

New Zealand
Doctor
Rata Aotearoa

HOW TO TREAT
Thyroid nodules

WHEN CARING
HURTS

Protecting yourself
from moral injury

**MENTORING
MIGRANTS**
Tui Medical's
long view on
growing GPs

**UNCHARTED
TERRITORY**
Bringing
health and
hope to gangs

**BIGGER BEGETS
BETTER**
Practices
unite in South
Wairarapa

**SIDELINE IN
BOTOX**
Ten top
tips to keep
yourself safe



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IN A pMDI¹

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COPD = chronic obstructive pulmonary disease; FEV₁ = forced expiratory volume in 1 second; ICS = inhaled corticosteroid; LABA = long-acting β₂ agonist; LAMA = long-acting muscarinic antagonist; pMDI = pressurised Metered Dose Inhaler.

REFERENCES: 1. BREZTRI AEROSPHERE[®] Approved Data Sheet. 2. Ferguson GT et al. *Lancet Respir Med.* 2018;6(10):747–758. 3. PHARMAC Pharmaceutical Schedule, December 2024. Available at www.pharmac.govt.nz/pharmaceuticalschedule. Last accessed December 2024.

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New Zealand Doctor Rata Aotearoa – More than medicine

Editorial

Take care out there



As reform drags the system down, rather than raising it up, doctors wrestle with the emotional toll of moral injury, balancing dedication with a feeling of powerlessness, writes **Barbara Fountain**

A GP I know recently left the world of general practice ownership to happily take up the challenge of being a locum GP. As she puts it – she's on a mission to help other GPs take the holidays she couldn't quite manage. And she is pretty happy with that.

Thinking about her CV and achievements, this GP figures she's provided in the vicinity of 100,000 consultations over the years.

Those 100,000 consultations have amassed from her GP training days, her associate days, her 10-minute appointment days, her resthome care, her after-hour surgery shifts and her days as a practice partner for the past 16 years.

There are plenty of satisfying moments in those 100,000 consultations, but no doubt some tough ones. Truth be told, those tough moments have become more frequent. It's not just the more complex patients; it's more ephemeral, and it's a health system that doesn't quite gel – for anyone.

I wasn't sure what the cover story would be for this issue, and then three things happened. Someone raised the issue of moral injury at a daily editorial meeting. Soon after, Jo



Between consults: off duty specialist GP Sandra Fountain (right) with her sister Barbara

Scott-Jones filed his First Time column on moral injury. My interest piqued, I headed to a session on moral harm and injury at the Goodfellow Symposium 2025 by psychologist Mary Miller and Auckland specialist GP Helen Johnston, ably reported by Alan Perrott.

You can sum up the many definitions of moral injury as the distress caused when acting or failing to act breaches an individual's morals or values.

In recent years, natural disasters like earthquakes and floods have hampered clinicians from providing the care they would want to provide. The COVID-19 pandemic exacerbated this feeling of constraint and, at times, helplessness even further.

But the past few years of reform, with constant uncertainty, have left many people in the health sector

scarred. It is not just clinicians feeling unable to provide the care they believe their patients should receive; it's the administrators unable to provide sufficient support to clinical colleagues and the managers unable to respond adequately to reasonable requests for funding and help.

Primary care may be lucky in being at arm's length from the in-house politics and resource bagging of public hospitals, but GPs and nurse practitioners live with the knowledge that a significant number of their patients will not get the referral they need, and some may even die prematurely.

They know their names; they sit right in front of them in a consultation. They are more than a name on a waiting list.

As I write, more cuts are planned at Health New Zealand Te Whatu Ora, private laboratory staff are planning

strike action, and senior doctors have also given notice; all of this will impact primary care. It is very easy to identify moral harm and injury; it is far more difficult to prevent.

The powerlessness is not unique to health. With public sector cuts across the board, many people will be distressed at not being able to finish work important to them and the people they care for in housing, education and social services. Likewise, in the private sector. In my own industry, senior journalists, made redundant, are walking away from important stories they will never get to finish.

These are tough times. There's a sort of malaise, and I'm a bit short on sage advice on how to get through it all except to repeat Dr Scott-Jones' mantra – "first, you save yourself".

On a chipper note, I want to end by

“It's not just the more complex patients; it's more ephemeral, and it's a health system that doesn't quite gel – for anyone”

shouting out to that GP and her 100,000 consultations – listening and caring for all the patients who came her way, looking after a resthome, speaking to the families, returning from holiday to waiting death certificates, making home visits, pulling strings when she could and finely crafting those referral letters with the eternal hope of success.

She's my sister Sandra, and she is friggin' awesome. ■
editor@nzdoctor.co.nz

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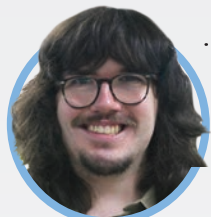
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References: 1. Flucelvax[®] Quad Data Sheet. CSL Seqirus (NZ) Ltd, available at www.medsafe.govt.nz. 2. Stein AN et al. Open Forum Infect Dis. 2024;11(5):ofae175. 3. Stein AN et al Abstract presented OPTIONS 2024, September. 4. CDC. Cell-based flu vaccines. Accessed November 2024. <https://www.cdc.gov/flu/prevent/cellbased.htm> 5. Rajaram S, et al. Ther Adv Vaccines Immunother. 2020;8:2515135520908121. 6. The Dark Side of Your Seasonal Flu Vaccine, and Its Startling Environmental Impact [Internet]. EnGen Bio. 2021 7. Audsley JM et al. Expert Opin Biol Ther. 2004;4(5):709-717. 8. CSL Seqirus Data on File #12: Environmental impact of standard egg vaccines 9. Ulmer JB et al. Nat Biotechnol. 2006;24(11):1377-1383 10. Flucelvax[®] Quad Data Sheet. CSL Seqirus (NZ) Ltd, October 2024, available at www.medsafe.govt.nz. 11. Poddia A. Vaccine. 2001;19(17-19):2673-2680. 12. Pelton S et al. Vaccines. 2020;8(3):446. 13. Bolkos C, et al. Clin Infect Dis. 2021;73(5):816-823. 14. Frey SE et al. Vaccine. 2014;32(39):5027-5034.

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Upfront *GPs in training*

GP registrars are the future of general practice, and *New Zealand Doctor Rata Aotearoa* wants to hear from them. We asked **Helen Ker** 12 questions about general practice, medical school and what excites her about her career ahead



Lower Hutt GP registrar Helen Ker loves to spend time outdoors

Helen Ker (she/her) is a second-year registrar at Hutt Union Community Health Service in Lower Hutt. She believes curiosity is among the characteristics of a good GP.

I decided to go into general practice because when I was growing up, I assumed all doctors were GPs. So, I went to medical school thinking that's who I'd like to be. Of all the different specialists, GPs seem to like their jobs the most. The specialty requires you to be well-rounded and pragmatic, which appeals to me.

Medical school felt like an extension of high school with more type-A personalities. I didn't enjoy it much then but, looking back, it was a pretty unique experience. I'm glad that the career I chose at 17 is still what I want to do now.

The best thing about being a registrar is having the time to learn, enjoy your consults and not rush people out the door.

The worst part of being a registrar is fronting over \$3000 to pay GPEP2 education fees for a year of minimal college involvement. The programme starts strong with a great GPEP1 year, but the last two years trail off, and you're basically left to your own devices. Most other specialty training programmes get more involved as you get on, and it's a given that your employer pays for your training costs – not with general practice.

I like to relax by spending time with friends and family, having people over for card-game nights and cooking. I love to spend time outdoors and have enjoyed many road trips within New Zealand over the past

few years. I recently learnt to swim. I also love to read.

What sometimes **keeps me awake at night** is the odd intrusive thought just as I'm about to fall asleep about something I've missed for a patient or something I could have done better. I worry that access to healthcare is becoming increasingly difficult for those on regular incomes, and I don't see much happening to change that.

What am I most excited to do in my career in general practice? I want to become better and better at what I do, form long-term relationships and treat multiple generations.

Is there someone in general practice I look up to? All the Wellington medical educators are awesome – wise and committed to rearing a new generation of well-equipped GPs. Thanks, Geetha Cox, Sarah Sciascia, Matt Anderson, Lucy O'Hagan, Sean Hanna, Nohoana Findlay and Naomi Dunwoodie.

A good GP is curious, takes people seriously, communicates well, and is happy sitting with risk.

How will my cultural upbringing influence the healthcare I provide? My mum is German, and my dad is third generation Scottish/Irish Kiwi. They are both teachers, and both of their dads were Protestant ministers. They've always encouraged fairness and work in service of those around you.

What needs to change in general practice? The rise of other primary care specialists is a great opportunity for us to develop a clearer understanding of our profession and what it is that we can uniquely offer patients. Primary care is already changing rapidly, and I want to see GPs play an active role rather than sit back and let the change happen to us. Obviously, I would also like to see the Government fund general practice better and have funding directly linked to the patient and their encounters rather than an abstract estimation of the cost of having them on the books.

What life experiences do I bring to general practice that will make me a good GP? Tough question: I don't know a life experience irrelevant to general practice. ■
Ka nui te mihi a koe, Helen

If you're a registrar and want to get your voice heard, get in touch with us at mjohnston@nzdoctor.co.nz

Registrar
Thinking

A few words from... **Bianca Yu**

Bianca Yu enjoys an ocean dip and splits her time as a GP between Tawa Medical Centre and Whakamātūtū, a mental health recovery clinic in Pōneke Wellington

The best thing about my general practice is that my working week is as a GP at both Tawa Medical Centre and at Whakamātūtū, a mental health recovery programme. I love working alongside therapists and clinicians from different disciplines and our Pou Ārahi [Māori leader]. We find common threads in what we do and foster positive behaviour change through a mana-enhancing approach. Being a part of the recovery journey for a tangata whai ora [a person seeking health] when many other forms of treatment have not worked for them is really empowering and humbling. I continue to learn so much. Tawa's diverse community has a huge heart, as does the surgery. It's a great place to be a GP.

The worst thing about my general practice is that there is never enough time! I'd love more space and time to spend with my patients and my colleagues. Health issues and people's stories rarely fit well into 15-minute appointments.

My greatest achievement was emigrating to New Zealand with my young whānau because it has opened up so many opportunities for us. We love being out in the bush or on the water. I am just starting out on my journey to connect with Rongoā Māori – my personal and professional practice is greatly enriched by this. It has been incredibly difficult leaving our family and the practice I'd been a part of for over 15 years, with an amazing bunch of GPs.

My funniest moment as a GP was when a wonderful patient allowed me to be part of her stress-releasing



Emigrating to Aotearoa with her young whānau is Bianca Yu's greatest achievement

process – making a jelly and then smacking it with a bat!

It might surprise other people to learn that I love dancing around to 120bpm music, and ramshackle huts sitting in the middle of fields.

"Pamplemousse" is **my favourite word**.

What keeps me awake at night? Well, put it this way, when I'm on holiday camping and getting in the water every day, I sleep perfectly!

The trait I most dislike in myself is struggling to turn off and getting stuck in my head. A dip in the ocean or getting out in the bush normally sorts this.

The trait I most dislike in others is negativity.

I relax by spending time outside with my whānau with minimal distractions, maybe a pack of Uno cards or a fishing rod. I have just started dinghy sailing and love it!

The three things I'd like to see changed about general practice are:

(1) A move towards more shared group appointments with multidisciplinary input. It can be more cost-effective and resources can reach more of the population. Loneliness is a huge factor in poor health. Developing a community who support each other is so valuable. (2) Secondly, we remain increasingly time poor as GPs. As external services are reduced, we are attempting to "plug the gap" where we can – this adds to the load on a consultation "to-do list". The more time poor we are, the risk increases of "quick fix" care, thus missing the root

“Pamplemousse is my favourite word”

cause of the problem. I feel the pillars of good health – sleep, nutrition and movement, emotional regulation tools, harmful substance reduction, etc, are often not given sufficient attention in a time-pressured appointment. (3) Our health improvement practitioners also play such an important role, maybe it should be a default that patients see the HIP when they see the GP.

My ideal dinner party guests would be Robin Williams, Anthony Bourdain, Tina Turner, Nigel Slater and Sir Billy Connolly.

If I wasn't in my current job, I'd love to set up ocean-dip groups – the restorative nature of cold water to connect with our stress cycle and the enjoyment of doing this alongside others is fantastic!

If I was stranded on a desert island, I would take books and a block of salt.

On top of my bucket list is to sail across the Cook Strait myself. ■

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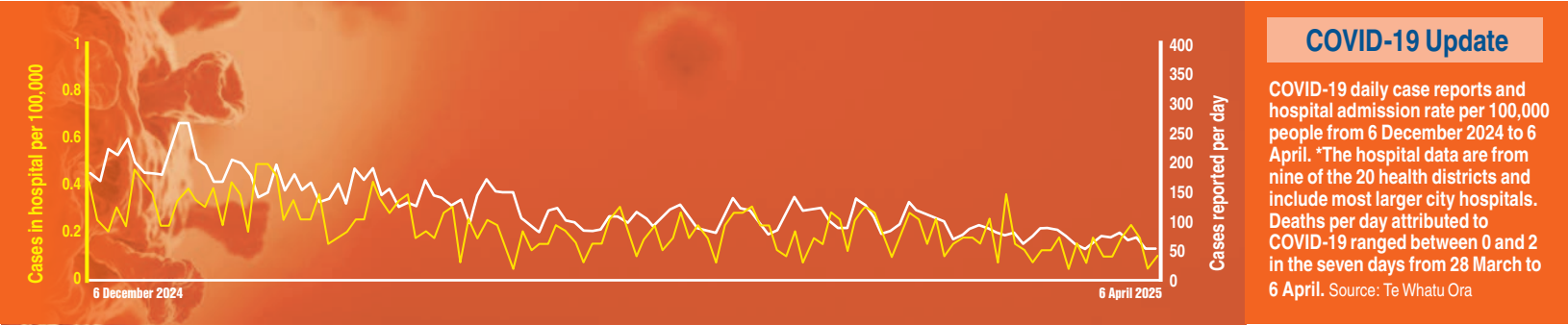
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COVID-19 cases and admissions*



Keeping it brief – round up of news from the last month



Amara Delbon on Unsplash

A link has been found between dementia and eye health

Otago study finds eye health and dementia link

Retinal microvasculature – the small blood vessels at the back of the eye – could show early signs of dementia, a new study from the University of Otago finds. The finding, published in the *Journal of Alzheimer’s Disease* (online 3 March), could help identify who might benefit from early intervention, potentially improving outcomes for those at risk, co-lead author Ashleigh Barrett-Young says in a media release. The researchers used eye scan data from the age-45 assessment phase of the Dunedin Multidisciplinary Health and Development Study, New Zealand’s longest-running longitudinal survey.

Treaty Principles Bill hits the scrapheap

The ACT Party’s Treaty Principles Bill has been scrapped, after failing to pass its second reading on 10 April, with 112 noes to 11 ayes. ACT was the only party to vote in favour, with National, New Zealand First, Labour, Greens and Te Pāti Māori voting against. However, leader David Seymour indicated that while he accepts the result, he still wants to have the discussion he believes the bill raises, and he would make the party’s next approach clear before the next election.

Tairāwhiti after-hours to forge ahead

Health provider Ngāti Porou Oranga plans to expand its existing after-hours primary care service at

Te Puia Hospital in Tairāwhiti whether its tender with Health New Zealand Te Whatu Ora is successful or not. Chair Na Raihania told *New Zealand Doctor Rata Aotearoa* that the charitable trust and subsidiary of Te Rūnanganui o Ngāti Porou has tendered to the health agency, but he’s still waiting to hear back. In the meantime, it is taking expressions of interest from doctors and nurses.

AUT to offer new psychology training

Auckland University of Technology is expected to train its first intake of associate psychology students in 2026, minister for mental health Matt Doocey announced in a media release. AUT is currently developing a curriculum with the University of Canterbury, the first to be selected to create the programme. The post-graduate diploma will be open to undergraduate students who have already completed a major in psychology, says Mr Doocey, with graduates of the first intake expected to be ready to join the clinical workforce in 2027.



Hamid Siddiqi on Unsplash

Nelson Te Whatu Ora staff have received Holidays Act remediation

Te Whatu Ora pays over \$20 million to Nelson staff

Te Whatu Ora has paid out \$20.6 million in Holidays Act 2003 remediation payments to its 3029 Nelson Marlborough staff, South Island deputy chief executive Martin Keogh says in a media release. Work to resolve these

payments has been “extremely complex and time-consuming”, Mr Keogh says. This is the 13th region to complete payments, taking the national amount paid to more than \$334.1 million across 45,667 employees. The agency intends to complete the remediation payments to current and former employees by July, he says.

All Blacks doctor John Mayhew dies

Former All Blacks and Warriors doctor John “Doc” Mayhew has died aged 70. Dr Mayhew was first involved with the All Blacks in 1988 and was the team’s physician for 131 tests before joining the Warriors. He was also a life member of Auckland’s Northcote Rugby Club, for which he played almost 200 games. Dr Mayhew suffered a heart attack in 2016, the same year he was appointed an Officer of the New Zealand Order of Merit for services to sports medicine. He stood down from his duties with the Warriors in 2019. He died peacefully on 9 April surrounded by loved ones, according to his death notice.

ProCare tackles admin burden with Heidi Health

ProCare and AI medical scribe tool Heidi Health have partnered to help reduce the administrative burden on GPs and allow them to spend more time with patients. Heidi Health can generate accurate, real-time notes during patient consultations. It also automates clinical documentation, meaning consultation notes can be used to create referral letters and patient summaries. At its core, says ProCare chief executive Bindi Norwell in a media release, the partnership is about alleviating workforce pressures to make healthcare more sustainable and accessible for primary care clinicians.

Stage two for Te Aka Whai Ora Waitangi hearing

Stage two of the Waitangi Tribunal’s urgent hearing into the disestablishment of Te Aka Whai Ora will kick off on 26 May. Stage one reviewed the process leading up to the authority’s demise, and stage two will examine the Government’s replacement plan

for Māori health and whether it remains compliant with te Tiriti. The Crown tried to delay proceedings, arguing the timing would not allow the inclusion of the Hauora Māori Strategy and the demands of an upcoming High Court case on the same issue.



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CDC reviewing water fluoridation in US

CDC ordered to review fluoride recommendations

Recommendations on fluoridated water are to be reviewed by the Centers for Disease Control in the US following an order from the Department of Health and Human Services, reports NPR (National Public Radio). The CDC has been directed to reconvene an independent panel of 15 health experts to examine the role of fluoride in water supplies and its public health impact. HHS secretary Robert F Kennedy Jr continues to express claims, contested by the broader scientific community, that fluoridation can cause arthritis, bone fractures, bone cancer, IQ loss, neurodevelopmental disorders and thyroid disease.

Six-year-old dies after tonsillectomy

A six-year-old Auckland child died in Starship Hospital on 7 April from complications following a routine tonsil operation at Southern Cross hospital the week before. Te Whatu Ora and the police are now investigating, reports RNZ, with Southern Cross chief medical officer Erica Whineray Kelly saying the organisation is supporting the health agency’s review and is devastated over the death. Auckland City Hospital group director of operations Mike Shepherd says the hospital and Te Whatu Ora extends their deepest sympathies to the family.

Shingles vax lowers chance of dementia

The zoster vaccine reduces the probability of a dementia diagnosis by approximately one-fifth over a seven-year follow-up period and is more effective and cost-effective in preventing or delaying dementia than existing medicines, a British study published in *Nature* (online 2 April) has found. The authors propose three explanations: changes in health-care pathways because of shingles, a reduction in reactivations of the varicella-zoster virus (VZV), and a VZV-independent immunomodulatory effect. The study found greater benefits among women than men.

Pharmacy groups join forces for better deal

The Pharmaceutical Society of New Zealand has led the development of the Pharmacy Sector Leaders Forum, with PSNZ president Michael Hammond telling *Pharmacy Today* that its core purpose will be to offer a unified voice when advocating for sector change and to make pharmacy more attractive to students pondering their career options. The PSLE, which was inspired by a similar move in the UK pharmacy sector, includes 13 representative bodies spanning community and hospital pharmacy, universities and the Māori and Pacific pharmacists’ associations.

