GP Voice

YOUR NEWS, YOUR VIEWS, YOUR VOICES

Fellowship and Awards ceremony 2026

Congratulations to the College's newest Fellows and award recipients

Helping families find their way
Dr Yvonne Lefort ONZM

General practice on the global field
Prof Marc Shaw MNZM

Medicine is a balance between science and art
Dr Shanthi Selvakumar

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

August 2026

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Dr Luke Bradford
College President

Kia ora koutou,

I'd like to first take a moment to reflect on GP26: Conference for General Practice, which took place in Tāmaki Makaurau Auckland from 30 July to 1 August.

This is an important date in the College calendar, and this year was no exception.

Thank you to all of the members who took the time to attend, and to the College team and Conference Innovators who worked tirelessly to pull this event together – it is no small feat.

Thank you also to all our members who chaired sessions, presented sessions, ran workshops, attended the AGM or contributed to the conference. Your expertise and knowledge provided delegates with an opportunity to learn more about everything from chronic disease management, adult ADHD care and culturally safe care to menopause, contraception, care for our ageing population and everything in between. We were glad to see 123 members attend our second annual pre-conference CME Day where practical skills and knowledge was shared and can now be taken back to practices around the motu.

Our Fellowship and Awards ceremony was another highlight for me. Being able to personally congratulate our 130 new Fellows, award recipients and our newest Honorary Fellow of the College was a great way to end the weekend.

For those who attended, I hope you enjoyed yourselves and took the opportunity to network and connect with new and familiar faces and came away with a renewed sense of pride and optimism for the future of general practice and rural hospital medicine. There is a lot of work to be done, but I hope you can see we are on the right path and gaining traction in our advocacy.

Also in this issue, we acknowledge our members who were recognised in the 2026 King's Birthday Honours List and highlight their achievements for our profession and the patients and communities they serve.

You can also read more news and updates from across the sector and find out more about the ongoing work and advocacy happening within the College. We'll have more stories to share with you from GP26 in the October issue of *GP Voice*.

Enjoy this issue,

Submit your feedback

Equity at the College

Sarah Herbert
Tumuaki Māori and Head of Equity and Advocacy

Sarah Herbert
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Head of Equity and Advocacy

Tēnā koutou katoa,

Honouring Te Tiriti o Waitangi, advancing hauora Māori, and enabling Māori leadership and partnership remain central priorities under our Rautaki Māori. Alongside this, the College's Equity pou focuses on achieving health equity for Pacific Peoples, tangata whenua and rural communities through education, culturally responsive member activities, workforce support, cultural safety, advocacy and system-level change. This year, the College has continued to progress practical initiatives that strengthen culturally responsive general practice in Aotearoa and support the future Māori, Pacific Peoples and rural medical workforces.

We began the year with the Hauora Māori Noho Marae for GPEP year 1 registrars, delivered in partnership by our Learning and Equity teams. The noho gave registrars the opportunity to experience tikanga and mātauranga Māori in a marae setting, including pōwhiri (formal welcome), hākari (sharing of a meal) and poroporoaki (farewell). Registrars, lead medical educators and kaimahi undertook wānanga together on hauora Māori, Māori models of health, equity and cultural safety, and considered how these learnings apply to future practice. The contribution of Iwi Māori Partnership Board representatives and hauora Māori leaders grounded the experience in local hauora aspirations and reinforced the connection between health, whakapapa, whenua, whānau, hapū and iwi.

Looking ahead, Whakaharatau will be held in September. This annual kaupapa Māori mock clinical exam supports Māori and Pacific registrars in a culturally responsive, exam-like environment where they receive constructive feedback from Māori and Pacific Fellows serving as examiners. It provides targeted registrar support while also contributing to the future Māori and Pacific medical educator pipeline.

The College has also strengthened Pacific workforce activity through supporting Pacific Health Day 2026 and the Health New Zealand Pacific Medical Workforce Pilot Funding. Pacific Health Day, planned and delivered with the Pacific Chapter, celebrated a decade of Pacific health leadership and brought together Pacific leaders, medical students, registrars, academics, College representatives and community members. The pilot funding supports Pacific registrars, medical students and educators through scholarships, tautai funding, exam preparation support and targeted medical educator funding. These initiatives respond to pressures experienced by Pacific registrars during training and help build connection, sustainability and leadership across the Pacific medical workforce.

These kaupapa sit within a broader programme of Rautaki Māori and equity work across the College. This includes regular engagement with Te Akoranga a Māui, monthly reporting and Summit Hui with Tokorima (Te Akoranga a Māui executive), support for Pacific Chapter–led initiatives, workforce insights, equity reporting, and advocacy that reflects the needs and aspirations of Māori, Pacific and rural communities. A recent rural equity example is the establishment of a Pou Whirinaki Māori for the Division of Rural Hospital Medicine for an initial 12-month period, strengthening Māori advisory and support capacity within rural hospital medicine training.

Together, this work demonstrates the College's commitment to Te Tiriti o Waitangi, equity, cultural safety and workforce development. It also reinforces that sustained change is built through trusted relationships with Te Akoranga a Māui, the Pacific Chapter, mana whenua, registrars, Fellows, educators, kaimahi and communities. Ngā mihi nui to everyone who has contributed to this work. It reflects the collective commitment, expertise and relationships needed to advance Te Tiriti o Waitangi, equity and culturally safe general practice across Aotearoa.

Sarah

The importance of research: Applications for funding open now

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 consultation 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. Applicants don't need to be a member of the College, or a doctor, to apply. Projects just need to be practical, practice- or rural hospital–focused and grounded in clinical work.

The final funding round for 2026 opened on Wednesday 5 August and will close on Wednesday 16 September. Whether you're interested in workforce, wellbeing, equity, rural health, new models of care or improving patient outcomes, funding is available to help you with your research project.

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

College advocacy: Months in review

June and July

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

Privacy Commissioner's report on Manage my Health data breach

The Privacy Commissioner released his final inquiry report into the cybersecurity breach that impacted the Manage My Health (MMH) portal. This was phase 1 of the inquiry and focused on what caused the breach and who was accountable.

The College, with support from MPS, provided feedback into this inquiry focusing on, for example, the limitations that GP practices have when it comes to choosing a patient portal. The concerns raised by the College were listened to and as a result there were a number of adjustments made to the Commissioner's recommendations in the report, including:

- GP practices are generally small businesses with little or no market power to require IT system or service vendors to have appropriate security
- Contracts [with service vendors] are often 'take it or leave it' contracts
- GP practices are not funded to employ security or contract specialists to check documentation or advise them on whether vendors are meeting their obligations.

Read the College's feedback into the inquiry report, and the final reports from the **Privacy Commissioner** and **Health New Zealand | Te Whatu Ora**.

Dr Bradford spoke on Radio New Zealand's *Morning Report* and *NZ Doctor* on this topic.

Response to MCNZ leadership changes

The College **issued a statement responding to the MCNZ leadership changes**. The statement supported MCNZ's statutory responsibility to set standards of clinical and cultural competence and ethical conduct for doctors and highlighted that their independence as a regulator is fundamental to public trust, patient safety and the integrity of our medical standards. As a member of the Council of Medical Colleges (CMC) we also supported **their statement**.

NZ Doctor published our response as part of their coverage on the topic.

Foundation Standard review project

The Foundation Standard review survey closed in mid-June and had over 400 responses. The survey is part of the overall review that is focusing on improving

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clarity and usability, reducing unnecessary burden and duplication and maintaining baseline quality and safety.

Physician associate regulation: Consultation decision and new consultation

MCNZ published its decisions following the consultation on the proposed framework for the regulation of physician associates (PAs). The decision confirmed the scopes of practice, prescribed qualifications and the supervision framework that will apply to PAs seeking registration in New Zealand. Read the College's feedback to this consultation.

