GP Voice

YOUR NEWS, YOUR VIEWS, YOUR VOICES

GP25: In unity, we have strength

GP25: Peter Anyon Memorial Address

Dr Gemma Herbison

Congratulations to our new Fellows and award winners

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

August 2025

In this issue

Editorial

Dr Luke Bradford

Dr Luke Bradford
President | Te Tumu Whakarae

Kia ora koutou

Thank you for all the kind messages and warm words I've received since stepping into the role President a couple of weeks ago.

New Medical Director

I'd like to welcome Dr Prabani Wood into the role of Medical Director. Prabani officially started the role on Monday 11 August, and I'm looking forward to working with her to progress the College's and wider workforce's advocacy efforts for swifter action and bold reform.

GP25: Conference for General Practice

Thank you to everyone who attended and who played a part in organising the GP25: Conference for General Practice in Christchurch. It was another successful conference with a programme full of inspiring speakers, robust research, networking and great socialising.

The Minister's announcement about GPEP funding and capitation reweighting signals that our advocacy and voice is being heard and that our expertise and specialism are valued as a vital part of the health care system. It was a great way to start the conference, and we'll share more information about the specifics when we can.

Having the opportunity to personally congratulate all our Distinguished Fellows, award recipients and new GP, rural hospital medicine and Dual Fellows was a real privilege, as was seeing all the whānau and friends at the ceremony acknowledging their loved ones walking across the stage in their College robes.

Remember to save the date for GP26 which will be held from Thursday 30 July to Saturday 1 August 2026 at the brand-new New Zealand International Convention Centre in Auckland.

2024 Workforce Survey

I encourage you to take some time to read the snapshot report highlighting key findings from the 2024 Workforce Survey. The survey doesn't just collect data, it reveals trends, highlights challenges and showcases the resilience of the GP and rural hospital medicine workforces. **Read the 2024 Workforce Survey Snapshot Report**.

This issue of *GP Voice* provides a great recap of GP25: Conference for General Practice as well as the usual advocacy highlights and updates from across the sector and within the College. More conference highlights will also be included in the next issue of *GP Voice*, out in October.

I hope you enjoy this month's issue.

Submit your feedback

Editorial

Toby Beaglehole

Toby Beaglehole
Chief Executive

Kia ora koutou

July has been a whirlwind month, from Government announcements to GP25: Conference for General Practice and our College AGM, there have been a lot of announcements to get our heads around.

It's also been just over 12 months since I joined the College as CE and I have a newfound appreciation for the mahi you do every day, and the value you add to health outcomes in communities right across Aotearoa.

I've had some time to take stock of where we are as an organisation, where we want to be and what we need to do to get there. **The Annual Report** will give you a good sense of where we've been and where we're heading - I encourage you to have a look through it.

Over the past year a range of changes have been made to ensure the College is well-positioned to support and develop our Māori and Pacific membership. These are actions I'm proud to have been part of and look forward to progressing.

These changes include the implementation of Rautaki Māori initiatives and working on a refreshed strategy with Te Akoranga a Māui. Changes in support of Te Tiriti were made to the College Rules following last year's AGM. We have also released our position statement on **Te Tiriti o Waitangi and Māori Health Equity** and are working with Te Whatu Ora on four Pacific health initiatives.

There were further proposed amendments to the Rules that were voted in at the AGM at GP25 which will further strengthen the College's governance and membership engagement.

Jumping in the deep end with the College's ongoing advocacy work is another element of the CE role that I'm learning about and enjoying. We've seen positive steps this year, from the Minister's announcements on funding and increasing access to services, to capitation improvements and the Waikato Medical School.

More particularly, the announcements from Minister Brown on Friday at GP25 are both a validation of the work that's been put in and a very positive sign for the recognition of the value of general practice – the indisputable importance of the work you do, every day.

My commitment to you is to continue that mahi, that advocacy, and to work with Luke, the Board and the College team to see your contribution to the communities of Aotearoa recognised and fairly rewarded. In particular, to continue the drive for a fully-funded three-year GPEP that would align us with other medical specialties.

We will continue to ask for your advice and expertise for our advocacy – through the stories we tell, our submissions and our position statements. We are also developing Special Interest Groups – the topics of which were voted on at GP25.

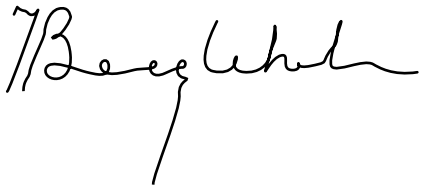
In wrapping up, I'd like to acknowledge Sam and the remarkable legacy she created during her tenure as President.

Sam, I've only worked with you for one of these seven years, but you have always been incredibly patient, insightful and available to provide support and advice to me, to our Senior Leadership team and your Board and the wider membership.

You have made my transition into the world of health and into the College as smooth and painless as possible. You have approached the role with humour and energy and rigour. Your fierce love for the job and all it entails are recognised within the sector, nationally and internationally.

Ngā mihi maioha Sam, for all of your mahi; keep in touch and good luck with all your future projects as we all know you will not be sitting still for long.

I hope you enjoy this issue!



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College Advocacy: Months in review

June and July

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 College's advocacy work from June and July.

College response to GPEP programme funding announcement

At GP25: Conference for General Practice, Health Minister Simeon Brown announced funding for:

- training fees for doctors in GPEP years 2, 3 and 3+ to encourage completion of their training in 2025
- Fellowship assessment costs for around 200 GPEP trainees to enable them to complete their training and become Fellows
- full ongoing training and education costs for an estimated 400 GPEP year 2 and 3 trainees each year from 2026.

The Minister also announced that capitation funding reweighting will be introduced from 1 July 2026. The College welcomed the changes to the capitation formula to include multimorbidity, rurality and deprivation as factors. This will be reviewed every five years starting in 2028 so that it stays fit for purpose.

Read the College's full statement.

College response to funding announcement (June)

The College responded to the funding announcement made by Minister Brown saying, "The College has been very vocal about not needing to create a new health service but investing properly in the current service – recognising the opportunity that lies within general practice to achieve better health outcomes, and this funding will go some way towards this goal."

Read the College's media statement: Recognition of the GP workforce's value to communities welcomed in funding announcement.

Read the full announcement from Minister Brown: **GPs to receive record funding boost | Beehive.govt.nz**

College response to changes in ADHD care

In 2022 the College wrote to Pharmac seeking the removal of renewal criteria for stimulant treatments. For the past two years, the College has been part of a multi-disciplinary group of experts collaborating to build a consistent model of service to support people with ADHD and increase access to more equitable care. As a result of this work, Pharmac and Medsafe consulted on a proposal to change the regulatory and funding restrictions for stimulant treatments for ADHD. The College submission supported this proposal.

Following the consultation, it's been announced that from 1 February 2026, vocationally trained GPs and nurse practitioners (trained in and working in a mental health scope) will be able to prescribe stimulant medicines for ADHD to adults (18 years and older).

Read the full decision notification from Pharmac: Decision to change the regulatory and funding restrictions for stimulant medicines for ADHD – Pharmac | Te Pātaka Whaioranga | NZ Government

Recent submissions and position statements

1. **MOH: Allen & Clarke:** Draft Guidance on establishing and sustaining human milk banks
2. **Pharmac:** Access to budesonide with eformoterol inhalers
3. **Pharmac:** Fund Comirnaty COVID vaccine
4. **College Position Statement:** Te Tiriti o Waitangi and Māori Health Equity position statement
5. **Pharmac:** Proposal to fully fund liquid nutrition replacement
6. **Privacy Commissioner:** How to comply with the Information Privacy Principle (3A)
7. **MedSafe:** Medicines Classification Committee – 74th Meeting
8. **Asthma and Respiratory Foundation NZ:** COPD Guidelines
9. **Pharmac:** Extension of prescription lengths to 12 months

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

MCC meeting update

Advocacy highlights

At the 73rd meeting of Medsafe's Medicines Classification Committee (MCC), the College made a submission highlighting its position on certain agenda items relevant to our specialist GP and rural hospital doctor workforces. Highlighted below are three of the items the College raised points on under the 'submissions for reclassification' agenda items.

Travel vaccines

The College did not support the Green Cross Health proposal for reclassification of yellow fever on the basis that it is a patient safety and quality concern. Travel medicine is a complex specialist area requiring an understanding of a person's health history, comorbidities and risk factors, which cannot be simplified.

- The College supports the application form for authorisation as a vaccinator to be for all travel vaccines, rather than singling out yellow fever, including the applicant type (Medical Practitioner, Nurse Practitioner, Registered Nurse) and if the applicant is an existing vaccinator or if this is a new application.
- The College notes that travel medicine should not be diluted by being broken down into specific vaccines.
- The College does not support pharmacist prescribing for all travel medicine, as the risks with vaccines are more than minor.

Allopurinol

The College proposed a change to the classification of allopurinol to:

- Prescription medicine except when supplied for prophylaxis of gout to people who meet the clinical and eligibility criteria of an approved training programme, when provided by pharmacists who meet the requirements of the Pharmacy Council.

The College supported pharmacist maintenance and titration of allopurinol with the initiation being completed by a GP, pharmacists being able to titrate and repeat medications while working in conjunction with a GP/NP, and the introduction of an annual check with a GP. Specific areas of concern relating to continuity of care were identified by the College and advice was provided.

Tenofovir disoproxil and emtricitabine (PrEP medication)

The College supported the proposal to change the classification of tenofovir disoproxil and emtricitabine to:

- Prescription medicine: except when supplied for HIV prophylaxis to people who are over 18, are HIV negative, and meet the clinical and eligibility criteria of an approved training programme, when provided by a pharmacist who meets the requirements of the Pharmacy Council.

The College supports reducing barriers to prescribing HIV PrEP. Its classification will expand access to HIV prophylactic medicines through exemption of prescription status enabling pharmacists to supply HIV prophylactic medicines under certain conditions to ensure patient safety, i.e. that there are clear protocols for responsibility of blood ordering and results with clear referral back to the medical practitioner (often sexual health clinics) protocols. As sexual health clinics and GP clinics cannot provide the level of accessibility needed for this medication, continuity of care is the main risk for patient care.

Read the College's submissions to MedSafe's MCC **73rd meeting** and **74th meeting** on our website.

Goodfellow Unit podcast: **Polycystic Ovary Syndrome**

Dr Ruveena Kaur is an endocrinologist, dually specialised in obstetric medicine. She works part-time as a Consultant with the Endocrinology Department at Auckland City Hospital and as an Obstetric Physician at National Women's Hospital.

Dr Kaur discusses Polycystic Ovary Syndrome (PCOS), covering its diagnosis, metabolic and reproductive health impacts, and long-term management. It highlights weight stigma, eating disorders, effective treatments, and the importance of inclusive, evidence-based care.

The key take-home messages of this podcast are:

- The 2023 International PCOS guidelines focus on a lifespan approach.
- Use the Rotterdam criteria when diagnosing.
- For adolescents, the use of ultrasound within eight years of menarche is not recommended.
- Remember to be vigilant for endometrial hyperplasia in the patient presenting with oligomenorrhea.
- The risk of endometrial hyperplasia progressing to endometrial cancer is increased if patient has other risk factors.
- A healthy lifestyle is key to management.

Listen to the podcast

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New Equity reaccreditation module launched

In July, the College launched its Equity reaccreditation module as part of the Cornerstone programme for practices wanting to maintain their Equity accreditation status.

The Equity reaccreditation module is designed to help practices reaffirm their ongoing commitment to health equity, strengthen relationships with their communities, and continue improving the health outcomes for their patients and whānau.

The module aligns with the College's Te Tiriti o Waitangi and Māori health equity position statement and our advocacy towards systemic and structural changes that are required in health and education to prioritise the elimination of health inequities, especially for Māori, Pacific Peoples and other priority populations.

The module focuses on outcomes-based evidence and reflective practice, providing the opportunity for practices to show how they are embedding equity into their everyday work.

The reaccreditation module was piloted from February to May this year, with six practices successfully completing the module and earning their Equity reaccreditation.

Dr Nina Bevin (Waikato-Tainui), Chair of Te Akoranga a Māui was one of the advisors for the module, contributing to its development before the pilot phase and says, "Achieving Equity reaccreditation recognises practices who are leading the way, delivering high quality care and demonstrating equitable practice in action."

