GP Voice

YOUR NEWS, YOUR VIEWS, YOUR VOICES

Medical Educator day
Waikato/Bay of Plenty Faculty

Te Whata Kura
A new online antibiotic guideline

Waste not, want not
Carefirst's climate care

WONCA Council and World Conference 2025
Dr Samantha Murton

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

December 2025

In this issue

Editorial

Dr Luke Bradford

Dr Luke Bradford
College President

Welcome to the final issue of GP Voice for 2025.

It has been a pretty significant year for our workforce, with some of the most positive changes and funding increases we've had in a long time.

While recognising that it isn't enough to address all the challenges, we must acknowledge that we are heading in the right direction, and **these funding boosts and changes to capitation** are a sign that our voices are being heard and that the College's advocacy is being recognised.

A lot of time and effort goes into our advocacy work, not all of it visible or a quick fix, but it is important to remind you of this and invite you to contribute to our advocacy work. This could be sharing your expertise for a College submission or position statement, engaging with our social media content, highlighting the rewarding nature of the workforce in your conversations, undertaking research (**remember to apply for REC funding**) or putting yourself forward for governance roles to represent your profession.

Looking ahead to the start of next year, we've got a new cohort of GPEP and RHM year 1 registrars starting their training with us, the rural WONCA conference is coming to Wellington in April, we've got **changes to prescribing lengths** and **ADHD diagnosis** coming into effect early in the new year, and our Specific Interest Groups (SIGs) will be established so we can start utilising your expertise and knowledge to target our advocacy more directly.

Another way we're advocating for members is by ensuring we have important and up-to-date clinical information that is easily accessible and updated as situations evolve. A 'hot topics' area on the website has been created with dedicated pages to current topics that are impacting our work and/or patients. **The current hot topic pages are ADHD, 12-month prescribing and measles.**

I've also got my wishlist of changes that I'd like to achieve, and I'm looking forward to progressing these further in the new year. I'll be keeping you updated and informed.

Also, if you've undertaken any research or have some innovative case studies to share, consider submitting an abstract for next year's College conference, happening in Auckland from Thursday 30 July to Saturday 1 August. Abstracts for GP26 are opening later this month, and we'd love to have a programme that showcases the diversity of our members, our work and our interests. Keep an eye out on ePulse and the **GP26 website** for more information.

I hope you will be able to have some time away to relax and refresh over the upcoming holiday season. I know that's harder for our rural peers who live in our very popular holiday destinations and have an influx of out-of-towners arriving, but I hope you have scheduled some time off when you are able.

We can't do our jobs to the best of our abilities if we are running on empty, so taking some time to spend with whānau and friends is so important.

Thank you for all the important mahi you continue to do every day. It is valued and appreciated, and it does make a significant difference to the lives of those in your communities.

Enjoy this issue of GP Voice and see you in 2026.

Goodfellow Unit podcast: **Foetal Anti-Convulsant Syndrome**

Dr Jamie Speeden is a specialist Child and Adolescent Psychiatrist working with children, young adults and their whānau from a private clinic on Auckland's North Shore. He is passionate about working from a youth development model and not just a medical diagnostic framework. He has particular interests in treating and working with children and young people with neurodevelopmental issues.

In this podcast, Dr Speeden covers Foetal Anti-Convulsant Syndrome (FACS), focusing on its causes, diagnosis and the role of general practice in managing the condition.

The key take-home messages of this podcast are:

- Help raise awareness amongst colleagues.
- FACS has lifelong developmental effects.
- Don't assume someone else has had 'the conversation' when prescribing.
- Also check around substances and alcohol.
- Set yourself a higher threshold – look at how seriously the rest of the world is already taking this issue.

Listen to the podcast

Submit your feedback

Editorial

Toby Beaglehole

Toby Beaglehole
College Chief Executive

Tēnā koutou katoa

This has been a year of deliberate progress rather than dramatic headlines. While the challenges facing general practice remain complex, the steps we have taken both visibly and behind the scenes are shaping a stronger foundation for the future. This is not about quick wins; it is about building resilience and relevance for the profession in a changing health landscape.

It has been a year of progress – some visible, some requiring patience. The funding boost and improved engagement scores signal that our advocacy and internal efforts are making a tangible difference.

The recent funding increase is not a complete solution, but it represents a significant step forward for general practice. Capitation changes and additional investment indicate that general practice sustainability is becoming more achievable. For a profession accustomed to doing more with less, this is a welcome shift.

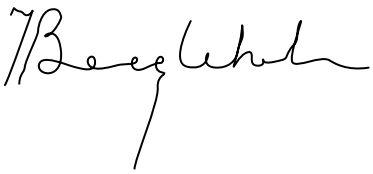
Our member engagement survey confirmed strong appreciation for College functions alongside calls for greater advocacy and training support. We have responded with improved communications, a refreshed app and enhanced member benefits. Internally, employee engagement initiatives have strengthened retention and morale, demonstrating that listening and acting on feedback delivers results.

The Board has reaffirmed the College's strategic plan as both compass and guardrails. Our focus is on shaping the future of general practice through addressing workforce pressures, supporting team-based care and ensuring clinical standards evolve with changing realities. With a stable workforce, improving financials and constructive relationships with funders, we are well positioned to lead.

The coming year will see us take deliberate steps to influence the future of general practice. This includes exploring an augmented GPEP 2 and 3 programme to ensure training reflects the complexity and diversity of modern care. We will also advance initiatives that strengthen multidisciplinary team models and embed adaptability into our standards. Alongside these, operational changes such as prescribing updates, ADHD diagnosis protocols and the establishment of Specific Interest Groups will support our broader strategic intent.

General practice is evolving, and we have a choice: observe or lead. We choose to lead. Thank you for your commitment throughout the year; your mahi matters and continues to shape healthier communities. Enjoy the break and let us approach 2026 with clarity and purpose.

Ngā mihi,



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College Advocacy: Months in review

October and November

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 October to December.

Hot topics

To ensure we have important and up-to-date clinical information for members that is easily accessible and updated as situations evolve, a 'hot topics' area on the website has been created with dedicated pages for current topics that are impacting members' work and/or patients. **The current hot topic pages** are ADHD, 12-month prescribing and measles.

12-month prescribing

The College released a position statement and patient resources in October, which can be viewed on the **12-month prescribing** hot topics page. We have also been active in the media on **trusting your clinical judgement in NZ Doctor**.

Primary Care Pathway for PGY2s

The College welcomed the establishment of the new Primary Care Pathway to give PGY2s the opportunity to train and work in general practice and gain more meaningful exposure to the specialist GP role. Following the **release of our media statement**, College President Dr Luke Bradford spoke to Newstalk ZB and Mediaworks about how the pathway could increase the GP workforce.

Measles

To keep members informed about the evolving measles outbreak, the College created a **'Measles' hub** on our hot topics webpage and sent guidance and resources to members to ensure they were prepared should cases rise. The College President and Medical Director also spoke to several media outlets including **NZ Herald** and **Radio New Zealand** on the outbreak, what to look out for and immunisations.

Independent GP funding proposal – Labour Party

Labour Party spokesperson Hon Dr Ayesha Verrall wrote an opinion piece in NZ Doctor about a proposal for an independent body to determine general practice funding, and **Dr Bradford was interviewed by NZ Doctor** where he said it was a positive idea but he would need to see more details on how the plan would actually work. Dr Bradford also **spoke in more depth about Labour's proposal** in an interview with Newsroom.

Funding free GP visits through Capital Gains Tax – Labour Party

Following the announcement of the Labour Party's campaign plan to fund free GP visits from a Capital Gains Tax, Dr Bradford spoke to a range of media outlets including Stuff, Mediaworks, NZ Herald and Radio New Zealand.

The College requested an amendment to the **original Radio NZ article headline** to better reflect what Dr Bradford said in the interview, making it clear he was discussing the part of the proposal relating to the free GP visits not the Capital Gains Tax.

Concerns about coroner's findings

A recent ruling and findings from the coroner's office has raised a number of concerns for the College. The case relates to the death of a woman after weight loss surgery. The findings were very concerning, and how the case was portrayed in the media, including naming the GP involved, was unacceptable given there were other factors at play that led to this sad outcome. We **shared our concerns with NZ Doctor** and via a **statement shared with members**.

We have reached out to the GP involved to offer our support and will be investigating this case further – we will keep members informed of any outcome.

Presentations and conferences

Dr Luke Bradford, President

- Keynote speaker at the GP academic weekend in Hamilton on the College's commitment to research, enhancing academic components of training and focus areas for the College in research.
- Participated on a panel discussion at the HiNZ 'Digital Health Week' conference, "Enabling integrated care: rethinking systems in whānau and community."
- Attended the Royal Australian College of General Practitioners' conference GP25 in Brisbane.

Dr Prabani Wood, Medical Director

- Presented at the GP Clinical Leaders' Symposium in November on 'Workforce and Connection'.
- Attended the Royal Australian College of General Practitioners' conference GP25 in Brisbane.

Quality Programmes team

Members from the College's Quality Programmes team attended the joint conference of practice managers in Australia and New Zealand (AAPMAANZ) in Melbourne in October and presented to delegates on "Supporting high-quality, compliant and sustainable general practice." This session focused on the latest updates to the Foundation Standard, practical strategies for maintaining compliance and tools to help practices deliver safe, equitable and effective care.

The interactive workshop featured scenario-based discussions, quick quizzes and spot prizes to keep engagement high while tackling complex regulatory updates.

Attending AAPMAANZ was invaluable for:

- strengthening relationships with practice managers and key stakeholders across Australia and New Zealand
- Understanding sector challenges and sharing practical solutions
- Showcasing RNZCGP's leadership in quality and safety in general practice.

These types of engagements ensure we remain at the forefront of best practice and continue to champion excellence in general practice.

Research

- Dr Bradford submitted an article on the Your Work Counts project to the *Journal of Primary Health Care*.
- Dr Wood released a new research report, ***Better health through better data.*** **Read her *NZ Herald* opinion editorial.**

Stakeholder engagement

Dr Luke Bradford, President

- Visited Northland-based GPs and rural hospital doctors in Kaitaia and Whangarei
- Facilitated capitation 'next steps' webinar with Health New Zealand
- ADHD meetings
- General Practice Leaders' Forum (GPLF) meeting
- Meeting with Collaborative Aotearoa on 'AI in primary care' framework
- Took part in the capitation and primary health target Expert Advisory Groups
- Chaired the PA Supervision group for MCNZ.