MCNZ then consulted on the draft Professional Standards for PAs which set out the principles, values and professional expectation for PAs working in New Zealand. The College also provided feedback to this consultation.

Stakeholder engagement

Dr Luke Bradford

- Travelled to Nelson: visited five practices, an after-hours, a PHO and attended a social evening with local GPs
- CMC meeting
- Medical Advisory Board meeting
- ACC meeting (cost of treatment regulations and e-Script)
- HQSC workshop – shaping primary care quality and safety priorities
- Rural generalism meetings with Te Whatu Ora
- GPLF hui.

Dr Prabani Wood

- Meeting to discuss Palliative Care
- Meetings on Specific Interest Groups (SIGs)
- Clinical Leaders Group meeting
- Meeting with Pharmac on HIV treatment
- Meeting with Paramedic Council on paramedic prescribing
- Meetings on PSA monitoring tests post-treatment for prostate cancer
- Filming for Women's Hub 'women's health' videos with Te Whatu Ora and Ministry for Women
- Meetings with ASMS on HPCAA
- Monthly RDSS Steering Group meeting
- Meeting with Office of the Privacy Commission and MPS
- National Quality Forum
- Meeting with NZTA to discuss next steps regarding the University of Auckland's research into cognitive testing
- Quarterly ACC meeting.

Submissions

- MCNZ: Consultation on Draft Professional Standards for Physician Associates
- Ministry of Health: Consultation on developing a specified prescription medicines list for designated paramedic prescribers

- Social Services and Community Committee: The College supported the CMC submission on Legislation (Definitions of a Woman and Man) Amendment Bill.
- Pharmac: Review of the Exceptional Circumstances Framework

More media and advocacy

- Funding uplift for general practice | Dr Luke Bradford | *Stuff*
- Tamaki Health's new unregulated role – Health Care Technicians | Dr Luke Bradford | *Radio NZ Nine to Noon*
- ACT party welfare policy announcement | Dr Luke Bradford | *NZ Doctor* and *Stuff*
- GPL1 use in New Zealand and run on effects for consumer practices at the supermarket | Dr Luke Bradford | *One News*
- Patient data safety (MMH) and Privacy Commissioner's call to overhaul existing legislation | Dr Luke Bradford | *Pharmacy Today*
- Workforce shortages and relocating patients from Hawke's Bay practice | Dr Luke Bradford | *Hawke's Bay Today*
- Use of counterfeit peptides (retatrutide) and patients reporting side effects | Dr Luke Bradford | *Herald Now*
- GP referrals for hospital specialists and wait times | Dr Luke Bradford | *Stuff*
- Regular column: Why the distinction matters: Recognising the value of specialist GPs | Dr Prabani Wood and Professor Dee Mangin | *NZ Doctor*
- Regular column: GP26 | Dr Luke Bradford | *NZ Doctor*

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. Collagen supplements
2. Understanding the determinants of health for Māori living with chronic disease in Aotearoa New Zealand
3. Using AI scribes in New Zealand primary care consultations: an exploratory survey
4. Trends in psychological distress: analysis of NZ health survey data (2011–2023)
5. Pacific people in Aotearoa New Zealand and the treatment of long-term conditions: a narrative literature review about Pacific people's understandings of health and wellbeing

A day to pause

Mindfulness and wellbeing for Waikato/Bay of Plenty GPs

Dr Alison Fawdry
Chair of Waikato/Bay of Plenty Faculty

One of the Waikato/Bay of Plenty Faculty's strategic aims is to support and sustain our members throughout their careers. In a profession where we spend our days caring for others, it can be easy to overlook our own wellbeing. Earlier this year, we were delighted to offer a Mindfulness and Wellbeing Retreat designed specifically for GPs.

The retreat had been almost a year in the planning. Our original date was unfortunately postponed due to one of the many summer rainstorms that swept through the Bay of Plenty, but the wait proved worthwhile. The event was eventually held in a beautiful lodge nestled in the Papamoa Hills, providing a peaceful setting away from consulting rooms, inboxes, results and the many demands of modern general practice.

Around 24 GPs attended the day, taking time to focus on themselves rather than caring for others. The programme was led by experienced mindfulness practitioner John Fletcher, who curated a thoughtful and varied day of activities designed to help busy minds slow down and reconnect with the present moment.

One aspect of the retreat that many participants found surprisingly challenging was John's invitation for us to spend most of the day in silence. As GPs, we are rarely short of words, and Faculty events often provide a valued opportunity to reconnect with friends and colleagues and share stories from our professional lives. However, John deliberately encouraged silence to help us remain present and to prevent the usual pressures and conversations about work from intruding on the day. We were given permission to gently converse over lunch, with the lighthearted suggestion that we try, where possible, to avoid 'talking shop'. While not always easy, many participants came to appreciate how the quiet created space for reflection, awareness and a deeper engagement with both the activities and the beautiful surroundings.

The day began with a gentle yoga session led by Dr Beena Hegde. Beena works in youth health services in Lower Hutt and understands first-hand the pressures and emotional demands that many doctors experience. Her calm and grounded approach helped participants ease into the day and begin letting go of the constant mental activity that often accompanies our work.

Throughout the day, participants explored a range of mindfulness practices. Diego Rosenberg, who blends Eastern and Western approaches to health and wellbeing, led a more energetic movement session that had us stepping well outside our comfort zones, showing off our 'power moves' and occasionally finding our voices in ways not often seen at a GP gathering.

One of the more challenging exercises involved moving mindfully through the stunning grounds of the lodge, simply observing the environment and paying

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attention to the experience of walking. For many of us, this proved surprisingly difficult. As doctors, we are accustomed to moving quickly from one task to the next, often planning several steps ahead. Slowing down and simply noticing required a different kind of discipline.

Perhaps the most physically memorable activity was the combination of a cold plunge followed by a hot sauna. While there was some initial hesitation, the majority of participants embraced the challenge and emerged feeling invigorated, energised and perhaps a little proud of themselves.

The day was complemented by exceptional food prepared with great aroha by Ana Jamio, originally from the Philippines. Sharing nourishing meals contributed to the sense of care, community and restoration that characterised the retreat.

While mindfulness is sometimes dismissed as simply a wellness trend, there is now a substantial body of evidence supporting its role in improving mental wellbeing. Research has demonstrated that structured mindfulness practices can reduce perceived stress, improve emotional regulation, lessen symptoms of anxiety and help prevent relapse in people with recurrent depression. Importantly, mindfulness does not eliminate the pressures of life or medical practice. Rather, it helps us develop a different relationship with stress and challenge, enabling us to respond with greater awareness, clarity and self-compassion.

For doctors working in increasingly complex and demanding environments, these skills have real value. They can help us remain present with our patients, recognise our own limits, and cultivate resilience in the face of uncertainty and change.

One participant reflected that they had taken away “centring thoughts on the present and appreciating the small moments that make up life as a whole” and intended to continue practising these concepts. This feedback beautifully captured the essence of the day.

My hope is that those who attended left feeling nourished, restored and better equipped to care not only for their patients, but also for themselves. I am equally hopeful that we can offer similar events in the future so that more of our Waikato/Bay of Plenty colleagues can experience time away from the busyness of professional life and gain practical skills that support their wellbeing.

If the Faculty is to achieve its goal of sustaining our members, we must continue to create opportunities that foster reflection, renewal, and meaningful connection. This retreat was one small step in that journey, and I hope it is the first of many.

Our new community platform is live for all Faculties and Chapters

Take me to the new online community

View our ‘getting started guide’ for tips on how to use the platform

Building confidence before exam day

Each year, the College supports GPEP year 1 registrars through the written and clinical mock examinations, offering a valuable chance to experience the exam format, reflect on progress so far and build confidence ahead of the final exams later in the year.

