GP Voice

YOUR NEWS, YOUR VIEWS, YOUR VOICES

New CQI reaccreditation module launched

Transforming futures
Dr Francis Katoa

Rethinking frailty management in Golden Bay

What do I say next?
An interview with Dr Sophie Ball

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

March 2025

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Editorial

Dr Luke Bradford

Kia ora,

We're already three months into 2025 and continuing with our advocacy work and other projects that are all focused on improving health outcomes for New Zealanders by ensuring we have a more well-resourced and supported workforce.

The College made 45 written submissions in 2024 on a wide range of topics that all in one way or another impacted our patients, our members and the wider health sector. Making submissions allows us as a College, and a workforce, to get our viewpoint on record and in front of those responsible for making the policy decisions.

Throughout the year we regularly ask for member contributions to assist us as we develop and write our submissions. We have a very diverse membership and with that comes a diverse range of perspectives and experiences that we can draw on. Calls for contributions are put into *ePulse*, so please keep an eye out for them, and if it is a topic that you feel strongly about, we'd love to hear from you.

I'm also working with external organisations to progress changes to processes, duplication and/or red tape that we come up against in our day-to-day work. Currently on my radar are police calls to GPs after hours, ACC notes requests, medical aspects of fitness to drive and unilateral hearing loss. Many of you talk to me about these pain points (and others), and it is a personal aim of mine to take these problems and resolve them.

We're also deep into the data analysis of the Workforce Survey results and we're looking forward to releasing summary findings in the coming months, with more in-depth coverage to be shared at GP25: Conference for General Practice in July.

This is really important data, and despite having a smaller response rate than we were hoping for, your input and feedback will give us crucial up-to-date information about how we're working and how we're feeling, and it will give us data to compare with previous surveys.

Alongside the Workforce Survey data is the Your Work Counts project that we continue to progress behind the scenes.

Work is underway with the College Policy and Advocacy team to write up the aims, processes and results of the project for the *Journal of Primary Health Care* that will reach more people outside of our membership and workforce. Final ethics approval for phase 2 is in process so that we can work with you to quantify patient utilisation data and move towards a safe patient load recommendation.

Dr Luke Bradford
Medical Director | Mātanga Hauora

The College made 45 written submissions in 2024 on a wide range of topics that all in one way or another impacted our patients, our members and the wider health sector.

Finally, registrations for GP25 will be opening mid March. This year's conference is being held at Te Pae in Ōtautahi Christchurch from Thursday 24 to Saturday 26 July. We'd love to have as many of you as possible join us, so take advantage of the early bird deals when they go live. Visit the conference website for more information and to register.

Enjoy this month's issue,

Luke

Editorial

Toby Beaglehole, Chief Executive

Kia ora koutou,

While the summer days continue to grace us with their presence, I hope you all have had rest and relaxation over this period whether that looks like books by the beach, family by the fire or rekindling relationships. While there is no shortage of challenges ahead, I trust that it has been a good start to 2025 for you all.

The College team have hit the ground running for the new year, with a new Minister of Health and submissions on the Treaty Principles Bill, Puberty Blockers and Medsafe Medical Classifications. We have also kicked off the 2025 academic year with a bang. We have a new cohort of 221 registrars for the GPEP and RHM programmes starting year 1 and have held eight Te Ahunga orientations around the motu for the 201 GPEP1 registrars.

Our focus for this year is on growing our workforce and continuing to advocate for change on behalf of our members. The new Health Minister, Hon. Simeon Brown, has signalled his commitment to increasing access to general practice, which the College is advocating will come from having more specialists trained and working in the community. Sam and I met with Minister Brown in mid-February to discuss his plans to ensure that we continue down this path. We focused on the smart investment that primary care offers to drive down the costs of secondary health care. The initial discussion went well, and we aim to continue to gain traction with the Government in this space.

Our challenge for 2025 is to continue to respond to the complex political, social and financial environment the College finds itself operating in, including the potential obstacles and opportunities throughout the year. We need to be able to respond swiftly, plot a new course if needed and forge ahead. We have the team and the tools to do that.

Member feedback

We are also focused on improving the member experience with the College and building trust with you. With this in mind, I want to address some of the member feedback we have had lately. We have had a few issues arise which boil down to taking the time to be thoughtful about the impact of changes we're making, then communicating what we're doing or proposing clearly.

I acknowledge we've messed up on a couple of occasions, and I want to reassure you that we've learned from that, we have listened to your feedback and tightened our internal processes. The intent of the changes and the internal reflection is to ensure that our decisions are considered, and our communications are succinct, clear and concise moving forward.

Toby Beaglehole
Chief Executive

We need to be able to respond swiftly, plot a new course if needed and forge ahead. We have the team and the tools to do that.

Fee increases

I also need to signal to you, our members, that we cannot sustain our member and learning activity with the current fees structure. Our biggest financial challenge is that Health New Zealand | Te Whatu Ora have held our funding at the same level for 2025 as the 2024 year (adjusted down for the reduced number of GPEP1 registrars).

Across the College, we still need to cover the inflationary costs and fixed costs that don't flex with reduced GPEP1 registrar numbers, so we have had to increase slightly both the membership fees and some learning fees. In general, we've kept increases to the absolute minimum – with clear guidance from the Board to use fee increases only as a last, justified, resort.

In some instances, we've had to add or increase fees to reflect the actual cost to deliver because it is no longer sustainable for the College to continue absorbing these costs while still delivering the same programmes and services. Recognition of prior learning is one where we pay for expert assessment and need to pass those costs on. We are well aware of the challenging circumstances you are working in, and no fee increases were entered into lightly.

Year ahead

2025 is going to be a big year. We've got the first tier of recommendations from the MCNZ Reaccreditation report to address, and we'll shortly release the recommendations from the Governance Review, which talk to being more purposeful in our governance activities, processes and structure. We also need to highlight and challenge the ever-increasing pressures on you, the GP workforce and our registrars, and champion a better deal and more sustainable policy settings.

Ultimately, success for the College in 2025 comes down to working constructively together – with you, with Health New Zealand | Te Whatu Ora, with the Minister and other stakeholders. We're being intentional about working smarter and listening harder.

I hope you enjoy this month's issue of *GP Voice* and I look forward to sharing the occasional thought in future.

Toby

Submit your feedback

2025 College election

Nominations open

The College is accepting nominations for the roles of College President and one College Board member. Any College Fellow in Financial Good Standing who has paid their annual dues and levies is eligible to apply for these roles.

Members were sent information on the roles and how to apply for them by email on Friday 21 February.

A copy of the College Rules stating who may hold office in the College and who may vote *(Rule 11)* and the election process *(Rule 21.7)* is available here.

Nominations must be submitted by 10pm on Friday 14 March 2024.

Timeline for the election process

21 February	Call for nominations for the roles of College President and one Board member
14 March	Last day for nominations
24 March	Voting opens (if more than one nomination is received for either role)
17 April	Voting closes
24 April	Announcement of the elected President and Board member
26 July	Elected President and Board member take office at the end of the AGM.

If you have any further questions, please email elections@rnzcgp.org.nz.

Space for your advertisement

To advertise with us, contact the Editorial team:
communications@rnzcgp.org.nz

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 advocacy work from February.

Meeting with the new Minister of Health

College President Dr Sam Murton and College CE Toby Beaglehole met with the new Minister of Health Hon. Simeon Brown to discuss the four things that would have immediate impact on delivery of health care but also meet his health targets:

1. Implementation of the Sapere Review (more capacity in general practice, fewer presentations in ED),
2. Pay parity for nurses (increase immunisations and preventative care),
3. Three years of funded GP training (more general practitioners and more training capacity in practices),
4. Simple data and digital solutions that make transitions of care much safer and reduces the inbox burden on GPs.

