GP Voice

YOUR NEWS, YOUR VIEWS, YOUR VOICES

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

February 2026

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Dr Prabani Wood

Dr Prabani Wood
Medical Director

Kia ora koutou,

Welcome to the first issue of GP Voice for 2026.

I hope you were able to take some much-deserved time over the summer holidays to relax with your friends and whānau and recharge ahead of 2026.

Over the past two months we have heard a lot about the Manage My Health (MMH) data breach and the impact it's had on both patients and practices. Losing patients' trust in the health care system and useful technologies and tools, such as patient portals, is extremely unfortunate. It is important that we acknowledge this and ensure we are providing impacted and worried patients with the necessary information about what is being done to remedy this situation. For those of you who are fielding questions from patients there are some useful resources that you can direct them to, including the Privacy Commission website , which explains how patients can find out if they are impacted, access support, keep up to date with MMH progress updates or how to make a privacy complaint. The College and I will also keep members informed of any new information via ePulse.

2026 registrars

I would like to welcome the 225 new GP and rural hospital medicine registrars, who have started their first year of training this week. We are so glad you have joined us and I hope you take every opportunity to get involved, learn and ask questions. General practice and rural hospital medicine are such amazing and rewarding (and challenging) vocations, especially when you can begin to see the impact you have on your patients' health and build those trusted relationships of care that can often last for generations.

Workforce changes

On Sunday 1 February, two major changes that will impact the work we do came into effect. We now have the option to offer extended prescriptions to patients and to diagnose and treat ADHD in adults.

These changes will be a learning curve for all of us, and the College will be keeping members updated via its hot topics pages 12-month prescriptions and GP ADHD prescribing on the website, as well as through GP Voice and ePulse updates.

I will be part of a joint webinar with HealthPathways Education on the ADHD changes, presenting alongside psychiatrist Dr David Codyre and Dr Justine Lancaster, National Clinical Lead, Community Care Pathways, on Tuesday 17 February, 7 – 8pm. Register to hear more about the new ADHD prescribing rules and boundaries, practical steps for screening and referral, managing ongoing care (including titration and supply issues), what to do if you choose not to offer ADHD care, training options and HealthPathways updates.

I also published an opinion piece in Stuff that provided patients with some information and insights into the 12-month prescribing changes. There has been a lot of talk about this change among the workforce and the public since the end of last year, and I know that many patients have already been asking us for an extended prescription. My column was centred on the message that extended prescriptions will be made on a case-by-case basis as everyone's health is unique and must be treated as such, and that patient and clinical safety must always be at the heart of every decision. **Read the full column**.

If the start of 2026 is anything to go by, we will be in for another busy year, concluding with the general election. It will certainly be interesting to see what else comes out in the lead-up to this year's Budget and the election. We saw some long-awaited positive changes last year, resulting in improved GPEP funding, plans for increased exposure to primary care for medical students and junior doctors, and planned improvements to capitation funding.

In the meantime, there is plenty to keep us occupied. Remember, if you have a research project that you would like to share, consider submitting an abstract for GP26: Conference for General Practice taking place in Auckland from 30 July to 1 August 2026. This is a great opportunity to share your ideas and research with your GP peers and the wider health workforce. **Read more and submit your abstract** before Friday 27 February.

Enjoy this month's issue.
Prabani

Submit your feedback

Welcome to our new 2026 trainees

Victoria Harrison

Victoria Harrison
Head of Learning

Tēnā koutou katoa

On Monday 2 February, 210 new GPEP year 1 registrars and 15 new rural hospital medicine (RHM) year 1 registrars officially joined our College whānau and have begun their journey to becoming specialists.

With 90 percent of medical conditions being treated in the community, it is critical we have a well-resourced workforce in every community right around the country who are valued and supported to care for their patients. One of our top priorities continues to be the future pipeline of GPs and rural hospital doctors, which we can achieve through increasing the number of medical graduates training through the College to become vocationally registered specialists, with an emphasis on encouraging and supporting registrars to train in rural communities across Aotearoa.

At the College, supporting our registrars is at the heart of everything we do. From day one, trainees are surrounded by a network of medical educators, teachers, advisors and peers who walk alongside them throughout the programme. So I, along with the rest of the College team, warmly welcome all of our new registrars into our training programmes.

Across February and March, our GPEP year 1 registrars will take part in one of four Hauora Māori Noho Marae. These immersive two-day experiences provide essential hauora Māori learning, including Māori health equity, Māori models of health, cultural safety, and engagement with mana whenua. All learning is grounded in the context of primary care and enriched by the marae-based setting.

