GP Voice

YOUR NEWS, YOUR VIEWS, YOUR VOICES

Commonwealth Fund:
International Health Policy Survey

Hīkoi for health care

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Spotlight on the Auckland Faculty

Hīkoi at Bastion Point, Ōrākei

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

April 2025

In this issue

Editorial

Dr Samantha Murton

Last month in quick succession the Health Minister made two significant announcements that have shown his commitment to increasing access to GP and primary care services and growing the workforce.

The announcements Health care boost means seeing a GP, faster and More locally trained doctors in primary care told us that there will be:

- 100 clinical placements for overseas-trained doctors to work in primary care
- incentives for primary care to recruit up to 400 graduate registered nurses per year for three years (with primary care providers in urban areas receiving $15,000 per graduate nurse, and $20,000 in rural areas)
- a new 24/7 digital service for New Zealanders to be able to access online medical appointments
- a $285 million uplift for general practice over three years provided by Health New Zealand
- an increase in the number of training placements at medical school by a further 25 each year
- up to 50 New Zealand–trained graduate doctors a year to train in primary care.

As a College, we welcome these announcements , while also highlighting that we are seeking more details to get a broader understanding of what exactly this means for us. Any additional funding for primary care will benefit our patients and improve health outcomes – as specialist GPs and rural hospital doctors who work in the community, this is our priority.

Increased investment in our workforce has been at the top of our wish list for some time now, particularly improving access to GP, rural hospital and primary care services, as well as growing and retaining the workforce.

Our main points in response were:

- By incentivising primary care to nursing graduates we hope they will see the value in what our workforce does and choose to stay in it for the long-term. We also noted that the real issue remains pay parity between primary and secondary nursing.
- Increasing telehealth availability will be beneficial but needs to be offered alongside improved support for face-to-face primary care services to ensure continued patient safety.
- Enabling more overseas doctors to gain general registration in primary care and gain valuable first-hand experience will help to increase workforce numbers. But we cannot take the focus off supporting our homegrown workforce.

Dr Samantha Murton
President | Te Tumu Whakarae

> “Increased investment in our workforce has been at the top of our wish list for some time now, particularly improving access to GP, rural hospital and primary care services, as well as growing and retaining the workforce.

- The announcement of 50 New Zealand–trained graduates a year being trained in primary care is also welcomed, but they need to follow the rewarding pathway of becoming a GP in order to grow the workforce. We also noted the need for additional support for our current specialist GPs who will be supervising these additional 50 graduates on top of their already busy workloads.

As always, we continue with our advocacy towards creating a more sustainable workforce that will ease the pressures for those of us working in it and improve the health outcomes of our patients and communities.

Enjoy this month's issue,

Goodfellow Unit podcast: **Travel during pregnancy**

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 essential travel considerations for pregnant individuals, focusing on a comprehensive pre-travel consultation.

The key take-home messages of this podcast are:

- The pregnant traveller is immunosuppressed and at greater risk of all causes of infection.
- Protection via immunisation may be compromised due to blunted immune response to inactivated vaccines and contraindications to others.
- Most pregnant travellers will be able to travel safely, but all risk cannot be eliminated.
- Some risks can be reduced through changes in itineraries, e.g. by avoiding malaria and zika endemic areas.
- Travel insurance is essential and the traveller needs to ensure it covers pregnancy complications and the newborn if delivered overseas.

Listen to the podcast

Submit your feedback

2025 College election

Voting open

Voting for the role of one College Board member for a term of three years opened on Monday 24 March. Members eligible to vote received an email on 24 March with the details and a unique link to the online voting portal provided by Vero.

To be eligible to vote, members must be in one of the following membership classes: Fellows, Members, and Associates in Training with dues and levies paid (as outlined in the College Rules).

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.

Eligible members can cast their votes until 8.00pm Thursday 17 April 2025.

There are seven nominated candidates:

- Dr Karl Cole
- Dr Alastair Dunne
- Dr Aniva Lawrence
- Dr Stephanie Taylor
- Dr Deborah Waxman
- Dr Geraldine Wilson
- Dr Pedram Zawarreza

For the role of President, one nomination was received – Dr Luke Bradford; therefore, an election will not take place. The confirmation of the new President and Board member will take place on the publication date, which is 24 April, with both taking up their new roles after the AGM on 26 July.

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.

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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 March.

Medicinal cannabis workshop with MCNZ

Medical Director Dr Luke Bradford and Principal Insights Advisor Simon Wright attended a day-long multi-agency hui discussing the current medicinal cannabis situation, concerns regarding practice and proper care provision.

Health Hawke's Bay presentation

Dr Bradford attended the symposium to meet local members and take part in a panel discussion on workforce development. He also gave a plenary on College work in 2025 and an update on the 'Your Work Counts' project.

Special Interest Groups

An initial working group has been developed to look at the proposed College model and involving those who already have functioning peer support and service options.

Pharmac

Dr Bradford had a meeting with Pharmac's Medical Director to cover upcoming medicine shortages, Pharmac consultations and the ADHD reclassification work.

Policy submissions

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

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Spotlight on the Auckland Faculty

Hīkoi at Bastion Point, Ōrākei

The Auckland Faculty recently held its first event for 2025. An opportunity for members to participate in a CME-accredited Hīkoi at Bastion Point, Ōrākei. The event had such a great response that extra sessions were added and saw 245 Auckland GPs and their whānau gather to learn, socialise, picnic and enjoy delicious ice-creams!

The hīkoi commenced with a traditional mihi whakatau, a warm welcome, and the delivery of the chronological history of Ngāti Whātua Ōrākei by the talented Ngāti Whātua edutainers. Their captivating story truly brought the cultural richness of the area to life.

Some of the wonderful comments shared by the participants

"I went on the hīkoi, and it was an honour and privilege to be part of the group to listen to what he had to tell us. I learnt so much – some of it really shocked me."

"Thank you so much for all your support to attend the hīkoi. It was very useful cultural training; a very rich informative session."

"The explanation of what happened with the Bastion Point protests clarified a lot of what had been confusing about this period."

"It was truly a brilliantly organised, well thought out event and an enjoyable day, with the added bonus of being educational, too."

The Auckland Faculty Executive wish to thank and acknowledge the crucial role played by members, who volunteer their valuable time to make such events possible. If you are in the Auckland area and would like to become involved with the faculty, they would love to hear from you.
Contact aucklandfaculty@rnzcgp.org.nz.

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GP25: Conference for General Practice

GP25: Conference for General Practice is taking place from Thursday 24 to Saturday 26 July 2025 at the Te Pae Convention Centre in Ōtautahi Christchurch.

Early-bird registrations are open until 20 May 2025, and we hope you can join us.

Theme

Mā te kotahitanga e whai kaha ai tātau
In unity, we have strength.

The theme for GP25 is 'belonging.' This whakataukī was chosen because a sense of belonging is a human need that reduces feelings of isolation and stress through connection to others and feeling supported by a larger community.

Programme

The full programme will be available on the conference website from early April. Thursday 24 July will have a CME/clinical skills focus with Friday 25 and Saturday 26 July a mix of keynote, panel and concurrent sessions. The College's Fellowship and Awards celebration will take place at the conclusion of the conference on the evening of Saturday 26 July.

We have announced two of the conference keynote speakers:

Sir Ian Taylor

Founder of Animation Research Ltd – a global leader in innovative technology solutions, covering major sports events worldwide and branching into diverse ventures.

Emma Twigg

Renowned five-time Olympic single scull rower who has established herself as one of the world's top athletes in her sport.

College award nominations open

One of the highlights of every annual conference is the Fellowship and Awards ceremony.

The past year has been another big year for general practice and rural hospital medicine. Now is your chance to celebrate the success of your colleagues by nominating them for a 2025 College award.

The awards, which will be announced at GP25: Conference for General Practice in Ōtautahi Christchurch, recognise the hard work and dedication of exceptional general practitioners and rural hospital doctors.

You can **nominate your colleagues here.**

Nominations close at **6.00pm on Thursday 17 April 2025.**

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

Have your say in the 2025 Commonwealth Fund International Health Policy Survey

Munira Z Gunja, Senior Researcher, International Health Policy and Practice Innovations, The Commonwealth Fund

Calling all GPs! Fieldwork for the 2025 Commonwealth Fund International Health Policy (CMWF IHP) Survey on primary care physicians officially launched last month. The survey is coordinated by the Commonwealth Fund, an organisation based in New York City that is dedicated to promoting an accessible, high-quality and equitable health care system for all.