Dr Prabani Wood, Medical Director

- Cancer screening programmes meeting
- **Regular meetings with ACC focusing on changes to improve medical certification processes**
- ADHD meetings
- Meetings with MPS
- Meeting with Health NZ on rural generalism project
- Met with the Funeral Directors Association to discuss death certificates for cremations
- National Quality Forum
- Quarterly catchup with Pharmac
- Meeting on NZ Graduate School of Medicine
- Primary Care Prevocational Pathway meetings
- Meeting with MSD.

Submissions/position statements

- 12-month prescribing position statement and resources
- Medsafe – Medical Classifications Committee 75th meeting
- Pharmac – Proposed changes to Options for Investment.

More media and advocacy

- Low enrolment rates for babies | Stuff | Dr Wood
- Perimenopause and menopause consultations | Consumer magazine | Dr Wood
- Safe use of paracetamol | Newstalk ZB | Dr Sam Murton for Med Safety Week
- Interview on First Specialist appointments being declined | Dr Bradford | TVNZ, to air in December
- How technology and AI are changing the way we work | Dr Wood | Radio NZ.

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. Paracetamol-associated knowledge, attitudes and practices of the New Zealand public: an online survey Trends in psychological distress: analysis of NZ health survey data (2011–2023)
2. Horny Goat Weed/Epimedium
3. Collagen supplements
4. Apple cider vinegar
5. Trends in psychological distress: analysis of NZ health survey data (2011–2023)

Submit your feedback

Help shape the future of general practice and rural medicine

The University of Auckland and The University of Otago are looking for GPs, rural clinics, urgent care centres and hospitals to host undergraduate medical students across multiple year levels. Students report that they value the high-quality placements they currently receive from their dedicated supervisors and clinic sites.

Placement numbers are reducing due to working and rooming capacity, while student numbers are growing to meet future workforce needs. With these pressures, your involvement is more vital than ever.

Students needing placements include Year 2s through to the final year of medical training. Placement experiences can vary anywhere between oneday to sixweeks or more depending on the year level of the student. Although requiring ultimate supervisor review, senior medical students are encouraged to work-up patients independently, and this can lead to much more efficient work streams.

Why host a student?

Research shows that early, quality exposure to general practice and rural medicine inspires career choices in these fields. Hosting students strengthens community-based care, builds future recruitment pathways, boosts team morale, and keeps knowledge for supervisors up to date. Plus, practices receive weekly remuneration, staff gain honorary academic titles, and your clinic helps to shape Aotearoa's next generation of doctors.

Ready to get involved?

Contact the following Heads of Departments based on the locality of your clinic – note that regions including and south of Palmerston North/Hawke's Bay are within the University of Otago catchment:

- University of Auckland – **Professor Sue Wells**
- University of Auckland (Rural Health Unit Director) – **Dr Kyle Eggleton**
- University of Otago Wellington – **Professor Lynn McBain**
- University of Otago Christchurch – **Dr Ben Hudson**
- Dunedin School of Medicine – **Professor Tim Stokes**

Building the future GP workforce

New Primary Care Pathway launches

A new Primary Care Pathway for early-career doctors is set to strengthen Aotearoa's GP workforce, and it's a welcome step forward for general practice.

From next year, up to **50 postgraduate Year 2 (PGY2)** doctors will have the opportunity to spend 12 months working in general practice and community settings through the new pathway, developed with support from Health New Zealand | Te Whatu Ora, the Medical Council and the College.

The aim is to give young doctors first-hand experience of general practice – the continuity of care, the complexity and the privilege of walking alongside patients over time – and inspire more to train as specialist GPs. Those who complete the pathway will be eligible to enter the **General Practice Education Programme (GPEP)**.

College President Dr Luke Bradford says it's an encouraging step.

"The job of a specialist GP is not for the faint-hearted, but it's one of the most rewarding parts of medicine. The more exposure junior doctors get to the realities of general practice, the more likely they are to choose it."

College Medical Director Dr Prabani Wood agrees, adding that support for supervisors will be crucial.

"We must ensure current GPs have the time and resources to mentor these doctors alongside their existing clinical and leadership work."

Expressions of interest for current PGY1s are open now, with expressions of interest for participating practices opening later this year.

For GPs, it's a chance to help shape the next generation and highlight the breadth of what our profession offers. The pathway won't fix every workforce challenge, but it's a positive step toward sustainable, community-based care and a future where every New Zealander has access to a trusted GP.

You can read more about the pathway on our website.

At a glance

What
New Primary Care Pathway for PGY2 doctors

When
Launching 2026 intake

Who
Up to 50 PGY2 doctors per year

Led by
Health New Zealand | Te Whatu Ora and the College

Why
To build a stronger, sustainable GP workforce for Aotearoa

> "The job of a specialist GP is not for the faint-hearted…The more exposure junior doctors get to the realities of general practice, the more likely they are to choose it.

Submit your feedback

Wellington Faculty 2025

A year of connection, celebration and community

It's been another vibrant year for the Wellington Faculty, with members coming together to learn, laugh, celebrate and support each other through a full and varied calendar of events.

We kicked off the winter season with a magical **Matariki celebration on Friday 20 June**, where we were warmly welcomed onto **Dr Sam Murton's beautiful Kapiti Coast farm**. Whānau and friends gathered around a glowing bonfire under clear, starlit skies to honour the Māori New Year. Families planted tōtara trees together, learned to weave whetū (stars) from harakeke and were treated to glow-worm walks and delicious kai cooked in the embers. With blessings shared in te reo and heartfelt reflections on connection, faith, hope and remembrance, it was a truly special evening of warmth, whanaungatanga and Matariki magic.

July brought **GP25** and once again we offered conference discounts for members, helping Wellington GPs make the most of this year's national learning and networking opportunities. The faculty also partnered again with **Evolution Healthcare** to host two **hands-on CME workshops**, a registrar-focused day on **2 August**, followed by another on **30 August** open to all members. Both workshops were well attended, offering practical, skills-based learning that was as popular as ever.

September saw plenty of friendly competition and laughter at the **Faculty AGM and Quiz Night at Bo Peep in Karori**, where members tucked into great pizza, swapped stories and tested their knowledge in a lively quiz that proved both fun and fiercely contested!

In October, the Faculty gathered for the **Old Fellow, New Fellow dinner** at **Foxglove**, a highlight on the Wellington calendar. This elegant evening celebrated both new Fellows beginning their professional journeys and those retiring after decades of service. With Lucy O'Hagan as our MC extraordinaire, we were treated to snippets of book reading and great camaraderie. It was a night of reflection, inspiration and deep appreciation for the shared vocation of general practice.

Throughout the year, the Wellington Faculty has been a hub of connection, creating space for professional growth, community and shared purpose. The Executive continues to encourage members to get involved, attend events and help shape the future of general practice in the region.

If you're based in the greater Wellington region, keep an eye out for your next Faculty gathering; there's always something worth coming along for.

Submit your feedback

Medical educator day

Waikato/Bay of Plenty Faculty

> *Teaching is the greatest form of optimism*
> **Colleen Willcox**

The Waikato/Bay of Plenty Faculty recently hosted a day-long educational event for the region's trainers. This was held in Rotorua in September, and we welcomed around 30 teachers to a well-received day of growing our skills.

Dr Seema Menon from Hamilton and Dr Fiona Whitworth from Tauranga led a session on the challenges facing our international medical graduates when they start practising medicine in New Zealand. We were all in awe of the effort that Seema puts into helping these doctors assimilate into our system. They face many challenges that range from getting to grips with Kiwi colloquialisms to navigating the ACC system. It's hard to learn the meaning of a 'box of birds' from a dictionary! Seema hosts groups at her house and gets them to practise again and again to learn the nuances of consulting here.

Dr David Spears, a very experienced medical educator, led a session that gave a structured approach to the learner with challenges. He guided us through the process of identifying a struggling trainee, then introduced a framework of different areas that might be revealed. These include knowledge gaps or difficulties with clinical reasoning. They may have time management or organisational issues. On occasion, there may be personal factors such as family stress or mental health issues that are impacting. The final step is to create a tailored intervention that targets that particular issue. It was a really helpful guide to this topic, and with approximately 15% of students being identified as struggling, it's an important area.

After lunch, Dr Richard Medlicott from Wellington gave an overview of artificial intelligence in general practice. A survey this year shows that 68% of us are using AI in some form and 22% use this daily. Richard gave us some fascinating studies on the comparison of AI virtual doctors and 'real life' physicians. The results were disturbingly close – even with empathy! The pace of change in this area is incredibly fast, and we all need to be thinking about how to incorporate this safely into our daily practice. The aim should be augmentation not replacement.

Dr Andrew Corin then co-facilitated a session with Dr Fiona Whitworth on using reflective writing in teaching. Andrew is a Tauranga GP and an award-winning author. The tool allows us to gather insights and deepen our understanding of ourselves and our patients. The 'through the mirror' technique goes beyond the surface of an interaction and asks us to examine firstly our emotional response, then to go 'behind the mirror' to look at our assumptions and

influences. Then 'the refracted light' stage allows insights and learnings to be revealed and finally allows us to think about how to apply the learnings to our future practice. It was a very powerful way to promote a deeper questioning of what transpires within a GP consult.

Our final session was a very well-received presentation on the different types of mana and a deep explanation of whakawhanaungatanga by Dr Jethro Leroy. We learnt that there could be personal mana (mana tangata), genealogical mana (mana whakapapa), environmental mana (mana taiao) and mana in leadership (mana rangatira). Jethro then really beautifully shared how to build whakawhanaungatanga with people in a consult. This process is where we recognise the 'threads that connect us and how to weave these threads tighter.' It is particularly important to our Māori patients but is also really key to all our patient interactions. It's about building bridges of connection which then can lead to the Kaupapa aspect of the Hui Process, which is the clinical purpose of a session.