To our new registrars who might be reading GP Voice for the first time, I'd like to say welcome. On behalf of the wider College, we are here to support you through your training journey and into Fellowship. Your regional Faculty group and College Chapters will also provide a great source of support.

I'd also like to acknowledge our group of fabulous medical educators who will be teaching, supporting and mentoring our new registrars and helping them to develop a solid understanding of the job and a strong foundation of knowledge that will carry them through the rest of their training and beyond.

The knowledge and skills you learn over the coming years will equip you to deliver the complex, comprehensive, timely and equitable care that this workforce and our teams are known for, and we look forward to working alongside you to achieve this.

So be curious, ask questions, get involved and have some fun along the way.

Victoria

Submit your feedback

College Advocacy: Months in review

December and January

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 January and February.

ADHD

As of 1 February, GPs now have the option to diagnose and treat ADHD in adults. The College has provided information and guidance for members on the **ADHD hub** on the website and will continue to update this with any new information that members need to know.

Medical Director Dr Prabani Wood, alongside Psychiatrist Dr David Codyre and Dr Justine Lancaster, National Clinical Lead, Community Care Pathways will be running a webinar on what these changes mean for members on Tuesday 17 February, 7 – 8pm. **Register to attend**.

12-month prescribing

Also coming into effect on 1 February was the 12-month prescribing changes, allowing GPs and other prescribers to offer extended prescriptions for patients, if it is clinically safe to do so. The College will continue to update the **12-month prescriptions hub** on the website with any new information or updates.

Medical Director Dr Prabani Wood wrote a patient-focused opinion editorial in *The Post (paywalled)* in February highlighting the changes, what it might mean for patients and emphasising that patient safety will always be at the heart of every decision made because there is not a one-size-fits-all approach to health care. **The full editorial is avaliable on our website.** Dr Wood also spoke to the *NZ Herald* ahead of the changes coming into effect.

Regulation of physician associates/assistants (PA) consultation

The Medical Council of New Zealand's (MCNZ) consultation on how the PA workforce will be regulated going forward is open and seeking feedback. The College has received a lot of feedback from members on the proposal that will be worked through and incorporated into the College's submission.

You can provide feedback for the College's submission by filling out **this form** by 9 February, or members **can make an individual submission to MCNZ** by 12pm 16 February.

Manage My Health data breach

Following the news of the breach, College President Dr Luke Bradford spoke to a range of outlets about the data that had been compromised and what it means for patients and practices.

Listen to his Newstalk ZB interview where he highlights the frustration from GPs and practices and discusses the potential for this to impact overall trust in the health care system and with technology and other platforms that are useful tools for patients and practices alike.

You can also access useful information for both your practice and patients on the Privacy Commission's website.

Stakeholder engagement

Dr Luke Bradford:

- Primary Health Target Advisory Group meeting
- Attended regular progress update meetings on the Manage My Health situation with Health New Zealand and other relevant organisations
- Waikato Medical School Medical Advisory Group.

Dr Prabani Wood:

- Meeting to discuss guidelines for GPs to support patients with serious mental illness
- Meetings with Pharmac
- Primary care sector meeting
- Discussions with MPS and the Funeral Directors' Association to confirm cremation regulations and the role and expectations of GPs in this process. See the update on page 18.

Submissions/position statements

- Smoking and vaping position statement
- Funding of RSV Vaccine nirsevimab for pēpi and tamariki in Aotearoa

More media and advocacy (from mid-December 2025)

- Exam season ends for GP registrars | NZ Doctor
- Menopause and mental health and the training GPs receive | Dr Prabani Wood
- First specialist appointment decline rates | Dr Luke Bradford
- Medicinal cannabis prescribing | Dr Prabani Wood
- How do we know what supplements we actually need? | Dr Prabani Wood | Radio NZ
- Anti-depressant use and education | Dr Prabani Wood | Otago Daily Times
- Primary Care Pathway | Dr Luke Bradford | Newstalk ZB.

Welcoming our newest members

This week the College welcomed its newest intake of 225 registrars who are starting their journey to become specialist GPs or rural hospital doctors.

This year sees 210 registrars starting the General Practice Education Programme (GPEP) and 15 registrars entering the Rural Hospital Medicine Training Programme (RHMTP).*

GPEP registrar demographics	RHMTP registrar demographics
Female: 135	**Female:** 11
Male: 73	**Male:** 4
Gender diverse: 2	
Māori: 29 (13.8%)	**Māori:** 6 (40%)
Pacific Peoples: 16 (7.6%)	
Not Māori or Pacific Peoples: 167 (79.5%)	**Not Māori or Pacific Peoples:** 9 (%)
Note: 2 registrars are both Māori and Pacific	
Under 30 years old: 60 (28.6%)	**Under 30 years old:** 10 (66.7%)
30–40 years old: 107 (51%)	**30–40 years old:** 4 (26.7%)
40–50 years old: 39 (18.6%)	**40–50 years old:** 1 (6.7%)
50+ years old: 4 (1.9%)	
College employed: 112	
Practice employed: 97	
Self-funded: 1	

* Note: Registrar numbers were correct at the time of publication.

