GP Voice

YOUR NEWS, YOUR VIEWS, YOUR VOICES

You shared, we listened
2025 member engagement survey

Wairoa Hospital
A hidden gem for RHM registrars

Silicosis and other lung disease in engineered stone workers in NZ

Being the Doctor
Lucy O'Hagan on stories, struggles, and showing up

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

October 2025

In this issue

Editorial

Dr Prabani Wood

Dr Prabani Wood
Medical Director

Kia ora koutou,

Welcome to the penultimate issue of GP Voice for 2025 and my first editorial as Medical Director.

My first few weeks have shown me the vital role that the College plays in advocating for our general practice and rural hospital medicine workforce. Recently, there has been good progress made with regard to more funding to support doctors training to become specialist GPs. If we are to have a sustainable workforce, we urgently need to retain the specialist GPs we already have. A huge part of this will involve better job sizing of our roles so that all the work we do, including the vital non–patient-facing work, is recognised and remunerated.

We know the challenges facing the sector. We also know the vital role that specialist GPs play in the health care system. We help people live longer, healthier lives and save the health system money while doing so. We achieve these amazing outcomes by building longitudinal relationships with our patients. Due to years of underfunding, our ability to provide continuity of care, in particular, has been eroded. If we want a well-functioning health system in New Zealand, primary care needs to be adequately resourced and specialist GPs need to be recognised as leaders in primary care. Specialist GPs need to be supported to lead primary care teams in their communities.

I am enjoying getting involved with the wide range of advocacy work that is already under way. I have a few ideas of my own on how we can further promote the value of what we do, and I will be sure to share updates on our progress and regularly seek feedback from the membership.

I thought it important to highlight the ‘Mind This’ case studies from Dr Peter Moodie that we have included in this issue. The cases highlight the wide scope of practice for specialist GPs. They are a useful means for us to think about our own practice when it comes to areas such as medication prescribing, referrals and follow-ups, consultation notes and collaboration with other sectors in the health system.

There has been a lot of media coverage about various HDC cases over the past couple of months, not all related to or involving us, but we are the workforce who is often the first point of contact for people’s medical concerns. I hope you find these case studies useful, and I would like to pass on my thanks to Dr Moodie for the time he gives to the College to write these up and relate them, where relevant, to the work that we do.

A reminder that if you have a topic in mind that you’d like to share, please email the GP Voice editorial team at communications@rnzcgp.org.nz, who can work with you to get this published.

Enjoy this issue,
Prabani

You shared, we listened

2025 member engagement survey

Rachael Dippie

Rachael Dippie
Head of Membership

Tēnā koutou katoa

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

Over August and September we conducted our second annual member engagement survey. This survey is designed to be a shallow dive into some of the functional areas of the College, seeking feedback and thoughts to help us identify areas for improvement.

It was very pleasing to see an upward tick across all aspects of the survey.

This is what we heard:

- Members value the functions of the College, and it was pleasing to see a lift in meeting members expectations across most functions. There are some areas where the respondents would like to see more effort placed – mainly in the areas of attracting more GPs and rural hospital doctors to the profession, facilitating the training of rural hospital doctors and advocating for better health care outcomes with Government and agencies.
- Our communications channels saw a slight lift in engagement and satisfaction. We have made a number of improvements to ePulse and GP Voice since the last survey, and we will continue to refine all our communication channels to aid readability and applicability.
- Over a third of respondents (37%) had engaged in a Faculty or Chapter event in the past 12 months. This is similar to the 2024 survey. Of the respondents that belong to a Chapter, 41% had attended a Chapter event in the past 12 months. Of those that belong to Te Akoranga a Māui, 42% had attended a Te Akoranga a Māui event in the past 12 months.
  - 84% of Fellows that responded said our CPD programme Te Whanake is easy to use – an increase from the 2024 survey.
  - Since last year's survey we have implemented ways to increase our customer service responsiveness, so it was pleasing to see a significant increase in satisfaction with our customer service levels.
  - Finally, our member benefits awareness has grown since the last survey, with EAP Services ranking top in awareness as well as value. We have worked on increasing awareness of all benefits since the last survey; the College app increased the most at 11%, which correlates with a notable increase in usage.

Thank you to the 1300 members who completed the survey and shared your views openly. Our annual survey is an important channel to hear the sentiments of our members, and we now have some clear direction regarding what it is that we need to focus on in our immediate workplans.

One of those outcomes is adding a new member benefit. You told us you would like us to offer a discount on health insurance. We are pleased that a discount for Southern Cross Health Insurance will soon be added to the College app.

And continuing with our member engagement, I will end with the results of our GP25: Conference for General Practice survey. This year's conference took place at the end of July in Ōtautahi Christchurch, with just under 700 members attending. Overall, we were very pleased with the feedback received, with 95% of delegates satisfied overall. This year we held a pre-conference CME workshop day with over 150 members attending. This was particularly successful with 92% satisfied and 41% stating the day was 'excellent'.

Planning for GP26 is already under way – the date for your diaries: Thursday 30 July to Saturday 1 August 2026 at the New Zealand International Conference Centre in Auckland.

Lastly, can I please ask that you check that your contact details, Faculty and any Chapter involvement is up to date on your member dashboard, which you can log in to from the website and then click on 'edit details'. If you have trouble accessing your details, give us a call on 0800 965 999 or email membership@rnzcgp.org.nz. We're here to help.

Hei konā mai

Rachael Dippie
Head of Membership

Goodfellow Unit podcast: **Kindness in healthcare**

Nicki Macklin is a health researcher, educator, and advocate whose work focuses on kindness, leadership, and the human experience of health care. Her past work history includes working as an occupational therapist before becoming involved in primary health service design, delivery and evaluation. Nicki's recent PhD explored how kindness is defined and practised in health care settings, and what conditions allow it to thrive, from health care teams to the boardroom.

In this podcast, Nicki discusses kindness and leadership, covering how kindness in health care is different from simply 'being nice'.

The key take-home messages of this podcast are:

- Reframe kindness – it's a skill and is strongly linked to safety and wellbeing.
- Kindness literally saves lives.
- Systems need to remember that care is a value.
- Share kindness as a value and help embed it in our organisations.
- Culture change starts at the top – kind leadership is essential.

Listen to the podcast

Submit your feedback

College Advocacy: Months in review

August and September

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

Submission on the Healthy Futures (Pae Ora) Amendment Bill

The College made both a written and oral submission to the Health Select Committee on the Healthy Futures (Pae Ora) Amendment Bill. The oral submission was presented by College President Dr Luke Bradford and the College's Hauora Māori Clinical Fellow Dr Jess Keepa.

The College's position is that we do not support the Healthy Futures (Pae Ora) Amendment Bill as it risks undermining the foundations of a fair and effective health system by weakening obligations to Te Tiriti o Waitangi, reducing local, clinical and iwi input, and centralising control in ways that could deprioritise the effective and equitable delivery of primary care. The College's submission highlights how these changes may affect GPs, their ability to deliver culturally appropriate care, and the broader aim of achieving Pae Ora (healthy futures) for all.

Read the College's full submission on our website.

Listen to College President Dr Luke Bradford's interview on Radio NZ: **'Doctors fear law change would gag health workers from speaking out.'**

Dr Bradford also attended the following meetings:

- Supervision and registration of physician associates, MCNZ
- Select committee on menopause management education and changes in practice
- Council of Medical Colleges (CMC) cultural safety hui
- CMC meeting
- Mental health in primary care response hui
- National Quality Forum.

Quality team

- Renewal of our MoU with the Practice Managers and Administrators Association of NZ (PMAANZ). This MoU underscores our joint commitment to key priorities like the Foundation Standard and Cornerstone programmes, while recognising the essential role of practice managers in helping our members achieve quality standards in general practice.

- We are seeking clarification from the Ministry of Health on their definition of a non-core children's worker in regulated health services such as general practices. The need for this has come about as Police vetting services are declining requests for non-clinical roles in a general practice (practice managers and reception staff, for example), citing that it does not meet their criteria. We have issued interim guidance to practices supported by legal advice to ensure practices are still meeting their obligations for these roles under the Children's Act 2014 for Foundation Standard. You can read more here.
- We have recently updated our Foundation Standard guidance on the use of unregulated health workers and standing orders. While current legislation permits this, we want to ensure our members, as issuers of standing orders, are well supported and informed when they choose to use this provision. You can read more here.

Submissions

- Dementia Mate Wareware Action Plan (MoH)
- Healthy Futures (Pae Ora) Amendment Bill (Health Select Committee)
- Proposed changes to the blood monitoring and prescribing requirements for clozapine (Medsafe)
- MOU between the College and NZ Society of Cosmetic Medicine (NZSCM)
- Proposal to fund ticagrelor for people after minor stroke or high-risk TIA (Pharmac)
- EAC Drugs – MoDA scheduling (MoH).

Journal
OF PRIMARY HEALTH CARE

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

For between issue reading, visit the 'online early' section.

Trending articles:

1. Horny Goat Weed/Epimedium
2. Trends in psychological distress: analysis of NZ health survey data (2011–2023)
3. Protecting primary healthcare funding in Aotearoa New Zealand: a cross-sectional analysis of funding data 2009–2023
4. Primary health care utilisation in Aotearoa New Zealand: a descriptive study of trends from 2008 to 2023
5. Globe artichoke

Submit your feedback

Quality in Practice: Burwood Health

A Cornerstone CQI module case study

Burwood Health opened in November 2019 as a purpose-built medical centre for the local community. Two local practices were combined to create a centre that could meet the demands of the growing local population. They offer a range of services to their local community and continue to expand to meet the demands of their population.

We caught up with Tahlia Simpson, Business Manager at Burwood Health, to find out about their experiences with the Cornerstone CQI module, why they did it and what they learnt from it.

