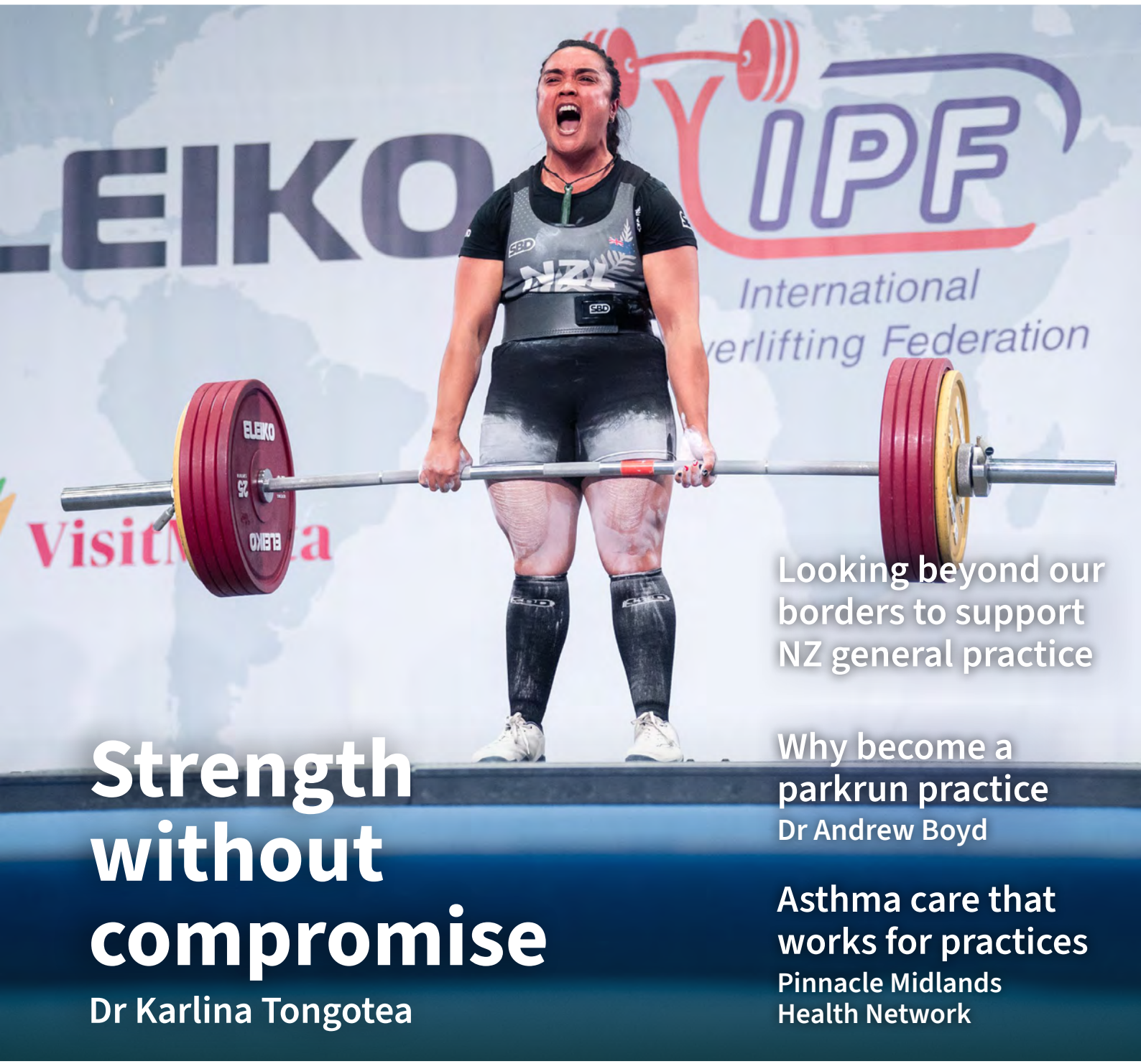
GP Voice

YOUR NEWS, YOUR VIEWS, YOUR VOICES



Strength without compromise

Dr Karlina Tongotea

Looking beyond our borders to support NZ general practice

Why become a parkrun practice

Dr Andrew Boyd

Asthma care that works for practices

Pinnacle Midlands Health Network

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

April 2026

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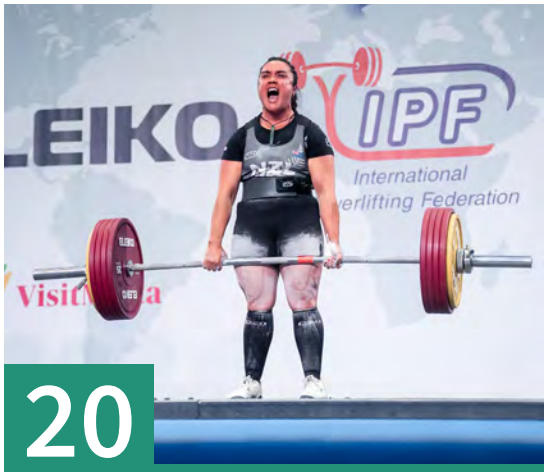


Editorial

Dr Luke Bradford

Dr Luke Bradford
College President

Welcome to the April issue of GP Voice.

In another win for our workforce, the College welcomed the **Minister of Health's announcement** that from 2027 Health New Zealand | Te Whatu Ora will become the direct employer of GPEP year 1 registrars, replacing the College in this role. Registrars will choose to be either Health New Zealand employed, practice employed or self-funded.

Alongside the additional funding for registrars past their first year of GPEP training and the new primary care pathway for PGY2s, this announcement continues to build the attractiveness of being a specialist general practitioner, which will result in a more sustainable primary care system in New Zealand. **Read the College's full statement.**

This issue is big on highlighting the great work, initiatives and solutions that our members and peers in the wider health sector are doing to improve health outcomes and address the challenges we are facing, through recruitment evenings in Southland, incorporating continuous quality improvement in practices, and Morbidity and Mortality (M&M) meetings in Taupo, with primary, secondary and community care coming together to discuss, educate and learn from each other.

For those who missed the ADHD webinar run by HealthPathways last month, you can read a review of what was discussed by Prabani, David and Justine. Over 1100 people dialled in to the webinar and over 600 of those were College Fellows. I hope you found the advice and guidance useful – whether your practice is offering ADHD care or not. We've also got the ADHD hub for members to refer to.

Looking ahead to next week, the rural WONCA conference will be held in Wellington from Friday 10 to Monday 13 April, hosted by Hauora Taiwhenua Rural Health Network. From the College, medical director Dr Prabani Wood will be presenting rural GP data from the College's workforce survey, and Sandy Bhawan will share case studies on Quality from rural general practices. Rural GP Chapter Chair Dr Mark Smith will be presenting on a rural endorsement pathway. Having rural WONCA in New Zealand for the first time will really put a spotlight on rural health issues and highlight the importance of building a sustainable and thriving rural health system.

Speaking of WONCA, by the time this issue is published I would have just come back from the Philippines where I attended the Asia-Pacific WONCA conference. I had the opportunity to present a poster about *GP workloads and the implications for teaching, clinical governance, learning and quality*. The poster reiterated the Your Work Counts project data, focusing on the non-contact clinical work GPs do (teaching and CME, clinical governance and management).

Submit your feedback

The poster highlights that GPs should be spending around 30 percent of their time on this work (but in reality it is far less than this) and highlights that safe and sustainable general practice requires that this non-clinical, but critical, work should be protected. It also calls for pay parity with our hospital-based peers. You can **view a copy of my poster here**.

Enjoy this month's issue.

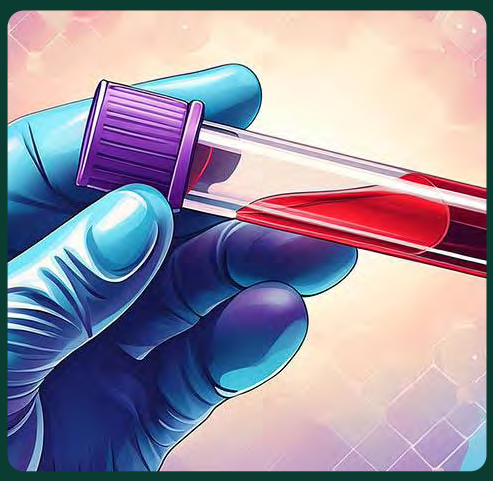
Goodfellow Unit podcast: **Full blood count**

Dr Alwyn D'Souza is a consultant haematologist at Capital & Coast District Health Board. His special areas of interest are haematopoietic stem cell transplantation ('bone marrow transplantation') and lymphomas. He also has an interest in medical education and is the current chair of the NZ Joint Training Committee in haematology.

In this episode, Dr Alwyn D'Souza delves into the intricacies of the full blood count, discussing its significance, interpretation of results, and the clinical implications of various blood parameters.

The key take-home messages of this podcast are:

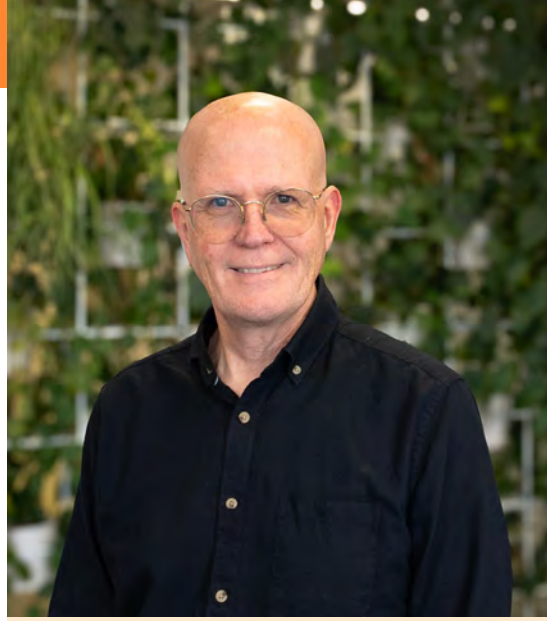
- Look at the blood count in its entirety.
- Most conditions have patterns of abnormality.
- The severity of the abnormality tells a story.
- If abnormalities are mild and have not been commented on, then follow up to see if trends develop.



Listen to the podcast

Improving the College's digital systems

Rowan Dixon



Rowan Dixon
Head of Corporate Services

Kia ora koutou

One of the clearest messages we hear from both registrars and educators is this: when systems are hard to navigate, they get in the way of learning. Over the past year, a significant amount of work has gone into changing that by putting the learner journey at the centre and building the right foundations around it.

For registrars, this means having one place that brings their programme journey together. Learning progress, requirements and what is coming up next are easier to see and understand, rather than being spread across multiple tools or emails. Information is received in a timely fashion, assessments and programme milestones are simpler to access and track, and the experience is more consistent regardless of where you're training, what stage you're at, or which programme you're on. Just as importantly, it means less time spent chasing up, and more time focused on learning, reflection and development.

For our lead medical educators, medical educators, teachers and assessors, the improvements are equally important. Clearer visibility of learner information means having access to the right data at the right time to support learners effectively. More consistent processes reduce unnecessary variation by managing how education activities are reported, while shared systems improve coordination with the College and reduce reliance on workarounds. Less duplication means less double handling of the same information across different tools or formats, freeing up time for teaching and assessment rather than administration.