College President Dr Luke Bradford says, “I am optimistic that the changes to GPEP funding now extending beyond the first year of training will encourage those who have an interest in general practice but have been put off by the financial barriers to make the step towards becoming a GP and adding to our current workforce numbers.”

Discussions are also ongoing for a similar funding boost for the RHMTP and to boost the crucial rural hospital doctor workforce across Aotearoa.

To the new registrars, Dr Bradford says, “Over the next few years of your training, whether that is through GPEP or the RHMTP, you will be challenged and encouraged to think about your place in the health system and how you want to make a difference.

“The specialisms of general practice and rural hospital medicine will allow you to have a significant and ongoing impact on the health and wellbeing of your patients. Being able to support your patients and care for them in the community is a real privilege, and you’ll use all the knowledge and skills that you are about to gain to do so, while continuing to learn and keep up to date with the ever-evolving health care landscape and patient complexities.

“On behalf of all our members, we welcome you to the College and look forward to supporting you on your journey to Fellowship.”

Extra information for medical students or graduates

Read more about specialising as a general practitioner or a rural hospital doctor. Can’t decide? You can also do both through our Dual Fellowship pathway.

Goodfellow Unit podcast: **Grief: a personal journey**

Suze Malcolm is a psychologist with over 20 years of experience. Her practice is based in Wellington, and she works in adult mental health. In this episode, Suze discusses the complexities of grief, emphasising its individualised nature and the importance of understanding the emotional responses to loss.

Suze highlights the significance of listening and validating the experiences of those grieving, while also addressing common misconceptions and traps that clinicians may fall into. The conversation explores various therapeutic approaches, cultural considerations, and the dual process model of grief, ultimately reinforcing the idea that grief is a normal human experience that requires compassionate support.

Listen to the podcast

Quality in practice: Bream Bay Medical Centre

Bream Bay Medical Centre (BBMC) is a GP and nurse-owned rural VLCA practice, with two clinics serving an enrolled population of approximately 9200 patients. They are part of a small community, and their team works with other local providers to offer wraparound services for their patients. They are an accredited teaching practice and have also completed the Cornerstone CQI reaccreditation module pilot in late 2024. The culture of their practice is grounded in valuing colleagues and the community they care for. This commitment starts with the owners and is reflected through the entire team.

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

We caught up with Kay Brittenden, practice manager at BBMC to find out about their experiences with the Cornerstone Equity reaccreditation module, why they did it and what they learnt from it.

What did you do to gain the Equity reaccreditation module?

We had given equity some thought and made a conscious effort during the three years to document what we were doing. In the past, we felt we did what was required regarding equity for our patients; however, we weren't good at the documentation. This time, we had prepared better, documenting our projects and our programmes.

We concentrated on the high-needs patients of our enrolled population. This included the topics below (not an exhaustive list):

- Mental health
- Chronic care (for example COPD)
- Abdominal aortic aneurysm and atrial fibrillation
- Ambulatory sensitive hospital admission rates.

We used data lists to help identify and prioritise patients and ran specialised nurse-led clinics. Extra supports were utilised when needed to give wrap-around services for patients when required, e.g. HC and HIP, local community support groups.

What did you find were the key differences between the Equity module and Equity reaccreditation module?

The Equity module concentrated more on policy and process; the Equity reaccreditation focused on how we worked and reflected on our processes and results.

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

The reflection, with an equity lens, on what we did well and what we could improve on was a new process. Feedback from a new staff member was helpful in this process.

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

We have taken on board the recommendation from the staff member and will put a process (re: unconscious bias) in place at the orientation of any new staff. The team have a higher confidence in their skill set and the knowledge and skills of each other.

What is different for patients?

Our chronic care clinics are now permanent, so health outcomes have improved overall. We believe our reputation in the community has improved, and patients have a higher level of trust with the practice and the team.

If you're interested in finding out more about the Equity reaccreditation module, visit the College's website where you can also purchase the module.

