

GP Voice



YOUR NEWS, YOUR VIEWS, YOUR VOICES

In tune with medicine

Dr Dickson Fung

Planting the seed early
General practice at CareerFest Southland

The specialist skill patients don't see

Alcohol and 15-minute appointments
Dr Hēmi (James) Enright



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

October 2026

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Medical Director's editorial

Dr Prabani Wood

Kia ora koutou,

With the General Election rapidly approaching, we have seen the expected flurry of policy announcements and promises across the political spectrum, especially on the topic of health care, and some recent announcements directly impact general practice.

First, after advocating directly to Health New Zealand | Te Whatu Ora and the Ministry of Health for broader influenza vaccine eligibility because of the severity and volume of cases circulating in communities, we were pleased to see a commitment to extend the funded vaccine to all under-fives for the 2027 winter season.

We kept up the momentum as we wanted to reduce the impact of this year's winter illness as well, given we were still seeing a large number of cases as we head into spring. We welcomed the further announcement to fund influenza vaccines for all tamariki under five from 1 September this year, and we quickly encouraged members and practices to proactively reach out to patients and inform them of the change.

Decision-makers were responsive to our advocacy and understood that it is our general practice teams on the frontline of community care, seeing firsthand the impact of seasonal illness and knowing where preventative actions can have the greatest effect.

The announcement that cervical screening in general practice would be funded from March 2027 was another win for patient health.

While the expanded eligibility for flu vaccinations and cervical screening announcements were positive for the health outcomes of our patients, they are not perfect, and we made a point of highlighting the equity gaps in both.

Removing cost as a barrier to access the flu vaccine and cervical screening is significant and will mean more people can engage with these vital services. However, the College called for other measures to help those who face further challenges in accessing care, such as those who cannot easily attend appointments during standard business hours, those who live in rural or remote communities, those who have dependants, or who have transport, cultural or other related barriers.

In other member news, the College has developed guidance for members on the use of cognitive screening tools in fitness to drive assessments for older adults. This followed research out of the University of Auckland that was commissioned by the New Zealand Transport Agency Waka Kotahi (NZTA) and the Office for Seniors.



Dr Prabani Wood
Medical Director



This guidance should also be used alongside NZTA's [Medical aspects of fitness to drive: a guide for health practitioners](#). The College guidance along with the other mentioned publications can be found on the 'Fitness to drive' webpage. The Minister for Seniors [released a statement](#) to highlight this research and also supported the work undertaken by the College to keep members informed and supported.

To complement this work, in this issue of GP Voice you'll find Dr Peter Moodie's latest 'Mind This' column where he outlines a coroner's case involving a tragic road accident, a GP's fitness to drive assessment, and where the obligations lie in ensuring all relevant systems, organisations and parties are aware of the assessment's outcome.

I hope you enjoy this issue,

Prabani

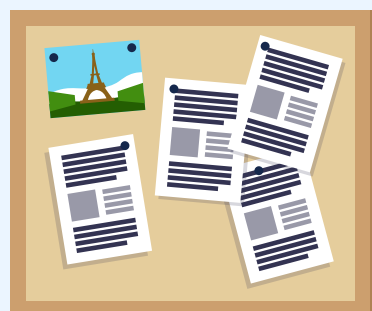
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Health New Zealand
Te Whatu Ora



Put general practice at the centre of health policy

Toby Beaglehole, Chief Executive

Kia ora koutou,

Election years have a way of flattening health into slogans and soundbites. Our job as your College is to put a clear, evidence-based case in front of the people seeking your vote and those able to change the system. We're telling them what general practice delivers, what is at risk, and what needs to change if Aotearoa is serious about better health outcomes.

You've heard it before – Aotearoa New Zealand directs around 6 percent of its health budget to primary care, compared with an OECD average closer to 14 percent. That is nowhere near good enough. Patients face cost barriers, some communities struggle to enrol with a practice, and the pressure lands downstream in emergency departments and hospitals.

One theme came through strongly at our conference: these issues are connected. Workforce shortages, underinvestment, rural access, clinical leadership, AI, and the erosion of continuity all lead to the same question. Will the system be designed around the real work of general practice, or continue to treat that work as interchangeable, invisible or secondary?

In my conference plenary, I described general practice as attention paid over time: being the clinician who knows the whole person well enough to notice when something has changed, and who has the tools to respond safely. Technology, including AI, should give clinicians time back, strengthen learning and support safer decisions. It must preserve the relationship, judgement and continuity that make general practice effective.

Prabani sharpened that argument through a clinical lens. Vocationally trained GPs are expert generalists. They manage complexity, uncertainty and risk, coordinate multidisciplinary teams, teach and supervise, and carry decisions over time. Unless the system recognises that expertise, it cannot fund it, train for it or build sustainable models of care around it.

We need a deliberate shift in investment upstream, pay and conditions that make general practice a compelling career, protected time for teaching, supervision, governance and non-patient-facing work, and safeguards for continuity, prevention and whole-person care.

This is what the College will take into November's general election. It is a practical proposition: invest in general practice because it is where the health system can best keep people well, reduce avoidable hospital pressure, and provide comprehensive, continuous care close to home.

Medicines, technologies and models of care will keep changing. Our responsibility is to shape that change and ensure it strengthens general practice. We should move quickly when innovation genuinely supports clinicians and



Toby Beaglehole
Chief Executive



patients, and carefully when equity, privacy, safety, continuity and trust are at stake.

Between now and November, we will make the case plainly and repeatedly. Invest in general practice. Recognise vocationally trained GPs as clinical leaders. Protect continuity. Build the Māori, Pacific and rural workforce. Resource teaching and supervision. Govern technology well. Put general practice at the centre of health policy, where the evidence says it belongs, and where we know it belongs.

Ngā mihi,

Toby

Start thinking about your research project for 2027

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 your patients, 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 to apply. Projects need to be practical, practice- or rural hospital-focused and grounded in clinical work.

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.

There are three research funding rounds each year. The next funding round will open in early 2027 so start thinking about your research project today!

Visit the [Fund your research](#) page to learn more about the funding guidelines, application dates, previously funded research topics and how to submit your application.



College advocacy: Months in review

August and September

The College is a strong, constant advocate for general practice and rural hospital medicine. We use our voices and experiences to inform Government, politicians, other sector organisations, the media and 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 August and September.

Minister's announcement: Skin cancer treatment expanding into GP clinics

At GP26: Conference for General Practice, Health Minister Simeon Brown [announced that skin cancer treatment will be expanding into GP clinics](#) as another way of ensuring more people can get access to the care they need in the community and closer to home.

College President Dr Luke Bradford was interviewed by [NZ Doctor](#) (paywalled), Newstalk ZB and One News.

Extended funded flu vaccination for under-fives

Following a [letter from the College](#) to representatives at Health NZ and the Ministry of Health advocating for more funded access to the influenza vaccine in the wake of the severity and the volume of cases circulating in the community, the College welcomed the news that the influenza vaccine would be funded for all children aged six months to five years for this season, and the 2027 winter season.

We also communicated advice and guidance to practices on how to keep patients and staff well through streaming, triage and the use of PPE.

[Read our media statement.](#)

[Read the Minister of Health's statement.](#)

Dr Bradford was interviewed on this announcement and on the impact of winter illness in communities by Newstalk ZB, Mediaworks, [Radio New Zealand](#), [NZ Herald](#), [3 News](#), The Platform, NZ Doctor and [One News](#).

Development of NZ Endometriosis guidelines

The College welcomed the announcement that Health NZ would be adapting RANZCOG's Australian Living Evidence Guideline: Endometriosis for use in New Zealand, highlighting we wanted to see a guideline that has equity of access and cost as a large consideration given the health care inequities that we face as a country.

We were also quick to publicly address the narrative that gave the impression that general practice has not been a part of endometriosis care until now, with Medical Director Dr Prabani Wood saying in our [media statement](#), "GPs are already diagnosing and treating endometriosis every day and have been for years. What we do not have is easy, funded access to wider services these women need. Pelvic physiotherapy and other allied health support are essential for the many women who need more than medication to manage their symptoms."



Cervical screening in general practice to be funded

The announcement that cervical screening in general practice would be funded from March 2027 was another announcement that the [College supported](#), while also noting that more details were required to show how this plan will reduce, not widen, health inequities.

Removing cost as a barrier to accessing cervical screening is significant and will mean more people can engage with this vital service. However, the College called for other measures to help those who face other challenges to accessing care, such as those who cannot easily attend appointments during standard business hours, who live in rural or remote communities or who have transport, dependants, cultural or other related barriers.

Dr Wood spoke about these health inequities on [Waatea News](#).

Fitness to drive assessments

The College developed guidance for members on the use of cognitive screening tools in fitness to drive assessments for older adults, following the release of some research from the University of Auckland, which was commissioned by the New Zealand Transport Agency Waka Kotahi and the Office for Seniors. The College guidance should be used alongside NZTA's *'Medical aspects of fitness to drive: a guide for health practitioners'* document.

The College guidance along with the other mentioned publications can be found on the ['Fitness to drive' webpage](#).

The Minister for Seniors, Hon Casey Costello, [released a statement](#) to highlight this research and also supported the work undertaken by the College to keep members informed and supported.