For the College, these changes significantly reduce manual work through automation and better system integration, reduce the risk of errors through eliminating double handling, and replace spreadsheets and emails for managing work. They give us stronger oversight of education programmes, better visibility of progress, and earlier identification of risks so that we can respond proactively rather than reactively.

Having a single source of truth also means more reliable data to support decision-making and planning. Over time, this creates capacity to shift effort away from administration and towards higher value work such as quality improvement, learner support and innovation.

The work does not stop here though. The College's Te Kāpehu Whetū programme will continue to evolve through regular, incremental releases. Upcoming work will focus on fully supporting GPEP year 2, ensuring current GPEP year 1 learners can transition to GPEP year 2 smoothly, and refining the experience based on feedback from learners, educators and staff. The goal remains simple and consistent: systems that support learning and teaching rather than getting in the way.

Submit your feedback

We hope our new registrars are enjoying the benefits of these systems already, and we will continue to update you, our membership, as we progress with Te Kāpehu Whetū.

Rowan Dixon
Head of Corporate Services

General Practice Education Programme

Applications for the 2027 General Practice Education Programme (GPEP) intake are open until 10.00am on Monday 13 April 2026.

GPEP is a vocational training programme for doctors who want to become specialist general practitioners. It includes a mix of clinical and academic postgraduate training. With the majority of medical conditions being treated in the community, more GP registrars will be a great asset to our medical community. GPEP is a three-year full-time equivalent (FTE) programme of study with part-time options available.

From 2027, GPEP year 1 registrars will be able to choose between being employed by Health New Zealand | Te Whatu Ora, being practice-employed or self-funded.

Find out more

If you know someone who may be interested in specialising as a GP, please direct them to the College's 'specialise as a GP' webpage.

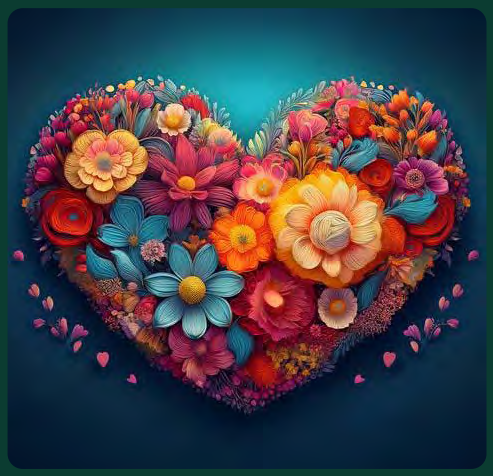
Goodfellow Unit podcast: **Medical ethics**

Professor Angela Ballantyne teaches bioethics within the medical programme at the University of Otago Wellington. She has held roles with the World Health Organization in Geneva, Yale University and the National University of Singapore. Angela also contributes to national expert groups on AI research ethics, reproductive ethics and immunisation policy.

In this episode, Angela discusses some commonly encountered medical ethics cases in general practice.

The key take-home messages of this podcast are:

- Develop epistemic humility regarding the limits of your own knowledge.
- These conversations are hard for doctors.
- A healthy rebalancing process – certain patient groups will be pushing back and challenging.
- Be reflective – unconscious bias, patient rapport, etc.



Listen to the podcast

College Advocacy: Months in review

February and March

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 February and March.

Changes to employment for GPEP year 1s from 2027

From 2027, Health New Zealand | Te Whatu Ora (Health NZ) will take over the employment of registrars in their first year of GPEP training who would have previously been College employed. The options for registrars to be practice employed or self-funded remains unchanged.

The College and Health NZ worked closely together on this change, which will support a smoother transition into GPEP. It also means GPEP registrars who choose to be Health NZ employed will have employment conditions that align with other medical specialities – something the College has long advocated for.

Alongside other recent investments, including the additional funding for College fees beyond the first year of training and the new primary care pathway, this announcement demonstrates the positive impact of sustained and targeted investment in primary care and highlights to medical graduates that there has never been a better time to join our GPEP training pathway.

Read the Minister's statement.

Read the College's statement.

The College president spoke about this change to ***NZ Doctor* (paywalled)** and on Newstalk ZB's news bulletin. Health Minister Hon. Simeon Brown discussed the change in this **Newstalk ZB interview**.

Adult ADHD care

In February, the College and HealthPathways hosted a webinar to provide practical guidance on the new ADHD prescribing rules and what they mean for everyday practice. College Medical Director Dr Prabani Wood presented alongside psychiatrist Dr David Codyre and Dr Justine Lancaster, National Clinical Lead, Community Care Pathways, Health NZ. **Read more on page 30**.

College President Dr Luke Bradford spoke to the *NZ Herald*, **Radio NZ's *Morning Report***, **The Platform** and the ***Bay of Plenty Times*** about the changes for adult ADHD care being carried out by specialist GPs. Dr Michael Buckley spoke on **Radio NZ's *Nine to Noon programme*** about ADHD medication shortages.

Submit your feedback

New GPEP and RHM intake

The College welcomed the 2026 General Practice Education Programme (GPEP) and Rural Hospital Medicine Training Programme (RHMTP) cohorts beginning their training.

This year saw 210 doctors starting GPEP and 15 starting the RHMTP. This year's intake also had the highest number of Māori registrars starting the training programmes – 29 for GPEP and 6 for the RHMTP, illustrating the College's ongoing commitment to attract, recruit and retain Māori doctors. Dr Bradford spoke to *NZ Doctor* and Newstalk ZB about our newest members.

Read the College's media statement in full.

Stakeholder engagement

Dr Luke Bradford:

- **'The seen and unseen work of general practice: A national diary study of NZ general practitioners'** was published in the *JPHC* by Dr Bradford, Dr Sam Murton, Simon Wright and Jordan Schulde.
- ***NZ Doctor* column on the importance of training the next generation**.
- Presented at WONCA's Asia Pacific Region conference in the Philippines on the Your Work Counts data (focusing on the non-contact work)
- Bilateral meetings with ACRRM and the Canadian GP College.
- Presented at the Australasian College of Health Service Management (ACHSM) and Royal Australasian College Medical Administrators (RACMA) conference in Auckland on the integration between primary and secondary care.
- Rural WONCA host organising committee meetings.
- Waikato Medical School Advisory Board meeting.
- Meeting with the Primary Health Target Advisory Group.
- Meeting with Health New Zealand | Te Whatu Ora on ADHD care (with medical director Dr Prabani Wood).
- Attended GPLF and Council of Medical Colleges (CMC) meetings.

Dr Prabani Wood:

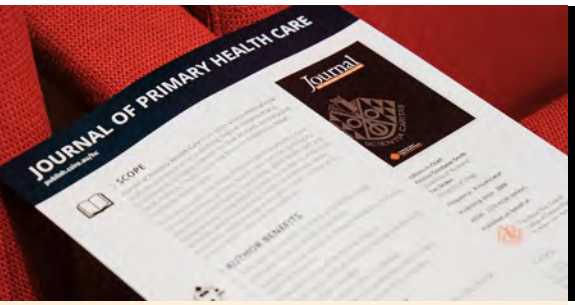
- **NZ Doctor column on the evolution of the specialist GP role**.
- Travelled to Dunedin and Christchurch to see the GP consultant model in action at a practice; meetings to discuss the importance of primary care research and learn more about the Pegasus PHO-run GP peer groups to see how they are improving patient care.
- Moderated a session at the Goodfellow conference.
- Cancer Screening Programmes meeting.
- Ongoing work with GPNZ, the Pharmaceutical Society, Pharmacy Guild and Te Whatu Ora to improve PMSs so electronic prescription are safer and easier to use for prescribing.
- Met with academics from Denmark to discuss Quality in General Practice.
- Attended the National Quality Forum.
- Attended the Primary Care Sector Group meeting.
- ADHD care meetings.

Submissions

- MCNZ: Cultural competence, cultural safety and hauora Māori (March)
- Pharmac: Changes to the Pharmaceutical Schedule (March)
- MCNZ: Regulation of Physician Associates/Assistants (February)
- Office of the Privacy Commissioner: Draft guidance on the Privacy Code of Practices – incorporating Privacy Principle 3A (February)
- Parliament's Justice Committee: Proposed Arms Bill (February)
- CMC: Draft strategic plan and draft manifesto 2026–29 consultation
- CMC: Joint Colleges' submission on the Regulation of Physician Associates/ Assistants

More media and advocacy

- Pathways for UK doctors wanting to live and work in New Zealand | Pulse Today | Dr Luke Bradford
- Waikato Medical School and training the next generation | *TV1News* | Dr Luke Bradford
- Keeping ourselves well as we head towards winter | *Breakfast* | Dr Luke Bradford
- MCNZ Torohia report | *NZ Doctor* | Toby Beaglehole
- MediMap data breach | Stuff Digital | Dr Luke Bradford



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. Editor's Choice: The seen and unseen work of general practice: a national diary study of New Zealand General Practitioners
2. Tongkat Ali/Long Jack
3. Collagen supplements
4. Understanding the determinants of health for Māori living with chronic disease in Aotearoa New Zealand
5. Apple cider vinegar

Strengthening the primary care workforce

What the new GPEP employment model means for general practice

The future of New Zealand's primary care workforce took an important step forward with the announcement last month that Health New Zealand | Te Whatu Ora (Health NZ) will become the direct employer for General Practice Education Programme (GPEP) year 1 registrars from February 2027.

GPEP year 1 registrars will have the choice now between being Health NZ employed, practice-employed or self-funded.

For The Royal New Zealand College of General Practitioners, this change represents more than an employment shift. It is a significant milestone in removing longstanding barriers to GP training, strengthening the workforce pipeline and supporting the sustainability of general practice for the years ahead.

Removing barriers to GP training

One of the most persistent challenges facing general practice training has been the transition from hospital-based employment into community-based training. The 2022 Malatest report identified this transition as the single biggest barrier preventing house officers from entering GP training.

By enabling continuity of employment with Health NZ for GPEP year 1 registrars, this new model directly addresses that issue.

"House officers can now have confidence to become GPEP registrars through continuity of employment and pay parity with other specialist vocational programmes," says College Chief Executive Toby Beaglehole.

"This announcement is a very positive step forward in removing barriers for doctors entering general practice training."

Aligning pay and terms and conditions with other vocational specialist training pathways helps ensure that general practice is seen as an equally attractive and viable choice.

Building on positive momentum in primary care

This change sits alongside broader initiatives already under way to strengthen the primary care pathway for doctors, including the introduction of a new primary care pathway for PGY2 doctors and renewed GPEP years 2, 3 and 3+ funding.

Taken together, these developments signal a clear commitment to investing in general practice as a cornerstone of the health system.

"Alongside the new primary care pathway for PGY2s, this is another step forward that continues to build the attractiveness of being a specialist general practitioner," says Toby. "We know specialist GPs are vital to the health of our communities and are on the frontline of our health care system."

For the College, the goal remains clear: To grow and sustain the GP workforce by supporting more doctors into training and ensuring they are well supported throughout their vocational journey.

Supporting a sustainable workforce pipeline

The College continues to work towards enrolling 300 registrars into GPEP each year, recognising the scale of workforce need across both urban and rural communities.

Under the new model, Health NZ will become the employer for registrars who are not employed by a private practice during their first year of GPEP training. Importantly, this change does not alter the option for registrars to be employed by a private general practice (practice employed), which remains a core and valued component of the training pathway.

The College's role remains unchanged

While employment arrangements will change for some registrars, the College will continue to provide leadership over all aspects of GP education and training.

This includes responsibility for educational content, training standards, quality assurance, and clinical placements, ensuring that the high standards of general practice training in Aotearoa New Zealand are maintained.