Comments from some of the pilot practices:

"*We enjoyed communicating with our team and reminding ourselves what equity looks like... We are proud to say that equity is always at the forefront of our practice.*"

"*Being able to reflect on where we have improved over the last three years is rewarding.*"

The Continuous Quality Improvement (CQI) reaccreditation module was also launched earlier this year in February.

More information on the Equity and CQI reaccreditation modules, including how to purchase them, is available on the College website: The Cornerstone Modules.

> "Achieving Equity reaccreditation recognises practices who are leading the way, delivering high quality care and demonstrating equitable practice in action.
>
> Dr Nina Bevin, Chair of Te Akoranga a Māui

The story of our membership

2024 Workforce Survey

The 2024 Workforce Survey was carried out between October and December 2024, with 1,374 members taking part and completing the survey.

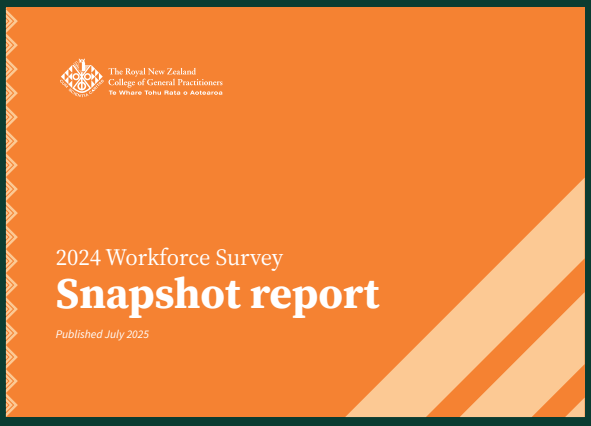
Every two years, the College carries out this survey to capture the pulse of the ever-evolving specialist GP and rural hospital medicine workforces. The survey collects data, reveals trends, highlights challenges and successes, and showcases the resilience and adaptability of the workforce across the country.

Results show that our members are constantly evolving and adapting to the changes in patients' needs. With an ageing population and increased complexity of cases, new roles and skillsets are being welcomed into our multi-disciplinary teams to address patients' physical, mental, social and holistic needs. New tools and technology, such as Artificial Intelligence (AI) are being carefully incorporated into our members' daily work to reduce some of the administrative burdens that come from managing such a diverse patient load.

At GP25: Conference for General Practice, College President Dr Luke Bradford spoke to some of the key findings from the survey that have been published in the 2024 Workforce Survey Snapshot Report.

This year's findings deepen our understanding and reaffirm the importance of listening to those at the heart of health care delivery.

This Snapshot Report is the first in a series of 2024 Workforce Survey reports.



Read the Snapshot Report

Submit your feedback

Northland Faculty's Really Great Russell Conference

The Northland Faculty's Really Great Russell Conference was held in the sunny Bay of Islands in late May, and once again delivered with all the greats: weather, food, speakers, and atmosphere!

An opportunity for GPs and Registrars from across the Northland region to come together to learn, engage, and renew friendships in true collegial spirit.

Thanks to Dr Chris Poplar, Dr Angela Wong, and Dr Tanya Quin for organising a packed programme over the weekend, offering a broad range of speakers from Surgery to Psychiatry, the latter involving audience participation and bin bags! Each session was followed by the opportunity to ask questions of the experts and engage in lively discussions.

Saturday evening saw a Kapa Kaiaka Social for registrars and teachers; a meet and greet for all, followed by an amazing dinner – great conversations, renewed and new friendships, and connections were made.

The conference is a highlight for the Northland Faculty and is a testament to the determined work of the Executive and outgoing Chair Dr Tanya Quin.

Submit your feedback

GP25: In unity, we have strength

GP25: Conference for General Practice has now wrapped up – and what an incredible few days it was in Ōtautahi Christchurch. Our annual conference is always a highlight in the College calendar and this year was no different. It was great to see so many members attend – we had over 700 attendees at this year's conference, which was a huge turnout and a great way to come together!

Mā te kotahitanga e whai kaha ai tātau
In unity, we have strength.

This year's whakataukī was chosen to reflect the importance of unity and belonging during a time of significant change in the health sector – particularly in primary care and rural hospital medicine. Issues around workforce capacity and training remain critical, and GP25 provided the perfect platform to connect, kōrero, and reflect on the future of our profession.

Over the conference, attendees engaged in a packed programme of informative plenary presentations, panel discussions, hands-on workshops, and practical sessions tailored to GPs, rural hospital doctors, medical students, registrars and others across the primary health care sector.

A big thank you to all our speakers, facilitators, sponsors, exhibitors, chair people, and delegates – your contributions, energy, and insights made GP25 a truly memorable event. From the clinical content to the social events, the sense of connection and community was felt throughout.

And for those of you who were unable to attend, here are some highlights from the weekend:

- **CME Workshop Day:** A well-attended day full of hands-on practical workshops on a broad range of topics from ADHD and ingrown toenail excision to joint injections and everything in between. We have received positive feedback from those who attended.
- **Social functions:** After a full day of insights at the conference, the GP25 Quiz night at Fat Eddies was a great way for conference attendees to unwind with their colleagues and enjoy a laugh or two! We also had conference attendees join the park run on the Saturday morning, which was led by Andrew Boyd (parkrun health and wellbeing ambassador). It was a great way to connect through fitness, albeit an early, cold start!
- **Keynote speakers:** Emma Twigg spoke about resilience coming from the people you surround yourself with, and Sir Ian Taylor spoke about finding new ways to do things and trusting the people around you. You can read more about their keynotes on page 14.

- **Other plenary speakers:** The Minister attended the Friday morning session and announced a raft of funding and changes which you can read about on page 14, while Professor Dame Helen Stokes-Lampard and Dr Samantha Murton engaged in a fireside chat, which you can read a high-level summary of on page 16. Dr Luke Bradford presented the results of our 2024 Workforce Survey on Saturday, which you can read more about on page 10.
- **Peter Anyon address:** The Peter Anyon Memorial Address is given by a GPEP year 2 registrar and is focused on their journey in general practice, their experiences so far, and where they see the future heading. This year it was given by Hamilton-based Dr Gemma Herbison; we have included her moving address on page 17 for you to read.
- **Concurrent sessions:** There were over 100 concurrent sessions run over the two days, which was an incredible turnout from those who put abstracts in. We will be sharing summaries of some of these in *GP Voice* over the next few issues.

Ngā mihi nui to everyone who joined us in Ōtautahi Christchurch. We hope you left feeling inspired, supported, and part of a strong and connected community.

Save the date for GP26

We look forward to seeing you at GP26 in Tāmaki Makaurau Auckland, from Thursday 30 July to Saturday 1 August 2026 at the new New Zealand Convention Centre.

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. Horny Goat Weed/Epimedium
2. Protecting primary healthcare funding in Aotearoa New Zealand: a cross-sectional analysis of funding data 2009–2023
3. Trends in psychological distress: analysis of NZ health survey data (2011–2023)
4. Milk thistle
5. Vaping and smoking in adolescents 14 and under in Aotearoa New Zealand: cross-sectional study of e-screening data

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GP25: Keynote and plenary speakers

Minister of Health, Hon. Simeon Brown

The Minister, Hon. Simeon Brown, spoke on the Friday morning of GP25. During his speech he emphasised the importance of growing and sustaining the primary care workforce to ensure high-quality patient care. He stated that the government's five key health priorities include fixing primary health care, reducing emergency department wait times, clearing the elective surgery backlog, and investing in health infrastructure. Key initiatives the government has announced so far as a result of these priorities include funding for overseas doctors, nurse practitioners, and a new medical school at the University of Waikato.

Minister Brown also talked about how the government is committed to retaining health care talent and improving primary care funding, which he said has been underfunded compared to hospitals. He announced $175 million in funding for general practices, which included a 13.89% uplift and $59 million for improved patient access. The capitation formula will also be re-weighted to include multi-morbidity, rurality and deprivation, benefiting high-needs practices.

The Minister also announced that the government will fund GP training to boost the workforce and establish a primary care advisory group for ongoing sector input. You can read the College's response to this announcement here.

Emma Twigg

The five-time Olympic single sculler spoke about her 20-year rowing journey which was the ultimate story in perseverance and resilience. When Emma was young, she woke up one morning and thought, "One day I'd like to be an Olympic champion," and that's what she set out to do.

Emma came ninth at the Beijing Olympics in 2008 and fourth at both the 2012 London Olympics and 2016 Rio Olympics. After the 2016 Olympics, Emma retired from rowing and spent time ticking off things she felt she'd missed out on while pursuing her Olympic dream – she climbed Mount Kilimanjaro, completed an ironman and ran a New York Marathon.

After two years off the water, Emma started training again in 2018, and in 2020 reached her dream of becoming an Olympic champion when she won gold at the Tokyo Olympics. She then went on to win silver at the 2024 Paris Olympics.

The key take-home message from Emma's keynote was about resilience coming from the people you surround yourself with. Emma shared slides showing all the international medals she won during her career, explaining that when we talk about an athletic career it's generally defined by the tangible things – the medals.

Above: Hon. Simeon Brown
Minister of Health

Below: Emma Twigg
Five-time Olympic single sculler

"What's not on this slide is the really important parts…for me the people have been the most important part of my journey, and I truly wouldn't have achieved what I have without those people."

Sir Ian Taylor

Following Dr Gemma Herbison's moving Peter Anyon address where she talked about the need for humanity alongside excellence in clinical care, Sir Ian Taylor started his keynote speech by thanking Gemma for her service to health care.

Sir Ian founded Animation Research Ltd (ARL), a global leader in innovative technology solutions, covering major sports events worldwide. Sir Ian spoke about his journey in technology, and when he talks about a journey, he uses the whakataukī:

Kō ngā tahu ā ō tapuwai inanahi, hei tauira mō āpōpō
The footsteps we lay down in our past create the paving stones of where we stand today.

Sir Ian's talk focused on finding innovative ways to do things and trusting the people around you; for example, during COVID, his staff figured out a way to cover American sports from New Zealand remotely. Before COVID, this had never been done!

Sir Ian touched on his favourite motto, "bugger the boxing, pour the concrete anyway," tying into his mantra of building an action plan instead of a business plan.

One of his key take-home messages was that when leading a team, "if you believe you have the best team in the world and they tell you they can pour concrete without boxing, trust them. Give them all the resources they need and let them fly."

Professor Bev Lawton

Named the Kiwibank New Zealander of the Year (2025), Professor Bev Lawon has driven critical advancements in cervical cancer screening, maternal health, and indigenous health equity. Bev's advocacy led to New Zealand's historic shift to HPV self-testing as the primary method for cervical screening – making Aotearoa the first high-income country to do so.

Bev said she was asked to speak about anything she liked, "so I thought I'd concentrate on something general practice has done so well at."

And that topic was cervical cancer. During Bev's career, the HPV vaccine and the self-test have been rolled out. "We're going to eliminate cervical cancer and you're going to be a large part of that."

Since the self-test was rolled out in September 2023, a significant number of screens have taken place. "The rates have gone up; we're reaching people who've never been screened before and people who were behind in their screening."

Above: Sir Ian Taylor
Animation Research Ltd (ARL)

Below: Professor Bev Lawton
Kiwibank New Zealander of the Year (2025)

Bev also shared some very promising news from Scotland, where they have close to a 90% HPV vaccination rate. They have detected no cases of cervical cancer in women born between 1988 and 1996 who were fully vaccinated between the ages of 12 and 13.

"We should be part of that journey of vaccination, when we see someone who's got a child in vaccination age…we can do a lot of good."

Fireside chat with Professor Dame Helen Stokes-Lampard and Dr Samantha Murton

At GP25, a fireside chat between Professor Dame Helen Stokes-Lampard, National Clinical Chief Medical Officer at Health New Zealand | Te Whatu Ora, and then College President, Dr Samantha Murton, was an interesting part of Friday's morning programme. Their chat highlighted critical developments in general practice, focusing on recognition, training, and leadership challenges.

There was excitement about funding for the GPEP training programme, and the Minister's supportive approach to general practice, including the acknowledgment of GPs as specialists. They also highlighted the importance of Fellowship and professional accreditation, accreditation, with a focus on needing to have College Fellowship to be called a specialist GP, and they talked about the need for training pathways that prepare GPs for future health care challenges with an emphasis on holistic, patient-centred care.