This year, registrars sat the written mock exam in mid-July. Completed online during regional seminar days, the mock exam provides an opportunity to practise under exam-style conditions, while also helping registrars understand where they are tracking before the traditional written exam later in the year.

Registrars also took part in the clinical mock exams at the beginning of August. These sessions give registrars the opportunity to work through three clinical examination cases and receive supportive feedback from educators and peers.

Behind the scenes, a great deal of preparation goes into making the mock exams run smoothly. From planning the timetable and confirming logistics to ensuring everyone has the right resources on the day, the process is a real team effort.

Our lead medical educators, medical educators and GPEP year 1 teachers play an important role in bringing the exams to life, running the sessions and providing thoughtful, practical feedback to support registrars' learning. They are joined by College staff who help coordinate the many moving parts in the lead-up to and on exam days.

Well done to all GPEP year 1 registrars who have taken part in this year's mock exams, and best of luck to those still preparing for their upcoming exams. We hope the experience provides useful insight, reassurance and momentum as you continue working towards the final exams later this year.

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Toiora 2026

New Zealand Medical Students' Association's annual conference

Left to right Luci Boldarin (Senior Education Coordinator), Caroline (sponsored delegate) and Abi Shepherd (Senior Education Support Advisor)

This June, the College was proud to head north to Tāmaki Makaurau for Toiora 2026, the New Zealand Medical Students' Association's annual conference, held from 5 to 7 June. More than 200 medical students from across Aotearoa gathered under the kaupapa of *toiora* – flourishing – for three days of learning, connection and inspiration, grounded in the Te Pae Mahutonga model of hauora.

For us, it was a chance to meet the future of the profession where they are. Our team hosted a trade stand across the weekend, talking one-on-one with medical students curious about a career in general practice and rural hospital medicine, and – we hope – planting a few seeds. We were also delighted to sponsor a student's place at the conference, covering the full cost of their attendance so that opportunity wasn't a barrier.

We asked our sponsored delegate Caroline to share what the weekend meant to her. Here is what she had to say:

> "Toiora 2026 was an inspiring blend of innovative ideas, lived experiences, practical advice, and honest reflections on the realities of becoming a doctor in Aotearoa New Zealand.
>
> My biggest takeaway from the conference was the power of vulnerability. Being open about our fears, mistakes, challenges and experiences creates space for others to do the same. This openness fosters genuine connection and allows people to learn from one another's journeys.
>
> The theme of vulnerability was evident throughout the conference. I heard it in Dr Timoti's reflections on his personal and professional

journey. I saw it in the story of a woman's preterm birth, which inspired the development of the Carosika Collaborative and its work to improve preterm birth outcomes and equity for whānau across Aotearoa. I also recognised it in the political discussions, where speakers openly shared differing viewpoints to encourage conversation, challenge perspectives, and create space for respectful disagreement. These experiences demonstrated how honest conversations can be a catalyst for learning, connection and meaningful change.

Reflecting on the conference theme of Toiora, I left with the belief that vulnerability is fundamental to both wellbeing and flourishing. Through the stories, discussions and perspectives shared throughout the conference, I was reminded that improving health outcomes requires understanding the diverse experiences and needs of the communities we serve. This reinforced the importance of culturally safe and equitable health care.

The conference also highlighted the value of building trusting relationships and understanding the broader contexts that shape health. These principles resonate strongly with general practice and will continue to guide my development as a future doctor.

I am grateful to The Royal New Zealand College of General Practitioners for sponsoring my attendance at Toiora 2026. Their support enabled me to participate in an experience that challenged my thinking, broadened my perspectives, and strengthened my commitment to becoming a compassionate, reflective and culturally responsive doctor."

GP26: Reflecting on the horizon

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.

And just like that, GP26 has drawn to a close. From 30 July to 1 August, 873 delegates came together at the New Zealand International Convention Centre in Tāmaki Makaurau Auckland for three days of learning, connection, reflection and plenty of good kōrero.

This year's theme, inspired by Matariki, gave the conference a thoughtful and deeply relevant frame. It invited us to look back and acknowledge the journey of where general practice has come from and those who have shaped it, while also looking ahead to the kind of future we want to help build for our patients, our whānau and our communities.

The programme began on Thursday with the pre-conference CME Workshop Day, giving members a practical, hands-on start before the main programme opened on Friday. From there, the conversation ranged widely. Artificial intelligence and digital tools were explored – not as shiny new add-ons, but as very real questions for the future of general practice: how do we work smarter, support our teams and make space for innovation, while holding on to the relationships that sit at the heart of good primary care?

Sessions on multidisciplinary care, mātauranga Māori and primary care brought that same balance of curiosity and groundedness. They reminded us that the future of care cannot simply be more digital, more efficient or more complex – it also needs to be equitable, sustainable and shaped by the aspirations of the communities we serve.

The speaker line-up brought energy, challenge and depth to the programme. Delegates heard from Dr Michael Wright, Dr Nina Bevin, Professor Dee Mangin, Dr Luke Bradford (College President), Dr Mark O'Brien, and College CE Toby Beaglehole on the future of general practice in their panel discussion. Dr Prabani Wood presented on the changing nature of what it means to be a specialist GP in her session 'recognising vocational training and evolving the GP consultant role'. Dr Paea Tonga and Dr Karlina Tongotea joined Julian Wilcox for a fireside chat about their reflections on the journey and road ahead as the next generation of GPs.

We heard from two keynote speakers, Paddy Gower and Sir Ashley Bloomfield, as well as the Minister for Health, Simeon Brown. Together, all these plenary speakers offered a mix of big-picture thinking, practical insight and honest reflection on the realities facing general practice today.

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Of course, conferences are never only about what happens on stage. For many, the real value of GP26 was also found in the conversations between sessions, the reconnections over coffee, the new introductions, and the sense of being part of a wider professional community. That spirit of kotahitanga (unity) came through strongly: a shared belief that, together, we can keep working towards care that supports whānau, strengthens communities and contributes to Pae Ora (Healthy Futures) for all in Aotearoa New Zealand.

A heartfelt thank you to everyone who helped bring GP26 to life – our speakers, sponsors, exhibitors, volunteers, staff and, most importantly, every delegate who made the time to be there. Your presence, questions, stories and commitment are what make this community so strong.

Like Matariki rising on the horizon, we leave GP26 carrying both what has shaped us and what is still ahead. We hope delegates returned to their practices feeling connected, encouraged and ready for the mahi to come, and we look forward to welcoming you again next year.

GP26 was a chance to pause, reconnect and look ahead together. Grounded in the themes of Matariki, the conference brought together practical learning, bold conversations and a strong sense of shared purpose, reminding us that the future of general practice will be shaped not only by new tools and ideas, but by the relationships, communities and values that sit at the heart of primary care.

Fellowship and Awards 2026

Congratulations to the College's newest Fellows and award recipients who crossed the stage to be congratulated by College President Dr Luke Bradford at GP26: Conference for General Practice in Tāmaki Makaurau Auckland on Saturday 1 August.