The College and Health NZ have worked closely to design this model and will continue to collaborate to ensure the transition is seamless for registrars and practices alike.

What this means for members

For College members, this announcement represents a positive step towards a more stable and sustainable general practice workforce.

By reducing barriers to entry, improving employment continuity and strengthening alignment with other vocational training programmes, the changes support the long-term health of the profession and the communities GPs serve.

Practices will continue to play a vital role in training registrars, and members can be confident that the College remains firmly focused on advocating for general practice, supporting high-quality training and strengthening the future workforce.

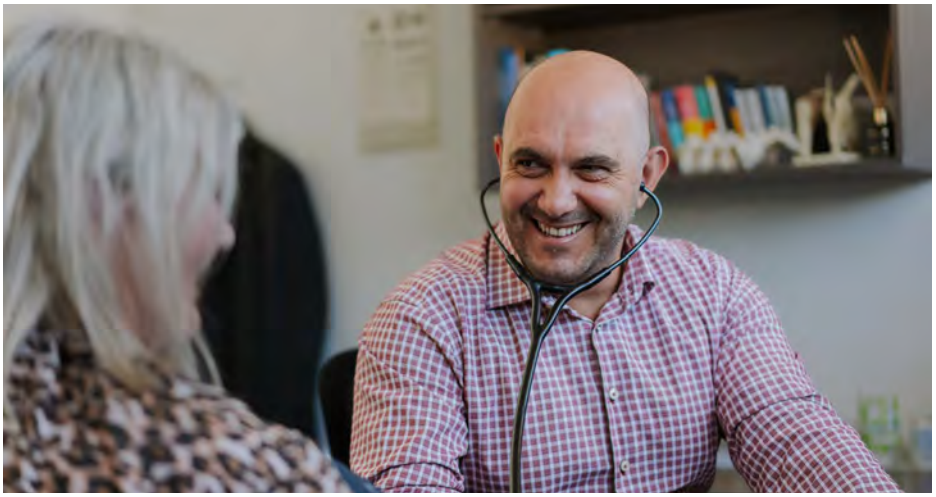
Looking ahead

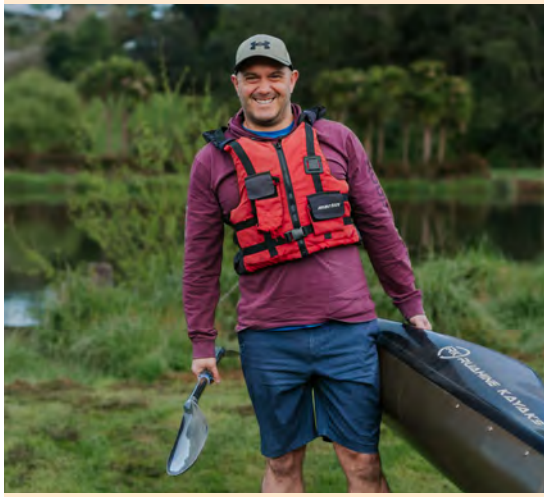
Applications for the 2027 GPEP intake are open now and will close on Monday 13 April 2026. The College and Health NZ will continue working together to ensure prospective registrars are well informed and supported throughout the application process.

As workforce challenges continue to evolve, this announcement reflects a shared commitment to strengthening primary care and ensuring general practice remains an attractive, supported, and sustainable career choice.

For the College, it is another important step in building a strong future for general practice in Aotearoa New Zealand.

Looking beyond our borders to support New Zealand general practice





General practice has always been built on connection – between doctors and patients, practices and communities, and organisations working toward a shared goal. As workforce pressures continue to be felt across Aotearoa New Zealand, those connections matter more than ever.

That spirit of collaboration sits at the centre of a new international recruitment campaign delivered in a partnership between The Royal New Zealand College of General Practitioners (the College) and Health New Zealand | Te Whatu Ora (Health NZ). The campaign focuses on strengthening the GP and rural hospital doctor workforce by telling a clear, authentic story about what it means to practise in New Zealand, and why general practice here is both professionally rewarding and deeply connected to community.

By working together, the College and Health NZ are making it easier for international doctors to understand GP and rural hospital doctor roles, vocational pathways and the professional and community support available. Consistent, joined-up messaging helps reduce confusion, smooth recruitment pathways and ensure expectations are clear from first interest through to practise in New Zealand communities.

Member stories at the heart of the campaign

At the centre of the campaign are the voices of College members themselves. Three UK GPs who moved to New Zealand – Andrew, Jenny and Luke. They share their personal journeys and day-to-day experiences of practising in Aotearoa New Zealand, bringing the realities of general practice to life for a UK-based international audience.

> **A sustainable GP workforce is essential to the health of our communities. This campaign reflects our commitment to working in partnership by supporting international recruitment while upholding the standards, training and values that define general practice in Aotearoa.**

Dr Luke Bradford, College President

Submit your feedback

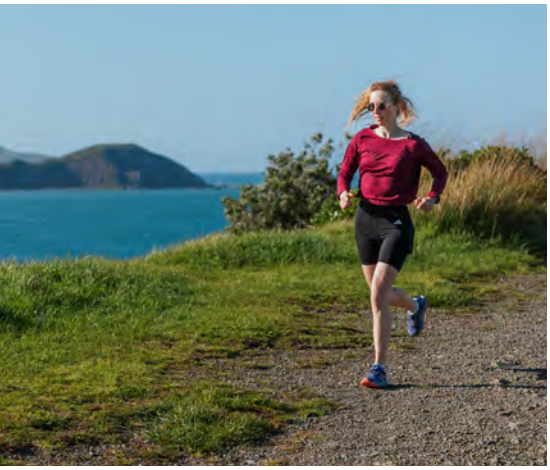
Through video storytelling, Andrew, Jenny and Luke speak candidly about the scope and variety of their work, the relationships they build with patients and whānau, and the professional satisfaction that comes from being part of a community-focused health system. Their stories reflect what members know to be true: that GPs are highly trained specialist doctors providing continuity of care across the lifespan.

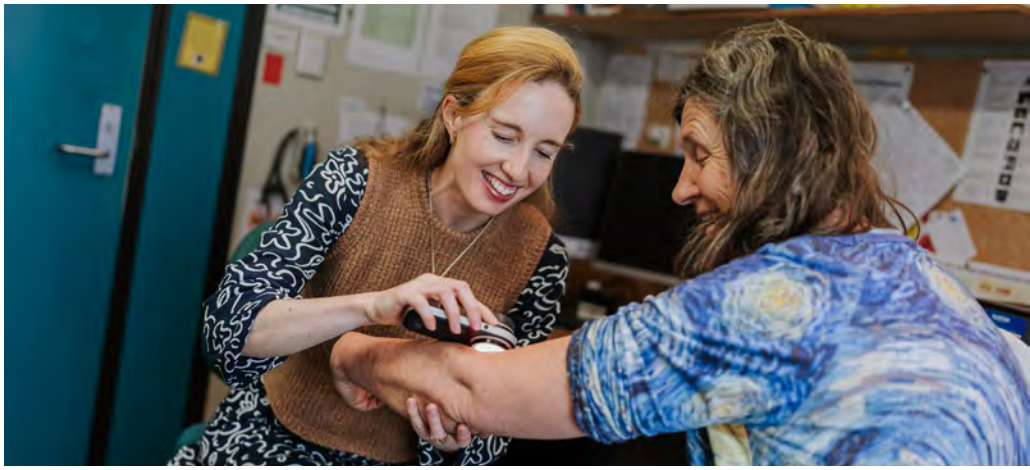
By showcasing real people and real practice, the campaign moves beyond generic recruitment messaging. It presents an authentic picture of general practice in New Zealand that is grounded in lived experience, professional pride and connection to community, helping potential recruits better understand what practising here can truly offer.

Looking ahead

This campaign forms part of a longer term approach to workforce sustainability; one that relies on strong partnerships, clear pathways and a shared commitment to the future of general practice. Working with our partners is key to securing the GP workforce our communities need now and into the future.

Watch Andrew's story **Watch Jenny's story** **Watch Luke's story**





Spotlight on Waikato–Bay of Plenty Faculty

The Whole GP: Community, Learning and Wellbeing

General practice is a profession built on care – care for patients, communities, and families. Yet behind every consultation room door is a GP who also needs connection, support and space to grow. Across the region, the Waikato–Bay of Plenty Faculty is championing a simple but powerful idea: when GPs are supported in mind, body and knowledge, everyone benefits.

Throughout the year, the Faculty is creating opportunities for doctors to reconnect with one another beyond the clinic walls. In Hamilton and Tauranga, quiz nights bring together GPs, colleagues from secondary care, and friends for evenings filled with laughter, friendly competition, and conversation that stretches far beyond medicine. These relaxed gatherings remind members that collegiality is one of the profession's greatest strengths.

Supporting wellbeing is a key priority. Members can take part in local fitness events like Tauranga's City to Surf and Hamilton's Round the Bridges with discounted entry – simple ways to stay active and model healthy habits.

Professional life can also be complex and sometimes challenging. That's why the Faculty continues to strengthen its commitment to collegial support through **Ka Hono** – a programme offering members up to five fully funded mentoring sessions with experienced GPs. For some, it provides a sounding board during difficult clinical decisions; for others, it is a space to reflect on career direction or personal wellbeing.

Recognising that everyone's needs are different, the Faculty has also expanded access to external coaching and mentorship providers, subsidising sessions so members can choose the support that fits them best. In a health care environment that often feels demanding, these connections ensure GPs never feel they are navigating their journey alone.

Alongside support comes growth. Education remains a cornerstone of the Faculty's work, with opportunities designed to keep GPs curious, confident, and connected to best practice. Late last year, the region's GP trainers gathered for a successful Educators Day, where 30 teaching doctors came together to share insights, strengthen their teaching skills, and build the educational capacity of the profession.

The Faculty also continued to support members attending the GP25 Conference in Christchurch, with subsidies helping make attendance possible for more doctors. Looking ahead, there is even greater excitement building for the GP26 Conference in Auckland.

In August, learning will continue closer to home with the Faculty's upcoming **Education Symposium in Papamoa** – a chance for members to deepen their knowledge, share ideas and reconnect with colleagues in a collaborative learning environment.

Caring for the mind is just as important as growing knowledge. Recognising the pressures faced by modern clinicians, the Faculty has introduced a new mindfulness programme led by practitioner John Fletcher. Fully funded for practices, the programme offers practical techniques designed specifically for busy health care professionals supporting emotional wellbeing, reducing stress, and improving communication and focus within teams.

For many practices, these sessions provide something rare: a moment to pause, breathe and reflect together.

The Faculty also understands the importance of celebrating the human side of medicine. One memorable event featured GP and performer Dr Lucy O'Hagan and her moving performance *Everything but the Medicine – A Doctor's Tale*. With humour and honesty, the show explored the emotional complexity of general practice, resonating deeply with audiences who recognised their own experiences within the stories.

Milestones are also celebrated with warmth and pride. Events such as the New Fellow / Old Fellow Dinner and the New Fellows Graduation Ceremony acknowledge the journeys of those entering the profession and honour those who have contributed decades of service to their communities.

At the heart of the Faculty's wellbeing focus lies a new initiative – the inaugural **Restore and Revive Retreat Day** at Ridge Country Retreat in Papamoa. The day invites GPs to step away from their busy schedules and reconnect with their own wellbeing. Through reflection, conversation and time in nature, the retreat is designed to nourish the caregivers who give so much of themselves to others.