The College has been one of the Fund's research partners for many years and New Zealand–based vocationally registered GPs have contributed to past surveys.

The 2025 CMWF IHP Survey is one of the only studies that explores and collects reliable health-related data across three continents, in 10 countries: New Zealand, Australia, Canada, France, Germany, the Netherlands, Sweden, Switzerland, the United Kingdom and the United States.

Topics covered include GPs' views on access to care, use of telehealth, care management for patients, care coordination with other providers, use of information technology, provider experiences with their practice, and perspectives on the health care system. The survey has been running for over two decades in a triennial cycle.

Why participate?

Your experiences as a practising specialist GP matter. For at least the past two decades, countries around the world have been bracing for a shortage of physicians, a problem that has reached crisis proportions in recent years. Physician burnout during the COVID-19 pandemic has only exacerbated the shortage at a time when regular health care has been disrupted, the prevalence of behavioural and mental health conditions has spiked, and people's access to basic primary care has been severely compromised.

Ensuring every GP can provide the highest quality of care to patients requires all stakeholders to have real-time, evidence-based data that shows which models and policies work and which don't. The CMWF IHP Surveys are an opportunity for health systems around the world to have a better understanding of how GPs experience practising medicine in each participating country and to learn from one another how improvements can be made in health care.

“

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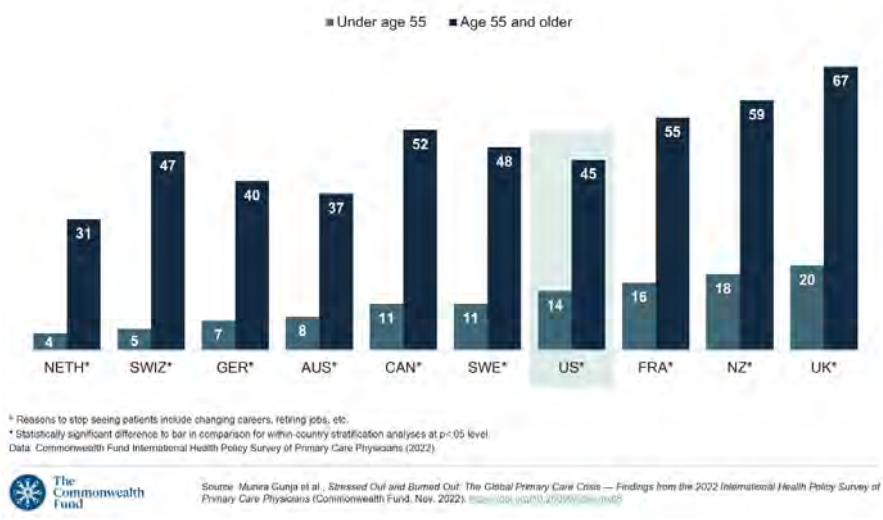
What did the 2022 Commonwealth Fund International Health Policy Survey reveal about GPs around the world?

In all participating countries, potentially a third or more of older GPs plan on leaving the workforce in the next one to three years. This means the majority of GPs in all surveyed countries may soon be younger professionals who are likely to be burdened by stress and burnout. Older GPs in New Zealand were among the most likely to report that they planned to stop seeing patients in the near future.

Figure 1: Percentage of primary care physicians who said the plan to stop seeing patients in the next one to three years^



> Nearly half of older primary care physicians in most countries say they intend to stop seeing patients in the near futrue.

What can our health system learn from other countries to address workforce shortages?

Many countries have already taken steps to make additional investments in primary care. For example, Australia, which has committed $750 million toward improving primary care, established its 'Strengthening Medicare Taskforce' to provide recommendations for growing its primary care workforce. In 2019 the United Kingdom pledged to expand the number of general practitioners through several broad initiatives, including enhanced recruitment efforts among junior physicians, international recruitment and deployment of multidisciplinary teams.

How to have your say

On 19 March, College Medical Director Dr Luke Bradford sent an email invitation to vocationally registered GPs which contained further information and a link to the survey.

The survey will take around 20 minutes to complete and is open until Sunday 18 May.

If you have any further questions, you can contact Simon Wright, Principal Insights Advisor, on simon.wright@rnzcgp.org.nz

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. Respiratory research with Māori and Pacific children living in Aotearoa, New Zealand: a systematic review and narrative synthesis
2. Rural Māori experiences of accessing heart health care: a Kaupapa Māori qualitative analysis
3. Cultural safety in paramedic practice: experiences of Māori and their whānau who have received acute pre-hospital care for cardiac symptoms from paramedics
4. Horny Goat Weed/Epimedium
5. Interprofessional communication between general dental practitioners and general medical practitioners: a qualitative study

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Quality in Practice

Travis Medical Centre

The Quality Programmes team ran a promotion that finished in March 2025 in which practices who completed either the Continuous Quality Improvement (CQI) or Equity module accreditation went into the draw to win one of five $700 Amtech Medical vouchers for their practice.

Congratulations to Travis Medical Centre – our fourth prize draw winner!

Travis Medical Centre is a GP/manager-owned practice in the east of Christchurch with an enrolled population of approximately 6,600. They have an even mix of quintile 2–4 made up of:

- 12 percent Māori
- 2 percent Pacific Peoples
- 1,500 high needs
- 2,000 Community Services Card holders.

They are a multidisciplinary team with a flat hierarchy where everyone is supported to be the best they can be, to pursue their interests and contribute to the improvement of the practice. We caught up with Nurse Nicky to find out about the team's experience completing the Cornerstone CQI module, why they did it and what they learnt.

What motivated your practice to complete the Cornerstone CQI module?

We are a long-term Cornerstone-accredited practice and Health Care Home and Hikitia accredited. We have always focused on quality care and meeting the needs of our community.

Tell us a bit about your CQI initiative

The CQI initiative we implemented at Travis focuses on improving the care and diabetes management for Māori and Pacific patients living with high HbA1c levels (above 64 mmol/mol). The primary goal of this project is to reduce the health inequities faced by these populations, which are disproportionately affected by diabetes.

To help guide us we followed the Kia Kotahi Partnership in Design framework, which is a flexible, six-step, values-based framework ensuring people and their whānau are at the centre of (re)designing equitable health and wellbeing services in a genuine, purposeful partnership.

A key difference of this co-design framework from eurocentric approaches is its foundation in whanonga pono (values) and it is informed by Te Tiriti

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o Waitangi. We worked closely with patients and their whānau to develop culturally sensitive, tailored strategies for improving access to care and overall diabetes management. We also used a LEAN methodology and the Triple Aim Framework, which helped us streamline care processes, improve patient experience, enhance population health and reduce health care costs.

What did you have to do or think about differently as you worked through the CQI module?

As we worked through the CQI module we had to adopt a more patient-centred and holistic approach. That involved understanding the medical needs of the patients and their cultural preferences, personal and social circumstances, and the challenges they faced accessing care.

We learnt that:

- flexibility was key in scheduling appointments, offering after-hours and phone/video consultations, and involving whānau in decision-making.
- we had to rethink data collection, as the initial survey approach was confusing for patients. Adjustments were made to ensure feedback was gathered more effectively, making it accessible and aligned with patient needs.
- holistic care has become an essential part of our CQI efforts, addressing the medical aspects of diabetes care and the social, emotional, and financial challenges patients face.
- incorporating continuous feedback loops helped us refine the care process, ensuring that our efforts were always aligned with what patients needed at each step of their journey.

What is different for your team because of doing this work?

This initiative has fostered a more collaborative and holistic approach within our team, and we now:

- Work together more effectively across disciplines within our Travis team, including doctors, nurses, a health improvement practitioner, health coach, social worker, and also when the patient wants it, we refer them to a culturally appropriate diabetes nurse specialist, which all contributes to a comprehensive care plan for each patient.
- Understand the importance of cultural competency and how it plays a significant role in improving patient engagement and outcomes.
- Regularly use data-driven decisions to refine our care delivery, constantly seeking opportunities for improvement.
- Have learned to be more adaptable in response to patient needs, such as offering flexibility in appointment scheduling or finding creative solutions to logistical challenges like transportation and financial barriers.