Prof. Dame Helen talked about the comparison between UK and New Zealand health care systems, and they identified that some of the emerging challenges for New Zealand's health care system will be the regulation of physician associates, addressing underrepresented healthcare areas (dental, reproductive health), and creating supportive environments for GP training and retention.

Overall, their discussion was insightful and focused on emphasising the need for strategic leadership and a forward-looking approach to general practice.

Dr Samantha Murton (left) and Professor Dame Helen Stokes-Lampard (right)

Submit your feedback

GP25: Peter Anyon Memorial Address

Given by Dr Gemma Herbison

The Peter Anyon Memorial Address is given by a GPEP year 2 registrar at the College's annual conference and is focused on their journey in general practice, their experiences so far, and where they see the future heading. The presentation is given in memory of Dr Peter Anyon, who is recognised as having made an important and valuable contribution to the vocational education of general practitioners.

At GP25: the Conference for General Practice, Hamilton-based GPEP year 2 registrar Dr Gemma Herbison delivered the address first thing in the morning on Saturday 26 July. We have included her moving address below for you to read.

Dr Gemma Herbison

Delivering the Peter Anyon Memorial Address at GP25

Kia ora koutou,

Ko Gemma Herbison tōku ingoa.

I'm a GPEP2 registrar, a dance teacher, a new mum-to-be, and this past year, unexpectedly, a hospital patient. It's a privilege to be here giving the Peter Anyon address. I've been asked to reflect on my journey to general practice, experiences of GPEP1, and where I see us heading. I feel humbled and a little intimidated, especially as I know many of you have walked down this path much further than I have. But what I want to talk about today is not just the clinical journey, but the emotional one. I believe that right now, no matter how long we've been in medicine or general practice, we're all grappling with similar questions – questions like:

- How do we care deeply without burning out?
- How do we hold space for suffering when we're barely keeping our own heads above water?
- How do we deal with the endless uncertainty?
- And how do we stay human, in a job that so often demands more than we have to give?

If there's one thing my time in general practice and as a patient has taught me, it's this: people don't remember the diagnosis – they remember feeling believed and cared for. As general practitioners, we are uniquely placed to bring humanity back to a system losing touch with it. That's what I want to explore today.

The path to GP

So, what makes me me? I grew up in Tāmaki Makaurau Auckland to an accountant father from Invercargill and a paediatric dietitian mother from Tuakau. I'm the eldest of two and I am lucky to still be very close with my younger brother. I was one of those kids who thrived on praise. I loved learning and was determined to do well. But my real passion was dance. For most of school, I thought I'd be a professional dancer – until an injury in Year 13 forced me to reconsider. A career advisor told me, "You're academic and like people – you should be a doctor." "Okay sure," I said. So, I went off to Otago.

Like many, I had a bit too much fun in my first year. I was waitlisted for medicine and didn't get in. So I pivoted, completing a degree in physiology and public health. Those years were formative, cold, taught me resilience, self-direction, and the value of curiosity over certainty. I loved my studies and proudly graduated top of physiology, earning a place in medical school as a postgraduate.

I chose to return to Auckland – not just for family, but also so I could go back to teaching dance. Somehow, I managed to juggle pre-clinical medical training with teaching dance and Pilates. It wasn't easy, but it gave me balance. The creativity and connection I found in the studio grounded me in a way that clinical training alone never did, so I've been doing it ever since. Medical school, however, doesn't always value that balance.

In my third year, I flew to a dance medicine conference in Hong Kong, returning jet-lagged the morning of our final progress test. I scraped through with a borderline pass. Despite strong marks elsewhere, that one score meant I was 'tagged' and faced repeating the next year if I scored borderline in just one more progress test. Overnight, everything felt uncertain; my worth, my identity as a capable student, even my place in medicine. The system didn't care what else I was achieving, carrying, or who I was beyond that test number.

That moment revealed something important, and uncomfortable, about how medical training often devalues our humanity. Instead of learning how to be whole people who care for other whole people, we're taught to perform, to compete, to prove ourselves. And unless we consciously challenge that lens, we risk carrying the same reductionist thinking into our clinical practice. To my supervisors the next year, I looked fine. But inside, I was bracing for failure. That seeded uncertainty and reminded me how fragile the illusion of control is, especially in a system that demands so much but allows so little space for being a diverse human.

I share this because students and registrars you supervise may be carrying unseen burdens: illness, caregiving, responsibilities, financial strain, trauma, academic pressures – all while trying to excel in a culture mistaking composure for coping. If we want a future workforce that values people over performance, we need to be curious about how someone is doing as a person, not just clinically. Because we ultimately want doctors who do the same for their patients.

Starting GPEP1

After taking a year's break from medicine teaching dance full-time, I returned determined to be a doctor who saw the whole person. I did my TI year in Rotorua Hospital, then worked there for three years. I loved the hospital community but felt frustrated we treated problems, without caring about the people experiencing them. I wanted to know about my patients' lives and jobs. It was my now husband who said on holiday, "You know you're describing a GP, don't you?" So I signed up for GP training that evening!

When I started GPEP1, I felt all the things I imagine many of you did – nervous, excited, hopeful… and completely unqualified. On my first seminar day, I came home and cried. Not because anyone was unkind, but because I felt so out of my depth. The 2024 Bay of Plenty GPEP1 cohort were some of the most articulate, compassionate, brilliant young doctors I had ever met. I was beyond intimidated. In our first simulated consult, I froze and couldn't recover. Later that same day, I was asked to give a 30-second 'spiel' on sarcoidosis and I nearly burst into tears. On the outside, I probably looked fine. I knew how to play the part – how to ask good questions, how to sound competent. But under the surface, my legs were again kicking furiously to stay afloat.

I think we underestimate how isolating this kind of imposter syndrome is, especially in a profession that rewards certainty and control. We talk a lot about resilience in medicine, but not nearly enough about the loneliness that can come with trying to appear resilient. How many of you feel, or have felt, like no one truly understands you because the person you are presenting on the outside is much more put-together than the one on the inside? How often have you answered, "Yeah, I'm doing fine," when what you really meant was, "I'm not really coping"? There's this unspoken culture in medicine where vulnerability is weakness, and asking for help can feel like failure. So, we put on our professional faces, we tell ourselves it will get better – and all the while, we drift further from each other.

I was lucky to have supervisors and mentors who shared their own experiences and uncertainties with me in a way hospital consultants never had. They didn't expect me to have all the answers, they just expected me to be present, listen and care.

I encourage you when you go home to share your messy bits with your colleagues, your juniors. Not in a superficial, "See I'm just like you" way, but to say "Yeah, it's real; often this sucks." The irony is that general practice itself is probably the most messy and uncertain specialty. Instead of diagnoses, it often gives you complexity and ambiguity. But this, perhaps, is also a quiet superpower of general practice: We're not there to impress. We're there to accompany. To meet people in their messy, uncertain realities, and stay with them, even when we can't offer neat solutions.

Becoming a patient

So just as I was beginning to get comfortable in the 'grey' of general practice, life did what it often does – it threw me entirely off balance. My dad had two TIAs and my mum was diagnosed with endometrial cancer. I became a family member; scared, waiting for results, realising how long "only two weeks" until a clinic appointment could really be. Then, I became a patient, critically unwell, vulnerable and voiceless.

It started suddenly and spiraled quickly. I remember flashes of being loaded into an ambulance in Rotorua, and the next thing I remember is opening my eyes, finding I was intubated, not knowing I'd been flown to Auckland DCCM. I experienced things I had only ever documented in notes: delirium, hallucinations, central lines, ventilators, scans, confusing ward rounds, lots of doctors telling me their opinions and plans. But more than the medical crisis itself, what's stayed with me is how it felt to be on the other side.

- I remember the terror of waking up with a tube down my throat. I was wide awake and couldn't tell anyone.
- I remember a nurse telling me, "The doctors will be around in two hours to decide whether the tube can come out," and thinking two hours??!!
- I was delirious for the vast majority of my stay.
  - I hallucinated bugs on the walls.
  - I became convinced that everyone in the hospital hated me because I had used up all the hot water when I had a shower.
  - I hallucinated an abusive man and when I tried to apologise to my nurse for his behaviour was told, "There is no one in the bed next to you."
- I had withdrawals from a sedative agent, and felt like my body was on fire, but I couldn't scream because I had no voice having just been extubated.
- I couldn't control my bodily functions for multiple days, and when I finally could, and asked for help to use the commode, I was told to just 'go' in a nappy until the nurses had a break. The indignity of that is difficult to comprehend.

We forget how scary and dehumanising hospitals are. I'm a doctor who worked there and I'm still struggling with that trauma. What about patients who don't understand the systems or language?

There were kind staff, but many were run off their feet or out of their depth. Excellent clinical care wasn't enough to stop the helplessness I felt. What was missing was humanity; a person to acknowledge what had happened to me, not just my body. The only doctor I truly remember is not the one who diagnosed me or solved all my medical problems. It was the night-shift registrar who sat with me in the middle of one terrifying night when I was delirious and said, "I'm here, what do you need?"

We as GPs can validate patients' emotions in ways hospitals often don't. Even just a text message after receiving a discharge summary saying, "Gosh, I see you've been through a lot, let me know if you need anything," can matter. I know it is so frustrating when patients refuse to go to hospital; it's easy to get annoyed. But if we can acknowledge their fears, we help. I think about the chest pain patients, waiting for hours only to be told, "It wasn't a heart attack; you're fine, go home" – and having their hours of fear, uncertainty and discomfort dismissed.

As the system strains worse, we must advocate for patients and remind our colleagues that behind the vitals is a scared, vulnerable person. This reality is uncomfortable for many clinicians because we have been quite literally trained to see the problem, not the person.

Returning to work

Coming back after illness wasn't triumphant. It was slow and uncertain. Terrible orthostatic hypotension kept me from sitting upright for weeks. But the College and my supervisors held space for my recovery in a way I'm not sure the hospital would have.

I found myself less focused on 'right' diagnosis, more on helping people feel safe. Saying things like: "That sounds really hard," "I see why you'd be worried," "You're NOT overreacting." Because what I noticed most after being a patient was just how much uncertainty people live with. Not just medical uncertainty, but emotional and existential: Is this going to get worse? Will anyone believe me? Am I going to be okay?

We don't always have answers. But we can sit beside the uncertainty, especially as wait times and delays grow and grow. That, I think, is the future and the heart of general practice. We don't fix uncertainty; we hold it. That in itself changes things. Maybe not the outcome. But always the experience.

Conclusions

We work in a system growing more impersonal, rushed, and task focused. But general practice at its best is the opposite. We see the long arc of lives. We witness grief unfold. We notice abuse signs. We explain highly confusing hospital discharges. In a medical world where many feel unseen or dismissed, we have the privilege to be where people feel heard.

But I want to be honest: this is hard. Holding space for others' pain when your own cup is empty is exhausting. We can't keep asking GPs to be infinitely kind in an unkind system. Many of us are burnt out, rushing between consults, managing inboxes, carrying growing workloads in a system we didn't design and can't fix. When you're under-resourced and overwhelmed, empathy can feel like just one more thing you're failing at, when in reality, it's the part that probably needs most protecting. When I was a delirious patient, all I needed was someone saying, "I'm here for you."

Going forward I think acknowledging how much we are each struggling is going to make the struggle more bearable. Giving ourselves permission to get it wrong, to suck sometimes, to be honest about limitations, and recognise that we are doing our best in an imperfect system – that's how we stay human.

My hope is this: If we as GPs can just be human, whole people doctors, who support the development of more human, whole people doctors, we will be making a difference.

Submit your feedback

Congratulations to our new Fellows and award winners

On Saturday 26 July, the College hosted its Fellowship and Awards ceremony at the conclusion of GP25: Conference for General Practice, at Te Pae Convention Centre in Ōtautahi Christchurch. The ceremony is always a highlight, and this year was no different. It was a fantastic evening filled with aroha, whānau, music and celebration.

Congratulations to the College's new GP, rural hospital doctor and dual Fellows and members who received a College award at this year's Fellowship and Awards ceremony.

Our new Fellows

The members below received their Fellowship at the ceremony. Well done to all of you!

DRHM Fellows

Ms Heather Penman

Dr Andrew Riddell – Waiho i te toipoto, kaua i te toiroa (Let us keep close together, not far apart)

Dr Elizabeth Rimmer – We're all still learning! I aspire to support young doctors into Rural Hospital Medicine. Gratitude to Kai and Te Wairoa whānau.