Taken together, these initiatives tell a larger story. They reflect a Faculty committed not only to clinical excellence, but to the wellbeing, resilience, and connection of its members. By investing in learning, mentorship, celebration and balance, the Waikato–Bay of Plenty Faculty is aiming to nurture a community where every GP – from new graduate to seasoned Fellow – can thrive.

The hope is that when doctors are supported, the care they give back to patients becomes stronger, kinder and more sustainable. And that in turn benefits the communities they serve.

GP26: Coming together to shape the future of general practice

E tū Matariki ki te tahatū o te rangi, ka mua, ka muri

Matariki stands on the horizon, a symbol of the past and the future

General practice is moving into a new era, shaped by technology, interdisciplinary connectedness, mātauranga Māori, and collective purpose.

GP26 will jointly acknowledge our whakapapa, where we have come from and how we have been guided by those who have come before us, whilst also looking to what lies ahead and the future we are contributing to. As we move towards the horizon, our collective aspirations ground us, serving our whānau and communities in order to support the attainment of Pae Ora (healthy futures) for all in Aotearoa New Zealand.

Like Matariki rising on the horizon, GP26 invites us to reflect, renew and reinvigorate – grounded in the wisdom of our tūpuna (ancestors) and inspired by the future we are shaping for our mokopuna (future generations).

Registrations are now open for GP26: Conference for General Practice, the College's stand-out annual conference, which brings together GPs, rural hospital doctors, registrars, medical students and primary care leaders from across Aotearoa New Zealand.

Taking place from Thursday 30 July to Saturday 1 August in Tāmaki Makaurau Auckland at the brand-new New Zealand International Convention Centre in the centre of the city. GP26 offers three days of learning, inspiration and connection, with a programme designed to support GPs and rural hospital doctors at every stage of their careers.

Topics that will be highlighted at GP26 include advances in artificial intelligence, digital tools, new models of multidisciplinary care, and the interface between indigenous knowledge and primary care – all of which can be drawn on to support relationships between GPs and their patients and communities, which sits at the heart of general practice. We'll examine how future-focused care can be equitable, sustainable, and grounded in kaupapa that reflects our community aspirations.

The event begins with a pre-conference, hands-on CME workshop day, which will be focused on topics relevant to members which will be focused on topics that are relevant to members and that have been selected by Medical Director Dr Prabani Wood.

Across the conference, attendees can choose from a wide range of concurrent sessions, covering clinical updates, research insights and practical tools for everyday practice. Poster presentations will showcase emerging research and innovation from colleagues around the country.

Beyond the concurrent sessions, GP26 offers plenty of opportunities to connect. Delegates can attend a lively conference social function and celebrate the profession and new Fellows at the Fellowship and Awards Ceremony – one of the highlights of the College calendar.

The conference also provides space for important professional conversations, including the College's Annual General Meeting, for members to share ideas about the future of the profession.

Whether you are looking to deepen your clinical knowledge, reconnect with colleagues, or be inspired by the latest thinking in primary care, GP26 is an event not to miss.

Early bird registrations are now open. Visit the **conference website** to view the full programme and secure your place.

The importance of research

Applications for funding opening soon

Health research is essential for workforce sustainability in Aotearoa New Zealand. Some of the most important and innovative research starts with what you do every day – in consulting rooms, rural hospitals and communities across the motu.

If you've ever wondered, or discussed with a colleague, how care could work better for those you care for, how workloads could be reduced or streamlined, or how care could be made more equitable, why not turn that question into a research project.

The College's Research and Education Committee (REC) supports research that strengthens general practice, rural general practice and rural hospital medicine, and builds evidence directly from the realities and first-hand experiences of frontline care.

The funding is available to anyone with a relevant research project – you don't need to be a member of the College to apply. Projects just need to be practical, practice- or rural hospital–focused and grounded in clinical work.

The second of three funding rounds for 2026 opens on **Wednesday 22 April**, so now is the time to take that idea of yours further. Whether you're interested in workforce, wellbeing, equity, rural health, new models of care or improving patient outcomes, funding is available to help you turn your insights into impact.

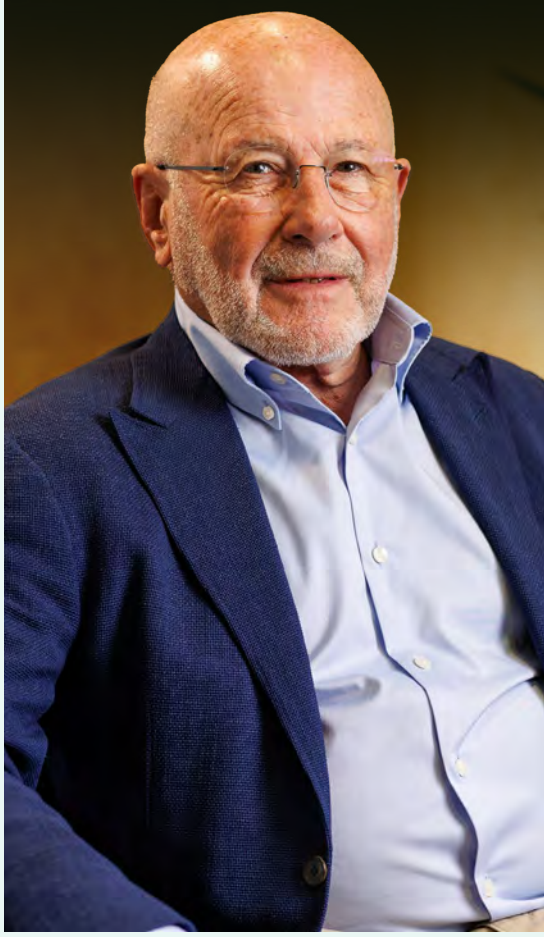
Visit the '**Fund your research**' page to learn more about the funding guidelines and application dates and to apply.

MIND THIS

Who is responsible for assessing whether a private patient is fit for surgery

Dr Peter Moodie

Peter Moodie is the College's Clinical Advisor



The Case

Last year a report by Coroner Hesketh was published and commented on by national media. The media focus was on the actions of a general practitioner (Dr D) who was criticised with respect to the quality of his referral.

The case centred around a woman (Ms M) who was clinically a high surgical risk and who died following weight loss surgery in a private hospital in Gisborne.

Ms M, a nurse, was 50 years old with a history of rheumatic fever necessitating a mitral valve replacement several years previously; she was also prediabetic and hypertensive. She had a BMI of 62 and was taking warfarin for atrial fibrillation. It is hard to avoid the conclusion that she was anything other than a very high surgical risk.

In early 2021, Dr D referred Ms M to Gisborne hospital for bariatric surgery; however, the referral was declined because her BMI was 2 units above their cutoff point of 60.

Unbeknownst to Dr D, Ms M then contacted a private surgeon in Hastings requesting gastric bypass surgery; however, the surgeon declined to carry out the operation in his private hospital as he felt she was too great a surgical risk and would have been too far from home if something went wrong. He did, however, suggest that she contact a gastric surgeon (Mr S) in her hometown of Gisborne. He wrote to Mr S and sent a copy to her general practitioner. Amongst other things, he referred to her history of an aortic valve replacement.

Ms M then on her own volition made an appointment with Mr S for review in his private clinic. A day before this consultation was scheduled, Ms M rang and requested Dr D send a referral letter to Mr S. Dr D later explained that he wrote the referral in haste and had expected a more detailed discussion with the surgeon later if he decided to proceed with the surgery.

From Dr D's letter, the Hastings surgeon's letter and Mr S's, we can conclude that Ms M had:

- prediabetes
- atrial fibrillation
- chronic rheumatic disease
- plastic repair of aortic valve
- morbid obesity, and
- was taking warfarin.

Submit your feedback

So, what was the problem?

Firstly, despite the patient (who was a nurse) and several other health professionals stating that she had an aortic valve implant, she in fact had had a prosthetic mitral valve. Indeed, on receiving the patient notes from her previous practice when the patient transferred to Dr D's care, her classification list stated that she had a prosthetic aortic valve. Dr D manually corrected her classification list to mitral valve replacement. Unfortunately, as he hurriedly wrote a brief letter to Mr S, he had the referral letter from the Hastings surgeon in front of him, and in his correspondence to Mr S, Dr D incorrectly referred to a prosthetic aortic valve.

Mr S later stated to the Coroner that if he had known that it was a mitral valve replacement, this would have been "a game changer," and he would have managed the case very differently.

The increased surgical risk for patients with prosthetic mitral valves compared with prosthetic aortic valves relates to the degree of anticoagulation they need. This poses an increased risk of post-operative thromboembolism and haemorrhage.

Ms M was managed as a prosthetic aortic valve patient, so her target INR was incorrectly lowered. However, her post-operative complications were due to intra-abdominal bleeding and the Coroner raised concerns about the monitoring she received post-surgery on the private hospital ward, resulting in a delay in recognising that she was seriously unwell and transferring her to the public hospital, where she later died.

In addition to identifying the wrong valve, the Coroner was critical of Dr D's referral in that he had not enclosed a copy of a cardiology opinion provided in Christchurch in 2018 (the opinion was quite positive, stating that her echocardiogram findings were stable and that she would require a cardiology follow-up in 2023).

Coroner Hesketh was quoted in the media as stating:

"I am of the view that Dr D has a professional duty to record all relevant information in a referral letter that is requested of him and required by a specialist surgeon. In this case, that should have included a more detailed history of Ms M than was recorded, taking into account the nature of the surgery being considered."

What are the lessons?

Lesson 1: As soon as you are confronted by a legal entity (including the Coroner or the HDC) seek medicolegal advice.

Dr D did not seek advice from his indemnifier when providing the Coroner with his report. He didn't realise his professional risk and didn't supply various documents in an orderly way, which the coroner criticised.

Lesson 2: Dr D acknowledged that he had made mistakes but should have sought professional advice prior to making such comments.

Neither the anaesthetist nor the surgeon admitted responsibility but rather claimed that being told that the valve in question was aortic rather than mitral was a "game changer."

Lesson 3: Perhaps all referrals should have a disclaimer attached?

This case puts additional pressure on general practice when making a private surgical referral. In the public hospital setting, a patient would be admitted by

junior staff with full case notes written up and probably a ward round discussion about risks. In private, these procedures fall on the surgeon and anaesthetist, who may not have the same access to the patients' old notes.

Finally, what did the Chief Coroner say about the College's letter?

The College proposed that when the coroners ask clinicians for information, they should advise doctors that they should seek legal advice from their indemnifier. The Chief Coroner said, "No."

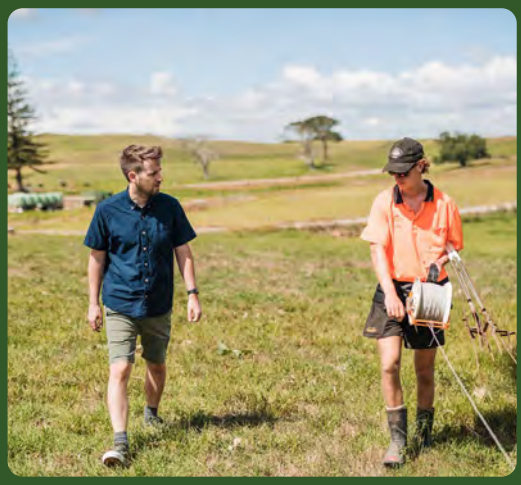
The College explained that we are always available to discuss any matters that impact on general practice. The Chief Coroner said that "was very helpful." In fact, several coroners do send drafts of their findings to the College for comment and we have been able to bring about changes to the final document.