What motivated your practice to complete the Cornerstone CQI module?

We wanted to improve services for our population, specifically our diabetic patients. We also wanted to become a practice to support registrars. While patient care is our main focus, we are also dedicated to training and supporting a new generation of GPs in Aotearoa. Incorporating our registrars into the quality improvements that we are focusing on in the future and participating in our diabetic care appointments is an important part of our patients' wellbeing as well as registrars' training within the practice.

Please tell us a bit about your CQI initiative

We undertook a review of the practice's diabetic patient population to ensure patients were accessing appropriate health care as and when required. A team led by practice doctors and nurses to address patients' ongoing health needs identified key areas, including:

- patients with an HbA1c >65
- identifying diabetic patients not seen for more than 12 months
- updating patient Read codes within the practice management system to diabetes mellitus (C10).

The practice then initiated nurse-led diabetic care clinics with the purpose of offering 30-minute appointments to diabetic patients, whereby health initiatives were discussed and implemented. From these appointments, patients could then either continue to monitor and improve their health as required or speak further about their needs with either their doctor or the practice health coach or health improvement practitioner.

Submit your feedback

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

Whilst the practice already had a diabetic plan in place for our patients, it was not as cohesive as we would have preferred. This meant our team needed to work together to come up with the parameters for those patients, including whether we were going to include pre-diabetic patients in our CQI module and the beginning stages of our diabetic care performance. We also needed to decide how the clinic was going to work for initial appointments and what follow-ups were with the diabetic care nurse versus the patient's doctor. There were several group discussions regarding this and other factors before the clinic was initiated.

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

Our team now has clear guidelines for our diabetic patients, and we have been able to start incorporating this into other care plans and initiatives the practice is undertaking.

Our team also now has a dedicated nurse lead for diabetic patients, who has created a platform for the practice nurse team to have consistency in the care of diabetic patients. The new diabetic care clinics have meant that patients can see a clinical team member regarding their ongoing diabetic care without having to see their GP for every appointment. This has allowed other appointments for patients to be scheduled with the GP whilst ensuring ongoing care for our diabetic patients.

What is different for patients?

Overall, patients feel more empowered and supported in managing their condition. We're hopeful this will reduce secondary care input and maintain up-to-date research for best practice.

Patients have made reference to knowing who to go to for their diabetes care, and they tend to like having someone consistent overseeing their diabetes care.

It allows patients to be up to date with the screening needed to maintain and prevent or have early detection of any diabetes complications. This also allows recall and screening measures to be up to date on the patient management system (PMS).

“

Patients feel more empowered and supported in managing their condition. We're hopeful this will reduce secondary care input and maintain up-to-date research for best practice.

Submit your feedback

Wairoa Hospital: A hidden gem for RHM registrars

A rural hospital profile

Nestled between Gisborne and Hawke's Bay, Wairoa Hospital is more than just a rural health facility – it's a place where registrars can experience medicine at its most rewarding. With a tight-knit community, a strong teaching culture and opportunities to work across both primary and secondary care, Wairoa offers an experience unlike anywhere else.

For Dr Isaac Carrejo-Campbell, a Gisborne-based registrar, Wairoa was the ideal choice. "I wanted somewhere close to home, but also somewhere that had a reputation for really good people. Wairoa ticked all the boxes," he says.

Isaac points to the influence of inspirational doctors like Dr Margaret Fielding, who dedicated decades of service to Wairoa and was recognised with the Eric Elder Medal for her contribution to rural medicine at the College's recent Fellowship and Awards ceremony. Her legacy has helped cement Wairoa as a training hub.

Today, leadership has passed to Dr Liffey Rimmer, who has recently achieved Fellowship through the Prior Specialist Pathway. Dr Rimmer is now Clinical Director and plays an active role in teaching both registrars and fifth-year medical students.

Wairoa Hospital is officially accredited as a Level 2 rural hospital. It has a 10-bed ward, a two-bed ED, and a two-bed maternity unit, alongside more than 40 visiting specialist outpatient clinics each month. The hospital is closely

> "I wanted somewhere close to home, but also somewhere that had a reputation for really good people. Wairoa ticked all the boxes.

Submit your feedback

integrated with Te Wairoa Medical Centre, owned by Māori GP couple Dr Turuki Tahuri and Dr Mania Campbell-Seymour, the town's only GP service, which is housed in the same building. Many doctors work across both the hospital and the practice, a unique opportunity to follow patients seamlessly from hospital to primary care.

Registrars are well supported in Wairoa, with on-site accommodation provided and a flexible approach to contracts. "They worked with me to set hours and conditions that really suited my situation," Isaac says. "It was an incredibly supportive environment."

The patient population provides rich learning opportunities. With around 65% Māori residents, Wairoa offers a chance to practise medicine in a bicultural context and develop strong skills in equity and cultural safety. High levels of acuity and late presentations also mean registrars gain hands-on experience with complex cases.

Despite challenges from Cyclone Gabrielle's impact on the realities of rural resourcing, the hospital has shown resilience and innovation. During the cyclone, local teams kept care flowing by integrating the GP practice's IT systems into hospital workflows, ensuring continuity for patients despite power and communication outages.

Isaac describes Wairoa as "a place with a really strong sense of community – patients rarely come in alone; they come surrounded by whānau. There are, of course, plenty of challenges in both Wairoa and the low-resourced health system, and it certainly took me a little while to get used to. By the end though, I realised how special this place and these people are. It's the kind of place you want to go back to."

That inspiration is already flowing into the next wave of doctors. Dr James Strickland will begin his placement at Wairoa Hospital next year, continuing to grow the cohort of registrars choosing the region.

"My first exposure to Wairoa was as an ICU registrar in Hawke's Bay Hospital," James explains. "Part of that role was helping with unstable patient transfers via helicopter or fixed wing. I went to Wairoa several times to pick up sick patients, and every time I found the team culture incredibly helpful."

For James, that experience made the decision clear. "I chose to go there as it's my 'local' rural hospital. I live in Hastings, and I'd like to establish a role there once I've finished training."

With registrars like Isaac and James choosing Wairoa, the hospital is building momentum as a place where rural careers can take root.

With new teaching programmes now in place, including PGY2 rotations and Otago University's Rural Immersion Programme starting in 2024, Wairoa is firmly on the map as a training hub. For registrars seeking a placement that combines variety, challenge and community connection, Wairoa Hospital is a rural gem waiting to be discovered.

"For registrars seeking a placement that combines variety, challenge and community connection, Wairoa Hospital is a rural gem waiting to be discovered.

Submit your feedback

2025 mock exams: Supporting our registrars

Every year, the College supports registrars by running written and clinical mock examinations. This gives the registrars an insight into the exam format and gives them the opportunity to prepare for their end-of-year exams.

This year we had 207 registrars sit the written mock exams in July. It's a formative assessment completed online during the registrars' regional seminar day; the real exam is a traditional written exam with registrars putting pen to paper.

Two hundred and nineteen registrars sat the clinical mock exams, where registrars have the opportunity to do three clinical examination cases and receive feedback from the educators and their peers.

Preparation is key, and a lot of logistics and planning go into making sure everyone involved is well prepared and equipped with the resources they will need on the day.

Our lead medical educators, medical educators and GPEP year 1 teachers play an important role in this process, running the exams and providing invaluable feedback to the registrars.

There is also a contingent of College staff involved, both in the lead-up to and on the days of the exams.

Well done to all the GPEP year 1 registrars who have sat their mock exams this year, and best of luck to those who are yet to sit their exams. We hope it helps you with your preparation for the final exams later this year!

Submit your feedback

MIND THIS

A delayed referral for an abnormal PSA test

Dr Peter Moodie

Peter Moodie is the College's Clinical Advisor

The case

Errors in the management of PSA results are a regular cause for complaints to the Health and Disability Commission (HDC), and there are at least five that I can easily identify. In this case, an abnormal PSA was identified in 2019 but not actioned until 2021. One mitigating factor was that Dr B had had serious health issues requiring multiple surgeries over this time, and at least part of the time, he was "working from home."

The sequence of events was:

- **7 May 2019:** A PSA result for Mr A (in his 70s) was recorded as 11.8 mcg/L.
- **20 May 2019:** There are case notes relating to a discussion and possible examination but no repeat of the PSA.
- **4 May 2020:** A PSA was 13.4 mcg/L and a clinic note stated "contact urology"; however, no urology referral was made.
- **11 June 2020:** Dr B made a note to "contact the urology department"; however, a referral did not occur.
- **6 August 2020:** Dr B set a task for their health care assistant to arrange for a urine test and PSA. The urine test was done but there is no record of a PSA result.
- **19 December 2020:** Dr B set up a PSA recall for Mr A, but there was no record of this having been followed up.
- **3 February 2021:** A PSA was 17.3 mcg/L, and a note stated, "ref urology for advice: done." However, the referral was never sent.
- **19 and 22 February 2021:** A staff member became aware that the referral had not been actioned and met with Mr A to progress the referral; however, there is no record that Dr B was contacted about this and there was still no referral made.
- **14 April 2021:** Mr A contacted the medical centre as he had not heard from the urology department. Dr B was contacted, and did send a referral, but it was to the internal medicine department for management of Mr A's blood pressure.
- **29 April 2021:** A PSA was 29 mcg/L and a semi-urgent referral to urology was made.
- **17 June 2021:** Mr A had a prostatic biopsy which showed a stage 3 cancer.

The lessons

Firstly, Dr B had obvious health issues which were likely to have impacted the management of Mr A. In these circumstances a clinician should be warned about the possibility of impairment by their own doctor. Their practice also needs to be vigilant and offer extra support to help them manage their workload.

Secondly, recall management in primary care is quite onerous and needs to be managed very carefully with clear systems in place so that patient results and correspondence from the hospital are followed up and actioned in a safe and timely manner.

