.

In New Zealand, Thyroseq® molecular analysis of FNA specimens of thyroid nodules is available, but only if the FNA specimens are sent to Sullivan Nicolaides Pathology laboratory in Brisbane who in turn send it to the Sonic laboratory in New York, USA. The turnaround time is about four weeks. The cost to the patient is AU$2,100 (~NZ$2,300) and this is not covered by the patient’s health insurance.

In the near future, Idylla ThyroidPrint® molecular analysis of FNA specimens of thyroid nodules will be available in New Zealand with results available in 24 hours. Idylla ThyroidPrint® looks at 10 epithelial and stromal cell target genes associated with thyroid cancer. It stratifies risk into low (observe) and high (operate).

The American Thyroid Association (ATA) guidelines recommend three options for the management of patients with Bethesda 3 thyroid nodules:

1. Diagnostic thyroid lobectomy
2. Close observation
3. Molecular analysis of Bethesda 3 nodules.

Molecular analysis of FNA specimen needs to be considered alongside the history, examination findings, thyroid function tests, ultrasound findings and FNA cytology. Molecular analysis of FNA specimen gives valuable additional information to help decide which of the above three options is most appropriate.

In summary, molecular analysis of thyroid nodules is a useful adjunct to ultrasound and cytology in the evaluation of thyroid nodules for malignancy. It is particularly useful in patients with indeterminate cytology (Bethesda 3 and 4) and may reduce the number of diagnostic thyroid lobectomies.

For further information on molecular testing of your patient with a thyroid nodule, contact Dr Francis Hall on francis@drfrancishall.co.nz

References:

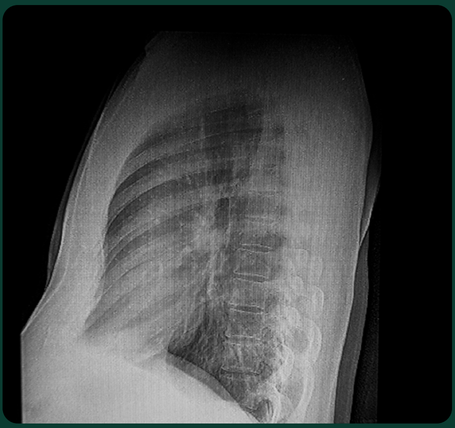
1. Tessler FN, Middleton WD, Grant EG, Hoang JK, Berland LL, et al. ACR Thyroid Imaging, Reporting and Data System (TI-RADS): White Paper of the ACR TI-RADS Committee. (2017) Journal of the American College of Radiology : JACR. 14 (5): 587–595. doi:10.1016/j.jacr.2017.01.046
2. Middleton WD, Teefey SA, Reading CC, et al. Multi institutional Analysis of Thyroid Nodule Risk Stratification Using the American College of Radiology Thyroid Imaging Reporting and Data System. (2017) American Journal of Roentgenology. 208 (6): 1331–1341. doi:10.2214/AJR.16.17613
3. Ali SZ, et al. The 2023 Bethesda System for Reporting Thyroid Cytopathology. Thyroid 2023; 33: 1039–1044.
4. Nasr C, et al. Real-world performance of the Affirma genomic sequencing classifier (GSC)-a meta analysis. JCEM 2022; 108: 1526–1532.
5. Steward DL, et al. Performance of a multigene genomic classifier in thyroid nodules with indeterminate cytology. A prospective blinded multicenter study. JAMA Oncol. 2019; 5: 204–2012. doi:10.1001/jamaoncol.2018.4616.
6. Zafero M, et al. A thyroid genetic classifier correctly predicts benign nodules with indeterminate cytology: two independent, multicenter, prospective validation trials. Thyroid 2020; 30: 704–712.
7. Unpublished data (internal analysis based on 132 indeterminate samples compared to the surgical gold standard).
8. Haugen BR, et al. 2015 American thyroid association management guidelines for adult patients with thyroid nodules and differentiated thyroid cancer. Thyroid 2016; 26: 1–133.

Goodfellow Unit podcast: **Chest wall deformities**

Dr Christine Goh is a consultant cardiothoracic and transplant surgeon who has been trained in both Australia and New Zealand.