Hospital bonuses to remove patients from lists

Incentive payments are being offered to English hospitals to remove an estimated 300,000 people from waiting lists who, according to the National Health Service, do not require elective care or treatment. The NHS has instructed trusts to “validate” their lists. However, *The Guardian* reports that the cap limiting payments to 5 per cent of a trust’s waiting list is to be scrapped – meaning trusts could claim unlimited payments for removing ineligible patients. As of February, the overall waiting list included 6.24 million patients.

HIV self-test kits now available in pharmacies

HIV self-screening tests are now available in some pharmacies in New Zealand. Having the tests will increase accessibility and help normalise testing for the infection, advocacy organisations tell *Pharmacy Today*. Those who receive a positive result will still need to see their doctor for a formal diagnosis, but Rodrigo Olin of Burnett Foundation Aotearoa says the self-tests will hopefully encourage more people to check their HIV status. However, expert Samarina Musaad says the Point of Care Testing regulatory framework, currently being

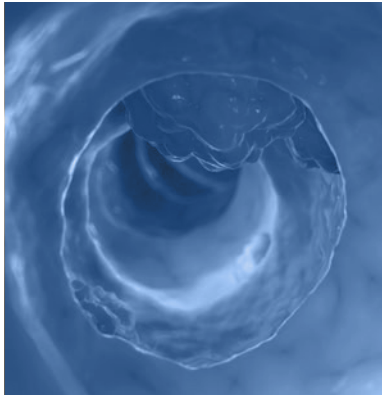
developed by the Government, is urgently needed to ensure all tests of this kind meet New Zealand standards. The Panbio self-test is available at Unichem and Life pharmacies.

New bill should end NP prescribing barrier

A long-standing prescribing barrier for nurse practitioners and other authorised prescribers should disappear, thanks to an amendment bill introduced into the house in March. The Medicines Amendment Bill will amend Section 29 of the Medicines Act 1981, which was to be amended with the Therapeutic Products Act 2023 until that was repealed as part of the Coalition agreement. Section 29 allows for unapproved medicines imported by Pharmac to be used as alternatives during shortages but only applies to medical practitioners. The bill will allow other professions, such as dentists, pharmacist prescribers and midwives, to prescribe replacement medicines.

Poor oral health linked to pain, migraines in women

Women with poor oral health are much more likely to experience migraines and abdominal and body pain, new research from the University of Sydney finds (online 10 April). Published in *Frontiers in Pain Research*, the study is the first to examine oral health, oral microbiota and pain commonly experienced in women with fibromyalgia, says Faculty of Medicine and Health associate professor and lead investigator Joanna Harnett, and found specific oral microbes correlated with certain pain conditions, suggesting a potential relationship between oral health and the nervous system.



Erkhan on Getty Images

Five researchers have won scholarships to investigate cancer in Māori

Māori cancer research gets record funding

Five researchers from across Aotearoa have been awarded research scholarships to improve cancer outcomes in Māori, according to a media release from the Cancer Society and Māori Cancer Leadership Aotearoa. The research will see the recipients (four

PhD and one master’s student) focus on issues including key barriers to cancer screening; access to care and the experiences of those diagnosed with symptomatic breast cancer; how tumour bacteria can help improve the effectiveness of immunotherapy for people with colorectal cancer; and improving outcomes for Ngāi Tahu whānau impacted by a CDH1 gene mutation, which increases the risk of stomach cancer and lobular breast cancer.

Lobbying hinders junk-food ad ban

Plans to ban junk-food advertising from bus stops and billboards in the UK to protect public health have been hindered by lobbying from the advertising industry, according to an investigation in *The BMJ* (online 8 April). Information obtained by *BMJ* shows advertising companies are warning local councils of the financial crisis they will suffer should the restrictions on promoting products containing high fat, salt and sugar go ahead. McDonald’s had the largest out-of-home advertiser spend in the UK in 2024, at £86.3 million (about \$193.8 million).



Supplied

New Zealander of the Year 2025 and former GP Bev Lawton

HPV champion named Kiwi of the Year

Women’s health advocate and former Newtown Medical Centre GP Bev Lawton (Ngāti Porou) has won the Kiwibank New Zealander of the Year Award for her pioneering work to make HPV self-test screening the main cervical screening method in Aotearoa. Professor Lawton founded Te Tatai Hauora o Hine National Centre for Women’s Health Research Aotearoa 20 years ago and her award citation notes the critical advancements she has also driven in maternal health and indigenous health equity. Professor Lawton, who was out of the country at the time of the announcement, described the win as a privilege. ■

Items collated and written by Alan Perrott, Barbara Fountain and Zach Thompson

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NEW ZEALAND PRIMARY HEALTHCARE AWARDS HE TOHU MAURI ORA

Waikato medical assistant model creates new-doctor pipeline

For more than a decade, Waikato's Tui Medical group has quietly been helping dozens of overseas-trained doctors break into the system through its medical assistant programme. Reporter **Fiona Cassie** speaks to the owner about its success

It started as a pay-it-forward gesture by two Hamilton specialist GPs who arrived in New Zealand from India in the 1990s.

Now, employing overseas-trained doctors as medical assistants is well embedded into the service model of the Waikato-based Tui Medical group of general practices and urgent-care clinics.

The group has about 14 doctors trained in countries as diverse as Ukraine to China. They work as assistants and receive education and mentoring support as they navigate the New Zealand Registration Exam (NZREX) pathway to become a doctor here.

Specialist GP and Tui owner Navin Rajan and fellow specialist GP and executive director Stanley Koshy estimate

“I think all of us recognise that today they are medical assistants, but tomorrow they are our [medical] colleagues”

STANLEY KOSHY

that their training pathway has helped at least 35 overseas doctors enter the New Zealand health system over the past decade.

Paying it forward has paid off. More than 60 per cent of former assistants return to Tui's seven practices and two urgent-care clinics as GP or urgent-care registrars after completing a hospital internship and gaining full registration.

And many stay – about a dozen of its nearly 50-strong doctor and nurse practitioner workforce started as medical assistants.

The programme has been a good recruitment pipeline for the group, says Dr Rajan. Generally, it is also cost-effective – Tui pays medical assistants the same as a first-year enrolled nurse, with both sides viewing this like a training stipend towards registration and a doctor's salary.

It is also rewarding to help overseas doctors, some of whom had lost hope of ever practising medicine in New Zealand, Dr Rajan says; for example, a Russian paediatrician who worked as

a resthome health care assistant for seven years before coming to Tui is now a paediatric registrar.

“It has been very gratifying for all of us – the doctors as well as the directors here – that we have contributed to somebody's success in life.”

The overseas doctors come from health systems regarded as non-comparable to New Zealand and are on the Medical Council's NZREX pathway to registration.

After passing NZREX, the last hurdle to full registration is one of the toughest – gaining a two-year PGY1/2 internship, which, until recently, could only be done in a public hospital.

Medical assistant “graduates” from Tui made up four of the 10 candidates of the 2023 Waikato pilot that allowed overseas doctors on the NZREX pathway to spend 18 months of their PGY1/2 internship in general practice.

Dr Rajan and Dr Koshy hosted doctors on the pilot and hope to host more after the March announcement to extend it to 100 placements in general practice over two years.

The NZREX pathway is largely unchanged, the pair say, since they arrived as Indian medical graduates in the mid-1990s. But Dr Koshy says one difference is the difficulty of getting a foot in the door of a New Zealand hospital to become familiar with the Kiwi health system. “[We] found a whole lot of them were struggling to get in the system and we thought ‘pay it forward’.”

Tui was also part of the 2013/15 physician associate demonstration in general practice.

“After that, we said, ‘Why can't we do this for foreign-trained doctors?’”

Drawing on ideas from veteran specialist GP trainer and senior colleague Leo Revell, the pair produced a medical assistant model that includes an ongoing education programme, regular audits of the assistant's learning progress and ensures patient consent and awareness that the assistants are not registered doctors in New Zealand.

The programme only employs international medical graduates who have met the NZREX entry criteria, so Tui knows they are competent in medical theory and English. The IMGs, who work under the supervision of a doctor, progress through a three-stage medical assistant pathway that helps fill a niche in the Tui service delivery model while preparing them for the clinical exam and an internship place.

“And if anything goes wrong, it is the doctor, obviously, who is going to be liable,” Dr Rajan says. But to date, he says, Tui has not had any safety issues or patient complaints related to medical assistants.

“We've gone from a position where doctors had concerns about working with medical assistants to a situation



Tui Medical specialist GP and executive director Stanley Koshy with fellow specialist GP and Tui Medical owner Navin Rajan

Medical assistant mentorship ‘pretty great’ opportunity

PHILIPPINES-TRAINED DOCTOR PAULA RIGOR began as one of Tui Medical's first medical assistants and is now an urgent-care specialist; Chinese-trained Sandra Chao has returned as a GP registrar.

Both say the low pay offered to medical assistants was outweighed by the mentorship, mock exams and collegial support that helped them pass the NZREX and adapt to a very different health system. “It was pretty great, actually,” says Dr Chao.

China doesn't have a primary or urgent-care system, says Dr Chao, and in the Philippines, it was rare for patients to be included in decision-making, says Dr Rigor. The medical assistant job introduced them to the New Zealand system, which was invaluable.

Nearly a decade since starting at Tui, Dr Rigor is now mentoring her own medical assistants.

“I feel like it gives them some sort of motivation and encouragement – that, yes, it does take time, but eventually it works because I'm a living example of it,” she says. ■

where doctors don't want to work, particularly afternoon shifts, without a medical assistant.”

During a six-week orientation, novice medical assistants are introduced to the primary care system and taught how to work with the practice management software. That readies them for stage one of the programme, usually lasting between three to six months, answering phone calls from patients – often repeat prescription requests under set protocols – which helps the IMGs become familiar with Kiwi colloquialisms and the New Zealand Formulary. Stage two is to step into a triage role – between six and 12 months, in its urgent-care clinics – a role now largely done by rostered medical assistants under supervision.

The third and final stage of the programme – usually at least nine months after starting and lasting until the assistant gets a house officer internship

– is to carry out pre-consultations, including taking a patient history and carrying out an initial assessment before handing them over to the doctor, similar to a medical student on a general practice rotation. All is good practice for the NZREX clinical exam.

From the start, Dr Koshy has included IMG medical assistants in the group's Thursday morning training sessions alongside GPEP1 registrars, medical students on placements and nurses on an NP or RN prescribing programme.

Dr Rajan's specialist GP wife, Seema Menon, also offers at least three mock clinical exams in the lead-up to NZREX to help assistants hone their skills, which has contributed to good pass rates, says Dr Koshy. “I think all of us recognise that today they are medical assistants, but tomorrow they are our [medical] colleagues.” ■

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Retention not registration crux of workforce problem

► **Stephen Forbes**

The departure of 60 per cent of overseas-trained doctors within two years of New Zealand registration is a retention issue, not a registration one, says Medical Council chair Rachelle Love.

In the year to 30 June 2024, the council registered 1318 overseas-trained doctors. After a year, about 40 per cent left the country. After two years, the figure rises to 60 per cent.

“Over the past two years, only 0.5 per cent of doctors who have applied for registration have been declined. Over 99 per cent of doctors are able to get registration. So, the idea that the registration process is driving people overseas isn't supported by the data,” Dr Love says.

The Government has already signalled plans to streamline the process for overseas healthcare workers moving to New Zealand to solve what health minister Simeon Brown calls a “global war for talent”.

Releasing a report, *Putting Patients*

First: Modernising Workforce Regulation, last month, Mr Brown said he wanted to ensure the people who are coming into New Zealand to work in healthcare have high clinical safety standards and are appropriately trained.

“But we also want to make sure that we don't have a process that is so cumbersome that they would go to Australia instead... We actually want to be an attractive place for healthcare workers to be able to come and to be able to work, and that means our regulatory bodies need to be able to make those decisions in a timely manner.”

Dr Love, an otolaryngology, head and neck surgeon, says Health New Zealand Te Whatu Ora doesn't conduct exit interviews of overseas-trained doctors leaving the country.

“So, we don't have the data because we don't ask the questions.” But there is no doubt that remuneration plays a part in their reasons, she says.

While retention remains the key challenge, the Government is also eyeing broader structural reforms – including the possible amalgamation of the 18



Medical Council chair Rachelle Love

regulatory bodies – to make New Zealand a more attractive and sustainable destination for medical professionals.

In May last year, the Ministry of Health recommended amalgamating the Medical Council, Nursing Council, Pharmacy Council and the 15 other authorities into a single body responsible for the entire health workforce.

Dr Love says amalgamation might help solve some of the “sustainability issues” some smaller authorities face. But she didn't know if it would work for the Medical Council.

“From the Medical Council's point of view, we already have one of the most effective regulatory processes.” ■ sforbes@nzdoctor.co.nz

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1

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2

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*This list is not exhaustive; refer to an allergy specialist where appropriate. †Device batch and expiry details required | **ASCI**: Australasian Society of Clinical Immunology and Allergy | **AAIs**: Adrenaline Auto-Injectors | **GAR**: Generalised Allergic Reaction.

References: 1. ASCIA. Adrenaline (Epinephrine) Device Prescription. Retrieved from: www.allergy.org.au. Accessed February 2025. 2. Cardona V, Ansotegui I, Ebisawa M, et al. World Allergy Organization Anaphylaxis Guidance 2020. Volume 13, Issue 10, 100472. 3. ASCIA. Adrenaline (Epinephrine) Injectors Frequently Asked Questions (FAQ). 2025. Retrieved from: www.allergy.org.au. Accessed February 2025. 4. The Pharmaceutical Management Agency. Available at: www.pharm.govt.nz. Accessed February 2025. **Mandatories:** EPIPEN® & EpiPen® Jr Auto-Injectors are Restricted Medicines. Indication: For the emergency treatment of anaphylaxis in adults and children ≥ 15 kg. Contraindications: are relative as this product is intended for use in life-threatening emergencies; contraindicated in certain types of arrhythmia; cerebral arteriosclerosis; shock; during general anaesthesia with halogenated hydrocarbons or cyclopropane; if vasopressors are contraindicated. Precautions: allergy to sulfites, cardiac dilation, heart disease including cardiac arrhythmias, coronary artery disease or insufficiency, hypertension, the elderly, diabetes, narrow angle glaucoma, severe renal impairment, hypercalcaemia, hypokalaemia, hyperthyroidism, psychoneurosis, parkinsonism, asthmatic children, maternal hypertension >130/80. Do not inject into hands, feet, ears, nose, buttocks, genitalia or intravenously. Interactions: sympathomimetic agents, alpha-adrenergic blocking agents such as ergot alkaloids and phenolamine, non-selective beta blockers, digoxin, quinidine, halothane, cyclopropane, trichloroethylene, see data sheet for CNS and other medicines that can potentiate adrenaline. Adverse Effects: tachycardia, respiratory difficulty, sweating, pallor, nausea, vomiting, sleepiness, hallucinations, palpitations, redness of face and skin, psychomotor agitation, impaired memory, angina, potentially fatal ventricular arrhythmias including ventricular fibrillation, cerebral haemorrhage and pulmonary oedema from severe hypertension, rare cases of stress cardiomyopathy, rare cases of serious skin and soft tissue infections. Dosage & Administration: Administered intramuscularly: Adults ≥ 30 kg: a single EpiPen® delivers 300 mcg; Children 15-30 kg: a single EpiPen® Jr delivers 150 mcg. EpiPen® and EpiPen® Jr are funded medicines, special authority criteria apply. Before recommending this medicine, refer to full Data Sheet (www.medsafe.govt.nz). EPIPEN® and MyEpiPen® are Viatrix company trade marks, Viatrix Limited, Auckland. Copyright © 2025 Viatrix Inc. All rights reserved. NZ-EPI-2025-00014. TAPS 2407MM-0217.



Countdown to new 24/7 service

IT PROVIDER MIDDLEWARE New Zealand has been selected to deliver the shared digital health record data service necessary to the success of a new 24/7 online medical service due to start operating in July.

Health New Zealand Te Whatu Ora acting chief information technology officer Darren Douglass confirmed, in a written statement, that Middleware was selected from an existing panel of integration partners.

The agency has earmarked \$4 million up to the end of June for the shared digital health record.

Te Whatu Ora director living well Martin Hefford confirms work is on track for the 24/7 online medical service announced in March.

Mr Hefford says the procurement process for the service, which has \$164.6 million funding over five years, was in progress as *New Zealand Doctor Rata Aotearoa* went to print and he could not provide any further details. Likewise, potential providers contacted were reluctant to comment. ■ sforbes@nzdoctor.co.nz

High Court rules Medical Council didn’t ‘censor’ anti-vax doctors

► Fiona Cassie

A High Court challenge has unsuccessfully argued that the Medical Council’s 2021 guidance statement on the COVID-19 vaccine and anti-vax claims was unlawful. The judicial review of the statement was filed by the anti-COVID-19-vaccine doctor group, New Zealand Doctors Speaking Out with Science (NZDSOS), which also claimed it breached the New Zealand Bill of Rights Act 1990.

Following a hearing in the High Court in Wellington last year, Justice Peter Churchman ruled that the now-revoked statement was not unlawful, did not breach the act nor was it issued for an improper purpose.

Medical Council chair Rachel Love, in an emailed response, said the council welcomed the High Council decision, which “affirms the council’s role in setting expectations of professional conduct during a global health crisis”.

NZDSOS, in a post on its website, said the ruling “represents a troubling trend of medical regulatory bodies becoming enforcement agencies for government policy” and that the court had incorrectly assumed that “the world has just experienced a pandemic of unprecedented proportions”. NZDSOS steering committee member and specialist GP Alison Goodwin says, by email, that it has lodged an appeal.

The 40-page ruling looked at the grounds for review raised by NZDSOS, including its claim that the statement was issued improperly “to censor medical and dental practitioners and prohibit them from expressing any views to their patients or publicly about any risks of the COVID-19 vaccine”.

The joint guidance statement, issued

by the medical and dental councils, expected doctors and dentists to be vaccinated unless medically contradicted and to provide evidence-based advice and information about the COVID-19 vaccine.

“As regulators, we respect an individual’s right to have their own opinions, but it is our view that there is no place for anti-vaccination messages in professional health practice, nor any promotion of anti-vaccination claims, including on social media and advertising by health practitioners,” the 2021 statement concluded.

The court examined NZDSOS claims with Justice Churchman concluding that the Medical Council had the power under the Health Practitioners Competence Assurance Act 2003 to issue the guidance statement without consultation. It did not prohibit doctors from expressing “any views on any risks of the COVID-19 vaccine”, his decision found.

The NZDSOS lawyer Lisa Hansen argued that the statement’s purpose was a “de facto vaccine mandate” and breached Section 11 of the Bill of Rights as it constrained the right to refuse medical treatment.

The council’s lawyer, Simon Mount, responded that promoting public health and safety during the pandemic was of “sufficient importance to justify any limitation on the right to refuse medical treatment”. Justice Churchman said the statement was not a mandate and reaffirmed earlier court rulings that the Government’s eventual health worker vaccine mandate was a justified limitation on the right to refuse treatment during the pandemic.

Ms Hansen argued that the statement breached Section 14 of the Bill of

‘Full picture’ to come

It is still unclear how many doctors were investigated and disciplined by the Medical Council following complaints about COVID-19 vaccine misinformation and conduct.

Medical Council chair Rachel Love, in an emailed response to queries from *New Zealand Doctor Rata Aotearoa*, acknowledges the “strong public interest in understanding the full picture”. But some complaint processes remain ongoing, Dr Love says.

“Once all matters are concluded, the council intends to carry out a comprehensive analysis of COVID-19 related cases and outcomes,” she says.

New Zealand Doctor reported in mid-2023 that investigations into 11 of the 20 doctors referred to the council’s professional conduct committee for COVID-19 related concerns had been completed. Four of those had been referred to the Health Practitioners Disciplinary Tribunal.

To date, tribunal decisions upholding Medical Council charges have been released on radiologist Peter Canaday and doctor and former television presenter Samantha Bailey. A tribunal hearing of a third doctor, Bruce Dooley, was held in March with a decision still pending.

The Health and Disability Commissioner found three doctors in breach of the code for allegedly sharing COVID-19 vaccine misinformation. ■

Rights, limiting a doctor’s right to freedom of expression.

