GP Voice

YOUR NEWS, YOUR VIEWS, YOUR VOICES

Welcome to our new 2025 trainees

College Insights
Commonwealth Fund

From GP to MP
Dr Neru Leavasa

Celebrating fellowship, community and family

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

February 2025

In this issue

Editorial

Dr Samantha Murton

Dr Samantha Murton
President | Te Tumu Whakarae

Kia ora koutou,

Happy New Year! I hope as many of you as possible were able to take some time off to relax and recharge over the festive season. I know for some that wouldn't have been an option, so I hope you have some time off booked in for the near future.

The definition of relaxing will vary for all of us – it could be anything from early morning walks on the beach and spending time with friends and family, to ticking a great walk off your bucket list, travelling and exploring a new city or starting a DIY project – whatever you did (or are planning to do) I hope it brought a sense of enjoyment and you returned to work refreshed, focused and ready to support your communities.

Our medical director Luke Bradford had a column published by *The Post* in early January with some advice and suggestions for the public on how to help our workforce to have a (slightly) less stressful holiday season. If you missed it, you can **read it here**.

2025 started off with a bang and the announcement of the Cabinet reshuffle, including a new Minister of Health – with this portfolio falling under the responsibility of Simeon Brown. At the time of writing this, I have reached out to our new Minister and invited him to visit my practice for a tour and an initial introduction and discussion about general practice and primary care, including the vital role we play and the cost effectiveness of the care we provide.

The College has also invited him to speak at GP25: Conference for General Practice happening in Ōtautahi Christchurch from 24 to 26 July. This is a prime opportunity for him to address us directly and allow our membership to hear what his vision, priorities and next steps are for health and especially our workforce.

The College looks forward to also meeting with our new Minister and discussing how we can work together to achieve the outcomes that we know would make a huge difference to our workforce and the patients we serve.

I'd like to acknowledge Hon Dr Shane Reti for his dedication to the role of Health Minister. We did have some successes and achievements over his tenure and having a Minister who truly understood what it's like to work in the community was an asset.

Looking at our advocacy work, in January the College made **a submission on the Principles of the Treaty of Waitangi Bill** consultation. Thank you to the members who provided their views and helped to shape the College's submission and to those who provided their own individual or group submissions.

> "The College team's work on ADHD medications has been exemplary and the changes that have recently been announced will make a huge difference.

College submissions are made from a health, equity and workforce perspective and outline how the passing of proposed Bills or legislation may or may not help with the College's commitment to improving health outcomes for New Zealanders and providing timely and equitable care.

Registrations for GP25 will open in March so be sure to look out for the earlybird deals, book your flights and join us for some learning, education, networking and, of course, fun.

Enjoy the first issue of GP Voice for 2025,

Goodfellow Unit podcast: **Estradiol gels**

Dr Stella Milsom is a reproductive endocrinologist at National Women's Hospital.

In this podcast Stella discusses the clinical use of Estradiol gels, focusing on the two available options in New Zealand: Estradiol (Sandrena/sachets) and Estradiol Hemihydrate (Estrogel pump). Stella will cover dosing, absorption, safety considerations, and the latest updates to Pharmac criteria.

The key take-home messages of this podcast are:

- Flexibility and choices are always good when prescribing.
- For some women, estrogen in tablet form is contraindicated. These women now have two options for a transdermal or through-the-skin medication.
- Even if women are on the patches, there is a backup option if estrogen patches are in short supply.
- Some women will prefer the gel to patches.

Listen to the podcast

Submit your feedback

Welcome to our new 2025 trainees

Victoria Harrison, Head of Learning

On Monday 27 January, 200 new GPEP and 20 new rural hospital medicine (RHM) year 1 registrars officially joined our College whānau and have begun their journey to becoming specialists.

With 90 percent of medical conditions being treated in the community it is critical we have a well-resourced workforce right around the country in every community that is valued and supported to care for their patients.

As we start 2025 with a new Minister of Health, we'll be looking to engage with him to address GP workforce challenges and improve health outcomes for New Zealanders. One of the top priorities continues to be increasing the numbers of medical graduates training through the College to become vocationally registered specialists, with an emphasis on encouraging and supporting registrars to train in rural communities across Aotearoa.

Throughout February and March, our GPEP year 1 registrars will attend Te Ahunga, a two-day event designed to welcome and introduce all new registrars to the programme. Te Ahunga provides an opportunity for whakawhanaungatanga – getting to know their local medical educators and other registrars in their region, as well as members of the College team.

This is where a large part of the registrars' health equity, cultural safety and hauora Māori teaching for the year takes place and provides time for them to learn and develop important skills that will help throughout training and into their careers.

Te Ahunga also provides an important opportunity for registrars to stay on a marae and connect with members from the community of that marae and our specialist hauora Māori medical educators.

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

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

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

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

Victoria Harrison
Head of Learning

Submit your feedback

Month in review

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 submissions made in December 2024 and January 2025.

December/January policy submissions

- Treaty Principles Bill
- Unlocking the potential of active ageing
- Extension of the provisional vocational assessment period
- Medicines Review Committee
- Safety measures for the use of puberty blockers in young people with gender-related health needs

Principles of the Treaty of Waitangi Bill

The College's submission

The Justice committee called for submissions on the Principles of the Treaty of Waitangi Bill in November 2024. The purpose of the Bill is to set out the principles of the Treaty of Waitangi in legislation and require, where relevant, those principles to be used when interpreting legislation.

The College is committed to honouring Te Tiriti o Waitangi and achieving Māori health equity. Te Tiriti o Waitangi affirms a place for everyone in Aotearoa New Zealand, emphasising Māori self-determination and allowing non-Māori governance without the ceding of Tino Rangatiratanga by Māori.

The College supports the notion that Te Tiriti o Waitangi provides equal constitutional rights for all people and recognises the following key founding documents:

- He Whakaputanga o te Rangatiratanga o Nu Tireni (1835), (the Declaration of Independence of the United Tribes of New Zealand) affirms Mana Motuhake and Tino Rangatiratanga (ultimate sovereignty) amongst northern iwi Māori.
- Te Tiriti o Waitangi builds on He Whakaputanga o te Rangatiratanga o Nu Tireni (1835) through provision of Crown obligations and recognition of Māori rights articulated in Articles One, Two, Three and the Ritenga Māori Declaration.
- Internationally these rights are supported via the United Nations Declaration on the Rights of Indigenous Peoples which affirms Māori rights to experience, at a minimum, the provision of equitable access to health services, quality of health care experiences and health outcomes.

The College is committed to honouring Te Tiriti o Waitangi as articulated in the College rules. This guides our work across the College, including proactive identification and prioritisation of actions that seek to achieve Māori health equity and support Māori health advancement. We also prioritise initiatives that support our members in developing cultural safety capabilities through our training, continuing professional development and quality programmes.

Summary of the College's position

The College rejects the Treaty Principles Bill, asserting that meaningful dialogue with Māori must first occur and be rooted in equity, justice and fairness. It is essential to recognise that both historical and contemporary breaches of Te Tiriti o Waitangi have resulted in significant inequities for Māori. Aotearoa New Zealand must unite in prioritising and realising Māori rights and Tino Rangatiratanga.

We unreservedly support initiatives and advocate for a health system that centres Te Tiriti o Waitangi and applies the principles of Tino Rangatiratanga, equity, active protection, options and partnerships (WAI2575). Failure to acknowledge Māori health rights will contribute to ongoing Māori health inequities and the perpetuation of systemic injustices which will have broader implications for societal health and cohesion.