In this podcast Christine Goh discusses the two most common congenital chest wall deformities. These are characterised by abnormal development and appearance of the chest wall. The key take-home messages of this podcast are:

- Pectus excavatum is more common than pectus carinatum.
- Spontaneous regression is rare.
- Symptoms vary and are non-specific.
- Non-surgical treatment usually has limited improvement.
- Surgery has a high success rate with low recurrence.



Listen to the podcast

Submit your feedback

HealthPathways

College endorsement highlights the power of partnership

Streamliners and Health New Zealand | Te Whatu Ora are thrilled to announce that New Zealand HealthPathways have officially been endorsed by The Royal New Zealand College of General Practitioners (the College).

The endorsement highlights HealthPathways as an essential tool for clinicians and recognises the successful partnership at local, regional and national levels between Health New Zealand | Te Whatu Ora, Primary Health Organisations (PHOs), Streamliners and HealthPathways teams.

HealthPathways is a trusted, online tool designed for and in collaboration with clinicians. Each pathway is developed by clinical editors in collaboration with subject matter experts to support health care professionals by providing quick access to locally relevant, evidence-based guidelines and resources.

The official College-endorsed guidance underscores HealthPathways as a trusted, clinically reliable tool that supports GPs at the point of care.

“HealthPathways has a broad range of topics, is well informed with robust evidence and is a useful tool for primary care practitioners in New Zealand who are providing comprehensive and complex whole-of-life care within their communities,” says Dr Luke Bradford, the College’s Medical Director.

HealthPathways supports national consistency, enhancing care pathways and aligning the health care system to improve patient outcomes across Aotearoa, says Dr Justine Lancaster, who serves as both the Clinical Lead, Care Pathways and Value-Based Care at Health New Zealand | Te Whatu Ora and Regional Clinical Advisor (NZ) for HealthPathways.

“The College’s endorsement is a testament to the quality, clinical integrity and relevance of HealthPathways in New Zealand.” says Dr Lancaster.

“This recognition is a tribute to the dedication of our small but mighty teams from across the motu, and to the innovative, collaborative spirit of partnership between Health New Zealand | Te Whatu Ora and Streamliners.

“The College’s endorsement of HealthPathways marks a significant step forward, strengthening support for GPs and advancing Health New Zealand | Te Whatu Ora’s commitment to quality, consistent and equitable health care nationwide.

“The endorsement provides GPs and the wider health care community with further reassurance that HealthPathways meets the highest standards of clinical integrity and evidence-based practice and supports Health New Zealand | Te Whatu Ora’s goals of quality care.

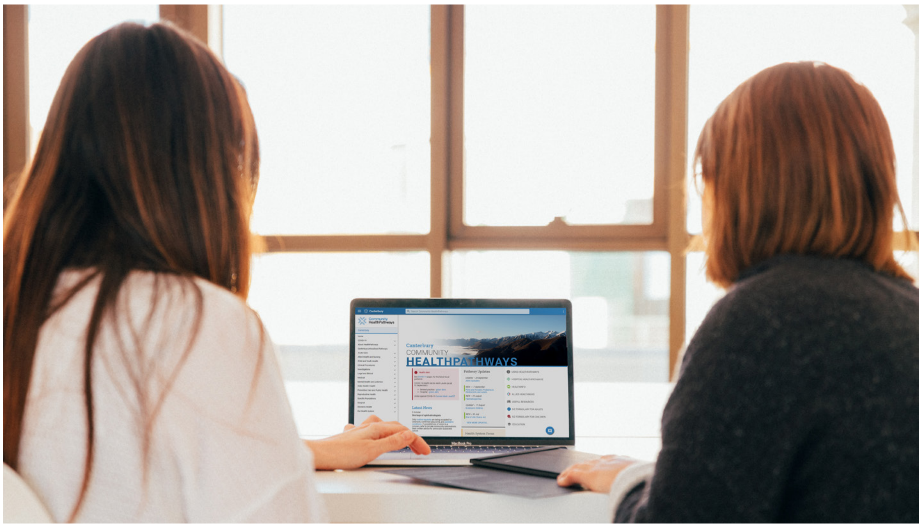
ENDORSED GUIDANCE
VALID UNTIL 30 SEPTEMBER 2027

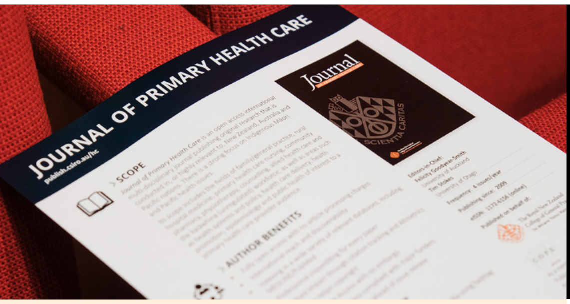
> “The endorsement provides GPs and the wider health care community with further reassurance that HealthPathways meets the highest standards...