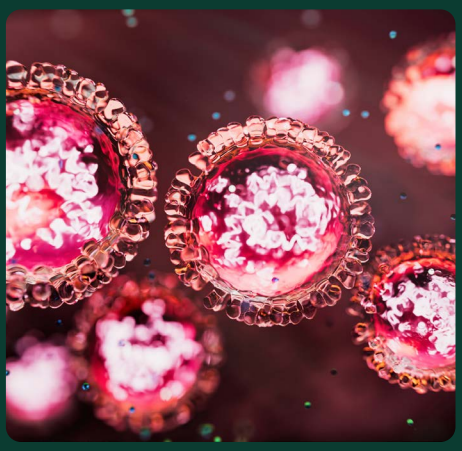
Goodfellow Unit podcast: **Measles outbreak**

Nikki Turner 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

How does the Foundation Standard link in with your CPD?

Many of you have told us the same thing: The work you do to meet the Foundation Standard requirements is real learning, but it hasn't always been easy to see how that fits within the Te Whanake CPD programme.

In response to this feedback, the College has developed a new resource that clearly maps the **Foundation Standard quality and safety activities to the Te Whanake CPD Framework**, making it easier to recognise, record and reflect on the learning you're already doing in your practice.

The intent is simple: Reduce duplication, acknowledge your day-to-day Quality work and ensure it genuinely counts towards your CPD.

What this means in practice

Audits and reviews

Work such as reviewing adverse events, patient complaints, health and safety incidents auditing, repeat prescribing or medicine reconciliation and differentiating equity data can be logged as learning under the patient outcomes category.

Policies, procedures and systems

Leading or contributing to updates of policies and procedures in areas like clinical governance, recalls, standing orders, medicines management or infection control can be logged as CPD when there is learning involved.

Practice planning

Developing or reviewing plans such as Māori health plans, emergency response plans, business continuity or end-of-life access plans can also count when they involve active learning or improvement.

Training

Training you undertake or deliver for Foundation Standard purposes, including infection control, Te Tiriti o Waitangi and Children's Act child protection training may be recorded under the CME learning category, with reflections (if appropriate) adding further value.

How it links to your CPD

You can claim one CPD credit per hour of learning, up to 12 credits per triennium for Foundation Standard–related activities. Add a reflection to any activity to deepen its learning value and earn extra CPD credits.

Identified gaps can feed directly into your professional development plan or annual conversation.

A review of the Foundation Standard will be under way this year to ensure it continues to meet the quality and safety needs of care delivered by general practice in Aotearoa New Zealand and reflects the realities of modern, team-based primary care.

This work sits alongside our broader commitment to listening to members and shaping quality programmes that support your practice.

Find out more about this new resource.

Journal
OF PRIMARY HEALTH CARE

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

For between–issue reading, visit the 'latest' section.

Trending articles:

1. Tongkat Ali/Long Jack
2. Collagen supplements
3. Horny Goat Weed/Epimedium
4. Apple cider vinegar
5. Pine bark

MIND THIS

Missed bowel cancer

A 40-year-old person with an adenocarcinoma of the colon and the missed opportunities to diagnose it.

Dr Peter Moodie

Peter Moodie is the College's Clinical Advisor

The story

Ms A told her general practitioner that she had irritable bowel syndrome (IBS), and this was formally put into her notes in May 2020 by Dr B as "eating problems with IBS also."

Dr C saw Ms A in July 2021 with a three-day history of abdominal bloating and pain. Ms A again said that she thought it was her IBS that was causing the symptoms. She also stated that the IBS was reasonably controlled if she watched her diet, but this had not been the case over the previous week. Dr C noted that there were "no red flags" and prescribed Mebeverine (Colofac).

In August 2021, Ms A had a phone consultation with Dr C for a repeat of her usual prescriptions, and Dr C recorded that the Mebeverine had been helpful.

Dr D saw Ms A in November 2021, who agreed that IBS could be very painful. Dr D went through a HealthPathway with Ms A and recorded that there were "no red flags." Dr D continued with the Mebeverine and ordered a blood test (not specified).

Dr E saw Ms A in December 2021 when she reported that her symptoms were worse, the Mebeverine was not helping, and she had lost six kilos over a four-week period. She had started on a FODMAP diet along with going gluten "free(ish)," which the doctor thought was possibly the cause of the weight loss. She wanted answers, and Dr E arranged for blood tests, stool samples, an ultrasound and started her on amitriptyline and omeprazole.

In January 2022, Dr E texted Ms A and told her that her blood and stool tests were all normal and asked if her symptoms had improved. She texted back saying that the omeprazole had helped significantly, but she still had diarrhoea. In March 2022, Dr E again contacted her to tell her that there was an incidental finding on her ultrasound (probable hepatic meningioma). The radiologist suggested a repeat ultrasound in three to six months.