Stakeholder engagement

Dr Luke Bradford:

- GPLF meeting
- Annual meeting with MCNZ and medical colleges
- Meeting to discuss flu vaccination eligibility with Health NZ, Pharmac, Ministry of Health
- Cancer Screening Programmes meeting
- Meeting with College CE Toby Beaglehole and Labour's health spokesperson Dr Ayesha Verrall
- Keynote presentation at PMAANZ conference
- Pinnacle Board meeting
- Visit to Matamata Medical Centre
- Attended Waikato/Bay of Plenty Faculty's celebration for new Fellows.

Dr Prabani Wood:

- Quarterly College and ACC meeting
- Meeting on infectious disease education in primary care
- Meeting with Health NZ on prescription quality project
- Visit to Golden Bay Community Health Centre
- Attended and spoke at Waikato/Bay of Plenty Faculty's Education Symposium



- Meeting with MPS on HPCAA, Privacy Act and Coroner reports/recommendations
- Cancer Screening Programmes meeting
- Meeting with Ministry of Health, Ministry for Seniors and NZTA re fitness to drive assessments.

Quality Programmes Team:

- Foundation Standard workshop at PMAANZ conference

Submissions

- [Ministry of Business, Innovation and Employment: Proposed changes to streamline and update ACC regulations](#)
- Petitions Committee: [Petition of Aly Cook](#)
- Pharmac: [Proposed changes to the Practitioner Supply Order list and rules](#)
- Governance and Administration Committee: [Crimes \(Virginity Testing Practices\) Amendment Bill](#)
- Nursing Council: Consultation on proposed standards of competence and prescribed qualifications for nurse practitioner and registered nurse prescriber scopes of practice.
- Australian Bureau of Statistics: Draft Occupation Standard Classification for Australia
- Medsafe: 76th meeting of the Medicines Classification Committee agenda (adjustment to submission in April due to meeting postponement and further agenda items).

More media and advocacy

- Opinion editorial: [Specialist GPs expert generalists fulfilling a distinct role in primary care](#) | Dr Prabani Wood | NZ Doctor
- College media release: [College of GPs and Gestalt trial AI-powered practice for future GPs](#)
- [Tauranga doctor honoured with prestigious national medal](#) | Tauranga Local News
- [Community Service Medal for Tauranga doctor](#) | The Weekend Sun
- [Gisborne doctors with national awards](#) | NZ Herald
- [The mind-boggling reason given for why women weren't told they needed cancer tests](#) | Dr Luke Bradford | Stuff
- [College calls for pay parity between specialist GPs and hospital specialists](#) | Dr Luke Bradford and Dr Prabani Wood | NZ Doctor
- [NZ's antibiotic overuse](#) | Dr Prabani Wood | Radio NZ
- [New programme seeks to ease onboarding for overseas GPs](#) | Toby Beaglehole | NZ Doctor
- Restaurant Association report out saying weight loss drugs are having an impact on the industry with people ordering less, and smaller, meals | Dr Luke Bradford | One News



Connecting members through their shared interests

At GP26: Conference for General Practice, the College officially launched its Specific Interest Groups (SIGs), designed to give members a new way to connect, collaborate and share expertise with colleagues who have similar clinical and professional interests.

SIGs are member-led communities that bring together members with a shared interest in a clinical field, professional topic or health system issue, creating opportunities for networking, learning and the exchange of ideas.

When College President Dr Luke Bradford launched the SIGs at GP26, he said, “While every one of us is first and foremost a specialist GP or rural hospital specialist, many members also have particular clinical interests and expertise that they want to continue developing and sharing.”

The launch marked a significant milestone for the College, following years of member feedback calling for more opportunities to connect with peers around particular areas of practice.

The ADHD SIG has led the way as the College’s pilot group. Since its establishment, it has attracted members who are connecting online through the College’s new community hub.

Supporting the initiative is a new governance framework designed to ensure SIGs remain member-led while promoting cultural safety, equity and alignment with College values. Work is also underway to establish a SIGs Council to provide oversight and support for future groups. Once the council is established, the College will look to expand the SIGs beyond ADHD, and we will publish further information in *ePulse*.

As new SIGs are established, they will provide a valuable forum for members to learn from each other’s experiences, discuss emerging issues and contribute their expertise to the wider work of the College.

The launch reflects the College’s commitment to strengthening member engagement and creating more opportunities for members to connect, share knowledge and shape the future of general practice together.

Have you logged into the new online community hub?

At GP26, the College launched a new online community hub for members to connect with Faculties, Chapters and Specific Interest Groups. Built exclusively for College members, it’s a private, members-only hub where you can connect with peers, share ideas and resources, and continue conversations beyond CME and social events.

[Visit the platform](#)

and log in with your College credentials. These are the same credentials you use to log in to your member dashboard.

If you have any questions about the community hub please email the friendly team at: communications@rnzcg.org.nz

If you would like to be added to the ADHD SIG, please email: membership@rnzcg.org.nz



Spotlight on the Registrars' and Affiliates' Chapter

This year has been one of listening closely, asking better questions, and using what we hear from you to shape the work of the Registrars' and Affiliates' Chapter.

As your Chapter Committee, our role is not simply to sit at the table on behalf of registrars and affiliates. It is to make sure the experiences, pressures, ideas and concerns of registrar and affiliate members are carried into College conversations with clarity and purpose. In 2026, that has meant being more visible, connected, and deliberate about asking what you need from us.

The Chapter brings together registrar representatives from every year level, alongside Te Akoranga a Māui, Pacific and rural representation. We advocate through College committees and working groups, and we also support members as they navigate training, contracts, placements, wellbeing, and the realities of moving from hospital-based practice into general practice.

Our annual survey was the next step in that work. We asked about registrar burnout, ideas for enhancing the GPEP2 and GPEP3 education programme and feedback on the Primary Care Pathway. These are not abstract issues; they sit at the centre of how registrar training feels day to day, and how well the system prepares us for sustainable careers in general practice. Every response helped sharpen our priorities and gave us evidence to take into conversations where registrar voices need to be heard.

We also focused on practical support. Our July webinar on contract negotiation and the things many of us wish we had known earlier was designed especially for GPEP1s signing their first contracts, while remaining open to anyone who wanted to join. Sharing that kind of knowledge is part of the Chapter's direction: Advocacy is essential, but so is helping members feel less alone and better equipped.

At our AGM on 31 July, held at the College conference and online via Zoom, we looked ahead. The Chapter is entering a period where connection, representation and responsiveness need to be at the forefront of our work. That means strengthening the way we hear from members, building continuity across year levels, and ensuring diverse registrar experiences are reflected in our priorities.

We are pleased to welcome new Committee members Dr Paea Leakehe from the Pacific Chapter and Dr Kiri Manning from Te Akoranga a Māui. Joining us as GPEP1 representatives are Dr Krishna Giri, Dr Nidha Ayoob and Dr Syahrul Nizam Shaarani. Continuing on our Committee are Dr Amanda Smith from



Dr Ella Barclay, Registrars' and Affiliates' Chapter Chair, and **Dr Wrex Liao**, Registrars' and Affiliates' Chapter Treasurer



Te Akoranga a Māui, Dr Regan Fernandes for GPEP2, Dr Ronan Finn for GPEP3 and above, and Dr Ben Booker from the Division of Rural Hospital Medicine. Finally, our Executive continues with Dr Ella Barclay as Chair, Dr Charlotte Trevella as Secretary and Dr Wrex Liao as Treasurer.

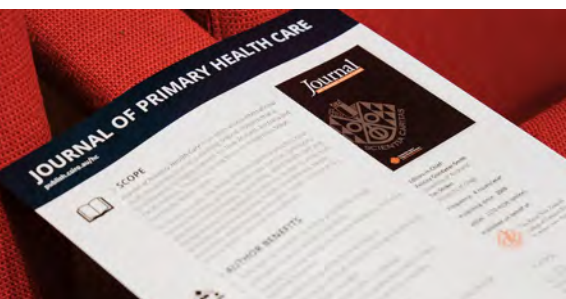
We are continuing to ask members about the issues emerging now, including the controversies regarding GPEP1 clinical time and experiences of parental leave with the training programme. If something is affecting you or your cohort, we want to know.

The direction of the Chapter is clear: we will keep listening, keep advocating, and keep turning member experience into action. Registrars and affiliates have limited spare time and a great deal riding on training decisions, employment conditions, wellbeing, and the future of general practice. Our job is to make sure your voice is not only represented, but actively shaping what comes next.

Please keep sending your questions, concerns and ideas to registrarchapter@gmail.com – it guides our mahi.

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Advocacy is essential, but so is helping members feel less alone and better equipped.



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. [Using AI scribes in New Zealand primary care consultations: an exploratory survey](#)
2. [Understanding the determinants of health for Māori living with chronic disease in Aotearoa New Zealand](#)
3. [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](#)
4. [Ascending the Poutama: culturally responsive diabetes care for Māori communities](#)
5. [Cultural safety in paramedic practice: experiences of Māori and their whānau who have received acute pre-hospital care for cardiac symptoms from paramedics](#)



Planting the seed early: general practice at CareerFest Southland

Ask a secondary school student what a doctor does, and you will hear about surgeons and emergency departments. General practitioners rarely get a mention. That is the gap a group of Southland GPs set out to close in August, at an event the College had never had a presence at before – CareerFest Southland.