Distinguished Fellowship

Dr Lorraine Brooking, Ngāti Porou, Ngāi Tūhoe

Associate Professor Susan Hawken

Dr Nathan Joseph, Ngati Kahungunu, Rangitane, Muaupoko, Ngai Tahu, Ngati Ranginui, Ngati Raukawa, Ngati Tuwharetoa and Ngati Maniapoto

Associate Professor Rawiri Keenan, Te Āti Awa, Taranaki

Dr Johan Peters

President's Service Medal

Dr Sophie Ball

Dr Bronwyn Campbell

Dr Rona Carroll

Dr Lucy Gibberd

Dr Sue Tutty

Community Service Medal

Dr Paul Cooper

Dr Sam Fuimaono

Dr Wikitoria Gillespie, Ngāti Kahungunu

Dr Claire Isham

Dr Stephen Kara, Tainui

Dr Reeta Lochan

Dr Bhavana Patel

Dr Neil Whittaker

Equity Award

Professor Bev Lawton, Ngāti Porou

Honorary Fellowship

Professor Paparaangi Reid, Te Rarawa

Eric Elder Memorial Medal

Dr Patrick McHugh

James Reid Award

Dr Matthew Born

Humphrey Rainey Prize for Excellence

Dr Niamh Hammond

Dr Amjad Hamid Memorial Medal

Dr Fiona King

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Peter Anyon Medal

Address given by Dr Paea Tonga

Orator's Gold Medal

Dr Sam Fuimaono

The Division of Rural Hospital Medicine (DRHM) Nikau Award

Sandra Suomikallio

New Fellows DRHM

Dr Joshua Andrew Coulter

Dr Anna Gray

Dr Meghan Elaine Ryall

Dr Rebecca Wire

New Fellow Dual Fellowship

Dr Isaac Carrejo-Campbell

Dr Ralston D'Souza

Dr Katie Smith

New Māori Fellows

Dr Molly Marie Anderson

Dr Tamara Birchall

Dr Elizabeth Bernice Byrnes

Dr Coll Campbell

Dr Jia Gan

Dr Jordan Bailey Gibbs

Dr Melissa Elizabeth Hassan

Dr Madelin Hobson

Dr Jade Elissa Hollis-Moffatt

Dr Ashleigh Lauren Ātaahua Kendall

Dr Derryn Jayne Kathy Manga

Dr Laine Rianne Ramari Marsh

Dr Hiria Nielsen

Dr Toni O'Regan

Dr Holly Shuja

New Pacific Fellows

Dr Esther Hausia-Fonua

Dr Ron Manulevu

Dr Hemisha Patel

Dr Celine Tekikina Louisa Sinclair

New Fellows

Dr Rozanna Abdul Latif

Dr Farah Alqes Mekhael

Dr Wiktoria Armstrong

Dr Jordan Leah Baldwin

Dr Melanie Bass

Dr Sarah Beetham

Dr Andrew Boyd

Dr Roza Brajkovich-Payne

Dr Megan Brew

Dr Anna Chodyra

Dr Revati Chopara

Dr Brooke Clarkson

Dr Dilip Das

Dr Lucas Doorakkers

Dr Mallika Podimenike Ekanayake

Dr Nazar Ali El Hassan

Dr Rita Flaherty Manulevu

Dr Nilakshi Fonseka

Dr Lulu Fu

Dr Bridget Gilmour

Dr Abhishekh Gotadki

Dr Lauren Summer Gowland

Dr Rosemary Clara Isobel Grant
Dr Steven Grimson
Dr Raya Habboosh
Dr Ayesha Haque
Dr Daniel Herbert
Dr Jessica Rose Hiess
Dr Michael Hutchinson
Dr Tahira Jokhio
Dr Hai Sue Kang
Dr Aung Kyaw
Dr Lira Lecias
Dr Gavin Gao-Xiang Lee
Dr Jean Lee
Dr John Lee
Dr Ee Ling Loo
Dr Nadhila Mazlan
Dr Sarah Jane McArthur
Dr Milica Milovanovic
Dr Sandy Mitchell
Dr Theresa Mittermeier Chia
Dr Manoj Mangesh MohiteDr Adrian Ng
Dr Ben Ng-Wai Shing
Dr Laudi Olijve
Dr Nick On
Dr Louise Parker
Dr Mamta Patel
Dr Welikadaarachchige Thilini Perera
Dr Jonathan Mark Phillips
Dr Cornelia Alice Pragassam
Dr Asha Geetanjali Prakash
Dr Mohini Puri
Dr Anna Maria Quirke
Dr Amy Hartley Rankin
Dr Tom Reynolds
Dr Jacob Peter Rollo
Dr Olof Rydin
Dr Saima Sadiq
Dr Karyn Schischka
Dr Sabine Schmid
Dr Gunpreet Singh Sethi
Dr Jaya Sharma
Dr Priyanka Sharma
Dr Natasha Stephanie Clare Smith-Jones
Dr Logitha Sritharan
Dr Michelle Louise Stewart
Dr Visakham Ann Sundgren
Dr Elysia Tan
Dr Julia Elizabeth Turnbull
Dr Asvini Vijayakumar
Dr Lisa Wain
Dr Laura Weekley
Dr Hayley Wilson
Dr Lynn Wong
Dr Georgia Rose Bell Yarrow

Please note: *These are the new Fellows who were present at the Fellowship and Awards ceremony in 2026. Congratulations also to our Fellows who were unable to attend this year's ceremony.*

Find your favourite moments from the ceremony through the link below

Fellowship and Awards Ceremony 2026


on and connection to the community I serve.

Helping families find their way

Dr Yvonne LeFort (FRNZCGP) on breastfeeding medicine, family care and listening to mothers.

Breastfeeding Medicine Association of Aotearoa's March event. Left to right, Dr Katie Fourie, Catherine Watson, Dr Yvonne LeFort and Dr Whitney Davis.

For more than 30 years, Dr Yvonne LeFort has sat alongside families through some of the most tender, tiring and life-changing moments of early parenthood. Her career has taken her from family medicine training in Canada to general practice in Aotearoa New Zealand, and eventually into a field she helped pioneer here: breastfeeding medicine.

Today, Yvonne is Medical Director of Milford Breastfeeding Clinic in Auckland, a Fellow of The Royal New Zealand College of General Practitioners, the Canadian College of Family Physicians and of the Academy of Breastfeeding Medicine, and Co-Chair and founding member of the Breastfeeding Medicine Association of Aotearoa. Recently, she was appointed an Officer of the New Zealand Order of Merit for services to breastfeeding medicine, recognition she hopes will also shine a light on the families, clinicians and advocates who have helped grow the field.

Her work has helped shape national and international understanding of breastfeeding care, particularly in the diagnosis and management of infant tongue-tie. But the story behind that work is very human. It begins not with a policy paper or a podium, but with her own experience as a new mother trying to breastfeed, looking for practical help, and discovering how hard it could be to find. We sat down with Yvonne and asked her to reflect on this journey.

What first drew you to breastfeeding medicine?

It really began at home, with my own babies. When I had my first child in New Zealand, I was determined to breastfeed, but when things became difficult, the only option I was offered was medication to stop my milk production and wean. I felt disappointed that my medical colleagues had little understanding

Dr Yvonne LeFort
ONZM, DFRNZCGP

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or practical appropriate advice for me, a vulnerable first-time mother. Four years later, after my second child was born in Canada, I had a different feeding challenge. This time, a lactation consultant was able to help, but my primary care doctor, although kind and sympathetic, didn't have any practical advice to offer beyond her own breastfeeding experience. That contrast stayed with me.

From there, bit by bit, my curiosity grew. I did some contract work with a doctor who founded a breastfeeding clinic and was gifted Dr Ruth Lawrence's *Breastfeeding: A Guide for the Medical Profession*. That book was a bit of a lightbulb moment. It helped me see that breastfeeding medicine was not just encouragement or 'keep going' advice. It was diagnosis, treatment, prescribing, investigation and clinical care – the sort of work GPs are trained to do.

What has kept you passionate about this work throughout your career?

The families, without question. Breastfeeding challenges can be exhausting, painful and emotionally overwhelming, especially when parents feel they have tried everything or are not being heard. Sometimes people come to me feeling very discouraged, and you can see the relief when someone takes the time to listen carefully, examine the baby, understand the feeding story and put the pieces together. It is challenging work, but it is incredibly rewarding when you can help someone reach their breastfeeding goals or simply help them feel that they are not failing.

Why is general practice such an important setting for breastfeeding medicine?