There were no further consultations with the general practice.

In May 2023, Ms A was seen by an ENT clinic for a follow-up of a melanoma excision and she reported that she had a lump in her neck. An FNA showed that this was an adenocarcinoma of a lymph node, and subsequently, a malignancy was found at the hepatic flexure of the large bowel.

The findings

The Commissioner sought independent general practice advice and concluded:

That Dr E breached the Code as "no examination was undertaken or weight documented on 13th December 2021; and MS A was not referred to gastroenterology in December 2021 nor was she referred or reviewed in person on or soon after the January 2022 consultation."

Dr D was initially criticised for not documenting their physical findings; however, Dr D successfully argued that by referencing the Clinical Pathway Dr D would naturally have done a physical examination. Dr D was not found to have breached the Code.

The lessons

- The Commissioner will inevitably find fault with case notes.
- When at least three doctors see a patient with the same problem there needs to be a careful re-evaluation of the diagnosis. This is particularly so when it is the patient who has made the diagnosis.
- As the Commissioner has noted, an earlier diagnosis may not have made a lot of difference.
- As Dr D commented, even if Ms A had been referred earlier, she still might not have qualified for a colonoscopy.

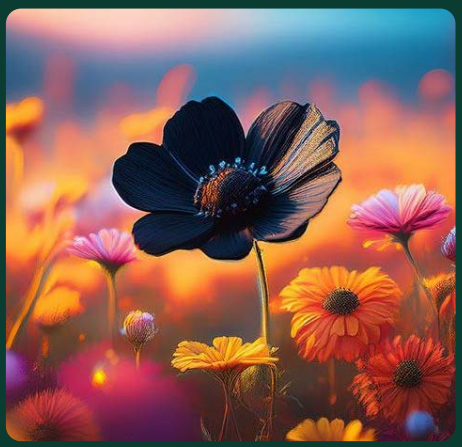
Goodfellow Unit podcast: **Fibroids**

Dr Jessica Dunning is a New Zealand–trained obstetrician and gynaecologist. She is a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (FRANZCOG). Jessica also practises as a consultant obstetrician and gynaecologist at Te Toka Tumai Auckland as part of the minimal access surgery team. Her clinical interests are in the diagnosis and treatment of endometriosis, abnormal uterine bleeding and fibroids.

In this podcast, Dr Dunning discusses fibroids, including symptoms, diagnosis and treatment options. We explore the implications of fibroids on women's health, particularly regarding fertility, and the various medical and surgical interventions available, along with the importance of individualised care.

The key take-home messages of this podcast are:

- Fibroids are really common and mostly asymptomatic.
- You don't have to do anything unless symptoms are present.
- If people do have symptoms, there are lots of treatment options available.
- Management can be tailored to the individual's needs.
- Be aware of the risk of sarcoma, but not everybody needs a hysterectomy just because of that potential risk.



Listen to the podcast

Submit your feedback

From clinic to podcast

The use of Integrated Professional Support for GPs.

By Dr Louise Kuegler, FRNZCGP

Specialist GP Dr Louise Kuegler practises in a Counties Manukau–funded primary care clinic, balancing face-to-face consultations with telehealth, while also shaping the future of health care through teaching roles at Counties Manukau and the University of Auckland and as an examiner for the New Zealand Medical Council.

Her passion for women's health and clinical education runs deep.

"Better education: Better health outcomes… I truly believe when clinicians stay up to date with evidence and practice, it translates directly into excellent, responsive and equitable health care for our communities," Louise says.

That belief sparked the creation of 'The Specialist GP Podcast', a platform designed to showcase clinicians working at the top of their scope. After nearly a decade as Deputy Director and podcast host at the Goodfellow Unit, she missed the creative process of podcasting – researching topics, finding experts and recording episodes. When postgraduate training freed up time and colleagues encouraged her to keep going, the idea took root.

Unlike mainstream GP podcasts, 'The Specialist GP Podcast' avoids common topics like diabetes or gout. Instead, it dives into areas often overlooked, guided by cases and ideas submitted by GPs. Each episode ends with "Practical Clinical Pearls" – key takeaways for specialist GPs and primary care professionals. The podcast does not receive funding from the industry, so the content is completely independent.

The journey hasn't been without surprises. "I learn so much from every episode," she admits, "and I'm amazed at how willing colleagues are to share their expertise."

Technical hiccups have tested her resilience – like the day the recording platform crashed, forcing three pivots before an offline solution saved the interview. "My blood pressure was high that day," she laughs.