Finally, it is concerning that there have been so many complaints relating to PSA management. The reality is that no matter what you might think about the efficacy of PSA testing, once you offer the test you must give a clear explanation on how you are going to manage the results.

Goodfellow Unit podcast: **Thyroid nodules**

Dr Ben Chan is a consultant Head and Neck surgeon at North Shore Hospital and has previously worked in Christchurch, where he was the Chair of the Head and Neck Cancer multidisciplinary team. He is an expert in the surgical treatment of thyroid cancer, as well as cancers of the oral cavity, throat, salivary glands, sinonasal tract, and skin.

In this podcast, Dr Chan discusses thyroid nodules and the recent changes in assessment and management.

The key take-home messages of this podcast are:

- Nodules are common and nothing to worry about 90% of the time.
- Manage patient stress levels without being over-the-top reassuring.
- Even the ones that are cancerous, the majority are slow-growing and super treatable.
- Be aware that when thyroid cancer becomes advanced, there may not be a big lump out the front of the neck.

Listen to the podcast

MIND THIS

Another case of a failed follow-up of a PSA test

Dr Peter Moodie

The case

Following a PSA test in November 2012, Mr A was diagnosed with prostate cancer, and Dr C, a urologist, performed a radical prostatectomy. Initially, Dr C followed up Mr A with PSA testing and indeed did continue this for some time after, when Dr C saw Mr A for a hydrocele and erectile dysfunction.

In January 2013 Dr C wrote to Dr B (Mr A's general practitioner) that Mr A should have six-monthly PSA tests and be referred if there was any PSA activity (greater than .05mcg/L). In fact, Dr C ordered two more PSA tests in July 2013 and January 2014.

Dr B appears to have not put Mr A on a recall in January 2013 when he received Dr C's discharge letter; however, in June 2014, he was put on an annual recall by a practice nurse. This recall was updated in 2018 so that the patient was automatically sent a blood request form. Although Dr C requested six-monthly PSA tests, BPAC guidelines advise that after two years these tests can be done annually, and this is what Dr B did.

Notwithstanding the documented recall system, Mr A did not have a test in either 2015 or 2017. The reason for these non-attendances is not explained; however, the Commissioner curiously concluded that it was likely that Mr A was never invited as his non-attendance should have triggered a follow-up call.

In 2018 Mr A's PSA had risen to .08mcg/L and by 2021 was 2.7mcg/L. Mr A was finally referred when, in 2022, the PSA was 67mcg/L and he was found to have bony metastases.

Dr B explained that their general practice had been subject to a lot of disruption over the years, and they had the major responsibility for overseeing some 400 to 600 inbox records per week. Dr B had obviously been distracted by the standard pathology reporting that (for routine screening) the results up to 2021 were "within the normal range." Dr B also noted that from 2018 Mr A had access to portal which allowed him access to his laboratory results.

How could we stop this scenario repeating itself, again?

1. The urologist could have maintained responsibility along with a recall system.
2. There should have been a formal handover between the urologist and the general practitioner where the patient was carefully discussed AND the GP formally accepted responsibility.

Peter Moodie is the College's Clinical Advisor

3. The standard pathology comments relating to PSA testing should be amended to note that for post cancer surgery, the PSA should be zero.
4. When a PSA test is ordered, there should be a question: “Is this test for general screening, or surveillance.” In that way, the standard ‘normal range’ could, where appropriate, be reset to zero.

Conclusion

When a recall is missed or misread there is really no defence other than to admit the failing; however, we do need to look at ways to ensure that errors do not occur.

I get an annual recall from my dentist, which is a good thing for both of us. The recall system makes commercial sense in that the dentist gets a return of at least $150 for each successful recall, and it carries no clinical risk; if I don’t make an appointment, that is my problem. For general practice, there is little, if any, commercial gain, and the system is expensive to set up and run as failings can easily bring medico-legal risk, as with this case.

General practice and the College have set a very high standard for recall responsibilities – far higher than anything that can be achieved by secondary care. It is time that the technical and commercial issues around screening/recall tools are addressed. A workshop with all interested parties present would be a great start.

Being the Doctor

Lucy O'Hagan on stories, struggles, and showing up

Dr Lucy O'Hagan

College Fellow, and *NZ Doctor* columnist Dr Lucy O'Hagan has recently launched her new book *Everything but the Medicine*, in which she reflects deeply on being a doctor, weaving stories from her patients and her whānau, including her burnout and recovery. We sat down with Lucy to talk about what it means to 'be the doctor' in today's world.

Which books have shaped your approach to medicine and writing?

"I'm drawn to books that ask bigger questions of medicine – about healing, culture, and the relational side of our work." Early on I read Eric Cassell, Ian McWhinney and Arthur Frank. Glenn Colquhoun's writing has inspired generations of New Zealand doctors, and more recently works like *Tātaihono and Ora: Healing Ourselves*.

In your book you reflect on what it means to be a 'good doctor.' How do you hold onto those values in busy everyday practice?

Lucy says the ideals – kindness, humility, listening – are deceptively simple. "Patients pick up quickly whether they feel judged or safe. Some days, hope is harder to find, but it's about trusting that the other person already carries capacities within them." For her, it's less about perfection, more about consistency: showing up as human.

> "Some days, hope is harder to find, but it's about trusting that the other person already carries capacities within them.

You write openly about your own life – your brother's death, your child's epilepsy, your marriage ending, your burnout. Was it hard to be that open?

"Yes – and no," she says. Lucy grew up in an open family, so speaking about hard things felt natural. But medicine often tells us to hide our vulnerabilities behind professionalism. "When I burnt out, I knew silence would only feed my shame. By speaking about it I free others to speak too."

Lucy's advice to GP trainees: "Be yourself in the consult room. Patients respond to authenticity."

You've moved from rural practice in Wānaka to urban 'high needs' health. What drew you there?

"I like to take myself to the edge of what I can do, then challenge myself to try something else. It's a sort of human mountaineering!" Lucy says. "Working with people who haven't always been well served by health systems is challenging, but it's also incredibly rewarding. You encounter people with their own priorities, their own ways of surviving often with great warmth and dignity."

Part of that journey has been working to better serve Māori patients. What has that meant for you?

"It's ongoing work, which isn't so much understanding te ao Māori as it is understanding te ao Pākehā! Ko wai au? Who am I? What are the assumptions, judgements, privileges and culture that I bring into the room?" Lucy reflects. It's not a journey with a destination; it's a commitment to keep moving forward through a foggy discomfort. But there are great rewards for all of us."

"In the consultation room I come back to whanaungatanga," she says. "Relationships are the core of healing. Without them, the medicine can't do its job."

What did you hope this book would do?

Lucy wanted to write the book she wished she'd had as a younger doctor. "Something that acknowledges the shadows and the invisible labour we do as GPs. I've been moved by colleagues who've said, 'I felt seen'."

You've spoken about the toll of this work, and your own experience of burnout. How do you balance self-care now?

Self-care outside of work is just one element. What interests me is how to manage ourselves in a consultation when we hear very big stories. We want to be kind and compassionate but not carry these stories. I talk about that a bit in the book.

> "Be yourself in the consult room. Patients respond to authenticity.

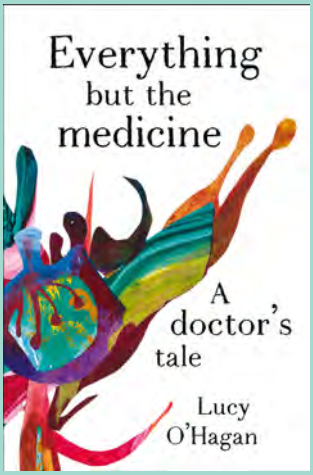
Many GPs might feel drawn to writing but unsure where to start. What advice would you give a colleague about sharing their reflections?

Anyone can do writing as reflective practice. It's fantastic. If you want to put that writing into the world then you need to think hard about confidentiality and learn the craft of writing.

Finally, looking ahead: what do you see as the biggest issue facing general practice that needs system-level change?

I think we need to be clear on our values and what matters. Our performance as GPs is measured in reductionist micro tick boxes. The things that really make a difference in a consultation are not counted or even seen. They need to be. Or we will be funded to be robots.

Lucy O'Hagan's reflections will resonate with many of us. She reminds us that being a GP is not just about clinical decisions – it's about the stories we witness, the relationships we build, and the courage to stay human in the room.



You can get a copy of Lucy's book, ***Everything but the Medicine*** from a great bookshop near you or **online** from your local independent bookshop.

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

GP25: Concurrent session overviews

Cultural safety in practice: Moving beyond awareness

Dr Tawa Hunter

Dr Tawa Hunter challenged clinicians to think critically about what cultural safety looks like in everyday practice. She emphasised that cultural safety goes beyond cultural competency, where competency focuses on learning about others, safety requires reflecting on our own biases, the culture of the institutions we work in and how these shape care.

Key points from her kōrero:

- **Defined by patients, not clinicians:** Cultural safety is measured by how care is experienced by whānau, not how we perceive ourselves.
- **Beyond awareness:** It requires ongoing self-reflection and institutional change, not a one-off training or checklist exercise.
- **The stakes are high:** Inequities in Aotearoa persist because of structural racism and unsafe practices – for example, Māori babies are less likely to be resuscitated at birth, and Indian mothers experience the highest perinatal mortality rates.
- **Competency vs safety:** Cultural competency is knowledge-based and defined by clinicians. Cultural safety is relational, reflective and accountable, with the goal of achieving equity.
- **Everyday practice matters:** Dr Hunter shared personal experiences of how insidious stereotypes become normalised in clinical settings, influencing care in ways clinicians may not even recognise.
- **Equity is not optional:** "Without equity, there is no quality." Cultural safety saves lives, restores trust and allows whānau to thrive.