The Treaty Principles Bill is fundamentally divisive and perpetuates victim blaming and deficit explanations of Māori health inequities. The Bill also fails to address the broader determinants of health that contribute to Māori health inequities. The existence of health inequities among Māori is unacceptable and reflects the ongoing failures of successive Governments to uphold Māori rights articulated in Te Tiriti o Waitangi.

You can read the submission on our website.

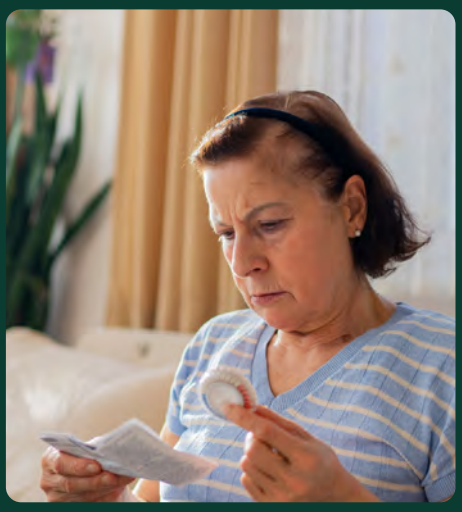
Goodfellow Unit podcast: **Nutrition and mental health**

Julia Rucklidge is a Professor of Psychology and a Clinical Psychologist in the School of Psychology, Speech and Hearing at the University of Canterbury.

In this podcast Julia provides an update on the relationship between nutrition and mental health. She explores the current state of mental health and delves into the role of diet. Additionally, she explores whether a 'good diet' alone is sufficient for optimal mental health, what micronutrients are and when we should consider them for patients.

The key take-home messages of this podcast are:

- While patients might think they eat a 'healthy' diet, it may well incorporate a lot of ultra-processed food.
- Half of calories consumed in the Western world come from ultra-processed foods.
- Research has robustly shown, based on epidemiological studies and controlled trials, that our choice of diet is influencing our mental health.
- Supplementation with additional micronutrients may be necessary for some people, even if they eat a good diet.
- There are RCTs that have demonstrated the efficacy of broad-spectrum micronutrient supplementation for the treatment of ADHD, aggression and symptoms associated with autism, depression and stress.



Listen to the podcast

Submit your feedback

Celebrating fellowship, community and family

The Waikato/Bay of Plenty Faculty hosted a heartwarming biennial Fellowship Celebration lunch in November. The event was a true testament to the strength of our community and a wonderful opportunity to come together and recognise the achievements of those who have attained Fellowship in the past two years. It was an occasion filled with joy and shared pride as we recognised our new Fellows. One of the highlights of the celebration was the emphasis on family. It was heartening to witness the support and love from family, friends and loved ones who joined us in celebrating this significant milestone. During the ceremony, Jo Scott-Jones, reminded us of the joy that our work brings. It served as a powerful reminder of the purpose and fulfilment we find in serving our patients and communities.

Below: *Alison Fawdry, Chair (far left) and representatives from the Waikato/Bay of Plenty Faculty.*










COLLEGE INSIGHTS

Highlights from the International Forum on Quality and Safety in Healthcare

Sandy Bhawan, Manager Quality Programmes

In November last year I attended the International Forum on Quality & Safety in Healthcare in Brisbane. The forum brought together over 5,000 health care professionals from across the globe. The event, jointly organised by the Institute for Healthcare Improvement (IHI) and BMJ Group explored the theme of 'Pushing Boundaries,' focusing on innovation in health care quality and safety. The conference highlighted the need for creative, community-centred health care models and new approaches to address evolving health challenges.

Key highlights and takeaways

Opening Ceremony and Keynote Address: The conference began with an Aboriginal smoking ceremony, a sacred ritual involving burning native plants to produce smoke, symbolising cleansing and renewal. Dr David Rosengren, Director General of Health for Queensland Health, followed with a keynote urging delegates to not just push but reform boundaries in health care, inspiring attendees to embrace change and innovation.

Innovative Approaches in Primary Care – Study Tour to Inala: An off-site study tour to the Inala Community Health Centre and Inala Primary Care was a key highlight. Inala serves a large refugee and migrant community and faces health care challenges compounded by socioeconomic issues, language barriers and mental health concerns. Key innovations included the development of Cubiko software for HR management and its commercialisation to other general practices, the increasing use of social prescribing, and a shared medical appointments model where multiple patients with similar conditions are treated in one session by a nurse and pharmacist. These approaches, developed with frugality and community collaboration, offer valuable lessons for improving care in underserved areas.

Empowering Leadership for Equity: Debbie Sorenson, CEO of the Pasifika Medical Association in New Zealand and Tanya Hosch from the Australian Football League shared powerful stories about leading equity efforts in health care. Sorenson spoke about building a relational system within Pasifika communities, advocating for outcomes-based funding and pushing for better representation and health care access. Hosch discussed her experience navigating the health care system with a disability, highlighting systemic biases and the need for more inclusive, compassionate care.

Smoke Ceremony

Inala Health Centre

Digital Health Transformation: The Australian Government's Digital Health Blueprint 2023–2033 emphasised the importance of data in delivering a person-centred, connected health system. The session underscored the need for trust and transparency in digital health, aligning with broader efforts for the College's Te Kāpehu Whetū project, which focuses on designing systems for the member journey and safeguarding member data while ensuring ongoing consent.

AI and Healthcare Performance: Liesl Yearsley, founder of AKIN addressed the growing role of AI in health care. She cautioned against allowing AI to be driven solely by profit and advocated for its use in ways that enhance human life and societal values. I'd highly recommend her TEDx Talk.

Shifting Healthcare Culture: Duncan Brown and Robert Styles led a session on shifting from individualistic ('me') to collective ('we') thinking in health care. They shared strategies for fostering cooperation and empathy, essential for transforming health care systems. The session stressed that to improve patient care, health care professionals must shift away from self-preservation and adopt shared goals focused on the collective wellbeing of both staff and patients.

Other notable presenters included Jana Pittman – doctor, former athlete and author; Simon Kuestenmacher from the Demographics Group who reaches 35 million people a month on social media; and experts from the Australian Alliance to End Homelessness and Micah Projects addressing homelessness and health.

The forum was a powerful reminder of the need to push boundaries in health care. From innovative community health models to leadership for equity and the integration of digital tools, the event provided valuable insights into how health care systems can be transformed to meet the needs of diverse and vulnerable populations. The forum's key themes – innovation, collaboration and equity – offered a blueprint for the future of health care, where compassion, technology and systemic change converge to improve patient care globally. The key message: there is no quality without equity.

I'd highly recommend attending a forum if you get the chance – in 2025 forums will be held in Utrecht, Singapore and Canberra.

"...the event provided valuable insights into how health care systems can be transformed to meet the needs of diverse and vulnerable populations.

Submit your feedback

COLLEGE INSIGHTS

Commonwealth Fund

Primary care research partners meeting – Is the grass greener?

Simon Wright, Principal Insights Advisor

New Zealand general practitioners were the fourth most likely to be 'extremely' or 'very' satisfied with practising medicine when compared with general practitioners from nine other high-income countries in 2019. In 2022, during the COVID-19 pandemic, levels of high satisfaction dropped significantly in almost all these countries, but New Zealand GPs were still the fourth equal most likely to report high levels of satisfaction.

Figure 1: Overall how satisfied are you with practising medicine?
The percentage of GPs answering 'extremely satisfied' or 'very satisfied', 2019 and 2022

These findings were taken from The Health Foundation (UK) report *Stressed and Overworked*, which is based on data from the Commonwealth Fund's International Health Policy Survey of primary care physicians in 10 countries.