- Additionally have enhanced communication among the team and patients, ensuring everyone is on the same page and that no patient falls through the cracks.
- Offer the redesigned questionnaire to all patients with diabetes to ensure they are offered all the services available to them and a plan tailored to their needs. Our Health Coach is initiating this at the time of recalls.

What's different for patients?

For patients, the differences have been profound and include:

- Improved access to care: For example, a patient working night shifts who previously found it difficult to attend 8am appointments was offered afternoon phone consultations. This flexibility allowed them to receive care without disrupting their work schedule. We noticed that patients >80 HbA1c weren't getting blood tests, so we offered in-practice tests, which was much appreciated.
- Culturally relevant support: Māori and Pacific patients now feel more comfortable and understood in the health care environment. Involving whānau in consultations and having Māori or Pacific health care professionals available has improved trust and engagement. One patient shared that the presence of a Māori diabetes nurse made them feel more at ease discussing their health.
- Tailored diabetes management plans: The focus on individualised care has led to better outcomes. For instance, patients with high HbA1c levels (above 64 mmol/mol) received personalised care plans, including education on diet, medications and lifestyle changes, leading to better glucose control and reduced complications.
- Holistic support: A patient facing financial challenges was able to access support from a social worker, who helped them with transportation costs for medical appointments and funded scripts. Additionally, home visits were arranged for those who couldn't attend the clinic, ensuring that diabetes education and monitoring were still provided.

Overall, patients are experiencing a more personalised, supportive and culturally aware approach to their diabetes care. This has resulted in better management of their condition and greater satisfaction with the health care they receive. The project has significantly reduced barriers to care, allowing Māori and Pacific patients to engage in their diabetes management more effectively.

MIND THIS

Acts of parliament related to health care need to be read carefully

Dr Peter Moodie

Peter Moodie is the College's Clinical Advisor

The case

In 2021 Mr A was suffering from the late stages of motor neurone disease and required hospital level care in a nursing home (NS1). His speech was reduced to the point of being able to say little more than 'yes' or 'no'; however, he made it clear to the nursing home doctor (Dr 1) that he wanted to end his life using the newly enacted End of Life Choice Act.

Dr 1 was not sure if Mr A qualified due to his inability to communicate effectively; however, Dr 1 discussed the matter with several colleagues who knew Mr A and also sought advice from the Support and Consultation for End of Life in New Zealand group (SCENZ). Dr 1 concluded that it was likely that he was competent to make this decision. At that point, Dr 1 went on vacation but when they came back, Dr 1 found that Mr A had been transferred to another nursing home (NS2) as NS1 was not able to offer hospital-level care because of staff shortages.

When Mr A was admitted to NS2, his daughter specifically stated that Mr A was on an end-of-life pathway. The staff acknowledged this but probably did not recognise that they might be expected to become involved in the actual process. He was subsequently reviewed by the nursing home doctor (Dr 2). When Dr 2 became aware of the end-of-life request, they formed the view that Mr A did not meet the requirements for assisted dying due at least in part because of his very poor communication skills. Dr 2 further stated that they had been involved with a similar case where the patient had been turned down in a formal assessment and this had caused significant distress to the patient and their family. Dr 2 further noted that MOH guidance specifically stated that patients should not be given false hope if their application was going to declined.

Mr A's family were not happy with Dr 2's assessment and sought advice from Dr 1. Dr 1's view was that Mr A should at least be formally assessed and arranged for the family to contact SCENZ. A formal assessment by an Attending Medical Practitioner (AMP) was arranged by SCENZ and then by an Independent Medical Practitioner (IMP). Both doctors agreed that Mr A fulfilled the assisted dying criteria and that the process could go ahead.

This might have been the end of the struggle, but more was to come. Firstly, NS2 stated that they didn't want the procedure to occur on their premises. A bed at the public hospital was then arranged but the hospital put in a proviso that they might have to cancel the procedure even on the morning of admission if they had a bed shortage.

Mr A subsequently underwent his assisted dying procedure at a friend's home.

The findings

The Commissioner found:

1. Dr 2, in giving an opinion as to whether their patient fulfilled the criteria for end-of-life care, inadvertently acted as an AMP and therefore should have known the suitability criteria. It was acknowledged that the Act had only recently been applied, and that another document by the MOH, entitled 'Conversation guidance', did give a slightly different view.
2. NS2 inadvertently caused distress by not making it obvious that they did not want to have anything to do with the actual assisted dying process; however, it was their right to refuse.
3. The public hospital, by refusing to give final consent until 8am on the morning of the proposed procedure, put an impossible psychological burden on the patient and their family. The hospital agreed to start a national debate on the topic.
4. Dr 2 acted with care and compassion, but it behoves us all to make sure that we fully understand new legislation when it involves patient care.

Goodfellow Unit podcast: **Navigating Work and Income**

College Fellow Dr Cathy Stephenson is a GP at Mauri Ora Student Health Service, Victoria University of Wellington. Her special areas of interest include sexual health, sexual assault, contraception, mental health and well-being, gender-affirming health care, and improving health for vulnerable communities.

In this episode Cathy discusses the role of the Ministry of Social Development (MSD) and Work and Income, exploring how to navigate the system to ensure your patients receive the right supports and services.

The key take-home messages of this podcast are:

- Please consider employment as a positive health intervention
- Connect with your regional health and disability team
- Don't forget about the Disability Allowance and Child Disability Allowance

Listen to the podcast

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A landmark shift in acne treatment

Widening access to isotretinoin

In 2008, New Zealand took a pioneering step that would change the treatment landscape for acne patients, especially teenagers struggling with severe cases. Dr Peter Moodie, then Medical Director of Pharmac, led the charge to widen access to isotretinoin, a potent acne medication. Before this, only dermatologists had the authority to prescribe the drug, limiting access to those who could afford private consultations or waited months for a specialist appointment.

The decision to allow general practitioners to prescribe isotretinoin was a significant shift. It was not just a medical decision but one with profound social and mental health implications. As Dr Moodie explains, “We wrote the original paper some 15 years ago, and by chance, last year it was read by a GP in Ireland who was researching articles on widening access to isotretinoin. We had a Zoom meeting, and rather unwisely, we agreed to update the paper.”

This move was driven by the recognition that acne can have serious mental health consequences for teenagers. The stress and self-esteem issues caused by severe acne can often lead to depression. The changes in prescribing practices allowed a greater number of patients to access isotretinoin, offering a lifeline for those who would have otherwise been unable to afford or access treatment. Prof. Bruce Arroll says, “The concern about the isotretinoin causing depression has been disproved in other research and almost all patients are very pleased with the results.”

The results were profound. In the years following the change, the number of isotretinoin prescriptions increased dramatically. According to a recent paper published in BMJ Open, isotretinoin prescriptions rose by 87% from 26,897 in 2008 to 50,613 in 2023. And perhaps most notably, New Zealand became the only country in the world to report a reduction in the prevalence of acne.

“This has transformed the treatment of acne and made it available to all Kiwis as a funded prescription,” said Prof. Arroll, a key figure in the research and a longtime advocate for equitable health care. “The hero in this process is Dr Peter Moodie, who created the opportunity back in 2008 and initiated the research to be done on the usage. While all Kiwis have access, there is still an ethnicity and socioeconomic gap, with quintile 1 still getting more than quintile 5.”

The widening of access was more than just an increase in prescriptions, it was an attempt to address long-standing issues of inequity in health care. The data revealed that while Māori and Asian populations experienced a substantial increase in prescriptions, Pacific People saw a more modest rise indicating that challenges in achieving equity persist.

Dr Moodie reflects on the importance of this initiative noting, “In New Zealand, we should be proud of the depth and accuracy of our government pharmaceutical databases. They contain a wealth of data that other countries can only dream about.”

The research also underscores a global shift in how isotretinoin is prescribed. Before 2009, prescribing was heavily restricted, with most prescriptions written by private dermatologists. Now GPs and nurse practitioners are part of the prescribing process, enhancing access and efficiency. As the study concluded, “Expanding the prescriber cohort has resulted in a substantial increase in prescriptions with primary care now issuing the majority of isotretinoin prescriptions.”