Justice Churchman disagreed with the NZDSOS argument that the statement aimed to “ban doctors communicating any dissenting views on vaccination” and said instead that it “sought to prevent anti-vaccine misinformation” during a global health crisis. The limitation on doctors’ rights to expression was proportionate given the importance of protecting public health and safety, he said.

NZDSOS had also claimed that the council had unlawfully referred doctors to professional conduct committees for prescribing ivermectin for COVID-19, based on statements from the RNZCGP and Medsafe (strongly recommending ivermectin not be prescribed for

COVID-19) when there was evidence in support of its effectiveness. Justice Churchman said after weighing competing evidence, he considered there was greater support that ivermectin was not a viable COVID-19 treatment, noted that not all doctors alleged to have prescribed ivermectin for COVID-19 were referred to the professional conduct committee and that he did not regard the PCC referrals that were made were unlawful. ■

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D Copies of the **High Court NZDSOS vs Medical Council decision** and the **HPDT Samantha Bailey decision** can be found at **nzdoctor.co.nz** in Document Archive under Vault

COVID-19 were “inappropriate, inaccurate, misleading or had the potential to mislead”. Also, the videos compromised public safety and were inappropriate towards fellow medical practitioners.

In a July 2021 video, she said COVID-19 was another example of “industry players” generating “false pandemics” to make billions. “With COVID-19, it has gone to a whole new level as complicit politicians and most media outlets have gone along with an engineered fabrication involving an invisible pathogen that has never been shown to exist.”

The 106-page document includes expert evidence on the videos’ content, including that viewed together, they contributed to a false narrative that viruses do not cause disease.

Dr Bailey did not attend or participate in the tribunal hearing but had

participated in the previous professional conduct committee process that led to the charge. The tribunal found that the videos did fall within Dr Bailey’s general scope of practice.

Regarding freedom of speech, the tribunal says Dr Bailey can express her opinion on medical matters. However, professional standards required her to do so in a balanced way, with sufficient evidence from reputable sources, especially during a pandemic when the potential for harm was greater.

The tribunal ordered cancellation of her registration, censure, a fine of \$10,000, conditions on re-registration and a payment of \$148,450, the equivalent of 60 per cent of the total costs of the PCC investigation and tribunal hearing. ■

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The power of diet in Diabetes Management

New Zealand is at a tipping point, with type 2 diabetes rates soaring and around 20% of adults affected by pre-diabetes¹. Without intervention, many will go on to develop type 2 diabetes, which significantly impacts quality of life and increases the risk of heart disease, kidney failure, and vision loss.

Dietary interventions that can be sustained have the potential to improve glycaemic levels, reduce risk of diabetes complications and improve health-related quality of life³.

What is the latest dietary advice?

Recent clinical guidelines from the New Zealand Society for the Study of Diabetes (NZSSD) and the European Association for the Study of Diabetes (EASD) provide evidence informed advice on the prevention and dietary management of type 2 diabetes^{2,3}.

Where is New Zealand headed?

Recent research using age-period-cohort (APC) modelling has projected over the next 20 years, the volume of type 2 diabetes in New Zealand will increase by 90%².

The predicted increase from 3.9% to 5.0% of the population is driven by population growth, an ageing population and an increase in the risk of developing type 2 diabetes².

The role of diet

With diet playing a critical role in both the prevention and management of type 2 diabetes, providing clear messaging around what to eat, can empower people with the tools and support to self-manage their condition and improve patient outcomes³.

It’s clear that dietary changes such as **increasing fibre intakes to at least 35g per day** are protective against diabetes with a wide range of carbohydrate intakes acceptable^{2,3,4}.

Can meal kits support people to improve their physical and overall health?

Recently published research from - a multi-center, three-stage trial (n=200) shows that quality whole food ingredients and recipes delivered to people at risk of diabetes can support positive behaviour changes and improvements in body composition and quality of life^{5,6}.

My Food Bag & Diabetes NZ

My Food Bag and Diabetes New Zealand have partnered to launch a new Diabetes Plan — a nationwide initiative to empower New Zealanders at risk of or living with type 2 diabetes in the kitchen — helping them make healthier, more informed meal choices that could change the trajectory of their health.

We know there isn’t a one-size-fits-all approach to eating for diabetes, that’s why you’ll see a range of meal types and cuisines on the menu including vegetarian, vegan, low carb, and healthier twists on family favourites.

Supporting behaviour change

It takes time and consistency to build healthier habits, so the Diabetes Plan includes 12 weeks of emails with evidence-based information, tips and advice to support positive and sustainable behaviour changes.

Alongside the new meal kit range, the partnership also includes a free recipe book packed full of 30 diabetes-friendly recipes.

For more information visit:

www.myfoodbag.co.nz/meal-kits/diabetes-plan



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Simple, healthy & delicious recipes to help patients manage and prevent type 2 diabetes.

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HELPING PATIENTS MANAGE DIABETES THROUGH DIET?

We've created a free resource with 30 delicious simple, healthy and delicious recipes for diabetes management, prevention and healthier eating

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Diabetes Friendly recipes
At least 5 nutritionist-approved recipes every week designed to suit the whole family.

High quality carbs
Low Glycaemic Index carbs like bulgur wheat and quinoa featuring along with veggie carbs to support blood sugar control.

Focus on whole foods
Fibre containing foods including vegetables (2-3+ serves per plate), legumes, whole grains, nuts and seeds.

Weekly nutrition information for the first 12 weeks

Hope still for Māori voice despite Te Aka Whai Ora ‘kick in the guts’

► Alan Perrott

Never mind the politics, says former Te Aka Whai Ora chief medical “activist” Rawiri McKree Jansen; next time, we’ll take the equity message straight to the people. “Imagine if there had been an episode or a series of episodes on *Shortland Street* that had something to do with Te Aka Whai Ora, and a whole lot of people went, ‘Fuck you [to the Government], it’s on TV, it’s all good.’”

During a typically expletive-drenched contribution to a panel at the Collaborative Aotearoa 2025 conference on the demise of the “once-in-a-lifetime” agency, Dr Jansen said, if given his time again, “I would have done something different. We could have spoken in interesting ways to the whole of New Zealand to say, ‘Fuck you. Of course, we should do Te Aka Whai Ora.’”

The specialist GP, now working for Tend, was joined by Te Puna Ora o Mataatua chief executive Chris Tooley, who sat on the authority’s interim board and Calton Irving, who was Te Aka Whai Ora chief clinical officer, allied health, before becoming director of Māori health and consumer at Te Tāhū Hauora (Health Quality & Safety Commission).



Former Te Aka Whai Ora leaders Rawiri McKree Jansen (chief medical “activist”), Calton Irving (chief clinical officer, allied health) and Chris Tooley (member of the interim board) at Collaborative Aotearoa 2025

“Are we actually okay, as a country, wasting \$1 billion keeping one million of our citizens sick?”

All three pointedly wore Te Aka Whai Ora-branded shirts. The fight to exist began on day one, says Dr Tooley: “It was a mess, with a lot of politics. We had no CE, no executive; everything was highly political, and a new government was likely. “So, reading the tea leaves, we only had nine to 10 months before [the Labour Government] lost power, and we were really trying to reset things as fast as we could to entrench as much as we could...”

The strategy, he says, was to look past the agency’s \$500 million establishment budget and chase the \$29 billion given to Health New Zealand Te Whatu Ora: “That was our target, right? Not the crumbs that we were getting.”

It became a cooperative effort, with the two agencies collaborating on sub-committees: “The dream was to have a role in creating their infrastructure, creating their leverage, and we got there to a point. We could see the potential of what could happen if we had had the ability to carry on.”

Te Aka Whai Ora is gone but the need

Essentials

- ◆ Future equity strategies should engage the public directly, not rely solely on political channels, a Collaborative Aotearoa 2025 audience heard.
- ◆ The disestablishment of Te Aka Whai Ora has mobilised Māori voices and strengthened advocacy for equitable care.
- ◆ Māori leadership sees opportunity in increased activism, but many patients still feel the system is failing them.

remains unchanged, says Dr Irving: “The system doesn’t work if it doesn’t work.” He says back-peddling on equity has one outcome: “Māori dying too young; Māori dying too often.”

Dr Irving highlighted a 2022 University of Auckland study that found health inequity for Māori costs the health system \$39.9 million per year and when avoidable early death and lost wages are included, this figure leaps to \$823.4 million.

“Are we actually okay, as a country, wasting \$1 billion keeping one million of our citizens sick?” he asked. “Because, and I’m trying very hard not to swear like Rawiri, but this is something we can

take out of the room: the truth is the truth and that is eternal...”

The healthcare decisions of the current government are also destroying trust, says Dr Jansen, with the abandonment of the extended bowel cancer programme being a perfect illustration. “Of course, we have to have bowel screening happen at a much younger age (for Māori or Pacific peoples). And we got it across the line. Right? And then they snatched it off us. What does that mean? That’s about trust. Do we have a health system which is trustworthy? If you’re a Māori, you’re going ‘hell no.’”

He predicted the primary care capitation equity adjuster, which provides additional funding for practitioners treating Māori or Pacific patients, will be the next to go.

But if the speakers remained hopeful “a change is gonna come” as long as, says Dr Tooley, everyone becomes a “pebble in the shoe” of the system, an audience member, who declined to be named, dropped a blunt challenge. “Excuse me,” she said, “I’m not meaning to insult, but it feels like you guys are up there making the money, but we’re down here, and we’re still hurting.”

“Don’t assume that I’m feeling great because I’m not feeling great. I feel attacked and attacked and attacked.”

“We just feel like everything’s being taken away from our health system so that we are just meant to die early. That’s what it feels like. And so...I’m listening to you, but it just feels like we are having to wait and hope money gets down to us and hope that things change...”

“You know, there’s a whole lot of issues happening to our people, and you talk about hope. What hope? What hope are you talking about? We still got people dying.”

It was left to Dr Jansen to offer reassurance. “I want to have a dollar each way if you are cool with that. I want to go ‘fuck you’, as well, you know, because we’ve got this government that does dumb shit like the Treaty Principles Bill, right? And that was really unnecessary and it’s a real kick in the guts.”

“It’s so annoying, like disestablishing Te Aka Whai Ora and going against equity programmes everywhere, and that’s a really deeply troubling place for us to be.”

“But on the other hand, and I really want to acknowledge this, because fuck, man, [Māori] got activated. Like, I’m sitting in clinic because I missed the [hikoi against the Treaty Principles Bill], but I’m watching it in between patients. I’m checking in, and that march was just fucking awesome.”

“You know, our people got activated and they got a record number of submissions on it. So, there’s things where I’m so filled with joy and hope. You know what I mean? Like [Te] Matatini [festival], and I’m the worst kapa haka ever, but I’m, ‘That’s amazing.’”

“So, I really hate the kick in the guts, but I am totally optimistic about the future for Māori. The one-million Māori nation is in good place. We’ve got lots of good stuff going on, and I think we’ve got a fabulous future...and I’ve got 15 grandchildren. Just saying...” ■

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¹This was an open-label, randomised, controlled, two-arm effectiveness study of patients aged ≥18 years with symptomatic asthma at 74 general practice clinics in Salford and South Manchester, UK. Patients were assigned to either FF/VI 100/25 or 200/25 OD, or optimised usual care and followed up for 12 months. The primary endpoint was the proportion of ACT responders (improvement from baseline of ≥3 or achieving a total ACT score ≥20) in patients initiated on Breo vs. continuing on usual care (as prescribed by GP) at month 6 in the primary effectiveness analysis population. The primary endpoint was met (p<0.001). Data presented are from a subset of patients prescribed ICS/LABA at baseline initiated on Breo or continued on their ICS LABA: 25% relative difference in responders; 14% absolute difference. In this study there was no difference in serious adverse events reported between Breo and usual care. The most common serious adverse events of special interest were cardiovascular disease, asthma and bronchospasm, and pneumonia.² *At randomisation, investigators reported that 95% of patients used the inhaler correctly after the initial demonstration of correct usage (week 0), and did not require additional instruction.⁴ **Fewer asthma patients made critical errors with the Ellipta inhaler after reading the patient information leaflet vs Accuhaler (3/70 (4%) vs 9/70 (13%), p=0.221 NS); MDI (2/32 (6%) vs 8/32 (25%), p=0.074 NS) and significantly fewer vs Turbuhaler (3/60 (5%) vs 20/60 (33%), p<0.001).
References: 1. GlaxoSmithKline New Zealand. Breo Ellipta Data Sheet. GSK NZ; 2021. Available at: <https://medsafe.govt.nz/profs/Datasheet/b/breoelliptainhalation.pdf> (Last Accessed on Nov 2021). 2. Woodcock A, et al. Lancet 2017;390:2247–2255. 3. van der Palen J, et al. *NIP Prim Care Respir Med* 2016;26:1–8. 4. Svedater H, et al. *NIP Prim Care Respir Med* 2014;24:14019. ABBREVIATIONS: ACT, Asthma Control Test; ICS, inhaled corticosteroid; LABA, long-acting β₂-agonist.

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“Everything we do shows what happens when you give autonomy to the people. We are not provider driven; providers just love to market their bullshit and at the end of the day you can have all the services, but if you don’t have the people with you, you’re useless”

Reporter **Alan Perrott** talks to an ex-cop who is devoting his life to delivering healthcare and change into the heart of Bay of Plenty’s gang culture

Waata Heathcote knocks on the door, steps back and readies himself. Mr Heathcote’s got no idea what’s going on inside or how he will be received, but he’d been up late the night before, talking to an occupant, a gang member and convicted methamphetamine trafficker, fresh from prison, who was threatening to rip off his ankle bracelet and wreak havoc. “He’d come off one of the kaupapa we run at the marae. He’d clearly been using [meth], he was skinny as a fiddle, but [the course] had impacted him, and I’d ended it saying: ‘Just feel free, please contact me.’ “He had a home [detention] bracelet on his ankle, and he’d had an argument with his in-laws. “I get the first call at 10:30 on a Friday night, he was losing the plot. His korero to me was ‘I’m just going to rip this effing thing off and I’m going to go into Whakatāne and cause carnage.’ After staying on the phone until the man cooled down, Mr Heathcote (Ngāti



Pūkeko) got him to agree to a coffee in the morning. So, there he was, knocking on the door. Mr Heathcote is matter of fact about what followed: “I just sat with him, and we spoke about him, about his life... now he works for me; and that’s been a six-year journey.” Where many work on the frontline, Mr Heathcote has crossed no-man’s land to offer help in what many would see as the opposing trenches. Since July 2018, his prosaically named Waiariki Whānau Mentoring has been going where only armed police usually dare, deep into the heart of gang and prison culture, safe guarded only by their mana and the kaupapa they represent. These, he says, are “the hardest of the hard to reach”. People with little cause to trust: “They are hurt, and the system only hurts them more.” The vast majority experienced sexual assault from a very early age, completely disconnected from te ao Māori and found refuge and belonging within gangs and gang life. “The system and iwi Maori have forgotten how to manaaki the people; they figure it requires a dollar. “It doesn’t, it just requires you to put your hand on their shoulder and say ‘my brother, I love you. I’m here. What do you need?’ “And that’s what I do.”

Waiariki Whānau Mentoring is based in Whakatāne with eight offices and about 60 staff spread across the wider Bay of Plenty region. But it is very much driven by Mr Heathcote – “I am at the stern of the waka” – and with little more than force of will, he has got gang members lining up for vaccinations, allowing nurses into their whare to check in on whānau, One of 350 Black Power and Filthy Few members who attended Waiariki Whānau Mentoring’s first hauora event in Rotorua in 2020

Reaching out into uncharted territory

From the Ministry of Social Development, to policing, to Oranga Tamariki, to going it alone – one man’s journey to find the best way to help the ‘super hard-to-reach’

and sharing their deepest secrets to help heal themselves emotionally, physically, spiritually and culturally. The proof, he says, is in the numbers. Of the more than 3000 audited referrals received by Waiariki Whānau Mentoring in the last financial year, 86 per cent were self-referred. Eighty per cent of those they engage with grew up without a biological father, 95 per cent have used methamphetamine and 60 per cent have been to prison. In the last two years, 57 released prisoners have completed the Waiariki reintegration programme, with only one, to date, then reoffending. Mr Heathcote has lots of numbers because researchers are queuing to study gang life. Waiariki Whānau Mentoring even has one of its own, Stella Black (Ngāi Tūhoe, Whakatōhea, Te Whanau-a-Apanui and Ngāti Whakāue), a volunteer from the University of Auckland. About 70 per cent of the programme’s current staff are graduates of their “boutique kaupapa”, a four-part, post-prison reintegration programme. “They come off the streets,” says Mr Heathcote. “Street-savvy chiefs, leaders, who can knock on doors and go into spaces no-one else can. “Access is no problem for Waiariki.”

But it takes a toll, not only does he carry the tales of broken lives, his work poses an existential threat to the pipeline of broken lives gangs rely on for new recruits, even as they embrace him. Which carries obvious physical risk, especially given his disgust towards everything and anything connected to methamphetamine use and distribution. Over the 48 hours prior to talking to *New Zealand Doctor Rata Aotearoa*, Mr Heathcote had taken steps to address self-care and workload, and plans to step back from the day-to-day stress and take more of an oversight role. Once our interview ends, he plans to take off his work shirt and head down the road to sit in the river for an hour: “Just to separate myself for everything.” It’s not before time. Mr Heathcote, 44, started off with



Waiariki tumuaki ahurei Waata Heathcote (left) with Te Whatu Ora pandemic readiness senior adviser Jason Sayers at a 2023 event that delivered 64 health checks and more than 100 engagements by a mental health and addiction team

the Ministry of Social Development, assessing client welfare dependency. He then joined the Police and was based in Whakatāne: “I was looking at the same people that had been queuing up to see me at MSD, and then I locked up a lot of the people I’m seeing now... but the thing about it is, you know, as a police officer, I always made sure they not only saw Waata as the person in the blue uniform; they saw Waata as a Māori.” After leaving the police, he was “kind of shoulder tapped” by Oranga Tamariki to work with high needs children. But he grew weary of a system that wasn’t set up to change lives: “I ended up talking to one of the kaimahi: ‘Where is your guys’ prevention plan?’, ‘Oh, we don’t have one’, and

I’m like: ‘Oh, I’m out’. I pulled the plug the same day. “That the system was just a never-ending cycle of persecution using statutes and laws around obligations and the safety of whānau, but with nowhere in any of that supporting whānau to lead the outcome or the aspiration. “It was all system, so I left. But I had seen where the gaps were, and that was about mentoring, advocacy and brokering.”

Around this time, he had a conversion experience. It’s personal, he won’t discuss it in any depth and chooses his words carefully, but it drives his work: “Now that was a miracle, brother, but I just keep my walk. “[Everyone] knows that I’m strong in my faith. I don’t hide it, but I don’t go out there and preach it. “I’m not a hardcore Christian or soldier. I’m just me. When [gang members] ask me: ‘Why are you so different?’ I just say: ‘This is my walk, whānau.’



Engaging and supporting youth within gang whānau is a key target for Waiariki Whānau Mentoring

“But I don’t go: ‘Hey, my brothers, you need to find the Lord’. Never ever, ever, ever once have I done that, ever, because I don’t sit in a church. Waiariki is my church, and for us as Māori, we’ve always been connected to the Atua, for ever. That’s who we are. It’s just that I haven’t forgotten it, that’s all. “I’ve kept strong to that, but I do sometimes ask, you know, ‘why have you put me in this position?’ “This is some hard stuff.” Inspired and newly unemployed, he dedicated himself to helping gang

members and whānau access the support they need: “So that’s what we do. We are the conduit, the net catcher, for the most vulnerable communities.” His leap of faith came in July 2018 when he got together \$130 and registered his new company. After a friend with a building in Whakatāne offered free office space, he went door to door asking if anyone had old computers they didn’t need. Things moved slowly at first, with a team of three, including himself, providing what would now be called a navigator service to about 50 whānau. Then COVID-19 hit: “By the time we had that first lockdown, it was me and my cousin working with like 116 families. By ourselves. It almost killed us, but then Civil Defence here contacted the Government and said: ‘You need to come and look at what these guys are doing.’” Media interest followed, and patched gang members packaging and delivering food parcels appeared on the 6 o’clock news.