The US-based Commonwealth Fund began its international health systems research in 1998 and has since conducted seven primary care surveys, 10 surveys of the general population (18+) and nine surveys of older adults (65+). Its comparative research reports are one of the few ways of knowing how New Zealand compares internationally. The research probes many aspects of health care, including access, management systems and coordination, as well as 'hot issues' such as clinician burnout.

In November 2024, I was privileged to be supported by the Commonwealth Fund to attend a meeting of its primary care research partners in Lisbon. I also attended the European Public Health Conference, where I participated in the Commonwealth Fund's pre-conference session on the value of comparative health system research. It was almost surreal to meet the people I have been collaborating with virtually since 2019 and to meet them in a former palace!

The agenda included presentations from the Commonwealth Fund as well as by country representatives on their respective health systems. Time was spent discussing future research priorities, how we can collaborate more effectively, and how to make our work both more relevant and influential with policymakers and care providers.

So, is the grass greener in other countries? Figures 2 and 3 below are taken from the Commonwealth Fund's *Mirror, Mirror 2024* report. While primarily focused on the underperforming US health system, they show that system performance is not just a matter of resourcing. In fact, what I sensed from all the presentations and discussions I had in Lisbon was that behind the numbers, clinicians and administrators everywhere are really struggling in the face of increasing demand.

Many conference presentations discussed the causes of this demand, such as extreme heat and air pollution, and harmful commercial products and practices. For instance, alcohol and processed food are linked to nearly 7,500 deaths per day in Europe. Additionally, new research links indoor pollution from gas cookers to nearly 40,000 premature deaths and hundreds of thousands of asthma cases annually.

This suggests that the greenest grass will probably be in countries where policymakers take research seriously and act in the public interest to address commercial determinants of ill-health and issues like climate change.

Figure 2: Health care performance rankings

	Aus	Can	Fra	Ger	Neth	NZ	Swe	Swiz	UK	US
Overall ranking	1	7	5	9	2	4	6	8	3	10
Access to care	9	7	6	3	1	5	4	8	2	10
Care process	5	4	7	9	3	1	10	6	8	2
Administrative efficiency	2	5	4	8	6	3	7	10	1	9
Equity	1	7	6	2	3	8	-	4	5	9
Health outcomes	1	4	5	9	7	3	6	2	8	10

Figure 3: Health care system performance compared to spending

> "...the greenest grass will probably be in countries where policymakers take research seriously and act in the public interest to address commercial determinants of ill-health and issues like climate change.

Submit your feedback

Quality in Practice

Avondale Family Doctor

The Quality Programmes team are running a promotion until the end of March 2025. Practices who complete either Continuous Quality Improvement (CQI) or Equity module accreditation go into the draw to win one of five $700 Amtech Medical vouchers for their practice.

Congratulations to Avondale Family Doctor - our third prize draw winner!

We caught up with Wendy, the practice manager, to find out about the team's experience completing the Cornerstone Equity module, why they did it and what they learnt.

Tell us a bit about your practice

Avondale Family Doctor is a solo GP practice with two nurses and one practice manager/receptionist. We're a VLCA practice with a culturally diverse patient population, and as a team, we're very passionate about equitable patient care, health promotion and positive health outcomes for all our patients, with a special focus on Māori, Pasifika and those with high needs.

Do you have tips for other small practices wanting to get accreditation?

Being a small team, we work together to plan, identify barriers and implement equity. Our Health equity policy was a team collaboration led by Dr Khan; Nurse Pam is our Equity Champion who leads and oversees the implementation of our equity initiatives.

We have a monthly team meeting, weekly clinical meetings and morning huddles to check on progress. We also have a monthly meeting with our PHO clinical advisor to review health targets, identify health equity gaps and discuss the way forward to achieve the targets.

We are a team that communicates effectively and open communication is encouraged. Completing the Equity module required communication, sound teamwork and a good understanding of what we wanted to achieve.

What motivated your practice to complete the Cornerstone Equity module?

Avondale Family Doctor recognises the longstanding barriers to health care for identified groups of people (particularly Māori), and the practice is committed to eliminating these inequities and improving health outcomes for our Māori patients.

Submit your feedback

We believe patients of all cultural backgrounds should be able to access quality health care services and treatment and have these services delivered to them in a culturally inclusive and respectful manner. We're committed to the ongoing education of practice staff to ensure culturally competent practice and aim to be inclusive in the way we deliver health care services to patients from all backgrounds. We work to remove barriers to health care and address any issues of inequity that may prevent patients from accessing services.

What did you have to do to gain the Cornerstone Equity module accreditation?

We researched our patient database to better understand our patients' needs for their medical requirements and the challenges they faced. Team meetings were held to discuss the results and form a plan of action to better address our patients' needs.

What has changed for your team following this work?

All team members are aware of their roles in achieving equity, and we support each other in achieving the best health outcomes for all our patients. The staff performance appraisal was updated and now includes equity goals, health promotion/training and cultural safety. Completing the module has given us a sense of achievement and assurance that we are giving our patients the best possible care.

What is different for patients?

Patient experience has improved as we have agreed as a team to consistently offer the following (as much as possible and depending on workload):

- Extended consultations for education on health, diagnosis and health outcome, and follow-up in nurse-led clinics
- Whānau involvement in patient care and decision making with the patient's consent
- Accommodating patients who walk into the clinic to aid in health care accessibility
- Phone consultations and home visits by Dr Khan where needed
- Accommodating other family members in one consultation slot
- Consultations for contraception and minor ailments by practice nurse Nileshnee, a registered community nurse practitioner
- Discretionary funding/care where there are financial barriers
- Free Uber service where there are transport barriers
- Free interpreting service for refugee patients and patients with English as a second language
- Resource material/patient information pamphlets in appropriate languages
- Multilingual staff.

Cornerstone

The Quality Programmes team are running a promotion until the end of March 2025.

Complete either the Continuous Quality Improvement (CQI) or Equity module accreditation for a chance to win one of five $700 Amtech Medical vouchers for your practice. Winners will be drawn in September, October and November 2024, and February and March 2025. If you have any questions about this promotion, please email the **Quality Programmes team.**

Find out more about the CQI and/or Equity module today.

Submit your feedback

College funding available for research projects

Research plays a critical role in advancing health care by investigating potential innovations in treatments, improving the health outcomes of patients and ensuring overall best practice in the workforce.

For patients, research leads to the development of new medications and treatments that enable them to have more effective and targeted options for their care to improve their quality of life.

Undertaking research in areas of personal interest can be highly rewarding. By balancing clinical practice with research, you have the opportunity to influence the future of health care, address unmet needs and contribute to the broader medical community's progress.

The College encourages members to undertake research projects and has funding available for research projects that benefit general practice, rural general practice and rural hospital medicine. Applicants don't need to be members of the College to apply; the research just needs to be relevant to the workforce, so people working within a general practice are encouraged to apply.

Applications are reviewed by the College's Research and Education Committee (REC). Grants are typically between $5,000 and $20,000, although up to $40,000 can be awarded.

There are three funding rounds per year and the **first round is open now with applications being accepted until Wednesday 5 March 2025.**

Information on the funding rounds is also shared with external research groups and organisations who share it with their networks.

REC has funded research on diabetes management and primary care, rural placements of health professionals, the impact of Health and Disability Commissioner complaints, and whether New Zealand's health care system provides equitable access to ADHD medications.