"The endorsement should also empower GPs to feel confident in their clinical decision-making, which supports Health New Zealand | Te Whatu Ora's aim to reduce clinical variation and ensure equitable care for all New Zealanders," says Dr Lancaster.

As well as recognising the progress made to date, this endorsement also lays the groundwork for deeper collaboration in the future.

"We're more aligned than ever in our shared mission to enhance health care delivery and improve patient care," says Dr Lancaster.





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. Who uses yoga and why? Who teaches yoga? Insights from a national survey in New Zealand
2. The impact of nurse prescribing on health care delivery for patients with diabetes: a rapid review
3. Ethical assessment of virtual consultation services: scoping review and development of a practical ethical checklist
4. Patient perceptions of barriers to attending annual diabetes review and foot assessment in general practice: a qualitative study
5. Rural hospital contributions to community health: community perspectives from a New Zealand rural hospital

Submit your feedback

Rethinking mastitis

Guideline changes and recommended treatment

A HealthPathways Education Webinar

The Mastitis and Breast Abscess pathway has been updated on HealthPathways nationwide.

Dr Yvonne LeFort, Jenny Lester and Dr Danielle Gerrad discuss the Academy of Breastfeeding Medicine's clinical protocol The Mastitis Spectrum (2022) and practically what this means for improving mastitis and breast abscess care for breastfeeding mothers.

The key take-home messages are:

- A painful red breast in a breastfeeding/lactating person is unlikely to be bacterial mastitis at its onset. Treat initially as tissue inflammation and reassess within 24–48 hours.
- Treatment of inflammation includes:
  - Use ice/cooling to breasts (not heat).
  - Use gentle lymphatic drainage not deep massage (see resource in the 'For patients' section of the pathway).
  - Breastfeed as usual, not more and no less, including the affected side.
  - If expressing, continue to pump to meet baby's requirements – no more.
  - Ibuprofen/paracetamol can be advised for discomfort and with patient information regarding follow-up and prevention of recurrence.
- In the case of recurrence of mastitis, you can request a milk sample for culture.
- Review progress in 1–2 days and watch for persistent systemic signs such as fever or failure to resolve presenting symptoms before using antibiotics.
- Get skilled breastfeeding help to adjust milk production to meet the baby's needs when hyperlactation or a drop in production is occurring.

Watch the webinar recording.

You will also find the recording in the 'For health professionals' section at the bottom of the Mastitis and Breast Abscess pathway. Check out the Mastitis and Breast Abscess pathway on HealthPathways. Click the link and then select your region. If you haven't logged in to HealthPathways before you will need to request access.

About the presenters

Dr Yvonne LeFort is a GP and breastfeeding medicine doctor, Jenny Lester is a clinical nurse specialist and lactation consultant, and Dr Danielle Gerrad is a GP and HealthPathways clinical editor.

Submit your feedback

Giving a voice to the dying

Hospice New Zealand

What is it like dying while living in Aotearoa New Zealand?

Dying Reviews is a world-first online rating system that is giving a voice to Kiwis dying from a terminal illness.

Nearly 40,000 people die in New Zealand every year, with close to 90 percent of these deaths not being sudden. The dying stage of life can take weeks, months or years, and traverses all age groups.

Dying Reviews enables people who are dying to provide honest ratings about their experiences across all sectors of society – the great, the difficult and the unsettling.

Hospice New Zealand is behind the campaign, and CEO Wayne Naylor says modern living has allowed us to push dying out of sight and out of mind.

“Our societal taboo around dying means that those living in this stage have never been asked at scale what it is like to walk in their shoes. Up until now, no one has been thinking about how we can do better for them,” says Naylor.

“What is it like to deal with your bank, your workplace, your telco or council while you’re in your dying stage of life? We think Dying Reviews is the way towards a society that is more compassionate interacting with people at this stage of life.”