Radio NZ interview on state of the workforce

Dr Murton and a representative from the Australasian College of Emergency Medicine had a half-hour interview on Radio New Zealand's Nine to Noon programme discussing closed books and other workforce issues that are impacting the delivery of health care and ED waiting times. Listen to the interview.

Special Interest Groups (SIGs)

An initial meeting was held to discuss the way forward and configuration of organisational structures that support the development and ongoing mahi of SIGs. Further meetings will be had, aiming to have something in place for our College conference in July.

NZTA – Medical aspects of fitness to drive

We are working with NZTA around issues raised following the release of the updated *Medical aspects of fitness to drive*. Specifically, as it is an online document, how will we know when updates occur and what version is live. Therefore, our request is to have annual updates as opposed to ad hoc ones. Secondly, the current guidelines are very heavily focused on providing written information to patients. We are working alongside MPS to request that this is lessened.

National Quality Forum (NQF)

The quarterly NQF is an opportunity to work across the health system to ensure patient safety and outcomes are appropriately measured, and targeted support is provided in areas of concern. The College is the general practice representation in this arena.

ACC

Work with ACC is currently focused on the unnecessary duplication of notes requests, the length of notes requested and the remuneration for the work done. A particular focus has been on case officers asking patients to request their own notes. There is separate work occurring around how ACC supports us as providers in the long-term to give clarity to patients and around process and purpose of assessments.

NZ Police

A meeting was held with the Detective Inspector (DI) of Coronial Services around certification of death in the community. Joint work will continue and focuses on education around our responsibilities under the law. However, the DI was in total agreement that Police contacting family members of doctors or climbing fences and shining torches through bedroom windows is entirely inappropriate. She has undertaken that with any new examples of this that are reported, she will speak to that officer's supervisor and demand education and apologies. Therefore, if any of these events occur to you, please reach out to Dr Luke Bradford by email luke.bradford@rnzcgp.org.nz.

NZ Audiological Society

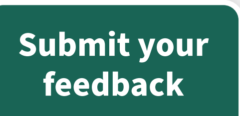
An update regarding unilateral hearing loss and the referral process can be found on page 19. Whilst agreement has been reached with the national body of ENT surgeons and the Association of Audiologists, there remain process issues at Health New Zealand | Te Whatu Ora, and I am working with the HNZ Chief Medical Officer for a swift resolution.

Submissions

- Pharmac – Proposal to change the regulatory and funding restrictions for stimulant treatments for ADHD
- Pharmac – Proposal to widen access to medicines for blood cancer, inflammatory bowel diseases, eczema and rheumatoid arthritis
- MCNZ – ACLS Certification of PGY1
- Pharmac – Proposal to fund the contraceptive pill desogestrel
- The Office of the Privacy Commissioner – 'Health on the Road' guidance and updated Health Information Privacy Code.

Research

The Commonwealth Fund, International Health Survey 2025 – five GPs participated in the pretesting of the 2025 survey. The survey is now in market for all Fellows of the College who have been invited to take part. New Zealand is compared with countries with comparable health systems against specific indicators. See latest information here.



Removal of the renewal criteria for stimulant treatments

On 1 December 2024 Pharmac removed the renewal criteria for stimulant treatments (methylphenidate, dexamfetamine and modafinil).

This change means that:

- Anyone starting on a stimulant treatment (requiring a Special Authority approval) will be able to access funded treatment without the requirement for this approval to be renewed.
- Anyone with a current or recent (expired within the last two years) Special Authority approval for these treatments will automatically be issued an approval that is valid without the need for it to be renewed. Pharmac and Health New Zealand | Te Whatu Ora will manage this so people do not need to do anything for this to happen.

Prescribers need to continue to manage ongoing prescribing and seek specialist input as needed to consider whether treatment remains appropriate and whether an individual is benefiting from it.

This change comes following a consultation that the College was supportive of in its submission proposal to remove the renewal criteria for stimulant treatments. In the submission College Medical Director Dr Luke Bradford said:

"The current arrangement is an unnecessary bureaucratic hurdle for specialist GPs, other specialists and patients. The proposed removal of the Special Authority rule requiring ADHD patients to obtain approval every two years to enable patients to continue using stimulant medications is welcomed; it will support specialist GPs by freeing up specialist time to carry out additional ADHD assessments and improve access for patients."

For more information about the decision see the Pharmac website.

Applications open

General Practice Education Programme

Applications for the 2026 General Practice Education Programme (GPEP) intake are open from **Wednesday 5 March until 12.00pm on Tuesday 8 April 2025**. GPEP includes a mix of clinical and academic postgraduate training for people who already have a medical degree. With 90 percent of medical conditions being treated in the community, more GP registrars will be a great asset to our medical community.

It is at least a three-year full-time equivalent (FTE) programme of study. There are also part-time options available. If you know anyone you who you think may be interested in specialising as a GP, please direct them to the College's website.

Submit your feedback

New CQI reaccreditation module launched

The College has recently launched a new Continuous Quality Improvement (CQI) reaccreditation module for practices who wish to maintain their CQI accreditation in the College's Cornerstone programme.

Completion of the Cornerstone modules (CQI and Equity) are additional ways to show patients your ongoing commitment to upholding timely, equitable, high standards of service, and they support practices in their quality improvement journey and learning environments as teaching practices.

CQI accreditation operates on a three-yearly cycle, and the new reaccreditation module has been designed to be both efficient and resource-conscious. The requirements for reaccreditation are not the same as the initial CQI module.

The reaccreditation module focuses on two key areas:

1. CQI self-assessment: A structured reflection to help practices evaluate and strengthen their team's capacity in CQI.
2. Advanced CQI principles: Encourages practices to apply three CQI principles to a completed initiative to expand its impact and reach and to embed measures for ensuring sustainability of the initiative in the long term.

This reaccreditation module has been developed and refined over several months and was piloted by a group of practices around the country. On average, most of these practices completed the module and gained reaccreditation within four months.

Dr Kirsty Lennon, a GP from Raumati Road Surgery, one of the pilot practices, shared the journey of the practice's reaccreditation and how it benefited patients and their team. Hear what Dr Lennon had to say in this video.

Why complete the reaccreditation module?

CQI can help practices build resilience and adjust to the evolving needs of patients and their whānau now and in the future. Over the next three years, CQI will play a vital role in supporting national health priorities, including:

1. Access: Ensuring all New Zealanders have equitable access to health services regardless of where they live.
2. Timeliness: Providing efficient health care services.
3. Quality: Delivering safe, accessible and user-friendly care that continues to evolve and improve.

Read more about the Cornerstone Programme and modules.

Completion of the Cornerstone modules (CQI and Equity) are additional ways to show patients your ongoing commitment to upholding timely, equitable, high standards of service.

Submit your feedback

MIND THIS

Many agencies, no coordination

Dr Peter Moodie

Peter Moodie is the College's Clinical Advisor

The case

The Coroner has recently written an opinion on the death by suicide of a 21-year-old man, Mr X, where he makes significant criticism of the lack of coordination and information sharing by the various agencies involved in his care.

Mr X, at the age of 11, suffered a serious head injury following a fall from a bicycle (he required reconstructive facial surgery). His abnormal behaviour is thought to have been a consequence of that traumatic brain injury (TBI).

At the age of 13 he made a suicide attempt, and by 14 he was using cannabis and other psychoactive drugs. His general behaviour pattern was such that he would call for help with health services in times of acute need but would then be difficult to contact for follow-up.