CareerFest Southland, run by Southland Youth Futures and Great South, filled ILT Stadium Southland on 6 and 7 August. More than 2100 students were booked in across the two days, from Southland Boys' and Girls' High Schools through to Fiordland College, Māruawai College and Ruru Specialist School, alongside a community session open to the public on Thursday evening. About 60 exhibitors lined the floor, from universities and Rio Tinto to the New Zealand Police.

Among them, for the first time, was a stand dedicated to becoming a specialist GP.

Eight GPs – Drs Amy Rosario, Kirsty Thwaites, Jacqui Walker, Dayna More, Caroline Steward and Pallavi Shankar, led by Dr Aisha Paulose (Southland LME) and Dr Steven Murugayah of Winton Medical Services who put together quizzes, posters and prizes to draw students in – along with four medical students Adam Swney, Youssef Aldhufairi, Nadeen Saleem and Maddi Campbell, staffed it across the two days.

The College stand was, by every account, very busy. “We were on our feet for most of the day, and I don't think we stopped talking to people,” Steven said of the event. “It was great to engage with all the young rangatahi about what it means to be a GP.”

Our usual workforce campaigns target medical students and junior doctors, by which point many have already formed a view of what general practice is. So getting in front of high school students is a longer game, but for many students CareerFest is their first real conversation with someone actually doing the job.

“Encouraging students to see the possibilities within general practice from a young age has always been a goal of mine,” Aisha said. “After more than five years of advocating for opportunities like this, it's incredibly exciting to see it become a reality. Having the chance to speak with students about general practice and engage in open conversations about our specialty was a real privilege.”



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It was great to engage with all the young rangatahi about what it means to be a GP.





“By sparking their curiosity early, we can help them gain a better understanding of the broad scope of skills involved in general practice and the vital role GPs play in the healthcare system and wellbeing of our whānau and communities.”

And word travelled quickly: Other Southland schools have indicated they would welcome the same conversation – a promising first step for promoting general practice as a career.

If you are thinking about something similar, the College’s marketing and engagement team would be happy to support your efforts to reach rangatahi in your region. Contact us on communications@rnzcgp.org.nz



The specialist skill patients don't see

Across Aotearoa New Zealand, specialist GPs walk alongside patients through both ordinary and profoundly difficult moments. Three GP Fellows are bringing a new College campaign to life, helping more New Zealanders recognise it takes to be expert generalists: the years of training, building therapeutic relationships with your patients and managing clinical risk and the uncertainty in every patient interaction.

At the centre of the campaign is a simple message: Your GP. The specialist who knows you. It reflects what happens in general practice every day: a relationship built over time, details remembered, and subtle changes noticed because a person has been known for years, not minutes.

For specialist GPs, the message names a familiar truth. Relational continuity is not an optional extra. Holding a person's history, family context and clinical picture together and recognising when something no longer fits is a defining specialist skill of general practice. The [three members featured in the campaign](#) – Dr Vivienne Coppell, Dr Hohepa Cumming, and Dr Mariam Contractor – each bring that message to life in a different way.

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Knowing a patient is not the warm part of the job that follows the clinical part. It is the clinical part.



Dr Vivienne Coppell describes general practice as almost an upside-down specialty. The expertise, she says, is not held in one body system or one diagnosis, but in the whole person – their illness, uncertainty, responsibilities, family pressures and everyday life. She will see someone as a person with diabetes, not 'a diabetic'. It is a small shift in language, but a profound shift in care: from treating a condition in isolation to walking alongside a person as they live with it.



Dr Hohepa Cumming speaks with warmth and directness about the long pathway to becoming a specialist GP: six years at university, years as a junior doctor, then specialist GP training on the road to Fellowship. For him, naming general practice as specialist work matters because the skill behind it is too often unseen. "Most New Zealanders have no idea," he says of the training and pressure carried by the role.



For **Dr Mariam Contractor**, knowing someone well can change what is seen. She recalls a patient she had cared for over many years, a woman who had previously had gastric banding surgery and was often a little nauseated. When the woman returned with nausea and weight loss that did not fit with what Dr Contractor knew of her, she acted quickly. Stomach cancer was found early enough to treat. To another clinician, the symptoms might have seemed expected. To the GP who knew her, they were a warning sign.



The campaign's whakataukāki, He hononga whānau, he oranga whānui – through strong whānau connection, wider wellbeing can flourish – captures that idea well. Developed with the College's Marketing and Engagement team, Te Tiriti and Equity team, Tumuaki Māori and Hauora Māori Clinical Fellow, and drawing on Dr Cumming's kōrero, it recognises what many members know from practice: health is shaped by whānau, community, trust and connection, as well as by diagnosis and treatment.

Stories like these are at the heart of the campaign, and at the heart of the message for members. The relationship between a specialist GP and a patient is not simply the warm part of the job that sits alongside clinical work. It *is* clinical work. It is the knowledge that helps a GP hear what is unusual, notice what has changed and understand what might otherwise be missed.

That is why this campaign belongs to members as much as it belongs to the College. Drs Vivienne, Mariam and Hohepa are the first to step forward, but their stories stand for thousands more: the specialist GPs who know when a patient is not themselves, who understand the pressures of time, clinical risk and uncertainty sitting behind a consultation, and who keep showing up for people, whānau and communities over time.

You can [find out more about the campaign](#) on the College's website.

Share your story as a specialist GP

Drs Vivienne, Mariam and Hohepa have generously shared a glimpse of what specialist general practice looks like in real life. This campaign will continue to be a key part of our advocacy work and there is room for many more member voices.

We are looking for Fellows who would be willing to share their story. It could be a photo at your practice and a few words about the people and communities you serve, or a short selfie-style video if that feels right for you. Your experience could help the public better understand the role of specialist GPs, and help future doctors see the meaning, variety and impact of a career in general practice.

[Complete the form](#) at and we will be in touch.



GP26 plenaries: Recognising the work only GPs can do

Across the GP26 plenary sessions, one story kept returning to the surface. General practice is relationship-based, clinically complex, system-critical work, and its future depends on recognising that expertise, protecting continuity, finding strength in the discipline of the work, and leading change together.

From Dr Paea Tonga's deeply personal Peter Anyon Address to the future-focused leadership panel, the plenaries told a clear story about the quiet privileges that shape health, the identities and relationships that make care possible, the need to recognise GPs as expert generalists, and the collective leadership required to ensure the system is built around general practice rather than expecting general practice to absorb everything around it.

The quiet privileges that shape health

Dr Paea Tonga's Peter Anyon Address opened GP26 with a reminder that the foundations of health are often the things easiest to take for granted: a warm, dry, safe home; regular healthy meals; information a family can understand; and a health system that reaches people before illness becomes irreversible. Sharing her own family's experience of migration, illness and loss, Dr Tonga connected the personal to the systemic, showing why primary care matters most when it sees the whole person and their whānau, not just a diagnosis or funding category.

Her address set the emotional and ethical frame for the rest of the conference. General practice is where inequity becomes visible, where relationships build trust, and where clinicians can help families access the quiet privileges that make long, healthy lives possible.

The discipline to keep showing up

Dr Karlina Tongotea's plenary brought together two worlds that, on the surface, seem far apart: general practice and world champion powerlifting. But her story showed how closely they are connected. The discipline, resilience, sacrifice and perseverance needed to become a GP were the same qualities that helped her step onto the international platform, lose a world title and come back to reclaim it.

Her message was generous and energising – excellence is not built in one defining moment, but in thousands of quiet hours of showing up, failing, learning and trying again. For every GP in the room, it was a reminder that the work of general practice already develops the skills needed to pursue hard things, whatever each person's 'championship' may be.

Making space for identity, training and joy

The fireside chat with Dr Paea Tonga and Dr Karlina Tongotea stayed with the same themes but brought them closer to the GP training pathway. Their reflections moved between practical changes such as stronger financial support for GPEP1 registrars, more training places, and CME entitlements that match hospital colleagues – and the personal realities of building a career while holding culture, family, exams and passions outside medicine.

Both speakers spoke candidly about feeling not Tongan enough, not Māori enough, not Kiwi enough, and about the value of bringing that duality into the consult room. Their advice to registrars was generous and grounded: find a good study group, practise until it becomes ordinary, and do not let fear of exams crowd out the relationships and joy that sustain a long GP career.

Naming the work of expert generalists

Dr Prabani Wood laid down one of our main professional challenges: if general practice continues to be described only through access, targets and throughput, the expertise of GPs becomes invisible. She argued for saying clearly that GPs are expert generalists not to create hierarchy, but because a system that does not understand the work cannot design, fund or support it properly.

Her priorities were practical – parity of recognition with hospital colleagues, capitation that reflects vocational training and clinical responsibility, protected time to teach and supervise, high standards in vocational training, and funded CPD so GPs can be present wherever decisions about general practice are made. At the centre was the principle that ran through GP26: relational continuity is not a nice-to-have, but the foundation of safer, better care.