> “
> People in this stage of life are still living, but everything has changed. Their energy and priorities are changing, and daily life has probably become harder than it needs to be.

How it works

Hospice New Zealand is encouraging anyone diagnosed with a terminal or life-limiting illness, their whānau or close friends to write a review, enabling them to give honest ratings and express what it’s like for them.

A Dying Review takes between five and 10 minutes to complete. It can be good, bad or anything in between. It is a five-star rating system designed to be easy to navigate, just like other rating systems used for ride sharing, travel and restaurant experiences.

“People in this stage of life are still living, but everything has changed. Their energy and priorities are changing, and daily life has probably become harder than it needs to be.”

Karen, 42, who has incurable breast cancer hopes Dying Reviews will reveal the challenges people like her face and ignite conversations to look for improvements.

dying reviews
★★★★★

"I've got a chemo card, but I don't like to use it because people think I want sympathy. But imagine if I could use it to get fast tracked or skip the queue when I'm dealing with organisations and all the admin. I don't want sympathy, I just want a way to get things done, with compassion, so I can focus on what matters: living fully the life I have left."

Hospice New Zealand wants to hear from a diverse range of New Zealanders.

"Once we have over 600 reviews (a robust sample) we will analyse the findings and start the national conversation," says Wayne.

"We'll be able to reveal some overall star ratings and champion those organisations that have scored well for their approach. For organisations that are performing poorly, Hospice NZ intends to work constructively with them to offer solutions like developing compassionate policies and training for their staff.

Hospice NZ plans to run the campaign year on year to continue the conversation about dying well and gain valuable, ongoing insights into how New Zealand organisations treat terminally ill New Zealanders and their whānau.

The following are examples of reviews that have been submitted.

[redacted] Dementia Care

A lack of kaupapa Māori respite care was hard. Māori space with Māori kai, carers and residents would have been beautiful for our mother.

★★★★

[redacted] Department
[redacted] Super
[redacted] Insurance

The day after Mum died, Dad wanted to sort out all the admin. The wait times are excessive, so you ask for callbacks.

We then had [redacted], [redacted] and [redacted] all calling at the same time and had to make a call in the moment as to, for example, hanging up on [redacted] mid-convo and telling them we'll have to call back, then taking the call from [redacted] to switch off [redacted] Super. Which puts you at the back of the queue again for [redacted].

★

Submit your feedback

A free privacy health check for primary health care

By Michael Webster, Privacy Commissioner

The trust that New Zealanders have in their primary health care services is that you've had a high degree of medical training and that you're absolute sticklers for patient confidentiality. Regardless of whether someone is seeing a specialist general practitioner, a nurse, the practice manager or speaking to front desk staff, they expect that when they visit 'their doctor', their information will be kept private.

Given the high degree of sensitive information your practices hold, privacy can go horribly wrong incredibly fast when employees don't know how to do privacy well. The good news is that my office has recently updated our free online health privacy training module. *Health 101: Introduction to the Health Information Privacy Code* is a great way to upskill for the privacy requirements that are specific to health. It's training that remembers where you're up to so can be done over several sessions, and anyone that finishes it will receive a certificate of completion. Quizzes along the way test your knowledge in a manner that keeps positive learning at the forefront.

I see a lot of privacy breaches reported by the health sector, and I know that you can greatly improve your practices by training your staff to do privacy well. A blind person contacted my office because their GP centre doesn't have accessible forms for them to fill in, so the receptionist reads the form out in the waiting area and asks the patient to respond, meaning the whole waiting area hears their medical information. That person told us, "I suggested a room be set aside for me to do this if the centre was not planning on making forms accessible. I was told this wasn't possible. Getting a GP appointment is difficult due to a shortage of GPs in my area, so I put up with it." That is not okay.

Neither is staff gossiping about what they've seen at work. One clinic notified us because a staff member had seen a patient's file then told their mutual friends that person had herpes. In this case the employee had accessed that patient's file multiple times without a work reason to do so.

People shouldn't have to accept poor privacy practices, and training is a quick way to improve how staff operate. Often people don't know what to do, or they make simple mistakes that, because you're in medicine, have big consequences. That's especially true when demand is high and staff are working faster and harder: mistakes become easier.