His GP in the Hawke's Bay where his mother lived had prescribed antidepressants for him, presumably following his suicide attempt in 2012. At that same time, he also came under the care of the HB Child and Adolescent Family Service (HBCAFS), and in 2016 Mr X was reviewed and followed up by a consultant psychiatrist. He was assigned two social workers (one private and one public). He was also seen by a clinical psychologist who in 2018 suggested that he should have an ACC-led assessment for his TBI, and he was subsequently seen privately by another psychiatrist. In addition to the various antidepressants, the TBI expert started him on dexamethasone.

Mr X divided his time between Hawke's Bay and the Wairarapa where his father lived, and in October 2020 his mother contacted Te Haika (a phone-only access, mental health service) who subsequently referred him to the Wairarapa Community Mental Health Team (WaiCMHT).

Over the next seven months Mr X had frequent contact with the WaiCMHT, often in crisis situations, and he was seen on five occasions by four different locum consultant psychiatrists; he missed another two consultations. In May 2021 Mr X made another crisis call to Te Haika, and they arranged for his case worker to contact him the next day. WaiCMHT were unable to contact him and an informal case conference determined that they should try to get him back to his GP for further care. It appears that the case was closed at that point.

Two months later Mr X took his own life.

The Coroner's findings

The Coroner was critical of the delay in Mr X having a psychiatric review of his TBI, which he considered critical information. He further criticised the fact that these reports were not available to the various agencies and individuals managing his care.

He specifically commented the "bewildering reality that a client can be engaged with different parts of the national healthcare system… yet each provider can be completely unaware of the existence or the contribution of the other."

He was critical of the poor case records and that Mr X had been discharged from WaiCMHT without a formal discussion with his family.

The person most likely to have an integrated set of records in these complicated cases is the GP but ONLY IF they are part of the management loop. The GP case notes are also probably the easiest to be shared through some variation to GP2GP.

Should general practice insist on a more coordinated approach, especially for complex, high-risk patients like Mr X? And should there be funding to ensure that coordination occurs?

Goodfellow Unit podcast: **Acute altitude illness**

Dr Jenny Visser is a College Fellow. She is a lead academic for Travel Medicine Postgraduate Studies and Senior Lecturer for the Department of Primary Health Care and General Practice, University of Otago, Wellington.

In this podcast Jenny discusses acute altitude illnesses including several conditions that may occur in individuals travelling to high altitudes usually above 2500 metres (8200 feet).

The key take-home messages of this podcast are:

- Don't be frightened and don't ignore the warning signs
- Watch for the headache of acute mountain sickness
- Watch out for the person in your party who doesn't have the same exercise tolerance as the day before
- Go slow; time is your friend
- Never go on to a higher altitude with symptoms.

Listen to the podcast

Submit your feedback

What do I say next?

Everyday mental health conversations in primary care

An interview with Dr Sophie Ball, book co-author and FRNZCGP

Dr Sophie Ball
Book co-author and College Fellow

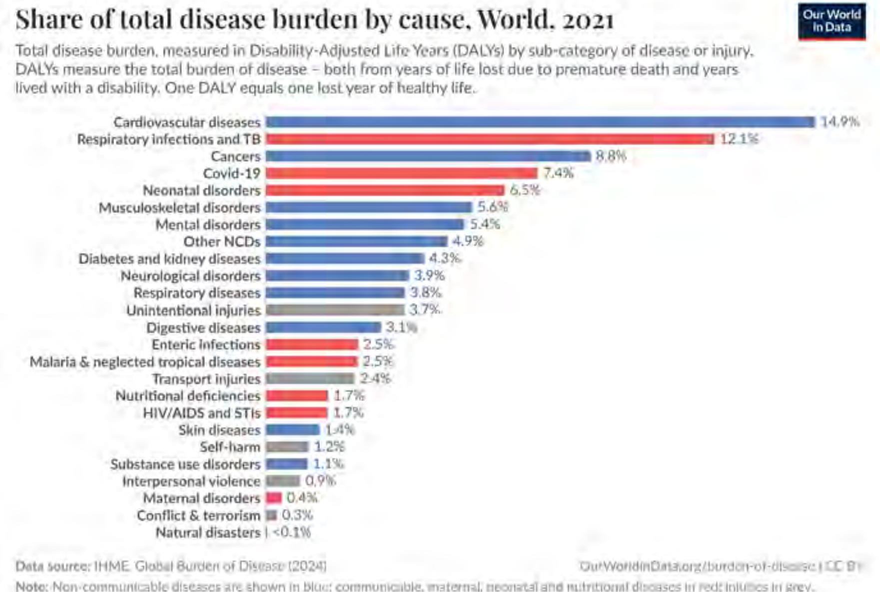
Dr Sophie Ball and Dr Liz Moulton have co-authored the book *What do I say next? Everyday mental health conversations in primary care*. It aims to address the significant problem experienced by GPs, trainees and other primary care health professionals of how to complete a useful and safe consultation with patients with mental health distress within the constraints of a standard-length primary care appointment. The book focuses on enhancing the repertoire of communication skills available for mental health consultations, providing a range of tools and techniques drawn from accepted models, including cognitive behavioural therapy (CBT), transactional analysis (TA), motivational interviewing and acceptance and commitment therapy (ACT), illustrating how to apply these within a typical primary care consultation.

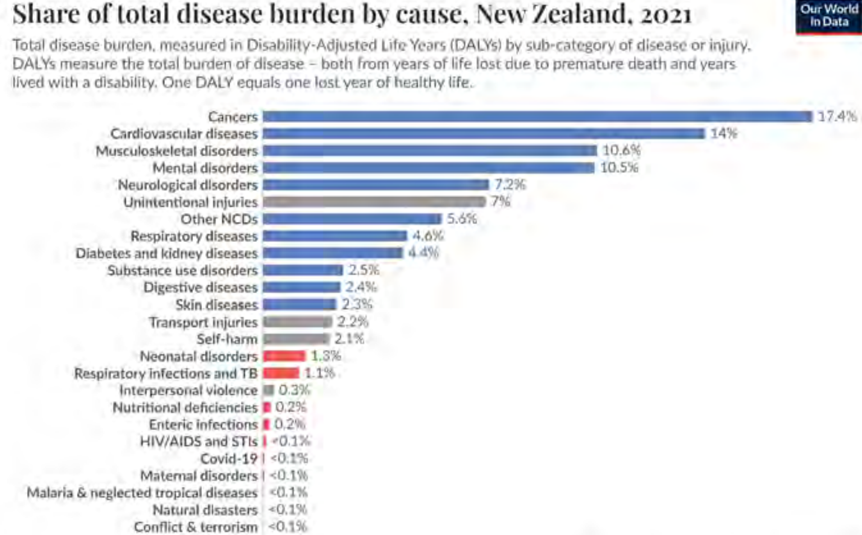
We sat down with co-author and College Fellow Dr Sophie Ball to talk to her about the book.

Where did the idea to write this book come from?

When I started as a GP in the UK around 15 years ago, I had been taught a lot of communication skills to encourage people to talk. In mental health consultations it felt like there were so many things to talk about. After much more than the allocated time for the appointment had passed, I would notice the time, realise how late I was running and how many patients were waiting, and try to very quickly wrap things up. Maybe a timid offer of a referral onwards for some form of therapy or a medication.

Most GP and medical training starts with the physical. Often training does not go into detail about options for how to structure mental health consultations or discuss management – mine didn't. Yet these are important skills to have for two reasons. Firstly, we all know mental health is a frequent presentation in general practice (see graphs to the right), and secondly, because these can be intense conversations. Frequent, intense conversation can mean that not only do we miss our breaks but it can leave us feeling stressed and, over time, at risk of burn-out.