Cultural safety requires courage, accountability, and a willingness to challenge the structures and assumptions that perpetuate inequity.

Patients should not all be treated the same: A scoping review of general practice training in cultural models

Dr Lisa Collins

Dr Lisa Collins, a GP trainee from Belfast Northern Ireland, presented her MPhil research examining how cultural models are integrated into GP training worldwide. Having worked in both New Zealand and the UK, she highlighted the stark differences in how cultural concepts are acknowledged and applied in practice.

Her scoping review explored four models – cultural competence, cultural safety, cultural humility, and transcultural care, and examined how they are taught (or not taught) in GP training programmes across countries.

Key points from her session:

- **Patients should not all be treated the same:** GP trainees often default to 'treat others as you would want to be treated,' but cultural safety requires 'treating others the way they want to be treated.'

- **Training gaps:** Of 19 articles identified (2008–2024), none were based in the UK or New Zealand GP training. Most cultural learning happens informally, often through exposure rather than structured teaching.
- **Critical reflection is essential:** GP trainees frequently fail to reflect on their own biases, stereotypes and the power dynamics in consultations. Anti-racism and cultural self-reflection need greater emphasis.
- **Patient-centred care:** Models that centralise the patient's perspective – rather than clinician definitions – are key to delivering safe, equitable care.
- **Role of mentors:** Cultural mentors can provide invaluable insights and improve communication between doctors and patients yet are underutilised in training.
- **Next steps:** Dr Collins is working with members of the Travelling Community in Belfast to co-design a workshop for medical students aiming to embed these models earlier in training and reduce the need for 'unlearning' later in practice.

Cultural education cannot remain an afterthought in medical training. To reduce inequities, GP registrars need structured teaching, cultural mentorship and a shift from uniform treatment to care shaped by patients' lived realities.

Cultural safety and the medical profession in Aotearoa: A training framework and the pursuit of Māori health equity

Dr Mataroria Lyndon

Dr Mataroria Lyndon presented on the newly established cultural safety training framework for vocational medicine in Aotearoa, developed alongside Professor David Tipene-Leach and Dr Sam Murton. He grounded his kōrero in the vision of Kīngi Tāwhiao – "our mokopuna shall inherit a better place than I inherited" – reminding us that health inequities remain stark for Māori and other marginalised communities.

The framework adopted by all medical colleges in 2023 marks a shift from cultural competency to cultural safety, ensuring that doctors not only gain knowledge of other cultures but critically reflect on their own biases, power, and institutional structures.

Key points from his session:

- **From competency to safety:** The difference between cultural competence and cultural safety is that with competence we often end up 'othering' the other person. We go out and we learn about somebody else's culture, somebody else's way of doing things, so that theoretically we can better understand why they do what they do and treat them accordingly.
- **Defined by patients:** Cultural safety is determined not by clinicians or institutions but by the people and communities receiving care.
- **Not just individual practice:** The framework calls for action at multiple levels clinician, team, institution and system to dismantle structural barriers to equity.
- **Education matters:** Trainees cannot provide culturally safe care if their learning environments are unsafe. Evidence shows racism and bias in training and assessment directly impact Māori students' experiences and retention.
- **Proficiencies for practice:** Critical consciousness, shared decision-making, respect for diverse identities and embedding cultural safety across curricula are central to the framework.

- **A system-level challenge:** Recent government moves to remove cultural and equity requirements from health regulation highlight why ongoing advocacy and implementation are critical.
- **Extending to all contexts:** Cultural safety applies in face-to-face and virtual care alike. Patient choice in how they access services must remain central.

Dr Lyndon's message was clear: "You can't be clinically safe without being culturally safe." Achieving health equity for Māori and other communities will require commitment across the profession – not just from individual clinicians but from the systems and structures that shape medical education and practice.

Kaupapa Māori as a model for effective engagement in primary and community care

Kim Laurence

Psychotherapist Kim Laurence spoke about Te Whare Hīnātore – a pilot kaupapa Māori service run by Auckland City Mission – Te Tāpui Atawhai.

Te Whare Hīnātore is open to any wāhine, or those who identify as wāhine, in need of a safe space to live. It operates as a modified therapeutic community where the programme is trauma-informed according to each person's needs.

Te Whare Hīnātore is a 12-week programme and 12-week aftercare programme for wāhine who need support; for example, homeless women with untreated mental health issues, trauma or have come from violent relationships. They wanted to create a service that took women who didn't fit the tick-box criteria for other services.

Each journey is personal and may include psychotherapy, group sessions, parenting, or alcohol and/or other drug programmes. The residential programme runs for 12 weeks, but staff stay in touch and continue to support the wāhine (known as raukura) for another 12 weeks after they have left the whare.

They used the Kaupapa Māori model; for example, instead of being individual-driven, focusing on being whānau and community-driven, or being relationship-driven rather than paperwork-driven.

Kim gave some examples of quick wins of 'what you can do tomorrow':

- Prioritise whakawhanaungatanga (the first two minutes count)
- Use plain language; avoid jargon
- Offer for whānau to join appointments
- Normalise te reo greetings: Kia ora, Tēnā koe
- Reframe non-compliance as having 'barriers'
- Advocate for cultural training, signage, whānau-friendly spaces
- Think about the environments like the entrance, reception and rooms
- Become familiar with other Kaupapa Māori services for referrals.

Integrating Tikanga o Te Hauora o Tūranganui a Kiwa with the SROI Framework

Dr Shirley Keown and Dr Ngahuia Mita

Doctors Shirley Keown and Ngahuia Mita spoke about integrating Tikanga o Te Hauora o Tūranganui a Kiwa at Turanga Health.

Turanga Health is an iwi health provider that bridges health gaps for Māori in Tairāwhiti, focusing on holistic care initiatives that seek to connect with whānau in their whare or in their kāinga (community settings where whānau work, learn, live and play).

Turanga Health's vision of 'building family wellness for future generations' brings a unique approach to wellbeing. They implemented Tikanga o Te Hauora o Tūranganui a Kiwa, a community health service offering many services such as mental health, addictions, general practice, workplace wellness, antenatal and smoking cessation.

They lead with tikanga:

- Principle- and practice-based adaptations
- Establishing scope as kaupapa setting (mā wai, mō wai, nā wai i karanga etc.)
- Stakeholder engagement as Whakawhanaungatanga
- Nā tō rourou, nā taku rourou ka ora ai te iwi (inputs – activities – outputs).

The programme has been running for 15 years, starting off with around 10–15 participants, and they now have 200 participants who report the following benefits from attending the programme:

- Uplift in vitality and energy
- Increased sense of purpose and meaning
- Increased social connection
- Increased sense of happiness and joy
- Increased ability to manage their own health.

Mana, whakawhanaungatanga, and how to improve these in a clinical context

Dr Jethro Leroy

Dr Jethro Leroy started off his presentation by highlighting that some leaders are driven by power, and some are driven by mana. "I would choose mana all day long," he says.

Dr Leroy outlined the Hui Process:

- Mihi: Initial greeting and engagement
- Whakawhanaungatanga: Building relationships and making a connection
- Kaupapa: Attending to the clinical purpose of the session
- Poroaki/whakamutunga: Closing the session.

Then Dr Leroy asked, as clinical professionals, what can we do to help incorporate the Hui Process?

- We can be mana enhancing – use our good clinical communication practices
- Allowing whānau to come into the room when they want to
- Heads are sacred – always ask permission.

He advised that Māori patients don't complain but they just won't turn up to their appointments or won't take their medication.

Silicosis and other lung disease in engineered stone workers in New Zealand

Dr Adrienne Edwards, Health New Zealand
Sue Cotton, WorkSafe New Zealand

Introduction

Silicosis is a preventable, progressive, fibrotic lung disease resulting from inhalation of respirable crystalline silica (RCS) dust. Engineered stone workers can be exposed to very high levels of RCS, leading to premature death from silicosis and other interstitial lung diseases. Prevention, early detection and removal from ongoing exposure are vital, with specialist general practitioners (GPs) playing a critical role.

Case finding

ACC, WorkSafe and Health New Zealand | Te Whatu Ora, supported by the Dust Diseases Taskforce, established the Accelerated silicosis assessment pathway, where anyone who has worked with engineered stone in New Zealand for at least six months in the past 10 years can have their health assessed. The pathway starts with a GP examination, where a claim can be lodged based on the exposure threshold, even in asymptomatic workers. A Silica Exposure HealthPathway has been implemented nationally to guide GPs.

As of August 2024,[1] 22 engineered stone workers had been diagnosed with simple or complicated silicosis, and a few more with probable or possible accelerated silicosis from 222 claims lodged. Uptake of the assessment pathway by the approximately 1,000 workers eligible has not been as high as hoped. Radiological health monitoring of engineered stone workers is ad hoc, and the true burden of silicosis is unknown.

Case studies

Three case studies highlight that waiting for symptoms to develop is too late. Primary prevention and health monitoring are key. Some case study summaries have been included on the pages that follow. View the full case studies.

1. The 2025 review is underway.

Case 1: Patient diagnosed too late without radiological health monitoring

A 56-year-old male stonemason presented to their GP with chronic cough and breathlessness. No co-morbidities, no regular medication.