But it wasn’t just a matter of improving access. The study also highlighted the crucial role of education. Pharmac launched an educational programme to equip new prescribers with the knowledge needed to safely administer isotretinoin, ensuring that the medication’s potent effects were managed appropriately. “Many countries have restrictions on patient access to isotretinoin, similar to New Zealand in 2008,” said Dr Moodie. “This is the first study demonstrating that, given appropriate postgraduate education and support, the isotretinoin risk–benefit profile can be enhanced to safely deliver high-quality, timely and equitable patient access to isotretinoin in primary care.”

While the increase in isotretinoin prescriptions has been a success in many ways, the data also shows areas where there is still work to be done. Disparities remain, particularly for Pacific communities, and further research is needed to address these gaps.

The team behind the BMJ Open paper – Dr Peter Moodie, Prof. Bruce Arroll, Jason Arnold, Rachel Roskvist and Dr Diarmuid Quinlan, the Irish GP who contributed to the updated study – has helped shape a system that has not only transformed acne treatment but also set a precedent for other countries to follow. As Dr Moodie reflects on the broader implications of this research, it’s clear that the work in New Zealand will serve as a model for expanding access to essential health care services worldwide.

A change for the better

The widening access to isotretinoin is more than just a medical policy, it’s a victory for equity and mental health. While there’s still work to be done to close the gaps in access for some populations, the success of this initiative proves that with thoughtful policy and dedicated research, a significant change can be made for the betterment of public health.

You can read the paper here.

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> … given appropriate postgraduate education and support, the isotretinoin risk–benefit profile can be enhanced to safely deliver high-quality, timely and equitable patient access to isotretinoin in primary care.

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Hīkoi for Health

A people's inquiry into health care reform

In late-April College Fellow and GP Dr Glenn Colquhoun and general hospital physician Dr Art Nahill will embark on a 'Hīkoi for Health', travelling from Kaitaia to Wellington collecting health care stories and ideas for reform from communities along the way.

Travelling in an eye-catching second-hand van that has been painted to resemble an ambulance by Nigel Brown, a New Zealand artist known for his work that engages with social and environmental issues, the duo will make their way down the country to present the collected ideas to Parliament in May.

The idea for the trip emerged from their concerns about the current state of New Zealand's health system and the lack of significant action to address the well-documented challenges. Growing waiting lists, pressures on emergency departments, difficulty accessing primary care services and burnout levels within the workforce all add to the urgency of their message.

Dr Colquhoun says, "Our health system has a mauri – a life force. After 30 years interacting with patients it feels like there is some dynamic living thing that connects us together. Protecting this is at the heart of health. I'm angry that it seems unappreciated by those who are charged with looking after it."

Dr Nahill says, "I see this journey less as a protest and more as an attempt to create a positive movement for the reform our health system requires. We can't wait for governments to 'see the light' – we need to shine our passion and ideas so brightly they can't turn away."

"I see this journey less as a protest and more as an attempt to create a positive movement for the reform our health system requires.

The artwork on the ambulance portrays the current state of the health care system. In general appearance the art is expressive and free flowing on the set backgrounds. It draws on the artist's medical and artistic experiences and was designed to be eye-catching so communities can make their own interpretations and relate it to their own experiences. Inside, the van doubles as a recording studio where stories and solutions will be captured.

On the website, you can find the itinerary of the route being taken and take the opportunity to share your own health care stories and ideas for change.

Follow their journey via **#HikoiForHealth**

About the organisers

Dr Glenn Colquhoun is a general practitioner who has dedicated much of his career to youth health services in the Horowhenua region. He has extensive experience in community health care delivery, particularly focusing on addressing health care inequities and improving access to medical services for young New Zealanders. Glenn is a poet and children's writer. His first collection *The Art of Walking Upright* won the Jessie Mackay Award for Best First Book of Poetry award at the 2000 Montana New Zealand Book Awards. He was awarded the Prize in Modern Letters in 2004 and a Fulbright scholarship to Harvard University in 2010 to explore medical humanities. *Ngā Wāhine E Toru / Three Women* and *Myths and Legends of the Ancient Pākehā*, his examinations of oral poetry in New Zealand, were published in 2024.

Dr Art Nahill is a Harvard-trained physician and award-winning clinical teacher whose career has spanned nearly 30 years. During that time, he worked in primary care, acute and chronic medicine at Auckland and Middlemore Hospitals, and in telehealth. While still working in consultative roles, he reluctantly retired from clinical medicine in 2023 when he felt the failure of government as kaitiaki of the public health system had made the hospital environment unsafe for patients, staff, and doctors. Art is also an award-winning poet who has published widely in both the US and New Zealand, including four books of poetry. He is a former correspondent for the Boston Globe newspaper in the US and has published numerous articles about the need for health care reform here in New Zealand.

Submit your feedback

New professors in primary health care and general practice announced

New professors Angela Ballantyne, Eileen McKinlay, Maria Stubbe and Ben Darlow with Head of Department Lynn McBain (centre).

Recently Otago University welcomed four new professors to the Department of Primary Health Care and General Practice at their Wellington campus, reflecting the growing importance of the academic discipline.

The new primary health care professors are Ben Darlow, Maria Stubbe, Angela Ballantyne and Eileen McKinlay. Their promotions were announced in December and took effect from 1 February. They were promoted alongside fellow Wellington academic Jason Gurney from the Department of Public Health.

The Head of the Department of Primary Health Care and General Practice, Professor Lynn McBain, says having four staff promoted to professor is hugely significant, with only about 15 primary health care professors across the entire country.

"Primary health care is an emerging academic discipline in the medical school, and has only been around for about 20 years," she explains.

"Our General Practice Department in Wellington was first established as a unit within the Department of Medicine before becoming a standalone department in the 1990s and then evolving to Primary Health Care and General Practice. Since then we have been employing a broader range of academic staff, not just general practitioners."

The four new professors all come from different backgrounds – none are GPs. Ben is a musculoskeletal physiotherapy specialist whose passion is supporting people to participate in healthy, active lives; Maria is a social scientist and applied sociolinguist who has published widely on research relating to health communication, health services, workplace language and discourse analysis; Angela is a bioethicist who writes on ethical issues related to clinical practice, data sharing and public health, and Eileen is a registered nurse who researches interprofessional collaborative practice in health care delivery.

Lynn says general practice has flourished with the recognition that access to high-quality primary health care improves health outcomes.

"Primary care is close to people in the community; it gives continuity of care which is really beneficial for people's health and allows that overall comprehensive care for patients. Primary care should be, and is in New Zealand, the basis of the health system.

"It has also become obvious that we need to move towards interprofessional team care, with staff who have a variety of skill sets."

Lynn says being promoted to professorial level is a huge achievement for the four academic staff, who had to demonstrate they had made outstanding contributions and shown leadership in the areas of teaching, research and service during their career.

"It is quite a high bar to reach in New Zealand and particularly at Otago University.

"We are just thrilled this has happened. I am very proud of them all. And I hope it's a bit of an inspiration, a goal for others, that they can see that promotion to professor is possible."

The four new professors of Primary Health and General Practice are:

Ben Darlow

Ben's passion is supporting people to participate in healthy active lives, particularly when they have back or joint pain. He achieves this through clinical practice as a musculoskeletal physiotherapy specialist, supporting the learning of medical and other health students, and collaborative interprofessional research. Ben's research has explored how people make sense of back and joint pain, created tools to measure health knowledge and beliefs, co-designed resources that support people to recover from or live well with back and joint pain, and developed and tested new models of community-based health care. Ben partners with people who have lived experience of the conditions he researches so that their perspectives can inform all stages of research and implementation. He focuses on achieving equity in research participation and outcomes. Ben's research directly informs his clinical practice and teaching. He led redesign of the pain learning curriculum for University of Otago medical students.

> "Primary care should be, and is in New Zealand, the basis of the health system.

Angela Ballantyne

Angela is a bioethicist specialising in human research ethics and feminist bioethics. She also writes on ethical issues related to clinical practice, data sharing, and public health. A common unifying theme across her work is a focus on justice, equity, vulnerability, power, and exploitation. Angela teaches medical ethics in the medical programme at the University of Otago, Wellington. She is interested in health policy and the practical application of bioethics and has served on national expert committees for research ethics review, COVID-19 immunisation policy, the use of AI and algorithms in health, and assisted reproductive technologies. She has always been curious about the intersection of culture and bioethics and enjoys travelling and working overseas, including in the United States, Singapore, Switzerland, Australia, and England.