The Waiariki Whānau Mentoring mobile health service at a 2024 hauora event that delivered 102 vaccinations to gang whānau

the gang wives and the gang rangatahi. “We’re not built on the pillars of an organisation. We’re built on the pou of the voices of the people, people who share with us about the inequities within the health system, within all the systems they’re not able to access because everyone pushes them away, even our own push them away. “That’s why they became the super hard to reach. “But everything we do now, we are doing because of COVID. It opened doors.” Knowing the hesitancy, anxiety and outright hostility likely to come from gang members towards COVID-19

“I was looking at the same people that had been queuing up to see me at MSD, and then I locked up a lot of the people I’m seeing now”

vaccinations, Mr Heathcote used his networks to get leaders to meet with the regional medical officers of health so they could ask whatever questions they had. “No-one else had done that.” That meeting resulted in their first event which hosted Black Power whānau from Whakatāne, and delivered 23 vaccinations. “That might not sound like a lot, but it was huge for us and started the ripple effect. Then we started running them in Kawerau with the Mob, in Tauranga with the Filthy Few and the Mob, in Rotorua with the Mob, the Black Power and the Filthy Few, and then Tokoroa with the Black Power. “Huge events, you know, we’re talking 3–4–500 people at them. Patched members, together.” As he’d hoped, the Government has

noticed, and contracts are coming. From immunisation and vaccinations to a mobile nursing service offering health checks, Waiariki Whānau Mentoring is now moving into HPV, mental health and support for homeless whānau. “It can be the simple stuff, like just giving whānau a toothbrush. People understand the state of dental health in areas like this. Kids brushing their teeth, even once a week, come on whānau you need to be doing that. But that’s what we have to do, it’s having those conversations.” Waiariki has recently secured a mental health crisis response contract in partnership with Tūhōi Hauora and opened a social supermarket alongside Foodstuffs North Island.

But if his work is increasingly embraced, Mr Heathcote remains a disruptor. “Everything we do shows what happens when you give autonomy to the people. We are not provider driven; providers just love to market their bullshit and at the end of the day you can have all the services, but if you don’t have the people with you, you’re useless. “[Māori] culture is one of the worst in dealing with ingrained trauma; it’s take a concrete pill, harden the fuck up, and sweep it under the carpet. But you have to drag everything out from under the carpet to heal or you just stay a negative gangster and you’ll continue to do what you’ve done because it’s all you’ve known. “Culture change comes from within.” He celebrates his staff who have dropped the patch to help others: “They are role models within the community to show that this is what it looks like [to change], that it can happen. “There is a ripple effect happening within our space now. It’s not just the ones or twos anymore, it’s [gang] chapters, and we’re four generations deep. “It’s all been worth it, I wouldn’t change it for the world.” ■ aperrott@nzdoctor.co.nz



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STELLAR SUPPORTER PROFILE

CrestClean is sponsoring the Business Achievement Award in the 2025 New Zealand Primary Healthcare Awards | He Tohu Mauri Ora. **Grant McLauchlan**, CrestClean's managing director, tells us what it means to be a Stellar Supporter

Why is CrestClean sponsoring the primary healthcare awards?

CrestClean has been a long-time supplier to the New Zealand healthcare sector. Maintaining cleanliness in primary care facilities is vital for ensuring patient safety, preventing the spread of infections, and creating a welcoming environment. We are proud to show our support for excellence in the healthcare sector.

What is CrestClean's key area of involvement in primary care?

As the preferred supplier of cleaning and hygiene services to many healthcare organisations across New Zealand, we understand the crucial role cleaning plays in minimising healthcare-acquired infections. Through our specialised HealthClean systems and processes, and with over 900 personnel trained in professional healthcare cleaning through the Master Cleaners Training Institute (MCTI), we ensure a safe, clean and hygienic environment for all providers and their communities.

What is it that interests you personally about the category CrestClean is sponsoring?

As a 100 per cent homegrown, New Zealand-owned business, CrestClean has long embraced the business excellence philosophy, striving to improve sustainability, safety and wellbeing, and customer service. The Business Achievement Award acknowledges the winner's commitment to



CrestClean's Grant McLauchlan
Image: Supplied

achieving excellence in business operations and customer service.

What do you hope this sponsorship will achieve for the entrants in this category?

The process of entering a Business Achievement Award is an opportunity to step back, reflect on key aspects of your business and assess areas for measured improvement.

What is a great experience you have had in primary care that you can share with us?

During the COVID lockdowns, our highly skilled and resourced teams across the country stepped up. They worked alongside and supported many healthcare facilities through the most challenging conditions. This experience reinforced our commitment to training and the continuous upskilling of our people.

How would you describe the sector in three words?

Committed, dedicated, selfless.

If you were asked to name a popular song as the anthem for primary care, what would you choose?

Heroes (David Bowie). ★



CrestClean
Healthcare

Funding signals shape Vote Health before delivery

► **Martin Johnston**

When it comes to Vote Health in Budget 2025, it could be called Budget 2024-and-a-quarter, given the early announcement of a sizeable chunk of funding.

No sooner had Budget 2024 been delivered last May than the ruckus began over its omission of the 13 cancer treatments promised by National. Enter stage right: new Pharmac funding over four years for 54 medicines for cancers and other conditions.

"Pharmac will receive a \$604 million funding boost for medicines, which is a pre-commitment against next year's Budget," then-health minister Shane Reti said last June, calming the troubled waters over the 13 cancer treatments but not answering Treasury's suggestion the money might have been better spent in primary care.

Fast-forward from then to last month, and primary care got its very own pre-commitments:

- a \$285 million, three-year performance-based capitation and procedure-based funding boost, on top of an as-yet-unknown annual capitation increase
- \$23.94 million over four years for international medical graduates from "non-comparable" health systems to do most of their pre-vocational training in general practices
- \$23.3 million over four years for a funded primary care pathway to registration for New Zealand-trained doctors
- just over \$30 million over five years for primary care incentives to hire new graduate nurses
- 34.2 million over five years for primary to increase primary care nurse practitioner training places
- \$164.62 million over five years for a 24/7 digital GP and NP consultation service
- an increase of 25 training placements at medical schools.

Budget 2025 will be delivered by finance minister Nicola Willis in Parliament on 22 May. It will spell out – mostly in the language of accountants – the Government's revenue and spending plans for the financial year starting on 1 July and will be accompanied by the usual avalanche of supporting documents and media releases.

An Olympic-sized pool of journalists and analysts, including one or two from *New Zealand Doctor Rata Aotearoa*, will tap out stories and analysis until 2pm in the so-called "lock-up" at the Beehive. These folk get early access to the documents and hear from the

Essentials

- ◆ Vote Health was set at \$29.637 billion last May.
- ◆ It will exceed \$30 billion in Budget 2025.
- ◆ A number of pre-commitments have been made in primary care and medicines.

finance minister but can't publish anything until 2pm.

Vote Health for 2024/25, the current financial year, is \$29.637 billion. That's the money "voted" by Parliament for operating the system, including hospital staff wages and primary care funding, and capital expenditure for the likes of new buildings, CT scanners and cars.

The money is voted via "estimates of appropriations". The appropriations are groups of services. One appropriation is called delivering primary, community, public and population health services, and it was to get \$9.088 billion this year. Another, the biggest, is delivering hospital and specialist services, and it was to get \$14.611 billion.

But as things change during the year, "supplementary estimates" get voted back in via the next year's Budget process.

No doubt we will hear again of "record" spending in health as Vote Health rises to cover a bigger, older population. Budget 2024 provided \$1.43 billion for the "future funding track/demographics cost pressures", according to a Cabinet paper from health minister Simeon Brown. The estimate for Budget 2025 is \$1.37 billion, with the same again the following year.

These baked-in sums add up to the often-stated \$16.68 billion over three Budget cycles. Each Budget cycle is four years, so the overlapping cycles cover six years in total. The new money of about \$1.4 billion a year gets counted multiple times, first when it is new, then repeatedly in the baseline.

Whether Vote Health 2025 returns to the track of inflation-adjusted rises in operational health funding per capita will be for the analysts to tell us. ■ mjohnston@nzdoctor.co.nz

BUDGET COVERAGE
The *New Zealand Doctor Rata Aotearoa* website, nzdoctor.co.nz, will provide coverage of Budget 2025 on 22 May

Primary care's share of funding pie not just static, it's falling

► **Fiona Cassie**

Successive governments say they are prioritising primary healthcare, but the sector's funding share is static and has even fallen in real terms, says a Victoria University of Wellington study.

The Health Service Research Centre study looked at the amount of capitation and flexible funding allocated to PHOs between 2009 and 2023, compared with total Vote Health funding.

The results, published online on 27 March in the *Journal of Primary Health Care*¹ confirmed that, on average, New Zealand allocated 5.4 per cent of the national health budget to those funding streams with little fluctuation over the period. One of the authors, Jackie Cumming, says it also found that real per-capita funding for primary healthcare has been flat and actually fallen.

Last year, *New Zealand Doctor Rata Aotearoa* published similar data released to it from Health New Zealand Te Whatu Ora for 2014 to 2024 which showed a slight decline in Vote Health share

from 5.42 per cent in 2013/14 to 5.14 per cent in 2023/24.

"All governments recently have said that primary healthcare is a really important contributor to overall health, system efficiency and cost-effectiveness – and there is international evidence to back that up," Professor Cumming says.

"So, they say they are prioritising primary healthcare, but we don't see it in the funding figures."

Also, much of the reporting of increases to primary healthcare funding is in nominal dollar figures, she says.

"When you take into account population growth and inflation, what we are seeing is real per-capita [funding] growth is virtually nothing."

The actual dollars allocated per person over the past decade, when converted into 2023 dollars to account for inflation, is "basically flat and, in fact, it's actually gone down in the last year or so", Professor Cumming says.

"If primary healthcare was a priority, you would think that resources would follow, but what we are saying is that

real per-capita resource into primary healthcare has barely changed over this quite long period of time.

"Therefore, it's not surprising that our emergency departments, for example, are overwhelmed."

General Practice Owners Association chair Angus Chambers says the study findings confirm the "system doesn't value us, no doubt about it".

The Government's recent announcement of an extra \$95 million a year in targeted funding, on top of the usual annual capitation increase, might change the funding share "a little bit", Professor Cumming says.

On average, New Zealand currently spends \$244 per person on primary healthcare, she says.

"Even at face value, when you look at it that's not very much money if we are wanting a really strong and powerful primary healthcare system."

The Victoria study did not include money allocated through other funding streams, including immunisations,



Primary care's slice of Vote Health has stayed static at about 5.4 per cent for more than a decade, despite talk of prioritising the sector, a Victoria University of Wellington research team confirms

after-hours, primary mental health and rural health or funding for non-PHO Māori and Pacific providers. ■ fcassie@nzdoctor.co.nz

Reference
1. Irurzun-Lopez M, Jeffreys M, Cumming J. Protecting primary healthcare funding in Aotearoa New Zealand: a cross-sectional analysis of funding data 2009–2023. *Journal of Primary Health Care* 2025;27 March. Open access, doi:10.1071/HC24155



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“I knew the Government had a certain amount to spend, and I got my fair share from the minister of finance. So, I never went back for more”

PETE HODGSON

PETE HODGSON was the health minister from October 2005 to November 2007 as part of the Labour-led Helen Clark Government, taking over from Annette King. District health boards had been in place for five years, and PHOs were starting to get their mojo. Vote Health was worth \$9.68 billion in 2005/06 when Mr Hodgson took over the portfolio. In his last Budget, it grew to \$11.93 billion in 2007/08.

WYATT CREECH became health minister in February 1999 after a Cabinet reshuffle under prime minister Dame Jenny Shipley in the National-led Government. It was seven years into the health reforms started by Simon Upton in 1992. Crown health enterprises had already been replaced by hospital and health services, and four regional health authorities were now the Health Funding Authority. It was a short tenure of 10 months for Mr Creech. Vote Health in 1999/2000 came in at \$6.67 billion, up 5.4 per cent on the year before.



“At the end of the day, you want to be able to put your hand on your heart and say you did your best to balance the different pressures you faced”

WYATT CREECH

Former health ministers talk Budgets and how to spend them

The health portfolio is often characterised as a poison chalice, not the least because health ministers face the wrath of Cabinet colleagues as, alongside social development, Vote Health takes the lion's share of the annual Budget. Ahead of Budget 2025 this month **Stephen Forbes** tracked down two former health ministers – Wyatt Creech and Pete Hodgson – for a chat about the challenge that is Vote Health

Getting a reasonable slice of the annual Budget for Vote Health was never an issue in his time, says Mr Hodgson

“I knew the Government had a certain amount to spend, and I got my fair share from the minister of finance. So, I never went back for more.

“I had about three-quarters of a billion for operating expenditure, plus capital spending,” Mr Hodgson says. “I had two decisions to make: how much to pass on to the DHBs and what new services to buy with the money I didn't pass on to the DHBs.”

New services could have included new vaccination programmes, which would have been purchased via the DHBs anyway.

Mr Hodgson was, until quite recently, still involved with health funding controversy. Until May last year, he was chair of the Southern Partnership Group, looking at the new Dunedin Hospital build.

Mr Creech, now retired in Wellington, says the health portfolio involves balancing the needs and demands of those on the frontline with the fiscal constraints of the day. Health is one area where there's never enough money to go around.

“No matter how far you go, you will always find there are people who think you should have done more,” he says. “I

would go around the country quite a bit and speak to doctors. You would see proposals for projects that looked sensible.”

But, he says, that didn't mean he could secure the funding to ensure those proposals got the green light. He was the health minister during Sir Bill English's first stint as finance minister. “We were trying to achieve certain goals. We wanted to spend money to keep as many people as we could out of hospital.”

Secondary care isn't cheap, and the benefits of preventative care can't be overstated, says Mr Creech.

Both former ministers found deciding how much is enough to spend on health a constant challenge. A common measure is health spending as a percentage of GDP. In 1999, New Zealand sat around the OECD midpoint, Mr Creech says. It's a useful benchmark – but a relative one. Countries often used for comparison, like Australia, face many of the same financial and demand-side pressures, so simply matching their spending levels doesn't necessarily provide a solution.

Mr Hodgson acknowledges the criticisms around using GDP comparisons, not because of what's included in GDP itself, he says, but because countries differ in what they consider health spending. For example, some include

services like clean drinking water, while others record them elsewhere on the balance sheet.

“According to where we are in terms of our riches as an economy and a low-to medium-income nation, we would expect to spend less on health as a percentage of GDP,” he says.

Looking at New Zealand's health spending as a percentage of GDP since the 1990s, the amount spent tends to be similar over time and only oscillates slightly between centre-left governments, which spend slightly more and centre-right governments, which tend to spend less, Mr Hodgson says.

But he's concerned about where things are heading. “Certainly, last year's Budget was dreadful for health.”

As for “record spends”, every year is a record, says Mr Hodgson. The health spend never drops in absolute terms. “You've got to look beyond the headlines.” A growing population costs, he says. “If you are going to have 50,000 people arriving in your country per annum, that means you have to pay for new schools and three-quarters of a hospital...And we have an ageing population and the demographics around that are pretty obvious.”

Mr Creech says during his time as minister, officials were already warning the Government of the increased

pressures due to the country's growing and ageing population.

“We knew at some point, we were going to see a boom in those demographics, and that would impact budgets.”

He notes the push by current health minister Simeon Brown to reduce waiting lists. “They are issues no matter who the minister of health is, whether they are National or Labour.”

Mr Creech says that in recent years he's had firsthand experience of the health system as a patient and says the doctors and nurses on the frontline do a great job.

As for Budget 2025, Mr Hodgson says Mr Brown will have his work cut out. The \$16.68 billion over six years in additional health funding announced by National as part of Budget 2024 won't cut it in the face of rising cost pressures, he says.

Despite the challenges, Mr Creech is confident Mr Brown will be across the issues in the portfolio. Sometimes, as the health minister, you feel like you are caught between a rock and a hard place, he says.

“At the end of the day, you want to be able to put your hand on your heart and say you did your best to balance the different pressures you faced,” Mr Creech says. ■

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Tenure timer

There have been 15 health ministers since 1990, when Simon Upton took up the role and ignited National's health reforms. If you take out the sterling service of Labour's Dame Annette King and National's Tony Ryall – 70 months, nine days and 70 months, 17 days respectively – the average tenure is 20 months.



Living alone can come with challenges



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Reference: 1. van Leeuwen KM, et al. What does quality of life mean to older adults? A thematic synthesis. PLoS One. 2019;14(3):e0213263.





From lived experience to peer support – NZ’s first mental health minister on what makes him tick

When the Coalition Government formed in November 2023, Matt Doocey became the country’s first mental health minister. Following a Cabinet reshuffle in January, he is now solely focused on that portfolio. Deputy editor **Patrice Dougan** spoke to him about the role, his priorities, and the car crash that changed his life

A dramatic car crash as a teenager gave Matt Doocey a harsh introduction to mental health.

After being thrown out of the back windscreen of a car rolling end-over-end travelling at 100km/h, Mr Doocey was duly taken to Timaru Hospital and treated for his broken bones, but says the follow-up appointments all centred around his physical injuries.

“No one ever said to me that I should be mindful of the knock I’ve had to my head or even engaged in any follow-up support,” he says.

It was the 1980s and mental health was not given the attention it is today.

“I developed mental health issues such as depression and anxiety, I struggled to concentrate, I was probably taking some risky behaviours,” Mr Doocey says in an interview with *New Zealand Doctor Rata Aotearoa*. “I was also drinking a lot, becoming more isolated. But I think as a young male, the biggest issue was that I was just not prepared to talk about it, and I didn’t want to ask for help.”

In the end, he took the advice of people around him to get some professional help and describes that as a light-bulb moment.

“I not only started a relationship with my mental health that I have today – I call it a relationship on purpose because, like any relationship, sometimes it’s good and sometimes it’s not so good. So, I’m aware of that now and manage it.”

“Health ministers are always focused and, at times probably, distracted by physical health and it felt like mental health always, well, fell off the table, so to speak”

It also prompted him to head down the path of counselling psychology. “I wanted to do that person’s job to help other people,” he says.

Now, as the country’s first mental health minister and, since early this year, solely dedicated to that portfolio, he’s combining his two lifelong passions of politics and mental health.

“It’s a real privilege to be New Zealand’s first mental health minister but, let’s be very clear, just giving someone a job title hasn’t necessarily made a difference on the ground,” Mr Doocey says. “Clearly what this government and I choose to use the role for, to make that difference, is how we should be measured.”

The Waimakariri MP was schooled at St Bede’s and went on to study counselling psychology at WelTec (Wellington), and later, social policy and healthcare management in London where he worked for 15 years. He worked for a mental health trust in a high-needs area, and later the NHS, moving up management and leadership roles, eventually landing a job as assistant director at the Tavistock Clinic, before moving back to Christchurch in 2013.

He worked at Canterbury DHB for a year before being selected to run for the National Party, initially in the Christchurch East seat before switching to the Waimakariri electorate when Kate Wilkinson retired.

A desire to help his hometown post-Canterbury earthquakes prompted the move back from London, and once home he realised there was “a very big discussion about mental health” happening. Moving into politics seemed like a valuable way to continue that discussion, Mr Doocey says. His experience in NHS leadership, while initially difficult: “My real calling, I thought, was face-to-face work with people”, taught him that shape, design and delivery of services had a big impact on the therapeutic outcomes.

He has pushed for a dedicated mental health minister since entering politics, he says.

“[Over] my two terms in Opposition, I just became increasingly of the view that it was time New Zealand had a first stand-alone mental health minister,” he tells *New Zealand Doctor*.

Essentials

◆ Matt Doocey is New Zealand’s first mental health minister.

◆ Mr Doocey has a background in counselling psychology and has worked in mental health trusts and for the NHS in London.

◆ Wait times, workforce and early intervention are key areas Mr Doocey has prioritised.

“When you look at – irrespective of what colour government – previously, health ministers are always focused and, at times probably, distracted by physical health and it felt like mental health always, well, fell off the table, so to speak.”

He was “always in [the] ear” of the various National leaders throughout their time in Opposition about the importance of having a mental health minister, he says.

A separate minister, rather than its own ministry, was the best option, he believes, to avoid mental health “being siloed even further”.

The minister is responsible for the \$2.6 billion in ring-fenced funding, while also being able to work across departments and with ministerial colleagues on ways to improve mental health overall.

He believes it’s a position with bi-partisan support, and mental health is an issue best served without the influence of three-year election cycles.