General practice is where we see the whole person, and often the whole whānau. We understand that feeding an infant does not happen in isolation. It sits alongside recovery from birth, mental health, culture, finances, family expectations and the practical realities of life at home. That makes general practice, or family medicine, an ideal backdrop for caring for the breastfeeding dyad. Early, skilled support can prevent problems from becoming more serious, whether that is damaged nipples, recurrent mastitis, faltering infant growth, painful breastfeeding or complexities of breastfeeding while requiring medical management of other conditions.

You've worked nationally and internationally in this field – what lessons do you think New Zealand general practice can teach the world?

New Zealand general practice has a real strength in its resourcefulness and its willingness to meet people where they are. GPs here often go the extra mile, whether that means thinking practically about cost, working closely with nurses and allied health colleagues, or taking the time to understand the different cultures and circumstances of the people in front of us. I think that whole-person, whānau-centred approach is something we do very well, and it has a lot to offer internationally.

What are the biggest changes you've seen in breastfeeding medicine over the years, and what challenges remain?

One of the biggest changes is that breastfeeding medicine no longer feels like such a lonely space in New Zealand. For years, I was one of very few doctors working in

International panel at the Breastfeeding Medicine Network of Australia and New Zealand (BMNANZ) in Sydney in May. Left to right, Dr Melody Jackson, Dr Anne Eglash, Dr Yvonne LeFort, Dr Elien Rouw, past president of the Academy of Breastfeeding Medicine, and Dr Marnie Rowan.

this area, travelling around the country to teach and support colleagues. Now, more doctors recognise it as a field that needs specific knowledge and skill, and there are published clinical protocols, a clear scope of practice and even board certification in breastfeeding medicine available to support your practice. The biggest challenge, though, is equity. Most breastfeeding medicine care still remains private, which means many families miss out. I would love to see breastfeeding medicine properly recognised and funded within our public health system. Those who are breastfeeding their infants deserve access to the best available evidence and care from all medical professionals when experiencing challenges.

What advice would you give GPs who want to develop a special interest while maintaining a broad general practice role?

I'd suggest starting small and finding others with the same interest. Upskilling is important, but so is having a community to learn with through peer review, case discussions, webinars or conferences. Groups like BMAA can be a helpful place to connect with colleagues, ask questions and find guidance on where to begin. A special interest doesn't have to replace broad general practice; it can grow alongside it and add real depth to the care you provide.

If you are uncertain as to where to start you can contact one of the Board members of BMAA by emailing **hello@bmaa.org.nz** for help. As we are a charitable foundation, we welcome any financial support you may wish to offer if unable to take a more active role at this time.

What are you most proud of in your career?

I am proud of helping to build a community of doctors interested in this field. For a long time, I felt a bit like a lone medical practitioner travelling around the country to teach, advise and reassure others that yes, this is real medicine, and yes, doctors have an important role to play. In 2017, with support from the College, I started a Breastfeeding Medicine Peer Review Group for GPs. From that grew the Breastfeeding Medicine Association of Aotearoa, formed in 2024 to

support equitable access to high-quality, evidence-based breastfeeding medical care. It has been wonderful to see doctor members now spread across the country and across different areas of medicine.

Receiving an ONZM is significant recognition – what does this honour mean to you?

It is very humbling. The real reward has always been hearing from families who have been able to continue breastfeeding because their problem was identified and treated. Those messages and conversations stay with you. I hope this honour brings more recognition to breastfeeding medicine itself, and to the need for families to have access to evidence-based medical care when breastfeeding is not going well. For me, it is about helping make that care visible, valued and easier to reach.

RECOGNITION OF LEARNING – LOG YOUR CPD

Goodfellow Unit podcast: **Familial hyperlipidaemia**

In this episode, cardiology researcher Dr Jocelyne Benatar and chemical pathologist Dr Cam Kyle bring their specialist expertise to a practical discussion on familial hyperlipidaemia (FH) and what it means for primary care.

Dr Benatar and Dr Kyle cover how to recognise FH in practice, confirm the diagnosis, and understand why standard cardiovascular risk algorithms are not designed to detect these patients.

The key take-home messages of this podcast are:

- FH is very common, underdiagnosed, and undertreated.
- Normal risk algorithms are not intended to pick up these patients – look at the pattern of cholesterol.
- Supplements are untested drugs; they are not safe.
- Gene testing is vital.
- Time is important – don't delay.

Listen to the podcast

General practice on the global field

An interview with Professor Marc Shaw (FRNZCGP) on travel medicine, humility, and seeing the world with care.

Professor Marc Shaw

FRNZCGP

For Professor Marc Shaw, travel medicine has never been only about vaccinations, malaria tablets or pre-departure checklists. It is, as he puts it, "general practice on the global field," a specialty shaped by culture, geography, history, safety, communication and care.

Over more than three decades, Marc has helped shape travel medicine in New Zealand, drawing on his experience as a GP, expedition doctor and lifelong traveller. As Medical Director of Worldwise, New Zealand's first travel health service, he has helped build a network of clinics supporting travellers before and after they head overseas, while also educating health professionals and contributing to international travel medicine research. His work has taken him from post-travel infectious disease surveillance and rabies research to humanitarian aid and remote expeditions, earning recognition from organisations including the Centers for Disease Control in Atlanta. It is a career shaped by curiosity, clinical leadership and a deep belief that travelling well means travelling with care.

Recently appointed a Member of the New Zealand Order of Merit, he sat down with us to talk about his reflections on the journeys, lessons and people that have shaped his career.

What first sparked your interest in travel medicine?

Marc says that it began with travel itself. In the late 1970s, after working as a house surgeon at Waikato, Marc travelled from Indonesia to Nepal and then overland to London by bus, a 90-day journey through countries including India, Pakistan and Afghanistan.

"It was the images of travel that I found entrancing," he says. Seeing places such as the Buddhas of Bamiyan before they were destroyed, and connecting those images with history, culture and theatre, made him want to learn more. As New Zealanders began travelling more widely, Marc saw the need for a medical specialty that could help them do it safely and well.

What has changed most in travel health over the past three decades?

The scale and purpose of travel have changed enormously. Marc says around 1.5 billion people now cross international borders each year, and they are not just tourists. Business travellers, humanitarian workers, military personnel, refugees, migrants, sports teams and eco-travellers all have different health needs.

"The practice of medicine is changing as a result of each of these groups," he says. Better preventive care and education have also shifted the focus. Diseases such as cholera and typhoid, once central to travel consultations, are now approached with more nuanced risk assessment rather than blanket advice.

What lessons have travellers and expeditions taught you?

One of the biggest lessons has been to listen. During his OE, Marc studied at the Royal Academy of Dramatic Art in London, which helped him understand what he calls the 'micro theatre' of one-to-one interaction. Medicine, he says, often sits within that same intimate space of communication.

"When you go overseas, sometimes you have to shut up and just listen," he says. For Marc, travel also carries responsibility: to respect the people who live in the places being visited, the environment, local customs and the cultures that remain long after the traveller has gone home.

How has being a GP shaped your approach?

Marc sees travel medicine as an extension of general practice. On expeditions, the GP or medical officer becomes more than a clinician, often the historian, storyteller, academic and moral guide of the group.

"Their behaviour matters, and their standards matter," he says. "A general practitioner's role is not necessarily to diagnose disease, but to minimise disorder."

What should GPs keep an eye on over the next decade?

Infectious disease remains important, particularly in light of COVID-19 and emerging threats such as Ebola, Marburg and avian influenza. But Marc also points to safety, security and traveller behaviour. Destinations such as Barcelona, Venice and Amsterdam are already pushing back against overtourism, and he believes respect will increasingly shape how welcome travellers are in the world.

What do you hope to pass on to the next generation of doctors?

"Caring is important," Marc says. So is humility. Doctors may hold social status, but he believes they must earn it through behaviour, standards and consideration for others. If anything, he hopes people might say he shared a little wisdom along the way.