Eileen McKinlay

Eileen is a registered nurse who researches interprofessional collaborative practice (IPCP) in health care delivery. Working effectively in an interprofessional health care team improves health outcomes for patients, reduces safety and risk incidents, increases staff satisfaction and may lead to a reduction in health inequity because IPCP focuses on the delivery of culturally safe, patient-centred care. Eileen has investigated how IPCP is expressed in primary health care settings and how health sciences and social care students learn about IPCP through interprofessional education (IPE). IPE is inherently collaborative, and Eileen has established relationships with tertiary education providers around Aotearoa New Zealand and is undertaking research on IPE with international collaborators. She is currently Director of the Centre for Interprofessional Education, seconded from the Primary Health Care and General Practice Department on the Wellington campus.

Maria Stubbe

Maria is a social scientist and applied sociolinguist who has published widely on research relating to health communication, health services, workplace language and discourse analysis. She is director of the interdisciplinary Applied Research on Communication in Health (ARCH) Group and co-leads research in the Department of Primary Health Care and General Practice on the Wellington campus. Previously she helped establish the long running New Zealand Language in the Workplace Project and Wellington Corpus of Spoken New Zealand English at Victoria University of Wellington. Recent research includes conversation analysis of real-life health interactions, exploring narratives of health and illness, and evaluating primary and community health services relating to diabetes, mental health, respiratory illness and immunisation, with a focus on intercultural care and health equity. She has led major externally funded research projects and particularly enjoys working with postgraduate students and collaborating with other researchers, health providers and service users across Aotearoa New Zealand and internationally.

The College would like to congratulate Ben, Angela, Eileen and Maria on this wonderful success. We look forward to working alongside you to better the future of primary health care in Aotearoa New Zealand.

Senior drivers and driver licence renewals

To ensure senior drivers have plenty of time to complete their driver licence renewal process, NZ Transport Agency Waka Kotahi (NZTA) wants to increase awareness that they can renew their licence as early as six months before it expires. Renewing early won't affect the new driver licence expiry date.

Senior drivers are required to renew their driver licence at age 75, 80 and every two years after that, and need to present a medical certificate when renewing. These can be issued by GPs, registered nurses and nurse practitioners operating within their scope of practice.

"We understand how important it is for senior drivers to have enough time to get a medical certificate, and if required by their health practitioner, book a practical driving test. To ensure this process runs as smoothly as possible, we want to make senior drivers aware that they can start the renewal process early," says Karina Morrow, NZTA Senior Manager Safer Drivers.

What senior drivers need to know:

- To apply to renew their licence, they need to visit a driver licensing agent in person.
- They need to take:
  - a completed Application for issue or renewal of driver licence (DL1) form
  - a medical certificate issued within the last 60 days
  - their current photo driver licence or other acceptable evidence of identity.
  - EFTPOS, credit card or cash to pay the $21.50 renewal fee.
- They may also need to complete a practical driving test if recommended by their doctor. There are two types of practical tests a doctor may require:
  - On-road safety test which assesses a driver's ability to meet the minimum safe driving standard.
  - Occupational therapist driving assessment which assesses competency in a range of situations and where a medical condition may be a factor in driving (such as post-stroke, Parkinson's disease, multiple sclerosis, etc).

There's more information about renewing from age 75 and over on NZTA's website: Renewing for seniors

Resources

NZTA offers a range of resources for senior drivers renewing their licence and Staying Safe courses run through Age Concern.

Resources or Senior drivers

Staying Safe courses available in your area

Submit your feedback

Antibiotic Conservation Aotearoa

Evidence-based resources to support optimal care for patients with URTIs

Associate Professors Stephen Ritchie and Mark Thomas, Faculty of Medical and Health Sciences, The University of Auckland

Viral upper respiratory tract infection (URTI) 'treatment' is the reason for a very large proportion of all antibiotic prescriptions in Aotearoa New Zealand. This occurs despite all prescribers being aware that URTIs are almost always caused by viruses, and therefore that antibiotic treatment is commonly futile and not infrequently causes significant adverse effects.

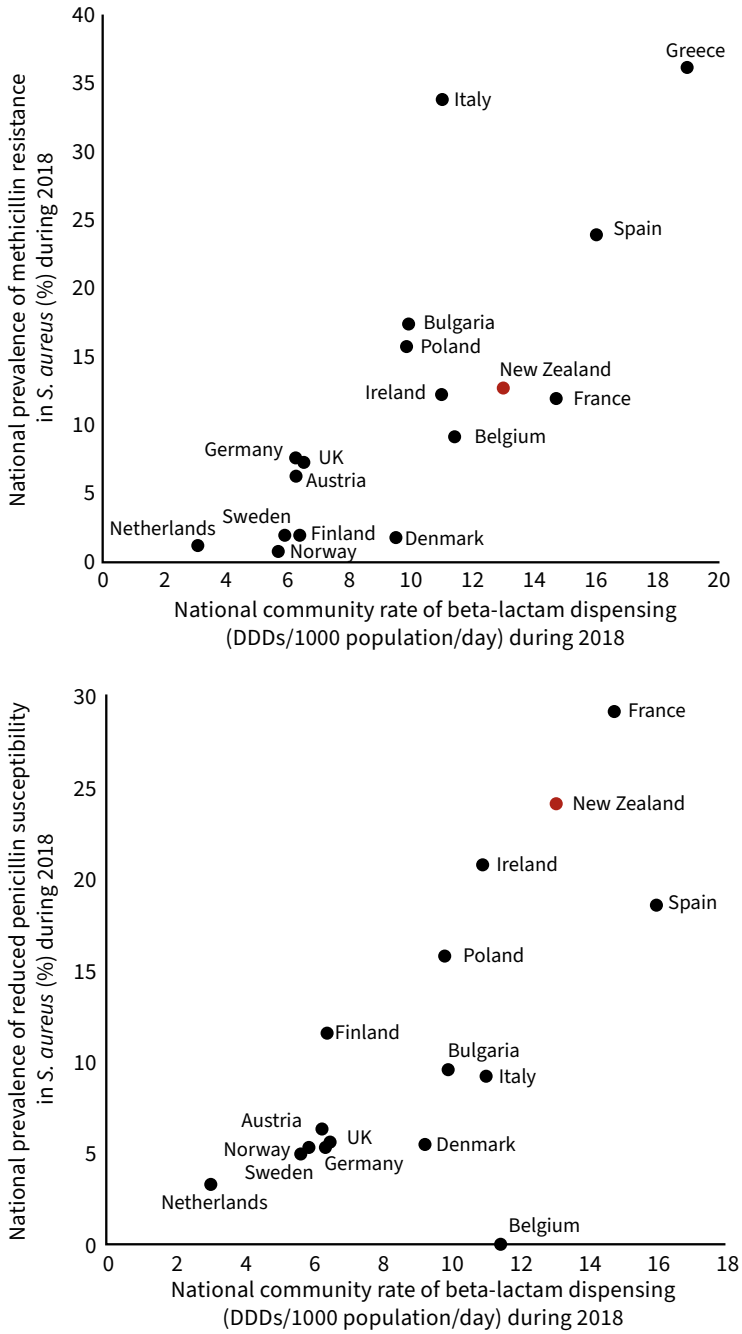
All antibiotic consumption, whether prescribed to treat bacterial meningitis or to 'treat' a common cold, contributes to the selection of antibiotic resistance in the bacteria that circulate among us. However, antibiotic treatment that serves no useful purpose should be reduced to the bare minimum to avoid adverse effects, the waste of precious health resources, and to reduce the selective pressure that favours the proliferation of antibiotic-resistant bacteria in our communities.

Figure 1 shows that in nations such as the Netherlands, Sweden, Norway and Finland, which have low rates of community dispensing of penicillin and cephalosporin antibiotics (less than half the rate in New Zealand), the prevalence of methicillin resistance in *Staphylococcus aureus* (MRSA) and of reduced susceptibility to penicillin in *Streptococcus pneumoniae* are approximately one fifth the prevalence in New Zealand.[1]

Reducing our high rates of community prescribing of penicillins and cephalosporins for patients with URTIs, in whom these antibiotics are extremely unlikely to provide any benefit, would help to reduce our high prevalence of antibiotic resistance and prolong the utility of these very safe and effective medicines.