“If you were to ask me what I think will be one of the biggest successes in this role, I truly believe that if the Government was to change [at a future election], then an incoming government would say, ‘that role worked and we want to continue with it.’”

Mr Doocey’s key priorities are focused on reducing waiting times, training more mental health professionals and investing more in prevention and early intervention. He introduced mental health targets into last year’s Government Policy Statement on Health for the first time; three of them revolve around wait times and timeliness of treatment.

The latest Government targets quarterly report released in early April show all three of the wait-time targets are improving and two are being met at a national level.

He admits, in a media release accompanying the target data, there is a lot more work to do, but says the data gives a clearer understanding than we’ve had before.

In the interview with *New Zealand Doctor*, prior to the release of the target data, Mr Doocey says the reporting is broken down by health district and also via young people, rural, Māori and Rainbow demographics. He understands that even if the national data appears on target, there will be areas that aren’t, and he expects each of the four regions to track their data on a detailed level and to put action plans in place to meet those targets.

Wait times are part of the targets because they’re a major issue and barrier for those seeking help, he says.

“Very few people say to me, ‘oh Matt, when I got seen that didn’t help me’. It says to me, when people get access to services, they’re generally well supported, but what people say to me is, ‘in a time of need, I looked around and found a very fragmented mental health system, and it took me a long time to be seen’. So, for me it is about joining up the continuum and really driving timely access to support.”

He is also a big advocate for lived-experience peer support workers – which he describes as “quite a game-changer in mental health”, and which he’s been increasing over the last year. Alongside peer support services in emergency departments, he announced the establishment of six “crisis cafes” to be rolled out across the country over the next two years, and established a \$1 million fund to train more level 4 peer support lived-experience certifications.

A crisis cafe is a peer-delivered service, providing a safe, relaxed, non-clinical setting for people who are in distress related to either mental health and/or addiction issues, and need to talk to someone face-to-face.

“I think there’s a huge opportunity there, not only to better resource and utilise our workforce, but I think there’s a real opportunity there around lived experience...When people come into our EDs or crisis cafes to be met by someone who’s been there before, can share their experience – not to tell the person what to do, but just to offer them hope that you can get through in your time of need – is quite powerful I think.”

Mr Doocey’s time as mental health minister has not been without controversy. His \$10 million Mental Health and Addiction Community Sector Innovation Fund, which opened last July, was hit by a barrage of criticism – predominantly over the requirement

for applicants to have a minimum \$250,000 in the bank. This was rolled back in March, to \$100,000, after “feedback from the sector”.

And Mr Doocey’s status as a minister solely dedicated to mental health only came about when he was stripped of his other Cabinet portfolios at the beginning of the year, in the reshuffle that saw Simeon Brown replace Shane Reti as health minister. Mr Doocey lost his ACC, Tourism and Hospitality, and Youth portfolios.

But he says he’s not in the role for slogans and announcements, he’s focused on implementation and the reality on the ground.

“I’ve been very clear that I’m going

to trial a lot of new things,” he says.

“Some things will work, maybe some things won’t work as well as we thought. But it’s the ability to get into the detail and do a number of different things under those areas of reducing waiting times, training more mental health workers and investing more into prevention and early intervention.

“And I think that’s really the magic of this new role. [It’s the] first time in New Zealand we’ve got a minister focused solely [on mental health] and that gives me the ability to really have time to think, to develop policy with the officials and ensure that the ideas are then implemented.” ■

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Minister on the job

• **New mental health and addictions facility officially opened in Whangārei (11 April):** Matt Doocey, alongside health minister Simeon Brown, officially opened the purpose-built Manaia House, with 75 consultation rooms, consolidating the region’s community mental health and addiction services, previously spread across four locations.

• **Auckland University of Technology to offer new psychology training (10 April):** Working alongside the University of Canterbury to develop the training programme for the new “associate psychologist” training programme for 2026, which is designed to support the psychology workforce.

• **Funding limit change (27 March):** The match-funding requirement for the \$10 million Mental Health and Addiction Community Sector Innovation Fund will be reduced to \$100,000 from the previous \$250,000. Round one of the funding saw money awarded to: MATES in Construction, The Mental Health Foundation, Youthline, Wellington City Mission, Rotorua Youth One Stop Shop and the Sir John Kirwan Foundation.

• **Construction begins on new adult mental health building in Christchurch (20 March):** Alongside Mr Brown, attended a sod turning to officially mark the start of construction on a new facility at Hillmorton Campus, which will provide 80 inpatient beds for adults with acute needs. It’s expected to be completed by the end of 2027.

• **Pacific community-led solutions to address alcohol harm (7 March):** A new \$330,000 funding initiative to help prevent and address alcohol-related harm in Pacific communities officially launched, the first significant investment in this area, according to Mr Doocey.

• **Expanded specialist youth services coming for regions in need (6 March):** Details for a \$3.5 million annual funding boost to increase access and expand specialist infant, children and adolescent mental health services in Tairāwhiti, Counties Manukau, and Waitematā are released.

• **Mental health peer support extends to Wellington Hospital ED (4 March):** The start of a new peer support service at Wellington Hospital Emergency Department is officially marked. It’s an initiative that Mr Doocey says will help people gain faster access to mental health support. Auckland Hospital and Middlemore Hospital already have the service rolled out. The scheme will be extended to Christchurch and Waikato EDs, with a further three locations yet to be announced.

• **Community-based approaches to reduce alcohol harm (28 February):** A new Community Action Fund focusing on local and community-led early prevention, intervention and innovation to reduce alcohol harm – particularly among high-needs groups most affected – will provide \$1 million in grants, projects and contracts. ■

Matt Doocey has experience of navigating his own mental health issues. He pushed for the creation of a dedicated mental health minister, and took up the role after the 2023 election

Hagen Hopkins



Barbara Fountain, editor of *New Zealand Doctor Rata Aotearoa*, and Paul Hutchison, GP and senior medical clinician at Tamaki Health



Paul Charlick, specialist GP at Auckland's Balmoral Doctors; Heidi Muller, specialist GP at Three Kings Accident and Medical Clinic; and Michael Wah, specialist GP at Dr Zhuang & Wah Surgery in Auckland



Locum GP Helen Fisher, with Te Kuiti Medical Centre NP Bridget Woodney



Ruby Faulkner, GPEP2, with David Small, who is a GPEP3 at The Doctors Greenmeadows in Napier



Specialist GP Lucy Gibberd, medical advisor at MPS; and Zara Bolam, urgent-care specialist at The Nest Health Centre in Inglewood



Ministry of Social Development health and disability coordinator Liz Williams; regional health advisors Mary Mojel and Larah Takarangi; and health and disability coordinators Rebecca Staunton and Myint Than Htut

Relaxing at Goodfellow

Members of the *New Zealand Doctor Rata Aotearoa* news team – **Alan Perrott**, **Steve Forbes**, **Zach Thompson**, **Patrice Dougan** and **Barbara Fountain** – joined around 541 delegates at this year's Goodfellow Symposium at the Due Drop Events Centre in Manukau, south Auckland on 22 and 23 March. Delegates mingled among the stands at the end of the first full day of presentations. Photos by Simon Maude



Olivia Blackmore and Trudee Sharp, NPs at Gore Health Centre; and Gaylene Hastie, NP at Queenstown Medical



Lori Peters, NP and advanced health improvement practitioner at Mahitahi Hauora; and Jasper Nacilla, NP at The Terrace Medical Centre in Wellington



Te Whatu Ora Waikato emergency medicine specialist Marlize Alberts and Grant Le Roux specialist GP at Horotiu Hauora Family Health in Hamilton



Lalith Martyn, urgent-care specialist at Bakerfield Medical and Urgent Care, Auckland; with Premita Vijay, nurse manager and Satendra Vijay, urgent-care specialist at Fellbrook Medical Clinic in Auckland



MFAS financial adviser Hamish McPhail



Te Whatu Ora NP intern Melanie Sutton; New Zealand Formulary pharmacist Stacey Smith; Pharmacist clinical lead of medicines management Melissa Copland; Te Whatu Ora Nelson Marlborough NP Sue Dawkins; and New Zealand Formulary pharmacist Kirsten Simonsen



Papakura Marae Health Clinic and Elizabeth Knox Home and Hospital NP Moana Taylor; Mercury Bay Medical Centre NP Cecilia Worthington; and Arataki Wellness Centre specialist GP Tane Taylor



Tāmaki Health and Oceania Health NP Bibin Baby; Health-I Care NP Daisy Jose; Whitecross acute-care NP Martin Du Plooy; Whitecross GP Simon Vari; and GP locum Maja Kubicka



Hillcrest Medical Centre specialist GP Denise Porter and Little London Medical Clinic specialist GP Clare Harford



Te Whatu Ora West Coast pharmacist prescribers Kerri Miedema and Julie Kilkelly



University of Auckland medical student Esther Lee, and Auckland-based GP Susan Smith



Mary Toloa, specialist GP at Porirua and Union Community Health Service; Mara Coler, clinical pharmacist at Tū Ora Compass Health; and Bhavna Mistry, specialist GP at Porirua and Union Community Health Service



Pharmacotherapist and pharmacist prescriber Leanne Te Karu; specialist GP and Health Navigator chief executive Janine Bycroft; and pharmacotherapist and pharmacist prescriber Linda Bryant



Kenepuru Accident & Medical Clinic nurses Karen Barnett, Mel Wimsett and Samantha Christensen



Specialist GPs Jason Pryke and Alistair Blomley from Riccarton Clinic in Christchurch



Kenepuru Accident & Medical Clinic urgent-care specialist Will Vaatstra, urgent-care registrar Courtney Storm and urgent-care specialist Shaun Counsell



Community Health Partnerships primary care pharmacists Jane Young and Estelle Lang



ACC medical advisor Hein Pretorius with Hamilton's Anglesea A&E NP Mike Haden-Jones



Olga Fomchenko, GP at Hobsonville Family Doctors, and Sharon Laing-Vao, nurse prescriber at Think Hauora



Auckland Eye marketing manager Marié Dickinson (centre) and her husband, Wilf Truter (left); with ophthalmologist Aaron Wong

Moral harm at work leads some GPs to ‘cave of shame’ response

▶ Alan Perrott

Mary Miller’s session at the 2025 Goodfellow Symposium could have been subtitled: “Physician, heal thyself.”

Speaking for over an hour at Auckland’s Due Drop Event Centre on 22–23 March, the clinical psychologist broke down the moral harm, moral injury and self-harm GPs can inflict on themselves simply by doing business as usual.

Originally identified in returned Vietnam War veterans, the idea of moral harm and injury presents similarly to post-traumatic stress disorder but is fuelled by unresolved responses such as guilt and shame or having to do something contrary to your values.

“When we experience a difficult situation, it can bring up a flood of emotional responses...a surge of compassion to get in there and make a change, or your emotions can be more difficult to manage – anger and frustration or guilt and shame...”

“The thing is, it is because you care about something; it makes you more vulnerable to have a reaction.”

Such responses peaked during the COVID–19 pandemic, with clinicians of all stripes doing their best within the universal constraints of limited time, funding, staffing and equipment, Dr Miller says. “Add to that the high ethical standards you try to work by, and your own personal values, wanting to be trustworthy, respectful and respected... and on top of that, the public scrutiny, the threat of complaints, and you have more chance of moral pain than turning into moral injury because it really feels personal.”



Clinical psychologist Mary Miller

Dr Miller used herself as an example of how molehills can become mountains. She sometimes gives patients her phone number as a gesture of goodwill, which rebounds when texts arrive when she is busy or relaxing – sometimes just to book an appointment, but also when the patient is in serious difficulty.

In isolation, each moment can be dealt with, but they accumulate.

Dr Miller says she feels guilt at pushing people away with glib set-piece responses and sometimes wakes at night, worrying if she handled tricky conversations as best she could.

Dr Miller was joined by Auckland specialist GP Helen Johnston who related her own experience when a seemingly minor clinical lapse resulted in a patient getting a late cancer diagnosis.

“I had very strong feelings of shame and whether I was a bad doctor. Maybe I didn’t care enough? Maybe I’m not reliable enough?”

Dr Johnston drew on the support of colleagues and was able to have an honest conversation with the patient: “But

it could have so easily turned into a more difficult time for me.”

Dr Miller talked of the “cave of shame” some crawl into to isolate themselves while an emotional response spirals out of control.

The presentation drew strong reactions from GPs in attendance: “I find that friends have zero understanding of general practice,” says one. “Mostly, they want me to solve their problems, so I don’t find them useful for offloading...But, sometimes, family and spouse are not the best people to offload to either; you are bringing home your problems, and then they have to suffer as well. Sometimes I just think, ‘our poor families’.”

Another reflected on systemic injury: “I feel morally wounded that I’m expected, in 15 minutes, to solve someone’s difficult situation, and I have 20 of them in five hours. I really feel we’ve been sold a pup, and we’ve been forced into

this situation.”

A south Auckland GP talked of his practice, which has no clinician support in place, where he would hunker down with a colleague during every break to troubleshoot problems.

While sharing problems honestly and opening up, possibly with a specialist practitioner, is ideal, Dr Miller suggested a process anyone can try.

She invited GPs to reflect on difficult conversations: “Not just with other people, but the conversations you have in your own head.



Clinicians can crawl into a “cave of shame” when they feel unable to meet their own standards

“Think about events where something challenging happened and you’re left with those feelings and thoughts, and where your mind goes...”

That inner voice is often burbling away in the background, but Dr Miller suggests writing those thoughts down.

“Then imagine if you said those words to someone else, like a colleague in a difficult situation. Chances are you would never speak to someone else like that. That is your critical voice.

“Then, write down what you would say to a colleague, friend or loved one in a similar situation. That will be your self-compassionate voice.

“Give it a go and notice the impact the different voices have on you.” ■ aperrott@nzdoctor.co.nz

D Specialist GP Jo Scott-Jones discusses moral injury in his First Time column on page 70

Early detection pushed by new rheumatic fever and heart disease guidelines

NEW APPROACHES TO identifying potential acute rheumatic fever cases were among the changes to national guidelines presented at the Goodfellow Symposium 2025.

Rachel Webb, associate professor of paediatric infectious disease at the Kidz First and Starship hospitals in Auckland, outlined nine key messages, including not recommending the use of rapid antigen tests, which have poor sensitivity and specificity. “This is an area that urgently needs national oversight and clinical guidance.”

The guidelines will be made public soon. Dr Webb says they shift the emphasis to early detection but she acknowledges this will be tricky in rural areas where there are multiple barriers

to accessing recommended treatment and follow-up care.

There is also no evidence for using skin infections as a detection tool, she says. “[Skin infections have] epidemiological associations rather than at a patient level. I don’t know of any specific skin strategy that would reduce individual risk.”

Only symptomatic family members should be swabbed when looking at possible spread within a household, she says. However, siblings should be referred for an echocardiogram, especially those with severe symptoms.

The guidelines also encourage shorter hospital stays in areas with available community-based support.

Bedrest is discouraged for mild

and stable patients.

Asked about improving adherence, especially among young patients, Dr Webb talked about the benefits of a nurse-led programme being rolled out in Counties Manukau.

Nurses and psychologists are now working with young people and their whānau to explain the need for the medication and reduce stress around the “high burden” of adherence.

“Nurse-led public programmes are preferable wherever possible, but it does depend on region and the flexibility of providers,” Dr Webb says.

Asked how best primary care can support the early detection of rheumatic fever, she recommended GPs be on the lookout for patients with a

limp: “Limping is a key concern.”

Patients from higher-risk population groups who present with sore joints, limping and cardiac-related pain should be referred to hospital.

Dr Webb outlined nine principles for best practice rheumatic heart disease management, which included offering regular flu vaccinations, preventing endocarditis by supporting good oral healthcare and referring women with rheumatic heart disease to appropriate specialists to inform pregnancy decision-making.

The guidelines will incorporate culturally specific information developed by researcher and former specialist GP Debbie Ryan. ■ aperrott@nzdoctor.co.nz

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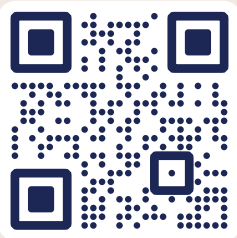
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- The importance of preventing COPD exacerbations
- The importance of single inhaler triple therapy (SITT)
- The cardiopulmonary risk with COPD
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References: 1. Trelegy Ellipta Data Sheet, GSK New Zealand, available at www.medsafe.govt.nz. [Accessed Jan 2025].

Trelegy Ellipta (fluticasone furoate/umeclidinium bromide/vilanterol trifenatate inhaler 100/62.5/25mcg per dose) is a **Prescription Medicine**. Trelegy Ellipta is indicated for the maintenance treatment of adults with moderate to severe chronic obstructive pulmonary disease (COPD) who require treatment with a long-acting muscarinic receptor antagonist (LAMA) + long-acting beta2-receptor agonist (LABA) + inhaled corticosteroid (ICS) and for the maintenance treatment of asthma in adult patients who are not adequately controlled with a combination of an ICS and a LABA. Trelegy Ellipta should not be used for the initiation of COPD treatment. **Trelegy Ellipta 100/62.5/25mcg is fully funded for COPD only; Special Authority criteria apply.** Patients should not take other LABA or LAMA or ICS while taking Trelegy Ellipta. **Precautions:** Physicians should remain vigilant for the possible development of pneumonia in patients with COPD and re-evaluate treatment if pneumonia occurs. Paradoxical bronchospasm may occur. Use with caution in patients with unstable or life-threatening cardiovascular disease, hepatic impairment, active or quiescent tuberculosis infections of the respiratory tract, systemic fungal, bacterial, viral or parasitic infections, ocular herpes simplex, narrow-angle glaucoma or urinary retention. Before prescribing Trelegy Ellipta, please review the data sheet for information on dosage, contraindications, precautions, interactions and adverse effects. The data sheet is available at www.medsafe.govt.nz.

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Dr. Greg King

Dr. Greg King is a respiratory physician at the Royal North Shore Hospital, The Woolcock Institute of Medical Research and Northern Clinical School, University of Sydney. He has a research and clinical practice interest and focus in asthma, COPD and bronchiolitis obliterans in haematopoietic stem cell transplant. His research involves complex lung function and imaging to measure physiology that is relevant to disease mechanisms and characterisation, to better understand and manage (and maybe one day - cure) airways diseases in the clinic.



Date: Saturday 7 June
Where: Plenary Room, GPCME North
Time: 7.00-7.55 am

What do you think about telehealth?

At this year’s Goodfellow Symposium, roving reporter **Zach Thompson** asked attendees: “How do you feel about telehealth in primary care?”



NP Michael Brenndorfer

Good for follow-ups, not full consultations

Telehealth appointments are beneficial if in-person relationships with patients have been established, says nurse practitioner Michael Brenndorfer. “I often use telehealth as a way of following up treatment [and] to check in on outcomes. I don’t think I’d feel comfortable doing a full assessment [that way].”

Mr Brenndorfer, based at Te Puna Manawa Trust in west Auckland, says he still needs to see patients in person. “So much of an assessment is what you see in front of you,” he says, and providing care over the phone creates a “bigger chance of missing things”.



Specialist GP Liz Harding

Antibiotic prescribing more likely

Phone consultations are “okay for most things”, says specialist GP Liz Harding, but not seeing a patient in person can make her prescribing habits more lenient. “I find that I get a bit more manipulated [by the patient] into prescribing antibiotics far more often than I normally would,” says Dr Harding, who is based at Auckland’s Herne Bay Medical Centre and does a phone consult “every couple of days”. “I don’t feel that the patient gets as thorough a consultation as they would face-to-face, so it’s not my favourite.” Dr Harding would “definitely” like to do either the same number of telehealth consultations or fewer in the next year.



GP registrar Marcel Fernando

In-person consults preferred

Offering patients telehealth is a good thing, but New Plymouth GP registrar Marcel Fernando prefers in-person consultations. “I do some phone calls... sometimes patients can’t come and see you,” says Dr Fernando of Carefirst Moturoa Medical Centre. Although he is happy to provide a virtual consult to patients, his preference for in-person consults means he doesn’t “go looking for telehealth”.