Leadership already in the room

Sir Ashley Bloomfield's keynote picked up that thread and turned it into a call to leadership. His message "no one is coming" was an invitation to recognise the leadership already embedded in general practice. GPs work across teams, communities, hospital specialties and whānau every day; they hold continuity in a fragmented system and are often closest to where practical innovation can happen.

He challenged the profession not to mistake pressure for powerlessness. The funded first year of registrar training and reweighted capitation showed that change can come from sustained engagement. Leadership, he suggested, is "an invitation to collective action" whether through practice quality, teaching, research, clinical governance, medical politics or executive roles.

Using new tools without losing what matters

College Chief Executive Toby Beaglehole's address brought the conversation to artificial intelligence but kept the focus firmly on the work of general practice. His story about noticing a subtle change in a friend's health before a serious diagnosis underscored what technology cannot replace: the knowledge that accumulates through relationships, attention and time.

His message was not to stand still, but to "make haste slowly". The College is using AI where it can better support members, exploring its role in medical education under clinical oversight, and working through the governance questions of equity, safety and privacy before these tools reshape consulting



Dr Prabani Wood



Sir Ashley Bloomfield

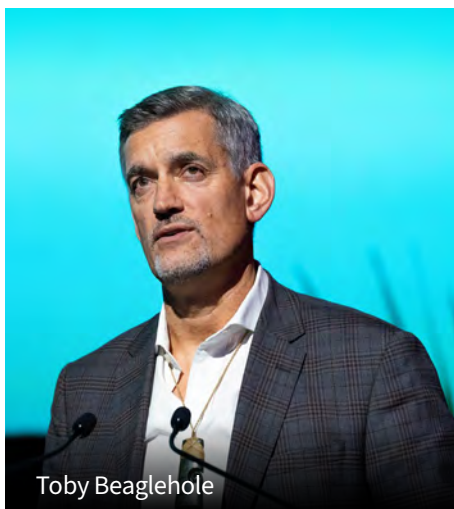


rooms by default. The principle was simple: AI should be built around the work, not the work rebuilt around AI.

The future of general practice, if we choose it

The leadership panel closed the Friday plenaries by asking whether the profession was optimistic, curious or anxious about the future. The answer was optimism, but not passive optimism. Professor Dee Mangin pointed to the evidence for generalism and continuity: more primary care clinicians increase life expectancy, and even a modest lift in continuity could save significant cost for older patients. Dr Nina Bevin welcomed progress in the Māori GPEP pipeline while warning that retention and corporatisation remain major risks. Sir Ashley Bloomfield returned to the need for hope with a plan, Dr Michael Wright showed how incentives have shifted Australia's GP workforce, and Dr Luke Bradford named the terms and conditions that would help level the field.

Together, the GP26 Friday morning plenaries told a story of a profession that knows exactly what it contributes: continuity, clinical judgement, cultural understanding, discipline, resilience, advocacy and leadership. The challenge now is to make that visible in the systems that train, fund and rely on general practice so the future is not something done to the profession, but something shaped by it.



Toby Beaglehole



Dr Paea Tonga(left) and
Dr Karlina Tongotea(right)



Left to right: Toby Beaglehole, Dr Nina Bevin, Professor Dee Mangin,
Sir Ashley Bloomfield, Dr Michael Wright, Dr Luke Bradford



MIND THIS

When the doctor's warning is ignored

Dr Peter Moodie

The recent coronial findings into the deaths of Peter and Eileen Field raise questions extending well beyond the circumstances of one tragic road accident. They concern the way the New Zealand Transport Agency (NZTA) deals with medical advice, where responsibility lies when administrative systems fail to act on that advice, and whether highly sensitive medical information is being handled with the degree of privacy that patients are entitled to expect.

Peter Field, aged 83, and his wife Eileen died following a collision with a truck in March 2023. The subsequent investigation found that immediately before the collision, Mr Field pressed the accelerator rather than the brake. The Serious Crash Unit concluded that had he braked normally, the collision would have been avoided.

The Coroner's examination of Mr Field's medical fitness to drive is particularly troubling.

A doctor's instruction that was not followed

In 2021 Mr Field's doctor assessed his fitness to drive as "borderline". On the medical certificate provided to NZTA, the doctor ticked the section relating to conditions on the licence and wrote "Review 1 year". One might reasonably think that instruction required a further medical review within one year.

However, NZTA renewed his licence for two years and did not contact the doctor to ask what "Review 1 year" meant or whether there was a clinical reason for the shorter period.

The Coroner considered the doctor's intention sufficiently apparent to recommend that, in future, where a health practitioner records a concern of this sort without specifying a particular medical condition, NZTA should contact the practitioner for clarification. The case demonstrates a potentially serious weakness in the system: clinically significant information was available to the licensing authority but was not acted upon.

The distinction matters. The doctor had not simply certified an elderly patient as fit to drive for another two years. He had described the situation as borderline and expressly requested review after one. The doctor also warned Mr Field that he may not qualify in a year's time.

NZTA effectively overrode that proposed safeguard without consulting the person who had imposed it.

When something goes wrong, blame the doctor?

NZTA's response to the Coroner is equally concerning.

It pointed out that health practitioners have obligations to notify NZTA where they believe somebody is medically unfit to drive and likely to continue driving. That

Peter Moodie is the
College's Clinical Advisor



obligation certainly exists. NZTA's current guidance expressly reminds doctors of their responsibilities under section 18 of the Land Transport Act (1998).

But that rather misses the point.

Mr Field's doctor had already communicated a concern. The question is not simply what more he might have written. It is also why the organisation receiving the information did not seek clarification.

There is a wider issue here for primary care.

When adverse events occur across the boundary between general practice and large health or government organisations, there can be a temptation to examine minutely what an individual might have done differently while paying rather less attention to failures within the institutional system.

Those working in primary care will recognise similar arguments when Health New Zealand is defending care provided in hospitals: If there is an opportunity to suggest that a GP should have referred earlier, followed up differently or communicated something more explicitly, responsibility can migrate surprisingly quickly towards primary care.

GPs should be scrutinised where appropriate, but scrutiny must operate equally in both directions.

What happens to the patient's private medical information?

There is another problem with the medical fitness-to-drive system which receives much less attention: privacy.

NZTA requires doctors to provide medical information to assist it in determining whether patients are safe to drive. Its own guidance requires consideration of conditions including diabetes, cardiovascular and neurological disease, cognitive impairment, mental health conditions and medications.

Yet the patient must take the resulting documentation to a driver-licensing agent, which can mean presenting it to a clerk at a counter, potentially with other customers close enough to overhear a discussion.

That creates an obvious tension. We ask doctors to disclose sufficient clinical detail to enable safe licensing decisions, while the physical process through which that information is subsequently handled may give neither doctor nor patient confidence that sensitive information will remain private.

Clinicians may understandably hesitate before recording unnecessary intimate clinical details on a document.

The Privacy Act 2020 establishes obligations concerning the collection, storage, use and disclosure of personal information. Health information receives additional protection precisely because of its sensitivity. Whatever the precise legal classification of NZTA is, once it receives medical information, an agency requiring such information has a responsibility to design systems that protect it appropriately.

This problem should be solvable. Medical information could increasingly be transmitted securely and directly from the clinician to NZTA, with licensing agents receiving only the information necessary to process the licence.

“

GPs should be scrutinised where appropriate, but scrutiny must operate equally in both directions.



A system problem, not simply a doctor problem

The deaths of Peter and Eileen Field were the result of a tragic sequence of events. No single administrative decision can simply be said to have caused their deaths.

But the Coroner has identified an important warning.

If NZTA asks doctors for their clinical judgement, it must have systems capable of recognising and acting upon that judgement. If an instruction is unclear, the answer is to ask the doctor, not disregard it and later point to what the doctor might have written more clearly.

The lesson from the Field case should therefore extend beyond older-driver licensing. Responsibility must follow information. An institution cannot demand clinical information, fail to act upon an obvious warning within it, and then place the principal responsibility for making the system work back on the individual doctor.

Lessons?

When the College is asked to endorse any form such as a Fitness to Drive document, we should look quite carefully “under the bonnet”:

- Who will read the medical opinion?
- If the advice is not followed by the agency, how will this be communicated to the doctor?
- How secure is the information repository, and is there a log of who has accessed the records?

Finally, we should congratulate the Coroner who sent a provisional report to the College and we were able to comment on what we thought were possible shortcomings prior to it being published.

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



In tune with medicine

Dr Dickson Fung is a specialist GP based in Tāmaki Makaurau. We caught up with Dickson to hear about his musical hobby outside of general practice.

Music entered Dr Dickson Fung's life early. Born in Hong Kong, he began learning the piano at four and a half after receiving a miniature piano that he played incessantly. When he begged for lessons, his prospective teacher set an unusual condition: he first had to learn how to add fractions, a skill the teacher believed was necessary for reading dotted rhythms. His father (although not a musician himself) nurtured that early interest by regularly playing recordings of violin performances he had taped from a weekly classical music radio programme.

After moving to New Zealand, musical influences continued to shape his path. His cousins played violin in youth orchestras and competitions, while a close friend also took up the instrument. When a violin teacher began offering lessons at his primary school, Dr Fung decided to learn as well, adding the violin to his piano studies.