Rural Hospital Medicine Training Programme

Applications for the Rural Hospital Medicine Training Programme (RHMTP) are open until 10.00am on Monday 13 April 2026. Successful applicants can commence training in August 2026 or February 2027.

RHMTP offers a unique pathway to become a rural hospital specialist, combining hands-on clinical training in hospitals and general practice, the development of core procedural skills required for confident rural hospital practice, and a supported academic component through the University of Otago. RHMTP is well suited to doctors drawn to a rural lifestyle, a broad scope of practice, and making a meaningful difference to rural health outcomes and communities.

If you know someone who may be interested, please encourage them to visit the College's '**specialise in rural hospital medicine**' webpage to find out more and to apply.



Do you have a story you'd like to share?

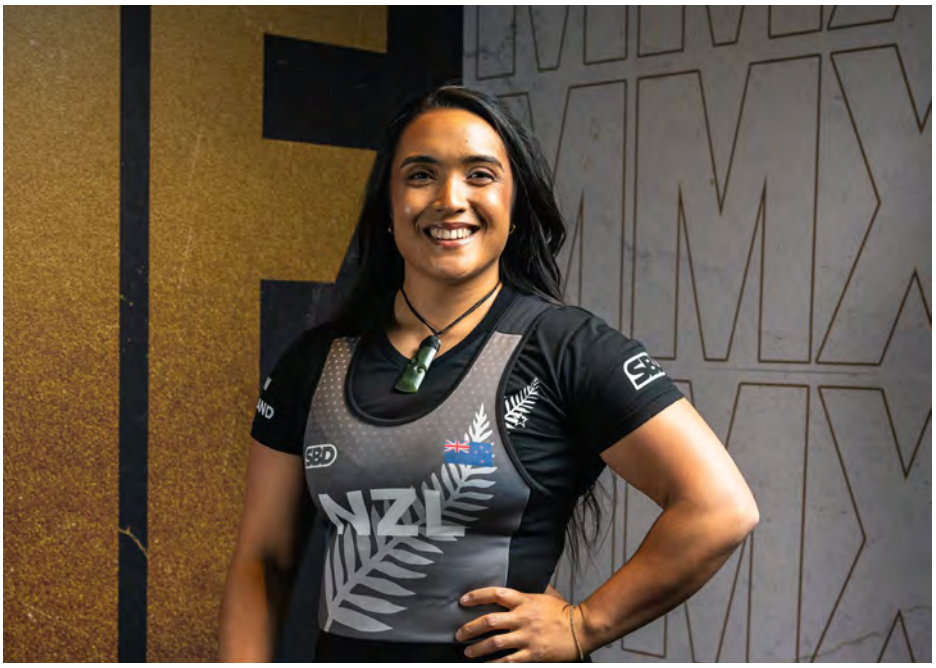
Make your voice heard

Submit your article to the Editorial team:

communications@rnzcgp.org.nz

Strength without compromise

College Fellow and world champion powerlifter Karlina Tongotea on discipline, identity and backing yourself.



Specialist GP and world champion powerlifter Karlina Tongotea lives a life that is anything but balanced, and she's unapologetic about it. A Māori/Tongan wahine from South Auckland, Karlina has competed internationally in powerlifting throughout her medical career, juggling three days a week in general practice with four intense training days that demand discipline, structure and resilience.

After losing her world title in 2024, Karlina made the bold decision to step back her GP hours to give herself a fighting chance on the world stage. The result? Reclaiming her world title in 2025 and a renewed understanding of what it takes to perform at an elite level while staying well. For Karlina, strength is about far more than medals. It's about representation, service, and showing others, especially Māori and Pacific whānau, what's possible when you back yourself and commit fully.

We caught up with Karlina to find out what it takes to juggle two demanding disciplines – being a specialist GP and powerlifting.

For members who don't know you yet, how would you introduce yourself and what does a 'normal week' look like?

Kia ora! I'm Karlina Tongotea, a Māori/Tongan wahine born and bred in South Auckland. I've been powerlifting internationally my entire GP career, so it's

Submit your feedback

actually my norm. I'm a GP three days a week and train for around four hours a session on the other four days. It's busy and not very balanced, but it's the stage of life I'm in, and I love the experiences it gives me.

Take us to one defining moment from the 2025 World Champs. What was it like?

World Champs 2025 was important because I'd lost my world title the year before. I was competing against full-time athletes and realised I needed to dedicate more time to training and recovery. Three months out, I reduced my GP work to two days a week. It was extremely challenging, but it taught me I'm resilient and can turn setbacks into something positive, like winning my world title back.

What drives you to compete at this level?

Sport has always been a huge part of my life. I love competition, being fit and being strong. My whānau have been an incredible support, but like most athletes, I love winning and the pursuit of it.

When motivation is low, what does discipline look like day to day?

Motivation is unreliable, so I choose routine and discipline. Life is rigid but well planned. Non-negotiables include consistent sleep, fixed training times, simplified meals and routines that conserve energy. It's inflexible, but a sporting career is short, and for now it's absolutely worth it.

What mindset skills cross over between specialist GP work and powerlifting?

The skills I learned as a doctor help me most in sport. Breath work keeps me calm under pressure, something I learned during intense hospital on-call shifts. GP work has also taught me to step back and see the bigger picture; one bad training session doesn't define the whole journey.

How do you decide which opportunities to say yes to?

I weigh the potential positives. If saying yes might help even one wahine feel brave enough to try strength training or study, that outweighs my nerves. Confidence follows action, even if the fear doesn't disappear.

What have you learned about recovery and staying well?

The basics matter most! Enough sleep, good nutrition and reducing external stress. GP work carries a heavy cognitive load, and I've learned the importance of boundaries, speaking up when overwhelmed and asking for help. Feeling supported makes me a better, more empathetic specialist GP.

Does being an athlete influence how you talk to patients about health behaviours?

Yes. I focus on consistent, incremental and sustainable change. I encourage patients to take small steps and only progress once those steps feel manageable and consistent.

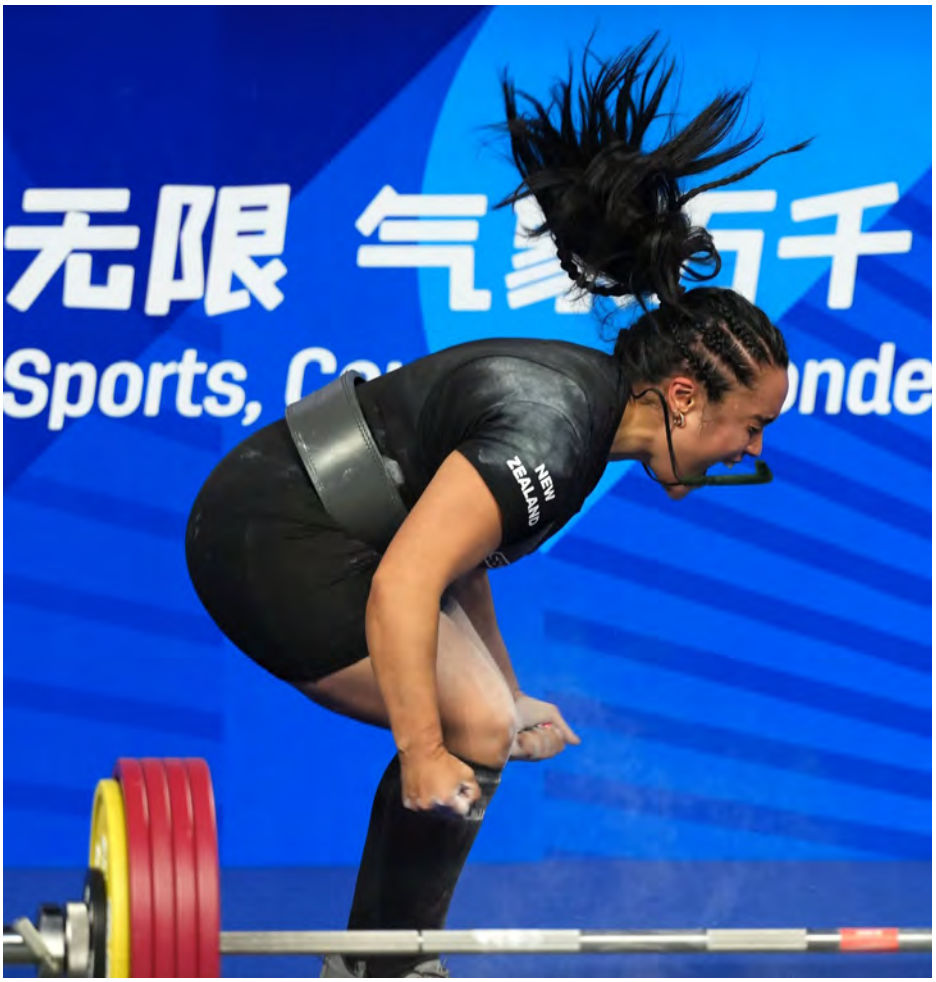
How does your cultural identity shape your approach to strength and service?

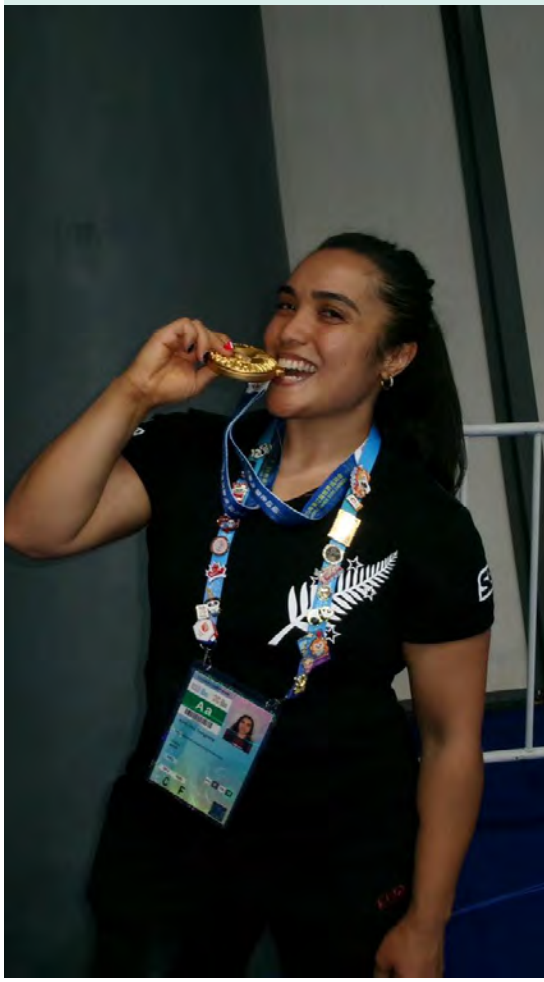
Representation is powerful. When Māori and Pacific people see me doing this, they know they can too, whether that's in sport, medicine or anything else.

What would you say to GPs who feel there's no space for their passion right now?

Now more than ever, we need something outside work that fills our cup. Start small, even 10 minutes doing something you enjoy, and build from there.