GP registrar Abhi Gotadki

An interim solution to sector woes

Telehealth consultations are helping to make general practice more sustainable for the workforce, says GP registrar Abhi Gotadki. “I moved from [just] face-to-face to having a mix of telehealth to get some experience,” says Dr Gotadki, who does at least a couple of telehealth consults daily. He finds the “balance” particularly useful for working around his daughter’s school hours and reducing the inbox queries he receives. However, while telehealth can make the profession more attractive, he doesn’t see it filling the gap long term. “It’s about getting the right mix of patients that would be clued in with the technology and at the same time, their doctor can safely assess or maybe triage and then direct them. “Eventually, it’s only probably going to be suitable for a certain cohort of patients.”



Specialist GP and urgent-care registrar Amanda Mitchell

Phone consults ‘fantastic’ for students

Phone consults are “fantastic” and should have been part of primary care long ago, says Auckland specialist GP Amanda Mitchell. Virtual consults are particularly helpful for her student patients who have moved cities to attend university. “Some of them have mental health issues, and they don’t want to be explaining all that to another doctor. “[Now they] just phone me. I never could’ve [offered] that once, so I’m a real fan.” Based at Westgate Medical Centre, Dr Mitchell says she expects her telehealth use to remain the same over the next year.



Urgent-care registrar Jonny Wood

Underused in Aotearoa compared to UK

Telehealth is “very good” for patient access when “used appropriately”, says Jonny Wood, a registrar at the Royal New Zealand College of Urgent Care. “I’ve been surprised that there isn’t more of it [in New Zealand] compared to the UK,” says Dr Wood, who emigrated to Aotearoa in 2021. While he hasn’t used telehealth much yet as a doctor, he is very eager to pursue it, he says, based on his own experience as a patient. “When I was in the UK, I used a telehealth GP provider and [had] very positive [experiences].” Telehealth is good for patients with common and easily treatable issues who need timely access, says Dr Wood.



Specialist GP Preetam Durshanapally

‘Absolutely’ aiming for more

“One or two” of Preetam Durshanapally’s consultations are currently done via telehealth daily, he says, and he is “pretty comfortable” seeing patients virtually. But plans to get involved with online medical service CareHQ mean Dr Durshanapally, a specialist GP working across two Health Improvement Group-owned practices in Auckland, will “absolutely” be doing more telehealth over the next year.



Specialist GP Sarah Helagi-Mccarthy

Telehealth ‘fragmenting’ general practice

Moves to establish a greater role for telehealth in primary care are “fragmenting” general practice and contributing to the workforce crisis, says specialist GP Sarah Helagi-Mccarthy. While telehealth services aim to take “the burden off GPs”, an easier solution would be to “just give the GPs more money”, says Dr Helagi-Mccarthy. “They give money to everybody but us and then wonder why all the doctors go over to Australia.” Her concerns about the viability of general practice are not for her career, the Whangārei-based doctor says, but for “young ones starting out”. As for virtual consultations, she says more “administrative stuff”, such as referrals for sickness benefits, are easy enough to do over the phone but “if they’re unwell, I think you need to examine them”.



Specialist GP Tina Dirven

Good for patients unable to travel

Telehealth consults “[work] well for patients who can’t travel”, but examining someone in person is much easier, says specialist GP Tina Dirven. “I do quite a few phone consults, less so video – maybe one a day,” says Dr Dirven of Browns Bay Medical Centre in Auckland. “I think [telehealth] works well if you know the patients [and] you’re certain of their conditions.” For patients with physical afflictions, she says she can “get an idea about their diagnosis straightaway” in clinic, but it is harder over a virtual consult. “Rashes [can be] really hard to see over video.” In the coming year, Dr Dirven expects her telehealth use to remain the same.



Specialist GP Pedram Zawarreja

Good for known patients

“Straightforward” tasks like repeat prescriptions are fine to do via telehealth, but specialist GP Pedram Zawarreja prefers doing these consults for patients he already knows. Even then, if someone has symptoms, an in-person consult is preferred, because “there are limitations [to telehealth]”. “If they’re concerned, I ask them to come to the clinic,” says the Christchurch-based doctor and co-owner of Hornby Medical Centre. Dr Zawarreja anticipates his use of virtual consults to remain the same over the next 12 months.



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[^] Cure defined as HCV RNA below the lower limit of detection at 12 weeks post end-of-treatment (SVR12).² In treatment-naïve patients with chronic hep C GT1-6, SVR12 >99% in mITT and >97% in ITT after 8 weeks of treatment with MAVIRET.⁴

^{*} For treatment-naïve, non-cirrhotic or compensated patients. Some patients will need to take MAVIRET for 12 weeks or 16 weeks.²

MAVIRET is a fully funded treatment for hepatitis C³

GPs and healthcare professionals in the community can prescribe MAVIRET. No special authority required.³ Find information on testing for Hep C and treating Hep C with MAVIRET at abbviepro.com/nz/en.html. Password: Patients1st.



1. Ministry of Health. <https://www.health.govt.nz/publication/national-hepatitis-c-action-plan-aotearoa-new-zealand-mahere-mahi-mo-te-ate-kaka-c> Accessed January 2025. 2. MAVIRET Data Sheet. 3. PHARMAC. Pharmaceutical Schedule. <https://www.pharmac.govt.nz/> 4. Zuckerman E et al. Clinical Gastroenterology and Hepatology 2020;18:2544-2553.

mITT: modified intention to treat. ITT: intention to treat. GT1-6: genotypes 1-6.

MAVIRET is a fully funded prescription medicine on the Pharmaceutical Schedule with an XPHARM distribution arrangement.

MAVIRET® (glecaprevir 100 mg/pibrentasvir 40 mg) tablets. Prescription medicine. Please review full data sheet before prescribing. This is available on request from AbbVie Limited by calling 0800 900 030 or at abbvie/nz-mavi-ds. **INDICATIONS** MAVIRET is indicated for the treatment of adults and adolescents 12 years and older with chronic hepatitis C virus (HCV). **CONTRAINDICATIONS** Hypersensitivity to active substances or excipients; severe hepatic impairment (Child-Pugh C); concomitant use with atazanavir and rifampicin. **PRECAUTIONS** Risk of Hepatitis B virus reactivation; not recommended in patients with moderate hepatic impairment (Child-Pugh B); patients with lactose intolerance; risk of hypoglycaemia in diabetic patients; pregnancy; lactation; safety and efficacy of MAVIRET in patients younger than 12 years of age have not been established. See data sheet for details. **INTERACTIONS** Potential for significant drug interactions requiring dose adjustment of the following medicines administered concomitantly: atorvastatin, carbamazepine, ciclosporin, dabigatran etexilate, darunavir, digoxin, efavirenz, > 20 µg ethinylloestradiol-containing products; lopinavir; lovastatin; pravastatin; ritonavir; rosuvastatin; St John’s wort (Hypericum perforatum); simvastatin; Vitamin K antagonists. See data sheet for details. **ADVERSE EFFECTS** Headache, fatigue, nausea, serum bilirubin elevations. See data sheet for additional information on adverse effects in special populations. **DOSAGE AND ADMINISTRATION** The recommended oral dosage of MAVIRET in adults and adolescents 12 years and older is three glecaprevir/pibrentasvir 100 mg/40 mg tablets (total daily dose: glecaprevir 300 mg and pibrentasvir 120 mg) once daily at the same time with food. See data sheet for additional information on duration of treatment and use in special populations. Version 7. ©2024 AbbVie. All rights reserved. AbbVie® is a registered trademark of AbbVie Inc. MAVIRET® is a registered trademark of AbbVie Manufacturing Management Unlimited Company. AbbVie Limited, PO Box 11437, Manners Street, Wellington 6142, New Zealand. TAPS BG4214. NZ-MAVI-240050. MAV0240. January 2025.

The person shown is a model.

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Alien in your surgery? Put your own mask on first before helping teens

▶ Patrice Dougan

The stage between childhood and adulthood is only second to the first 1000 days of life in importance for healthy development, says Dame Sue Bagshaw, and primary care can have a major impact on helping teenagers find their feet.

Speaking to the Goodfellow Symposium 2025, Dame Sue described herself as “more of a youth worker” these days than a GP, spending most of her time at the Christchurch Youth Hub. She gave a run-down of tips for understanding teenagers and effectively engaging with young people as a GP.

“So, what do we do...Well, first of all, when you have an alien in your surgery, first put your own mask on and then attend to the mask of somebody else,” she says. “Breathe! Acknowledge emotion – really important. And I think the next most important for me is where are they at? So, listen to how they are responding to the questions you are asking.”

Human brains aren’t fully developed until age 25, so children and teenagers are less able to regulate their emotions and respond to stressful situations. In early teenagers, Dame Sue estimated the pre-frontal cortex is likely only functioning about 20 per cent of the time, compared with about 80 or 90 per cent in adults.

“So really important, first rule of thumb with communication – acknowledge emotion,” she says. “Acknowledge emotion, and then you’re introducing logical thought.”

She also advised GPs to be careful of their communication through expressions, as teenagers read faces differently from adults.

“They often see anxiety as anger,” she says. “So, watch your facial expressions when you’re talking to a teenager because they’re reading something, which may not be something you wanted to communicate.”

She recommends taking an authoritative approach.

“I would suggest that if you have a teenager in your surgery, they will see you as a parent type,” she says. An authoritative-style delivery “would be so helpful for them. So, good, clear boundaries, consistent, positive, predictable support and being able to talk about it”.

The teenage years into early adulthood can be a vital stage for healthy development and attachments, leading to positive outcomes in adulthood.

“What I like to think is teenagers have this kind of, if you like, opportunity to be a second attachment,” Dame Sue says. “So, they’ve got really flexible, developing brains, and you can almost be their second attachment if they missed out at the beginning through no fault of their own – and often nobody



Youth health advocate Dame Sue Bagshaw

Essentials

- ◆ Adolescent brains are still developing, making teenagers less able to control emotions and stress.
- ◆ Primary care teams can be a stabilising force in young people’s lives, putting protective factors in place and steering them towards good decision-making and healthy choices.
- ◆ Don’t forget foetal alcohol spectrum disorder when presented with signs of neurodivergence.

else’s fault – then you can give that second chance. And that’s why I think it’s such an important stage in life, that connectedness comes across all the time.”

Looking at the balance of protective and risk factors, she says, it’s often really difficult to alter risk factors, but “we can put in protective factors”. One is having a trusted adult outside of parents who a teenager can talk to about their struggles.

“We can put in helping them to find a group to belong to. We can put in helping them to develop a skill, have opportunities to contribute,” she says.

“The most important person on your team is a youth worker because that’s their job. You can’t do it because you’re busy doing medicines and therapies and all that kind of stuff.

“I would really love it if we had a youth worker in every team.”

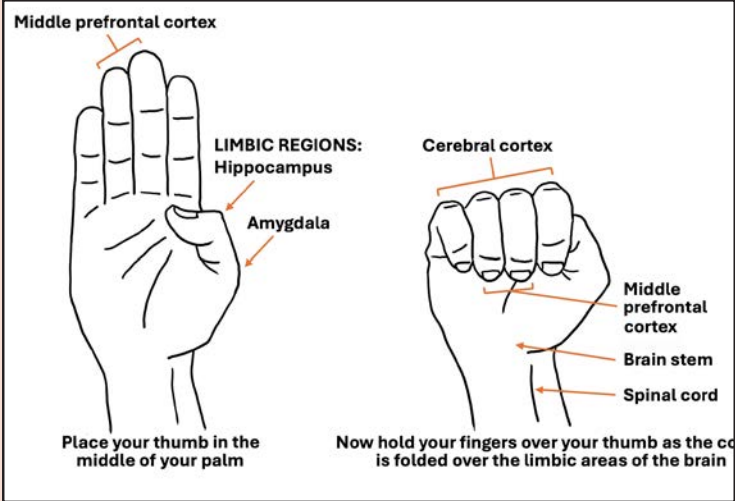
Early intervention is critical, she says, but often, that means getting young people into the clinic in the first place. Creating a youth-friendly environment, trying to make it cheaper or going out to schools can help.

“They’ve been through a lot these aliens, and then they’ve got to go through puberty,” she says, adding:

“[There’s] lots of things happening – physical, sexual...all of those things they have to go through to become an adult. It’s no wonder they’re so tired and can’t get out of bed in the morning. It’s exhausting.” ■

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A guide to teenage brains



The hand model of the brain (Daniel Siegel, 2010)

Emotional regulation. The pre-frontal cortex is still developing during adolescence, which means young people are less able to regulate their emotions and control stress. Acknowledge their feelings and gauge where they’re at. Listen to what they’re saying.

Reward-seeking behaviour. With fewer dopamine receptors, teenagers are more inclined to seek immediate rewards. Reframe “risky behaviours” to “rewards seeking”. Steer young people away from activities that may lead to dependence, such as porn watching, video gaming, alcohol and drugs, so their receptors aren’t geared towards those rewards.

Calming the brain. Lower levels of gamma-aminobutyric acid are common in adolescence. Encourage teenagers to do breathing exercises and use calming techniques to promote GABA production.

Future thinking. Adolescents usually cannot think long-term, so don’t get too far ahead of them when planning care. Dame Sue recommends a time frame of no more than three to four months.

Abstract thinking. This hasn’t fully developed in teenagers, so try to avoid abstract concepts.

Explaining the brain. Dame Sue recommends Daniel Siegel’s “hand model of the brain” to help young people and their parents understand brain development. “[It’s] a really good, incredibly simple tool, I think, to actually help parents to know what to expect and not over-expect things.”

Neurodivergence: Pros and cons of labels

Don’t forget foetal alcohol spectrum disorder when assessing a young person with signs of neurodivergence, says Dame Sue Bagshaw.

It’s really much more common than we think but not very well diagnosed, she says. Diagnostic guidelines, released last year, are a great tool worth looking up.

“Try – if you’re kind of suspicious of neurodivergence in any way – try and ask for prenatal exposure to alcohol. It’s really tricky to ask, but if you can do that, it’s really helpful in terms of diagnosis.”

Dame Sue prefers to treat the symptoms people are struggling with rather than rush to labels. “You don’t want people to live up to their labels, but at the same time, what kind of label do you give them when there’s so much crossover? So, what I try to do is I say, ‘Look, I totally acknowledge all the things you are experiencing. What I would really like to do is not give you a label but actually help you to be the best you can be with all the things you’re experiencing.’

“Having said that, labels are helpful in terms of getting help, especially in education. So, it’s useful to have a label to a certain extent but try not to mislabel it...if you’re not getting the label right, then maybe you’re missing something which you could have been doing which would help better.”

And not forgetting the impact of colonisation and generational trauma and how that might present is also critical, she says. ■

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AI won’t replace clinicians, but ignorance will see you left behind

► **Stephen Forbes**

Medical professionals shouldn't worry about being replaced by artificial intelligence but by being superseded by those who can use the technology better than they can, according to Karl Cole.

AI is transforming healthcare, Dr Cole says, speaking at the Goodfellow Symposium 2025.

The Auckland specialist GP has a special interest in health IT and works at Papatoetoe Family Doctors. He is also a consultant with Spark Health on digital health and artificial intelligence and the clinical director for IT at ProCare.

"I can't keep up and I'm spending 12 hours a week working for Spark Health," he says.

"It's not the time to put your head under the blanket and think it's going to go away. I'll tell you now, this is moving much faster than anyone at Health New Zealand is going to tell you.

"My message would be there's a huge opportunity here. Don't worry about AI replacing you if you can think critically and adjust to it and use these tools the right way. You need to worry about the people who can use AI better than you."

Speaking at the conference, Dr Cole says the birth of AI can be traced to the 1950s. In the 1970s and 1980s, there

Essentials

- ◆ Healthcare professionals need to stay abreast of the latest developments in artificial intelligence.
- ◆ AI is best used to increase your productivity.
- ◆ Most AI tools operate using pattern recognition, not critical thinking and deductive reasoning.

was a lag in its development, but by the 1990s and 2000s, the evolution in machine learning and available data helped drive new growth. From the 2010s to the present, big data has seen a new surge in technology. And since 2020, there has been a noticeable expansion as the potential applications of AI have grown.

Medical professionals can now use AI in healthcare to enhance diagnosis and treatment, medical imaging to detect tumours and fractures, predictive data analysis, and robotic surgery.

Like the dot-com bubble in the US in the late 1990s, there is a lot of hype in the sector and there will be winners and losers in AI, Dr Cole says.

"People can see how much it is going to disrupt and revolutionise our work. If you think about the last 30 years of IT, it's going to happen again at hyper-speed [with AI] in the next five years."

Doctors need to be aware of what is coming next, so they aren't taken by surprise, he says.

"If you are smart you will be using it already to help you be more productive."

An AI tool he uses regularly is the Heidi scribe tool, he says.

"I'm still not confident with it summing up stuff I haven't seen yet. But it saves me a lot of time dictating and proofing later, and it is what I said. And it's a good summary most of the time."

Most AI tools operate using pattern recognition, not the critical thinking and deductive reasoning we associate with real intelligence, he says.

"But people don't realise how much that is going to utterly disrupt medicine."

That impact is felt already in diagnostics and radiology, which rely on pattern recognition.

He talks about an Aktia wearable blood pressure monitor he recently bought for \$400 as an example of how the technology can be used. The wrist-worn, cuffless blood pressure monitor uses optical sensors to send continuous



Auckland specialist GP Karl Cole

blood pressure readings to an app on his phone.

The AI-based monitors have been available in Europe for the past four years, he says.

Such tools can help transform how conditions like cardiovascular disease are treated.

Data is the fuel for AI, and without it, AI can't learn or make accurate predictions, he says. It also improves diagnostics, reduces errors, improves predictive analysis and allows for greater automation to streamline workflows from administrative tasks, like inbox management, to imaging analysis.

There is a global war over control and access to data, which is vital to make AI tools better, he says. And while he concedes there are issues around data security, it comes down to identifying what the problems are and addressing them. AI models are only getting better and are here to stay. ■

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Medical Council working on guidelines for AI use

THE MEDICAL COUNCIL is expected to release new guidelines for using artificial intelligence before the end of the year, according to board member Stephen Child.

A guest speaker at the Goodfellow Symposium 2025, Dr Child works in the department of general medicine at Auckland City Hospital and is the Southern Cross Health Society's chief medical officer.

He is part of a working group that has been drafting the Medical Council regulations on the use of AI in healthcare.

The new guidelines will go out for consultation with the health sector first, Dr Child says, but he expects them to be gazetted by the end of the year.

In his presentation, Dr Child spoke about some potential pitfalls of AI use in the medical world. He also discussed the International Association of Medical Regulatory Authorities (IAMRA) conference, which he attended in Baltimore last September.

Dr Child uses the Heidi AI tool in his private practice but says it's important that health professionals are aware of

the limitations of such technology.

"There's huge hype at the moment; everything is AI, AI, AI," he says.

"There are four rules when you are using artificial intelligence. One, informed consent. The patient should know you are using this as a tool. If it is in any way affecting your practise, then you need to inform the patient," he says.

"Two, privacy of any health information needs to be handled in the usual way. Three, you need to understand the limitations and the biases [of AI]. Four, and most importantly of all, it's a tool, and you are still responsible for its output. Now, those to me are the four golden rules."

There are privacy issues, he says, with some scribe tools storing some of the data offshore and this has been an issue for regulators.

"It's a tricky area, but basically just make sure you stay within the guide rails of your college's guidance and whatever you are using, you are comfortable with the privacy of that, and you've got the endorsement of the official bodies," Dr Child says.

Any doctor who relies solely on an AI tool for a diagnosis is playing with fire,

he says. "So, what am I going to do in the Medical Council if one of you guys makes the wrong diagnosis and your defence is, 'But the AI tool said it was probably reflux'. We are going to get into an interesting conversation."

What he took away from the Baltimore IAMRA conference last year was that the best use of AI in healthcare was pattern recognition, and some professions could be on borrowed time.

"Dermatology, radiology and ophthalmology are potentially in trouble. Because if you are just looking at a picture, it's likely the computer is better."

But people need to remember the vendors behind all the major AI tools are corporates seeking a return on their investment, Dr Child says.

"Where are they going to get the best return on their investment? Not false negatives...So they have to set these tests, so they never miss a disease, which means they are going to generate a 'shitload' of false positives, and the false positives are going to generate more business, so they don't care," he says.