Today, music remains a major part of his life. He freelances with professional-level orchestras and ensembles when time allows and supports the Manukau Symphony Orchestra's Tuakana Mentor programme, helping promising young and community musicians participate in large-scale orchestral performances. Just as importantly, playing keeps him connected with a community that has been part of his life for decades.

"I think it is the connections with people that keep me playing," he says. "The shared musical communication between friends working together towards a performance that the audience enjoys."

Medicine was another passion that began in childhood. Among his favourite toys was a miniature doctor's kit complete with a plastic stethoscope and thermometer. More significantly, he was inspired by the health professionals around him. His mother worked as a charge midwife, while his friend's GP parents frequently looked after him after school. Through their example, he witnessed a deep commitment to helping others, understanding communities and improving people's lives. Combined with his fascination with how the human body works, it was an influence that shaped his future career.

Yet there was a stage when it seemed he might have to choose between medicine and music. He led the New Zealand Secondary Schools Symphony Orchestra while at college and later played in the National Youth Orchestra during medical school. After five years of medical studies, he took a year away to begin a degree in violin performance.

He subsequently completed medical school, worked as a house surgeon and returned to finish his music degree. Through the generous support of the Creative New Zealand NZ Aotearoa Scholarship and the NZ UK Link Foundation, he then undertook postgraduate violin studies in the United Kingdom, alongside a Master of Science in Performing Arts Medicine with a focus on musicians' health issues, a



Dr Dickson Fung

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The parallels between music and medicine are numerous.

Both require attentive listening, communication and the ability to respond to others in the moment.





topic he remains passionate about. He notes that although there are crossovers with the field of sports medicine, there are specific performing-related health issues that affect musicians and performing artists, with significantly fewer support structures available for them compared to the athletic population.

In his general practice career so far, he has since had the privilege to work with musicians, sports teams, and in student health and with a military population, and as his career progresses, he aims to integrate this experience and what he has learnt to build better supports for the health needs of performing artists in New Zealand.

General practice ultimately provided the balance he was looking for. Unlike many hospital specialties, it offered a pathway that enabled him to continue pursuing both professional interests.

The parallels between music and medicine are numerous. Both require attentive listening, communication and the ability to respond to others in the moment. In a consultation, a GP must listen carefully to a patient's story, notice subtle cues and adapt accordingly. A violinist does much the same when performing with fellow musicians.

"Performing is a live, interactive process," says Dr Fung. Whether in an orchestra or a consultation room, success depends on people listening to one another and working together towards a shared goal.

Music has also influenced his role as a College medical educator. Advanced musical training involved intensive mentoring, repeated practice, public masterclasses and receiving feedback under pressure. Having experienced this himself, he believes he has greater empathy for trainees undertaking assessments and examinations.

Maintaining interests beyond medicine is also critical to his wellbeing. Music reminds him that his identity extends beyond being a doctor and provides opportunities to connect with lifelong friends and communities outside health care.

“

**I think it is
the connections
with people that
keeps me playing**



“Health is just a small part of a jigsaw in each person’s being,” he says.
“Ultimately, life is for living towards what is valuable to us.”

Occasionally, his two worlds intersect in unexpected ways. At a recent concert in Hamilton, he performed alongside a violinist whom he had seen as a patient years earlier for playing-related pain. The young musician had recovered and was now studying towards a performance degree. Seeing him pursue his passion and performing beside him was particularly rewarding.

For GPs who may have set aside their own hobbies and interests, Dr Fung offers simple advice: make room for them.

Stepping outside the ‘doctor’ identity, he says, allows people to reconnect with other passions, build relationships beyond medicine and gain fresh perspective. In doing so, they are reminded why health care matters in the first place: helping people stay well enough to live meaningful, rewarding lives and continue doing the things they love.

RECOGNITION OF LEARNING – LOG YOUR CPD

Goodfellow Unit podcast: **Heart failure and diabetes**

Professor Bruce Arroll is Professor of General Practice and Primary Health Care at the University of Auckland. A practising GP at Greenstone Family Clinic in South Auckland from 2006, he moved in 2024 to the Calder Clinic at the Auckland City Mission, and also provides special consultations using Focused Acceptance and Commitment Therapy.

In this episode, Bruce Arroll explores the management of coexisting heart failure and type 2 diabetes in primary care, covering surprising presentations, screening strategies, treatment priorities, medication nuances and lifestyle advice.

The key take-home messages of this podcast are:

- With heart failure, up-titrate all the drugs quickly.
- Where heart failure and type 2 diabetes coexist, prioritise treatment of the heart failure.
- Have the conversation about pill load.
- Get everyone exercising, at all ages.



[Listen to the podcast](#)



What can we do about alcohol consumption in 15 minutes?

Dr Hēmi (James) Enright
Ngā Puhi, Ngāruahine, Ngāti Ruanui

We know that alcohol-related harm costs New Zealanders around \$9.1 billion in disability-adjusted life years in 2023.¹ Around half of this cost (\$4.8 billion) is due to Fetal Alcohol Spectrum Disorder (FASD).¹ There is no safe level of alcohol consumption associated with cancer risk, and even light alcohol consumption (one drink per day, <12g alcohol) is likely to increase risk of developing oesophageal, oropharyngeal, liver, colon and breast cancers.² Alcohol is New Zealand's most harmful drug from the societal and health impacts that it has on us.³

Alcohol-related harm disproportionately affects Māori, youth and people living in deprivation.⁴ Despite the extent of evidence showing us that alcohol is not good for us, we continue to minimise our risk, normalise consumption (now with 0% alcohol products) and perpetuate the industry-generated idea of individual responsibility, even though alcohol harm affects all of us.⁵

In general practice we are all familiar with the dashboard and screening for alcohol-use disorder. We've learnt about the AUDIT and now CAGE screening tools.⁶ We regularly check in and have these discussions, but are we using the right frame and approach to these conversations? Like many of us, I've been on a journey to learn more about alcohol. From the effects it has had on my whānau, with my paternal great-grandfather returning from World War I and using alcohol as a coping mechanism for trauma, to growing up in New Zealand where 'getting on the piss' is seen as a rite of passage for young men.

Early on in my training, I often normalised alcohol consumption within recommended guidelines,⁷ afraid of being seen as the 'fun police'. Recently, I have challenged my perceptions of alcohol harm and changed my approach in practice. This followed submitting evidence for a District Licensing Committee licensing hearing, researching the impacts of alcohol-related harm on Emergency Department presentations for Wellington City Council discussions, and speaking out on proposed changes to the Sale and Supply of Alcohol Act (2012) with members of the Health Coalition Aotearoa Alcohol Expert Panel.^{8,9}

Now more than ever, we need to be aware of how internationally, industry perpetuates ideas about individual responsibility, normalises unsafe consumption of alcohol and prevents action on alcohol-related harm.¹⁰ As a collective of primary care practitioners, we have a voice and can make a difference. So, next time I am in the consultation room discussing alcohol, I will lead discussions with the evidence and check myself and my tendency to normalise alcohol consumption and its negative effects on us all.



Dr Hēmi (James) Enright, Ngā Puhi, Ngāruahine, Ngāti Ruanui, is a GPEP3+ registrar based in Te Whanganui-a-Tara.

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REFERENCES

1. New Zealand Institute of Economic Research (NZIER). Costs of alcohol harms in New Zealand: updating the evidence with recent research: a report for the Ministry of Health [Internet]. Wellington (NZ): Ministry of Health; 2024 Jun 18 [cited 2026 Aug 2]. Available from: <https://www.health.govt.nz/publications/costs-of-alcohol-harms-in-new-zealand-updating-the-evidence-with-recent-research>
2. Jun S, Park H, Kim UJ, Choi EJ, Lee HA, Park B, et al. Cancer risk based on alcohol consumption levels: a comprehensive systematic review and meta-analysis. *Epidemiol Health*. 2023;45:e2023092. doi:10.4178/epih.e2023092
3. Crossin R, Cleland L, Wilkins C, Rychert M, Adamson S, Potiki T, et al. The New Zealand drug harms ranking study: a multi-criteria decision analysis. *J Psychopharmacol*. 2023;37(9):891-903. doi:10.1177/0269881123118201
4. Chambers T, Mizdrak A, Jones AC, Davies A, Sherk A. Estimated alcohol-attributable health burden in Aotearoa New Zealand [Internet]. Wellington (NZ): Health Promotion Agency; 2024. Available from: <https://doi.org/10.60967/healthnz.27048892.v1>
5. Towers A, Severinsen C, Lyons A, Ware F, Newcombe D, Esekielu M. Reconsidering our low-risk alcohol advice: the dark influence of the alcohol industry [Internet]. Wellington (NZ): Public Health Communication Centre; 2025 Dec 1 [cited 2026 Aug 2]. Available from: <https://www.phcc.org.nz/briefing/reconsidering-our-low-risk-alcohol-advice-dark-influence-alcohol-industry>
6. McCusker MT, Basquille J, Khwaja M, Murray-Lyon IM, Catalan J. Hazardous and harmful drinking: a comparison of the AUDIT and CAGE screening questionnaires. *QJM*. 2002;95(9):591-595. Available from: <https://auditscreen.org/cmsb/uploads/2002-hazardous-and-harmful-drinking-a-comparison-of-the-audit-and-cage-screening-questionnaires.pdf>
7. Health New Zealand. Drinking responsibly [Internet]. 2026 Jul 22 [cited 2026 Aug 2]. Available from: <https://www.healthnz.govt.nz/health-topics/mental-health/alcohol-and-drug-addiction/drinking-responsibly>
8. Sneyd S, Shields E, Enright HJ, Connor J. Unpicking alcohol protections: new Bill set to increase harm and reduce public voice [Internet]. Wellington (NZ): Public Health Communication Centre; 2026 Apr 22 [cited 2026 Aug 2]. Available from: <https://www.phcc.org.nz/briefing/unpicking-alcohol-protections-new-bill-set-increase-harm-and-reduce-public-voice>
9. Health Coalition Aotearoa. Alcohol [Internet]. 2024 [cited 2026 Aug 2]. Available from: <https://www.healthcoalition.org.nz/alcohol/>
10. Gilmore AB, Fabbri A, Baum F, Bertscher A, Bondy K, Chang HJ, et al. Defining and conceptualising the commercial determinants of health. *Lancet*. 2023;401(10383):1194-1213. doi:10.1016/S0140-6736(23)00013-2