How to apply

All the information you need, including the application form, can be found on the College website along with the funding round dates, FAQs and application guidelines.

Applications should reflect one (or more) of the following domains:

1. Advancing Māori health
2. Achieving health equity
3. Enhancing the practice of primary care through scientific discovery
4. Meeting the needs of rural general practice and/or rural hospital medicine.

Successful applicants are also encouraged to submit their final papers to the *Journal of Primary Health Care* (JPHC) and submit an abstract to the annual College conference to share their research with members.

If you have received REC funding over the past couple of years and your research project is complete, **consider submitting an abstract** to present your findings at GP25: Conference for General Practice happening 24–26 July in Ōtautahi Christchurch. Abstracts must be submitted before 5pm 21 February.

The 2025 REC funding rounds

Applications open	Applications close
22 January 2025	5 March 2025
14 May 2025	25 June 2025
20 August 2025	1 October 2025

MIND THIS

Coroner report on suicide

Dr Peter Moodie

On 23 November 2019 Ms T, a 23-year-old woman, committed suicide and the Coroner has recently released their findings. It is against coronial regulations to publish the mode of death, and for this case, how she died is irrelevant.

Who was Ms T?

At the time of her death Ms T was in a relatively stable relationship, although she did not perceive it as such. She was unemployed and on a benefit but seeking work.

Her childhood had been difficult, with reports of abuse. In 2014, at the age of 17, she was diagnosed with a psychotic disorder and schizophrenia where she heard voices and had intrusive thoughts along with intermittent paranoia. At one point she had been placed under a compulsory order under the Mental Health Act and had been an inpatient on more than one occasion, including in one instance for an attempted suicide. At the time of her death, she was an 'informal patient' and so was not being compulsorily treated.

Over the years, in addition to oral medications including amitriptyline citalopram, lorazepam and zopiclone, she had been prescribed sequentially, monthly injections of risperidone, olanzipine, aripiprazole and finally paliperidone. Her family actively encouraged her to desist from the IM medications and she frequently missed her outpatient appointments as well as her regular injections.

She had a history of alcohol and cannabis usage, the latter exacerbating her paranoia.

Management

Ms T's initial presentation and management in 2014 was through the psychiatric services of Counties Manukau DHB (CMDHB). From then until 2018 she was managed by CMDHB (now Te Whatu Ora) community services.

She had also been referred to a Māori mental health unit (Manawhanui) and subsequently the Community Alcohol and Drug Service (CADS); however, she was discharged from both services because of non-compliance.

Under the care of the community mental health teams, she continued to be non-compliant and missed appointments and regular IM injections. This came to a point in 2018 where she was threatened with being discharged from care. However, before this happened, she negotiated a transfer to general practice care.

Peter Moodie is the College's Clinical Advisor

The transfer of care was arranged between Manaaki House (a secondary care community unit) by email from an un-named staff member to a practice nurse, RN H at a local general practice (owned by 'The Local Doctors group'). The referral included information about Ms T's medication and a discharge plan. RN H never had any direct contact with the patient but she did question the appropriateness of the referral. There was a response from a mental health worker explaining that no one could force Ms T to have the injections but she might like to inform Dr C (a consultant psychiatrist) about the case if Ms T did default. RN H replied to the email and stated that she had contacted Dr C.

It appears that the practice sent a recall reminder to Ms T and she had her IM injection in June 2018. However, a subsequent text message sent to Ms T in July was ignored and that was the last time she attended the practice.

The practice never had any formal handover from Manaaki House and a discharge letter was not sent. An agreed DHB pathway for management of such a patient stated that on receipt of a discharge letter, medications and directions should be entered into the case notes.

Ms T did attend another branch of the same general practice group where she was seen once. The doctor assumed that Ms T was getting her injections from Manaaki House and at her request was referred back to that clinic. Her referral was declined on the grounds that although the general practitioner had identified that she was hallucinating and on IM medication she also requested counselling, which was not a service that Manaaki offered. She was however, put on a waiting list.

In August 2019 Ms T died by suicide. Notwithstanding her apparent non-attendance for her regular medication, she was found to have a therapeutic dose of paliperidone in her system. No attempt appears to have been made to find the source of this management.

In September 2019 Dr C reviewed Ms T's file (presumably upon notification of her death) and called for a 'Serious Event Review' but the review never happened.

The Coroner concluded

"Ms T was an extremely vulnerable person with a history of suicidal ideation which she had acted on, on at least one occasion. Her lack of insight and non-compliance was almost certainly a consequence of her schizophrenia and paranoia. I find that she ought not to have been discharged from specialist care without careful consideration. This is a case crying out for integrated and coordinated care."

"…To discharge her without a formal referral and acceptance is contrary to good practice and contributed to the exacerbation of her symptoms."

Te Whatu Ora stated that care was less than ideal due to budgetary constraint, and the Coroner's response was, "Notwithstanding that however, there are steps which ought to be followed to ensure such patients do not slip between the cracks of care and support as I find happened to Ms T. I do not consider excuses about a lack of capacity or being too busy to be acceptable."

"

…To discharge her without a formal referral and acceptance is contrary to good practice and contributed to the exacerbation of her symptoms.

The coroner further stated

The Royal New Zealand College of General Practitioners (the College) has helpfully advised me that it will give the following advice to its members (advice which I endorse and thank the College for its assistance):

a. GPs should be wary of referrals from secondary care where there is no clear documentation or peer-to-peer communication. A consultant psychiatrist is the peer of a GP and in cases like this, a careful and well-documented discussion needs to occur.

b. Secondary care is resourced and funded to manage such referrals.

c. In additional to a clear management plan, GPs should ensure there is a clear and seamless pathway to enable referral back to secondary care if a case becomes complex and difficult to manage.

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

Submit your feedback

Ethical considerations for telehealth services

A case study of a practical ethical checklist for direct-to-consumer services

Dr Tania Moerenhout, FRNZCGP and Senior Lecturer at the Bioethics Centre, University of Otago, and Dr Madeleine Reid

Primary care has recently seen an expansion of technology use to support the provision of care. Telehealth consultations surged during the height of the COVID-19 pandemic and many GPs have been eager to try one of the new AI scribes to facilitate notetaking during consultations.

The introduction of new technologies into primary care presents promising opportunities but also challenges and potential pitfalls. It takes time to collect robust evidence for the impact of new tools (do they actually work and improve quality of care?) and to adjust existing systems and work processes to integrate the technologies successfully. When things go wrong with technology, there is often an ethical tension lying underneath related to, for example, privacy, equity, fairness, bias, respect for persons, etc. However, assessing health technologies from an ethical perspective remains challenging. Technology assessment frameworks tend to focus on cost and effectiveness as metrics with ethical considerations being harder to quantify or capture altogether. This leaves GPs operating in an area with high levels of uncertainty regarding both the effectiveness and ethics of new technologies.

We decided to focus on direct-to-consumer telehealth services in our study because these services are currently not integrated into existing evaluation models such as the Foundation Standard of the College, and they also seem to have a stable or increasing use while many traditional GP practices have seen a decline in video consultations since the COVID-19 pandemic, returning to face-to-face consultations and some phone consultations for the majority of clinical interactions.

To ensure a tool for ethical evaluation would be accessible to most stakeholders including industry partners, clinicians and patients, we opted for the development of a practical ethical checklist specifically tailored to direct-to-consumer virtual consultation services. This checklist was developed based on a scoping literature review. It consisted of 25 questions along six core themes:

1. Privacy, security, and confidentiality
2. Equity
3. Autonomy and informed consent
4. Quality of care
5. Patient empowerment
6. Continuity of care.