"But we care because we're doctors, and we've sworn a code of ethics to care

Essentials

- ◆ The Medical Council is expected to release guidelines for using AI before the end of the year.
- ◆ Board member Stephen Child highlighted his four golden rules for AI use – informed consent, privacy, understand AI limitations, remember you are still responsible for the output.
- ◆ Some medical jobs are potentially at risk from AI.

for our patients."

False-positive results are a problem for vulnerable patients and health professionals alike, he says.

"They are a major problem for the professionalism and the sustainability of our profession, but they are built into the AI systems we are being shown." ■

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*Clear or almost clear skin was achieved in 55% of Psoriasis patients at Week 4⁵

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Third clinic opens for Pacific provider amid growing demand

► Alan Perrott

South Auckland-based Pasefika Medical Family Group has opened its third practice, aiming to reach a target of 10,000 enrolled patients by the end of the year. “That’s the wish,” says PMFG chief executive Galumalemana Vai Naseri. Health minister Simeon Brown opened King Street Medical Centre at 32 King Street in Papatoetoe, Auckland, on 15 March. The new practice joins PMFG’s Weymouth Medical Centre and the Panmure Medical Centre, which have about 3500 and 3700 enrolled patients, respectively.

PMFG operated as Health Star Pacific Trust until April 2021, when it was taken over by the group’s four-strong senior leadership team: Ms Naseri, chief financial officer Roshni Devi, chair Richard Johnston and clinical director Qusai Ali.

Ms Naseri says the expansion was a response to growing patient demand and limited space at the Weymouth Clinic.

The King Street practice will be staffed by two part-time GPs job-sharing with the other two sites until patient enrolments can support the recruitment of new clinicians, she says. The practice aims to reach 3000 enrolments by the end of the year.

Marketing is based on social media and a leaflet drop, Ms Naseri says, but

PMFG is also looking to restart a radio show focusing on health messages it previously delivered via Radio 531PI and Nui FM.

Besides GP appointments, the clinic will offer services such as minor surgery and diabetes screening.

Patients also get access to the social services offered by the group and through its PHO, National Hauora Coalition, including Mana Kidz, the AWHI Healthy Homes Initiative and the AWHI Ora programme provided by Tū Whakaruruhau.

Patients enrolled with PMFG can access appointments and services at any of the three clinics.

National Hauora Coalition chief executive Rachel Brown (Te Atiawa, Ngāti Mutunga ki Wharekauri, Kāi Tahu, Tuahiwi, Kāti Māmoe) says the PHO’s collaboration with the Pacific provider is about supporting equity and wellbeing while the group’s holistic approach to care has created strong community connections.

PMFG is now providing healthcare at nine schools across south Auckland, Ms Brown says.

NHC relationship lead AWHI Healthy Homes Initiative Evita Toala says the group provides language-appropriate support to families within the programme, which provides resources such as curtains and heaters.

This connection has seen 200 referrals passed on to the AWHI Healthy Homes Initiative, with more than



Attending the opening of the new King Street Medical Centre in Papatoetoe are Pasefika Family Health Group chief executive Galumalemana Vai Naseri, tamariki ora lead Louise Roberts and pou hononga relationship lead AWHI Healthy Homes Initiative Evita Toala

100 being homeowners, Ms Toala says.

While aligned with kaupapa Māori PHO, National Hauora Coalition, PMFG is also part of the Pacific Collective of practices, which became a significant player in the COVID-19 response.

Providers continue to collaborate on events, even as they compete for patients: “When we are invited to take part in an event in west Auckland,” says Ms Naseri, “we just go, even though we don’t have GPs out there. But if someone tells us they don’t have a GP, we tell them to go somewhere like The Fono.”

PMFG also chose the King Street site because it is not too close to other Pacific providers, she says.

Mr Brown, Health New Zealand Te Whatu Ora chief clinical officer Richard Sullivan, and several senior Pacific clinicians and healthcare leaders attended the opening on 15 March.

“We felt so privileged that [the minister] made the time available to be with us,” says Ms Naseri. She says Mr Brown spoke generally about primary care but did talk about prioritising diabetes diagnosis, treatment and prevention. ■ aperrott@nzdoctor.co.nz

Hospice funding gap despite rising demand

► Chris Valli

HOSPICE MARLBOROUGH is helping more people than ever, but a growing funding gap is posing a challenge, according to a new report.

The report by consultancy firm Martin Jenkins concluded that in the absence of government intervention, beds will soon close, referrals for space will have to be prioritised and care via telehealth will need to be widespread.

Five hospices commissioned the report on behalf of the 28 publicly contracted entities.

Hospice Marlborough is not one of those five hospices, says chief executive Carole Crawford. However, she says government funding to date has ranged from 50 per cent to 64 per cent of what is needed to maintain its 24/7 services to Marlborough. The hospice must fundraise between \$880,000 and \$1 million annually to maintain current services.

The report found hospices are increasingly short of cash and soon will not be able to raise enough money to

meet the demands required of them. Due to growing demand and rising costs, total expenditure would exceed revenues from government and community sources in less than 12 months.

Last year, it cost \$226 million to run hospice services nationwide but the Government provided \$114 million.

“We stand by our vision that our Marlborough community has equitable access to specialist palliative care and can live and die with compassion, dignity, in comfort and in peace”

Hospices raised \$112 million from community donations, fundraising and other sources to break even.

“Providing highly skilled specialist medical and clinical staff to serve our community is expensive but we stand by our vision that our Marlborough community has equitable access to specialist palliative care and can live and die with compassion, dignity, in

comfort and in peace, in their place of choice,” Mrs Crawford says.

“We strive to meet the needs of our community by working with patients, whānau and our partners. We know that Marlborough’s population will continue to grow, especially in the older age groups, as it continues to be a popular

four beds in its inpatient unit for those that need it, while its specialist palliative care services are now mostly provided where patients live and choose to be.

“Our community contacts in February 2025 were double that of the previous year – 402 compared to 271 – this being a deliberate change to our model of care in order to support the growing number of people in Marlborough with life-limiting illness,” she says.

Hospice New Zealand chief executive Wayne Naylor says the population is set to continue rising, adding there was an expected increase of 50 per cent in people who would benefit from hospice care in the next 20 years.

“We’ve known that for quite some time, and our government has not responded,” Mr Naylor says.

Hospice Marlborough will continue to work with the hospice network to secure what their services need to be for the community now and in the future, Mrs Crawford says. ■

Chris Valli is a Marlborough-based journalist

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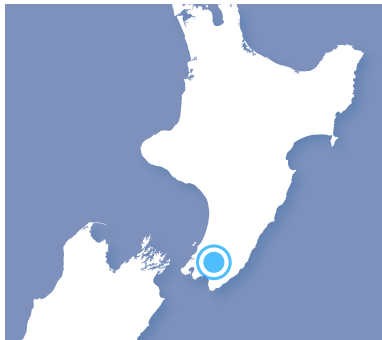
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Stronger together: South Wairarapa partnership ‘godsend’ for local practices

A long-discussed partnership of practices in South Wairarapa has finally become a reality. **Zahra Shahtahmasebi** finds that bigger can be better



The South Wairarapa Practice Partnership has brought a 20-year-old discussion to life, uniting the general practices of Greytown, Featherston and Martinborough. At the end of June 2024, the merger was finalised, with the newly formed entity – the SWPP for short – now owned by Latitude Health, the commercial subsidiary of Tū Ora Compass Health.

“It’s a fully amalgamated entity and it’s a mouthful,” laughs Tū Ora Compass Health deputy chief executive officer and Latitude Health director Mabli Jones. “It’s my fault – the name should be something way better,” Ms Jones says.

But name aside, nine months on, the partnership has been great for the region, adds Featherston Medical Centre specialist GP and SWPP clinical director Harsha Dias.

“It always seemed to be a sensible option to have a bigger practice, a bigger population base. It’s good for the use of resources and would be better for recruitment.”

The pedigree

All three practices have been long-standing in their respective communities, seeing generations of Wairarapa locals.

Seven years ago, Latitude Health bought Greytown Medical Centre from its retiring GP owners. In 2021, the practice moved into the newly built Five Rivers Medical Centre, housing general practice and other allied health services, including lab, ultrasound, DEXA scanners and physio.

After Latitude Health started to explore what a merger might look like between Greytown, Featherston and Martinborough, the SWPP came to be: a limited liability partnership fully owned by Latitude Health, with the aim that staff from the three practices will buy in and eventually take over.

Martinborough Medical Centre specialist GP and SWPP clinical lead Steve Philip says the idea to amalgamate has been talked about since he started at the practice as a locum 20 years ago.

At the time, Martinborough worked with Greytown and Masterton Medical

South Wairarapa Practice Partnership (the SWPP)

◆ **Location:** Featherston Medical Centre, 14 Wakefield Street, Featherston; Greytown Medical Centre, 30 Bidwills Cutting Road, Greytown; Martinborough Medical Centre, 5 Oxford Street, Martinborough

◆ **PHO:** Tū Ora Compass Health

◆ **Staff:** 10 GPs, three nurse practitioners, 14 registered nurses, 17 administrators, three health care assistants and one emergency care paramedic

◆ **Owner:** Latitude Health

◆ **Enrolled patients:** 12,500 across three practices

◆ **Funding:** Capitation, rural funding, patient co-payments, ACC

Centres but that slowly filtered back to each operating individually. Further attempts to merge failed due to funding, resourcing and infrastructure challenges.

“We always wanted to be part of a bigger system...We got to that point about three times before but never quite finished it,” says Dr Philip.

But having Latitude come on board and buy the practices was a big help, he adds.

“It’s working well...with staff recruitment right across the board, services offered and extra training facilities which we’re doing with registrars and nurses. It’s a good system to be part of a bigger group. We were too small just Martinborough by itself, let alone the other two practices.”

Dr Dias, who has been at Featherston Medical Centre for the past 11 years, bought the practice from GP Mike Berry in 2015 before selling up to Latitude Health for the merger last year.

“There’s a lot to contend with, with any amalgamation like this...but now we’ve probably got a much more robust system, and we are heading into trying to achieve better aims for our community,” says Dr Dias.

By country standards, the three practices are next door to each other, all within 10 to 15 minutes’ drive and they all do “their own thing”, he adds.

Each practice across the Wairarapa takes one evening per week to provide in-person after-hours care from 5pm to



The South Wairarapa Practice Partnership, in which three general practices have come together into one amalgamated entity, has greatly impacted its community in just nine months. Back row: Neill Carson SWPP business manager, Elwyn Eastlake SWPP board chair, Harsha Dias clinical director, Pip Maynard Martinborough board member. Front row: Cara Ruscoe nurse practitioner, Liz Mellish Featherston board member, Steve Philip clinical lead, Justine Thorpe board member and Tū Ora Compass CEO

7pm, with Featherston taking Mondays, Greytown Wednesdays, and Martinborough Thursdays. Carterton Medical Centre takes Tuesdays.

Martinborough is also a PRIME practice with an extended care paramedic on board, which helps deal with acute demand, whereas Greytown provides remote and school-based clinics. All three practices open from 8am to 5pm.

Virtual care is provided through Practice Plus. On Fridays, weekends and public holidays, patients can attend Wairarapa After Hours Service, based at Masterton Medical Centre, which is next door to the Wairarapa Hospital.

The patients

Next on the list is scaling up to serve the growing population in the Wairarapa better, explains Ms Jones. The enrolled population at the SWPP is currently at 12,500, and because of the merger, the practices have been able to reopen their books.

Of the three, Greytown Medical still has plenty of space to take on more patients, and being housed inside a bigger centre means it has room to expand and be used differently.

For continuity of care, enrolled patients are encouraged to see their registered provider, but the merger has

allowed the practices to be more fluid – GPs from Featherston can now do sessions at Greytown and vice versa, says SWPP business manager Neill Carson.

From the community, the feedback has been positive, with long-standing challenges like the lack of GPs in Greytown being nipped in the bud from the get-go, Mr Carson adds.

It’s excellent to know that the community has a backup, Martinborough Medical nurse practitioner Cara Ruscoe says. If Martinborough is full and unable to provide appointments, patients can go to Greytown if an urgent slot is available. “Today, the paramedic was off sick. We were able to move patients and direct them elsewhere – otherwise, we would’ve had to rebook,” Ms Ruscoe says.

Rural practices see a lot of trauma cases and are often the first port of call following a farm accident, Dr Dias says. There’s a high Māori population, and Greytown and Martinborough have more older patients. There are generations of the same family who have always lived in the area, and this has always been their doctors, says Ms Ruscoe.

There’s a huge range regarding who comes through the door on any given day, says Dr Dias.

“We see an enormous variety right across the spectrum, and that’s one of the great things about practising in this

environment: one minute you’ve got someone chainsawing their leg, and the next minute you’re seeing a baby.”

The Wairarapa region is large and sparsely populated, which makes access to healthcare hard – the local hospital is a 30-to-40-minute drive away from each of the small towns, which means the practices often deal with a lot of complex cases, says Mr Carson.

“In rural general practice, you’ve got to deal with whatever comes in because the hospital is too far away from people. So, sometimes, you’re managing stuff that maybe in a city practice, you would refer off.”

Virtual or telehealth care is also not always suitable for everyone, depending on connectivity or the case the patient is presenting with.

But the SWPP continues to impact clinicians and patients alike significantly, says Ms Jones. “We have a good foundation but bringing it together has made it way stronger.”

The people

With Greytown struggling to recruit a permanent GP for at least a year before the merger, the SWPP has opened the doors for improved support across the three practices.

“Our real pain point was no GPs at

Greytown for quite some time, and actually, the merger has brought GPs there for the first time in a year or so,” says Ms Jones.

In general, the partnership has improved staffing and resource issues across the board, adds Mr Carson.

“We’ve had those natural challenges that have happened across all of the practices and just knowing that we’ve got this bigger, wider team and we’re not going to have to solve it alone. We’ve been able to move staff as and when the needs have arisen,” Mr Carson says.

Across the three practices, the team includes 10 GPs, three NPs, 14 registered nurses, 17 administrators, three health care assistants and one emergency care paramedic.

The nursing team have been a huge strength to the team, Dr Dias says. “They do a lot of things that they probably wouldn’t get to do in a city practice, and we are highly reliant on them.”

A bigger team is more attractive to job hunters, Ms Jones adds, helping to boost the recruitment and retention of clinical staff in the rural Wairarapa area. The region has been at the forefront of developing the NP role, with one at Martinborough and two at Greytown, who have greatly added to the service over the years, says Ms Jones.

“They are prescribing; they carry their own list of patients, but they will

be the first to say that actually working alongside GPs is a huge value-add for them. When we’ve seen nurse practitioners working by themselves at Greytown, it has been a real struggle. But having GPs to work alongside them is huge.”

The broad range of experiences available across the three practices has created a great training environment for GP registrars. Creating valuable teaching opportunities and growing a pipeline of new GPs has been a big focus point, says Dr Dias. He hopes this will eventually include more scope for training NPs, nurses and reception staff.

Featherston has also been successful in recruiting overseas doctors, from Sri Lanka in particular, says Ms Jones. “One comes and has a positive experience and then feeds that to colleagues back home.”

Setting up the SWPP has resulted in substantial changes for staff – while everyone can see the benefit, both for themselves and the community – it hasn’t been without challenges, says Mr Carson.

“Changing [practice management systems] for any practice is probably one of the biggest things you can do and we’re still in the throes of that and working through those teething issues.”

The SWPP is also not immune to the challenges facing primary care across the country, he adds. “We’re still at the frontline, trying to wade through some of those challenges, especially funding. The positive thing has been the resilience, but it’s worth acknowledging that it is a difficult field.”

Ms Ruscoe says that each practice has its own culture, so merging those aspects takes time, but the way everyone has worked together has helped the teams feel more cohesive.

From the beginning, the SWPP had the involvement and support of the region, with an advisory board including local representatives who gave insight into what the community was thinking, providing feedback and answering questions along the way. It has been a real highlight for Ms Jones.

“You can never underestimate how that smoothed the way for us...They were able to answer those questions and they’ve been real champions of the endeavour.”

For Dr Philip, activating the merger has been a godsend.

“From the point of view that I can actually re-look at what I am doing. Staff have been able to sit down and say, ‘What do I want for the future? How do I want to work?’

“And that’s the exciting thing about merging together and how we can actually plan the services for our community.” ■

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Zahra Shahtahmasebi is an Auckland journalist

PHO gag order

A retired accountant was gagged from speaking further on a report he compiled on the finances of seven PHOs.

On 28 March, lawyers for the Auckland-based PHO and network ProCare sent Murray Lilley a “cease and desist” letter, asking he no longer discuss the report with media or share it, stating the report contained incorrect and misleading information about ProCare Networks Ltd and its charity structure, and makes incorrect inferences or claims about its use of government funding.

In February, Mr Lilley sent an email to health minister Simeon Brown attaching his report that collated details from PHO annual reports and other sources. In the last week of March the accountant, who founded the insurance/general practice data sharing system Konnect, was interviewed by RNZ on the report.

New Zealand Doctor Rata Aotearoa had received a copy of the report from a reader and decided not to publish due to gaps in data and concerns over some data interpretations.

However, Mr Lilley’s concerns, expressed in the report and in an interview with *New Zealand Doctor*, over the absence of national standardised reporting of PHO finances leading to poor transparency, reflects the occasional experience of *New Zealand Doctor* reporters in covering PHO and network annual reports.

Mr Lilley noted, for example, that some PHOs bundle capitation and other government funding into a single revenue total while other PHOs do not report capitation funding as revenue.

When *New Zealand Doctor* spoke to him, before he had received the letter from ProCare’s lawyers, Mr Lilley said he had not released or published the report, which he had prepared on his own behalf, beyond sending it to the minister’s office. He did not know how the report got into wider circulation.

Cuts halted

Workforce restructuring and redundancies in some parts of Health New Zealand Te Whatu Ora has been halted by an agreement with the PSA union.

PSA litigation has consequently been withdrawn, although litigation on other parts of the agency’s workforce is still heading for a hearing at the Employment Relations Authority.

An agreement was reached on three change proposals following cost savings from operational efficiencies and staffing reductions, including voluntary redundancies, interim chief human resources officer, Fiona McCarthy, says in a media release.

The agreement has halted changes for the National Public Health Service, and the data analytics section of the Planning, Funding and Outcomes group, as well as the community mental health services, funding and investment section of Planning, Funding and Outcomes. ■

Patience pays off for patients – and staff – of Dunedin practice

► **Zach Thompson**

After years of wanting a larger space, Dunedin North Medical Centre has finally found a home to meet the needs of staff and its 7000-odd patients, says specialist GP Daniel Pettigrew.

The vision for a bigger practice space has existed for about a decade and a half, says Dr Pettigrew.

However, several “false starts” delayed the move, especially when securing suitable real estate was challenging due to the University of Otago’s ongoing expansion in the area.

A few years ago, the opportunity came knocking when the medical centre was approached by a potential landlord intending to develop a section, Dr Pettigrew says. With land scarce and development costs only getting higher, working with the landlord took much of the business risk out of the equation.

Now, just 200m from its previous location, Dunedin North has a new purpose-built facility with a modern, spacious environment – one that has already made a tangible difference.

“It’s been very transformative for our practice...and it seems all our patients are very happy with it as well.

“We’ve gone from having not enough space to do all the things we wanted to do to an excess of space. It’s a nice problem to have.”



Dunedin North Medical Centre celebrated the opening of its new premises on 27 January. Specialist GPs Tim Bolter, Victoria Taylor (with her two daughters), Marie Neylon, Craig Pelvin and Daniel Pettigrew

More room means more possibilities. The team plans to use the additional space, which includes an extra five consulting rooms (from seven to 12), for special interest fields, such as gynaecological and exercise medicine, says Dr Pettigrew, who also works one day a week at central Dunedin’s Servants

Medical Centre and sits on its board of trustees. Training has also been a long-standing desire, and the move has enabled Dunedin North to take on one GPEP1 and one GPEP2 registrar. Ideally the practice hopes to expand its current roster of 12 part-time GPs

– equating to six full-time positions – and six nurses. The long-awaited move was celebrated on 27 January with close to 50 guests – including suppliers, former staff and representatives from the practice’s PHO, WellSouth Primary Health Network. ■ zthompson@nzdoctor.co.nz

New Greymouth clinic for Poutini Waiora

► **Patrice Dougan**

KAUPAPA MĀORI HEALTH and social services provider Poutini Waiora is expanding in Greymouth with a new purpose-built facility to meet what it says is growing demand for holistic health services on the West Coast.