Asked which episode stands out, Louise says she's proud of them all, though she credits Dr Nicky Macklin's discussion on kindness in health care leadership and Dr Sandra Spilig's insights on professional transitions as particularly meaningful.

Beyond podcasting, 'The Specialist GP' platform offers LARC training, mentoring and curriculum design support. "It truly takes a village," she reflects – a sentiment that echoes through her work, her teaching and every carefully crafted episode.

For more, visit www.specialistgp.co.nz and discover how better education can lead to better health for all.

Dr Louise Kuegler, FRNZCGP
Specialist GP and host of
The Specialist GP Podcast

> "I learn so much from every episode... and I'm amazed at how willing colleagues are to share their expertise.

ADHD in primary care

Dr Antonia Arlidge, FRNZCGP

Dr Antonia Arlidge, FRNZCGP

A major shift in the care of ADHD is occurring, with new prescribing changes allowing GPs and NPs to initiate stimulant prescribing. This move has been met with some controversy. There is a sense, even among those who celebrate the change, that the accompanying support for such a move has been lacking (such as funding for training and patient assessments). Many have felt it is yet another thing lumped on primary care, and many patients seem to have the impression it will mean stimulants can be prescribed in a standard 15-minute consultation.

Of course, nothing has changed the importance of diagnostic integrity, but the shift to primary care being able to initiate prescribing after an appropriate diagnosis is an opportunity I believe we should all embrace.

Many will think it is simply too much to consider including lengthy ADHD assessments in a busy GP clinic. This is understandable, but I would argue there is so much more than assessment. Embracing ADHD, knowing who to refer for assessment and how to manage a patient after assessment is vital. In the long term it will make a huge difference to patients and their whānau, your patient–clinician relationship, and it will also save time and costs when looking after conditions co-occurring with ADHD.

The practice I work at has long been involved in neurodiversity care, with some practitioners being more immersed than others. We have the benefit of having a close working relationship with a wonderful psychologist working in private practice locally who has expertise in neurodiversity assessments for all ages and therapy. Although in the future we may work towards having the means to do assessments, we are currently focusing on the recognition of those who would benefit from assessment and the management of the outcome of that assessment in conjunction with our local psychologist. We plan to utilise funding such as disability allowance for funding assessments as needed. This is by no means the only way of doing things, but given the current capacity of our clinic, we cannot currently spend 60–90 minutes on an ADHD assessment. In saying this, I believe having a good understanding of the assessment process is vital, just as many psychologists working in the area would argue it is important for them to understand the medications even if they can't prescribe. It allows us to support our patients better.

The te reo Māori word often used for ADHD is 'arorereti ni' – 'attention goes to many things.' I personally prefer this term and feel it could also describe the role of GPs. Our ability to manage so many different and often complex and intersecting conditions while switching quickly between differing consultations where you don't know what could be coming up does take a special kind of brain.

Submit your feedback

There are three critical components of management:

1. Psychoeducation is the foundation upon which everything else is layered
2. Non-medication strategies – coaching, therapy, etc.
3. Medication – stimulants and non-stimulants.

My advice would be to review (or re-review) the webinars and content out there, such as from **Goodfellow** and **Dr Sidhesh Phaldessai's Masterclass**. For the very keen, you can deep dive, but for every GP, I would encourage updating knowledge from more recent research on ADHD in adulthood, its differing presentations and connections to co-occurring conditions (such as chronic fatigue/pain, inflammatory conditions). Also, know your medicines, understand the pharmacology, optimise, do the psychoeducation (there is so much more to management than medicine), and always monitor and reassess.

I would argue ADHD is a chronic condition not unlike diabetes that, left untreated, can lead to awful outcomes and increased morbidity and mortality, but managed well can completely turn around a person's life course. Also, like diabetes, it needs regular review, engagement with trusted practitioners who understand the condition and a means to monitor for progress. One tip would be to use screening questionnaires such as ASRS to monitor progress while titrating medicines like an HbA1c blood test for diabetes or a PHQ9 might be used for depression.

Also, building a network – one's own MDT – to discuss cases is incredibly helpful.

ADHD is straightforward to treat but challenging to treat effectively; doing so benefits patients, families, society and ourselves immensely.

It can help everything else fall into place; all the multiple presentations for symptoms that are hard to pin down or that don't seem to respond to the 'usual treatment' can improve with the understanding of 'this is how my brain works and this is what I need to support my wellbeing.'

Roles and responsibilities in death verification and certificates

Dr Prabani Wood, College Medical Director

In conjunction with the Funeral Directors Association of New Zealand and MPS, the College has been working to clarify the roles and responsibilities of GPs (and nurse practitioners) in death verification and the issuing of death certificates. This is a particularly important issue for GPs working in more rural regions, covering a large geographical area.