Source
IHME, Global Burden of Disease (2024)

What does this book aim to add for primary care and GPs?

This is the first book written to focus on mental health communication in primary care. The aim is to provide GPs enough tools so they can be flexible in their approaches to mental health consultations, working with what is best for each patient/whānau. The book is written to be as practical as possible. It suggests a range of ideas for how to navigate through a consult with a focus on what a management plan, appropriate to primary care, could look like.

The first section provides background and explains some of the underlying theory. Then the majority of the book in part two is based around common clinical scenarios. You could read the book front to back or use it as a quick reference guide. If you are new to working in primary care and see that your next patient has a recent discharge from ED after self-harm, you could flick to the relevant scenario for some quick tips before calling the patient in.

The aim is for us to feel confident about mental health consultations and, with that, an excitement for what we can provide and that will work in the scope and time given in primary care. A hope is that this book supports more conversations and that more patients and whānau feel supported to manage their mental health.

A hope is that this book supports more conversations and that more patients and whānau feel supported to manage their mental health.

How has your background inspired you to write this book?

Alongside being a GP, I worked for seven years as a GP Liaison for mental health and addictions with Counties Manukau DHB. I learned huge amounts over this time from a range of colleagues, including mental health, OT, physio, mental health nurses, psychologists, psychiatrists and many others. Over this time, part of my role was being involved in education sessions for primary care and visiting practices to talk about mental health. This made me realise there was still under-training and interest in this area.

I had also undertaken some training, including a mental health postgrad paper at Auckland University and some FACT and ACT training. I have worked in a number of settings where there is a particularly high proportion of patients with MHA needs, including at the women's prison in South Auckland, at Anxiety New Zealand and for the Salvation Army.

I felt there was still a gap between the training I received and what we could be doing that would be appropriate in primary care. It is not about us training to become therapists or counsellors or HIPs, but about knowing about foundational approaches that can support mental wellbeing and align with the approaches any of our colleagues, such as HIPs, may be using. I wanted to share this information as a fast-track for colleagues who did not want to spend seven years in these various roles, like I did, in order to acquire this knowledge. As well, it is particularly aimed at registrars and colleagues new to general practice, because I know that these conversations often felt overwhelming for me starting out.

Why now? Why should your GP colleagues read this?

Many guidelines advise the same approach to mental health, which includes considering alternatives to medication for those without severe depression. And most of the mood disorders we see in primary care would fall into this category. There are some recent suggestions that primary care may have an over-reliance on medication for mood* (but noting the under-prescribing seen in Māori in New Zealand). If we want to try to change this prescribing trend, we must provide prescribers with alternative options to offer instead of prescribing and give clear examples of how to deliver these. This book aims to

*****The Australian *Mental health: Productivity Commission inquiry* report (2020) recommended as a 'priority reform' that we 'address adverse outcomes from prescribing practices of mental health medication'. The report states that 'antipsychotic prescribing in aged care facilities is one element of this…arguably **a greater concern, given its frequency, is antidepressant prescribing.**' Recent Australian data has also shown that 12.4% of general practice encounters are mental health–related and most of these encounters are managed with medication (**61.6%**).

help in this space and be relevant whether clinical judgement is to use them as standalone management or alongside the use of other options including medication.

Over the last four years I have been working as a medical educator for registrars. I think this book could be useful for colleagues in educator roles who are looking for new ideas for teaching sessions for all levels of training GPs. These ideas could be a way to potentially think differently about mental health consultations and/or be useful to consider with new colleagues struggling with time management.

What do you do to support your own mental health?

Working in a setting where there are very high rates of mental distress, I find using tools outlined in the book helps me be strength-focussed and a partner in a patient's journey. This means I can see a number of patients in one session with these presentations without feeling exhausted and as though I am now carrying the problems myself. This is my main hope for my colleagues, particularly with the many current stresses in the primary care environment.

After a busy day, exercise would be my go-to stress reliever; just getting outside either walking the dog or playing basketball/netball with the teenagers. Connecting with GP colleagues to chat (and sometimes moan) always helps too!

Scan the QR code or click the following link if you would like to purchase a copy of **'What do I say next? Everyday mental health conversations in primary care'**.

You can also follow Sophie's YouTube channel, **"What do I say next"** for more helpful information and quick recaps to complement the book.

Submit your feedback

Transforming futures

Harnessing primary care to change Pasifika youth mental health

Dr Francis Katoa FRNZCGP

Dr Francis Katoa
FRNZCGP

Nearly 38% of Pasifika youth in Aotearoa New Zealand experience significant psychological distress, yet too few come forward until their conditions have worsened. Alarmingly, suicide rates in this group remain high, underscoring a critical gap in our health care system. Behind these numbers lies a complex reality; during puberty, when young brains are still developing in emotional regulation and decision-making, many struggle to express their inner stress. Coupled with chronic stress at home – from financial pressures and unstable housing – these challenges set the stage for a mental health crisis.

I grew up in a modest Tongan home, where the constant stress of financial worries was palpable. Our cultural values taught us not to burden our elders with our personal struggles. This background shaped my early understanding of stress and the reluctance many of us feel in speaking up. Today, when Pasifika youth finally enter our clinics, they often do so only after their conditions have escalated – lost opportunities for early intervention that could have prevented more severe outcomes.

Why we must act now

When Pasifika youth eventually seek help, the delay in diagnosis and treatment leads to a cascade of consequences: increased emergency admissions, chronic mental health conditions, and higher long-term costs that strain our entire system. Every missed opportunity to support these young patients is a systemic failure that affects us all. As doctors, we have a duty to bridge this gap by providing timely, culturally informed care.

Practical steps for improvement

Even when our practices are under pressure, we can take concrete, evidence-based steps to make a difference:

1. **Enhance training in adolescent development and cultural competence:** We must deepen our understanding of the unique challenges that Pasifika youth face during puberty. Short, focused training sessions – offered by local PHOs or regional health authorities – can equip us with practical insights on recognising subtle signs of distress and understanding the cultural contexts that shape these young patients' experiences.
2. **Strengthen referral networks to specialist services:** Given that wait times for specialist consultations can extend to six weeks or more, it is crucial to streamline our referral processes. By developing standardised protocols and designating referral coordinators, we can

ensure that once distress is identified, our patients are swiftly connected to the support they need. Additionally, utilising local resources like school counsellors and community mental health groups can help fill the gap when specialist services are delayed.

3. **Leverage digital health solutions:**
   Many young patients are digitally engaged, so we should embrace telehealth and mobile health applications that provide flexible, culturally tailored support. Digital tools can offer virtual counselling, mood tracking and self-help resources – making mental health care more accessible when in-person consultations are limited.
4. **Engage with community-led mental health literacy programmes:**
   Collaborating with local schools, churches and youth organisations can extend our impact beyond the clinic. Community-led initiatives help educate families and young people about the signs of mental distress and promote early help-seeking. This grassroots engagement ensures that support is culturally resonant and accessible.
5. **Advocate for policy change and increased funding:**
   Beyond individual practice, our collective voice is essential. By engaging with health boards, professional associations and policymakers, we can push for increased funding and systemic reforms that prioritise culturally tailored services for Pasifika youth. Such advocacy is key to creating a sustainable system that benefits everyone.

When I see a Pasifika youth in our clinic, I am reminded of my own early experiences – growing up in my modest Tongan home, where financial stress was a constant companion, and the cultural norm was to endure quietly. I was fortunate to have mentors who listened and believed in me; now it is my turn and perhaps yours to ensure that our young patients receive the care they deserve. Every practical step we take, from enhancing our training and strengthening referral networks to embracing digital solutions and engaging with our communities, builds a stronger foundation for their future.