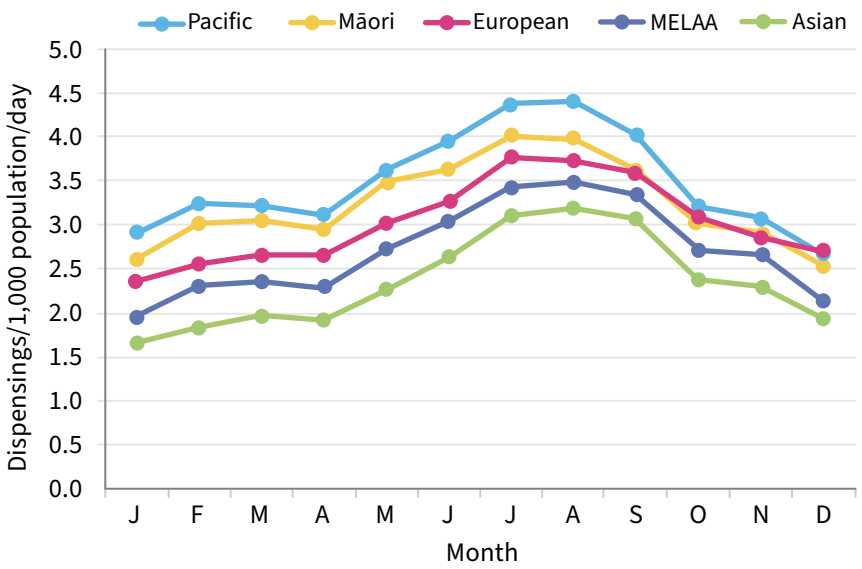
> “Reducing our high rates of community prescribing of penicillins and cephalosporins for patients with URTIs would help to reduce our high prevalence of antibiotic resistance.

Figure 1: The national prevalence of antibiotic resistance in relation to the national rate of community dispensing of beta-lactam antibiotics (penicillins and cephalosporins) during 2018 in New Zealand and a large number of European nations.[1]



There is currently sparse local data on rates of community antibiotic prescribing in New Zealand in relation to the prescriber's clinical diagnosis. However, the dramatic increase during winter months in the national rates of total community antibiotic dispensing, regardless of ethnicity, strongly suggests that a large proportion (perhaps 50%) of all community antibiotic prescribing is for patients with URTIs.[2] (Figure 2)

Figure 2: Monthly rates of total community antibiotic dispensing in New Zealand during 2015.[2]



Associate Professors Stephen Ritchie and Mark Thomas, and others at the University of Auckland, have created infographics and other resources that can support clinicians in reducing their inappropriate antibiotic prescribing for patients with URTIs. These can be found at: www.antibioticconservation.auckland.ac.nz[3]

Figure 3. Antibiotic Conservation Aotearoa website. (www.antibioticconservation.auckland.ac.nz)[3]

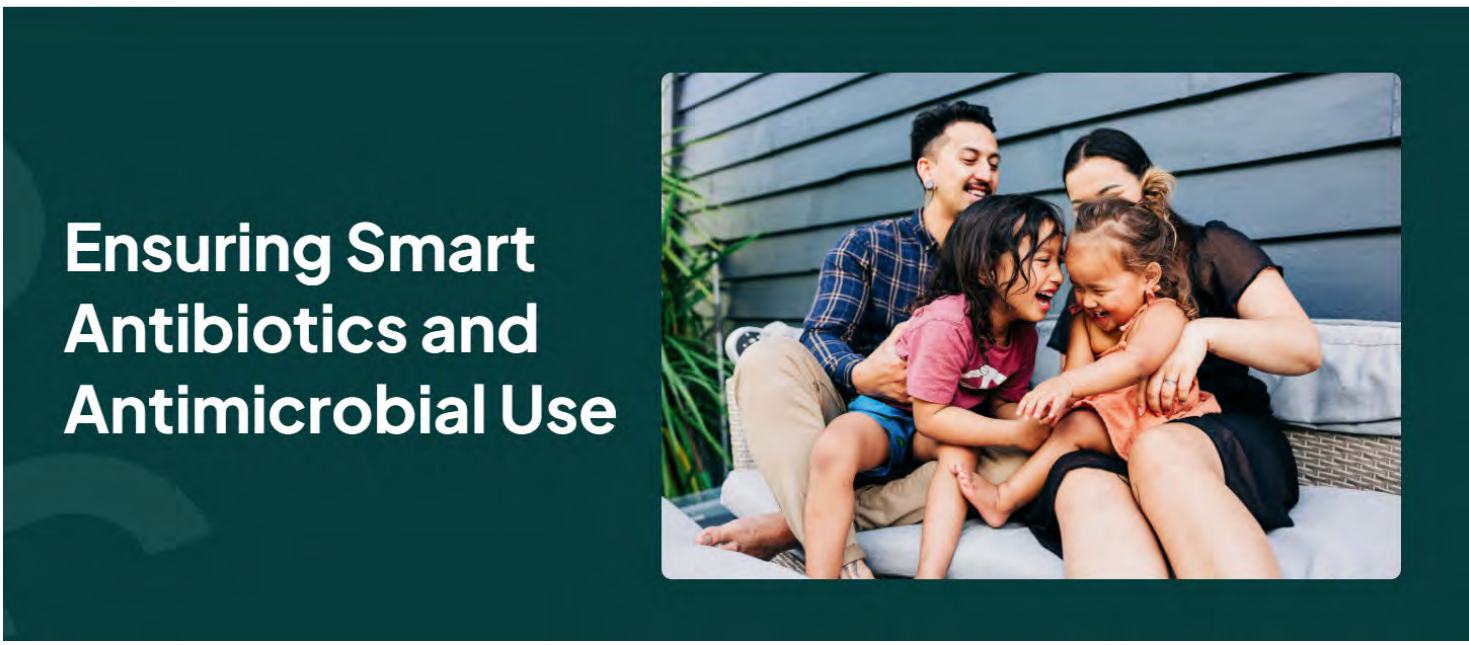
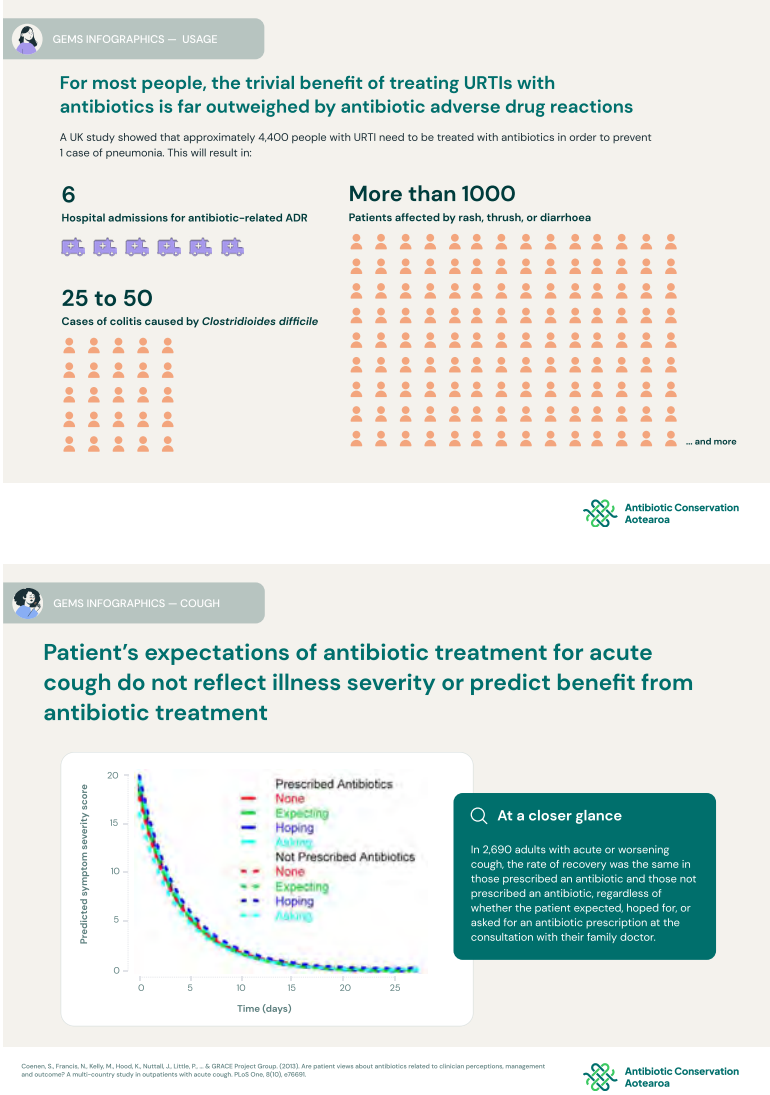


Figure 4 shows two of the 29 easily understood infographics that provide evidence-based, clinically relevant information on the optimal diagnosis and management of common URTIs for New Zealand prescribers.[3]

Figure 4: Two of the 29 infographics available on the Antibiotic Conservation Aotearoa website.[3]



We encourage community prescribers to visit this website and view the many readily understood, informative infographics and videos. We hope that these resources will support a wide range of community prescribers to significantly reduce their inappropriate antibiotic prescribing for patients with URTIs.