Our day finished with the Faculty AGM and an update from Steven Lillis on the New Zealand Graduate School of Medicine, which will be based in Hamilton. A very exciting project that looks to grow a lot of rural and community-based doctors. So we will need an ever-expanding pool of keen educators!

Thanks to all our presenters and attendees for the day. It was a varied and very useful collection of 'Tools for Medical Educators'.

Dr Jethro Leroy

Submit your feedback

MIND THIS

A sad death in a young teenager

Dr Peter Moodie

The case

At 8 o'clock one evening in 2022, a 14-year-old boy, Master A, was walking with his friends and family when they were spooked by a barking dog. Master A ran down an alleyway and collided with a bollard. For clarity, the 'bollard' was a U-shaped pipe structure turned upside down and cemented into the road; it was specifically designed to stop motor vehicle access to a lane.

Master A had obviously run into the crossbar of the bollard and immediately complained of severe abdominal pain. He was taken home, but he vomited on at least one occasion and was taken to a White Cross medical centre later that night by his sister. Amongst other investigations, he had an abdominal examination and a urine test. He was then given analgesia and observed for an hour. As he seemed to be settling, he was sent home at about 2am.

The duty doctor at White Cross stated that:

"My diagnosis was abdominal wall contusion with no current evidence of intra-abdominal trauma."

He was, however, concerned that there could be more significant pathology and explained that if there was any worsening of symptoms, they should go straight to the emergency department.

He further stated that:

"Out of an abundance of concern for Master A's safety and in the absence of his parents, I nevertheless offered the option of arranging…" a referral to the hospital. This was declined.

By the next morning Master A was in variable pain, and although he tried to eat some porridge, he could not tolerate much food. He was checked by his father at 4.30pm, at which time he was smiling and talking.

At about 9pm, Master A collapsed, vomited and appeared to fit. He was taken to the hospital by ambulance, but at 10.57pm he was pronounced dead.

A postmortem showed that he had peritonitis secondary to a perforated duodenum. The case was referred to the coroner, and a complaint was made to the HDC.

Peter Moodie is the College's Clinical Advisor

The findings

The coroner relied heavily on the HDC review, where the Commissioner found no significant failings by the White Cross doctor. The HDC did, however, comment that "informed consent" had not been documented along with the offer to send Master A to the hospital that night. Finally, there was a criticism that although Master A had been under observation at the White Cross clinic, it had been with him resting in a car; however, this was during COVID-19.

The lessons

- In this sort of case, blunt abdominal trauma is always part of a differential diagnosis, but the duty doctor did consider that, and the HDC and the coroner noted that the management within the confines of a general practice was adequate.
- The HDC noted that if Master A had been seen in the emergency department, the outcome might have been different. However, the family took Master A to White Cross because they didn't want to wait hours to be seen in the ED. They assumed that he would have been admitted if there was any reason to.

There is, however, one other possible scenario:

What if the general practitioner had been able to discuss the case with ED and directly arrange a CT in the hospital without Master A having to sit for hours in the ED? One day, we may achieve that type of integration of services, but don't hold your breath.

Goodfellow Unit podcast: **Long-term effects of child cancer treatment**

Dr Awras Majeed is a consultant generalist paediatrician working at Matatiki Child and Youth Health in Waitaha Canterbury. She is a Member of the National Child Cancer Network, working with the Late Effects Assessment Programme (LEAP).

In this podcast, Dr Majeed discusses the Late Effects Assessment Programme (LEAP) in New Zealand, a national service providing long-term surveillance for young people who have completed childhood cancer treatment.

The key take-home messages of this podcast are:

- Thinking about late effects can feel negative – It's important to say most survivors live healthy and happy lives.
- Treatment is less toxic – Survivors now live longer.
- Cancer type, age of diagnosis and treatment received are important for determining long-term late effects.
- Radiation is the main factor in the risk of second malignancy. Screening is important.
- As their GP, you might be the first person to have a conversation about fertility.
- The LEAP passport will outline everything about ongoing surveillance.

Listen to the podcast

Submit your feedback

MIND THIS

An ulcer and an overdose

Dr Peter Moodie

Case: The ulcer

HDC decisions can be quite lengthy, and this one – 31 pages with another 24 in appendices – records in exquisite detail the sad story of a 79-year-old hospital-level care patient in a nursing home who had a history of diabetes, CVA and poor communication skills. On 31 January 2021 he was found to have an ulcer between his great and second toe which was treated, largely by the nursing home and the Nurse Maude wound management team, without great success. On 15 June the patient had an unwitnessed fall, ascribed to his unsteadiness and the pain of the ulcers. He was admitted to a public hospital and the following day had an angioplasty to improve his peripheral circulation, but in August he required an amputation of his toes. He died not long after that.

The patient's daughter complained that there was poor communication by the nursing home staff along with a series of delays in referring to the Nurse Maude wound management service. This was compounded by the wound service taking a month to formally review the case and then a further delay in escalating the case to more intensive care.

The nursing home had a contracted general practitioner, Dr C, who visited once a week. However, Dr C was not alerted to the ulcer until a month after it was first reported by the nursing staff. At that time, Dr C organised swabs and an X-ray to exclude osteomyelitis and subsequently ordered antibiotics. Dr C further recommended a referral to a specialised wound service if the situation did not improve and noted that the ulcer was likely secondary to his diabetes and poor circulation.

The X-ray did not show osteomyelitis, and the referral to the Nurse Maude wound service by the nursing home noted that the doctor had suggested that an ultrasound should be organised to check for possible limb ischaemia. Dr C saw the patient on about three further occasions and was under the impression that there had been a referral to a vascular clinic. This followed a confusing story as to whether there had actually been a referral; however, Dr C was not copied into any of the resulting discussions between the nursing home and the Nurse Maude service.

At the end of the day, the nursing home and the Nurse Maude wound service were found to have been in breach of the HDC Code. An adverse comment was made about the general practitioner as they had not specifically recorded that they had considered vascular ischaemia as a possible cause for the foot ulcer. Dr C, however, pointed out that their investigations showed that they had considered that possibility.

Peter Moodie is the College's Clinical Advisor

So, from a general practice perspective, what are the lessons?

Basically, the nursing home was managing the foot ulcer and indeed didn't involve the doctor until a month had passed. They then organised the referral to an independent wound management organisation that didn't communicate with the doctor.

If you are the doctor for a nursing home, you need to be aware that referrals and management of certain conditions may well be going on without you being in the management loop. You must ask, who was the leader taking responsibility here?

Case: The overdose

The second case comes from a coroner's decision about the death of a woman under palliative care who may have died from a morphine overdose. Again, this case involved outside agencies not communicating adequately.

Mrs C was 71 years old and had a history of emphysema and COPD along with generalised anxiety, which limited her mobility to the point where she needed a walking frame, and she took midazolam as a sedative.

In April 2022 she was treated for a respiratory infection but did not respond and paramedics were called; however, she refused to go to hospital as the last time she had been admitted she had been told that there was nothing more that could be done for her chronic respiratory problems.

Interestingly, the paramedics referred her to a specialist respiratory group working within St Johns. This group visited and concluded that Mrs C required palliative care. The clinical lead doctor at the Ōtaki Medical Centre (ŌMC) agreed and referred her to the local hospice.

The nurse at the hospice assessed her and spoke to the hospice doctor who prescribed Mrs C with morphine liquid 1mg/mL at a dose of 2.5 to 5mL three times a day as necessary. At a later visit, probably by the hospice but not specified, morphine 10mg (probably long acting but not specified) twice a day was prescribed with instructions to continue with the liquid formulation as before. The script was dispensed by pharmacy BTP.

The hospice wrote to the ŌMC on at least two occasions explaining that Mrs C was receiving the two morphine formulations, but on neither occasion mentioned the strength of the liquid morphine, only the dose (2.5 to 5mL). The ŌMC did repeat the morphine tablets, which were then recorded on their database, but they never prescribed the liquid.

Mrs C, who actually lived in Levin, was then transferred to Levin doctors at the Horowhenua Community Practice (HCP) as she was essentially bedridden. At this point Mrs C's daughter realised that she was out of the liquid morphine and so contacted HCP for a prescription; however, as the notes had not yet been transferred, they declined the request. The daughter then contacted the old practice (ŌMC) and asked for help. The request was managed by an overseas-trained doctor, as neither their mentor nor the lead doctor were available.

“

If you are the doctor for a nursing home, you need to be aware that referrals and management of certain conditions may well be going on without you being in the management loop.

The ŌMC doctor checked the notes and saw that Mrs C was on 10mg morphine tablets and assumed that the request for liquid morphine was because she couldn't swallow the tablets, and so prescribed morphine liquid, 10mgs/mL, 1mL "as necessary." The script was dispensed by a different pharmacy from the one previously issuing the hospice's prescriptions.

Mrs C's daughter did not notice the change in strength of the morphine nor in dosage. She therefore continued to give her mother regular doses of 2.5 to 5mL, essentially a tenfold increase.

Mrs C died some days later and a death certificate was issued; however, some weeks later, after Mrs C had been cremated, her daughter realised the error she had been making. The case was referred to the HDC, but the complexity of the issues was identified, and it was treated as a case requiring education recommendations only.

The lessons

In both cases agencies were operating independently of the general practitioner and not keeping them fully informed. In the first case, the nursing home had referred the patient to a specialised wound clinic and the doctor was not aware of the treatment delays that were occurring.

In the second, only one of the medications was actually prescribed by the doctors and so the second medication (the liquid) was not recorded on the medical centre database. Further, the actual strength of the liquid was not recorded on the consultation documents.

When agencies become independent health providers, there is the risk that no one is really taking responsibility and leading the team.

"

In both cases agencies were operating independently of the general practitioner and not keeping them fully informed...When agencies become independent health providers, there is the risk that no one is really taking responsibility and leading the team.

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

Helping GPs weather the storm

The use of Integrated Professional Support for GPs.

By Dr Sandra Spilg, FRNZCGP

I have recently coined the term 'Integrated Professional Support' to describe the model of practice I have been developing. It is a combination of methods from coaching, mentoring and professional supervision, by doctors for doctors. This stems from my growing concern about the developments I am witnessing in our profession. It is hard to say – and harder still to hear – but the truth is that so many GPs are struggling. I felt it myself when I was inside the system, and I see it even more starkly now from the outside.