Dr Tania Moerenhout

Dr Madeleine Reid

We applied this checklist to six existing direct-to-consumer services in Aotearoa New Zealand, putting it into action and examining how well these services align with the identified ethical themes, as well as testing how well the practical ethical checklist works to do this type of assessment work.

We found that the services perform well in the areas of privacy, confidentiality and informed consent. Supported access for people with disabilities, interpreter services and use of te reo Māori were not always clearly offered, leaving room for improvement in the equity theme. Using the checklist also confirmed existing tensions in telehealth use.

First, accessibility is mainly improved through convenience (accessing the doctor from your own home, no need to travel, longer opening hours) rather than equity considerations, leaving the question of whether it is mainly the 'worried well' group of patients who are benefiting from these services.

Second, the focus on accessibility and convenience may negatively impact continuity of care. We know continuity of care improves outcomes and quality of care. The question then becomes whether we should be using telehealth services more effectively to support continuity of care rather than have accessibility as a priority. And lastly, telehealth interactions present limitations to comprehensive care due to limitations in the physical exam and in opportunistic screening and immunisations. The screened services were generally aware of these limitations and some worked within a hybrid model of both virtual and in-person consultations to solve this issue or referred to the patient's usual GP for questions that required a physical interaction.

Overall, we hope our practical ethical checklist contributes to both improving existing and new direct-to-consumer telehealth services and to reconsidering the big questions we still have not solved in telehealth use. It is not about whether to use virtual consultations, but rather a question of how we can use them best to improve the quality of care we provide to patients.

You can read the research we published in the *Journal of Primary Health Care* using the links below:

1. **Ethical assessment of virtual consultation services: scoping review and development of a practical ethical checklist**
2. **Ethical assessment of virtual consultation services: application of a practical ethical checklist to direct-to-consumer services in Aotearoa New Zealand**

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The question then becomes whether we should be using telehealth services more effectively to support continuity of care rather than have accessibility as a priority.

Submit your feedback

From GP to MP

Advocating for Pasifika Health

Dr Neru Leavasa, FRNZCGP

It all began when I was 14. After a rugby game, I took a hit to my knee and the swelling wouldn't go away. It didn't feel like a typical sports injury and when the pain persisted, I went to the doctor. After tests at Middlemore Hospital, I was diagnosed with osteosarcoma – a rare bone cancer – in my left knee. The doctors warned that if the cancer had spread, I might lose my leg. The fear of losing both my leg and my rugby career hit me hard, and when I woke from surgery and checked my leg, relieved it was still there, I felt an overwhelming sense of relief.

After surgery, I was transferred to an adult ward at Auckland Hospital for chemotherapy, as the team at Starship were not able to give me adult doses. I occasionally shared a room with adult patients, but I was well buffered by a dedicated oncology team. A correspondence teacher helped me keep up with school, providing a welcome distraction from the treatments.

My health journey had a huge influence on my decision to study medicine. I had always known that if rugby wasn't an option, health care was the next best thing. Despite missing a lot of schooling due to my illness, I still managed to get into med school.

Dr Kevin Karpik, my orthopaedic boss during my house officer years, suggested I explore general practice and sports medicine, combining musculoskeletal work with community care. Taking his advice, I chose general practice as my specialty, later focusing on sports medicine.

My Pasifika upbringing also shaped my career. My father, a Samoan chief, taught me the importance of family and community service. His values of giving back have remained with me throughout my life. My own experiences, like being placed in an adult ward at 14, also inspired me to advocate for vulnerable groups, particularly Pasifika youth in health care.

The health care system needs to better serve our youth, especially in Māori and Pasifika communities, by listening to their needs and providing services that align with their priorities. Being a good listener is key to improving service delivery.

Driven by a desire to give back, I became involved in local politics. As a GP, I ran wellbeing programmes targeting Māori and Pasifika communities in Māngere and set up a community trust to run these programmes alongside my clinic work. I always felt my impact could extend beyond the clinic, so I was encouraged by my brother-in-law to use my expertise to address social determinants of health through local government. I began working on community initiatives, focusing on grants and services for youth. Over time, I realised I could make a bigger impact at a national level, which led me to run for central government. While

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I always felt my impact could extend beyond the clinic, so I was encouraged by my brother-in-law to use my expertise to address social determinants of health through local government.

Dr Neru Leavasa (left) with Hon. Barbara Edmonds (centre).

the leap was daunting, I was compelled to use my health care and community experience to push for broader change.

During my time as an MP I maintained my medical registration by working part-time. Balancing both roles was tough, but transitioning back into health care after my political career was seamless. I was back in the clinic within weeks!

Being an MP changed my approach to medicine. I gained a deeper understanding of how social factors like education, employment and housing affect health outcomes. I learnt how to navigate the system more effectively, leveraging support networks and local MPs to advocate for my patients.

Today I continue to focus on Pasifika health and work closely with Pacific patients and providers. I am the clinical director for the **Cause Collective, New Zealand's only Pacific-led PHO**. The Cause Collective integrates health care with social services, offering support in youth education, training, employment, entrepreneurship and family harm prevention. This holistic approach aligns with my values of community-based care.

This role has been enriching, allowing me to work in areas such as economic development and cultural identity. As I aim to return to Parliament, this work enhances my skills, better positioning me to advocate for social issues in the future.

I first became involved with the Cause Collective through my long-standing interest in its work. Initially a PHO, the Cause Collective has since integrated social services with its health care offering. During my time as an MP, I frequently visited providers like the Cause Collective to gather feedback. When former clinical director Dr Hina Lutui went on sabbatical, she asked if I'd be interested in the role. Intrigued by the opportunity to learn more, I accepted and deepened my understanding of its integration with Te Whatu Ora and the Ministry of Health.

The Cause Collective focuses on three key goals: health and community, economic development, and cultural identity – goals that resonate with me personally. I believe that a strong sense of culture and financial literacy is essential for individual wellbeing. In my role, I contribute to these goals by overseeing programmes that improve health outcomes, support economic empowerment and help strengthen cultural identity. The holistic approach, combining health care with social support, is crucial for achieving long-term, positive outcomes for Pasifika communities.

Above: *Dr Neru Leavasa The Cause Collective.*

Left: *Dr Neru Leavasa with The Cause Collective team.*

Submit your feedback

My College journey and the evolution of general practice

**Dr Jonathan Simon, Dist. FRNZCGP,
Honorary Secretary 1991–1995**

I had the privilege of serving as the Honorary Secretary of the College from 1991 to 1995, during a period of significant change and growth for both the College and the wider health care system. Dr Tessa Turnbull, the Chairperson at the time, was a tremendous leader and my memories of those years are shaped by the dedicated people I worked alongside.

The vision for general practice during this period was one of an integrated, high-quality health care system led by general practice teams. It was an ambitious vision, one that has yet to be fully realised but is now more achievable than it was then.

The groundwork for improving quality in general practice was laid out in the mid-1980s by Dr Derry Seddon and Dr Tessa Turnbull, who focused on reaccreditation and establishing accountability in the profession. When I became Honorary Secretary we worked with remarkable presidents, including Doctors Murdoch Herbert, Rae West, Ashley Aitken and Tom Farrar, whose leadership provided stability during turbulent times.