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Submit your feedback

Patient blood management and improving outcomes

GP voices wanted

Dr Gustavo Duarte MD MBA, Clinical Director of Patient Service and Care, New Zealand Blood Service, Chair of the Aotearoa New Zealand PBM Working Group

Recently, the World Health Organization (WHO) published a call for action highlighting the critical importance of implementing patient blood management (PBM) in its policy brief *The urgent need to implement patient blood management.*

Patient blood management (PBM) is defined as a patient-centred, systematic, evidence-based approach to improving patient outcomes by managing and preserving a patient's own blood while promoting patient safety and empowerment. PBM targets several key factors such as preoperative anaemia, coagulopathy, blood loss and blood transfusions, which are independent risk factors associated with adverse clinical outcomes. Therefore, PBM is not restricted to optimal blood usage and its goal is not to reduce blood transfusions or restrict the use of transfusion or any other therapy per se. It is crucial to understand the difference between PBM and optimal blood use which enables us to shift the focus 'from the product to the patient' and sustain efforts to optimise patient outcomes.

From its origins as a strategy for surgical patients, PBM has evolved into a comprehensive care paradigm to manage anaemia and preserve a patient's own blood. It is being applied in the care of medical and surgical patients, pregnant women, neonates, children, adolescents, elderly people and the population as a whole. The overarching aim of PBM is to improve patient outcomes while saving health care resources and reducing costs.

The programme focuses on interventions that can take place several times during the patient journey, promoting anaemia identification and treatment, minimising bleeding risks, and optimising the patient's tolerance to anaemia (Figure 1).

On that same line, the WHO policy also aims to encourage the incorporation of PBM into daily clinical practice. In New Zealand, many centres have been successful in implementing PBM programmes. However, most of those programmes are focused on the intra-hospital setting, when time for interventions is limited. In that scenario, the involvement of primary care physicians is essential to maximising the patient's benefits. Experiences from overseas show that the engagement of primary care professionals on these projects is the difference between a limited-benefit approach and a sustained strategy to promote better clinical care.

To promote awareness and education around PBM and ultimately drive its implementation in the country, the Aotearoa New Zealand PBM Working Group was created two years ago.

This group is made up of health care professionals from all over the country, from institutions of different sizes, complexities, locations, budgets, and challenges. This group has been working together, meeting monthly, sharing best practices, accelerating the implementation of PBM programmes and representing the country at national and international conferences. In December of 2024, with the support of the New Zealand Blood and Organ Services, this team promoted the first New Zealand PBM National Symposium with the presence of international leaders on the matter. Despite these accomplishments, we are still missing an essential link in the chain of patient care.

Echoing the WHO document, we are calling on our primary care physicians to act, to understand the importance of this topic, and to join efforts to implement this patient-centred approach, enabling a coordinated effort among various stakeholders and optimising our chances of significantly contributing to better health care practices nationwide.

If you would be interested to learn more, or would like to join our working group, please email me at Gustavo.Duarte@nzblood.co.nz.

Figure 1: The classic three pillars of PBM programmes

	1st Pillar Optimise haemopoiesis	2nd Pillar Minimise blood loss and bleeding	3rd Pillar Harness and optimise tolerance of anaemia
Preoperative	• Screen for anaemia • Identify underlying disorder(s) causing anaemia • Manage underlying disorder(s) • Refer for further evaluation if necessary • Treat iron deficiency, anaemia of chronic disease, iron-restricted erythropoiesis • Note: anaemia is a contraindication for elective surgery	• Identify and manage bleeding risk (past/family history, current medications, etc) • Minimise iatrogenic blood loss • Procedure planning and rehearsal • Preoperative autologous blood donation (in selected cases or when patient choice)	• Assess/optimise patient's physiological reserve and risk factors • Compare estimated blood loss with patient-specific tolerable blood loss • Formulate patient-specific management plan using appropriate blood-conservation modalities to minimise blood loss, optimise red cell mass and manage anaemia • Restrictive evidence-based transfusion strategies
Intraoperative	• Timing surgery with haematological optimisation	• Meticulous haemostasis and surgical techniques • Blood-sparing surgical techniques • Anaesthetic blood-conserving strategies • Autologous blood options • Pharmacological/haemostatic agents	• Optimise cardiac output • Optimise ventilation and oxygenation • Restrictive evidence-based transfusion strategies
Postoperative	• Treat anaemia/iron deficiency • Stimulate erythropoiesis • Be aware of drug interactions that can cause/increase anaemia	• Vigilant monitoring and management of post-operative bleeding • Avoid secondary haemorrhage • Rapid warming – maintain normothermia (unless hypothermia specifically indicated) • Autologous blood salvage • Minimising iatrogenic blood loss • Haemostasis/anticoagulation management • Prophylaxis of upper gastrointestinal haemorrhage • Avoid/treat infections promptly • Be aware of adverse effects of medication	• Optimise tolerance of anaemia • Treat anaemia • Maximise oxygen delivery • Minimise oxygen consumption • Avoid/treat infections promptly • Restrictive, evidence-based transfusion strategies

References:

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Submit your feedback

Treatment of thyroid cancer: An update

Dr Francis Hall

Thyroid cancer overview

Thyroid cancer accounts for 1% of all cancers in New Zealand. The incidence of thyroid cancer is 13 per 100,000 per year. About 1 in 100 people develop thyroid cancer over the course of their lifetime. It is three times more common in women.

There are four main types of thyroid cancer.

1. Papillary thyroid carcinoma is the most common type of thyroid cancer and has a tendency to spread to lymph nodes. With good treatment it has an excellent prognosis. There are several variants of papillary thyroid carcinoma (tall cell variant, columnar cell variant, hob nail variant, diffuse sclerosing variant, solid variant, TERT positive) that have a worse prognosis.
2. Follicular thyroid carcinoma is the second most common type of thyroid cancer and has a tendency for haematogenous spread to lungs, brain and bones. It also has an excellent prognosis.
3. Medullary thyroid carcinoma is less common. It sometimes runs in families and has an intermediate prognosis. Serum calcitonin is a very useful marker to help diagnose medullary thyroid carcinoma and to assess response to treatment.
4. Anaplastic thyroid carcinoma is a very aggressive thyroid carcinoma and has a very poor prognosis.

There are other types of thyroid cancer that are less common, including primary lymphoma of the thyroid, squamous cell carcinoma of the thyroid, etc.

The treatment of differentiated thyroid cancer

Differentiated thyroid carcinoma (DTC) is the term used to encompass both papillary thyroid carcinoma and follicular thyroid carcinoma. The American Thyroid Association (ATA)[1] has guidelines on the treatment of differentiated thyroid carcinoma. In New Zealand, we generally follow the ATA guidelines. The ATA guidelines tend to be updated about every 5–10 years. The last ATA guidelines on the treatment of DTC were published in 2016. Updated ATA guidelines are expected this year.

The treatment of DTC usually involves one or more of the following:

1. Surgery
2. Radioactive iodine
3. Thyroxine

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.

External beam radiotherapy is indicated for some distant metastases and in anaplastic thyroid carcinoma. Targeted agents are used in some patients with distant metastases.

The 2009 ATA guidelines on the treatment of DTC divided patients with DTC into a three-tiered risk system: low risk, intermediate risk and high risk. In the 2015 guidelines, this three-tiered risk system was further described as a continuum of risk. Patients with DTC are discussed at a thyroid multidisciplinary meeting and treatment recommendations are made. Twenty years ago, nearly all patients with DTC were treated with total thyroidectomy, radioactive iodine (RAI) and a suppressive dose of thyroxine. Nowadays, treatment of DTC is more selective and is guided by the level of risk. Many patients are now treated with hemithyroidectomy and without either RAI or a suppressive dose of thyroxine. Of course, patients treated with a hemithyroidectomy avoid the need to take thyroxine and the potential complication of hypocalcaemia.