It is something that is often alluded to – *burnout is happening*, and right now, many GPs are overwhelmed. That doesn't mean anyone is weak. It means the pressures on the profession have become relentless. What I see happening to GPs is more than just long hours or heavy workload. It is a perfect storm – and I really don't think we notice it creeping up on us.

As GPs, we are typically skilled at battling the elements and trying a bit harder as the workload becomes more challenging to manage. Then we work harder and longer, giving up time for family, rest and the activities that usually restore us. As this balance tips, anxiety rises and exhaustion takes hold. And so often we just think: "Why can I not do this when everyone else manages – I am a failure."

GPs often describe themselves as 'people pleasers' as well as suffering from 'imposter syndrome'. This need to please others, to be perfect, to stay strong, to never let anyone down, pushes many GPs to keep going at any cost. Whilst these qualities make doctors caring and committed, they also leave them vulnerable when the load becomes unmanageable, when the storm becomes a hurricane.

Part of bearing the brunt of the storm is the deep disconnect that forms between the kind of medicine GPs believe in and the reality they're forced to deliver. GPs value thoroughness, continuity and high-quality care; yet the system demands speed, volume and constant availability. This gulf erodes a GP's sense of purpose, values and identity – the very elements that brought us into medicine in the first place.

Together, these forces create the conditions that foster burnout. Not because doctors are failing, but because no one can continue to carry this mismatch indefinitely. So how can GPs respond? This is where adapting Stephen Covey's Circles of Influence framework can help.

Dr Sandra Spilg has been a GP since 1991. She moved from Scotland to New Zealand in 2014. She retired from clinical practice recently to focus on supporting other doctors, particularly GPs.

The **outer circle** encompasses systemic issues largely beyond an individual GP's control, such as ongoing political changes and practice-level stressors. Battling these alone only drains energy.

The **inner circle** encompasses what doctors can influence: Where they can protect their energy, manage their boundaries, and create space for reflection. This is where Integrated Professional Support makes a real difference.

These outer circle pressures on GPs are real, and they won't subside overnight. But GPs are not powerless. By protecting what sits in their inner circle, there is space for a more sustainable way forward. Retention is not just about keeping GPs in post but keeping them well enough to stay. Integrated Professional Support is one part of ensuring that happens. Organisations such as the College, GenPro and GP Aotearoa all have a key role to play at that outer circle level.

The role of Integrated Professional Support is to help GPs step back, find practical ways forward, gain professional insight and perspective, and create protected time to reflect and manage the emotional load of practice. Together, these supports reduce isolation, make it easier to recognise stress early and help them stay balanced in the green (optimal performance) zone of the pressure-performance curve, helping doctors stay connected to the values that brought them into medicine in the first place.

Submit your feedback

Dr Jeremy Webber: World Triathlon Championships

We recently caught up with Dr Jeremy Webber after he competed in the World Triathlon Championships in Wollongong, Australia to find out more about his time across the ditch. Jeremy is a Fellow of the Division of Rural Hospital Medicine and, until recently, was the Clinical Director of Hauora Taiwhenua.

After a decade of expedition racing alongside fellow rural doctors, including embarking on an adventure race down in Kaikoura called GODZone with Dr Rachel Lynskey, Dr Mark Smith and Dr Garry Nixon, Jeremy decided to return to the triathlon scene.

We sat down with him to find out more about his time at the World Triathlon Championships and what inspired him to compete in Wollongong.

"I'd raced the Ironman World Championships back in 2010 and the 70.3 Worlds in Taupō just last year, but this was my first time at the World Triathlon Championships at that distance."

The race itself went well. A solid swim gave Jeremy a strong start, setting him up for a 16th-place finish. The heat made the run a real test of endurance, but he says it was a fun few days of sport and exciting to watch all the other events.

Jeremy's journey into triathlon began in school, when he didn't quite grow fast enough for rugby.

"I have dabbled in a variety of multisport over the years," Jeremy said.

When asked about fitting in training with his busy role, he said it's a balancing act.

"Training for an event like this means squeezing in a couple of hours most weekdays, with longer sessions on the weekend. It's a balancing act – work, family, and training – but having a structured programme helps.

"These days, with my kids getting involved too, we're able to share some of that active time together," Jeremy said.

Wollongong wasn't just about racing for Jeremy; he also watched his two children compete, followed by the elite and para-athletes. After the championships, he headed west for the Rural Medicine Australia conference, blending sport and professional development in one trip.

Looking ahead, Jeremy says he's keen to keep building fitness over summer and have another crack at Ironman Taupō in March.

"I'm always trying to be active in the outdoors," Jeremy said.

If you have an interesting hobby, passion or are enthusiastic about something, we are keen to talk to you! Email us on communications@rnzcgp.org.nz.

Above: Dr Jeremy Webber competing in the GODZone adventure race.

Below (left to right): Dr Garry Nixon, Dr Jeremy Webber and Dr Rachel Lynskey.

Submit your feedback

The WONCA Council and WONCA World Conference 2025

By Dr Samantha Murton, Dist. FRNZCGP

My final task as President has been to attend the WONCA World conference in Lisbon. This is to represent the College on the World Council, attend the WONCA World conference, receive Honorary Direct Life membership for my work on the voting and membership taskforce for the last two years, and present my research.

WONCA Council

The WONCA Council is held in person for two days prior to the World WONCA conference every two years. The College is a full member and has voting rights, which means our College can help to determine the direction and sustainability of WONCA. WONCA has representatives from 113 countries and 138 Member organisations.

Of particular importance at this World Council was that the membership were voting on changes to how voting occurs. The voting system has been in place for 27 years when WONCA was a small organisation with only 18 members. A voting and membership taskforce was established at WONCA World in Sydney in 2023, and I have been a part of that taskforce over the past two years.

The taskforce undertook a survey of all member organisations, interviews of the large, small and middle-sized organisations, gathered feedback from a reference group covering all regions and reviewed the material.

The recommendation put forward by the taskforce based on feedback from the membership was that:

- voting should change from vote per country to vote per member organisation
- the weighting of votes should reflect the membership numbers more fairly
- we should review the process in 7–10 years and not leave it for another 27 years.

All these resolutions were passed.

Being part of the taskforce has given me insight into the reasons that member organisations belong to WONCA, and they are wide and varied. For the 86 smaller organisations and significant number of developing countries, belonging to WONCA gives credence to their profession when their own country may not do that.

During the Council meetings and conference, I have had the opportunity to speak to many general practitioners and leaders from small and developing countries. Funding arrangements are enormously varied, politics have a significant influence, home visits may be a requirement, fiscal 'punishment' can occur for poor patient outcomes, and the number of patients per GP can vary from 1100 to 4000+. Every country has struggles and we can often learn from those who are clawing their way out of their own difficulties.

As a reflection of the development of Family Medicine/General Practice across the globe, it is pleasing to see there has been an enormous increase in the number of member organisations belonging to WONCA over the past 27 years. This has also helped the organisation have a global reach in other ways. Dr John Fogarty, Primary Care Lead for WHO, presented, thanked WONCA for the collaboration with WHO and stated that non-state actors like WONCA are critical to making change.

The WONCA leadership has been integrally involved in the development of several documents and guidelines created with WHO. One hundred and ninety-three countries have committed to Universal Health Coverage by 2030 as part of the Sustainable Development Goals, and WHO's documents help to support countries getting to this goal. There is often confusion about primary health care and primary care, but WHO makes it clear that primary health care is the whole and primary care is us.

In the opening statement on primary care, WHO states that:

"Primary care is the foundation for achieving universal health coverage (UHC). People in countries with strong primary care often live healthier lives and experience greater health equity. Investing in primary care can also reduce overall healthcare costs and ensure everyone receives the services they need."

Implementing the primary health care approach: a primer was published in 2024, and a document on strengthening palliative care is coming out soon along with a primary care checklist based on the 5 Cs of primary care, which are:

1. **First contact accessibility** ensures timely equitable access.
2. **Continuity** builds trusted relationships.
3. **Coordination** supports the integration of services.
4. **Comprehensiveness** ensures access to a full range of services.
5. **People-centredness** empowers people to take an active role in their health.

WONCA will continue to be involved as a key stakeholder in WHO's development of a reference package of primary care services, an integrated management of primary and acute care tool, family medicine postgraduate curricula development and support for bridging programmes, and WHO global patient safety action plan.

Other activities at the Council included election of new Presidents and executive members, decisions on where the next World conference will be, how these will be run and the development of organisational equity committees across the regions.

The President Elect for WONCA is Prof. María Pilar Astier-Peña from Spain. Pilar has been involved with WONCA for many years and has been the WHO representative for the past two years. Members at large were also elected and include the recent Young Doctor Movement chair, Cheryl Chan; current Treasurer WONCA executive, Steve Mowle; and Kim Yu, President-Elect of the California Academy of Family Physicians. All have been integrally involved with WONCA for many years.

WONCA World 2027 is in Cape Town and WONCA World 2029 will be in the Asia Pacific region hosted by Japan – make sure you go! The Asia Pacific Region has been a powerful voice in the development of WONCA, and a book is being produced to reflect this and set to launch at the Asia Pacific Region Conference in Iloilo, Philippines.

The Conference

The Conference started on Wednesday afternoon and had 4200 delegates, including 300+ young doctors at their preliminary meeting, 18 concurrent sessions to deliver 3500+ presentations. There were 10 keynote speakers, several social events and an awards ceremony.

Dr Tedros Adhanom Ghebreyesus, Director-General of WHO opened the conference and thanked us for the collaboration. There were many conversations about AI as well as a lot of caution discussed. Dr Andrew Bazemore from the US discussed Teams, Technology, Tools and Tailored care for the complex patients we deal with. Dr James Campbell, WHO Director of Health Workforce, discussed accelerating actions on health care workforce by 2030. Dr Cindy Lam from Hong Kong quoted Hippocrates that "life is short, but the art is long" and then talked on the long impact of the service we provide to patients, that our patients should be smarter after they have seen us, that primary care is so complex it is difficult to explain to someone who does not do it and that we should resist the downsizing and simplification of family medicine.