Dual Fellowship

Dr Ceridwen Hutchinson

GP Fellows

Dr Jinhee Ahn – 희망과 위로, 공감적 치료를 제공하고 싶습니다. Provide hope, comfort and empathetic care.

Dr Jake Aitken – Lets stop talking about it, and actually do something about providing culturally safe, equitable care

Dr Emma Aldridge – He aha te mea nui o te ao? He tangata he tangata he tangata! What is the most important thing in the world? It is people, it is people, it is people!

Dr Hadeel Alqadhili

Dr Tash Austin – "If you find it in your heart to care for somebody else, you will have succeeded." – Maya Angelou

Dr Esther Avnit – supporting the patients in the rural community , improving the access to medical care

Dr Sarah Ballam

Mrs Kimberley Barr – "Your vocation in life is where your greatest joy meets the world's greatest need." – Frederick Buechner

Dr Helen Bernhardt – To sit alongside a rainbow of people, sharing their humanity, feels like the culmination of all my life experience, education and is my life's work.

Dr David Burton

Beaudicia Carrasco – Thank you to my beautiful family

Dr Duanne Bascon Cavan – "The best way to find yourself is to lose yourself in the service of others"- Mahatma Gandhi

Dr Charlotte Louise Chapman – My journey as a GP Fellow: fluent in acronyms, caffeine, and pretending 15 minutes is enough.

Dr Alvan Wang Chi Cheng – It is a privilege to be a part of each patient's story.

Dr Samuel Cosgrove – "To leave the world a bit better, whether by a healthy child, a garden patch, or a redeemed social condition… this is to have succeeded." – Bessie Anderson Stanley

Georgia Crosson – Whāia te mātauranga hei oranga mō koutou - seek after learning for the sake of your wellbeing.

Dr Hohepa Manupiri William Cumming – Whāia te iti kahurangi, ki te tūohu koe, me he maunga teitei.

Dr Alison Curran – I am excited to continue developing my skills and knowledge in General Practice, in order to provide the best holistic care for my patients. I am looking forward to seeing how my GP knowledge can also enhance my practice as an Urgent Care Doctor.

Dr Katie Molly Ellen Czerwonka – He aha te mea nui o te ao? He tāngata, he tāngata, he tāngata. What is the most important thing in the world? It is people, it is people, it is people.

Dr Mamaeroa Koukouhepule Sise David – I carry my Tipuna with me always.

Dr Manasi Deshpande – As a GP, I strive to always be a strong patient and whānau advocate. I hope to always cherish the art of Medicine and the privilege of being let into people's lives. P.S. Rushabh, Dad, Mum, and Sanaj- this one is for you.

Dr Kirstie Jayne Douglas – Always remember the privilege that being a great GP brings.

Dr Harry Faulls – To listen with care, to act with clarity, to walk beside.

Dr John Alister Fletcher Fernando – Be kinder than necessary, because everyone you meet is fighting some kind of battle.

Dr Anna Flatt

Dr Seamus Flynn – "Why ask why? When how is so much more fun." John Leguizomo, Spawn

Dr Hayley Joanne Foster – I hope to heal with compassion and integrity.

Mr Daniel Fouhy

Dr Rebekah Goodwin

Dr Matire Harwood – In memory of Dr Marty Davis

Dr Tylah Anne Hawken – "I commit to healing with compassion, serving families, and practicing medicine that truly listens."

Dr Caroline Hill

Dr Ceridwen Hutchinson – "When we make training kinder and care fairer, we reshape the soul of healthcare."

Dr Jennifer Ann Irvine – I hope to significantly contribute to my community's health and wellbeing, and will strive to remain humble and patient-centered.

Dr Christina Jenkins – Thank you to Dad, Mum and my husband Nick for believing in me. Micah, Grace and Theo - you are more important than any achievement. I love you xx.

Dr Mary-Anne Kendon – I love people and their stories. Through General Practice I hope to have a positive influence on those stories.

Dr Eli Leckey – From babies to elderly and every health aspect in-between. Pretty much sums up GP. Humbling eh.

Dr Joyce Pui Yee Leung – Continuity of care is a strength in general practice, I hope to see my smallest patients grow up and support them throughout their life journey.

Mrs Elodie Mazoyer – Voltaire used to say "Doctors are men who prescribe medicines of which they know little, to cure diseases of which they know less, in human beings of whom they know nothing." So it makes me feel good that more women practice medicine now :-)

Dr Karina McCaffer – My aspiration is to provide holistic, patient-cantered care that supports the diverse needs of my community as well as contributing to training of future GP's.

Dr David McTaggart – To listen deeply, treat wisely, and care consistently—guiding each patient with compassion, respect, and hope, even when answers are uncertain or the path unclear.

Dr Tania Moerenhout – "Try to be a rainbow in someone's cloud. Develop enough courage so that you can stand up for yourself and then stand up for somebody else." Maya Angelou

Asrih Bin Mohammad Arif – "A good doctor's comforting and reassuring words are sometimes more powerful than the medicines."

Dr Sana Moin – "Whoever saves one life, it will be as if they have saved all of humanity."

Dr Sneha Nanjundaswamy – For me being a GP is the daily privilege of learning, listening and nurturing lives with empathy and purpose.

Dr David Neynens

Dr Ji-Young Park – Working for a healthier community, bridging of health equity gaps, and ensuring accessible and quality care for all in Aotearoa.

Dr Margaret Yvonne Paszyn – To provide compassionate, holistic care that empowers patients, supports their family, and honors the privilege of supporting them through every stage of life.

Dr Jonathan Penno – Live, laugh, love

Dr Rachelle Pound – Never underestimate the ripple effect of making a difference to one person's life.

Dr Justina Pratap – To excel as a GP with the perfect mix of Humanity and the art of Medicine

Dr Marina Pulu

Dr Sanjay Kumar Ram Belas

Dr Anna Ritchie

Dr Amy Rosario – I aspire to practice with competence, conscience and compassion.

Dr Emily Rose Ross

Dr. Lika Rump – "It's one thing to treat a cough — it's another to spot the loneliness hiding behind it. That's general practice."

Dr Ana Vaikoloa Tu'ifua 'Ofa-Ki-Alcorn Saafi – Tonga Mo'unga kihe loto - Tongas mountain is in my heart

Dr Ovida Ortiz Saikam – "Sumusui oku ralan tulun di mokilingos, ralan di poimponu kolisihan om kitonggungan." I choose to walk with people in healing, a journey rooted in love and responsibility.

Dr Amna Samad – Medicine knows no race, religion or border. To heal truly, we must stand against all injustice especially when it harms our fellow healers and the innocent.

Dr Satya Shanbhag – Service to mankind is service to God

Dr Madeline Somerville

Dr Dane Sorrenson – Balancing work and whānau has shaped who I am as a GP. I believe in a future where General Practice is valued and truly thrives.

Dr Kirsty Steggles – I aspire to provide high quality care to improve the lives of my patients in a caring and compassionate manner

Dr Nadine Stringer – "Maybe the best thing to do is stop trying to figure out where you're going and just enjoy where you're at." JD, Scrubs

Dr Rose Sutherland – It is a privilege to work alongside my patients, providing support and knowledge throughout every part of their health journey—both big and small.

Dr Tejaswi Tangirala – Helping patients heal and thrive through skilled, compassionate care in general practice, skin conditions, and upper limb injuries

Dr Victoria Switzer Taylor Simes – I aim to keep the patient at the centre of my care, to keep up-to-date and reflective, to collaborate, without sacrificing key family time.

Dr Katie Tizzard – Through empowering and supporting patients, I aim to give them the confidence and tools to take charge of their health and wellbeing.

Dr Karlina Pasepa Tongotea – Serving our people with a fierce energy and striving for equity.

Dr Leone Gonevakarua Vadei – "Hi, tell me how you doing?" (uh-oh here we go again). But do tell me, because you and me together - we can make it better!!

Dr Minet van Zyl – What we do is a privilege. People let us into the most intimate aspects of their lives, and look at us to help them.

Dr Ajay Mathew Varghese

Dr Rebecca Walker – Gratitude and Kindness

Dr Isabel Walraven

Dr Ella Margaret Williamson – I am proud to be a GP and hope to continue working with my patients to improve their health and wellbeing

Dr Pedram Zawarreza – You did not come here for nothing. You came to heal, to understand, and to love. Rumi

Dr Angela Zhang

Dr Yuchen Zhang – "Ehara taku toa i te toa takitahi engari he toa takitini" - My success is not mine alone, but it is the strength of many.

Above: Dr Luke Bradford (left) with Distinguished Fellows recipients.

Below: Dr Luke Bradford (left) and Community Service Medal recipient **Dr Sam Mayhew (right)**

College award winners

Distinguished Fellowship

Awarded for outstanding service to the College's or Division's work, or the science or practice of medicine. Distinguished Fellows embody our motto 'cum scientia caritas' – with knowledge, compassion,' and have made sustained contributions to general practice, medicine, or the health and wellbeing of the community.

Dr Glenn Doherty, Ngāti Porou

Dr Aniva Lawrence

Dr Jason Tuhoe, Hauraki, Ngā Puhi, Ngāti Pikiao

Dr Juliet Walker

Dr Andrew Webster

President's Service Medal

Recognises an outstanding contribution to the College or Division of Rural Hospital Medicine.

Dr Andrew Corin

Dr Maryann Heather

Dr Bryce Kihirini, Ngāti Moko, Tapuika, Tūhourangi

Dr Linda Pirrit

Community Service Medal

Recognises members who have made an outstanding contribution to general practice or rural hospital medicine through work in their own communities.

Dr Sarah Callaghan, Ngāti Porou

Dr Christine Coulter

Dr Brendon Eade

Dr Rachel Inder

Dr Jonathan Kennedy

Dr Monica Liva, Villages of Malie Samoa and Vaiea Niue

Dr Shelley Louw

Dr Sam Mayhew

Dr Maia Melbourne-Wilcox, Ngāi Tūhoe, Ngāti Porou

Dr Raewyn Paku, Ngāti Kahungungu ki Te Wairoa

Dr Sara Simmons, Ngāi Tahu, Ngāti Māmoe, Waitaha

Dr Juliet Tay

James Reid Award – Excellence and Innovation in Rural Health

For a rural medical practitioner or trainee (doctors and other medical professionals) who has demonstrated excellence and innovation in education or rural health research.

Dr Robyn Carey (DRHM)

Eric Elder Award

The Eric Elder Medal is awarded in honour of Dr Eric Elder, who was an inspirational rural GP affectionately known as the grandfather of vocational training in New Zealand. The medal is generally awarded to a rural general practitioner.

Dr Margaret Fielding (Dual)

Humphrey Rainey Prize for Excellence

The Humphrey Rainey Prize for Excellence is awarded to the top candidate overall across the General Practice Education Programme (GPEP) clinical and written examinations.

Dr Charlotte Trevella

Dr Amjad Hamid Medal

The Dr Amjad Hamid Medal is awarded in honour of Dr Amjad Hamid who was killed in the 2019 Christchurch terrorist attack. The medal recognises the top student of the University of Otago's GENA 728 paper, which is Cardiorespiratory Medicine in Rural Hospitals. Dr Hamid, a heart doctor, was a member of the College's Division of Rural Hospital Medicine.

This year there were two recipients:

Dr Madeline Carpenter
Dr Bronwyn Kjestrup

Fellowship and Awards ceremony orator

Each year, the Faculty Executive based in the city of the conference nominates a local member to give an oration at the Fellowship and Awards ceremony. The oration highlights their journey into general practice or rural hospital medicine, their experiences over their career and hopes for the future of health care in Aotearoa New Zealand.

Honorary Fellow, Dame Sue Bagshaw

Above (from left): Dr Luke Bradford, Dr Andrew Laurenson and James Reid Award recipient **Dr Robyn Carey**.

Below: Honorary Fellow, Dame Sue Bagshaw Fellowship and Awards ceremony orator

Submit your feedback

2025 Greg Judkins Prize for Reflective Poetry

Each year the College runs the Greg Judkins Prize for Reflective Poetry alongside Dr Greg Judkins, a retired GP and Distinguished Fellow of the College.