This guidance document outlines the following:

- The verification of death process and who can make this assessment
- Certifying a death and issuing a cause of death certificate (MCCD)
- Which deaths practitioners can and cannot certify
- The process if the primary practitioner is not available to certify a death
- Best practice tips.

We also recommend the website cremation.org.nz, which is updated regularly by the Chief Clinical Advisor to the Coroner. It is a valuable source of information on all issues related to death certification and cremation forms.

Submit your feedback

Thyroidectomy incisions

Five questions patients ask me about their incisions.

Dr Francis Hall

Although my main interest in wound management is with regard to thyroidectomy incisions, the questions, concepts and principles apply to most clean surgical wounds.

Question 1: When can I get my incision wet?

In 48 hours. Twenty-five years ago, I used to recommend not getting surgical wounds wet for seven days. Over the years I have steadily reduced this time to two full days and have noticed no difference in healing or wound infections. The above recommendations are for clean surgical wounds with direct closure. I also advise that surgical drain sites are kept dry for two to three days after removal of the drain, depending on the size of the drain site.

I am a lot more conservative if there is an underlying bone fracture or osteotomy. I like to keep skin grafts undisturbed for two weeks.

Question 2: Is sunlight good for my scar?

The short answer is keep the wound out of the sun for nine months. Most authorities recommend no exposure of fresh wounds to sunlight for six to 12 months.

Sunlight can cause post-inflammatory hyperpigmentation, resulting in the wound being darker or redder than the surrounding skin. For a wound to disappear, it needs to be flat, thin, preferably in a skin crease and the same colour as the surrounding skin. A dark or red wound will be highly visible.

While it is true that ultraviolet light can assist in wound healing, the beneficial effect of ultraviolet light on wound healing is dose dependent. Ultraviolet light is bactericidal; it also dries the wound. UVA rays penetrate quite deeply and can damage collagen. Low-dose ultraviolet light (photobiomodulation) can reduce inflammation, relieve pain and promote tissue regeneration. The problem with ultraviolet light and wound healing is controlling the dose of ultraviolet light and, therefore, most authorities recommend avoiding exposing a fresh wound to sunlight.

Question 3: What can I do to prevent scarring?

Silicone tape. The European guidelines for the management of surgical wounds recommend silicone taping of wounds as soon as the wound has healed.

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There is widespread support for this approach in the medical literature. It is recommended that silicone taping be performed for a minimum of 12 hours and preferably 24 hours a day for three months or longer. The silicone tape should extend 2.5cm beyond the wound in all directions. Silicone tape and sheets can be purchased through pharmacies or online. Silicone is also available as a gel, but the efficacy of silicone gel in wound management is not as well established as silicone tape and sheets. However, silicone gel is often more convenient for people with scars on their faces.

Silicone taping works by distributing the force of tension across a larger area, thereby decreasing tension on the wound. Silicone taping also helps to flatten wounds and keep wounds moist.

At the time of surgery, it is a good idea to apply porous paper tape or Steri-Strips across the wound to help distribute healing forces, start flattening the wound and keep the wound moist.

Question 4: What about cream or oil to help the scar disappear?

The main objective here is to keep the scar moist. While there is a myriad of products available, they all endeavour to keep the scar moist and prevent the scar from drying out. A simple moisturiser is all that is required. Use a moisturiser that suits you. Silicone gel can also be used. Some people recommend vitamin E cream, aloe vera cream, Mederma, products containing onion extract or green tea extract, and there is some level 1 evidence supporting some of these products[3].

Moisturisers can aid wound massage. Moisturisers may also interfere with the attachment of silicone taping.

Question 5: What about massaging the scar?

This is probably a good idea. Advocates of wound massage recommend massaging the wound after it has fully healed. Various techniques are described, with the most common techniques advocated being massaging parallel to the long axis of the wound, including directing over the wound and massaging in a circular fashion over the wound. Massaging the scar can be performed with or without the use of a cream or moisturiser. Advocates of wound massage claim that it helps to disperse the healing reaction and align collagen bundles, thereby improving the appearance and flexibility of the scar.

Summary

There is good evidence to support the use of silicone taping and avoidance of exposure to sunlight to minimise the appearance of a surgical scar. Regular use of a moisturiser and massaging the scar are also sensible options.