Top: Dr Samantha Murton's poster presentation at WONCA 2025.

Bottom: Dr Samantha Murton and Dr Michael Wright, RACGP President.

In the concurrent sessions there was a huge variety of presentations. One called the Hidden Workload in the UK was similar to the work we have done on Your Work Counts. A session on the specifications of a future primary care service made us all think about what we want in the future, and there were several presentations on interprofessional activities and the patient experience in different countries. A planetary health session had several presentations on inhalers changing to a lower carbon footprint. There was also a tool developed in the Netherlands looking at the practice carbon footprint – you can all give it a go: it's available online at **Envirometer**. The other fascinating presentation was on pharmaceutical waste in the Netherlands – drugs that are returned to pharmacies unused and how much money that wastes: $630 million euros per year. The conclusion was you could save that money and buy every doctor in the Netherlands an EV every year or you could double the workforce! There were many other excellent sessions that I was unable to get to, but if you get a chance to see some of the presentations online then make sure you watch.

Late on Saturday was the awards ceremony where WONCA Fellowships and various other awards are presented. I received an Honorary Life Direct Membership award for services to WONCA and family medicine globally. The final act was the handing over of the presidential chains to the new president – Karen Flegg passed these on to Viviana Martinez-Bianchi. Viviana speaks both English and Spanish and works in the USA as a Family Medicine academic and teacher. She was the WONCA representative to the WHO from 2016 to 2021 and has boundless enthusiasm and love for family medicine/general practice. WONCA is in good hands.

Submit your feedback

Waste not, want not

Carefirst's climate care

Darla Stroud-Bennett (sixth year MBChB), Lachie White (fifth year MBChB), Dr Kiyomi Kitagawa (MBChB, FRNZCGP)

Climate change presents one of the greatest challenges to the wellbeing of our communities.[1] The health care sector itself contributes significantly to greenhouse (GHG) emissions. Therefore, on the basis of care, we all have an opportunity – including general practice – and a responsibility to take meaningful action.[2] General practices are situated within the communities they serve and so are well positioned to witness and lead change for the people they care for.

Carefirst is a New Plymouth–based general practice operating across Westown, Moturoa, Bell Block and Merrilands that has taken sustainability seriously. In 2022, Carefirst commissioned Toitū Envirocare to conduct a report analysing annual greenhouse gas (GHG) emissions. The results were eye opening, in that waste sent to landfill contributed to 71% of the organisation's total carbon emissions, and so they set about making changes.

Carefirst Westown has significant recycling processes in place. They fully utilise the district council's kerbside collection for general recyclables, including plastics, tin, glass, paper and cardboard. In addition, Westown also collects and recycles batteries, ink cartridges, bottle tops, soft plastics and compostables. The practice's 'waste champion' is responsible for disposing of these at appropriate recycling facilities such as zero-waste hubs and supermarkets.

Efforts have also been made to reduce waste. Westown made changes to its supply chain ordering behaviours by making more frequent but smaller orders to minimise surpluses and therefore waste. These small changes produced large improvements. Council data demonstrated that Westown recycled just over 60% of their total waste generated in 2024; this figure went as low as 10% at the other practices.

To gain insight into any gaps, we conducted a waste audit over the summer of 2024 at all four practices. We wanted to know how well their recycling processes were being used and where improvements could be made. We found that the majority of waste in bins destined for landfill could have been diverted to recycling or composting facilities. This was similar across all four practices.

The results are evident. Although Westown diverts a significant component of its waste compared to the other practices, there is still room for improvement. So most importantly, what did we learn, and how can we improve? What can your practice do to improve its recycling and be a model for sustainability in your community?

Lessons from Carefirst:

1. Place recycling bins and signage wherever waste is produced, e.g. composable bins in bathrooms, clinic rooms and staff room.
2. Make recycling convenient. Personal motivation to recycle is variable – make the right choice the easy choice, e.g. a bin for cardboard recycling adjacent to the vaccine fridge for vaccine box packaging or a compost bin right next to the coffee machine.
3. Fully utilise the kerbside recycling collection run by your local council.
4. Nominate a waste champion. This person can produce recycling reminders, inform new staff of recycling processes and bin locations during orientation, and arrange appropriate disposal of recyclables at zero-waste hubs and supermarkets.
5. Do you own waste audit – you may find individualised areas for improvement.
6. Find community organisations to support you, e.g. Resource Wise Taranaki.

References

1. The Lancet. A Commission on climate change. The Lancet. 2009 May; 373(9676):1659.
2. Phipps R, Randerson R, Blashki G. The climate change challenge for general practice in New Zealand. NZ Med J. 2011 Apr 29;124(1333):47–54.

Submit your feedback

Tackling antimicrobial resistance: It starts with us

Antimicrobial resistance (AMR) is one of the most pressing global health challenges of our time – one that begins with and can be prevented through our prescribing decisions.

Every November, World AMR Awareness Week unites the human, animal and environmental health sectors to promote the responsible use of antibiotics. The 2025 theme, 'Preventing antimicrobial resistance together,' reminds us that while the issue is global, action starts locally with every prescribing decision we make.

In New Zealand, antibiotic use in the community remains high, with seasonal peaks linked to viral respiratory infections. The challenge for GPs is balancing patient expectations with clinical need using watchful waiting, delayed prescriptions and evidence-based guidelines to reduce unnecessary use.

This year's WHO campaign also highlights the environmental impact of antibiotic resistance. Wastewater, soil and food chains all play a role in spreading resistant bacteria, reinforcing that stewardship extends beyond the clinic to the whole ecosystem of care.

For GPs and rural hospital doctors, the practical steps are familiar but vital:

- Use antibiotics only when clearly indicated
- Review duration and dose to match current guidance
- Communicate the 'why' to patients and whānau – most infections get better without antibiotics
- Support infection prevention through vaccination, hygiene and health literacy.

By prescribing wisely and leading conversations in our communities, GPs and rural hospital doctors are helping to safeguard the future of modern medicine.

You can also read about the recently launched Te Whata Kura: a new online antibiotic guideline for primary and secondary prescribers across Aotearoa in this issue on page 30.

Te Whata Kura

A new online antibiotic guideline for primary and secondary prescribers across Aotearoa

Overview

A new national antibiotic guideline, ***Te Whata Kura***, will soon be released for use across Aotearoa New Zealand. *Te Whata Kura* – a name reflecting antibiotics as a taonga (precious resource) and the guideline itself as a repository of important knowledge – provides unified, evidence-based antibiotic prescribing recommendations for managing infections in both primary and secondary care.

Development and funding

Development of *Te Whata Kura* is part of a broader research project funded by Te Niwha, the Infectious Diseases Research Platform – co-hosted by PHF Science and the University of Otago and provisioned by the Ministry of Business, Innovation and Employment, New Zealand. Guideline development was led by a multidisciplinary team including general practice, paediatric and adult infectious disease, microbiology, immunology, pharmacy, public health, Māori health and specialist nurse expertise. Team members work within Auckland University, Te Whatu Ora, Otago University, Turuki Healthcare, and general practice and marae clinics. Te Whatu Ora, Health Pathways, Kidshealth, the College, Healthify, and the New Zealand Formulary and have provided their enthusiastic support for the creation and delivery of the guideline.

A draft guideline was initially developed by merging the many existing antibiotic resources and refined following expert review. An early release of the draft guideline, in October 2025, sought feedback on guideline content from a wide range of organisations, specialty groups and individual prescribers, specifically seeking suggestions to support equitable prescribing.

Accessibility and digital delivery

Te Whata Kura has been designed to be easily accessible, and to support equitable prescribing decisions for all health workers across primary and secondary care. Following human-centred design principles and in collaboration with Ara Manawa and RUSH Digital as design partners, the platform was developed as a comprehensive, online decision-support tool accessible via web URL or installable as a standalone progressive web-app on mobile devices. It provides patient-specific recommendations for common infections, including those in infants, children, adults, people with penicillin allergies, sepsis, severe illness, or recent MRSA isolation.

The Te Whata Kura team includes: Associate Professor Stephen Ritchie, Dr Lily Fraser, Dr Karen Wright, Dr Emma Best, Dr Maxim Bloomfield, Professor Stephen Chambers, Eamon Duffy, Dr Sharon Gardner, Dr Thomas Hills, Dr Anecita Gigi Lim, Dr Sarah Metcalf, Associate Professor Alesha Smith, Dr Leanne Te Karu, Associate Professor Mark Thomas.

Rationale and need

For many years, Aotearoa has had a profusion of antibiotic guidelines. Some primarily serve primary care (e.g. BPAC^{nz}, Community HealthPathways), while others are oriented to secondary care (e.g. the SCRIPT app used in Tāmaki Makaurau and the Empiric app used in the Wellington region). Others, such as those provided by the New Zealand Sexual Health Society, and those by Te Whatu Ora for the prevention, diagnosis and management of rheumatic fever have a relatively narrow condition-specific focus. This fragmentation has meant that until now there has not been a single, comprehensive national source of antibiotic guidance. The result has been variability between guidelines in their recommendations, infrequent guideline updates, and difficulties in auditing antibiotic use across a range of settings – all of which have undermined efforts to improve equity and quality in antibiotic prescribing.

Te Whata Kura will provide a consistent national standard, allowing all prescribers from Te Hāpua to Rakiura access to the same expert advice, and enabling more informative monitoring of appropriate and inappropriate antibiotic prescribing.

Addressing inappropriate and inequitable prescribing

Aotearoa's overall community antibiotic dispensing rate is among the highest in the developed world, contributing to high rates of antimicrobial resistance – including methicillin-resistant *Staphylococcus aureus* and amoxicillin-resistant *Escherichia coli*. Seasonal spikes in antibiotic use each winter, and high rates of prescribing for patients with self-limiting upper respiratory tract infections, demonstrate persistent overprescribing.

At the same time, there is underprescribing for patients in whom antibiotics are genuinely needed. Māori and Pacific peoples experience hospitalisation rates for infectious diseases more than twice those of other New Zealanders. By enabling equitable access to evidence-based prescribing guidelines and establishing regular national audit capacity, *Te Whata Kura* will support both reduction of inappropriate over-prescribing and increased timely, appropriate prescribing for those who currently are underserved.