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Growing the rural workforce, one placement at a time

In June, rural health care in Aotearoa received a welcome boost with the announcement that the University of Auckland's Rural Medical Immersion Programme (RMIP) will be expanding into Taupō from 2027.

This means fifth-year medical students will be able to undertake year-long placements in another rural community working alongside specialist GPs, rural hospital specialists and their multidisciplinary teams.

Taupō is now the programme's fifth long-term placement site, joining Hāwera, Hauraki/Thames, Te Kūiti and Wellsford. The expansion showcases a shared commitment across the health sector to grow a sustainable rural health workforce and create more pathways for doctors to build careers in rural communities.

Rural hospital specialist and RMIP Academic Lead Dr Hannah Lawn says the programme is about more than clinical training.

"Being able to expand into Taupō reflects the amazing support of its local clinicians to grow the rural medical workforce. By immersing students in both clinical practice and community life we hope to inspire more medical graduates to pursue rewarding careers in rural New Zealand, as we know students are six times more likely to return to rural health care following a long-term rural placement."

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Creating opportunities for medical students to learn, live and contribute to rural communities may be one of the most effective investments we can make for the future of the specialist rural GPs and rural hospital specialist workforces.



Photo: Dr Hannah Lawn with the current 2026 RMIP students



The year-long immersion programme gives students vital hands-on experience in settings where they can see the full breadth and depth of rural medicine first-hand. Having the opportunity to work closely with specialist GPs, rural hospital specialists and other health professionals gives students a deeper understanding of the unique opportunities and challenges faced by rural communities.

For the College, initiatives such as RMIP are a critical part of the rural workforce pipeline. While increasing training capacity is essential, attracting doctors into rural communities often begins much earlier during the medical school years. Having exposure to supervisors who advocate for this career, and meaningful connections with local communities, can help shape future decisions and encourage graduates to consider rural general practice or rural hospital medicine.

With around 900,000 New Zealanders living in rural communities, growing the rural health workforce must be a priority for decision- and policy-makers, and the RMIP has demonstrated how targeted investment in training and exposure can help to create a sustainable future for the rural workforce and the communities they serve.

“With ongoing workforce challenges affecting many parts of the country, creating opportunities for medical students to learn, live and contribute to rural communities may be one of the most effective investments we can make for the future of the specialist rural GPs and rural hospital specialist workforces.

Dr Lawn says that “for places such as Taupō, the benefits are significant. Rural placements help build relationships between future doctors and local communities, strengthen teaching capacity, and showcase the rewarding and varied careers available in rural health care. Not to mention having some of the country’s most beautiful and scenic backdrops right on your doorstep.”

RECOGNITION OF LEARNING – LOG YOUR CPD

Goodfellow Unit podcast: **RSV in older people**

Dr Hasan Bhally is the clinical director of the infection service at Waitematā Health. He is also an acute general medical physician and an honorary senior lecturer at the University of Auckland.

In this episode, Hasan Bhally discusses the virology, transmission, clinical presentation, diagnosis and prevention of RSV in older adults, highlighting the importance of vaccination and awareness of complications.

The key take-home messages of this podcast are:

- RSV is more common than you think, and underdiagnosed.
- In high-risk populations RSV can be worse than COVID and influenza.
- Be aware of complications extending beyond the acute respiratory problem.
- Prevention is key, as there is no effective antiviral treatment.



[Listen to the podcast](#)



YIHA: Reducing admin burden while keeping patients safe

Dr David Moeller FRNZCGP and Dr Calum Patrick

Like many colleagues, Calum and I found ourselves spending increasing amounts of consultation time gathering routine information for annual reviews and monitoring rather than making clinical decisions. Asthma, COPD, oral contraceptive and HRT reviews, mental-health screening, and the growing demand for ADHD and autism assessments were filling appointment books and inboxes. The administrative load was real, yet the clinical responsibility for safe prescribing and regular review remained non-negotiable under Medical Council of New Zealand guidelines.

Out of that frustration we built YIHA (Your Intelligent Health Assessment) – a rule-based, New Zealand-hosted online tool that lets patients complete guided, condition-specific assessments at home. Results flow automatically into the Medtech Evolution daily record, clinical inbox, screening tab and classifications. No AI or machine-learning decision-making is involved; the clinician retains full control of every next step.

In our own practice the impact has been practical. Using the asthma review as an example, 8 out of 10 patients who complete the YIHA assessment do not require a face-to-face appointment. Patients rate the experience 9.8 out of 10. One of

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Using the asthma review as an example, 8 out of 10 patients who complete the YIHA assessment do not require a face-to-face appointment. Patients rate the experience 9.8 out of 10.

Screenshots from the YIHA Asthma Review tool

Asthma Review

Information | Review my Asthma

These questions are about what you do when your asthma worsens

How do you manage if your asthma is much worse than normal (tick all that apply or leave blank if none apply)?

☐ Increase preventer use

☐ Separate reliever inhaler

☐ Monitor peak-flow readings

☐ Start treatment course

☐ Other (Please State)

These questions are about sudden asthma exacerbations (attacks)

Exacerbations are sudden progressive worsening of your symptoms such as shortness of breath, wheezing, cough and chest tightness. Exacerbations often require additional treatment, such as steroid tablets or hospital treatment.

Have you had an exacerbation in the last year?

Please choose one:

Previous | Next

Asthma Review

Information | Review my Asthma

These questions are about your asthma control in the past month.

These questions, known as the Asthma Control Test, assess your asthma and are a trademark of QualityMetric Incorporated. Asthma symptoms include wheezing, coughing, shortness of breath, chest tightness or pain.

During the last 4 weeks, how often have your asthma symptoms woken you up at night or earlier than usual in the morning?

Please choose one:

During the last 4 weeks, how much of the time has your asthma kept you from getting as much done at work, school or home?

Please choose one:

During the last 4 weeks, how often have you used your rescue inhaler or nebuliser medication (such as Salbutamol)?

Please choose one:

How would you rate your asthma control during the last 4 weeks?

Please choose one:

During the last 4 weeks, how often have you had shortness of breath?

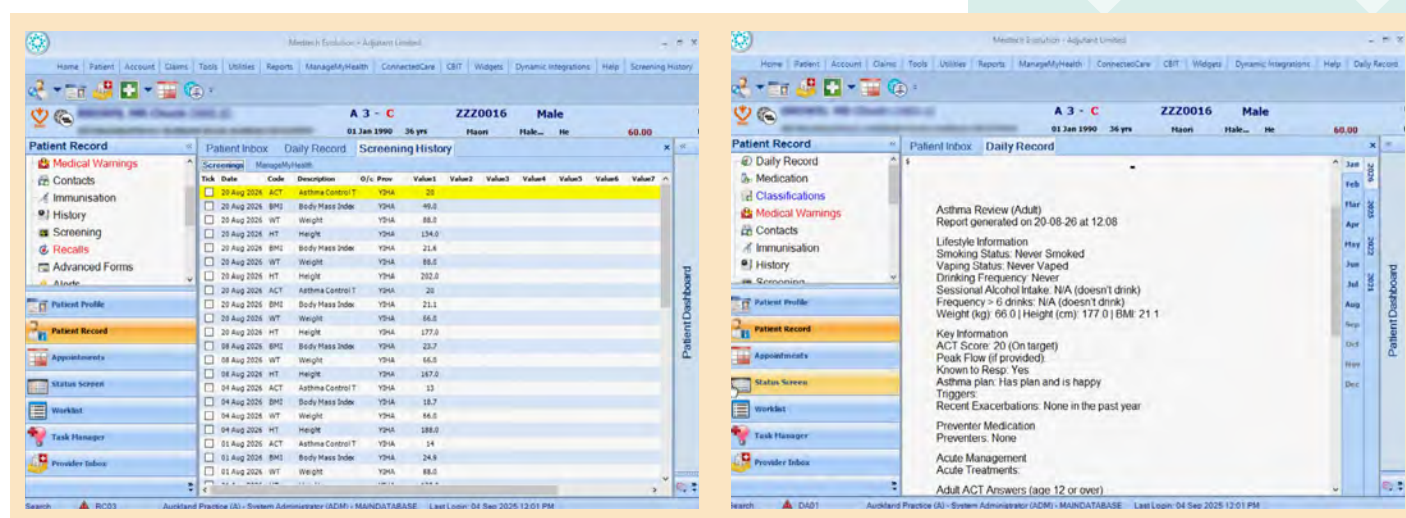
Please choose one:

You can give further details about your asthma control at the end of this review if you would like.