What did receiving an MNZM mean to you?

Personally, it was "a huge honour" and left him "over the moon and humbled." Professionally, Marc sees it as recognition that travel medicine is a specialty of real significance. He also sees it as something shared with the people who shaped and supported him, including his grandmother, mentors, colleagues and the staff who kept travel medicine alive through COVID-19.

RECOGNITION OF LEARNING – LOG YOUR CPD

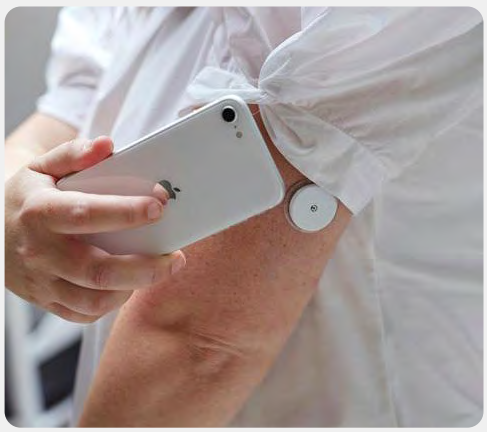
Goodfellow Unit podcast: **Type 2 diabetes management**

Helen Snell is a nurse practitioner specialising in diabetes and a nurse lead of the diabetes and endocrinology service based at Palmerston North Hospital. She has been a trailblazer in improving standards of diabetes care, as well as a driving force for registered nurses working in advanced practice roles.

In this episode, Helen Snell discusses recent updates in type 2 diabetes management, including changes to diagnostic criteria, new medications and practical tips for primary care providers. She covers glycaemic targets and treatment approaches, shifts in diabetes care paradigms, and the importance of addressing mental health and lifestyle factors.

The key take-home messages of this podcast are:

- Tackle clinical inertia – optimise diabetes therapies early.
- Talk to patients about what their goals are.
- If in doubt, pick up the phone to your colleagues in secondary care.



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Medicine is a balance between science and art

An interview with Dr Shanthi Selvakumar (FRNZCGP) about purpose, listening and community care

For Dr Shanthi Selvakumar, receiving the King's Service Medal is still something she is finding the words for. It was unexpected, she says, and deeply humbling. But for those who know her work as a family physician, ethnic migrant advocate, and long-time supporter of ethnic migrant women and children, the recognition reflects decades of service shaped by gratitude, purpose and a deep commitment to community.

Dr Shanthi's impact extends far beyond the consulting room. Alongside her work as a general practitioner, she provides free care to people experiencing abuse or financial hardship, leads volunteer medical missions across New Zealand and the Pacific, and has dedicated more than two decades to supporting migrant women and children through **Shakti Women's Refuge**, where she has served as Chairperson since 2019.

A passionate advocate, educator and community leader, she has also contributed to national domestic violence awareness initiatives and helped families navigate life in Aotearoa. Outside medicine, Shanthi is an accomplished Carnatic musician and conductor, bringing the same spirit of service and connection to the arts. In 2018, her commitment to community was recognised with a Kiwibank Local Hero Award.

We sat down with Dr Shanthi recently to find out more about her work with ethnic migrant communities, her thoughts on receiving a King's Service Medal and her advice for new GPs.

What inspired your commitment to supporting ethnic migrant communities?

"Being a migrant myself, it came naturally to me," she says. Shanthi left Sri Lanka as a fresh graduate, first moving to Papua New Guinea for her internship before coming to New Zealand in 1988. While her medical training meant she was able to work, sit exams and gain registration, she says she never forgot the help and support she received along the way. Colleagues and communities in Tokoroa and Waikato offered support at a time when she was building a new life in a new country.

"I appreciated every bit of help I received, and that gratitude stayed with me," she says. "When I was in a position to help fellow migrants and everyone as a general practitioner, it wasn't something new for me. It was natural."

What have your patients and communities taught you?

Her answer is immediate: to listen. "People come from different walks of life and bring different pleasures and pain with them," she says. "We shouldn't be judging, sitting as doctors." Shanthi prefers the term family physician to GP, because for her the role is about relationships with people, whānau and communities over time. "Delivering medicine is an art," she says.

"It's a mixture of art and science." Science matters, of course, but she worries the healing part of medicine can be lost when care becomes too rushed or transactional. "As family physicians, we do a lot of listening and a lot of healing by being there for people. We need to listen more and talk less."

How can general practice provide more culturally responsive care?

For Shanthi, culturally safe care begins with understanding where a patient is sitting – not only culturally, but personally. The science of medicine may be the same, she says, but the way it is explained and understood needs to be tailored. "Every community needs you to deliver care in a way they understand," she says. "Patients need to know they are in charge of their health."

That means asking questions, taking time, and being curious about why someone may not want to take a medicine, attend an appointment, or follow a treatment plan. Language can be a barrier, but she believes compassion can go a long way. "As long as you have compassion and understanding for where they are sitting, you can break those barriers."

You have advocated strongly for migrant women and children affected by domestic violence. What barriers still exist?

As chairperson of Shakti, an ethnic migrant women's refuge, Shanthi has spent many years advocating for women and children affected by domestic violence. She says the barriers can be complex: financial pressure, visa status, language, isolation, and not knowing what rights or support are available. Services have improved significantly over the years, and technology has made it easier for some women to find help. But Shanthi believes information needs to reach people much earlier, especially those arriving in New Zealand with limited English or little knowledge of the system. "At the entry point, there should be information about what their rights are," she says. "That is still a gap."

What advice would you give younger doctors?

She hopes younger doctors hold on to the purpose at the heart of general practice. "Traditional general practice is for the community, run by the community," she says. "We are community-based doctors." Shanthi acknowledges the pressures on younger doctors between family life, finances, workload and the changing business model of general practice, but she believes the work is most rewarding when it is grounded in service.

"You have to be selfless to become a family physician," she says. "You need to look at the patients coming into your room. They are there to teach you something, and also to receive something bigger than what you think you could deliver."

And what does the King's Service Medal mean to you?

"It was very unexpected," Shanthi says. "Very humbling." She has received awards before, particularly as a young classical singer, but this recognition feels different. It is not about achievement in the competitive sense, she says, but about service and the communities she has walked alongside. More than a medal, it represents a life's work shaped by gratitude, listening, and a belief that medicine is at its best when it reaches beyond the consulting room and into the lives of people who need care, advocacy and hope.

Goodfellow Unit podcast: **Mastering health literacy**

Carla White is Director of Health Literacy NZ and has worked in adult literacy since 2003 and health literacy since 2009, first with Workbase and now with Health Literacy NZ. With a background in organisational development and change management, she has helped health organisations address the impact of health literacy on their systems, services, workforce, and clients. Her work for the Ministry of Health spans medicine adherence, children's skin infections, gestational diabetes screening, and a recent professional development package for GPs and nurses to improve participation in cervical screening.

In this episode, Carla White discusses how clinicians can navigate challenging consultations involving medical misinformation and distrust of science. She explores practical communication strategies, the Ask–Build–Check model, and ways to build trust and understanding with patients.

Listen to the podcast

The key take-home messages of this podcast are:

- Use the Ask–Build–Check model at the start to find out what you're working with.
- Readiness to change – respect the uncertainty.
- Be yourself – let people know how much you care.

Do thyroid conditions run in families?

Dr Francis Hall

Sometimes it is the simple, very reasonable questions that patients ask that stop us and make us think. Often the question is simpler than the answer. “Should members of my family be checked to see if they have the same thyroid problem?” The simple answer is “Probably.” The more detailed answer is given below.