Mistakes include actions like emailing ACC but accidentally copying in someone that has no reason to see the file because your email system auto-filled an address. That's an easy mistake that can be prevented by adding a two-minute delay to sending emails (so they're held in the outbox and you have time to review and fix mistakes) and disabling the autofill function on your email address book.

> “
>
> Given the high degree of sensitive information your practices hold, privacy can go horribly wrong incredibly fast when employees don't know how to do privacy well.

Emailing ACC is a hot topic in health privacy because it often goes wrong. Over-disclosure of patient information is a good example here, where medical centres email unrelated information, like pre-existing conditions and lists of medications to ACC's authorised insurer. What happens after someone complains to my office, or an agency notifies a breach, is often an in-person meeting, an apology, a review and reworking of privacy processes with additional training for staff.

I'm sure you all know that prevention is better than cure; that works in privacy situations too. People need to know what to do and what's okay.

For example, take the caregiver for elderly people who took photos of residents using their personal phone and sent the photos to other people. To me it's obvious that that's not upholding the dignity of patients. But not everybody has the same level of commonsense, or the same life experiences to tell them that's not okay, which is where training comes in. Training yourself and your colleagues about what's allowed by law keeps privacy clear cut for staff. In this case a person lost their job (after the manager supervised the caregiver deleting the photos from their phone).

None of these examples I've shared are particularly sophisticated, which is the point. These are common issues that I see time and time again because people working in health care settings aren't confident about privacy, what it is, or their role in protecting it in everyday situations.

I'd encourage you to work through the updated Health 101 e-learning module to improve staff knowledge and lessen the likelihood of having to notify my office of a breach.

Health 101: Introduction to the Health Information Privacy Code

- A free online learning module
- A certificate of completion is awarded at the end.

elearning.privacy.org.nz

> “
> Training yourself and your colleagues about what's allowed by law keeps privacy clear cut for staff.

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

Submit your feedback

Melanoma New Zealand's new free counselling service

Melanoma New Zealand would like to let New Zealand GPs know about some new **free** patient support services we have recently introduced:

- **1:1 counselling service (online and phone)**
  Our experienced counsellor supports anyone affected by melanoma, including individuals, families, whānau and carers facing the challenges of a new diagnosis, ongoing treatments or post treatment. Up to four free sessions are offered, after which our counsellor will discuss with the patient what further support they would like, if any, and guide them to find alternative additional counselling. Individuals can book directly on the Melanoma New Zealand website, and we accept referrals from health professionals too.
- **Patient and family support groups (online)**
  These will involve monthly online group sessions (with separate groups for patients and for family members) facilitated by our counsellor. We're currently asking individuals to register their interest as we work to set these up once sufficient numbers have been reached.

One of the reasons for launching the counselling service and patient support groups is because of the findings of a Melanoma New Zealand survey of 108 melanoma patients (past and present) that identified that a significant percentage (60%) of patients experienced anxiety, and 74% identified fear of cancer progression as an impact of their diagnosis.

> “
> a Melanoma New Zealand survey... identified that a significant percentage (60%) of patients experienced anxiety, and 74% identified fear of cancer progression as an impact of their diagnosis.

Melanoma New Zealand's other services

As well as the new counselling service, we have a range of existing resources and services that may also be useful to GPs and their patients.

- **General public information on melanoma.org.nz**
  Information on melanoma prevention, early detection, risk factors and more are all available on our website, including a video on 'how to check your own skin' that you could suggest to your patients.
- **Patient booklets**
  We have two patient booklets you can offer to your patients that provide more information to someone following a melanoma diagnosis. These are available printed on request and digitally on our website melanoma.org.nz. (Note that both are currently being updated).
  1. Understanding Early Melanoma
  2. Understanding Advanced Melanoma

- **Nurse educator service**
  Melanoma New Zealand also offers free online consultations with a melanoma nurse educator for anyone concerned about melanoma, wanting general guidance and links to other services. The purpose of the consultation is to raise general awareness about skin cancer, and it is designed to complement (not replace) the care provided by an individual's usual health care provider.

We also invite GPs to contact us at Melanoma New Zealand if we can provide any further information or support, via email info@melanoma.org.nz, through our website www.melanoma.org.nz or by phoning 0800 463 526.

NEW SERVICE Melanoma New Zealand Counselling

Leave feedback and follow us

Help us improve the reading experience of GP Voice by completing our short survey.

Submit your feedback

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