The year 1991 was a particularly challenging one for the health care sector. Minister of Health Simon Upton introduced reforms that proposed replacing Area Health Boards with four Regional Health Authorities and transitioning hospitals to Crown Health Enterprises. The proposed model aimed to create a more commercial health care system but it proved unworkable in practice. Despite these challenges, the College continued to focus on measuring and improving quality in general practice, steering clear of the political upheavals that accompanied the rise of Independent Practitioners Associations (IPAs), which later evolved into Primary Health Organisations (PHOs).

The period also saw a shift in general practice as small independent practices began transitioning into larger practice teams working together. PHOs, which emerged from these reforms, became more inclusive of other providers, including Māori, and still play a vital role in New Zealand's health care system today.

Membership in the College grew significantly during these years and the organisation underwent a transformation. Previously led by volunteer GPs, education, training and vocational exams became increasingly demanding. To address this, the College began employing specialists and appointed a CEO to manage the expanding operations. The College also moved from the charming

villa on Palmer Street to a more professional office space on The Terrace, marking a significant milestone in its development.

One of the most memorable experiences during my time was the Treaty Workshop facilitated by Dr Irihapeti Ramsden ONZM. For many of us, it was the first encounter with the Māori perspective on the Treaty and its consequences, and it had a profound impact on the way we viewed our role in health care.

This period also saw the establishment of an environmental working party by Dr Nelum Soysa, inspired by Dr Helen Caldicott's work on the health impacts of environmental issues.

At the same time, the College was advancing general practice through initiatives such as the SouthLink Health programme, led by Emeritus Professor Murray Tilyard ONZM and the RNZCGP research unit at Otago University. The programme aimed to provide better management support for practices in the South Island and later the North Island.

Another significant moment was the visit of Professor Barbara Starfield from Johns Hopkins University, who demonstrated the value of the GP–patient relationship in creating the most effective health care system. Her visit helped shape the vision for a primary care–led system, a vision that has been supported by politicians across both National and Labour parties but has yet to be fully realised.

While the concept of a primary care–led health system remains elusive, the introduction of capitation in the 1990s was intended to reduce the dependence on fee-for-service models and to allow for the measurement of quality metrics. However, over time, capitation has contributed to the financial strain on general practices exacerbated by years of underfunding.

In the years since, general practice has been neglected and the COVID-19 pandemic has only further strained the GP–patient relationship. It can only be hoped that Simeon Brown, the new Minister of Health, understands the opportunity of developing and applying Artificial Intelligence (AI) to primary health care.

The use of AI could finally enable the primary care–led system that has long been envisioned. With AI, general practitioners could take a central role in supporting diagnoses, managing care and coordinating the patient journey. For general practitioners to assume this role will require a new kind of general practitioner with a different kind of training.

Reflecting on my time with the College, I am proud of what was achieved and hopeful that the future will bring the primary care–led health system that so many have worked towards for decades.

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Submit your feedback

From the military to the mountains

Dr Joe Browne's journey to rural New Zealand

Randal Benito, Rural Hospitals Locum Service, Hauora Taiwhenua Rural Health Network

After a long and notable career in the US Air Force, Dr Joe Browne found his military journey evolving into a fulfilling life of rural health care in Aotearoa New Zealand. With a background steeped in service and adaptability, Dr Browne's story is a remarkable testament to the power of following one's passions across borders and industries.

His introduction to Aotearoa came by chance in 1993 when a military hop brought him to Christchurch during his time as an ICBM missile launcher for the Air Force. This brief encounter with New Zealand left a lasting impression on him, sparking a dream to return. "I fell in love with the country," he reminisces, "and if I followed my dreams of becoming an Air Force doctor, I knew I could come back."

During this time, some of his most cherished memories from his early ventures to New Zealand involved travelling through the rural South Island with a friend, staying in bed and breakfasts and experiencing the local hospitality firsthand.

True to his word, Joe returned in 2010 as a physician and wanted to share his peaceful place, New Zealand, with his family before his deployment to Afghanistan in 2011. After retiring from the United States Air Force in 2013, he returned in 2017 for one year to work in Greymouth on the rugged West Coast as a general practitioner.

Joe embraced a new chapter in his career also working on the South Island's East coast in rural Oamaru, as a 'rural physician' mainly in the emergency department. He appreciates the slower pace of life in these rural areas, where he can make a meaningful impact on underserved populations while forming strong connections with his colleagues and patients.

Adjusting to rural New Zealand has been smooth for Joe. He finds the health care system here much more accessible than in the US, where exorbitant medical costs are often a barrier to care. Growing up in a military family, where socialised medicine was the norm, he appreciates New Zealand's public health care system. "In the US, I had to worry about whether my patients could afford the care they needed," he explains.

"Here, it might take a while to be seen, but at least the price is more affordable."

Dr Browne (Below) is practising medicine in Rural Hospital Medicine under a provisional general scope of practice at Oamaru Hospital.

One challenge Joe has encountered is the shortage of GPs in rural areas. The triage system means patients sometimes wait hours to be seen, as emergency cases take precedence. Despite these challenges, he finds the slower pace and understanding nature of rural communities refreshing compared to the more demanding environment in the US.

Dr Browne has also made strong connections within the community. One of the most unique aspects of his work in rural New Zealand is the presence of his "service dog" and loyal companion Hank, who has become an integral part of his routine at Oamaru Hospital Emergency Department.

He shares how Hank is becoming a welcome addition to both his patients and the rest of his team. Hank's presence is precious in the often-understaffed rural clinics, where long waiting times can leave patients uneasy.

This simple connection often opens the door for more relaxed and personal conversations during consultations, making Dr Browne's work easier and more fulfilling.

Hank's positive influence extends beyond just the patients; the clinic staff also benefit from his calming presence. In a high-pressure environment where back-to-back appointments and emergencies are the norm, Hank provides a sense of calm that helps relieve stress for everyone in the clinic.

As for the future, Joe is considering residency and potentially citizenship in New Zealand, drawn by the lifestyle, the beautiful landscapes and the genuine gratitude of the people he serves. "There's no litigiousness here. People are happy and grateful – it's mutual," he says.

With the opportunity to stay close to his family and enjoy the slower pace of rural life, Joe highly recommends the experience to other overseas doctors considering locum work in New Zealand.

In his own words: "I love New Zealand and I love working here."

Submit your feedback

Asthma: Let's get SMARTer!

Dr Rob Burrell

In Aotearoa, asthma is a significant burden of illness, inequitable in its epidemiology, and both the illness and the treatment create a significant carbon footprint. The illness means time off work for patients, reduced quality of life, 80–100 deaths per year and significant costs in both primary and secondary care.

With respect to the carbon cost of treatment and prevention, the ubiquitous asthma inhalers are the problem. Each metered-dose inhaler (MDI) is pressurised with a few grams of an extremely potent greenhouse gas, tetrafluoroethane, with heat-trapping potential that is 1,430 times more potent than carbon dioxide. A million Short-Acting Beta Agonist (SABA) MDIs are dispensed per year plus all the others, and the burden on the climate is equivalent to approximately 50,000 tonnes of carbon dioxide. The climate change potential released from a single SABA MDI is equivalent to driving a petrol car from Wellington to Taupō or approximately 290 kms.

These inhalers are not just an issue for the climate. They also prompt us to ask ourselves, are we treating this patient's asthma appropriately?