Example recommendations

Some prescribers may find that the guideline challenges existing habits – for example, recommending not to prescribe antibiotic treatment for patients with a sore throat who are not at an increased risk of acute rheumatic fever (ARF). This approach aligns with international best practice and evidence showing minimal symptomatic benefit from antibiotic treatment in low-risk patients. However, prescribers are likely to find that most recommendations are consistent with their current clinical practice.

Figures 1 and 2 illustrate guideline content for two common clinical scenarios in community practice. (The recommendations reflect those of the guideline at the time of writing in mid-November.)

Figure 1. Recommended community-based management for a child with extensive impetigo who recently had MRSA (methicillin-resistant *Staphylococcus aureus*) isolated from a skin lesion.

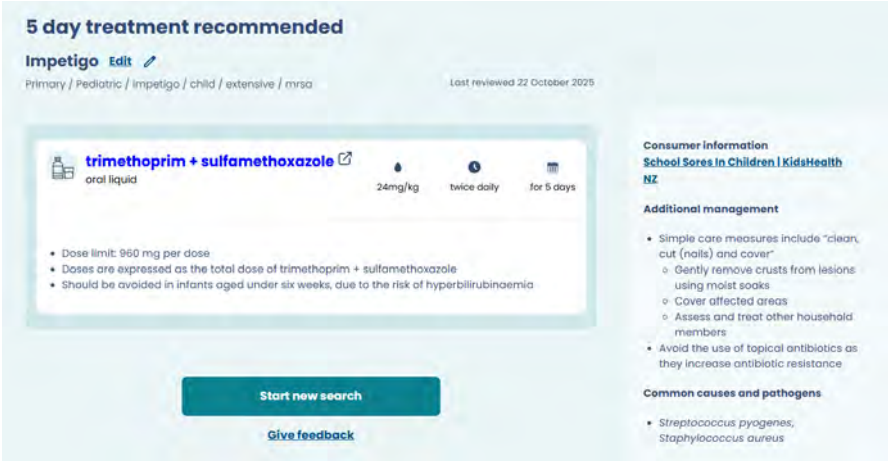
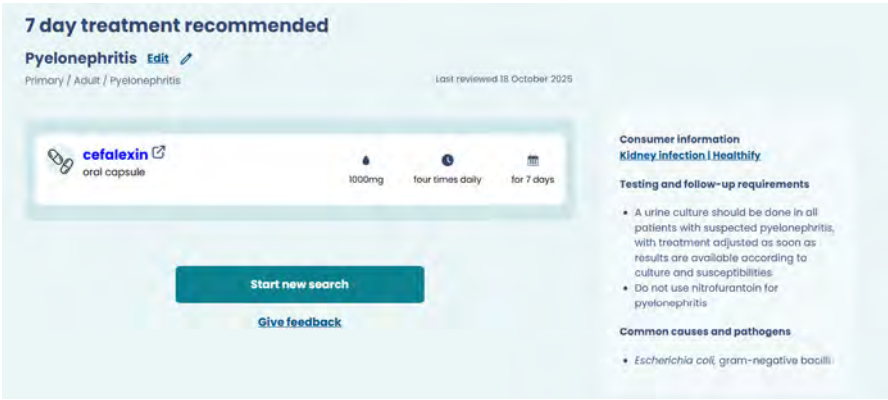


Figure 2. Recommended community-based management for a woman who is not critically unwell and presents with pyelonephritis.



Looking ahead

Te Whata Kura has been built for continual improvement and can collect feedback from users as they access the guideline in real time. The very large amount of feedback received during the October pre-release consultation period was overwhelmingly positive and included many helpful suggestions that have contributed to the creation of a final version of the guideline that we hope will be well received by clinicians and organisations across Aotearoa. We expect that its nationwide use will strengthen consistency and support equity in delivery of best-practice prescribing and contribute to reversing the rising prevalence of antibiotic resistance.

Key Messages

- *Te Whata Kura* provides nationally unified antibiotic prescribing guidance
- Developed by a multidisciplinary team from across Aotearoa
- Accessible via web or as an app on your mobile device
- Designed to promote both prudent use and equitable access to best-practice prescribing.

Submit your feedback

New 2025 COPD guidelines: Key updates for primary care

Asthma and Respiratory Foundation NZ (ARFNZ) launches 2025 update

The ARFNZ launched the 2025 *New Zealand COPD Guidelines* at the New Zealand Respiratory Conference, bringing the latest evidence into a concise, New Zealand–specific resource.

The update, by a working group of respiratory health experts, drew on local evidence and the international COPD-X (2024) and GOLD (2025) guidelines.

Unacceptable health disparities persist: COPD among Māori and Pacific people is more common, severe and fatal than among other New Zealanders. The guidelines highlight ways to deliver health care services in a culturally safe way to promote equity.

A section on the initial assessment of COPD has been added, emphasising the critical role of spirometry.

Non-pharmacological management of COPD remains essential: this may have more impact than drug therapy. There is guidance on smoking cessation, pulmonary rehabilitation, physical activity, breathlessness management, sputum clearance and nutrition.

Among the most notable changes is a stronger emphasis on stepwise pharmacological management, recommending long-acting bronchodilators: Usually a LAMA (long-acting muscarinic antagonist) or alternatively a LABA (long-acting beta-agonist) as first-line maintenance therapy with early escalation to combination LAMA/LABA for patients with persistent symptoms.

Inhaled corticosteroids (ICS) should be added for patients who exacerbate more than once a year, or who have one exacerbation needing hospital admission: single inhaler ICS/LAMA/LABA therapy is recommended. Patients with blood eosinophils ≥ 300 cells/µL are also likely to benefit from an ICS, but ICS should not be used routinely, or continued without evidence of benefit, due to the risk of pneumonia. An ICS-containing combination inhaler (ICS/LAMA/LABA or ICS/LABA) should form part of the regimen for any patient with asthma/COPD overlap.

A **'do-not' list** provides clear caution against prescribing regular short-acting beta-agonists, long-term oral corticosteroids, routine use of theophylline or nebulised bronchodilators in patients with stable COPD. Clinicians are encouraged to simplify regimens and review inhaler technique regularly.

All patients should have a written or electronic COPD action plan: These are available on the ARFNZ website for clinicians to personalise, print out and save to the patient's records. The updated version includes spaces to record the patient's normal oxygen saturation, the distance they can normally walk and a QR code link to a breathlessness guide.

For GPs, the update offers clearer decision pathways, simplified inhaler recommendations and a renewed focus on patient partnership. A four-step COPD consultation remains a practical feature: **A one-page tool to guide assessment, treatment and self-management.**

The full guidelines are available on the **ARFNZ website**. A summary is published in the *New Zealand Medical Journal* – 2025 Nov 7; 138(1625).

Goodfellow Unit podcast: **Palpitations**

Dr Niall Foley completed his medical degree at University College Dublin and now works as a consultant cardiologist across both public and private practice in Nelson. He completed his fellowship training in electrophysiology and cardiac devices. Alongside being a passionate teacher, he has a strong interest in cardiac pacing and complex cardiac devices, including conduction system pacing and leadless pacing.

In this podcast, Dr Foley discusses palpitations and what the patient often means when they use the term.

The key take-home messages of this podcast are:

- The vast majority of palpitations are benign.
- The most common reasons seen are Sinus tachycardia or ectopic.
- Don't underestimate the value of reassurance and exercise.
- For people with an interest, devices (such as Kardia and Apple Watch) can play a role in obtaining a diagnosis.

Listen to the podcast

Submit your feedback

Asthma care and climate

Progress, challenges and next steps

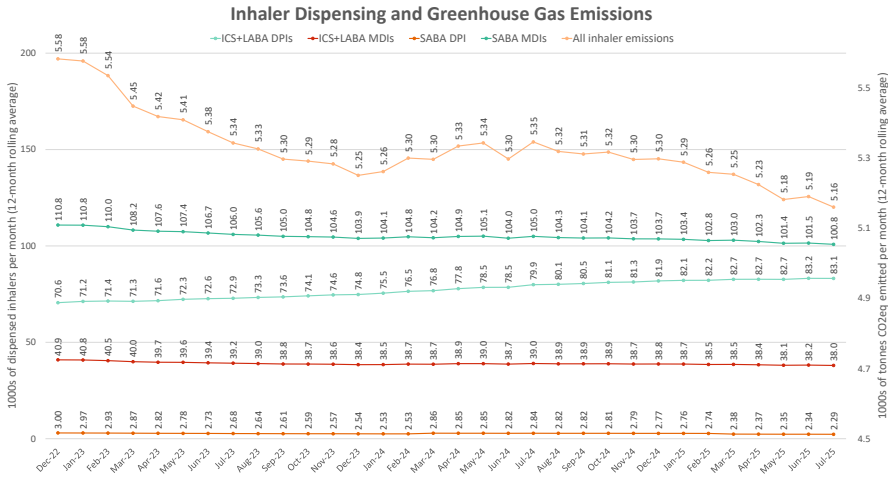
By Dr Rob Burrell and Simon Wright

Asthma care in Aotearoa is on the right track, and that's good news for patients and the planet. Dispensing data is all trending in the right direction:

- More inhaled corticosteroids (ICS) and long-acting beta2-agonists (LABA) combination inhalers are being dispensed, indicating increasing uptake of single maintenance and reliever therapy (SMART) and anti-inflammatory reliever (AIR) therapy.
- More dry-powder inhalers (DPIs) are being dispensed, which have a much lower carbon footprint than most metered-dose inhalers (MDIs).
- Fewer salbutamol MDIs, which are no longer recommended for asthma care in adolescents and adults or for long-term chronic obstructive pulmonary disease (COPD) care, are being dispensed.

These changes indicate better adherence to national guidelines and a growing awareness of environmental issues.

The short-acting beta2-agonist (SABA) MDI problem



Despite this progress, we still dispense over 1.3 million SABA MDIs annually, accounting for the vast majority of the 60,000 tonnes CO_2-equivalent emissions from all inhalers. The greenhouse gas emissions from inhalers are greater than from all the natural gas used to run New Zealand's hospitals!

Insights from clinicians

At the NZ Respiratory Conference, we asked delegates to tell us why so many SABA MDIs are being prescribed and what could be done to address this.