Greg is also a published poet and writer. His lifelong love of poetry and fiction led him to start writing short stories, inspired by glimpses of the extraordinary lives of the people he encounters in his medical work.

The 2025 competition

This year, the theme was 'surprise,' and there were two categories:

- **Short poem:** Up to six lines
- **Long poem:** Up to 25 lines.

The competition was open to all College members.

The judges

This year's competition was judged by Greg, alongside Dunedin poet Ruth Arnison and Dr Art Nahill, a retired poet-doctor.

The results

The winners were announced at the recent GP25: Conference for General Practice in Ōtautahi Christchurch.

Short poem winner

Dr Mary Obele

She brought her kuia in for meds,
And asked if wairua can get sick too.
A boy with stomach pain,
Told me his dad hit too hard.
The bloods were normal,
But her silence wasn't.

Dr Greg Judkins presenting the "Greg Judkins Prize for Reflective Poetry" at GP25.

Long poem winner

Dr Phil Weeks

Joy
A treasured patient gradually declining
I hold her gently shaking hand
I stumble awkwardly searching for the right words
Mere kindness cannot replace the sadness I feel
or my perceived inadequacy at not slowing the inevitable
Is Pathos really the best I can do?
Quietly I rage
I know the Pathology but still feel helpless with her suffering
I search my drying well of empathy
In vain
"We may need to find you somewhere special..... for when things get worse"
It seems as tame now
as it did then
But I see a sudden sparkle in her eye
and I do not have to wait long for the riposte
"Did you mean a coffin, doc?"
she wheezes laughing hard
Her tears of joy match mine of sorrow
then joy
as our laughter frees us both.

Dr Phil Weeks
2025 Greg Judkins long poem winner

Submit your feedback

MIND THIS

GP held responsible for gynaecology triage error

Dr Peter Moodie

The Case

In 2019, Ms A who was in her sixties, was referred by her general practitioner, Dr B, for urgent investigation of a possible bowel cancer. Three months later, a gastroenterologist, Dr E, identified that Ms A had no CT evidence of a bowel malignancy but that she had a mass in her abdomen which Dr E thought was a likely ovarian cancer. Dr E referred her back to Dr B and suggested that Ms A be followed up with an ultrasound and an urgent gynaecology referral. Dr E followed up his letter with a phone call.

Gynaecology and radiology referral

Dr B made urgent gynaecology and radiology referrals to the public hospital the same day that Dr E's advice was received. Dr B recorded in the referrals that the abdominal mass was "palpable".

That same day Dr B was sent electronic confirmation that both applications had been received. Some days later, Dr B was told that the urgent gynaecology referral had been declined "as there was insufficient information to triage the referral." Dr B was advised to reapply after a community-based ultrasound and three cancer markers, CA125, CEA and CA19-9 had been done.

Dr B had no access to community funding for an ultrasound and felt that the only relevant marker was a CA125, which came back abnormal within two days and was sent to the gynaecology department. Dr B warned Ms A that there would be a significant delay for the ultrasound, but that she should report back if her symptoms changed.

The following seven months

Dr B saw Ms A on a number of occasions, and at one visit some two months after the gynaecology referral, asked her if she had heard from the radiology department. When told no, Dr B instructed their staff to call the department to see what was happening and was given the information that "there was a long wait."

Ten months after the original referral, Ms A presented acutely with a possible bowel obstruction and was admitted that day. CTs and an ultrasound followed by a biopsy confirmed that Ms A had an inoperable ovarian tumour – this was the same provisional diagnosis made some seven months previously.

It was discovered that the radiology referral and confirmed acceptance by the hospital seven months previously had never actually been actioned. The

Peter Moodie is the College's Clinical Advisor

hospital receptionist Ms D explained that this was the first day in a new role and the actual appointment booking had never been booked. Notwithstanding this, two months after this referral, Dr B's receptionist was simply informed that "there was a long wait."

Health New Zealand Adverse Event Report (AER)

In the AER report, Health NZ acknowledged that there was a 'systems limitation' between the RMS and the RIS. In plain English, this means that the radiology receptionist was not responsible for booking the appointment. 'Systems limitation' is probably up there with Trumpian terms like 'alternative facts.' Astoundingly Health NZ had been aware of this problem for the previous six years, as there had been other similar incidents. They have, however, agreed to revisit the problem but can give no timeframe.

Health NZ stated that as the referral by Dr B had been declined (but subject to further tests being done), Dr B therefore bore responsibility for following up on the patient.

To summarise

Dr B identified that Ms A had some form of malignancy and appropriately made a referral, firstly to a gastroenterologist and then on their recommendation to a gynaecology department with provisional diagnosis of 'probable ovarian cancer.'

Dr B's referrals for both an ultrasound and an OPD appointment were electronically acknowledged. However, the ultrasound referral was never actioned, due to poor radiology processes. The gynaecology referral was declined because of 'incomplete information.'

It appears that acceptance of the gynaecology referral hung on the demand for an ultrasound and various cancer markers. Dr B did arrange bloods for one of the markers, but thought the others were irrelevant (which was backed up by NZ Health pathways). The radiology referral was accepted but never actioned by the hospital. Further, the acceptance of the gynaecology referral was dependent on the ultrasound being actioned.

The outcome

Health NZ admitted that they had inadequate safety tracking of referrals and were found to be in breach of the Code. They had known about these risks (and had had previous events) since 2014. They have promised to do a review of their processes.

Ms D, the hospital receptionist, came in for no real criticism and was adjudged to be a victim of poor training and a poor system.

Dr E, the gastroenterologist, was found to have behaved entirely appropriately. No one commented on the fact that it took three months for Ms A to get a CT.

Dr F, the gynaecologist, was cleared of responsibility by Health NZ as they were following a recognised triage pathway, and as the original referral had

been declined, the case remained Dr B's responsibility until it was accepted when the various tests had been completed. There was no comment about the quality of the triage tool that was used, or that Dr F had not acted on several red flags.

In reality, the hospital could have arranged all the tests that they demanded that Dr B organise before they would accept the referral. General practice is busy enough without having to act as a 'house surgeon' for a hospital department.

Expert opinion

Medical Protection Society, acting for Dr B, engaged an expert advisor (a senior general practitioner with a teaching role at National Women's) who made the following comments:

- "I see no support in the literature for the value of CEA and CA19-9 for the diagnosis of ovarian cancer, and I think to consider that the failure to perform these tests should in any way have impinged on the acceptance of this GP referral in a timely (urgent) fashion is frankly outrageous."
- Further: "I find the Gynaecology Department's response to this referral quite concerning. In my view a request for an urgent appointment for a solid 6x5x6cm adnexal mass in a symptomatic 60-year-old woman – essentially Ovarian Cancer until proven otherwise – requires exactly that, an urgent appointment."

Dr B

Dr B was criticised for not having put the patient on an active recall register to ensure that the public hospital had not 'lost' the patient within their systems. He was also admonished for not carrying out all the cancer markers without having spoken to the gynaecologist.

Lessons

1. As we have noted before, Health NZ will work to defend its staff quite vigorously and will have no hesitation in trying to lay the blame on primary care. In this case, that extends to defending a triage protocol which was clearly not fit for purpose.
2. It seems odd that Health NZ would carry out an AER of an event without involving the general practitioner.
3. While HDC do a very thorough job, they can sometimes 'miss the woods for the trees.' In this case, there were larger clinical issues that were not identified. In an ideal world, draft decisions could be vetted by a clinical group before becoming final.
4. It is an extraordinary situation where general practice systems are supposed to be designed to pick up failings in secondary care.
5. When a referral is obviously life-threatening, is it ethical to use a hospital triage protocol to demand that primary care must do work that could have been done more easily by the hospital service itself?

Submit your feedback

MIND THIS

Coroner's recommendations – Lorazepam

Dr Peter Moodie

The Coroner has asked the College to highlight to members the sad case of a 48-year-old man (Mr B) who died, probably accidentally, from a combination of alcohol and lorazepam ingestion.

The man, who lived in a provincial city, was known to have been a heavy drinker since adolescence. Although he was married with two children and supportive friends, his drinking was beginning to take a toll on his mental health and his relationships. He was said to have drunk "24 drinks a week," but this was an inaccurate figure.

On 19 February 2021, after a discussion with his wife, he was taken to the public hospital's Emergency Department, drunk and with suicidal ideation. He was assessed but not admitted and subsequently was seen by an urgent care clinic the next day. There he was prescribed lorazepam to help with his detoxification.

The urgent care doctor specifically recorded that the lorazepam should be given to his wife to administer (his wife was not at this consultation). Subsequently, his wife advised that she had no knowledge of this instruction; however, a friend who was there remembered that he had been told not to take the lorazepam if he was drinking alcohol.

On 24 February, Mr B took the day off work as he was feeling tired. He was seen by two sets of friends and relations during the day when they described him as being in a good mood, indeed planning to build a barbecue the next day. They did, however, note that on a not particularly hot day he was sweating profusely and on one occasion smelt of alcohol.

At 10 pm that night, his daughter found him unconscious in bed with vomitus around his mouth and front. She and a friend observed that he took a couple of breaths in response to painful stimuli but then appeared to arrest. CPR was started, and he was admitted to ICU where he died some days later.

Curiously, blood for toxicology was not taken until 9.30 am the next day, which showed lorazepam levels within the therapeutic level; however, blood alcohol levels were at 153mg per 100mL, approximately three times the legal driving limit.

Mr B likely died of hypoxia due to a high level of alcohol consumption and a moderate dose of lorazepam.

The fact that the urgent care doctor carefully noted that the lorazepam should be administered by another responsible person is to be commended. Unfortunately, that advice was not passed on to his wife.

Even a therapeutic dose of lorazepam in the presence of high alcohol can be fatal.

Peter Moodie is the College's Clinical Advisor

Access and Choice

Five years of progress in primary mental health

Since its establishment in 2019, the Access and Choice programme has transformed New Zealand's primary mental health landscape. Te Hiringa Mahara | Mental Health and Wellbeing Commission's report highlights significant achievements and charts the path forward for the continued integration and embedding of the programme.

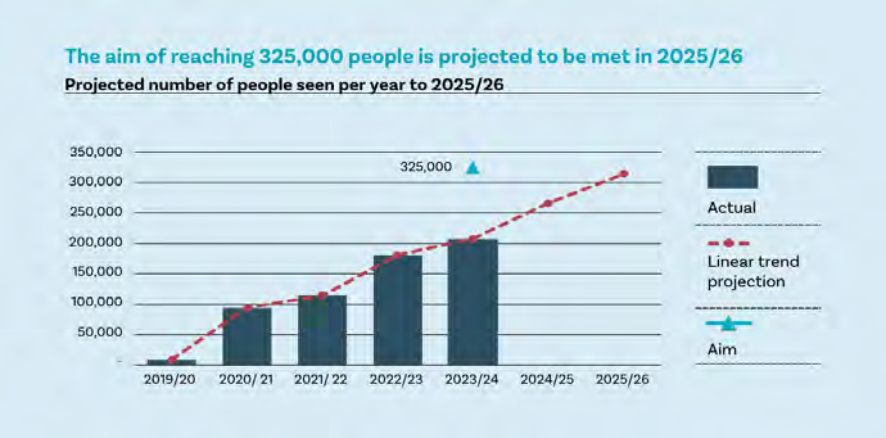
The IPMHA model

A key part of the programme is the Integrated Primary Mental Health and Addiction (IPMHA) service, providing accessible mental health and wellbeing support in GP clinics nationwide. This integration has proven invaluable, with GPs reporting that Access and Choice staff have alleviated time pressures and enhanced their capacity to support patients with mental health needs.

As of June 2024, IPMHA services reached 68% of enrolled general practice patients – just shy of the 70% target. While this represents substantial progress, IPMHA coverage varies widely by district. Furthermore, 32% of the enrolled population still lacks access to IPMHA services at their local practice, though they may access Kaupapa Māori, Pacific or youth services where appropriate.

Significant progress with room to grow

While the programme has achieved substantial reach – with over 207,000 people accessing support in 2023–24 and 1.6 million sessions completed since inception – these numbers fall short of the annual aim of 325,000 people. Despite this gap, Karen Osborn, Te Hiringa Mahara's CEO, emphasises the value of current achievements: "The impact of reaching people early is a huge net positive for Aotearoa – not just for those who need it, but for our health system, our workforce, and for New Zealand as a whole."