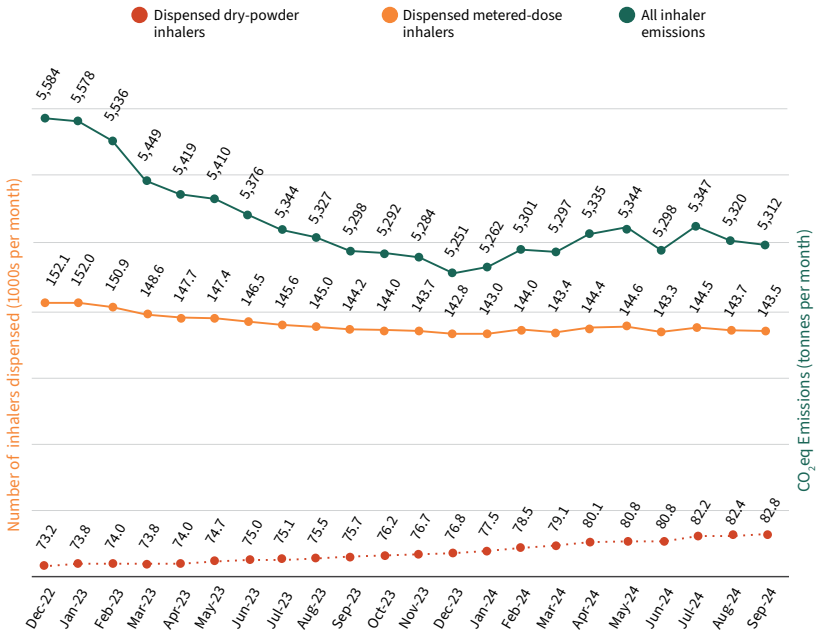
In 2024, in the Auckland area alone, one patient had over 200 salbutamol inhalers dispensed to them. Over 2,500 patients received 18 or more salbutamol inhalers. By definition, these people have poorly controlled asthma. The current Asthma and Respiratory Foundation NZ Adolescent and Adult Asthma Guidelines state that "SABA reliever as sole therapy (without ICS or ICS/LABA) is no longer recommended in the long-term management of asthma in adolescents or adults." The guidelines also define high SABA use as greater than three cannisters per year. Patients with poorly controlled asthma should be offered something better.

"Long-term treatment with ICS/fast-onset beta2-agonist reliever therapy is superior to SABA reliever in reducing exacerbation risk in adolescents and adults across the range of asthma severity."

About the author

Dr Rob Burrell mixes his anaesthesia job at Middlemore Hospital with his clinical lead role in Te Whatu Ora's Sustainability team.

Figure 1: Averaged inhaler dispensing and emissions



Looking at Figure 1, we can see the slow, steady rise in budesonide + formoterol, the so-called Anti-Inflammatory Reliever (AIR) therapy, or Single combination ICS/LABA inhaler Maintenance and Reliever Therapy (SMART). This rise represents an improvement in asthma therapy and control for New Zealanders, driven by better prescribing in primary care based on better guidelines and understanding.

Figure 2: ICS and LABA Inhaler Dispensing

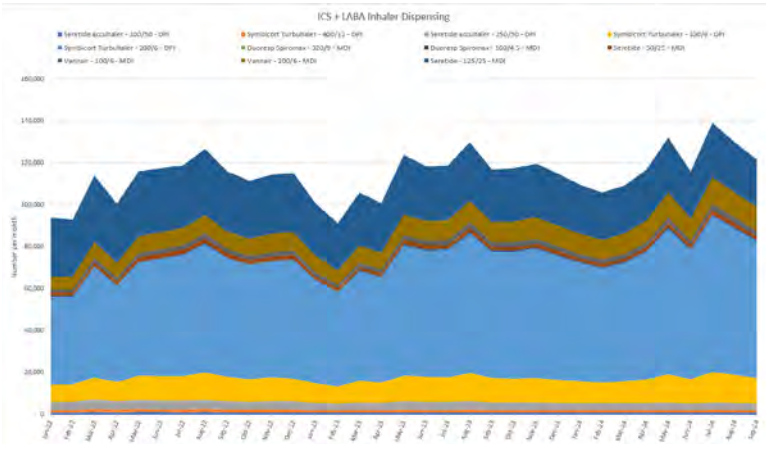
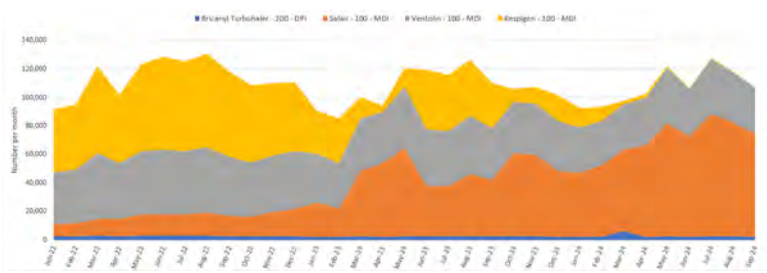


Figure 3: SABA Inhaler Dispensing



We are also looking for a decrease in SABA prescribing, which indicates better control for patients and significant greenhouse gas reduction.

What signals are there in our work that trigger us to stop and think about how good the asthma care is for the patient in front of us? One of the very best indications is the number of SABA prescriptions. We can trawl through patient records to look at this data but it is very labour intensive. A better solution would be for primary care software to be configured to raise a flag after three SABA prescriptions per annum. It doesn't take artificial intelligence just the will to do it. No doubt there are other subtle ways to incorporate better treatment algorithms into care records, the possibilities of which are endless.

This will not happen until medical practitioners demand it but it would make us better doctors. In the meantime, we should be rightly proud of the steady rise in SMART therapy. It is now time to get smarter with respect to SABA MDIs.

Journal
OF PRIMARY HEALTH CARE

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

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

Trending articles:

1. The impact of nurse prescribing on health care delivery for patients with diabetes: a rapid review
2. Patient perceptions of barriers to attending annual diabetes review and foot assessment in general practice: a qualitative study
3. Conventional medication adherence and self-treatment practices among South Asian immigrants: a qualitative study
4. Patient demographics and psychotropic medication prescribing in Australian general practices: pre- and during the COVID-19 pandemic
5. Community pharmacy service provision to adults with palliative care needs in their last year of life: a scoping review

Submit your feedback

How to diagnose and treat primary hyperparathyroidism

Dr Francis Hall

What symptoms do patients with primary hyperparathyroidism have?

Many patients with primary hyperparathyroidism have no symptoms. However, the most common symptoms patients have are vague and can include chronic fatigue, body aches, difficulty sleeping, memory loss, poor concentration, depression and headaches.[1]

Only 20% of patients with primary hyperparathyroidism present with the classical symptoms of hyperparathyroidism that we were taught at medical school:

Stones	Kidney stones
Moans	Abdominal pain: constipation, nausea, vomiting, peptic ulcers, pancreatitis
Bones	Bone and muscle pain, fractures, osteoporosis
Groans	Psychiatric: depression or psychosis

How do I diagnose primary hyperparathyroidism?

Request the following tests:

- Serum calcium (adjusted calcium) and phosphate
- PTH level
- Vitamin D level
- Creatinine and eGFR.

In hyperparathyroidism we see both a raised PTH level and a raised serum adjusted calcium level. It is important to exclude a secondary cause of hyperparathyroidism by checking the vitamin D level, creatinine and eGFR. Secondary causes of hyperparathyroidism include vitamin D deficiency and chronic kidney disease.

Once the diagnosis of hyperparathyroidism is made, I recommend referring the patient to either a surgeon who performs parathyroidectomy or to an endocrinologist.

Dr Francis Hall is Head of the Department of Otolaryngology Head and Neck Surgery at Counties Manukau DHB and 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.

How common is primary hyperparathyroidism?