Previous | Next



Screenshot of the Medtech Evolution interface:



my favourite pieces of feedback is simply: “Easy to use even for an 83-year-old.” Time-pressured single parents, full-time workers and people living remotely particularly value the ability to complete a review without taking time off work or travelling. YIHA currently covers more than 30 assessments, reviews and administrative forms, including asthma and COPD, HRT and oral contraceptive monitoring (supporting safe prescribing requirements), PHQ-9/GAD-7, ADHD and autism screening, home blood-pressure averaging, repeat-prescription requests and consent processes. Embedded educational videos and plain-language explanations are used deliberately to strengthen health literacy at the same time as data is collected. Practices can choose whether patients pay a modest fee for the remote review.

The goal was never to replace the consultation. It was to protect the consultation for the patients who need it most, while ensuring structured, guideline-aligned information is already in the record for those who do not. In a typical 5000-patient practice, the cumulative time released can be measured in many clinical hours each year – time that can be redirected to complex care, equity work and clinician wellbeing. YIHA was developed by practising GPs for practising GPs. It is designed to sit quietly inside existing workflows rather than add another system to monitor. For colleagues interested in exploring how structured patient-completed reviews can support safer prescribing, reduce administrative load and improve access for rural and time-poor patients, more information is available at yiha.health.

We remain open to feedback from the wider College community as the tool continues to evolve in response to real-world general practice needs.

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The goal was never to replace the consultation. It was to protect the consultation for the patients who need it most, while ensuring structured, guideline-aligned information is already in the record for those who do not.”



Thyroid nodules in younger patients: what changes the level of concern?

Dr Francis Hall

Thyroid nodules are uncommon in children and adolescents – and that is exactly why they matter. Otolaryngologist Dr Francis Hall sets out what raises the level of concern, and when to refer.

The prevalence of thyroid nodules increases with age, and nodules are much less common in younger patients. Using ultrasound, some studies suggest thyroid nodules occur in 1% of children less than 10 years old, 13% of adolescents (10–19 years old) and 65% of adults. Thyroid nodules are more common in women than men.

The risk of malignancy in a thyroid nodule increases with decreasing age. About 25% of thyroid nodules in children are malignant compared with 5% of thyroid nodules in adults. Therefore, the younger the patient, the more likely a thyroid nodule is malignant.

Radiation exposure

Radiation exposure to the thyroid is a major risk factor for developing papillary thyroid carcinoma, and children less than five years old are very sensitive to the development of radiation-induced thyroid cancer. Radiation exposure also increases the prevalence of benign thyroid nodules. Approximately 5% of children with differentiated thyroid carcinoma have a history of radiation exposure, and that exposure is usually due to medical treatment.

Up to 10% of paediatric cancer survivors develop thyroid cancer, with a median latency period of 10 years and a range of 5–20+ years. Even low-dose radiation exposure (0.1 Gy) is associated with an increased risk of developing papillary thyroid carcinoma. Because of the increased risk after radiotherapy in young children, some authorities recommend ultrasound surveillance.

Family history

Familial non-medullary thyroid cancer accounts for about 5% of all differentiated thyroid cancer (papillary and follicular thyroid cancer) and is divided into syndromic (95%) and non-syndromic (5%) forms. Therefore, a family history of thyroid cancer, either medullary or papillary, raises the level of concern that a thyroid nodule is malignant.



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.



Syndromes associated with an increased incidence of thyroid cancer include familial adenomatous polyposis (APC gene), PTEN hamartoma syndrome (PTEN gene) and DICER1 syndrome (DICER1 gene).

Red flags

In both children and adults, rapid growth of a thyroid nodule, cervical lymphadenopathy, a hoarse voice, and difficulty breathing or swallowing are all red flags, and prompt referral to a thyroid specialist is recommended.

Investigating a nodule in a young patient

It is recommended that thyroid nodules in the young are investigated in a similar fashion to adults, with thyroid function tests, ultrasound and fine-needle aspiration (FNA) depending on the ultrasound results. An important difference is that the threshold to perform FNA is lower in the young than in adults.

This is because thyroid nodules in children are more likely to be malignant than in adults, and thyroid cancer in children is more likely to metastasise than in adults, so the consequences of missing a thyroid cancer are higher. For both reasons, FNA is performed in a higher proportion of thyroid nodules in children than in adults.

Finally, surveillance of thyroid nodules with indeterminate cytology on FNA (Bethesda 3 and 4) is generally not recommended in the paediatric population.

What the cancers look like

The most common type of thyroid cancer in children is papillary thyroid carcinoma (90%), followed by follicular thyroid carcinoma (10%). When histology and tumour size are controlled for, lymph node involvement, extrathyroidal extension and pulmonary metastases are more common in children than in adults. Fortunately, despite the higher proportion of extensive disease, children are less likely to die from thyroid cancer than adults.

Thyroid cancer in children is much less likely to be BRAF positive than in adults, and more likely to be RET/PTC positive. The American Thyroid Association guidelines recommend that treatment of thyroid cancer in children and adults is based on risk stratification, which has resulted in fewer patients being treated with radioactive iodine.

Summary

Thyroid nodules are much less common in children than in adults but are more likely to be malignant, so early referral for specialist care is recommended.

Up to 10% of patients who have radiotherapy before the age of 10 subsequently develop thyroid cancer.

REFERENCES

1. Ringel MD, et al. 2025 American Thyroid Association management guidelines for adult patients with differentiated thyroid cancer. *Thyroid* 2025; 35(8): 841–985.
2. Francis GL, et al. Management guidelines for children with thyroid nodules and differentiated thyroid cancer. *Thyroid* 2015; 25(7): 716–759.
3. Lebbink CA, et al. 2022 European Thyroid Association guidelines for the management of pediatric thyroid nodules and differentiated thyroid carcinoma. *Eur Thyroid J.* 2022; 11(6).
4. Lai S-TT, et al. Approach to the pediatric patient with thyroid nodules. *J Clin Endocrinol Metab.* 2025 Jul 15; 110(8): 2339–2352.

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The younger the patient, the more likely a thyroid nodule is malignant.



SMART asthma inhaler dispensing has collapsed: Why?

Dr Rob Burrell and Simon Wright

Research showed a progressive increase in the use of Single Maintenance And Reliever Therapy (SMART) for over 12-year-olds with asthma between 2019 and 2022.¹ During the same period, the use of short-acting beta-agonist (SABA) only therapies declined.¹

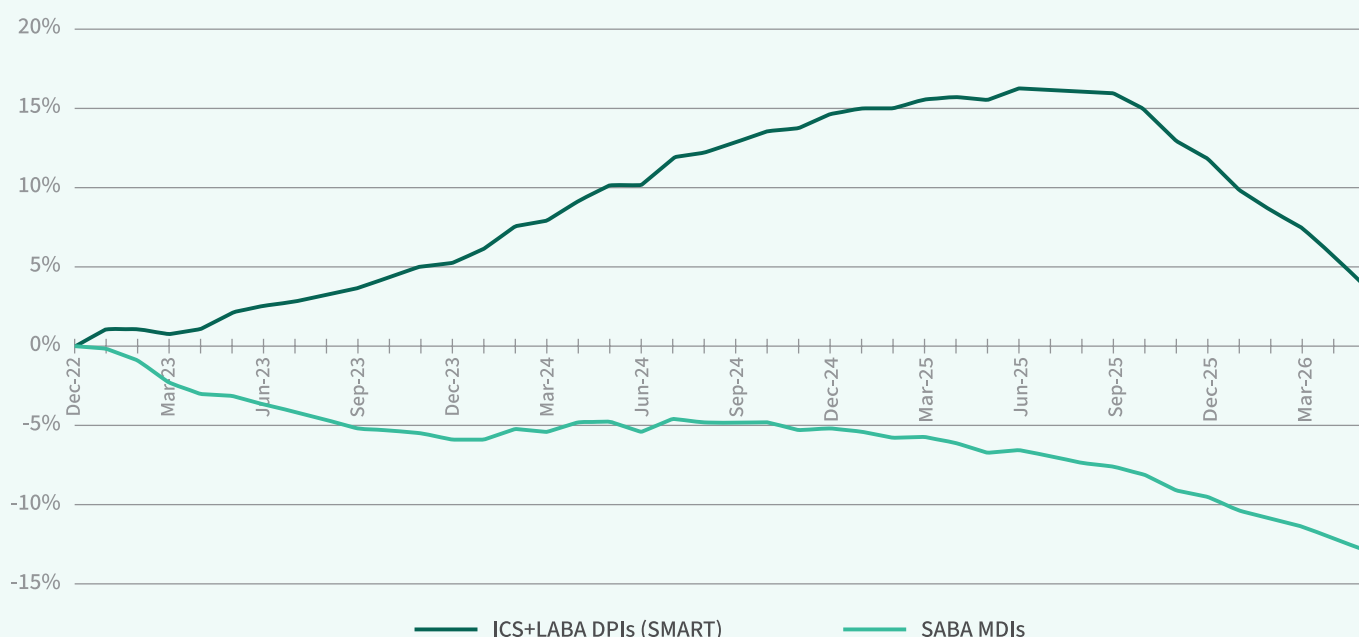
According to Health New Zealand dispensing data, these trends continued through until June 2025. However, the dispensing gains for SMART inhalers made in the 20 months from October 2023 to June 2025 have since been wiped out in just eight months. It is unclear whether the decline in SABA metered-dose inhaler (MDI) prescribing since September 2025 is part of the same phenomenon or the continuation of a longer trend (Figure 1). We don't know what has caused the SMART inhaler collapse, but we don't think it has anything to do with 12-month prescriptions.