Karlina's story is one of intentional choice, resilience and unapologetic commitment. In a profession where demands can feel endless, she offers a powerful reminder that excellence in medicine does not require sacrificing identity, passion or joy. Whether reclaiming a world title or supporting patients through incremental change, Karlina's philosophy is consistent: Progress comes from showing up, staying grounded and backing yourself through setbacks.





WEBINAR

SunSmart or SunSlack?

Earlier this year the Cancer Society hosted a webinar where they shared insights from a nationally representative survey of New Zealanders, exploring what people know, believe and do when it comes to sun protection and UV exposure.

Watch the webinar recording.

When a town learns together

Building safer care across the primary–secondary divide

Dr Robin Chan, Rural Generalist and Health NZ GP Liaison Lakes Region, and Dr Natalie Clarke, Pinnacle PHO GP Lead, Lakes Region

Dr Natalie Clarke and Dr Robin Chan

Often the most meaningful work in health care doesn't start with policies or technology. It starts with people sitting together in the same room listening to one another and being able to speak honestly about what's hard.

Several years ago, that's exactly what we did. Our local clinicians in Taupō created a community-wide, multidisciplinary morbidity and mortality (M&M) meeting with that very intention: to learn together, across boundaries, in a way that makes care safer for patients and kinder for clinicians.

The meeting brings together general practice, hospital services, community pharmacy, and other local providers. The tone is deliberately different from the traditional M&M meetings. The aim here is not to find fault, but to understand systems. We work to create psychological safety because a system that welcomes feedback is one that is confident, mature and oriented towards growth. A willingness to be vulnerable is a marker of a high-functioning team, not a weak one.

When we discuss a case, there is a structure that we follow. What happened? If there was a breach of standard or an error, why did it happen? What can we change to reduce the chance of it happening again? Importantly, outcomes are fed back at subsequent meetings, which closes the quality improvement loop.

This way of working, the stories, reflection, action and return has helped the forum endure over the years. The cases have been diverse, but the learning has been consistent. Risk often lives at the crossroads between primary and secondary care, between services and between people.

In a head injury case – a fall from a horse – the discussion moved beyond the individual's presentation to a system issue of inequity of access to CT imaging. We saw a similar issue later involving back pain, reinforcing how repeated stories can highlight the same structural gap and strengthen the case for change. The recommendation was to escalate this at a district level, and now Taupō Hospital has a CT scanner, publicly announced and available to the community.

A motor vehicle accident case prompted a different kind of response: the need for shared education around concussion. The outcome was a well-received, multidisciplinary Grand Rounds session, followed by nursing and senior officer review of concussion pathways and promotion of existing patient information resources. The learning wasn't in one silo; it spread across disciplines.

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Medication safety has been a recurring theme. A polypharmacy case from primary care led to recommendations for clearer triggers for medication review and better access to clinical pharmacy support. The practical outcome was significant – discharge summaries are now sent to a clinical pharmacist for medicines reconciliation and problem list updates, and a clinical pharmacist is embedded within all primary care clinics with additional remote availability.

The shift to telehealth brought its own risks. A case discussion led to recommendations focused on safety in remote care, including access to training resources, webinars, seminars and peer review. For doctors new to New Zealand, supervision and assessment of telemedicine skills became a core part of onboarding. Again, the response was collective and forward focused.

From a primary care lens, it is often through supportive peer groups that we can talk through mistakes or issues and receive feedback. The benefits of these community-wide M&M meetings that span professions and roles mean we gain a better and broader overview of processes, systems, pressure points across the wider sector, solutions and how primary care can play a part.

From our M&M meetings, our primary care clinicians have developed a better understanding of how secondary care uses Datix – a reporting database that records and manages incidents, risks, hazards and feedback. We don't currently have a system of reporting adapted to primary care. The closest we have in clinics is a patient complaints process. However, this is a separate type of process that doesn't allow clinicians to flag errors and incidents that have not resulted in a patient complaint.

With the recent shift towards responsibility to report SAC 1 and 2 incidents to the HQSC, we can acknowledge a gap in current resources and support. Creating a system of recording and follow-up on patient harm incidents may need to be on the radar for primary care clinics across New Zealand.

Our M&M meetings work because of the culture around the table. We name the pitfalls – scapegoating and self-recrimination – and actively steer away from them. We choose curiosity over blame, connection over defensiveness. We work in a system under pressure, and this kind of local, relational, system-focused learning is not a luxury – it is one of the most practical ways to make care safer for patients, and for each other.

Why become a parkrun practice?

By Dr Andrew Boyd

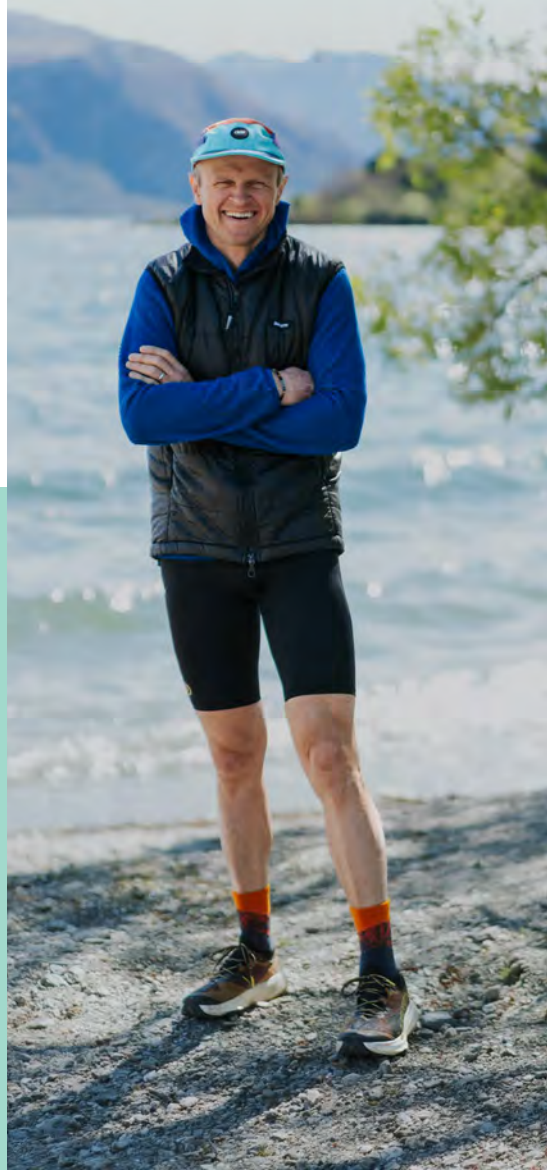
To misquote the poet John Donne, 'No general practice is an island.' Whilst the GP surgery remains a trusted and valued service in the community, primary care works best when we collaborate with other community providers to meet the wider health and wellbeing needs of our patients.

Every Saturday morning, at 67 (and counting!) locations across Aotearoa New Zealand, 5km parkrun events bring thousands of people together in a safe outdoor space to run, walk, volunteer and support anyone who attends. The positive wellbeing benefits of physical activity, being outdoors and volunteering are well established, but all too often those who have the most to benefit from opportunities such as parkrun miss out.

That's where parkrun practices come in. By partnering with a local parkrun event, primary care teams are ideally placed to support, encourage and signpost patients who would benefit from moving more, volunteering or simply reconnecting with their communities, to their local parkrun. Parkrun event teams – who are all volunteers – are welcoming and ready to help people who attend, in whatever way works for them.

Well established in the UK, Australia and Ireland, thousands of practices are already proud 'parkrun practices.' The result? Patients and staff participate in and benefit from the unique and evidence-based opportunities parkrun affords. And we are proud to announce a pilot collaboration with the College here in New Zealand, which is the fastest growing parkrun community in the world.

Dr Andrew Boyd, FRNZCGP
Parkrun ambassador



Parkrun practice pilot launching in Aotearoa New Zealand

The College has teamed up with parkrun Asia Pacific to launch a parkrun practice pilot initiative.

A pilot will be run in Auckland and Christchurch until the end of May 2026. Practices in these two areas can partner with their local 5km parkrun event, encouraging patients and practice staff to get involved with parkrun. This initiative recognises the physical and mental health benefits of walking, running, and volunteering in a safe, welcoming community space, something parkrun offers across the country.

We are asking for practices based in Auckland or Christchurch to register their interest and find out more about the pilot by visiting the parkrun website. Practices outside these areas are also welcome to register their interest, as if the pilot is successful, there is an intention to explore wider rollout. For further information, please email Andrew Boyd.

Submit your feedback

Specialising as a GP

Bringing the conversation to Southland

For doctors who are curious about where a career in general practice could take them, sometimes the most valuable insights don't come from a lecture theatre but from an honest conversation over a drink or some food.

That was the thinking behind the **Specialise as a GP** mix and mingle event held in Invercargill at the end of March, where local doctors and trainees were invited to learn more about the pathway to becoming a specialist GP and to hear directly from those already working in the profession.

Hosted in a relaxed, after hours setting at Speight's Ale House, the evening created space for open discussion about what general practice really looks like day to day: the variety, the challenge, and the privilege of working closely with patients, whānau and communities. Rather than focusing solely on entry requirements or training structure, the conversation centred on lived experience – why GPs choose this career, and what continues to make the work meaningful.

The event reflects the College's broader commitment to meeting future GPs where they are, particularly in regional centres like Southland. As Southland Lead Medical Educator, Dr Aisha Paulose has consistently highlighted that in her work with students and early career doctors, visibility and connection matter. Opportunities to talk directly with educators and practising GPs can make the idea of specialising feel both achievable and relevant, especially for those weighing up multiple career options.

Aisha took the feedback and with College support, has set up these mix and mingle events in both Dunedin and Invercargill over the last 10 years. They always receive good engagement with med students PGY1s and PGY2s.

"I'm deeply grateful to my colleagues who consistently give their time so generously to support these recruitment events. This means that doctors considering the region have meaningful opportunities to connect and ask questions," says Dr Aisha Paulose.

"Maintaining that sense of connection is vital, so we make a point of coming together socially several times a year. Events such as our mid-winter Christmas and end-of-year gathering provide valuable opportunities to support one another in the demanding clinical environment."