The age-adjusted prevalence of primary hyperparathyroidism is approximately 200 per 100,000 in women and 100 per 100,000 in men. Therefore, in a GP practice, of 1500 patients, approximately two patients will have primary hyperparathyroidism.

What are the long-term complications of primary hyperparathyroidism?

Severe classical primary hyperparathyroidism is associated with an increase in mortality.

The long-term complications of primary hyperparathyroidism include kidney stones, kidney failure, osteoporosis and fractures. Some but not all reports have shown an association between even mild primary hyperparathyroidism and an increase in mortality from cardiovascular disease and cancer.

Which patients benefit from surgery?

Most symptomatic and asymptomatic patients benefit from surgery.

In the 2022 guidelines for Evaluation and Management of Primary Hyperparathyroidism[2] the indications for surgery are:

1. Serum calcium 0.25mmol/L above normal
2. Skeletal involvement: bone mineral density by T score <-2.5
3. Renal involvement
    a. eGFR or creatinine clearance <60 mL/min
    b. Kidney stones
    c. Hypercalciuria woman >250mg per 24 hours, men >300mg per 24 hours.
4. Age > 50.

What is the role of imaging in the management of hyperparathyroidism?

Imaging plays no role in the diagnosis of primary hyperparathyroidism. Imaging (bone scan, renal ultrasound, CT scan of kidneys) plays a role in the assessment of the effects of primary hyperparathyroidism. Imaging (ultrasound, sestamibi, 4D CT, spect CT and MRI) often helps the surgeon to localise the site of the abnormal parathyroid gland prior to surgery.

What is the pathology of the parathyroid gland in primary hyperparathyroidism?

Approximately 85% of patients with primary hyperparathyroidism have an adenoma of one gland. Occasionally adenomas may involve two glands. The remaining 15% of patients with primary hyperparathyroidism have hyperplasia of all four parathyroid glands.

Rarely carcinoma of a parathyroid gland may be the cause of primary hyperparathyroidism.

Primary hyperparathyroidism is due to dysregulated growth of parathyroid cells and decreased expression of calcium-sensing receptors (CaSR) on the surface of parathyroid cells.

How successful is surgery for primary hyperparathyroidism?

Surgery for primary hyperparathyroidism is usually highly successful with many surgical series showing biochemical cure in 96%+ of patients with one operation.

Are there any other treatments for primary hyperparathyroidism?

Yes, asymptomatic patients with primary hyperparathyroidism that do not meet the above criteria are usually best managed conservatively with hydration, observation and frequent reassessment of their biochemistry (Ca, PO_4, PTH, creatinine, eGFR). Medical treatment includes avoiding dehydration, maintaining dietary calcium between 800 and 1000mg daily, depending on gender and age, maintaining a normal vitamin D level, bisphosphonates for decreased bone mineral density and bisphosphonates and/or cinacalcet to reduce serum calcium if it is too high.

Take-home messages:

1. Because primary hyperparathyroidism is often asymptomatic and has long-term health implications, it is recommended that serum calcium and PTH levels are included when routine blood tests are requested.
2. Patients with vague symptoms such as tiredness, fatigue, insomnia, depressed mood, poor concentration or poor memory should be screened for primary hyperparathyroidism.
3. Hyperparathyroidism is easily detected with the following blood tests: serum adjusted Ca, PTH, vitamin D, creatinine, eGFR.
4. Refer patients with a high PTH level and a high calcium level to a surgeon who performs parathyroidectomy or to an endocrinologist.

For further information on primary hyperparathyroidism, contact Dr Francis Hall on francis@drfrancishall.co.nz

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Submit your feedback

Primary care dementia challenges

Pablo Richly, Consultation-Liaison Psychiatry Clinical Lead, Waikato Hospital

An estimated 70,000 New Zealanders live with dementia. Primary care serves as the main resource for dementia assessment and management, as less than 3.6 percent of diagnosed individuals have access to memory clinics. Concerning ethnic disparities, Māori and Pasifika typically present with dementia at younger ages than New Zealand Europeans, with Pasifika often presenting at more advanced stages.

Evidence supports cognitive interventions including training, stimulation, rehabilitation and combined approaches with non-pharmacological interventions like physical exercise as effective first-line treatments. However, these interventions remain largely inaccessible throughout Aotearoa New Zealand.

Cholinesterase inhibitors, particularly donepezil, represent the primary pharmacological treatment for Alzheimer's disease. Donepezil, which was FDA-approved in 2004 and has been Pharmac-funded since 2010, has demonstrated cost-effectiveness in both mild-to-moderate and moderate-to-severe Alzheimer's disease through randomised controlled trials. While some countries like France have discontinued subsidising these medications, donepezil remains affordable in Aotearoa New Zealand.

Common side effects of donepezil include gastrointestinal symptoms (generally mild and transient), insomnia, muscle cramps, fatigue and anorexia. Although listed on the American Geriatrics Society's Beers list due to increased risks of orthostatic hypotension and bradycardia in older adults, these safety concerns rarely contraindicate its use.

Prescription data reveals concerning patterns. Between 2016 and 2020, only one-third of Aotearoa New Zealand's dementia population received funded anti-dementia medication, compared to over half in the UK. Māori and Pasifika were prescribed these medications at lower rates than those of European ethnicity, mirroring similar inequities observed among lower socioeconomic and rural populations in Australia.

A survey (n=43) completed by members of the College via ePulse revealed that while 93 percent of respondent GPs had over 10 years of experience and 88 percent estimated dementia prevalence at 1–10 percent in the elderly, 42 percent prescribed donepezil to less than 25 percent of diagnosed patients. Primary reasons for not prescribing donepezil included perceived poor efficacy (30%), side effect concerns (28%) and lack of confidence or experience (23%).

> "Between 2016 and 2020, only one-third of Aotearoa New Zealand's dementia population received funded anti-dementia medication, compared to over half in the UK.

Cost-efficacy concerned only 3 percent of respondents. Notably, among those citing “poor confidence/experience” as their main reason for not prescribing, 70 percent had self-assessed their dementia knowledge as average to good.

The low prescription rate of anti-dementia medications in Aotearoa New Zealand appears primarily driven by limited discussion of pharmacological options in primary care settings. This constraint potentially undermines patient and family involvement in treatment decisions. While global attention focuses on novel, costly disease-modifying treatments, Aotearoa New Zealand must review its approach to established interventions to ensure equitable and effective dementia care.

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The care you don't have time to give

Busy practice? Let Healthify He Puna Waiora support your patients' self-care

Dr Emma Dunning, Clinical Editor and Advisor, Health Navigator Charitable Trust

If you'd like to encourage your patients to take charge of their health but don't have time in your consultation, Healthify He Puna Waiora has free self-care resources that can help.

Te Kete Haerenga is a collection of free tools and information resources designed to empower your patients to manage their long-term conditions and improve their health and wellbeing.

The main workbook 'Your Journey to Wellbeing' is a 15-page downloadable PDF covering the groundwork of self-care planning, including a health conditions and medicines list, stages of change, action plans and goal setting. Think of this as the kete or basket.

Add to that basket self-care guides for specific problems your patient has identified. The guides are downloadable and editable and cover common presentations we often don't have time to explore fully:

Sleep Pain Stress Fatigue Medicines

Additionally, all tools and diaries within these resources can be linked or printed individually in your office or waiting rooms for patients to take away.

Sharing the completed kete can help you to gain insight into your patient's experience, to troubleshoot and to track progress. For your patients, they're a reliable source of evidence-based information, a structure for behaviour change and a companion on their journey to wellbeing.

Submit your feedback

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