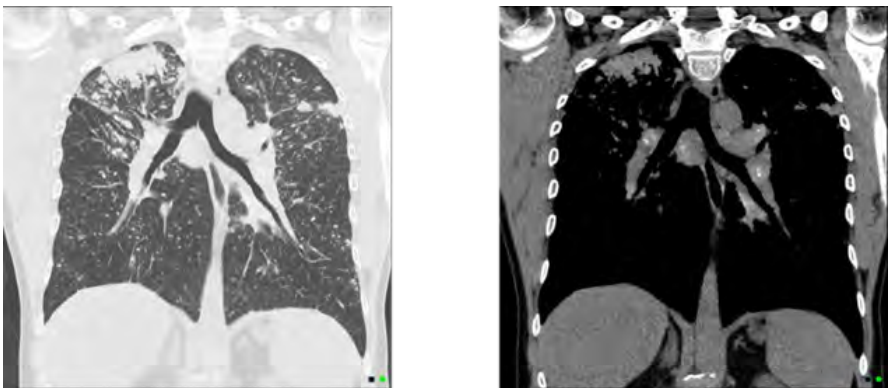
Occupational history: 25-years' exposure to RCS. Worked with marble and stone for five years before working with high silica content engineered stone without respiratory protective equipment (RPE).

Oxygen saturation 94% RA. No wheeze but crackles in the upper zones of the lungs.

Chest X-ray abnormal, with concern raised for malignancy. Normal immigration chest X-ray on arrival in New Zealand decades earlier.

CT scan (figure 1A) at baseline demonstrating apical predominant coalescing nodularity typical for complicated silicosis (left) and calcified mediastinal and hilar lymphadenopathy (right).

Figure 1A:



Diagnosis: Complicated (nodules >10mm) silicosis (chronic-exposure duration >10 years). At high risk of progression.

Treatment: Remove from workplace to prevent RCS inhalation. Prednisone therapy with no clinical response.

Figure 1B (from right to left): CT scan imaging demonstrating progressive fibrotic lung disease. Anti-fibrotic therapy (nintedanib) was prescribed without benefit. Referred for consideration of lung transplantation.

Figure 1B:

Case 2: An autoimmune disease presentation in a cleaner exposed to silica dust

A 53-year-old woman presented to the GP with progressive breathlessness and cough.

No co-morbidities, no regular medication.

Occupational history: Worked in stonemason business for 20 years. Exposed to RCS from high silica content engineered stone when cleaning the workshop. Wore no RPE.

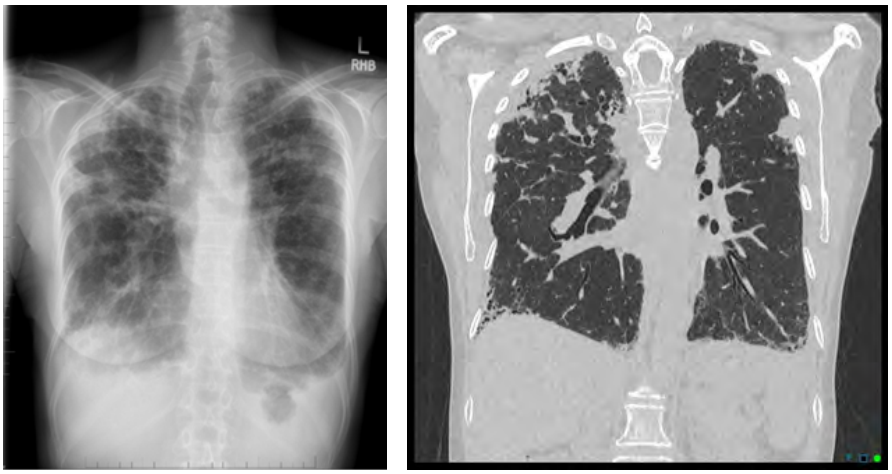
Chest X-ray (left) and CT scan image (right) demonstrating findings consistent with fibrotic interstitial lung disease with secondary pleuroparenchymal fibroelastosis, figure 2.

Diagnosis: Connective tissue disease ILD – a recognised manifestation of silica exposure.

Treatment: Prescribed prednisone and mycophenolate mofetil; however, the disease progressed. Anti-fibrotic therapy was prescribed without benefit.

Outcome: Died prematurely of respiratory failure.

Figure 2:



Case 3: Asymptomatic worker entered the case-finding pathway

Asymptomatic 33-year-old man (son of case 2) was a stonemason in the family-owned business.

Occupational history: >8 years' high-intensity RCS exposure without effective RPE. 15-pack per year smoking history.

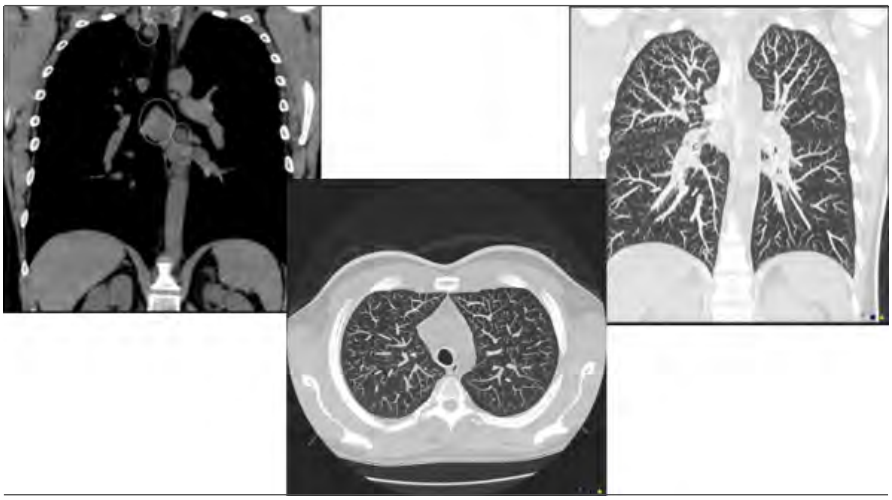
Chest X-ray was normal. Figure 3 is the baseline CT scan demonstrating simple silicosis – multiple small <10mm nodules throughout lungs (right) with associated calcified mediastinal lymphadenopathy (left).

Diagnosis: Accelerated simple silicosis (<10-year exposure history).

Treatment: Remove from exposure.

Outcome: Remains asymptomatic with stability of lung disease thus far.

Figure 3:



Key points

- Primary prevention is vital for silica-related lung disease.
- Claims through the Accelerated Silicosis Assessment Pathway should be arranged for workers exposed to RCS from engineered stone.
- Early disease can be asymptomatic and missed on spirometry and chest X-ray.
- Early detection enables removal from exposure, helping prevent progression.
- RCS exposure may also trigger autoimmune disease, asthma, kidney failure.
- Notify silica-related health conditions to a Medical Officer of Health.[2]

2. Medical practitioners must notify a Medical Officer of Health of a health condition caused by a hazardous substance – s143 Hazardous Substances and New Organisms Act 1996. RCS is a hazardous substance.

Joining the dots: A holistic approach for CKD diagnosis and management

The Chronic Kidney Disease pathway has been aligned nationally across most New Zealand HealthPathways regions, supporting the work of the Renal National Clinical Network.

Dr Walaa Saweirs and Dr Dianne Davis provide a practical and relevant overview of CKD diagnosis and management from a multidisciplinary perspective. HealthPathways > Chronic Kidney Disease pathway

- Quick links on the right of theHealthPathways webpage provide links to a one-page **Chronic Kidney Disease Quick Guide and At Home Sick Day Advice**
- Advice on diagnosing, modifying reversible causes, maximising lifestyle efforts, modifying disease progression and cardiovascular risk, and when and how to escalate for further support.

Watch the webinar recording. You will also find the recording in the 'for health professionals' section at the bottom of the Chronic Kidney Disease pathway.

HealthPathways Education is hosted by Streamliners in partnership with Health New Zealand | Te Whatu Ora.

Health New Zealand
Te Whatu Ora

Streamliners

Dr Walaa Saweirs is a consultant nephrologist (Te Tai Tokerau Renal Service) and the Chair of Early CKD Models of Care (Renal National Clinical Network)

Dr Dianne Davis is a College Fellow, specialist general practitioner and HealthPathways Clinical Editor, Northland.

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 in the North Shore. He is passionate about working from a youth development model and not just a medical diagnostic framework.

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 life long 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

Updated guidelines for genital herpes management in primary care

Katie McCullough, nurse practitioner and STIEF clinical lead

The Sexually Transmitted Infections Education Foundation (STIEF), in partnership with the New Zealand Herpes Foundation (NZHF), has released updated national guidelines for the diagnosis and management of genital herpes. These guidelines, which have been included across all HealthPathways, are designed specifically for use in Aotearoa's primary care settings and aim to support confident, evidence-based and consistent care for a condition that is both common and frequently misunderstood.

The resource offers clear, practical support for clinicians managing both straightforward and complex presentations of genital herpes. The updates incorporate current international evidence and are tailored to help general practitioners and nurse practitioners make efficient, informed decisions during time-pressured consultations. Importantly, the guidelines also place a strong emphasis on improving communication with patients, reducing stigma, and supporting long-term self-management.

The content includes concise clinical flowcharts for the management of first-episode genital herpes, recurrent herpes, and herpes during pregnancy. Each pathway outlines clear steps for assessment, diagnostic testing, antiviral treatment and follow-up, helping to simplify care planning and reduce variation in practice. The guidelines also provide up-to-date advice on the use of suppressive therapy and indications for referral when needed.

Beyond clinical management, the guidelines address the communication challenges that often accompany a diagnosis of genital herpes. There is practical guidance on how to discuss the diagnosis clearly and without judgement, with suggested language that helps reduce patient anxiety and correct common misconceptions. Strategies for addressing emotional responses and fostering shared decision-making are included, supporting a more holistic and respectful approach to care.

Designed to be adaptable across a wide range of clinical settings and patient populations, these guidelines aim to promote consistent, patient-centred management of genital herpes in general practice. They reflect an ongoing commitment to improving both the clinical quality of care and the patient experience in this often-stigmatised area of sexual health.