As one mentor once told me, "The difference we make in a young life today will echo throughout our communities tomorrow." Let us take this to heart and transform our primary care practices, because by supporting Pasifika youth we secure a healthier, more equitable future for all New Zealanders.

Sources:

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As one mentor once told me, "The difference we make in a young life today will echo throughout our communities tomorrow."

Submit your feedback

Treatment of hearing loss in general practice

Dr Luke Bradford, Medical Director

With 90 percent of medical conditions being treated in a general practice and the significant amount of patient contact that we have, the New Zealand Audiological Society (NZAS) has reached out and provided the information below about the treatment of hearing loss – specifically around Sudden Sensorineural Hearing Loss (SSNHL) and meningitis diagnosis.

Please have a read below and refer to your regional HealthPathways information on hearing loss for further information.

- Prompt assessment and treatment of Sudden Sensorineural Hearing Loss (SSNHL) is important given the research showing that early treatment can improve the chances of hearing recovery. Read more in this 2024 article in the Australian Journal of General Practice on SSNHL.
- Meningitis causes ossification of the cochlear, which can occur quickly. If a patient's hearing appears to be affected as a result of meningitis, a diagnostic hearing test (and if needed, a referral to the regional cochlear implant team) should occur promptly.

Visit the New Zealand Audiology Society website for more information.

Goodfellow Unit podcast: **Soālaupule**

Dr Vaaiga Autagavaia and Dr Mamaeroa David are both GPEP registrars working in general practice. In this podcast Drs Autagavaia and David discuss Soālaupule, an approach that creates equity by sharing power and decision-making. It helps GPs to connect better with families to ensure trust and leads to better clinical outcomes.

The key take-home messages of this podcast are:

- Remember, it's a community (collective vs just the individual)
- Keep in mind the foundational values
- Create time and space for our patients
- Share power more evenly
- Allow ourselves to be more open.

Listen to the podcast

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An update on closed books in general practice in Aotearoa New Zealand

A *Journal of Primary Health Care* paper

A paper in the *Journal of Primary Health Care* (JPHC) by Megan Pledger, Jacqueline Cumming and Maite Irurzun-Lopez has examined which health districts, formerly District Health Boards (DHBs), had the greatest number and proportion of general practices with closed books, and how this has changed since 2022.

This article comes as a follow-up to a Lottery Health Research–funded project that the three researchers were involved with in 2022 titled, '*The challenge of closed books in primary care access, health outcomes and equity in Aotearoa New Zealand.*'

One of the researchers, Megan Pledger, says, "The conclusions from the 2022 study were that high workloads, both in general and due to COVID-19, as well as restrictions preventing migrant GPs from crossing the border, were the main reasons that general practices stopped enrolling new patients. This led us to believe that by 2024, with the pressures of COVID-19 easing, more practices would have opened their books to new patients. However, this wasn't the case."

This recent study showed that there were 373 general practices with closed books, with Canterbury (56), Southern (37) and Northland (32) districts having the most practices with closed books. The districts with the highest proportion of closed books were Hutt Valley (73%), Lakes (70%) and Wairarapa (67%).

The study highlights that not being enrolled in primary health care is associated with poorer health outcomes. The researchers analysed all amenable deaths across New Zealand between 2008 and 2017 and found that those who died were more likely to not be enrolled, after adjusting for their age, gender, ethnicity and deprivation.

When looking at the New Zealand Health Survey, out of the people who presented at an Emergency Department, the unenrolled (40%) were more likely than the enrolled (26%) to go to the ED for a condition that could have been treated in a primary care setting.

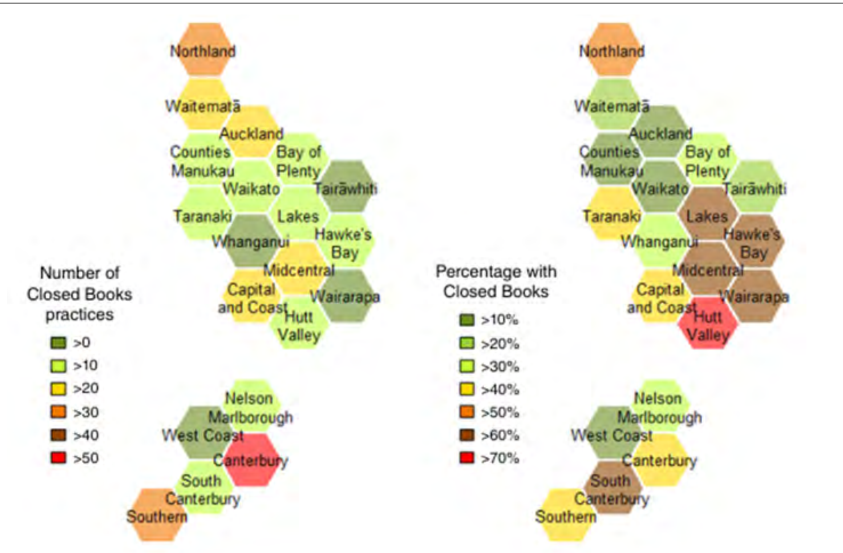
Megan says that Healthpoint is now collecting more data on this issue, particularly around limited enrolments, and the Ministry of Health has expressed interest in this information which is an encouraging step towards policy change.

"...out of the people who presented at an Emergency Department, the unenrolled (40%) were more likely than the enrolled (26%) to go to the ED for a condition that could have been treated in a primary care setting.

"While research funding has now taken us in different directions, the issue remains important, affecting patients and health care providers alike. We intend to continue exploring the issue where we can, as access to primary care remains a pressing concern in New Zealand," says Megan.

Read the full JPHC research paper.

Figure 1: The number and percentage of Closed Book general practices by district.



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. Patient demographics and psychotropic medication prescribing in Australian general practices: pre- and during the COVID-19 pandemic
2. Community pharmacy service provision to adults with palliative care needs in their last year of life: a scoping review
3. Conventional medication adherence and self-treatment practices among South Asian immigrants: a qualitative study
4. Struggling to afford medicines: a qualitative exploration of the experiences of participants in the FreeMeds study
5. Practice pharmacists in the primary healthcare team in Aotearoa New Zealand: a national survey

Thyroglossal duct cysts

Do they all need to be excised?

Dr Francis Hall

What is a thyroglossal duct cyst?

A thyroglossal duct cyst is a midline neck cyst formed from an embryological remnant of the thyroid near the hyoid bone. Between the fifth and seventh weeks the thyroid descends from the tuberculum impar, at the foramen caecum in the back of the tongue to its location in the lower neck. The track of descent may pass anterior, posterior or through the hyoid bone. As the thyroid descends the track from the back of the tongue to the lower neck involutes. Sometimes this track does not fully involute and a cyst containing thyroid tissue near the hyoid may persist. This cyst is called a thyroglossal duct cyst.

Other thyroid remnants

Thyroid tissue may be left anywhere along this tract from the base of the tongue to the thyroid. A lingual thyroid, sublingual thyroid and a pyramidal lobe are all examples of thyroid tissue remaining in this tract.

Symptoms and signs

A thyroglossal duct cyst usually presents in a child or young adult but may present at any age. They may be entirely asymptomatic. In autopsy series, thyroglossal tract remnants are found in 7% of the normal population. Thyroglossal duct cysts may become infected. It is thought that they become infected through communication with the pharynx. When a thyroglossal duct cyst becomes infected the cyst increases in size and becomes sore. The overlying skin may become inflamed and sometimes the cyst may spontaneously burst through the skin and discharge.