Certainly, autoimmune conditions tend to run in families. So, if a patient has either Hashimoto’s thyroiditis or Graves’ disease, there is a 7–10x increased chance of other family members developing that condition. Complex polygenic factors are involved, including HLA-DR genes, and in the case of Graves’ disease, TSHR genes are also involved. This is why the American Thyroid Association (ATA) recommends that individuals with a family history of thyroid disease should have their thyroid function tested starting at age 35 and every five years thereafter.[1]

In the case of thyroid nodules and goitres, there is a 3–5x increased risk of developing a thyroid nodule or a goitre in first degree relatives of a family member with a thyroid nodule or a goitre.

The most common type of thyroid cancer is papillary thyroid carcinoma (PTC). Most cases of PTC are sporadic but about 5–10% are thought to be familial.[2,3] Familial PTC is often multifocal, may affect younger individuals, and some studies suggest that it is more aggressive than non-familial PTC. Familial PTC is autosomal dominant. No specific genetic mutation has been detected.

Certain genetic syndromes, including familial adenomatous polyposis, PTEN-hamartoma syndrome, Carney complex and Cowden’s disease are all associated with an increased risk of developing thyroid carcinoma.

Medullary thyroid carcinoma (MTC) is much less common that papillary thyroid carcinoma. About 80% of cases of MTC are sporadic with the remaining 20% of cases familial. There is a lot written about familial MTC and the genetics are well known. The gene involved is the RET proto-oncogene and the mode of inheritance is autosomal dominant. Familial MTC is part of the multiple endocrine neoplasia syndrome (MEN). There are two main types of MEN that are associated with MTC:

1. MEN2a: the more common type.
2. MEN2b: the less common type. Marfanoid features and mucosal neuromas.

In addition to this, there is also familial MTC that does not have the other features of MEN2a but is probably best classified as a variant of MEN2a.

The ATA recommends genetic testing of all patients with MTC.[4] Family members of patients with MTC and the RET proto-oncogene can be screened to see if they are a carrier of the RET proto-oncogene and therefore at risk of developing MTC. Genetic mutations of the RET proto-oncogene are classified as highest risk (HST), high risk (H) or moderate risk (MOD). Family members with RET proto-oncogene are offered

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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prophylactic total thyroidectomy. This is similar to the concept of prophylactic mastectomy in women with the BRCA1 or BRCA2 gene mutation.

Those with the highest risk mutation (RET codon M918T) are offered prophylactic thyroidectomy before the age of one.

Women are 5–8x more likely to develop thyroid disorders than men. While genetics loads the gun, environmental factors may pull the trigger for thyroid disorders. Common environmental factors that interact with genetic predisposition include: iodine intake (either too much or too little), selenium, vitamin A, chemicals (bisphenol, phthalates), radiation and stress (which can trigger an autoimmune response). Because individuals in the same household are usually exposed to similar environmental factors, it is often difficult to determine whether a thyroid disorder is due to genetic factors, environmental factors or both.

In summary, family members of patients with medullary thyroid carcinoma and RET proto-oncogene should be screened for this gene and appropriate treatment should be instigated as per the ATA guidelines. Family members with a family history of familial papillary thyroid carcinoma should have a thyroid ultrasound and FNA of any suspicious thyroid nodules. There is no consensus as to when screening for familial PTC should begin, but as familial PTC tends to occur at a younger age than the more common non-familial PTC, it seems reasonable to do an ultrasound scan of the thyroid at the age of 18. Family members of patients with Hashimoto's thyroiditis or Graves' disease should have thyroid function tests, TPO antibodies and TSHR antibodies checked every five years from the age of 35 as per the ATA guidelines.

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Not every gallstone needs surgery

Dr Tom Hanna and Dr Peter Swan, Compass Surgical

Gallstone disease is one of the most common gastrointestinal conditions encountered in primary care. While laparoscopic cholecystectomy remains an effective treatment for symptomatic gallstones, not every patient with biliary colic requires immediate surgery, and careful patient selection remains important.

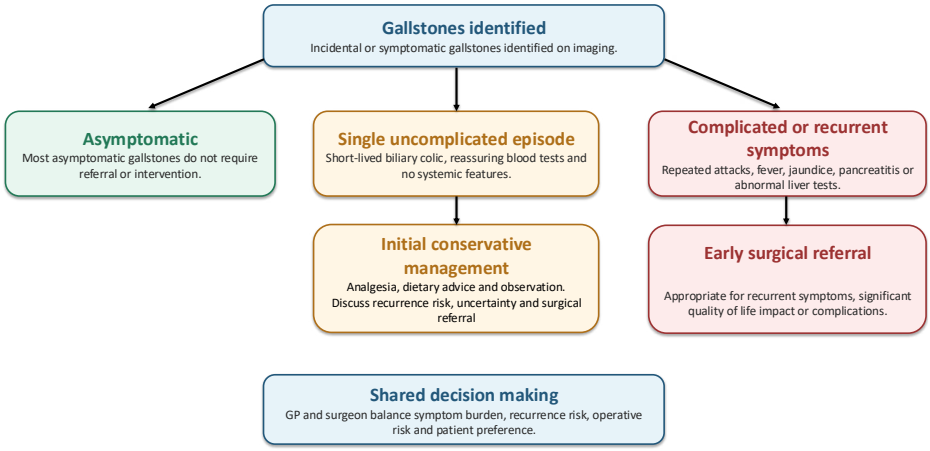
Traditional guidelines, including NICE recommendations, have generally supported elective laparoscopic cholecystectomy for symptomatic gallstones because recurrent pain and complications are common.[1] However, more recent evidence has highlighted a more nuanced reality. The RELAPSTONE study, a large multicentre cohort study published in 2024, demonstrated that while recurrence after symptomatic gallstone disease is common overall, a substantial proportion of patients remain symptom-free following an initial presentation, particularly after an isolated mild episode.[2]

Similarly, the recent UK C-GALL randomised trial compared conservative management with laparoscopic cholecystectomy in adults with uncomplicated symptomatic gallstones and found that many patients managed conservatively avoided surgery over follow up, with similar quality of life outcomes in selected patients.[3] Together, these studies challenge a reflexive 'operate after first presentation' approach and support more individualised decision-making.

FIGURE 1

Suggested primary care pathway for management of gallstones

A primary care pathway incorporating NICE guidance, RELAPSTONE natural history data and C-GALL trial evidence



Recognising biliary colic

Typical biliary colic presents with episodic right upper quadrant or epigastric pain, often occurring after meals and sometimes radiating to the back or shoulder. Pain usually settles within a few hours and is not associated with systemic features.

Dr Thomas Hanna is a transplant and general surgeon based in Auckland. He works at Auckland City Hospital and is co-founder of Compass Surgical, with interests in gallbladder disease, hernia surgery and minimally invasive surgery. He has a particular interest in patient-centred decision making and collaborative multidisciplinary care.

Dr Peter Swan is a transplant donor and general surgeon based in Auckland and Northland. He is also co-founder of Compass Surgical; his clinical practice includes the full breadth of general surgery with a focus on minimal access (laparoscopic and robotic) gallbladder disease and hernia surgery. Peter places special emphasis on practical, evidence-based care with clear communication to patients and referring clinicians.

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Patients with a single uncomplicated episode and normal blood tests can often initially be managed conservatively with dietary modification, analgesia and observation. GPs play an important role in helping patients understand the natural history of gallstone disease, recurrence risk and the possibility that symptoms may not recur.

However, recurrent episodes, increasing symptom frequency, or significant impact on quality of life remain appropriate indications for referral for surgical assessment.