STIEF
Sexually Transmitted Infections Education Foundation

STIEF continues to provide free, evidence-based printed materials to support patient education. These are suitable for waiting rooms, consults, or uploading to patient portals. They include:

- Genital Herpes – the Facts (booklet)
- Genital Herpes – Myths vs Facts (pamphlet)
- HPV and Cervical Screening
- HPV Vaccination
- HPV and Cancer (Throat and Anal)
- HPV and Genital Warts
- HPV and Males.

To order free clinic resources in bulk, email: info@stief.org.nz.

Confidential nurse-led helpline for patients

Clinicians may also refer patients to STIEF's confidential, nurse-led helpline. The helpline is open 9am to 5pm Monday to Friday and can be reached at 0508 11 12 13 from a landline or 09 433 6526 from a mobile.

The helpline provides clear, supportive, and non-judgemental information for patients newly diagnosed with herpes, and can help reduce anxiety, improve understanding, and support self-management – potentially reducing the need for additional follow-up.

Heart failure: Optimising care in the community

The Heart Failure pathway has been aligned nationally across HealthPathways in New Zealand. While the clinical guidelines are consistent across the country, check your local version for referral criteria and other local nuances.

Dr Andrew Aitken, Cardiologist, Wellington Hospital, Dr Jennifer Roberts (MN, EdD) Clinical Nurse Manager of Cardiology, Capital Coast and Hutt Valley, and Dr Justine Lancaster, College Fellow, General Practitioner, Regional Clinical Advisor for HealthPathways, provide a practical and relevant discussion on heart failure diagnosis and management.

Click here to watch the webinar recording. You will also find the recording in the 'for Health Professionals' section at the bottom of the Heart Failure pathway.

HealthPathways Education is hosted by Streamliners in partnership with Health New Zealand | Te Whatu Ora.

Hypothyroidism

Dr Francis Hall

The thyroid produces mainly (85%) thyroxine (T4) and some (15%) triiodothyronine (T3). Thyroxine is converted to triiodothyronine in certain tissues, including the liver, kidneys, gut and brain by the enzyme deiodinase 2 (DIO2). T3 is more biologically active than T4.

Thyroid-stimulating hormone (TSH) controls the amount of thyroid hormone produced by the thyroid through a negative feedback mechanism. TSH is produced by the anterior pituitary gland under the influence of Thyrotropin-releasing hormone (TRH) released from the hypothalamus. As the level of T4 rises in the blood, it has a negative feedback effect on both the hypothalamus and the anterior pituitary, resulting in a decrease in both TRH and TSH.

Symptoms of hypothyroidism

Thyroid hormone is essential for cellular metabolism and growth. The most common symptoms of hypothyroidism are:

1. Cold intolerance
2. Fatigue
3. Lethargy
4. Weight gain
5. Constipation
6. Dry skin.

There are a number of scoring systems looking at the symptoms and signs of hypothyroidism, including those by Billewicz and Zulewski.[1] The scoring systems are a useful teaching tool but have low sensitivity in diagnosing hypothyroidism.

In the newborn, untreated hypothyroidism can lead to cretinism, resulting in short stature, dysmorphic features and severe intellectual impairment. Fortunately, hypothyroidism is one of the diseases detected on the Guthrie test (heel prick) and early commencement of thyroxine results in preventing the development of cretinism. If untreated, hypothyroidism can result in coma and death.

Causes of hypothyroidism

There are four types of hypothyroidism. Primary hypothyroidism occurs when the thyroid fails to make enough thyroid hormone. Secondary hypothyroidism is due to the anterior pituitary not making enough TSH and tertiary hypothyroidism is due to the hypothalamus not making enough TRH. Peripheral hypothyroidism is due to aberrant expression of deiodinase 3 leading to deactivation of thyroid hormones.

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

Hypothyroidism affects about 5% of the population.[2] Some of the more common causes of **primary hypothyroidism** are:

1. Hashimoto's thyroiditis. This is an autoimmune thyroid condition. It is associated with thyroid peroxidase (TPO) antibodies in the blood. About 50% of people with Hashimoto's thyroiditis eventually become hypothyroid; therefore, it is recommended to check the TSH and fT4 levels once a year in patients with Hashimoto's thyroiditis.
2. Latrogenic
    a. Post total thyroidectomy
    b. Post hemi thyroidectomy (up to 20% in some studies)
    c. Post external beam radiotherapy to the neck
    d. Post radioactive iodine
    e. Lithium, amiodarone, tyrosine kinase inhibitors
3. Post thyroiditis
4. Severe iodine deficiency or iodine overload (Wolff-Chaikoff effect)
5. Down syndrome and Turner syndrome
6. Congenital absence of the thyroid.

In primary hypothyroidism we see an elevated TSH level and a decreased fT4 level. The standard treatment of hypothyroidism is thyroid hormone replacement therapy with levothyroxine.

Thyroxine

An endocrinologist once told me, "as a general rule of thumb, if the TSH level is between 5–10 mIU/L and the patient is asymptomatic consider simply repeating the TSH level in six months. If the TSH level is above 5 and the patient is symptomatic, start treating with thyroxine. If the TSH level is above 10, treat with thyroxine even if the patient is asymptomatic."

The usual starting dose of thyroxine is 1.6 µg per kg per day. In the elderly and in patients with a cardiac history, start at a much lower dose (25 µg per day) and increase slowly. In obese patients, it is recommended that the dose of thyroxine is calculated on ideal body weight (the weight if the patient had a BMI of 25 kg/m^2. Patients on thyroxine who become pregnant should increase their dose of thyroxine by 30%. In patients who have had a total thyroidectomy for either papillary or follicular thyroid cancer, the dose of thyroxine is titrated to the TSH according to the level of risk of cancer recurrence. In low-risk patients, aim for a TSH 0.5–2; in intermediate risk patients, aim for a TSH 0.1–0.5; and in high-risk patients aim for a TSH <0.1.[3]

There are four main commercial preparations of **thyroxine** tablets available in New Zealand:

1. Eltroxin (Glaxo Smith Kline)
2. Synthyroid (Abbott Laboratories)
3. Levothyroxine (Mercury Pharma)
4. Eutroxsig (approved but not funded).

Thyroxine tablets are taken 30–60 minutes before breakfast as some foods may interfere with the absorption of thyroxine from the stomach. After commencement of thyroxine or adjusting the dose of thyroxine, it takes 4–6 weeks for the TSH and fT4 levels to stabilise, so recheck the TSH and fT4 levels in 4–6 weeks. An important aspect of the treatment of hypothyroidism is to adjust the thyroxine dose so that the patient feels well and that the TSH and fT4 are both within the normal range. Recheck the TSH and fT4 levels annually.

Overtreatment (iatrogenic subclinical or overt hyperthyroidism) can cause atrial fibrillation and osteoporosis and should be avoided, especially in the elderly and postmenopausal women. Undertreatment (persistent low fT4) can result in an increased risk of cardiovascular disease.

A small proportion (5–10%) of patients on thyroxine with normal TSH and fT4 levels have persistent symptoms. One explanation for this is variations in the deiodinase 2 (DIO2), the enzyme that converts T4 to T3. These patients can be considered for combination therapy with both thyroxine (T4) and triiodothyronine (T3), although there is mixed evidence of support for this approach.[4]

Triiodothyronine (T3)

Liothyronine (T3) may also be used to treat hypothyroidism. In healthy adults, the usual starting dose of T3 is 20 µg per day and is adjusted up to 80 µg per day depending on the measured TSH level. Note that 25 µg of T3 is roughly equivalent to 100 µg of T4. Because T3 works faster and has a shorter half-life than thyroxine, it may be easier on patients to start and stop T3. This is sometimes done when patients are going to have radioactive iodine.

Whole thyroid extract

This is obtained from pigs and contains both T4 and T3. The dose of T3 and T4 in whole thyroid extract is not standardised, so it may be difficult to get good control of hypothyroidism as judged by blood tests (TSH, fT4 and fT3). Dr Hall has no experience with whole thyroid extract.

Summary

Hypothyroidism is a common condition that is usually easy to diagnose (high TSH and low fT4), and in the majority of patients, it is easy to treat.

References

1. Kalra S, Khandelwal SK, Goyal A. Clinical scoring scales in thyroidology: A compendium. Indian J Endocrinol Metab. 2011 Jul;15(Suppl 2):S89-94. doi: 10.4103/2230-8210.83332.
2. Layal Chaker, et al. Hypothyroidism. Lancet. 2017 September 23; 390(10101): 1550–1562. doi:10.1016/S0140-6736(17)30703-1.
3. Haugen BR, Alexander EK, Bible KC, et al. 2015 American Thyroid Association Management Guidelines for Adult Patients with Thyroid Nodules and Differentiated Thyroid Cancer. Thyroid. 2016 Jan;26(1): 1-133. doi: 10.1089/thy.2015.0020.
4. Jonklaas J, Bianco AC, Cappola AR, et al. Evidence-Based Use of Levothyroxine/Liothyronine Combinations in Treating Hypothyroidism: A Consensus Document. Eur Thyroid J. 2021 Mar;10(1):10-38. doi: 10.1159/000512970.

Multiple sclerosis in primary care

From early recognition to ongoing support

Multiple sclerosis New Zealand

Multiple sclerosis (MS) is a chronic, immune-mediated disease of the central nervous system that remains a leading cause of non-traumatic disability in young adults. Its variable nature and often subtle early symptoms can make diagnosis and management challenging, particularly in primary care, where many patients first present.

Over the past few decades, significant advances in diagnostics, especially MRI, and the development of internationally accepted diagnostic criteria, such as the McDonald criteria, have improved diagnostic timelines. However, delays persist; on average, people in New Zealand wait 4.5 years from first symptom to diagnosis.[1] International guidelines and evidence-based consensus, including the Brain Health Time Matters in MS initiative, emphasise that early diagnosis and treatment can maximise lifelong neurological and functional outcomes.[2]

Primary health plays a critical role in achieving this and in management after diagnosis, including relapse support, symptom management, and optimising the management of comorbidities. GPs are well placed to have significant impacts on the lives of people with MS and their families.