About the authors

Dr Rob Burrell mixes his anaesthesia job at Middlemore Hospital with his clinical lead role in Te Whatu Ora's Sustainability team.

Simon Wright is the College's Principal Advisor – Policy, Advocacy and Insights.

Some key feedback on the prevalence of SABA prescribing included:

1. **Habitual and 'just in case' prescribing:** This was seen as a problem amongst clinicians young and old. Hospital and emergency department practices reinforce SABA MDI habits.
2. **Patient attachment to the 'blue inhaler':** Patients often believe salbutamol works faster, and they feel reassured by its familiarity. Some dislike the sensation of dry powders when inhaled or fear change. Brand loyalty, for example, to Ventolin is strong.
3. **Device limitations and clinical needs:** DPIs aren't suitable for everyone. Many children under 12, patients with poor inspiratory flow and those with dexterity issues may struggle. MDIs remain essential in acute settings.
4. **Knowledge gaps and missed opportunities:** Many patients and some clinicians are unaware of the carbon footprint of inhalers. Education opportunities tend to arise during crises rather than when patients are stable and able to consider alternatives, so opportunities are not seized.

To respond to these challenges, delegates suggested:

- Smarter patient management systems, such as the new Indici dispensing alert or using the pharmacy Toniq system to flag high SABA MDI use.
- Removing (or at least reducing) SABAs from repeats when patients move to SMART or AIR therapy.
- Routine medication reviews at key ages – seven and 12 were suggested – and after exacerbations.

Patient education is also needed, and this needs to take place when patients are well, not just during crises. Clinicians can explain that SMART and AIR strategies offer better control and fewer flare-ups and highlight the environmental benefits. A useful aid for such discussions would be the Asthma and Respiratory Foundation's updated inhaler chart, which can be downloaded from their website.

Prescribing, and more than prescribing

Prescribers can make a big difference to the health of people with asthma by optimising treatment plans in line with the updated asthma and COPD guidelines. Where these don't seem to be working as well as expected, more personalised approaches may help with a focus on the treatable traits; that is, characteristics that can include comorbidities (e.g. anxiety, vocal cord dysfunction and reflux), risk factors (e.g. smoking and bone density) and self-management skills (e.g. adherence and inhaler technique). Prescribers can also use the EPiC dashboard theme on asthma to ensure best practice prescribing.

In New Zealand the social determinants of health are a major cause of asthma. GPs can, and should, refer patients to healthy homes providers as appropriate. Research shows that even modest home improvements can significantly improve the respiratory health of all household members, reduce demand for health services and improve educational and sustainability outcomes.

Cosmetic considerations in the treatment of thyroid conditions

Dr Francis Hall

Patients' concerns regarding the cosmetic outcomes of the treatment of their thyroid conditions may influence the treatment the patient and doctor choose. For many thyroid conditions there are a range of treatment options. Broadly speaking, treatment options fall into the following categories:

Medical treatment:

- Thyroid hormone replacement (thyroxine): hypothyroidism,
- Anti-thyroid medication (carbimazole)

Radioactive iodine (RAI):

- Hyperthyroidism

Ultrasound surveillance:

- Certain thyroid nodules, microcarcinoma

Surgery:

- Thyroid nodules that may be cancerous or are symptomatic
- Compressive / symptomatic goitre
- Thyroid cancer
- Hyperthyroidism

Ablative procedures:

- Ethanol ablation: symptomatic thyroid cysts

Radiofrequency ablation (RFA):

- benign symptomatic thyroid nodules
- autonomous hot thyroid nodules.
- papillary thyroid microcarcinoma (<1cm)

Generally, patients have no concerns regarding cosmesis with non-surgical treatments (medical, RAI, ultrasound surveillance and ablative procedures). Some patients may have considerable concerns about the cosmetic outcomes of surgery. This has led to the development of different surgical options. These options fall into two main categories.

1. Modifying the length of the incision.
2. Placing the incision away from the anterior neck.

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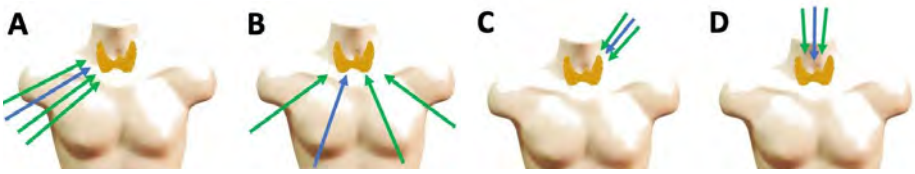
First let us discuss modifying the length of the incision. Traditionally thyroid surgeons made an 8–10cm incision in a skin crease overlying the thyroid. Over the last 20 years or so, many surgeons have made smaller incisions about 4–6cm long, believing this would result in an improved cosmetic outcome. The length of the incision is also influenced by the size of the thyroid mass and the patient's body habitus. Minimally invasive video assisted thyroidectomy (MIVAT) has taken this further with an incision measuring 1–2cm in length.[1]



Remote access thyroidectomy.

Next, let us discuss placing the incision away from the anterior neck, termed remote access thyroidectomy. Options here include performing thyroidectomy through a face lift incision, a peri areolar incision, an axillary incision and an intra oral incision[2]. These are not minimally invasive approaches and have been described as maximally invasive approaches by some surgeons. The existence of such surgical approaches highlights the importance to some patients of avoiding any surgical scar on the anterior neck.

The need for surgery is also influenced by guidelines such as those published by the American Thyroid Association (ATA)[3] and the American College of Radiology (ACR)[4]. The ACR guidelines state which thyroid nodules require fine needle aspiration (FNA), which in turn influences which patients are recommended to undergo surgery. Many patients with indeterminate cytology (Bethesda 3 and 4 nodules on FNA) may in turn be offered molecular analysis of their thyroid nodule.[5] This approach has been shown to reduce the need for surgery by 50–70% in patients with Bethesda 3 and 4 thyroid nodules.

The need for surgery is further reduced by ablative techniques. Most patients with a symptomatic thyroid cyst are cured by ethanol ablation. Some patients with thyroid nodules are suitable for radiofrequency ablation (RFA).[6,7] Thyroid nodules suitable for RFA include benign symptomatic thyroid nodules (ideally in the 2–5cm range), autonomous hot thyroid nodules and papillary thyroid microcarcinomas. Papillary thyroid microcarcinomas are papillary thyroid carcinomas less than or equal to 1cm in size. Ethanol ablation and RFA are commonly performed in America, Asia and Europe and are now available in New Zealand.

Patients' priorities may differ substantially from their doctors' priorities. For some patients their main priority may be surgically removing their thyroid. Other patients may want to avoid the potential complications of a treatment by avoiding a particular treatment. Some patients may not even want a beautifully healed surgical scar on their neck. It is important that the treating doctor listens carefully to the patient and not impose their priorities on the patient, before referring appropriately.

In summary, there are a range of treatment options for many thyroid conditions. Involve the patient in the selection of a treatment that best suits not only their diagnosis but also that patient's particular concerns.

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Transforming pain care by valuing Indigenous knowledge and worldviews

By Lívia Gaspar Fernandes, Cheryl Davies, Jean Hay-Smith, Chrystal Jaye, Hemakumar Devan

Indigenous experiences and worldviews offer valuable insights to transform health service delivery and advance health equity. In the field of chronic pain, Indigenous knowledge is often overlooked or is not incorporated into management and treatment strategies available in and endorsed by mainstream health care.

In Aotearoa New Zealand this means that meaningful exploration of concepts such as, but not limited to, tikanga, whanaungatanga, whānau, whenua, whakapapa and wairua in collaboration with Māori with chronic pain is not always part of a clinical consultation. However, agendas that are not inclusive of Indigenous experiences and worldviews may impede engagement by Indigenous peoples. We completed an integrative review to gain insight into what is valued in terms of care and chronic pain management, as reported by Indigenous peoples.[1]

We synthesised evidence of chronic pain experiences of Indigenous peoples across the globe. From 32 studies spanning North and South America and Oceania, eight were conducted in Aotearoa New Zealand with Māori participants. We interpreted the findings in relation to the literature authored by Māori and other Indigenous scholars, which supports its translation into practice in the Aotearoa context. We also used the Two-Eyed Seeing approach to privilege Indigenous voices and worldviews. We observed four thematic threads that evidence how contextual, historical and relational elements influenced how Indigenous peoples make sense of the chronic pain they experience.

Pain is interconnected with:

- **Nature:** Some frameworks (e.g. seasons) seemed helpful to understand chronic pain as dynamic and changeable over time. These frameworks may bring comfort and a sense of belonging, acknowledging both the good and challenging moments of living with chronic pain.
- **Indigenous identity:** To talk about chronic pain elicited talk about identity; doing so enhanced mana and provided strength. Recalling ancestors, whakapapa, cultural practices and traditional knowledge contributed to an optimistic orientation to manage pain.

- **Historical trauma:** Colonisation and intergenerational trauma have a collective and long-term impact on identities and culture and must be acknowledged in pain care. Holistic approaches to care were preferred to acknowledge and address trauma and promote healing.
- **The collective and relationships:** Meaningfully connecting with others and being able to participate in the community is paramount for dealing with the ups and downs inherent in living with and managing chronic pain.

The review findings are thought-provoking, suggesting health professionals require curiosity to explore and understand the complexities of living with chronic pain for Indigenous people and communities.

Suggestions and resources

Considering the clinical implications of this review, we highlight the following:

- Indigenous knowledge must be acknowledged and incorporated into pain care to uphold pain management strategies that are culturally grounded and safe.
- There are many ways of engaging with initiatives that are culturally safe in the field of pain, and doing so contributes to achieving health equity for Indigenous peoples. For example, see **Davies et al. (2025)** and **Antunovich et al. (2024)**.
- Valuing diversity in how chronic pain is understood matters. This may be done by exploring with curiosity how patients make sense of pain in alternative ways, perhaps moving beyond an 'anamnesis-assessment' interview style and talking with people about what makes them who they are.
- Developing trust relationships must prioritise the collective, including the person with chronic pain and their whānau (family networks and support groups). Wider community networks should also be involved when relevant.
- Also, as part of a collective initiative led by Indigenous and non-Indigenous clinicians and researchers from Australia, Aotearoa New Zealand, and Canada and the International Association for the Studies of Pain (IASP), we have contributed to the **2025 Global Year Factsheet on "Pain in Indigenous Peoples from Colonized Countries"**. This fact sheet calls for Indigenous-led solutions to pain care, highlighting practical actions at individual, health systems and societal levels.