When surgery becomes important

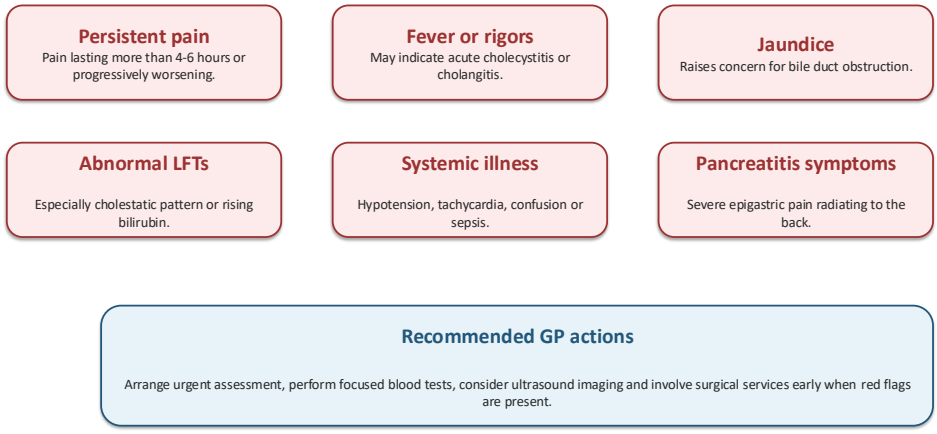
Laparoscopic cholecystectomy remains the definitive treatment for recurrent biliary colic and gallstone complications, including acute cholecystitis, pancreatitis and bile duct stones.[4] Modern surgery is safe and effective, commonly performed as a day-stay procedure, but it is not without risk. A balanced discussion around operative versus conservative management is therefore appropriate, particularly after a first uncomplicated presentation.

Persistent pain lasting more than several hours, fever, jaundice, abnormal liver function tests or signs of systemic sepsis should prompt urgent assessment for acute cholecystitis, cholangitis or biliary obstruction. Contemporary emergency surgery guidelines continue to support early specialist involvement in these patients.[5]

FIGURE 2

Red flag symptoms and indications for urgent referral

Clinical features suggsting acute cholecystitis, pancreatitis



The role of primary care

General practitioners remain central to the management of gallstone disease. The role of the GP is not simply to refer all patients directly for surgery, but to help patients understand the balance between recurrence risk, symptom burden, operative risk and patient preference. Early surgical referral remains appropriate for many patients, but modern evidence supports a more individualised discussion after an isolated uncomplicated episode.

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Creating capacity in general practice

The Cause Collective

E lē sili le ta‘i i lo le tapua‘i.
The work of one is never as strong as the work of many.

In the Pacific, navigation requires a collective effort. It relies on reading the environment – the currents, wind and strength of the crew – and adjusting course accordingly.

Primary care is facing a similar reality. Demand is increasing, presentations are more complex, and workforce constraints continue to stretch capacity. In many cases, general practice is carrying more than it was designed for.

While the need for change is widely acknowledged, the gap between strategy and day-to-day practice remains significant. At The Cause Collective PHO, the focus has been on redistributing where care sits across the system, rather than expecting general practice to manage it in isolation.

Working alongside a network of nearly 50 practices across Auckland, the PHO’s role is deliberately practical: translating system requirements into something usable, reducing administrative friction and supporting practices to respond to change without bearing it alone.

A key shift has been addressing demand more directly. Rather than continuing to layer services into general practice, Our Place Māngere, a new wellbeing hub, has been designed as a complementary extension and absorbing lower-acuity demand. This includes routine vaccinations, health screenings, follow-up monitoring and basic walk-in concerns both health and social.

Positioning the model as complementary, not competitive, has been critical to redistributing demand and building referral pathways that work in practice. This approach shifts from programme delivery to steering how care moves across the system, so pressure is shared rather than concentrated, allowing it to hold its course under strain.

Primary care doesn’t lack ideas. The priority now for The Cause Collective PHO is better navigation of demand, reducing avoidable pressure and creating sustainable capacity within the primary care sector.

Submit your feedback

Tongan Health Society

Taking health care to the community

Tongan Health Society is a Pacific-led primary and community health care provider with a long-standing commitment to improving health outcomes for Pacific peoples and other communities across Tāmaki Makaurau.

The Society has been operating for 28 years and has clinics in Onehunga, Panmure, Kelston, and Ōtāhuhu, as well as an Integrated Outcomes Unit, Ako Langimālie Preschool, social housing, Mana Kidz services which operate in eight schools, a community centre and gardens, and a research unit.

Integrated model of care

Through its Langimālie Integrated Family Health Centres, Tongan Health brings together general practice, mental health, social services, youth development, health navigation, education, community outreach, and research. This integrated model reflects a simple but vital understanding: lasting wellbeing is shaped not only by clinical care but also by family, culture, housing, education, income, connection and trust.

For general practice, this wider perspective on health is becoming increasingly important. Many patients and families encounter barriers that make it hard to stay engaged with health care consistently. These barriers might include cost, transport, language, work commitments, digital access, cultural expectations, previous experiences of the health system, or competing pressures at home. Tongan Health's approach aims to reduce these barriers by blending clinical care with culturally responsive support and trusted relationships.

Community-based delivery of services

A key aspect of this work is outreach. Rather than expecting everyone to visit a clinic, Tongan Health brings services to the places where people already gather, including churches, schools and community venues. This place-based approach helps make health care more visible, familiar and accessible. It also creates opportunities for early engagement, health education, screening, immunisation, support for long-term conditions and navigation to wider services.

The rationale is both practical and cultural. When care is given in trusted spaces, people are more likely to ask questions, raise concerns, involve their family, and stay connected to support. Outreach also helps identify unmet needs earlier, especially among people who might not otherwise seek help until a health issue becomes more serious. For communities managing conditions such as diabetes, cardiovascular risk, respiratory illnesses, or maternal and child health needs, this kind of engagement can have a significant impact.

All ages and stages

Tongan Health's programmes and services support the entire life cycle, from pregnancy and early childhood to youth, adulthood, and the elderly.

Kahu Taurima offers culturally appropriate maternity and early-years support for Pacific mothers, babies, and whānau.

Mana Kidz provides free, nurse-led, school-based health care to support tamariki. Youth navigation programmes help Pasifika young people build confidence, independence, and connections.

Whānau Ora navigation links families to wider support services such as housing, budgeting, and community resources.

For older people and caregivers, the Pacific Elderly Navigation programme offers advocacy and culturally sensitive guidance.

Blending the functions of community, culture and relationships

Together, these programmes show how primary care can extend beyond the consultation room while staying closely aligned with clinical needs. Tongan Health's model is not just about providing more services; it is about integrating those services in ways that are meaningful for families.

Tongan Health provides a strong example of integrated, community-led care in practice: clinically reliable, culturally grounded, relationship-focused, and aimed at improving outcomes for those who need support most.

Professional development

Tongan Health invests significantly in professional development by supporting staff with a wide range of training programmes, certifications, conferences, and targeted initiatives. This empowers them to grow both personally and professionally and to develop the next generation of leaders.

Additionally, **Tongan Health** offers health professionals the opportunity to practise medicine in a collaborative, culturally grounded, and innovative environment where they can make a significant impact on community wellbeing.

Connecting patients with cancer support in their community

1 in 3 New Zealanders will be diagnosed with cancer in their lifetime.

For general practices, that means cancer is already coming through your door into your waiting room, your consult room, and your patients' lives.

The Cancer Society is here in communities across Aotearoa New Zealand, supporting people at any stage of a cancer journey: while waiting for a diagnosis, during treatment, adjusting to life after treatment, or supporting someone they love. We offer practical and emotional support, trusted information, and guidance for patients, whānau and carers – close to where people live.

Like general practice, our support is rooted in community. GPs are often the first trusted point of contact for people facing cancer, and a simple mention from you can help patients and whānau connect early with support close to home.

Please remind your patients that Cancer Society support services are here for them and refer them to us when extra support would help.

Together, we can be there for the 1 in 3 this Daffodil Day and beyond.

0800 226 237 | cancer.org.nz

Leave feedback and follow us

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