A thyroglossal duct cyst presents as a midline neck mass near the hyoid bone and moves when the patient swallows. Sometimes the cyst is a short distance (1cm) from the midline. Usually the cyst is small, about 1–2 cm in size, but occasionally it may become quite large (4–6cm).

Ultrasound scans

An ultrasound scan of the neck will show a mass in the vicinity of the hyoid bone. This may be either cystic, solid or both. Before operating it is important to ensure that there is thyroid tissue in the normal location.

Differential diagnosis

An enlarged lymph node, a midline dermoid and a lipoma may all be clinically mistaken for a thyroglossal duct cyst. A careful history, physical examination

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.

and ultrasound will help make the diagnosis of a thyroglossal duct cyst. An ultrasound–guided FNA may further clarify any confusion. Although it has been said that there is a higher incidence of malignancy in ectopic thyroid tissue, this is a rare occurrence.

Treatment

Some surgeons recommend excision of all thyroglossal duct cysts to prevent episodes of inflammation. Asymptomatic thyroglossal duct cysts require no treatment.

The treatment of an infected thyroglossal duct cyst is antibiotics and analgesia. It is important that the antibiotic covers anaerobes. Amoxicillin and clavulanic acid (Augmentin, Curam Duo) is a good choice. If the patient gets worse, the infected cyst will need to be drained. This is best done with minimal disruption to the surrounding tissues. Ultrasound-guided needle drainage or freehand drainage of the cyst with an 18-gauge needle is recommended. Send the aspirate for culture and sensitivities. If the patient is still getting worse, then incision and drainage is recommended, again taking care to minimise disruption to the surrounding tissues. Make the incision in the line of an adjacent skin crease.

Surgery for thyroglossal duct cysts

If the decision is made to excise the thyroglossal duct cyst, it is recommended that the cyst is excised along with the middle portion of the hyoid bone (Sistrunk procedure) and any tract heading up to the base of the tongue. Approximately 1.5 cm of the middle portion of the hyoid bone is excised. This has been shown to markedly reduce the risk of recurrence. Usually (70%) but not always the pathologist sees some thyroid tissue in the specimen provided. Recurrence rates of 10% and complications in 10% of patients are commonly seen.

Ethanol ablation of thyroglossal duct cysts

Ethanol ablation of a thyroglossal duct cyst is a non-surgical, scarless treatment option. It is done under local anaesthesia with ultrasound guidance in the clinic. The patient can return to school or work the same day. After one or two ethanol ablation procedures a recurrence rate of 15% is seen. Ethanol ablation has an excellent safety profile, with a complication rate of less than 2%.

Summary

Thyroglossal duct cysts usually present in young patients as a midline neck mass near the hyoid bone that moves with swallowing. They may become infected. Not all thyroglossal duct cysts need to be excised. Definitive treatment is with either surgery or ethanol ablation in selected cases.

For further information on thyroglossal duct cysts, contact Dr Francis Hall on francis@drfrancishall.co.nz

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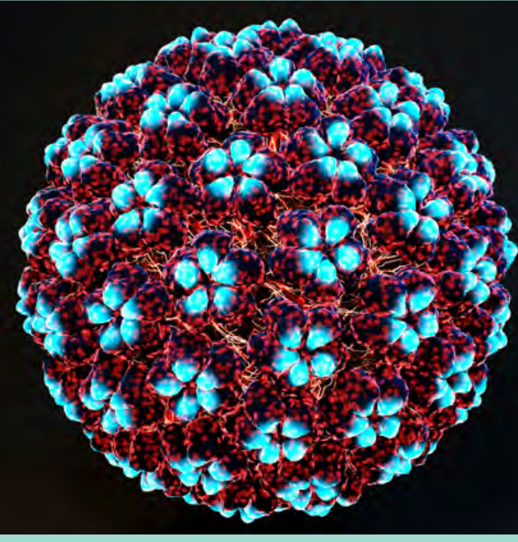
Health economy study on the cost of HPV-related cancers

The Head and Neck Cancer Foundation Aotearoa


Human Papilloma Virus

The Head and Neck Cancer Foundation Aotearoa has released a report on the cost of HPV-related cancers in Aotearoa New Zealand. Each year, around 600 New Zealanders are diagnosed with a cancer that can be caused by HPV infection. Working alongside Sapere, they aimed to quantify the economic burden of HPV-related cancers in New Zealand and the cost-effectiveness of the HPV vaccination.

The HPV-related cancers that are covered in the report include the following six cancers:

1. Oropharynx
2. Anus and anal canal
3. Cervix uteri
4. Vulva
5. Vagina
6. Penis

Preventing HPV-related cancers through vaccination has the potential to significantly reduce the burden of disease for individuals and their whānau, and the costs to our health system. A detailed economic analysis has not been conducted before. Some of the key findings of the report are included below.

Key findings:

- Each year around 600 New Zealanders are diagnosed with a cancer caused by HPV infection.
- These include oropharyngeal (throat), cervical and ano-genital cancers, with more than half being oropharyngeal cancer, which has been increasing by around 5% annually since 2006.
- The cost of treatment of HPV-related cancers is high and avoidable: >$105 million in 2019–2022.
- Further costs of pre-cancer detection and treatment could also be avoided. For instance, colposcopy and colposcopy-directed treatments of $49 million were incurred during 2019–2022.
- In addition to this, there is the cost of the cervical screening programme.
- HPV vaccination is recognised internationally as being safe and cost-effective at preventing HPV-related cancers, but New Zealand has poor vaccination rates and unacceptable inequities.
- Aotearoa New Zealand's own national targets are low by international standards (75% instead of 90%), yet the country has continually failed to meet these lower targets. Vaccination rates have been declining over time, with 32,000 young people missing out all together during the COVID pandemic.

- By comparison, other countries are achieving herd immunity with HPV vaccination programmes and are able to wind down cervical screening programmes and avoid other health costs.
- Low HPV vaccination rates represent a missed opportunity to reduce health system costs, as well as costs and burden of disease for individuals and their whānau.

The Head and Neck Cancer Foundation Aotearoa has been working with the Health New Zealand | Te Whatu Ora Immunisation team to develop and implement strategies to improve Gardasil uptake, such as:

- Inclusion of the HPV vaccination in the Aotearoa Immunisation Register;
- Resourcing iwi and kaupapa Māori services to improve vaccination rates among their communities as they see appropriate and effective;
- Adjusting the school-based immunisation schedule so that Gardasil is consistently delivered in Year 7 in conjunction with Boostrix;
- Reorganisation and resourcing of the school-based programme;
- Increasing the number of community pharmacies that provide Gardasil vaccines; and
- Enabling primary care to deliver greater numbers of Gardasil vaccines.

A high HPV vaccination rate is the best solution to Aotearoa's HPV-related cancers problem. The Aotearoa Immunisation Register now enables recall of unvaccinated individuals under the age of 27. Primary care providers play a vital role in improving HPV vaccination rates, particularly those individuals who missed out on vaccination during COVID-19.

You can read the full report here.

> "Primary care providers play a vital role in improving HPV vaccination rates, particularly those individuals who missed out on vaccination during COVID-19.