Addressing population-specific needs

In addition to IPMHA, the programme's structure incorporates tailored services for rangatahi and young people, Māori and Pacific people – populations experiencing disproportionately higher levels of psychological distress. These offer culturally responsive options for people.

This targeted approach has yielded results; for instance, 20% of all people who accessed services were young people aged 12–24 – equivalent to nearly 42,000 patients.

Mixed impact on referrals

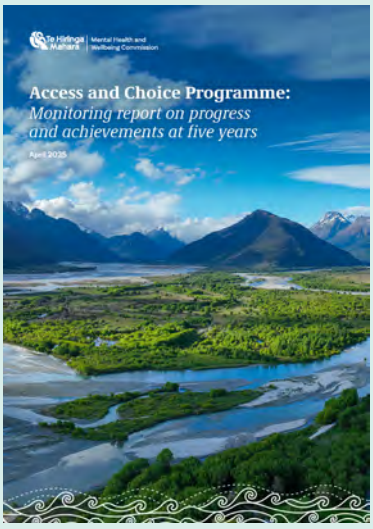
While the number of referrals from GPs to specialist services decreased from 2018/19 to 2022/23, the number of referrals from GPs for 'new clients' accepted into specialist services increased, suggesting more appropriate and/or improved quality of referrals. Despite this improvement, constraints in specialist services remain a barrier for people.

Moving forward

While achieving significant milestones, the programme aims to reach 325,000 people annually. We have made three recommendations that will help us get there. The things that need to happen include:

- addressing ongoing workforce needs
- raising awareness of the programme so that this valuable resource is more fully utilised
- enhancing productivity with the continued expansion of multi-practice models and virtual services.

Five years of Access and Choice is a milestone worth celebrating. Primary and community services are critical to ensuring people have early access to services and support when needed. Looking forward, it is time to bring renewed energy and focus to fully realise the impact of this programme.



Click here to read the full report

Submit your feedback

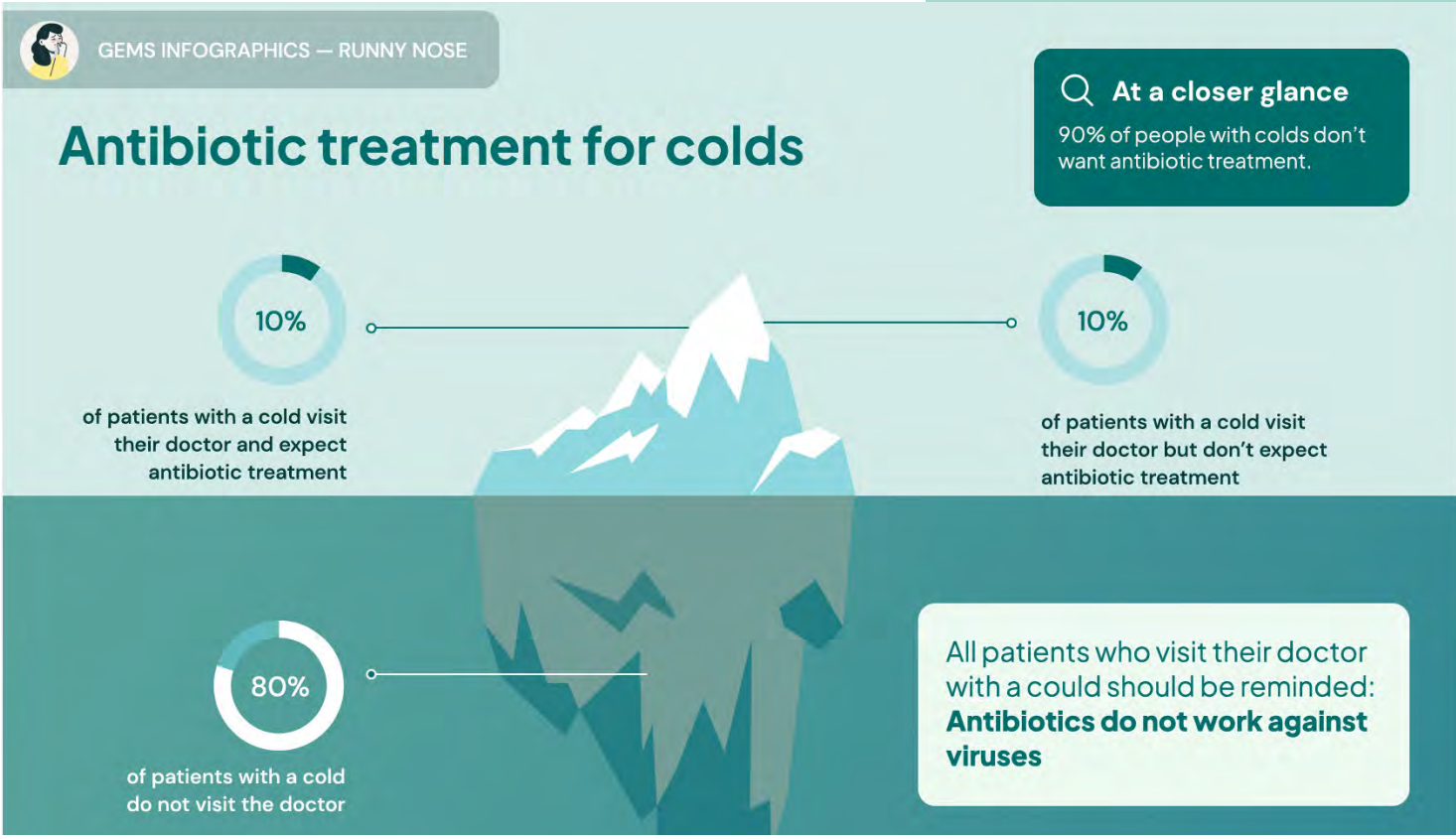
Colds: antibiotic ‘treatment’ provides no benefit

Associate Professors Stephen Ritchie and Mark Thomas
Faculty of Medical and Health Sciences, The University of Auckland.

Colds are always caused by a viral infection, most commonly a rhinovirus, coronavirus or adenovirus. Children have about 5–7 colds per year while adults have about 2–3 per year. Symptoms commonly begin about one day after exposure, and are most severe 2–4 days after onset, often lasting for 1–2 weeks.

One might expect that almost no one would consider visiting their doctor for a cold. In fact, a survey of 1000 adults in the UK in January 2011 found that 20% had recently visited or contacted their GP for an acute respiratory illness. Half of those who visited or contacted their doctor had expected an antibiotic prescription (Figure 1).

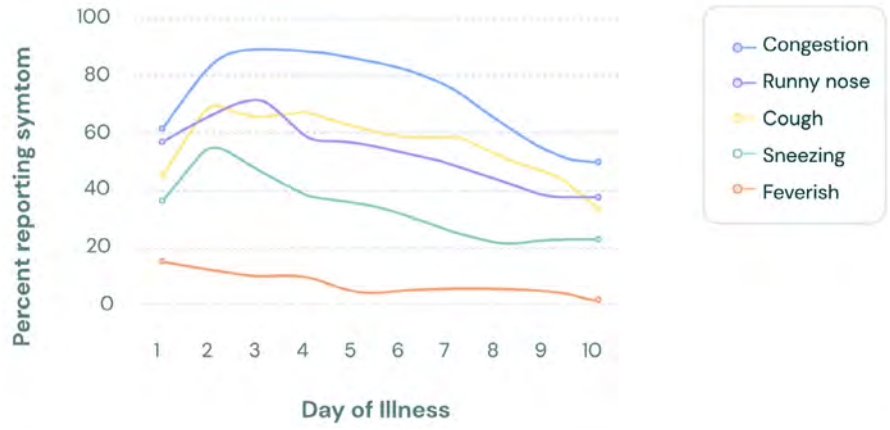
Figure 1: Rates of GP consultation and expectation of antibiotic ‘treatment’ in 1000 UK adults during 2011.[1]



A common reason for such GP consultations is that to the patient, the symptoms of the cold seem more severe or more prolonged than normal, or that the patient has a pressing, futile desire for a rapid full recovery.

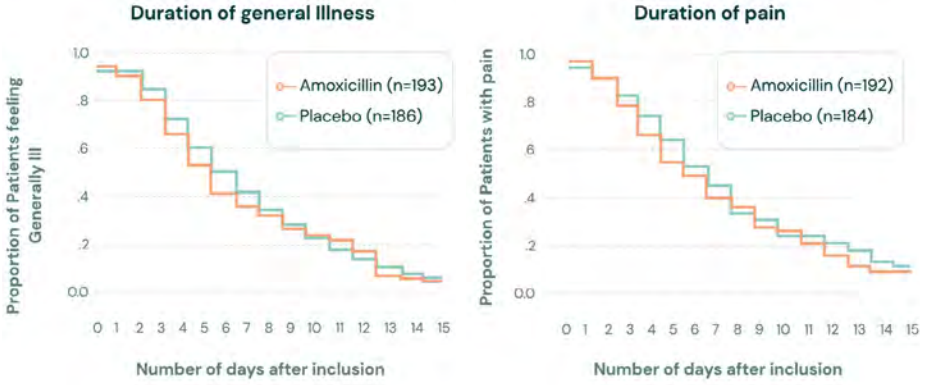
Daily diaries kept by the parents of 81 children aged 5–12 years, from the onset of a cold until recovery, found the most common symptoms were nasal congestion and discharge. In more than 50% of children nasal congestion, nasal discharge and cough all persisted for at least seven days. More than 70% of children still had some symptoms on day 10[2] (Figure 2). Patients who expect a quick cure for a cold are like King Canute trying to turn back the tide!

Figure 2: Proportion of children with cold symptoms from day of onset to day 10.[2]



A common explanation for prescribing an antibiotic for a person with a cold is to treat secondary bacterial infection. There is no evidence that such treatment influences the duration of symptoms. While *Streptococcus pneumoniae* and *Haemophilus influenzae* can commonly be isolated from purulent nasal discharge, cephalexin 'treatment' of children with colds neither reduces the prevalence of these bacteria in the nasal discharge nor alters the course of the cold.[3] In older children and adults with acute purulent nasal discharge and no clinical evidence of sinusitis, amoxicillin treatment reduced the duration of purulent nasal discharge, but had no effect on either the duration of the illness, or the duration of facial pain[4] (Figure 3).

Figure 3: Amoxicillin 'treatment' had no significant effect on the duration either of general illness or of pain in older children and adults with acute purulent rhinorrhoea.[4]



In contrast, treatment with xylometazoline (Otrivine) nasal spray significantly improved nasal airflow and symptoms of congestion for many hours after use (Figure 4a);[5] honey significantly reduced combined symptom score, cough frequency and cough severity (Figure 4b);[6] and application of camphor, menthol and eucalyptus oil (Vicks® VapoRub) to the anterior chest significantly reduced cough frequency and cough severity, nasal congestion, and combined symptom score (Figure 4c).[7]

Figure 4a: Xylometazoline (Otrivine) nasal spray significantly improves nasal airflow and symptoms of congestion.[5]

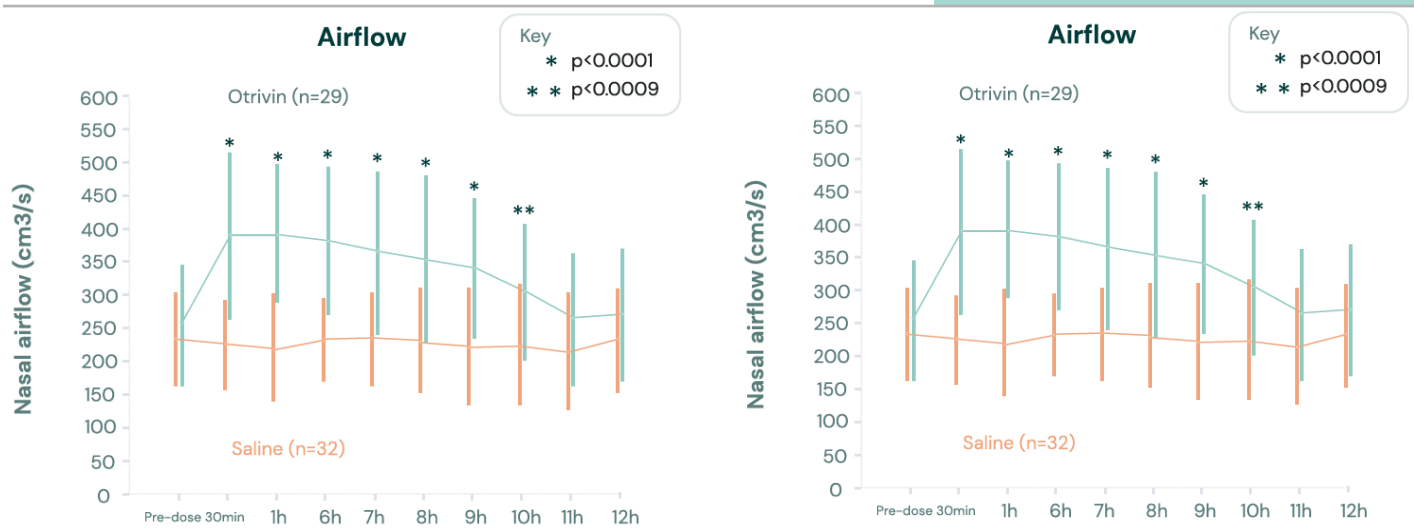


Figure 4b: Honey reduces combined symptom score, cough frequency and cough severity.[6]