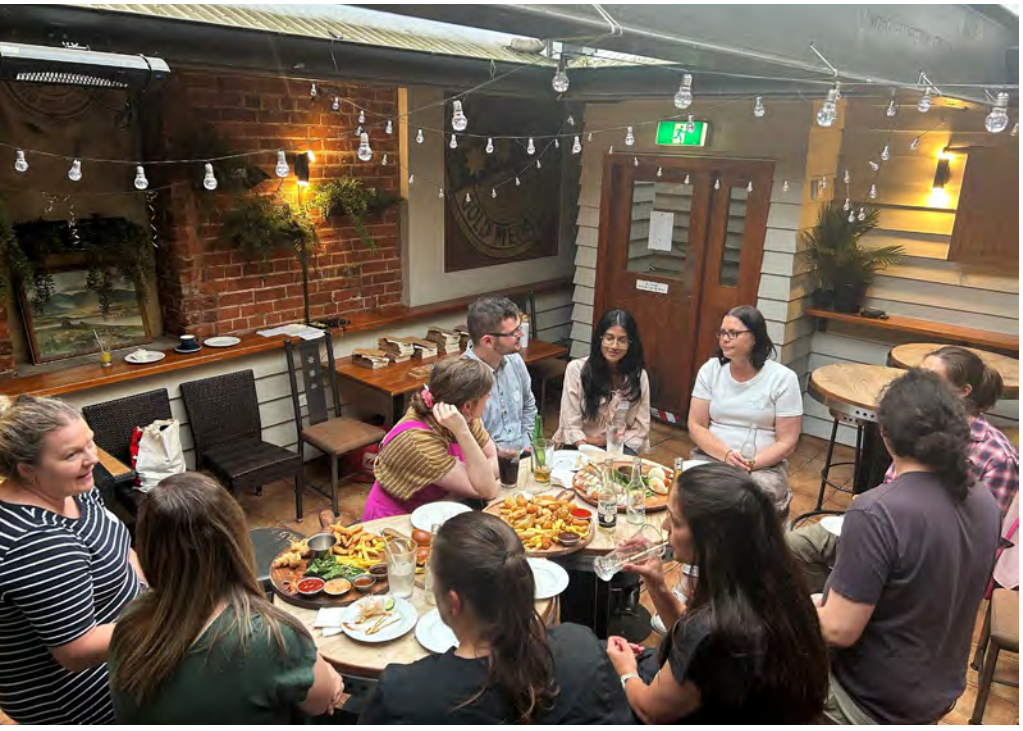
"Together, we've developed a network of more than 40 GPEP1, 2/3+ doctors, alongside highly skilled and experienced accredited teachers across Southland. The calibre of general practice here is exceptionally high. Southland's primary care community is both close-knit and welcoming, underpinned by a strong faculty I'm proud to be part of. That collegiality combined with the high standard of clinical practice makes it far easier to help interested doctors feel integrated, not only into the profession, but into the region as a whole. It's a part of the country that may not always be front of mind, but it is one that consistently exceeds expectations and doctors don't often leave once they have worked in Southland!"

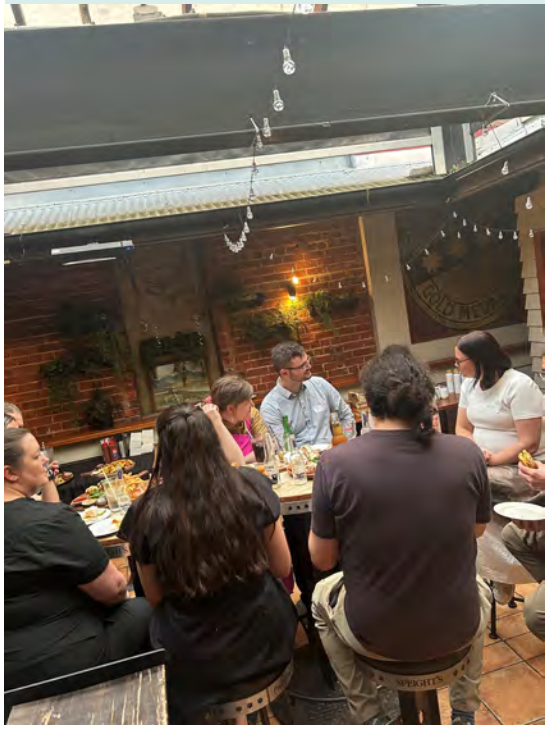
Submit your feedback

For attendees, the evening also offered a chance to demystify the General Practice Education Programme (GPEP), the College's three year postgraduate training pathway that enables doctors to practise independently as specialist GPs in Aotearoa New Zealand. Questions ranged from training structure and supervision to the flexibility general practice offers across urban and rural settings.

Importantly, events like this are not about a one way pitch. They are about listening – understanding what motivates the next generation, what concerns they have, and how the College and its educators can continue to support them. Aisha notes that these conversations work best when they are informal, collegial and grounded in real experience.

With strong engagement and positive feedback, the Invercargill mix and mingle is a timely reminder that sometimes the simplest format can be the most powerful: bring people together, share stories, and let curiosity do the rest.





College members recognised in 2026 New Year Honours

Three current and past members of the College have been recognised in the 2026 New Year Honours for their extraordinary contributions to health in Aotearoa New Zealand.

Professor Beverley-Anne Lawton has been appointed a Companion of the New Zealand Order of Merit for services to women's health, while retired general practitioners Dr Tania Pinfold and Dr Leonie Sinclair have each received the King's Service Medal for their contributions to youth health and community health.

Professor Beverley-Anne Lawton CNZM

Professor Beverley-Anne Lawton (Ngāti Porou) has led significant work and research to improve health outcomes for women and children across New Zealand and internationally.

Currently a Professor at Victoria University of Wellington, Professor Lawton founded Te Tātai Hauora o Hine – the National Centre for Women's Health Research Aotearoa – in 2008 and continues to serve as its Director. The Centre brings together a group of world-renowned scientists, researchers and fellows with expertise in maternal and infant health.

Professor Lawton has led a wide range of research focused on preventing cervical cancer through improvements to human papillomavirus screening. Under her leadership, the Centre has undertaken important work on HPV vaccination, self-testing, cervical screening and maternity care. Her research has also explored severe acute maternal morbidity and the impact of methamphetamine on the health and wellbeing of Māori pregnant women, their infants and whānau.

Alongside her research work, Professor Lawton contributes to several national and international advisory groups. She holds appointments on the Maternity Commissioning Framework Technical Advisory Group, the National Cervical Screening Programme Advisory Action and Equity Group, and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists Māori Health Committee He Hono Wāhine. She has also been a strong advocate for changes to cervical screening in Aotearoa to ensure the programme is safe and equitable for wāhine Māori.

Professor Lawton co-chairs both the International Indigenous HPV Alliance and the Alliance for Perinatal and Reproductive Justice. Her work has been recognised previously when she was appointed an Officer of the New Zealand Order of Merit in 2004.

Dr Tania Pinfold KSM

Dr Tania Pinfold has received the King's Service Medal for services to youth health following decades of dedication to improving health care access for young people

in Rotorua. As a general practitioner, Dr Pinfold identified a critical gap in health services available to young people and played a key role in establishing youth health services in the region.

During the 1990s she helped co-establish school health clinics in Rotorua, beginning with the first clinic at Western Heights High School in 1995. She later worked with the District Health Board to secure funding for wellness centres at five additional high schools. These clinics continue to operate today.

In 2002 she established a health clinic at the Rotorua Youth Centre Taiohi Tūrama, providing free health services for young people aged 15 to 24 living in Rotorua. Within 10 years of its establishment the centre was providing between eight and 10 thousand consultations each year, supporting young people with adolescent mental health concerns, sexual health needs and other health issues.

Dr Pinfold led the youth health service until 2019, guiding its growth and overseeing its transition across several premises before establishing a sustainable nurse-led model of care. She was also instrumental in establishing a health centre at the Rotorua Youth Justice Residence in 2010 and was a founding member of the Society of Youth Health Practitioners Aotearoa New Zealand in 2008.

Her work has also been recognised locally. In 2007 she received the Rotorua Zonta Club Women's Achievement Award for Community.

Dr Leonie Sinclair KSM

Dr Leonie Sinclair has been recognised with the King's Service Medal for her long-standing service to community health in Rotorua. Dr Sinclair began practising as a general practitioner in Rotorua in 1981 and built her practice over more than four decades to care for more than 2300 patients. Upon her retirement in 2025 she gifted the practice to ensure the continuation of quality care for the community.

She played a key leadership role in establishing Rotorua's standalone after-hours accident and emergency and medical facility. Working alongside every general practitioner in the region, she helped coordinate the proposal that led to the opening of Lakes PrimeCare in 1993 in a purpose-built facility. Dr Sinclair served as Chair of Lakes PrimeCare until 2007.

She also served on the Independent Practitioner Association Rotorua Area Primary Health Services Limited board from 2000 to 2019, including seven years as Chair. During this time, she represented the organisation in primary health contract negotiations with regional and local district health boards. While serving on the board she helped establish a scholarship programme supporting local school leavers to attend medical or nursing school.

As Chair she also oversaw the establishment of community-based nursing and pharmacy outreach services to support patients with vulnerable needs. These services were later consolidated into the Koiora Community Hub, which now supports thousands of patients and received the New Zealand Pharmacy Professional Service of the Year award in 2017.

The College congratulates Professor Lawton, Dr Pinfold and Dr Sinclair on this well-deserved recognition of their contributions to improving health and wellbeing across Aotearoa New Zealand.

ADHD in Adults

What's changing – your role, your options, your support

HealthPathways Education

Dr David Codyre, Psychiatrist and Clinical Director, Mental Health, Tamaki Health and **Dr Prabani Wood**, College Medical Director, alongside **Dr Justine Lancaster**, National Clinical Lead, Community Care Pathways, Health New Zealand provide a practical and relevant discussion on the changing processes to diagnose and manage ADHD in adults in Aotearoa.

The ADHD in Adults pathway has been aligned nationally across HealthPathways in New Zealand. While the clinical guidance is consistent across the country, check your local pathway for links to local providers, resources, and access criteria to services.

Legislative changes from **Sunday 1 February 2026** mean clinicians who meet competency expectations can now diagnose ADHD in adults (18 years and older):

- Initiation of stimulant prescribing is legally restricted to vocationally registered GPs (RNZCGP), psychiatrists, paediatricians and nurse practitioners with a scope endorsement.
- Non–vocationally registered GPs cannot initiate stimulants; however, they may prescribe on an ongoing basis once a vocationally registered GP, nurse practitioner (with scope endorsement) or psychiatrist initiates.

The key take-home messages are:

- ADHD treatment can be life transforming if done well, but treatment is not without risks. Diagnosis and prescribing require rigorous assessment and management standards.
- Competency expectations are outlined in the NZ Clinical Principles Framework for ADHD, which is linked from the ADHD in Adults pathway, alongside links to training options, ADHD provider directories, and other resources.
- A good ADHD diagnosis is structured, holistic, and history-based and supported (not replaced) by validated rating scales such as ASRS, WURS-25, NICHQ Vanderbilt Child Assessment – Parent Informant, school reports, and WHODAS-12. See the pathway for links.
- When initiating stimulant treatment following a diagnostic assessment by another practitioner, the prescriber needs to feel confident in both the competence of the other practitioner and in their own level of expertise. Medication choice and titration are individualised. Stimulants are first-line and effective for most patients, but brand responsiveness varies, and titration requires careful stepwise adjustment. When switching, match pharmacodynamic profiles, step down a dose, and re-titrate.
- Non-pharmacological treatments aim to minimise the daily impact of ADHD symptoms and associated difficulties. These include psychoeducation, addressing comorbidities and risk, and linking patients to non-pharmacological supports (CBT, mindfulness, lifestyle interventions).
- Consider using your health improvement practitioners (HIPs) to support assessment and management in general practice.
- The College offers a portal of endorsed education resources and courses and will support special interest groups.

Submit your feedback

Dr David Codyre provided more details on assessment and medications, including dose and titration. The question-and-answer section provided very useful context.

We encourage you to listen to the recording **here**.

You will also find the recording in the Information section, under 'For health professionals', at the bottom of the ADHD in Adults pathway. If you are new to HealthPathways, **sign up for your local site**.

HealthPathways Education is hosted by Streamliners in partnership with Health New Zealand | Te Whatu Ora. This session was also supported by The Royal New Zealand College of General Practitioners.

Goodfellow Unit podcast: **Older adults and medication management**

Professor Ngaire Kerse (MNZM) is a leading New Zealand medical academic and general practitioner specialising in the health and well-being of older people. As of 2026, she continues to serve as the Joyce Cook Chair in Ageing Well and is a Professor of General Practice and Primary Health Care at the University of Auckland.