Early recognition: Time matters

MS symptoms can be vague or mimic more common conditions, making early identification difficult. Nonetheless, timely referral to a neurologist – ideally within 10 days of symptoms – can dramatically improve long-term outcomes.[2] Symptoms that should prompt consideration of MS include:

- painful vision loss
- unexplained sensory changes or weakness
- progressive balance and mobility issues.

If these symptoms develop over hours or days and persist, particularly in the absence of infection or fever, a neurology referral should not be delayed. Thorough documentation and exclusion of common differentials support this process.[3] The National Institute for Health and Care Excellence guideline provides good information on what to look for and what to include in a referral.[4]

Recognising and responding to relapse

Ongoing vigilance for MS relapse is essential. A relapse is defined as new or worsening neurological symptoms lasting more than 24 hours without evidence of infection. Respiratory and urinary infections can be common in MS and may mimic or exacerbate symptoms – ruling these out is critical.[4]

Not every relapse requires treatment, but all suspected relapses should be reviewed by the MS team. GPs can facilitate this by:

- checking for and treating infection
- providing clear clinical assessment to MS clinicians
- ensuring timely referrals for suspected relapses.

The primary care team's role in this context is not only diagnostic but also supportive, ensuring continuity of care and reassurance.[5]

The GP Guide for MS Relapse Management developed by Fiona d'Young, MS Nurse at Auckland Te Whatu Ora, is a useful resource when seeing someone with a suspected relapse.

Managing comorbidities: a holistic approach

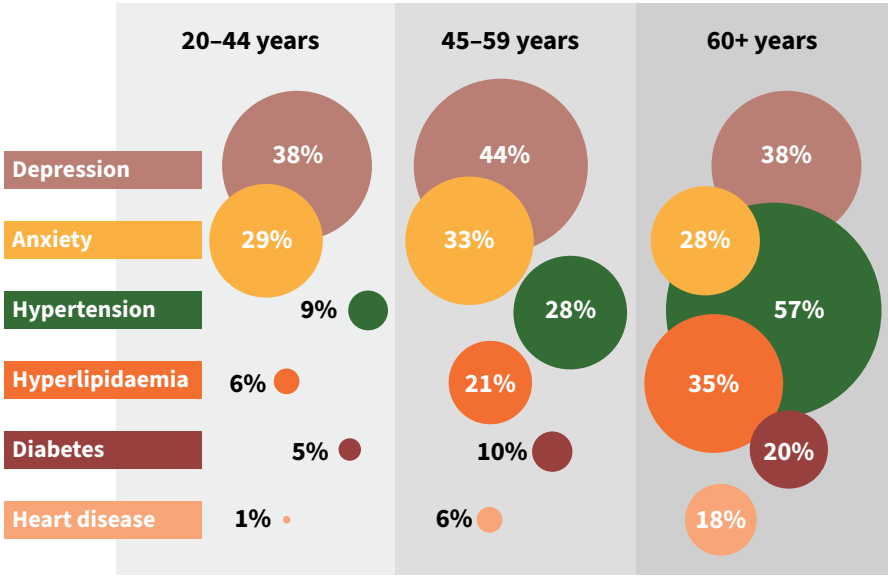
MS rarely exists in isolation. Depression, anxiety, cardiovascular disease, and other autoimmune conditions are more common in people with MS and can complicate both diagnosis and disease trajectory.[6,7] These comorbidities:

- may delay diagnosis
- are associated with increased disability at presentation
- influence cognitive outcomes and quality of life.

Primary care has a unique opportunity to address these through regular screening and proactive management. Practical measures include:

- monitoring cardiovascular risk factors
- screening for mood disorders
- encouraging smoking cessation and alcohol reduction
- supporting physical and cognitive activity
- medication reviews for polypharmacy.

Encouraging people to actively engage in their own health, supported by coordinated care between general practice and neurology teams, creates a strong foundation for living well with MS.[8,9]



Lifetime prevalence of common comorbidities on people with MS by age group[10]

Conclusion

While MS is complex, it is manageable – especially with timely, collaborative, and holistic care. As the first point of contact and a source of ongoing care, general practitioners are uniquely positioned to influence outcomes for individuals with multiple sclerosis. Additional resources and support are available via18 regional MS societies throughout New Zealand. The Menzies Institute offers a complimentary online course (https://ms.mooc.utas.edu.au/) designed to enhance awareness and understanding of MS. By maintaining vigilance for early signs, ensuring timely referral, monitoring for relapses, and addressing comorbidities, GPs hold a critical role in improving the lives of those affected by multiple sclerosis.

References

1. Dr Mason D, Dr Alla S, Dr Pearson J, Professor Richardson A, Professor Miller D. The New Zealand MS Incidence Study Update. 2015.
2. Giovannoni G, Butzkueven H, Dhib-Jalbut S, et al. Brain health: time matters in multiple sclerosis. Mult Scler Relat Disord. 2016 Sep;9 Suppl 1:S5-S48. doi: 10.1016/j.msard.2016.07.003.
3. Olek MJ, DO, Howard J, MD. Evaluation and diagnosis of multiple sclerosis in adults. 2024 Apr 30; cited 2024 Aug 14.
4. Multiple sclerosis in adults: management. London: National Institute for Health and Care Excellence (NICE); 2022 Jun 22. (NICE Guideline, No. 220.)
5. Olek MJ, D.O. Treatment of acute exacerbations of multiple sclerosis in adults. UpToDate 2024.
6. Marrie RA, Cohen J, Stuve O, et al. A systematic review of the incidence and prevalence of comorbidity in multiple sclerosis: overview. Mult Scler. 2015 Mar;21(3):263-81. doi: 10.1177/1352458514564491.
7. Magyari M, Sorensen PS. Comorbidity in Multiple Sclerosis. Front Neurol. 2020 Aug 21;11:851.
8. Butzkueven H, Giovannoni G, Arkelsten S, et al. Brain Health – Time Matters. 2024. MS Brain Health; Oxford Health Policy Forum; 2024.
9. Nociti V, Romozzi M. The Importance of Managing Modifiable Comorbidities in People with Multiple Sclerosis: A Narrative Review. J Pers Med. 2023 Oct 24;13(11):1524. doi: 10.3390/jpm13111524.
10. Marrie RA, Patten SB, Tremlett H, Wolfson C, Warren S, Svenson LW, et al. Why manage comorbidities in people with multiple sclerosis? Neurology 2016 -04-05;86(14).

Breast screening is being extended

Sarah Peacock, Communications | BreastScreen Aotearoa

Free mammograms are currently offered to women between the ages of 45 and 69 every two years. From 1 October 2025 the age for free breast screening will start to be extended.

Extending the age for breast screening across New Zealand in **year one will only apply to two age groups**, 70- and 74-year-olds, except for the pilot district of Nelson and Marlborough, which started 1 October 2024.*

From 1 October 2025:

Women who turn 70 **AFTER** 1 October 2025:	Are eligible for free mammograms every two years (from their last screen) until aged 75. **Note:** Some women may have screened at 69 and won't be due again at 70.
Women who are 70–74 **BEFORE** 1 October 2025:	Are eligible for one final screen at age 74, if booked before turning 75.

Extending the age range to include all women up to the age of 74 will be fully in place by the end of 2029. This phased approach will enable breast screening and cancer treatment services to progressively meet the additional demand.

Women aged 70 and 74 will be automatically identified through the new online breast screening system called Te Puna. A BreastScreen Aotearoa provider will then send them a personalised link to enrol/re-enrol and book a mammogram. This is a shift away from an opt-in to an opt-out enrolment approach.

GPs and primary care professionals are encouraged to talk with their patients to enrol/re-enrol and book a mammogram when they receive their secure personalised link. If women have not received an invite, please keep referring your patients through your current process to ensure all eligible women are invited.

***Age extension started as a pilot in Nelson and Marlborough on 1 October 2024 – so for women living in this district:**

Women who turned 70 **AFTER** 1 October 2024:	Are eligible for free mammograms every two years (from their last screen) until aged 75. **Note:** some women may have screened at 69 and won't be due again at 70.
Women who are 70–74 **BEFORE** 1 October 2024:	Are eligible for one final screen at age 74, if booked before turning 75.

For more information, please go to the BreastScreen Aotearoa section on tewhatuora.govt.nz or phone 0800 200 270.

Melanoma Awareness Month

Melanoma New Zealand invites you to support Melanoma Awareness Month by sharing some important messages with your patients to help prevent and detect skin cancer.

This October, Melanoma Awareness Month puts the focus on the urgent need for the early detection and prevention of skin cancer, with a nationwide campaign raising awareness and encouraging Kiwis to take action.

New Zealand has one of the highest rates of melanoma in the world – and the highest death rate.

"Skin cancer is the most common cancer in New Zealand – it accounts for more than 80% of all new cancer cases annually," says Andrea Newland, Chief Executive, Melanoma New Zealand.

"Melanoma is often visible and treatable if caught early, but too many people aren't checking or protecting their skin, and we want to change that," says Andrea.

There are around 7200 diagnoses of melanoma and 300 lives lost to melanoma in New Zealand annually. The vast majority of skin cancers are preventable (around 90%).

How you can help

Take a moment to talk with your patients about melanoma and how they can prevent and detect it. Feel free to reinforce our SLIP, SLOP, SLAP, SEEK, SLIDE guide and share our A–G guide on what to look for:

A few key messages to share with your patients

1. Melanoma is a type of skin cancer. It can progress quickly, and it can be life-threatening
2. The best way to prevent it is to be sun smart (SLIP, SLOP, SLAP, SEEK, SLIDE). Cover up with long-sleeved shirts, use at least SPF30 sunscreen, wear a hat and sunglasses, and seek shade
3. If you're concerned about any spots or moles, see your GP immediately. You can self-check your skin by using the A-G guide and there's a self-check video guide too – both available on Melanoma New Zealand's website melanoma.org.nz/all-about-melanoma/early-detection.