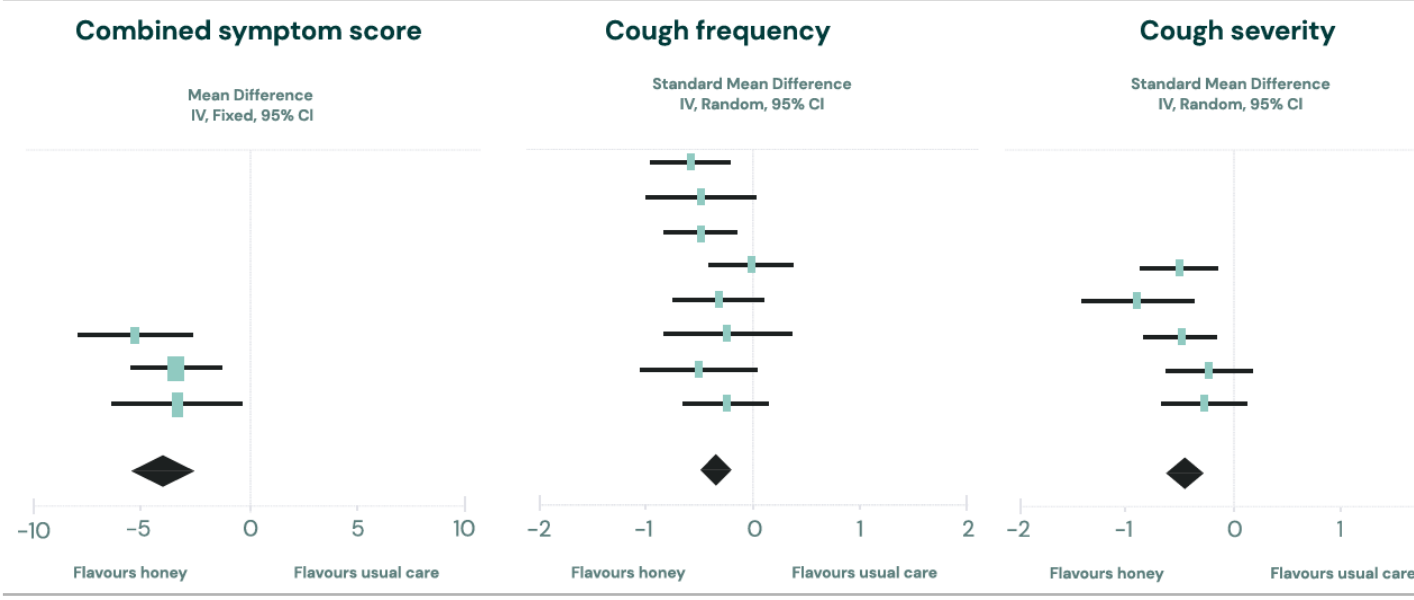
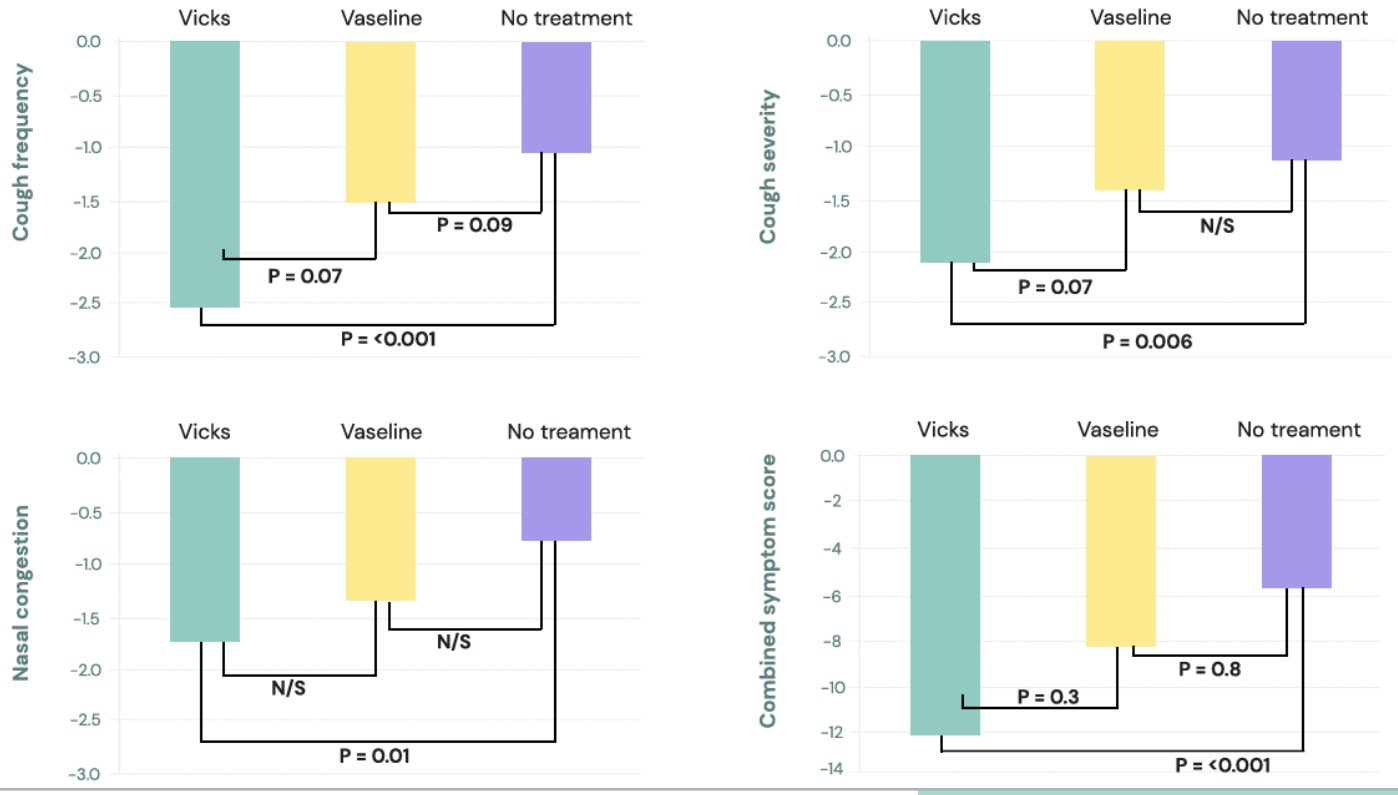


Figure 4c: Camphor, menthol and eucalyptus oil (Vicks® VapoRub) applied to the anterior chest significantly reduces cough frequency and severity, nasal congestion, and combined symptom score.[7]



Prescribers can use consultations with patients with colds to educate them that antibiotics provide no benefit, but that some readily available home remedies do provide significant benefit. This information can support patients to self-manage colds in the future. Strengthening patients' confidence in their abilities to care for themselves and their family members when they have colds can save patients the inconvenience and other disadvantages of unnecessary general practice consultations.

Associate Professors Stephen Ritchie and Mark Thomas, and others at the University of Auckland have created infographics and other resources that can support clinicians to reduce their inappropriate antibiotic prescribing for patients with colds and other URTIs. These can be found at: antibioticconservation.auckland.ac.nz.

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7. Paul IM, Beiler JS, King TS, Clapp ER, Vallati J, Berlin CM Jr. Vapor rub, petrolatum, and no treatment for children with nocturnal cough and cold symptoms. Pediatrics. 2010 Dec;126(6):1092-9. doi: 10.1542/peds.2010-1601.

Goodfellow Unit podcast: **Managing uncertainty in the consultation**

Dr Lucy O'Hagan is a College Fellow, writer and mentor. She works at Oratoa Cannons Creek in Porirua, having previously been a rural GP for 20 years, and is also a College medical educator supporting struggling registrars and providing professional development to teachers.

Dr O'Hagan explores how health care professionals navigate uncertainty in consultations, from diagnostic ambiguity to effective patient communication. It covers strategies for gathering information, using reasoning tools, and managing not knowing while maintaining patient trust.

The key take-home messages of this podcast are:

- "It's always too soon to panic."
- You don't need to know, but you do need to make a plan, and you do need to safety net.
- Go through diagnostic reasoning, which allows you to back yourself so that you can communicate uncertainty with confidence.

Listen to the podcast

Submit your feedback

Journey to Wellbeing Huarahi Ora

New guiding principles aim to reshape self-management support for people with long-term conditions

A major shift is happening to the way self-management support services for long-term health conditions (LTCs) are delivered in Aotearoa, moving away from traditional clinical models towards approaches that centre on whānau, culture and lived experience.

The Journey to Wellbeing | Huarahi Ora project, commissioned by Health New Zealand | Te Whatu Ora and led by the Health Navigator Charitable Trust (HNCT) in partnership with Health Literacy NZ, was launched following a comprehensive review of existing self-management support programmes. It found that previous models were often clinician-driven and not adequately serving Māori, Pacific Peoples or disabled people.

HNCT's Frances King, Ngāti Porou, who helped lead the project, says the old approach was largely individualistic, with power and design resting firmly in the hands of clinicians. "People felt they were being talked down to. For many, especially Māori and Pasifika, it seemed like they were being left to manage their health alone without the collective and cultural supports that are so central to their lives."

The previous Ministry of Health guidelines, published in 2016, were scarcely used by services. "We visited or spoke to about 40 to 50 services nationwide, along with whānau and community groups, and found almost none were using those old principles," King says.

Recognising the need for a 'paradigm shift,' the project developed a new set of seven guiding principles under Huarahi Ora, launched in November 2024. These emphasise whānau-centred and co-designed approaches, cultural safety, meaningful engagement, skilled facilitation, accessibility and sustainability.

"The principles are not just tweaks to existing programmes, they fundamentally reframe who holds the knowledge and power," says King. "They bring lived experience to the forefront – for example, through peer-led sessions – and acknowledge that effective self-management support is about relationships and community, not just individual behaviour change."

For GPs and primary care teams, this may mean partnering more closely with community providers, supporting whānau-inclusive sessions and integrating cultural expertise as well as clinical expertise. King notes the principles are designed to be practical, with reflective questions and links to resources that services can use to assess and adapt their delivery.

Although the approach is still new, having only begun implementation late last year, it has been formally endorsed by Health New Zealand | Te Whatu Ora under the current Government. King hopes this will give it the stability to embed despite the wider upheavals across the health sector. Ultimately, the shift aims to address sobering inequities.

"We know only about 10% of what drives health outcomes is health care itself. Around 40% is behavioural choices, which is exactly the space these programmes sit in," says King. "So, there is huge potential to make a difference here – if we do it in ways that truly resonate with people's worlds."