You can read the journal article, "*We do not stop being Indigenous when we are in pain": An integrative review of the lived experiences of chronic pain among Indigenous peoples* in the **Māori Health Review**.

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Patient experience surveys

Understanding access and barriers to care

The Health Quality & Safety Commission Te Tāhū Hauora (the Commission) undertakes quarterly national patient experience surveys to collect and measure feedback on health care and quality improvement across hospital, primary and community services. The primary care patient experience survey is one of the largest public survey programmes in the country, with approximately 32,000 patients completing the survey each quarter.

Earlier this year, the Commission added new questions into the primary care patient survey to better understand why survey respondents couldn't access care and what happened as a result.

Survey results show us:

- Patients value continuity of care, with 71% having a usual GP. Of the respondents with a usual GP or nurse, 84% saw that person at their most recent appointment.
- Most appointments are in-person (94%).
- About 20% of respondents reported a time in the past 12 months when they wanted care but were unable to get it.
- When asked about barriers, wait times for appointments (15%) remain the highest reason, and 6% reported difficulty seeing their preferred GP or nurse – reflecting again the desire for continuity of care.
- 3% reported clinic opening hours as a barrier, and 2% were unable to get through to the clinic to make an appointment.
- 54% of those unable to get care stated they had an urgent health need.
- 65% of those who stated wait times were too long or could not see their usual GP/nurse were offered options by their practice, including triage (22%), an appointment with someone else (25%), a referral elsewhere (25%) or other options (9%). Respondents were able to select multiple responses.

College Medical Director Dr Prabani Wood says that "across the primary care sector we understand the importance of continuity of care and the benefits it has on health outcomes. It is great to see from this survey that patients also value it. We know that continuity of care with a GP helps people to live longer, healthier lives and keeps them out of EDs and hospitals.

"The challenges to ensuring all New Zealanders, irrespective of where they live, have timely access to care are well-documented, with workforce shortages and closed books making access difficult. Solutions have been implemented to address this, including more telehealth providers offering virtual appointments. This alternative option for care is welcomed, and there are

patients who prefer this style of appointment, but telehealth services should be offered alongside improved face-to-face primary care services, as this survey feedback does highlight that this personal, ongoing and comprehensive face-to-face care is important to our patients."

You can find more information about the Patient Experience Surveys on the Commission's website: **Patient experience | Health Quality & Safety Commission Te Tāhū Hauora.**

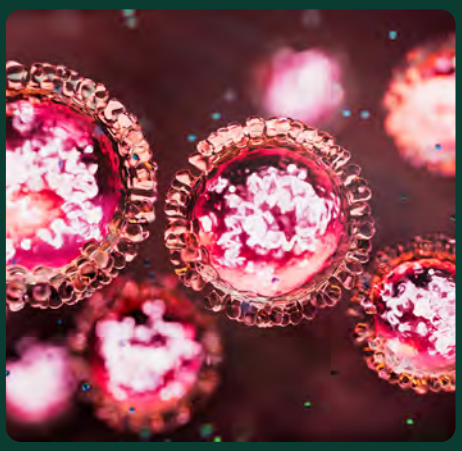
Goodfellow Unit podcast: **Measles outbreak**

Nikki is a Professor in the Department of General Practice and Primary Care and Medical Director of the Immunisation Advisory Centre (IMAC), at the University of Auckland. She has developed and evolved IMAC from its inception in 1996 into a national communication, coordination, education and research centre. She works part time as a General Practitioner at the NUHS Broadway clinic in Strathmore, Wellington.

In this episode Nikki discusses the key role of vaccination in eradicating measles, focusing on what immunisation actually protects against, and the crucial role primary care plays in the containment of the current measles outbreak.

The key take-home messages of this podcast are:

- Vaccination is the way we will eradicate measles.
- Start with your one year olds, make sure everyone is up to date.
- If you have additional energy and resources, then work up through the age groups.
- Do not give this live attenuated vaccine to the immunocompromised.
- A strong message of community protection, to help ring-fence those who can't be vaccinated.



Listen to the podcast

Submit your feedback

Common health care interactions and Cerebral Palsy

Amy Hogan – Researcher and Member Support Advisor, Cerebral Palsy Society of New Zealand

Every three days a baby is born in Aotearoa New Zealand with Cerebral Palsy (CP) – Hōkai Nukurangi.* It's a striking statistic for a condition that has a low profile.

The science around CP and lifelong conditions is evolving and producing a more sophisticated understanding of how people, including GPs, can support individuals and their families.

CP is lifelong and multidimensional – it may intersect with musculoskeletal, gastrointestinal, respiratory and mental health issues. Take time to ask your patient about fatigue, pain or functional changes – these may not be the presenting complaint but can shape the person's daily quality of life and self-management.

Making sense of diagnosis and documentation

GPs often hold the most comprehensive long-term record for disabled patients. However, many adults with CP were diagnosed in childhood and may not have accessible or up-to-date documentation in their current file.

When taking over care or updating records:

- Include the **type and features** of CP (if known)
- Note **mobility aids, communication methods** and **baseline pain levels**
- Record associated conditions (e.g. epilepsy, reflux, spasticity, fatigue)
- Where information is unavailable, note this transparently rather than omitting it.

Funding streams and referral requests

Many people with CP engage with multiple systems beyond primary care, including the Ministry of Health, Health New Zealand | Te Whatu Ora, and disability support funding (e.g. Individualised Funding, Equipment and Modification Services or ACC).

GPs are often asked to complete funding applications, referral and management forms for their patients. Whenever possible, document functional impact rather than just diagnosis. For example: "Requires mobility aid for transfers" provides more context than "spastic diplegia."

Cerebral Palsy (CP) is the most common physical disability in childhood. People with the neurological condition don't grow out of it, so there are a large number of adults living with it. It affects the movement, mobility and posture of approximately 10,000 New Zealanders.

CP is caused by damage to the developing brain during pregnancy, shortly after birth or up to the age of two. It can result in different movement types and affect different parts of the body depending on where the brain injury is, and CP can present on a broad spectrum. At least two-thirds of people with CP will have movement difficulties affecting one or both arms. Almost every daily activity – eating, writing, dressing – can be impacted.

The Cerebral Palsy Society of New Zealand is a charity that supports people living with CP and their whānau.

*__Hōkai Nukurangi__ is the te reo Māori term for Cerebral Palsy and translates to achieving what is important to you.

Specialist requirements and obligations

People with CP, and disabled people more broadly, often experience multiple layers of health care interaction. They may have regular contact with physiotherapists, occupational therapists, dietitians, speech-language therapists and orthopaedic teams.

While GPs often coordinate these relationships, the referral processes and follow-ups can vary significantly across regions. A proactive approach, such as confirming who holds ongoing responsibility for aspects of care, can reduce duplication and prevent gaps.

Common experiences in health care interactions

People with CP frequently report both positive and negative experiences in primary care. Themes include:

- **Access and environment:** Wheelchair users may struggle to reach counters, transfer to exam tables or fit in consultation spaces. Simple adjustments – such as a height-adjustable plinth or portable ramp – can improve access.
- **Assumptions:** Adults with CP are sometimes mistaken for paediatric patients or assumed to have cognitive impairment. Ask before assuming and include the person directly in discussions, even if they use a support person.
- **Pain and fatigue:** Pain is common but often under-reported. Asking, "How is your body feeling this week?" rather than "Are you in pain?" can elicit a more accurate picture.
- **Communication:** Allow extra time or written formats where speech or processing are affected. For some, a support person may interpret or relay information.

Final thoughts

Caring for people with CP requires awareness, flexibility and partnership. A small amount of extra planning can help create meaningful, inclusive care, benefitting the person with CP and their whānau.

You can learn more and access resources at www.cerebralpalsy.org.nz.

Submit your feedback

WellSouth's initiative to boost newborn enrolment and immunisation rates

WellSouth staff packing the newborn kete to be delivered to general practices.

The benefits of being enrolled with a general practice and receiving continuity of care from an early age help patients to live longer, healthier lives and prevent ED or acute hospital visits. Primary care teams within a practice are often the first point of call to address health concerns and provide trusted advice and support.

With this in mind, WellSouth has launched an initiative for parents and primary caregivers in Otago and Southland with the aim of increasing pēpi (newborn) enrolments, closing the equity gap, increasing six-week immunisations and supporting general practices in these regions to achieve immunisation targets.

Through the new Newborn Enrolment Kahu Taurima Programme, welcome packs are gifted to parents and caregivers when they visit the practice to complete the enrolment process for their pēpi. They contain newborn essentials in a woven kete bag, such as a bilingual te reo Māori and English baby book, biodegradable nappies and water wipes.

During a baby's first hearing test or upon discharge from a maternity unit new parents and caregivers are provided with an informational flyer that lets them know a gift pack is waiting for them.

Whānau identified as belonging to a priority population, such as Community Services Card holders and Māori and Pacific whānau, will also be offered a voucher for a visit to check in on the wellbeing of the new mum/primary caregiver. Follow-up calls are made by the WellSouth call centre to check in on these patients and support them to use the voucher and ensure their own health and wellbeing is also being looked after.

All 79 general practices across Otago and Southland are participating in this programme, highlighting the important role that general practice plays in the health of our communities.

WellSouth Pou Haumanu Māori | Clinical Advisor Māori Dr Miriama Ketu-McKenzie says that primary caregivers who may be overwhelmed or have less trust or connection with general practice and health services may not enrol their pēpi, and as a result, can find it harder to keep up with immunisations and other important developmental checks.

"These early days are critical for setting the conditions that lead to lifelong good health outcomes. Having an incentive alongside helpful advice can encourage primary caregivers to enrol their baby as soon as possible and book in for those important first health checks and immunisations.

Read more about WellSouth's newborn enrolment initiative.

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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