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1. Téot L, Mustoe TA, Middelkoop E, Gauglitz GG, editors. Textbook on Scar Management. Springer; 2020. Open Access. Available online.
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Psychological birth trauma

An overview and screening tool

Birth Trauma Aotearoa

Psychological birth trauma is a common and significant perinatal distress concern impacting predominantly mothers/birthing parents but also fathers/non-birthing parents and maternity staff. While birth trauma is more common than other perinatal mental health challenges, understanding and diagnosis has, until recently, been limited.

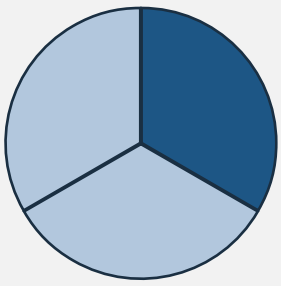
Birth trauma may be considered as trauma relating to predominantly labour and birth, but also pregnancy, postpartum and certainly baby loss. Trauma relates to the natural, nervous system-level response to threat – perceived and real threat being heightened in birthing situations.

There are various causes of birth trauma and every whānau's experience is different – the common threads throughout include:

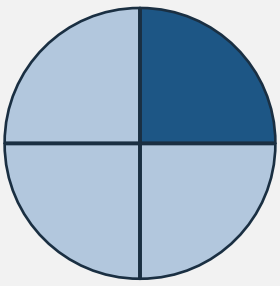
- loss of control/lack of autonomy
- fear for one's own or baby's life
- unconsented procedures and negative health care practitioner interactions
- a birth quite different to the one envisaged by the parent.

Trauma is 'in the eye of the beholder'[1] – what's traumatic for one person may be fine for another. Often, clinically normal births are experienced as highly traumatic by the mother and vice versa.

Research states that *one in three* mothers will consider their birth psychologically traumatic.[2] This is a far more prevalent mental health concern compared to, for example, postnatal anxiety and postnatal depression, for which estimates suggest a combined impact of one in four mothers/birthing parents.



One in three birthing parents experience birth trauma.



One in four birthing parents experience postnatal anxiety or postnatal depression.

Birth Trauma Aotearoa is a registered charity undertaking education, advocacy, research and support services for those impacted by physical and/or psychological birth trauma.

Negative and traumatic birth experiences can result in:

- breastfeeding challenges
- challenges with parent–baby bond, impacting child development
- fear of future pregnancy/birth
- relationship challenges
- mistrust of medical professionals
- feelings of shock/grief/confusion/anger.

While prevalent and impactful, birth trauma has, historically, been under recognised, underdiagnosed, and undertreated. The birth trauma community often reports their concerns being dismissed and minimised, partly due to misunderstandings among clinicians and partly due to a lack of birth trauma–specific screening tools.

Birth trauma screening tool

General practitioners are often one of the first clinicians parents see outside of the maternity system. GPs are in a unique position to be able to identify distress, screen for mental health challenges and guide whānau towards appropriate care.

The City BiTS **birth trauma screening tool** was developed by City University of London.

It is a screening tool for mothers/birthing parents, fathers/non-birthing parents, as well as maternity staff.

The tool includes a short scale involving five questions, and a longer, more in-depth scale, the shorter scale being ideal as a conversation starter and for short appointment times. Both scales are clinically validated and can assess for post-traumatic stress symptoms and clinical disorder (PTSD) according to DSM-5 criteria.

The tools are freely available and guides on their use are also available.

Birth Trauma Aotearoa encourages conversations around birth experience as a way to tackle the shame and silencing that is often experienced alongside birth trauma. These screening tools are a way to enable kōrero and find accurate diagnoses for distress. Birth Trauma Aotearoa is currently establishing birth trauma–specific support services to fill gaps in perinatal mental health care. Current birth trauma support services can be found on our support website **mybirthstory.org.nz**.

Case study

Marissa comes to your clinic at six-months postpartum. Her pregnancy and birth were reasonably straightforward, though she had an emergency caesarean following a homebirth transfer due to bleeding. Marissa's baby was in Neonatal Intensive Care for a short time. Marissa speaks of feeling "confused" by the birth, at times feeling "numb" to being a Mum, and generally "just wobbly" when she thinks about the birth. When you ask her about it, she gets teary and mentions

she hates driving past the hospital where she birthed. When you mention postpartum depression, Marissa tells you she "doesn't think that's quite it – I don't feel down, just off."

The birth trauma screening tool would be a valuable tool to go through with Marissa – having a conversation that validates her feelings, identifies the experience as highly negative or traumatic, and accurately diagnosing clinical concerns means improved treatment and care, and therefore wellness, for Marissa and her whānau.

The birth trauma screening scale, and instructions around use, can be found at: www.citybirthtraumascale.com.

Support for whānau can be found at: www.birthtraumaaotearoa.org.nz

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