In this podcast, Professor Ngaire Kerse talks about the challenges of managing multimorbidity and medication complexity in older adults. She discusses the definitions of multimorbidity, the vulnerabilities of older adults to medication issues, and the importance of regular medication reviews, with emphasis on appropriate prescribing and the role of health care professionals in supporting older adults in their medication management.

The conversation also covers specific medications like statins and aspirin, the management of hypertension, the risks associated with anticholinergic medications, and the need for equitable medication management for Māori and Pacific populations.

The key take-home messages of this podcast are:

- Ask about the pills, falls and incontinence.
- Encourage people to understand their own medication.
- As a minimum, review medications annually.
- What can be tapered off? What's not there that could be there?

Listen to the podcast

Asthma care that works for practices

What we're learning from quality improvement in Taranaki

Pinnacle Midlands Health Network

Small, practical system changes can make a meaningful difference in asthma care. Over the past two years, Pinnacle has shifted from pay-for-performance to a quality improvement programme (QIP), with a strong early focus and uptake on respiratory health – particularly asthma – in Taranaki.

Why we changed

The shift was driven by what Pinnacle was seeing on the ground. Target-based incentives can unintentionally disadvantage practices serving communities with the greatest barriers to care.

"Pay-for-performance didn't reduce inequities. It can pull money away from high-need communities because the teams facing the greatest barriers to care are least likely to hit targets. We needed an approach that supports system change, not just target chasing," says Pinnacle clinical director, Dr Jo Scott-Jones.

Rather than paying only for target achievement, Pinnacle's quality improvement programme provides a capacity payment based on enrolled service users (ESUs) supported by dashboards, practice-level data, resources, education and tools, and the flexibility for practices to choose improvement areas that fit their context.

Why asthma and Taranaki?

Asthma is a natural focus because it's common, clinically significant and measurable. In rural settings like Taranaki, better long-term control can also ease pressure on urgent care and hospital services and reduce disruption for whānau.

Jessica Knight, Pinnacle nurse lead in Taranaki, says the focus resonated locally. "In Taranaki, asthma control isn't just a guideline issue; it also affects urgent care demand, travel, and how stretched teams are day to day. Practices could see this as a practical way to make a real difference," she said.

What we focused on improving, and what helped change stick

Practices focused on practical, measurable indicators of safer and more effective asthma care – reducing SABA use without ICS and supporting ICS use following asthma admission.

This work is primarily tracked through process measures. "We're not overclaiming network-wide outcomes yet, but these indicators align with safer, more effective asthma management and long-term control," says Jo.

A key shift was moving away from 'GP-only' change. The work was most effective as a whole-of-team approach with GPs, nurses (including nurse prescribers and

One practice's year 1 shift (Taranaki, anonymised)

A Taranaki practice used Pinnacle's respiratory dashboard to identify patients receiving SABA without preventer therapy, then stratified the list by ethnicity and risk to prioritise follow-up. Nurses led proactive patient recalls, supported by GP oversight, with medication reviews and asthma action plan updates built into the process.

Over year 1, SABA-only patients reduced from 71 to 14, including an estimated 50 percent reduction among Māori patients. The team also strengthened recall systems and established a regular review rhythm, helping preventative care become routine rather than reactive. The practice credits the results to making the work visible (through data), manageable (through templates and workflows), and shared across the team, so improvements could be sustained.

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nurse practitioners), kaiāwhina and admin staff, supported by simple workflow changes and a shared improvement focus.

QIP was designed to align with the College's Cornerstone CQI module. Having usable data and practical support can reduce duplication and make CQI more achievable for busy teams, which matters for building Cornerstone-accredited teaching practices.

The training partnership with Asthma New Zealand

Katie Faaiuaso, nurse lead at Asthma NZ, says local delivery reduces barriers for rural teams and creates a safe space for shared learning and peer support that's hard to replicate online.

Through the partnership, Asthma NZ delivered locally facilitated, kanohi ki te kanohi (face-to-face) respiratory education sessions in Taranaki, tailored to general practice teams and focused on practical, evidence-based asthma and COPD management.

The training strengthened team confidence and capability. "Teams were better equipped to teach correct inhaler technique, proactively implement asthma action plans, and identify patients needing review earlier," said Jessica.

Where to next

Asthma is one part of a wider quality improvement programme, but it shows what's possible when improvement is practical, team-based and supported. The aim is to help practices deliver consistent high-quality asthma care, reduce inequities and sustain change over time, with a fair approach that doesn't disadvantage high-need communities.

Next steps in Taranaki include COPD training and a three-month respiratory push (April–June) aligned with Respiratory POAC funding. This includes templates and practice resources, and funded consults so high-risk patients can be seen free of charge, strengthening equity for those most affected.

Asthma NZ also plans to continue the partnership with Pinnacle by repeating and scaling the locally delivered training model, alongside ongoing support, networking and regular sharing of best practice.

WEBINAR

A Shared Digital Health Record for Aotearoa

Health Informatics New Zealand hosted a webinar exploring the new shared digital health record, which is currently in pilot and going live in mid-2026. The webinar provided an update on the pilot with early adopter practices and explained what the changes mean for general practice.

View the webinar recording.

Treatment of very small papillary thyroid cancers

Dr Francis Hall

What is papillary thyroid microcarcinoma?

Papillary thyroid microcarcinoma (PTMC) is defined as a papillary thyroid carcinoma less than or equal to 10 mm in size.

What is the natural history of PTMC?

The prognosis for PTMC is very good.

How is PTMC diagnosed?

PTMC is usually asymptomatic. It is usually detected initially on an ultrasound scan of the thyroid, which may lead to an ultrasound-guided FNA of a suspicious-looking thyroid nodule. Sometimes it is detected incidentally when other imaging is requested. Patients sometimes have their initial studies overseas and then may seek medical advice when they return to New Zealand.

How is PTMC treated?

First, it is important to exclude any adverse features – extrathyroidal extension or lymph node metastases – with an ultrasound scan of the neck; although uncommon, this sometimes does occur.

There are three ways of treating PTMC: Active surveillance, surgery or ultrasound-guided ablation, and each method has its pros and cons.

What is active surveillance?

Active surveillance involves performing regular ultrasound scans of the thyroid and the neck, initially every six months and then every year to detect any significant growth (>3mm) of the PTMC or lymph node involvement. The purpose of active surveillance is not to prevent progression but to prevent unfavourable events associated with tumour progression. If the tumour progresses, then the patient is offered either surgery or radiofrequency ablation (RFA). It is also important that patients who opt for active surveillance are motivated to avoid intervention and to have annual ultrasounds. They need to accept that they have a small cancer, and although there is a small chance of progression of their cancer, they are very unlikely to come to any serious harm.

Which patients are suitable for active surveillance?

The ideal patients for active surveillance of PTMC are patients over the age of 60 years (as their tumours have the lowest rates of growth) and with tumours that are not abutting the trachea, the common carotid artery or the recurrent laryngeal nerve (RLN). Patients with PTMC adjacent to the trachea or RLN and patients with nodal metastasis are not suitable for active surveillance. Ito observed that patients younger than 40 years had a progression rate of 8.9%, whereas it was 3.5% in patients between 40 and 60 years, and 1.6% in patients older than 60 years.

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 general practitioners.

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Tuttle et al. found that individuals diagnosed under 50 years of age had a nearly fivefold higher risk of tumour progression than individuals age 50 years or older (27.3% vs 4.6% at five years).

The 2025 American Thyroid Association guidelines for the management of differentiated thyroid carcinoma states that, "Active surveillance may be offered as an appropriate management option for some patients with cT1aN0M0 PTCs (PTMC)".

What is the evidence for active surveillance?

Ito reported on 3222 carefully selected patients with PTMC managed with active surveillance at Kuma Hospital. He showed that 6.6% had tumour progression, 1.6% had cervical node metastases and one patient had distant metastasis by 20 years. No patients died of PTMC.

Which patients with PTMC are better treated with surgery?

Patients with PTMC with any of the contraindications for active surveillance: age <20, nodal metastases, tumour adjacent the recurrent laryngeal nerve or tumour abutting the trachea along a broad front are good candidates for surgery. Usually, a hemithyroidectomy is appropriate. Radioactive iodine is usually not required unless there is significant lymph node involvement.

What about radiofrequency ablation for PTMC?

The 2025 American Thyroid Association guidelines for the management of differentiated thyroid carcinoma states that, "ultrasound-guided percutaneous ablation (RFA) may be considered as an alternative to active surveillance or resection (surgery) for cT1aN0M0 PTC in selected patients".

In 2025 Jeong, et al. reported on 65 patients with PTMC treated with RFA and followed for a median of 10 years. He noted no local, nodal or distant recurrences. Five (8%) patients developed new primaries, four of which were treated with RFA and one treated with surgery.

Cho, et al. in a meta-analysis of five-year follow-up results of thermal ablation for low-risk PTMC, reported there was no local tumour recurrence, lymph node metastasis, distant metastasis, or conversion surgery in 207 patients with PTMC.

Summary

PTMC has an excellent prognosis. Active surveillance, surgery or radiofrequency ablation are all approved treatment options, with the choice of treatment depending on the clinical situation.

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Suite of new sepsis pathways published for primary care

Sepsis Trust NZ

New pre-hospital sepsis pathways have now been published to support earlier recognition and treatment of sepsis in the community. General practices are being encouraged to familiarise themselves with the new suite of tools, available on the **Health Quality & Safety Commission Te Tāhū Hauora (the Commission) website**.

The Commission worked in partnership with Sepsis Trust NZ, HealthPathways and the national multidisciplinary Sepsis Technical Advisory Group to update the pre-hospital community sepsis pathways.

These tools are designed to support health professionals working in community and pre-hospital settings to recognise sepsis early and initiate timely management. They sit alongside the sepsis pathways for use in hospital settings.

The new pre-hospital pathways provide clear, standardised guidance to help identify suspected sepsis, initiate time-critical care, and ensure rapid escalation to emergency departments. They align with national sepsis principles and reinforce the importance of early antibiotics, fluid resuscitation, and clear clinical handover.

For GPs, the pathways are particularly relevant as 80% of sepsis cases start in the community, with patients often first presenting to general practice, after-hours services, or being referred to ambulance care. Improved alignment between primary care and pre-hospital services aims to reduce delays, strengthen communication, and support continuity of care once patients transition to hospital.

Clinicians are encouraged to continue maintaining a high index of suspicion for sepsis, especially in older adults, Māori and Pacific Peoples, those with comorbidities, and patients with recent infections or deterioration. Early referral and clear documentation of sepsis concern will help ensure the pathways are activated promptly.

General practices are being advised to ensure their medical and nursing staff are aware of, and have easy access to the new pathways, with Sepsis Trust NZ also available to offer further educational opportunities.

Sepsis Trust CEO Ally Hossain says the updated pre-hospital pathways mark an important step toward more consistent, equitable sepsis care across the health system, reinforcing that early recognition in the community saves lives.

"We know the majority of sepsis cases start in the community, so early recognition in primary care is critical.

"By strengthening how primary care, ambulance services and hospitals work together, these pathways support faster treatment, clearer communication and better outcomes for patients across Aotearoa – particularly for those most at risk.

"We are grateful to everyone involved in the Sepsis Technical Advisory Group, for their commitment and mahi," she says.

For more information about sepsis, or to access other clinical tools and learning opportunities, please visit www.sepsis.org.nz

You can view the resources here:

Pre-hospital community sepsis pathways

In-hospital sepsis pathways

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