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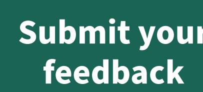


Reducing the environmental impact of asthma inhalers

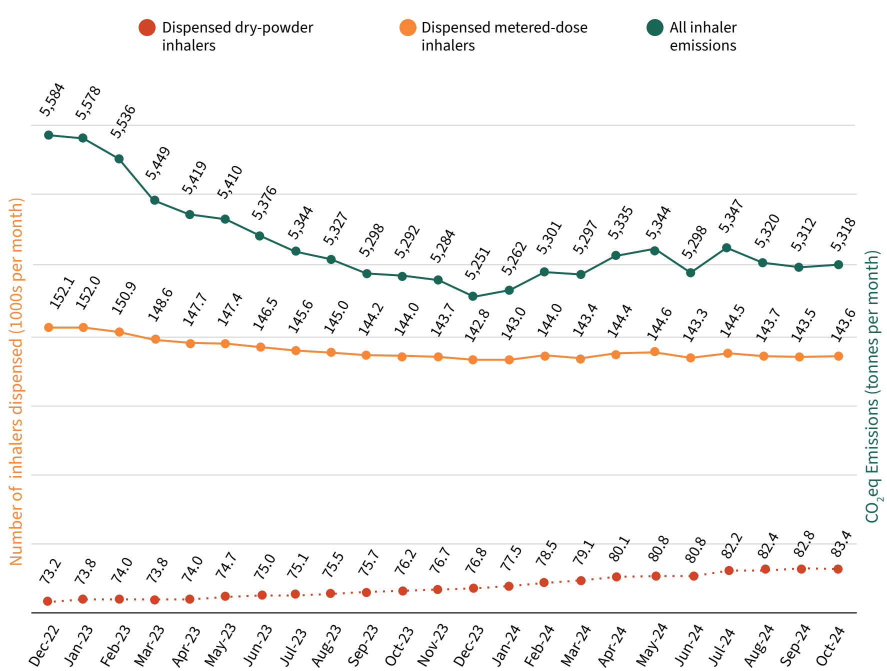
Even small changes can have a measurable impact

Dr Sara Hanning and Associate Professor Amy Chan

In 2019, the Global Initiative for Asthma (GINA) guidelines recommended against using short-acting beta2-agonists (SABAs) alone, advocating for inhaled corticosteroids (ICSs) for all asthma severities. Our New Zealand Asthma Guidelines reflected this change in 2020. This change reduces severe exacerbation risks and lowers carbon footprint by minimising unnecessary inhaler use.

In the past two years, we have seen a substantial reduction in carbon emissions in New Zealand (Figure 1). Although the reduction in pressurised metered-dose inhalers (pMDIs) seems small (a drop from 152,100 to 143,600 inhalers per month), this decrease, alongside an increase in dry powder inhaler (DPI) dispensing, has reduced carbon emissions by 266 tonnes per month.

Figure 1: Trends in inhaler dispensing and carbon emissions from December 2022 to October 2024



About the authors

Dr Sara Hanning and **Associate Professor Amy Chan** are New Zealand–registered pharmacists based at the School of Pharmacy, University of Auckland. Sara is interested in reducing the carbon footprint of the pharmacy sector with a particular focus on improving management strategies for medicines and associated devices like pMDIs when they are finished, unwanted or expired. Amy leads a research group that explores the intersection between digital technology, big data and respiratory health, with a focus on improving asthma care delivery and outcomes.

Improvements in inhaler use following NZ Asthma Guideline changes

Inhaler sales data from 2019–2020 suggests that SABAs represented 74% of total inhaler use in New Zealand and 76% of inhaler-related greenhouse gas emissions[1]. Since the New Zealand guidelines change in 2020, a progressive reduction in SABA dispensing was observed, with a corresponding increase in ICS with long-acting beta2-agonist (LABA) combination inhalers.[2] This trend seems to be continuing, as seen in 2024 compared with 2022 dispensing of SABA inhalers (Figure 2) and ICS+LABA inhalers (Figure 3).

Figure 2: Changes in the number of SABA inhalers dispensed each month from January 2022 to October 2024

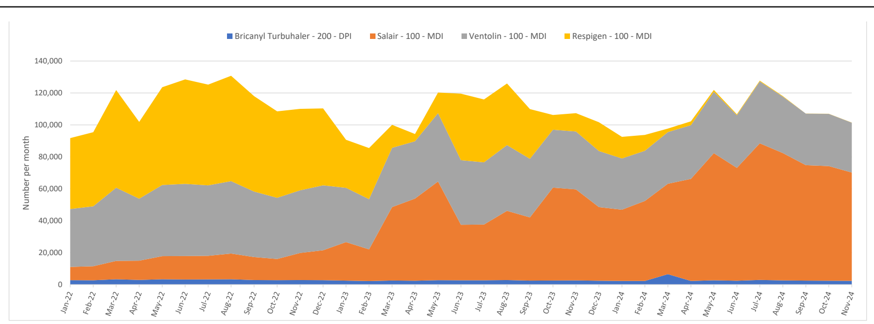
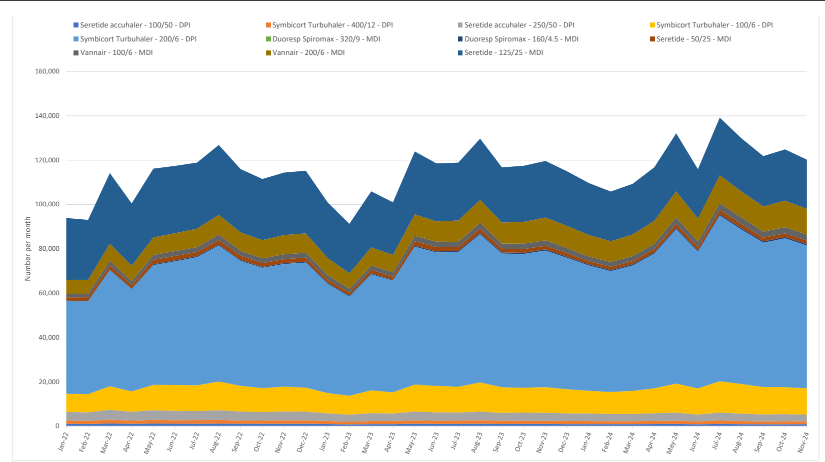


Figure 3: Changes in the number of ICS + LABA inhalers dispensed from January 2022 to October 2024



Environmental impacts depend on both the inhaler device and the brand

Not all inhalers are equal. Most of the pMDI carbon footprint can be attributed to the propellant, resulting in large differences in carbon footprint even within bioequivalent pMDIs, depending on the type and amount of propellant. This difference can be huge, ranging from 50g CO_2e up to 300g CO_2e per actuation – a brand switch from Ventolin to Salamol can reduce the carbon footprint by 16,312g CO_2 equivalents per inhaler.[3] While switching from pMDIs to DPIs substantively reduces the carbon footprint, switching brands can also have an impact, particularly if changing to a DPI is not appropriate. In New Zealand, Salamol is no longer funded and the carbon footprint of Salair, the current funded alternative to Ventolin, is not yet known, although work is underway to determine this.

In the UK, the SABA rEductioN Through ImplemeNting Hull asthma guidELines (SENTINEL) and SENTINEL Plus programmes successfully halved SABA overuse (defined as three or more SABA inhalers per year) whilst achieving lower carbon footprints by switching to a low-carbon SABA brand.[4,5] This demonstrates that both reductions in SABA and changes to lower-carbon pMDIs can have positive influences.

Medication availability and funding impacts

In New Zealand, medicine availability can change due to Pharmac funding changes or supply issues. In 2023, Respigen was discontinued when the manufacturing site closed. This can impact CO_2 emissions as brands have different carbon footprints.