The seven principles are:

Whānau centred

- Whānau voices are central
- Involved in decisions, actions and practices
- Recognised as experts in their own wellbeing

Co-designed

- Partners with community to meet community needs and priorities
- Prioritises relationships
- Builds capacity and capability

Culturally safe

- Respects cultural practices (e.g. tikanga and kawa)
- Ensures culturally safe content
- Supports a diverse and inclusive workforce

Meaningful

- Holistic and innovative
- Responsive and outcomes-focused
- Supports behaviour change

Accessible

- Welcoming, safe and reliable
- Integrated services
- Encourages and supports participation

Skilfully facilitated

- Emphasis on workforce development and support
- Draws on lived experience
- Provides mentoring

Sustainable

- Ensures continuity and connection
- Adequately resourced
- Strengthened by leadership and regular evaluation

> "These principles don't just tweak old programmes – they completely reframe who holds the knowledge and power."
>
> – Frances King, Health Navigator Charitable Trust

Summary

- **What:** The Journey to Wellbeing | Huarahi Ora project has launched seven new guiding principles for self-management support services for long-term conditions (LTCs).
- **Why:** A review found older traditional models were failing Māori, Pacific Peoples and disabled people – being too individualistic and clinician-driven.
- **Who:** Led by Health Navigator Charitable Trust with Health Literacy NZ, commissioned by Health New Zealand | Te Whatu Ora.
- **How is it different:** Emphasises whānau-centred, culturally safe, co-designed, peer-led, and accessible approaches, shifting power and knowledge to people and communities.
- **For primary care:** Encourages GPs and teams to partner with community providers, involve whānau, and blend cultural with clinical expertise.
- **Next:** Endorsed by Health New Zealand | Te Whatu Ora, with tools and reflective questions to help services adapt.
- **Goal:** To tackle inequities by making self-management support more relevant and effective for diverse communities.

To read more about the principles you can visit the following websites: journeytowellbeing.nz or huarahiora.nz

Sarah Travaglia and **Frances King**
Health Navigator Charitable Trust

Submit your feedback

Improving the uptake of cervical screening among sexual minority women

How health professionals can help

By Sonja J Ellis
Associate Professor, The University of Waikato

Current public health guidance recommends that everyone who has a cervix, is aged 25–69 and is sexually active undergo cervical screening. International research consistently indicates that the uptake of cervical screening among sexual minority women (e.g. lesbians, wahine takatāpui, bisexual women) is considerably lower than for heterosexual women.

While many sexual minority women do regularly engage in cervical screening, a sizeable minority have either never been for a cervical smear, or if they have been in the past, they have not routinely participated. In a recently published research article (Ellis, 2024) fewer than half of the 206 sexual minority women who participated had regularly engaged in cervical screening. This is comparable to the reported participation rate of Māori and Pasifika women, indicating that sexual minority women may potentially be an 'at risk' group for cervical cancer.

The study's findings

In this study, reasons for not engaging in screening regularly (or at all) were varied. One of the most reported reasons for not engaging in cervical screening was having never had sex with men. Regardless of cervical screening status, those who participated in the study indicated that a perception that women who have sex with women are not at risk of cervical cancer is prevalent, with many having been told by a health professional at some point that as a lesbian they did not need to have a smear. This points to a historical legacy of misinformation in which sexual minority women have been given the impression – or in some cases, directly told – that they do not need to engage in cervical screening. However, even where sexual minority women have taken on current guidance around cervical screening (i.e. that if you have a cervix, you need to engage in screening), heteronormativity in both health care generally and this process specifically means that many sexual minority women are reticent to engage. For example, it was common for participants to recount instances in which health care professionals had interacted with them as if they were heterosexual (e.g. assumed their partner was male; asked about birth control) during the appointment.

In addition, for sexual minority women who had never engaged in penetrative sex (the group least likely to engage in cervical screening) and/or have not engaged in routine gynaecological processes (e.g. pregnancy and childbirth), the screening process itself may feel particularly invasive. Any combination of these reasons might put sexual minority women off engaging in such an intimate process as cervical screening.

In this study, participants were also asked what things could be done to improve levels of engagement in cervical screening among sexual minority women. The analysis of participants' responses suggests three main considerations:

1. **Ensure that interactions with patients are inclusive** – don't automatically assume that the person in front of you has a male partner, that penetrative sex is invariably penile or that sexual relationships inevitably involve penetration. Avoid referring to contraception unless you are sure that the person is in a heterosexual relationship or has a medical reason to use it. Be aware that some people who have a cervix will not identify as women and use best practice of referring to patients by name or asking for their preferred pronouns rather than automatically using 'she' or 'her'.
2. **Ensure that information offers clarity to all** – provide clear evidence of the risk of HPV and cervical cancer for those who have never engaged in penetrative sex to enable informed decision-making around engagement in cervical screening. Provide a clear indication of the incidence of cervical abnormalities in sexual minority women specifically.
3. **Provide targeted health information/promotion** – use posters that indicate to sexual minority women that they are welcome in health spaces. Ensure that women who are diverse in gender and/or sexuality are visible in advertising and the promotion of cervical screening. Produce health campaigns that speak to the interests or lived realities of sexual minority women. As one participant wrote:

   "I am yet to see a public health campaign about it that includes anyone with dykey or butch or trans masculine vibes about them. And representation can help! A lot of ads in my lifetime have had more of a 'you are a mum, you are an aunty' kinda angle, which doesn't feel super inclusive of my queer life." (Lesbian, 35–44).

To find out more about the study and the ways in which sexual minority women feel marginalised in cervical screening, you can access the following open access research articles listed in the sidebar of this article.

Additional reading:

Ellis SJ. Improving cervical screening rates among sexual minorities: Insights from Aotearoa New Zealand. Health Promot J Austr. 2025 Jan;36(1):e904. doi: 10.1002/hpja.904. Epub 2024 Jul 22.

Ellis SJ. Are women-who-have-sex-with-women an 'at-risk' group for cervical cancer? An exploratory study of women in Aotearoa New Zealand. Sex Health. 2024 Feb;21(1):NULL. doi: 10.1071/SH23145.

Although there were some trans and non-binary (TNB) participants in the study, these papers do not focus on that group specifically. For information about the uptake and experiences of cervical screening among TNB people in Aotearoa New Zealand, you can read the following article: Carroll R, Tan KKH, Ker A, Byrne JL, Veale JF. Uptake, experiences and barriers to cervical screening for trans and non-binary people in Aotearoa New Zealand. Aust N Z J Obstet Gynaecol. 2023 Jun;63(3):448-453. doi: 10.1111/ajo.13674. Epub 2023 Apr 2

Work and Income updates

Dr Cathy Stephenson FRNZCGP, Principal Health Advisor | Ministry of Social Development

Firstly, thank you all for the mahi you already do to enable your patients to access timely and appropriate support from the Ministry of Social Development. You are a crucial partner in this process.

With the current unemployment and cost of living challenges, and nearly 200,000 people reliant on a health and disability related benefit, ensuring whānau are accessing everything they are eligible for and are supported into suitable paid employment where possible has never been more important. Please find below some key information and resources that we hope will support you in this work.

Assessing Work Capacity

You may have noticed that we have recently made some minor changes to the Work Capacity Medical Certificate that you complete online. The purpose of these 'prompts' is to encourage you to think about employment as a health intervention – as essential to wellbeing as medication you prescribe or therapists you are referring to.

We know that for nearly everyone, being in some form of suitable employment, even if it is only for a few hours a week, has tangible benefits for health and wellbeing, alongside improving financial security. We also know that the longer someone spends on a benefit, the harder it will be for them to move off it. So, keeping people engaged in conversations and planning for employment early in the course of their health condition is crucial. We don't expect you to do this alone! We have a team of Regional Health and Disability Advisors in every region, as well as our Health and Disability Co-ordinators. It is their role to support you with any Work and Income related queries or issues. If you don't know how to contact them, please let me know and I can share their details, or visit the recently launched Work and Income Community Health Pathway.

When assessing your patient's work capacity, please consider all types of work that might be possible for them rather than limiting your assessment to the types of work they may previously have done, or the kinds of employment that you believe are available in your region. It is our role at Work and Income to support clients to upskill or retrain and move into different types of work, and to connect them with employers who can provide the type of flexibility or accommodations that support their health needs, all of which can lead to much better long-term outcomes.

Supported Living Payment (SLP)

This benefit is for whānau living with conditions that severely and permanently impact work capacity. To meet SLP criteria, you need to state that your patient is not able to regularly work 15 hours or more a week in the coming two years (or have a terminal illness), at a minimum. If you are supporting a patient who you think will improve in the next two years, please do not tick this box on their Work Capacity Medical Certificate.

Although this benefit does pay a little bit more than our Jobseeker Support benefit for people with health conditions or disabilities (around $50 a week), people often stay on SLP for many years. Indeed, some SLP recipients will spend the rest of their working lives on this benefit, with all the financial and other challenges that can bring. They are also less likely to get access to employment assistance while receiving SLP because such assistance is targeted at those with work obligations. SLP recipients do not have work obligations.

Resources

Helpful resources that we have recently produced include:

- The **Tips for Health Providers** resource outlines some helpful pointers when filling in our forms or talking to your patients about Work and Income related support.
- The Goodfellow podcast **Navigating Work and Income** and Mobile Health webinar **Improving health outcomes – Work and Income support for patients** provide overviews of the different types of support we can offer your patients – both are eligible for CME points, in case you need an added incentive!
- Our Work and Income Community Health Pathway launched a couple of months ago and has a wealth of information on it, including the contact details of your local Regional Health and Disability team.

It is evident that true partnership between GPs and the Ministry of Social Development is required if we are going to make an impact for our whānau who rely on a health and disability benefit – if you have thoughts on how we can achieve this, or would like to provide feedback on the recent changes to our Work Capacity Medical Certificates, I would be grateful if you would complete this **two-minute survey** or feel free to email me your thoughts directly **Cathy.Stephenson006@msd.govt.nz**.

Nga mihi nui!

Let's partner to support the 1 in 3

The Cancer Society of New Zealand

The Cancer Society of New Zealand | Te Kāhui Matepukupuku o Aotearoa will hold our 35th Daffodil Day this month, raising funds to allow us to continue our work providing trusted community support services, investing in world-class research, and leading strong evidence-based advocacy.

We thank the College for its continued support of our annual appeal and the opportunity to share some messages with you in this August issue from our supportive care leaders.

The Cancer Society will work in alignment with you to ensure coordination and seamless support for those living with cancer across the entire cancer continuum – from prevention and early detection through to diagnosis, treatment, survivorship and palliative care.

We're not just a provider but a system connector and translator, trusted by both whānau and clinicians.

- We're here to walk alongside you and your patients – before, during and beyond cancer treatment. The Cancer Society provides wraparound support, including transport to treatment, accommodation, psychosocial services and culturally responsive navigation.
- We can make your job easier. Our services help reduce the pressure on your practice by addressing the social, emotional, practical and cultural needs of your patients and whānau. The team works closely with community providers, PHOs/GP services and Health New Zealand | Te Whatu Ora to ensure patients stay connected throughout the cancer continuum.
- Let's partner better. Refer earlier and think beyond treatment. We can support whānau right from diagnosis, and even post-treatment, as those living with cancer are a growing cohort. We're happy to visit your clinic, provide resources or co-design better referral pathways with you. Together, we can close the equity gap and improve outcomes.

What we want GPs to know and do:

- Know we offer free, practical and emotional support for anyone affected by cancer, and we have a strong equity focus.
- Know we can support your patients holistically, reducing pressure on your practice.

- Refer early – not just during the treatment stage. If patients decline a referral, you could let them know about our 0800 CANCER information helpline and info@cancersoc.org.nz in case they wish to connect with our services in the future.
- Connect us with your wider team, including practice nurses, social workers, and cultural advisors.
- Partner with us to improve systems, referrals, and reach into high-priority communities.

As a parting thought – if you donate this Daffodil Day and pick up a paper daffodil to wear, why not pin it up in your consult room at the end of the day as a reminder we're here and partnering together will enhance care.

How to get in touch with your local Supportive Care teams:

Michelle Gundersen-Reid
Manager Supportive Care
Cancer Society Auckland Northland
027 431 5609
mgunderson-reid@akcansoc.org.nz

Jenni Drew
General Manager Cancer Services
Cancer Society Wellington
04 389 0085
JenniD@cancersoc.org.nz

Saffron Mitchell
Head of Cancer Care
Cancer Society Waikato/Bay of Plenty
029 497 5143
saffronmitchell@cancersociety.org.nz

Craig Watson
Head of Cancer Services
Cancer Society Southern
027 807 2097
craig.watson@southerncancer.org.nz

Pauline Farquhar
Service Delivery Manager
Cancer Society Central Districts
027 469 3264
pauline.farquhar@cancercd.org.nz

Cancer Information Helpline
0800 CANCER (226 237)

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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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