Thank you for your support of Melanoma Awareness Month.

#MedSafetyWeek 2025

The tenth annual #MedSafetyWeek takes place this November, and you can help make medicines safer.

From 3 to 9 November 2025, more than 115 countries will take part in #MedSafetyWeek. Now in its tenth year, Med Safety Week is a global campaign to raise awareness about the importance of reporting suspected side effects of medicines. The theme this year is "We can all help make medicines safer."

Medsafe is calling on health care professionals and consumers to report any suspected side effects of medicines and to help raise awareness of pharmacovigilance in New Zealand.

You can support the campaign by:

- reporting any suspected side effects you encounter with your patients
- encouraging your patients to report any adverse events they experience
- spreading the word online by using the #MedSafetyWeek hashtag during #MedSafetyWeek between 3 and 9 November 2025
- sharing posts from the RNZCGP and the Ministry of Health on your social media channels to boost awareness.

Why report?

Your reports of suspected side effects help Medsafe identify and evaluate potential safety concerns. If a risk is confirmed, Medsafe can take a range of actions, such as updating medicine data sheets, issuing safety alerts, requiring packaging warnings, or even changing the classification of a medicine.

Reporting a patient's reaction also allows the Centre for Adverse Reactions Monitoring to place a danger alert on the National Medical Warning System for the patient. These alerts inform health care professionals of known risk factors, such as allergies or previous serious adverse reactions, that may be critical when making clinical decisions about a patient. This is especially important for health care professionals treating patients who are unconscious, confused, unable to communicate or unaware of their own medical history.

How to report

You can make a report using the **Centre for Adverse Reactions Monitoring online reporting form**. Some practice management software includes a reporting feature that can take information from patient notes, making it easier to create a report.

The report must include:

- a patient identifier
- the suspect medicine
- details of the adverse reaction
- reporter details.

Additional information isn't compulsory but is important to support the evaluation of safety concerns. If you can, include:

- medicine start and stop dates
- date of onset and clinical course of the adverse reaction
- concomitant medicines, comorbidities and medical history
- medicine dosages
- any action taken and what happened.

Anyone can submit a report. Remember that you don't have to be certain that the medicine caused the reaction – just suspicious.

You should get patient consent to make a report where possible.

Fluoroquinolone safety – your reports made a difference

Fluoroquinolone antibiotics, such as ciprofloxacin, norfloxacin, and moxifloxacin, have been associated with prolonged and disabling adverse events, including tendinopathy. Reports from GPs of adverse reactions to fluoroquinolone antibiotics have been valuable in informing our safety review and regulatory action.

As of 3 September 2025, the New Zealand pharmacovigilance database has 717 reports of adverse reactions associated with fluoroquinolone antibiotics. More than a third of these reports were submitted by GPs. Most of the recent reports are for ciprofloxacin and relate to tendon disorders (Table 1).

Table 1: Top five adverse reaction terms reported with fluoroquinolone antibiotics, January 2015 to August 2025. Source: New Zealand Pharmacovigilance database (accessed 3 September 2025).

Adverse reaction	Number of reports
Tendonitis	62
Tendon disorder	22
Tendon disorder	18
Arthralgia	12
Paraesthesia	12

The Medicines Adverse Reactions Committee (MARC) reviewed the safety of fluoroquinolone antibiotics in March 2025. They considered local reports as well as international regulatory action. As a result, the safety information in fluoroquinolone data sheets has been strengthened and expanded and now includes a warning that disabling adverse reactions may be potentially irreversible.

Community dispensing of fluoroquinolone antibiotics has decreased by 25 percent since 2019, suggesting good prescriber awareness of the associated safety concerns and the need to reserve fluoroquinolones for cases where other antibiotics are not appropriate.

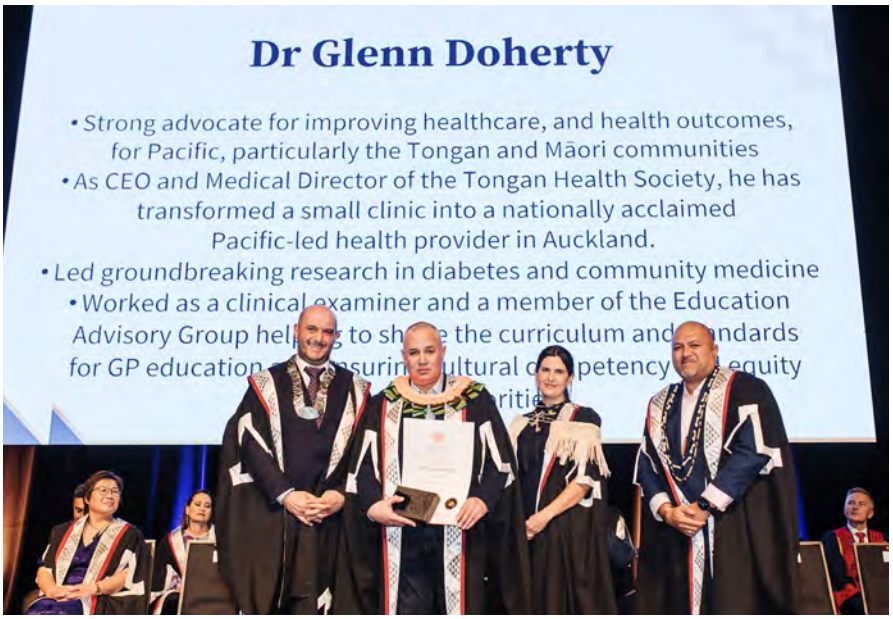
For more information on the safety of fluoroquinolone antibiotics, see the September 2025 edition of *Prescriber Update* and medicine data sheets.

New Zealand Primary Healthcare Awards | He Tohu Mauri Ora

Held in September, the 2025 awards provide an opportunity for the wider health sector and the public to see the dedication of the primary care health workforce and the contributions they make to improving the health outcomes of New Zealanders.

These awards celebrate the work that is already happening and encourage further collaboration to work towards having an equitable, sustainable and future-proofed primary care workforce.

Congratulations to the 2025 winners:



Medtech General Practitioner of the Year
Dr Glenn Doherty, Tongan Health Society Inc | Auckland

The judges said Dr Doherty is "a trusted and valued leader who walks alongside Pacific communities, championing health equity and access with compassion and integrity."

Dr Doherty also received Distinguished Fellowship at the College's 2025 Fellowship and Awards Ceremony. This honour is awarded to members who have made sustained contributions to general practice, medicine, or the health and wellbeing of the community.

GenPro General Practice of the Year
Manu Ora | Blenheim

Manu Ora is the only kaupapa Māori general practice in the upper South Island. The team provides extended consultations, wrap-around support, and outreach to reduce barriers to care and improve equity.

The judges said, "This entrant stood out for a service that has been designed with focus on kaupapa Māori, pan-iwi governance, community connection, and a multidisciplinary comprehensive approach with focus on continuity and impact on both patients and the system."

Two of our members, who are the co-founders and clinical directors of Manu Ora, Dr Rachel Inder and Dr Sara Simmons (Ngāi Tahu, Ngāti Māmoe, Waitaha) received a Community Service Medal at the College's 2025 Fellowship and Awards Ceremony to recognise the impact of their work within their community.

Boehringer Ingelheim Nurse Practitioner of the Year
Rebecca Fern, Te Iti Pounamu Hauora | Auckland

Green Cross Health Practice Nurse of the Year
Sarah Poupard, Taupō Medical Centre

Pharmacy Guild Community Pharmacy of the Year
Vivian Pharmacy Ltd | New Plymouth

ReCare Community or Primary Healthcare Pharmacist of the Year
Emma Griffiths, ProCare Network

ReCare Community Pharmacy Technician of the Year
Palki Kaur Patpatia, Pharmacy Care Group

Chemist Warehouse Young Pharmacist of the Year
McKinley Vollebregt, Tū Ora Compass Health

CareHQ Outstanding Contribution to Health
Kate Moodabe, Total Healthcare Charitable Trust

Medical Protection Practice/Business Manager of the Year
Yammi Lam, Four Kauri Family Medical Centre | Auckland

Primary and community funding to employ graduate RNs

Health New Zealand | Te Whatu Ora is funding employers to support the recruitment of up to 400 primary care graduate RNs across primary and community health care settings. With the next cohort of RNs graduating in early December, now is a great time to consider applying for employer funding. Graduate RNs can bring fresh energy and new ideas to clinical practice. If you're looking to employ, or have recently employed, a graduate RN (RNs must not have been employed for more than 90 days), why not take up this opportunity and apply.

Your employment could be a nurse's first step into a rewarding, long-term career. Employers can also use the additional enhanced capitation funding announced in the Budget 2025 to support the development of their primary care team, including recruiting graduate RNs.

Health NZ will provide funding up to:

- $15,000 per urban RN employed
- $20,000 per rural RN employed

Eligibility

- General practices
- NGOs
- Primary care providers
- Rural primary care and community providers (R1, R2, R3)
- Rural trust hospitals that provide primary care
- Hauora Māori and Pacific primary care providers
- Community providers, i.e. home and community support services, funded by Health New Zealand
- Aged care providers (except for retirement village only facilities).

Find out more and apply here, or for assistance please email graduateRN@TeWhatuOra.govt.nz.

Leave feedback and follow us

Submit your feedback

@RNZCGP

@The Royal New Zealand College of General Practitioners

@RNZCGP

@RoyalNZCollegeofGPs