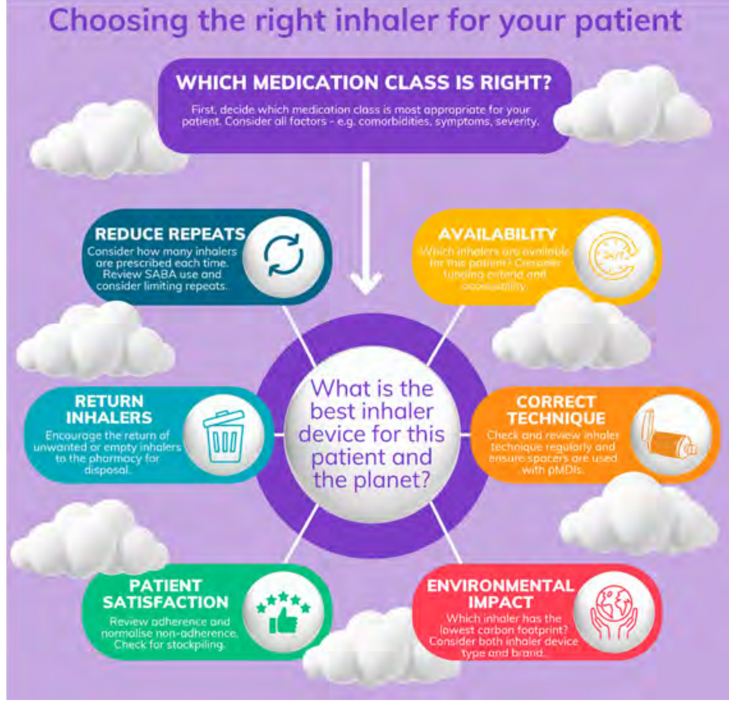
Multidisciplinary approach to reducing carbon footprint

Adopting a multidisciplinary approach with pharmacists and nurses can reduce the environmental impact of inhalers by promoting environmentally friendly choices and optimising inhaler technique. Correct inhaler use, including using spacers with pMDIs, ensures patients receive the full dose, and each inhaler lasts longer. This benefits both patients and the environment.

Recommendations

The GINA 2024 guidelines outline a four-pronged approach to selecting inhaler treatment for a patient, balancing patient preferences with carbon footprint. Figure 4 provides a summary of the GINA recommendations to support lower carbon prescribing.

Figure 4: Overview of recommendations to achieve environmentally friendly inhaler prescribing, adapted from the GINA 2024 guidelines.[6]



Changes to inhaler use can take time; phasing out CFC-containing pMDIs took over 20 years.[7] However, with today's tools, even small changes can make a difference. It's never too late to start to prescribe greener for cleaner air.

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Learning together, working together

Rethinking frailty management in Golden Bay

By Pegasus Health

The Clinical Connect Online Programme is designed for primary health practitioners within Aotearoa New Zealand who are working as a general practitioner, nurse practitioner, nurse or community pharmacist. The model is based on best practice principles of adult learning – providing time and space for reflection, discussion and considering how new knowledge relates to their own practice.

Dr Neil Whittaker (GP), Paula Finnigan (nurse) and Megan Peters (pharmacist prescriber) of the Golden Bay Medical Centre joined the online programme mid-2024.

Dr Whittaker says, “The programme ticked many boxes for how we learn best, with its pedagogical structure, evidence-based content and focus on the practical realities of primary care. It is developed by primary care for primary care. It differs from traditional professional development, which often follows a lecture-style format led by external specialists.”

For the Golden Bay team, the Clinical Connect Online Frailty topic sparked improvements particularly in the management of frailty in their patients. Their experience highlights how this topic encouraged an environment of collaboration, reflection and change. The team adjusted their approach to managing frailty, with Dr Whittaker noting, “We are so busy just trying to get through the work, which often meant focusing more on the patients’ immediate, urgent needs rather than long-term planning.”

This topic inspired them to develop a clear, coordinated frailty pathway as a crucial step toward improving care for this patient group, with additional funding helping to support its implementation. As Megan notes, “Having a multidisciplinary approach within the programme encourages the sharing of knowledge, experiences, and discussions around the focus topic. This not only strengthens team relationships but also enhances clinical support, all with the goal of improving patient outcomes."

Although the new frailty pathway is still in its initial stages, the team has already seen positive changes in patient care. They now take a more holistic approach to frailty management, addressing not just immediate needs but also long-term care planning. This ensures that patients receive care that respects their wishes and leads to the best possible outcomes. This shift has been particularly evident in end-of-life care, where there has been a concerted effort to avoid unnecessary and futile treatments to ensure patients’ dignity and comfort.

The programme ticked many boxes for how we learn best, with its pedagogical structure, evidence-based content and focus on the practical realities of primary care.

The multidisciplinary aspect of the Clinical Connect Online Programme was key to enabling these changes. With a varied group of clinicians attending the programme, they were able to approach challenges from different angles, ensuring that all aspects of patient care were considered. This collaborative approach encouraged comprehensive decision making, which considered a wide range of factors, from medical to emotional and practical needs. Paula said, "It's been amazing to see how bringing the multiple inputs for patients together is reducing the need for clinicians to address needs individually. So, the collaboration's been great."

Furthermore, the programme encouraged the Golden Bay team to reflect on their practice, challenging traditional ways of thinking. This reflection allowed them to identify areas for improvement that might have otherwise been overlooked. This holistic and reflective approach has not only enhanced the care they provide but has also created an environment of continuous learning and development within the team.

While the journey is still ongoing for this team, the Clinical Connect Online Programme has shown that by giving primary care professionals the tools, time, and space to collaborate and reflect, positive change is possible. This approach has led to improved patient outcomes and a more cohesive and effective approach to care.

College members receive a 15% discount off the standard programme cost. To learn more or to register your interest, visit: https://clinicalconnect.nz/

Part of the Golden Bay Frailty Management Team
From left to right: *Paula Finnigan (nurse), Mel Gray (nurse), Jo Sharpe (social worker), Brigette Gilmour (nurse), Dr Neil Whittaker (GP).*

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Empowering those who live and work in rural areas

The National Rural Health Conference

The National Rural Health Conference is being held in Ōtautahi Christchurch on 1–3 May 2025 at Te Pae Convention Centre. The conference is focused on building healthy, sustainable and resilient rural communities.

Over the years, the National Rural Health Conference has attracted a diverse range of participants from across the country and beyond, with sessions that address the evolving challenges and opportunities in rural health. This reflects the collective commitment to improving health outcomes for rural and remote communities.

This year's conference theme is all about 'empowerment.' The conference organisers, Hauora Taiwhenua Rural Health Network believe that empowering those who live and work in rural areas is key to creating sustainable and effective health care solutions. Through this theme, they want to highlight strategies, share success stories and foster collaborations that empower rural health professionals and communities to take charge of their health and wellbeing.

This year the keynote speakers include:

- Matt Chisholm – Former TVNZ Sunday reporter and host of Survivor New Zealand
- Dr Sophie Hart – Rural GP and adventurer
- Dr Carlton Irving – Rural health and community development leader
- Dr Rod Martin – President of the Australian College of Rural and Remote Medicine
- Dr Ganesh Nana – Economist

They have now released the programme, which you can view here:
https://www.nationalruralhealthconference.org.nz/programme

There will also be a Rural Hospital Medicine Training Programme registrar day on the pre-conference day, Thursday 1 May. This day is exclusively for Rural Hospital Medicine Training Programme registrars and their Educational Facilitators. The RHM registrar day provides an excellent opportunity for individuals to engage in focused discussions, share experiences and learn from each other. If you are an RHM registrar, please check your email inbox for your invite or contact drhmnz@rnzcgp.org.nz to find out more.

Find out more about the National Rural Health Conference:
https://www.nationalruralhealthconference.org.nz/

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