The 2020 *New Zealand Adolescent and Adult Asthma Guidelines* favour the use of budesonide, an inhaled corticosteroid (ICS), and formoterol, a long-acting beta-2 agonist (LABA), delivered in combination via a dry powder inhaler (DPI) as both the primary reliever and preventer of choice.² When compared with SABA-only therapies, the use of SMART reduces exacerbations and morbidity, and keeps patients in better health.^{3,4}

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Figure 1. Change in number of dispensed inhalers relative to December 2022



The collapse of SMART inhaler dispensing represents poorer health for significant numbers of people with asthma. We suspect it also represents poorer health equity, as the prevalence of asthma is substantially higher amongst Māori, Pacific Peoples and children living in socioeconomically deprived communities.⁵ This will certainly be the case if the collapse is related to the current cost of living crisis.⁶

A significant part of our focus on asthma inhalers has been because of the outsized carbon emissions of MDIs. The emissions associated with one SMART DPI are only 3.6 percent of those associated with one SABA MDI. At current dispensing volumes, SABA MDIs contribute about 77 percent of asthma inhaler emissions (46,860 tonnes of carbon dioxide equivalent annually), despite making up 46 percent of dispensed inhalers. By contrast, SMART DPIs make up 36 percent of dispensed inhalers but contribute only 1.8 percent of carbon emissions.

Driven by climate change regulation, inhaler manufacturers are slowly swapping propellants to lower emission options. Most New Zealand MDIs contain HFA-134a, which has a Global Warming Potential (GWP) of 1430 (it is 1430 times more potent than carbon dioxide). The propellant in Breztri, a new inhaler for COPD that is available in New Zealand, is HFO-1234ze, which has a GWP of approximately five, and new inhalers in the UK such as Clenil (beclometasone) use HFA-152, with a GWP of 140. GSK UK plans to market Ventolin (salbutamol) with HFA-152. These represent significant advances for the climate and make sense for patients who cannot manage a DPI.

Climate gains should not be at the expense of health and health equity. In the normal course of events, high-quality asthma care should be positive for health, health equity and climate. We'd welcome advice about what has caused the collapse in SMART DPI dispensing.

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Climate gains should not be at the expense of health and health equity.

REFERENCES

1. Noble J, Hatter L, Eathorne A, Hills T, Bean O, Bruce P, et al. Patterns of asthma medication use and hospital discharges in New Zealand. *J Allergy Clin Immunol Glob*. 2024 Apr 10;3(3):100258. doi: 10.1016/j.jacig.2024.100258.
2. Asthma and Respiratory Foundation NZ. New Zealand adolescent and adult asthma guidelines [Internet]. Wellington: Asthma and Respiratory Foundation NZ; 2020.
3. Beasley R, Holliday M, Reddel HK, Braithwaite I, Ebmeier S, Hancox RJ, et al. Controlled trial of budesonide-formoterol as needed for mild asthma. *N Engl J Med*. 2019 May 23;380(21):2020-2030. doi: 10.1056/NEJMoa1901963.
4. Patel M, Pilcher J, Pritchard A, Perrin K, Travers J, Shaw D, et al. Efficacy and safety of maintenance and reliever combination budesonide-formoterol inhaler in patients with asthma at risk of severe exacerbations: a randomised controlled trial. *Lancet Respir Med*. 2013 Mar;1(1):32-42. doi: 10.1016/S2213-2600(13)70007-9.
5. Health Quality & Safety Commission New Zealand. Key findings: Asthma equity explorer indicators [Internet]. Wellington (NZ): Health Quality & Safety Commission; 2021.
6. Norris P, Keown S, Symon V, George M, Richards R, Richards L, Bhawan S. Experiences of medicines access by people facing social disadvantage in New Zealand [Report]. University of Otago; 2025.



When knowing the right thing isn't enough

A new international study puts a name to something many GPs will recognise and suggests it may be quietly driving colleagues out of the profession.

Most GPs know the feeling. You are three minutes into a consultation, and you already know what this patient needs. You also know they cannot afford it, or that the wait list runs to next year. You do what you can, then call the next patient in.

That gap between knowing what good care looks like and being unable to deliver it has a name: moral distress. A new paper in the *Journal of Business Ethics* argues it is an under-recognised force behind the workforce pressures facing general practice.

The study comes from Dr James Greenslade-Yeats and Associate Professor Tago Mharapara at Auckland University of Technology, drawing on interviews with 50 primary care doctors, 26 in Aotearoa New Zealand and 24 in the United States.

A tension that is not evenly weighted

The researchers describe cost constraints and care imperatives as a morally asymmetrical tension. Both poles matter, but not equally, and for different reasons. Care is what drew most of us into medicine; cost is a reality we work within. Where doctors can engage with both on their own terms, the tension is productive. The damage comes when structural power sits elsewhere, in funding settings, contracts and access thresholds, and doctors lose the ability to act on the pole that matters most.

The paper describes three ways doctors manage that distress: drawing a line between their own values and the system's, stepping back from outcomes they cannot influence, or channelling the frustration outward into advocacy, teaching and reform. None is presented as right or wrong. They are simply what people do to keep practising.

Why it matters for the workforce

Our workforce conversation tends to centre on burnout, workload and administrative burden. The authors suggest moral distress may be quietly intensifying all three and is sometimes mistaken for burnout altogether. That distinction matters. Burnout is often framed as an individual capacity problem, answered with resilience training. Moral distress points somewhere else entirely, at the conditions that stop clinicians from doing what they know their patients need.

The College supported this research, and it is good to see work grounded in the realities of New Zealand general practice reaching an international audience.

The paper is open access at link.springer.com
– DOI 10.1007/s10551-026-06399-1.

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Burnout is often framed as an individual capacity problem, answered with resilience training.



Get spotted this October

This October is Melanoma Awareness Month, and you can get involved by supporting Melanoma New Zealand's Get Spotted campaign and *Check For Changes*, by La Roche-Posay.



Show your support by putting skin cancer in the spotlight this month and sharing a few important messages with your patients to help prevent and detect skin cancer.

About melanoma and skin cancer

- New Zealand has one of the highest rates of melanoma in the world – and the highest death rate.
- There are around 8,000 diagnoses of melanoma and 300 lives lost to melanoma in New Zealand annually.
- The vast majority of skin cancers are preventable (around 90%).
- Skin cancer is the most common cancer in New Zealand. It accounts for more than 80% of all new cancer cases annually.

How you can help

Take a moment to talk with your patients about melanoma and how they can prevent and detect it. Reinforce our SLIP, SLOP, SLAP, SEEK, SLIDE prevention message and share our A-G guide on what to look for on your skin.

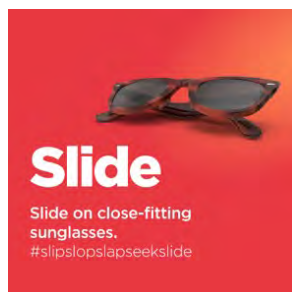
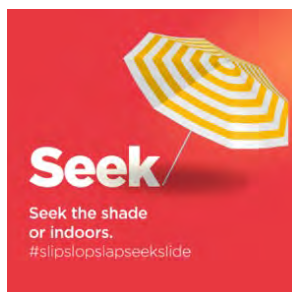
Getting spotted can make a difference – a few key messages to share with your patients

1. Melanoma is a type of skin cancer. It can progress quickly, and it can be life-threatening.
2. Knowing your skin – and knowing what to look for – could save your life.



3. Make checking your skin part of your regular health routine. Use the A-G guide or [Melanoma New Zealand's self-check video](#).
4. Look for a spot, freckle or mole that:
 - > is **new** or has changed in colour, shape or size
 - > looks **different** from your other spots
 - > is sore, itchy or bleeds
 - > is firm, growing or becomes raised quickly.
5. If you're concerned about something, get it checked straight away.
6. The best way to prevent melanoma is to be sun smart (SLIP, SLOP, SLAP, SEEK, SLIDE). Cover up with long-sleeved shirts, use at least SPF30 sunscreen, wear a hat and sunglasses, and seek shade.

More information about Melanoma Awareness Month can be found on the [Melanoma New Zealand website](#).



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