The extent of surgery is determined by the extent of the disease and pathology. Patients with multifocal cancer and patients with more aggressive thyroid cancers are treated with total thyroidectomy. Patients with DTC and involvement of cervical nodes require a neck dissection in addition to total thyroidectomy.

Patients with DTC treated with total thyroidectomy need thyroid hormone replacement therapy (thyroxine). The dose of thyroxine is monitored with serial TSH and fT4 measurement. The target level of TSH is determined by the risk stratification of the patient and is usually determined by the patient's endocrinologist. The target TSH level for the lowest risk patients is between 0.5–2.0mU/L (low end of normal range), intermediate risk patient (0.1–0.5mU/L) and for the highest risk patients is <0.1mU/L. A suppressive dose of thyroxine inhibits thyroid cell growth. A suppressive dose of thyroxine is associated with an increased (3.5x) risk of osteoporosis, hypertension, cardiac arrhythmias and ischaemic heart disease.

Patients with DTC are followed clinically and with ultrasound. Patients with DTC treated with total thyroidectomy are also followed with serum thyroglobulin and anti-thyroglobulin antibodies. Thyroglobulin is a marker of thyroid tissue. Both benign and malignant thyroid cells secrete thyroglobulin. The thyroglobulin level is interpreted in conjunction with the TSH level (stimulated or unstimulated thyroglobulin level). An undetectable stimulated thyroglobulin level combined with a low level of anti-thyroglobulin antibodies is associated with an excellent prognosis. With good treatment, patients with DTC usually have an excellent prognosis.

Papillary thyroid microcarcinoma

Papillary thyroid microcarcinoma is defined as a papillary thyroid carcinoma measuring 1cm or less. Treatment of this entity is controversial. Many advocate active surveillance with serial ultrasound. Some advocate hemithyroidectomy and others advocate radiofrequency ablation.

Non-invasive follicular thyroid neoplasm with papillary like nuclear features (NIFTP)

NIFTP is a new name for a very low-risk thyroid tumour previously known as encapsulated non-invasive follicular variant papillary thyroid carcinoma. It is best regarded as benign.

Medullary thyroid carcinoma

The ATA has separate guidelines for the treatment of medullary thyroid carcinoma. Patients with medullary thyroid carcinoma are generally treated with total thyroidectomy and central neck dissection plus or minus lateral neck dissection. In addition to clinical and radiological follow up, serial calcitonin measurement is an important part of their follow-up regime. Usually, medullary carcinoma has a less favourable prognosis than DTC.

Anaplastic thyroid carcinoma

Finally, the ATA has separate guidelines for the treatment of anaplastic thyroid carcinoma. It has the least favourable prognosis of the four main types of thyroid carcinoma, with very few people achieving long-term survival. Surgery is indicated only if complete resection is possible with minimal morbidity. Debulking procedures are not recommended. Treatment is mainly with chemotherapy and radiotherapy.

Take home points

1. The treatment of papillary and follicular thyroid cancer has become more selective, with low-risk patients now being treated with hemithyroidectomy alone.
2. Nowadays radioactive iodine is used less often than before in the treatment of thyroid cancer. RAI is reserved for patients with high-risk thyroid cancer and in some patients with intermediate risk thyroid cancer. It is not used in low-risk thyroid cancer.
3. The dose of thyroxine is determined by the target TSH range. The TSH range is determined by risk stratification of the patient: low, intermediate and high risk.

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Comorbidities and multiple sclerosis

Multiple Sclerosis Society of New Zealand

Multiple sclerosis (MS) is a chronic inflammatory disease of the central nervous system (CNS) that is highly variable in its presentation, disease course and outcomes. This variability is multifactorial with phenotype and individual factors contributing to how each person presents and progresses throughout their life. Significant advances in the diagnosis and treatments have changed the trajectory of MS and overall improved the quality of life for those with a diagnosis. More can be achieved with a collaborative approach to the management and care of a person with MS.[1]

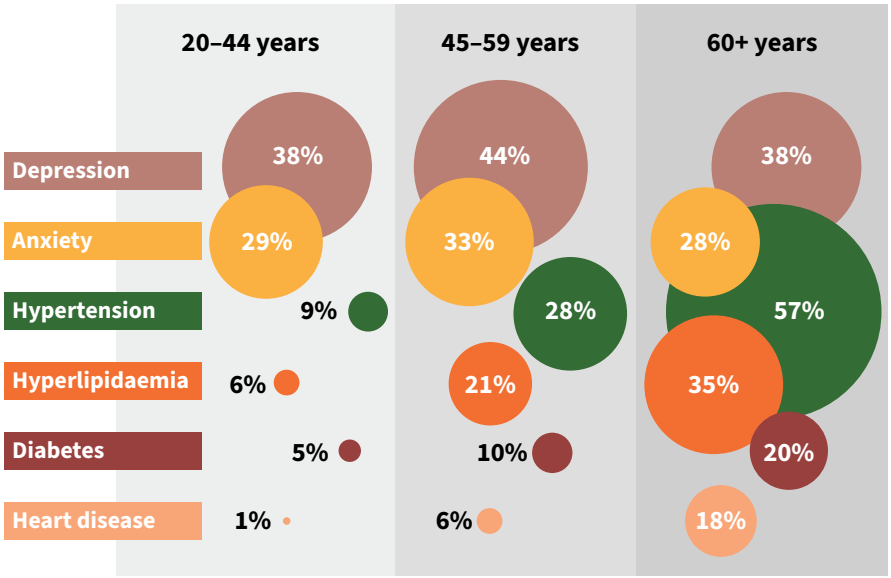
It is important not to manage a diagnosis in isolation. There is growing evidence that MS has an impact on a person's risk for comorbid conditions, and inversely comorbid conditions have an impact on an individual's MS. Active identification and management of preventable and modifiable risk factors can reduce these impacts.[2]

Looking at the incidence of comorbidities in MS – depression, anxiety, hypertension, hypercholesterolemia and chronic lung disease were found to be more prevalent in people with MS. Understanding the impact of comorbidities with MS has its challenges, and there was significant variability in the populations and methods used to study MS and comorbidities.[3] More recent large population-based studies have provided further insight into the understanding that people with MS have higher incidence of vascular, autoimmune, cancer and psychiatric comorbidities. While the relationships between comorbidities are complex and require further investigation to understand, it seems clear that comorbidities impact the course of MS and a person's quality of life.[4]

Comorbidity has been shown to delay the diagnosis of MS, have an impact on disability at diagnosis, and adversely affect the overall disease course. Associations between vascular comorbidity and earlier need for mobility aids, mood or anxiety disorders with an increase in overall disability, and cognitive impairment being more prevalent in those who have a comorbid condition have been found.[5]

Primary care plays an important role in the optimisation of a person's overall health in the presence of chronic conditions. While there are no specific guidelines, active consideration of complex and prevalent comorbidities with MS is a good place to start. For example, vascular disease is a complex comorbidity due to its effect on a different system and depression is a prevalent comorbidity in MS. Screening and proactive management of vascular disease and depression for people with MS can improve overall outcomes for individuals' health and wellbeing.[6]

Figure 1: Lifetime prevalence of common comorbidities in people with MS by age group[7]



Optimisation of a person's long-term care including vigilance with symptom management and medication review can have significant benefits. This doesn't need to be left to the neurologist, particularly in a person with comorbidities.

Importantly, encourage people to be proactive about their own health. Talk to people about the importance of adopting positive health behaviours:

- Physical activity
- Maintaining healthy weight
- Keeping mentally active
- Avoiding smoking and reducing alcohol intake
- Following medical advice and treatment for comorbidities.

These are all evidence-based ways individuals can have a positive impact to reduce the risk of relapse and slow progression in MS.[1]

While the management of MS is complex and made further so in the presence of comorbidities, there are many practical and beneficial ways to provide holistic and useful care. This does not entirely rest with one member of the health care team; a shared care approach that includes primary care teams is of greatest benefit. In fact, the best results can be led and coordinated by quality primary health care and have a real impact on a person's quality of life.

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