The new \$3.2 million facility will be built at 62 Shakespeare Street, Greymouth, on Poutini Waiora’s current site.

Poutini Ngāi Tahu owns the land and will invest in the build. Chief executive of its investment arm, Pokeka Poutini Ngāi Tahu, Lisa Tumahai, says the building will be a safe place for whānau Māori and the whole community to seek support.

“We’re pleased to offer our communities more and deliver the services they deserve,” Mrs Tumahai (Ngāti Tahu, Tainui, Ngāti Hikairo, Ngāti Kahungunu) says in a media release. “Our kaimahi are non-judgmental, ensuring that whānau always come first.”

Since 2019, Poutini Waiora has expanded its team from 22 to 45 kaimahi, operating from three clinics in Hokitika, Greymouth and Westport.



An artist’s impression of the new Poutini Waiora building in Greymouth, due to begin construction this month

Services include primary healthcare, mental health support, disability services, traditional Māori healing and mobile outreach immunisation services. “Our new facility will have dedicated whānau rooms, clinics and expanded office space to accommodate our growing team and the increasing need for our services,” Mrs Tumahai says. “During winter, we saw an increase in

the number of whānau seeking support for their mental health. Whānau are facing challenges, and the standard health system does not work for all.” Six kaimahi dedicated to mental health and addiction services will be based at the Shakespeare Street facility. The development follows a \$650,000 investment in new Poutini Waiora premises in Westport, announced last

August, and the \$300,000 refurbishment of office premises in Hokitika. The original building has been demolished and the construction programme is being finalised, with the foundations and floor slab scheduled for completion by early July. Kaimahi will work from temporary offices until the new building is complete. ■ pdougan@nzdoctor.co.nz



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Maia help you? AI in primary care

As artificial intelligence gains ground in various workplaces, the array of new software can be confusing. In the first in a series looking at AI tools in general practice, deputy editor **Patrice Dougan** dives into the different programs, so you don't have to

What is it?

Maia (Medical AI Assistant) is an artificial intelligence function on the shared electronic record system Conporto, sitting on its app bar. New Zealand-based and operated, Conporto is owned by Group Healthcare, which operates the reCare and reScript software. Its shared electronic network has access to patient information from primary care, five hospitals, and national records like the Aotearoa Immunisation Register and the New Zealand ePrescription Service. Conporto is in about 680 general practices and 1011 pharmacies in New Zealand, and Maia, which launched in January, is currently being used by about 1500 sites weekly.

What does it cost?

General practices gain complimentary access to Conporto and its features (including Maia, a dictation tool, and a telehealth video tool), when they sign up to be part of the record-sharing network.

What does it do?

Maia works as a clinical decision support tool, which Group Healthcare director and pharmacist Grant Bai describes as “hellishly accurate”. It can generate a fully anonymised encrypted case study using the real-time data Conporto pulls from its network. It can be used to highlight trends, flag missing tests, highlight potential adverse medicine reactions and suggest clinical pathways to manage health risks proactively.

Essentials

- ◆ Maia is a clinical decision support tool within Conporto's shared electronic health record system.
- ◆ Maia generates anonymised case studies, identifies trends, flags missing tests and highlights potential adverse medicine interactions to help clinicians manage patient care more effectively.
- ◆ The tool undergoes continuous audits, ethical reviews and strict oversight to prevent unauthorised access and minimise biases in its AI-driven insights.

Strengths?

Maia's strengths lie in its robust security features, with continuous oversight through audits and ethical reviews, says Mr Bai. “We have a multi-disciplinary committee that can monitor compliance and handle emerging concerns.” Everything is scrutinised, including unauthorised access to patient records, which will automatically be flagged and blocked. The company runs monthly audits, ethical reviews, and a continual refinement process to ensure there are no in-built biases or inaccuracies in the AI. Ongoing patient consent is required at every stage. Maia operates separately from the Conporto system to ensure patient confidentiality and data security. The data used for Maia is not stored anywhere, and that data isn't monetised either, he says. “But I think that probably the biggest thing compared to anyone else that I'm



Grant Bai, director of Group Healthcare, which has launched Maia through its Conporto platform

aware of is the anonymised case study generation...it analyses trends, gaps, suggests clinical pathways.” Maia's programming ensures it goes through a three-step process to land on its final case study summary, so it strips away unnecessary information. A process Mr Bai describes as “a bit like a consult”. Group Healthcare has recently been certified as ISO/IEC 42001:2023 compliant for Maia – an international standard for responsible maintenance and improvement of AI – one of only two New Zealand companies to do so, according to Mr Bai.

Urgent-care doctor Sarah Hartnell es-

“I think the biggest weakness with AI in healthcare is that people will be afraid to use it”

GRANT BAI

timates she has used Maia weekly since its launch and describes it as a useful tool that “allows a kind of snapshot”. As a clinician seeing patients unknown to her, Dr Hartnell says the ability to generate a quick and succinct summary of their medical history saves time and highlights the essential information she needs to do her job. The tool also provides insights into

potential care coordination needs and specific management recommendations for conditions, she says.

Weaknesses?

In trying to find someone who has used Maia to speak to for this article, *New Zealand Doctor Rata Aotearoa* came across a weakness – brand awareness. Mr Bai says the company soft-launched it in January and hasn't done any marketing for the product. And because it sits within a practice's PMS, many health professionals may be unaware it's a separate product. Dr Hartnell says that in her experience, Maia “sometimes goes down the garden path”, and for a while, was fixated on previous COVID-19 infections. That is happening less frequently now, she says.

“It should always be used as an additional tool, but you're not going to hang your hat on everything,” she says. “You're going to verify; you're not just going to take that as read and action everything from it.” In general, Mr Bai says: “I think the biggest weakness with AI in healthcare is that people will be afraid to use it. But the reality is these are tools to help the GP make positive decisions for the health of the patient. You don't have to take the [Maia] recommendation in any way, shape or form, but it just helps to shape your thinking and make sure you don't miss something.” He's keen to point out it's not a diagnostic tool and is not designed to replace a GP. “The best healthcare is delivered face-to-face... you're never going to get away from that.”

Key competitors

Intellitek Health ■ pdougan@nzdoctor.co.nz Disclaimer: Maia is a product of Group Healthcare, owner of The Health Media, publisher of New Zealand Doctor Rata Aotearoa

Dashboard provides window on primary care data

GREATER INSIGHT INTO the work of primary care will be delivered by a national primary care dashboard. The dashboard features were outlined to delegates at a recent Collaborative Aotearoa conference by General Practice NZ head of strategy and engagement data and digital Amanda Webb and Tū Ora Compass Health chief information officer Matt Lord. Ms Webb was keen to ensure delegates understood the dashboard is not a data repository, but a visualisation tool to provide an accurate national view of the primary healthcare system and is still in its early stages. The now live dashboard, which sits on a DataCraft Analytics Thalamus

platform, arose following a request last July from Health New Zealand Te Whatu Ora. Work is still being done on “The data provided is accurate and facilitates system-wide conversations quickly” MATT LORD Māori data governance, Ms Webb says, and is taking time as it needs to be done with authenticity. The 13 PHOs taking part are

Auckland PHO, Comprehensive Care, Cosine, East Health Trust, Eastern Bay Primary Health Alliance, Health Hawke's Bay, Mahitahi Hauora, Pinnacle, ProCare, The Cause Collective, Total Healthcare, Western Bay of Plenty PHO and Tū Ora Compass. With THINK Hauora and Te Awakairangi Health Network soon to join, that's 83 per cent of North Island PHOs bringing together the aggregated data of 3.197 million enrolled patients. The dashboard allows a user to delve into PHO data. For example, on closer inspection, two PHOs of comparable size and age profile – Comprehensive Care and Health Hawke's Bay – show significant differences when filters are

applied for ethnicity and deprivation. The benefits of the dashboard for PHOs are the ability to benchmark and identify health improvements and where these can be replicated, Mr Lord says. It will save time and effort and the need for external consultants to rework PHO data that, previously, PHOs were not providing consistently. The data provided is accurate and facilitates system-wide conversations quickly. Until now, he says, “all the agencies were coming to us for data, but we were all providing it in different ways”. The dashboard is for use by PHOs rather than general practice level. ■ editor@nzdoctor.co.nz

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Pegasus Health Group back in black, spends on share of practice

► **Fiona Cassie**

The Pegasus Health Group is back in the black with a \$2.2 million surplus, the 2024 annual report for the PHO and its wider network shows.

The previous year, the group reported a \$4 million deficit after absorbing a large bottom-line loss in its half-share of telehealth provider Whakarongorau Aotearoa. But in 2023/24, both the wider group, that has shares in a number of subsidiary services, and the parent company Pegasus Health (Charitable) Ltd reported surpluses alongside an increase in operating revenue to \$66.5 million from \$56 million the previous year.

Pegasus Health chief executive Kim Sinclair-Morris and board chair Barry Bragg say in the annual report that the network is a “strong contributor” to its population being 16 per cent less likely to end up in emergency departments than other similar-sized districts.

The “staffing challenges” it had to address in the network-owned 24 Hour Surgery were acknowledged by the pair, who say thanks to close collaboration with health partners and successful nurse recruitment, the urgent clinic was now back to 24/7 operations. Attendances for the 24 Hour Surgery were down from 90,000 to 77,700 in 2024.

There was a 3.4 per cent decrease in general practice consultations from 1.96 million to 1.89 million, while patient experience surveys showed 80 per cent reporting they could access GP/nurse care when needed in the previous 12 months.

“The “staffing challenges” it had to address in the network-owned 24 Hour Surgery were acknowledged by the pair”

The percentage of two-year-olds fully immunised was also down, from 91 per cent to 86 per cent and the percentage of children receiving B4 School Checks was also down, from 94 per cent to 91 per cent, but it was above the 90 per cent target.

The chair and CEO say the network’s purchase last year of a half-share in the “well-aligned, high performing” Lincoln Medical Centre practice, in a joint venture with the business arms of two Ngāi Tahu rūnanga, supported its “commitment to sustaining general practice in Waitaha”.

Financial statements show Pegasus

in late 2023 invested \$2.8 million in its half-share of the joint venture Te Whata Ltd, a registered charitable company, that was set up to buy the 10-doctor and nurse practice, the first general practice co-owned by the network. Pegasus’ half-share of Te Whata Ltd’s surplus in 2023/24 was \$154,000, the financial statements show.

Also reported in the annual accounts is the \$599,043 purchase of Christchurch occupational health business OH Well Limited in December 2023.

Whakarongorau Aotearoa, the national telehealth provider that Pegasus is a 50/50 co-owner of with ProCare, made a deficit for the second year running after making large surpluses during the pandemic, the financial statements show.

Pegasus’ share of the deficit in 2023/24 was \$472,000 – down from \$1.14 million the previous year. Pegasus also reported small deficits for its shares in two other co-owned services – a \$12,000 loss for its now 16.7 per cent share in telehealth provider Practice Plus and a \$17,000 loss for its half-share in shared electronic health record HealthOne.

The group’s Special Purpose Financial Statements, for its PHO function, shows its liability for unspent contract funding paid in advance had risen from \$2.8 million in 2023 to \$5.3 million in

Pegasus Health

- ◆ **General practices:** 97
- ◆ **Enrolled patients:** 488,748
- ◆ **Total revenue:** \$66.5 million*
- ◆ **Total surplus:** \$2.2 million
- ◆ **Total equity:** \$30.5 million

*Pegasus Health accounting policy is to not report capitation funding as revenue. In 2024 it reported just under \$160 million in “pass-through” funding from Health New Zealand Te Whatu Ora, ACC and MSD to general practices and other providers.

Source: Pegasus Health Annual Report 2024 and Pegasus Health (Charitable) Ltd Financial Statements 2024

2024. The largest proportion of that was \$4.1 million for service contracts it holds with Health New Zealand Te Whatu Ora. ■

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D Copies of **Pegasus Health Annual Report 2024 and Pegasus Health (Charitable) Ltd Financial Statements 2024** can be found at nzdoctor.co.nz in Document Archive under Vault

‘Pretty good year’ for Comprehensive Care

► **Stephen Forbes**

COMPREHENSIVE CARE IS back in the black after an improved performance in 2024, with chief executive Jacqueline Schmidt-Busby describing the year as “pretty good”.

The PHO posted a \$198,085 surplus for 2023/24, a significant turnaround from the \$755,933 deficit recorded the previous year (a 126.2 per cent improvement). Total revenue fell 3.9 per cent to \$63.02 million, but total equity rose 22.6 per cent to \$107 million.

Dr Schmidt-Busby says she wasn’t too concerned about the deficit posted in 2023 and had expected the organisation to bounce back in 2024.

“So, it’s been a pretty good year,” she says.

The PHO’s role as an intermediary between the Government and general practices comes with responsibilities, she says.

“We’re the funding and planning mechanism for the practices, and every dollar we receive, we need to account for,” she says.

“If it’s not leading to good health outcomes, we don’t do it.”

In 2024, Comprehensive Care distributed \$50.9 million in capitation-related service funding, down from \$54.7 million in 2023.

Most PHOs were “hammered” when COVID-19-related health funding ended last year, she says.

But Comprehensive Care understood the money was temporary, so it focused on understanding the true costs and overheads involved, ensuring it could return to business as usual when the funding dried up. One of its important projects in 2024 was investing in upgrading its data and digital infrastructure.

“We created a new insights portal so every day our practices can see their data from the day before.” That also feeds into the population health data the PHO needs to target programmes and assistance better, she says.

But while the PHO’s financials for 2024 were mainly positive, some practices in the network are still under pressure.

“These are tough times,” says Dr Schmidt-Busby. “And it’s hard when you have to say to practices, ‘We’d like to help you, but our hands are tied.’” she says.

“Some of them might have closed books,

but they are doing the best they can.”

The primary care sector has been in a constant state of flux, she says.

“It’s really hard because you’ve constantly got new legislation and policies coming out and then the reality of what the practices are operating under.”

In a statement accompanying the 2024 annual report, chair Lynne Coleman says: “The increasing pressures on primary healthcare cannot be overstated; we find ourselves at a critical juncture, where our health system is in dire need of strong leadership and visionary thinking.

“The sustainability of general practice is critically threatened, exacerbated by the ongoing challenges in capitation funding and rising operating costs.

“Practices have had to reduce services, scale back operating hours and, in some extreme cases, close entirely. This situation is not only financially concerning but also highlights a workforce issue we cannot ignore.”

Dr Coleman says the PHO’s “modest profit” for 2024 is nevertheless a significant improvement over 2023.

“This results from prudent spending and strategic investment of our

Comprehensive Care

- ◆ **General practices:** 39
- ◆ **Enrolled patients:** 183,340
- ◆ **Total revenue:** \$63,016,074
- ◆ **Total surplus:** \$198,085
- ◆ **Total equity:** \$1,073,821

Source: Comprehensive Care Annual Report 2024

resources. Additionally, our educational programmes have gained traction, generating a return on investment – particularly in youth mental health initiatives...” ■

sforbes@nzdoctor.co.nz

D A copy of the **Comprehensive Care Annual Report 2024** can be found at nzdoctor.co.nz in Document Archive under Vault or simply use the Search function

Keeping score

I’m one of four GP owners in our group practice. We have had some disruption with a change in practice manager, and the new manager is still finding their feet. As directors, we need to get better at knowing where the practice is at. Can you suggest areas for reporting from my manager?

– *Getting to grips, Auckland*



Fiona Mines

- future asset purchase recommendations and costings
- reporting on debts/loan facilities – refinancing, overdrafts, etc.

Clinical and quality reporting

- clinical project reporting – long-term conditions, CVDR, diabetes reviews
- immunisation, smear, and mammogram rates
- performance programme reporting
- clinical policies review/update
- significant event reporting and analysis
- complaints, patient satisfaction reporting
- professional development and quality improvement plan
- progress towards accreditation
- legal compliance audit.

Health and safety reporting

- Health and safety reporting
- risks and hazards identified/compliance
- accidents that have been reported
- incidents reported to WorkSafe
- critical incidents/near misses
- sick days taken
- health and wellness initiatives.

Resources reporting

- recruitment and retention planning, succession planning
- staff training and development plan reporting
- staff performance management, disciplinary matters
- staff satisfaction, workplace morale
- population analysis, staffing ratios and workforce planning
- IT systems report
- premises and asset management.

This list may appear daunting, and you might decide some of the above areas don’t need regular reporting. However, financial and health and safety reporting should be part of your monthly management reporting.

Performance targets and other clinical reporting areas may be reported quarterly, although if accreditation assessment is approaching, it might also be moved onto the monthly list. Likewise, if you feel projects that reflect performance payments aren’t meeting the target, you might report on these more frequently. Once you have regular reporting for key areas, you should be able to pick up areas of concern sooner and agree on the actions needed to help address them. ■

Fiona Mines is a HealthyPractice adviser, MAS



MAS staff are happy to answer any questions about practice issues or dilemmas. Email your questions to business@mas.co.nz



STELLAR SUPPORTER PROFILE

BD Rowa™ pharmacy automation is sponsoring the Product or Service of the Future – Prevention and/or Detection of Health Risk Award in the 2025 New Zealand Primary Healthcare Awards | He Tohu Mauri Ora. John Barrett, business unit director of BD Rowa™, tells us what it means to be a Stellar Supporter

Why is BD Rowa™ pharmacy automation sponsoring the primary healthcare awards?

Our main area of involvement is within pharmacies, which ensures seamless medication management and access for all. By sponsoring these awards, BD Rowa™ pharmacy automation recognises pharmacy professionals’ innovation, dedication and impact.

What is the key area of involvement of BD Rowa™ pharmacy automation in primary care?

BD Rowa™ robots have been at the forefront of pharmacy automation for over two decades, providing cutting-edge solutions that streamline medication dispensing, improve inventory management and reduce medication errors. Our automated storage and retrieval systems optimise workflow in community pharmacies, hospitals and aged-care facilities – allowing healthcare providers to focus on what matters most: patient care. BD Rowa™ solutions ensure medication management efficiency, accuracy and precision through seamless integration with healthcare IT systems.

What interests you personally about the category BD Rowa™ pharmacy automation is sponsoring?

Pharmacy automation is more than just technology – it’s about empowering pharmacists and healthcare teams to work smarter, not harder. I am passionate about supporting innovations that improve efficiency, reduce burnout

and enhance patient safety. Recognising excellence is essential, as it celebrates achievements and drives future advancements in medication management and healthcare technology.

What do you hope this sponsorship will achieve for the entrants in this category?

BD Rowa™ pharmacy automation aims to elevate awareness of automation’s role in primary healthcare and encourage further innovation. We hope this recognition will inspire entrants to continue pushing boundaries, fostering collaboration, innovation and excellence in pharmacy services.

What is a great experience you have had in primary care that you can share with us?

Some decades ago, I worked in critical care nursing across Australia and the UK. This experience at the coalface shaped my commitment to ensuring those responsible for delivering care at all levels should have access to the best available tools and resources. Enabling our amazing primary caregivers with these tools will significantly improve patient outcomes.

How would you describe the sector in three words?

Innovative, essential, transformative.

If you were asked to name a popular song as the anthem for primary care, what would you choose?

Work Smarter, Not Harder (Sean Conn). ☆



Commercial goals, clinical values not at odds, says Tāmaki boss

► Fiona Cassie

Tāmaki Health’s “pumping the brakes” on buying general practices has been deliberate, says the corporate’s chief executive Lloyd McCann.

Back in 2018, when *New Zealand Doctor Rata Aotearoa* published its first practice ownership map, Tāmaki’s forerunner, Nirvana Health Group, was the biggest player in the practice market. The largely Auckland-based group had 44 practices and urgent-care centres compared to Green Cross Health’s 38 centres. Both groups were buying a steady two or three practices or so a year.

But as the pandemic tailed out, Green Cross Health put the pedal down and Tāmaki, which in 2022 became 90 per cent owned by Australian private equity firm Mercury Capital after the 2021 collapse of its sale to Green Cross

“We as a health system need to become much more comfortable around being commercial”

Health, took its foot off. By the time we published our latest ownership map in late 2024, Green Cross Health had 65 centres to Tāmaki Health’s 49.

“You could say in the years preceding there had been a focus on acquisitions,” says Dr McCann when asked by *New Zealand Doctor* how Tāmaki views itself now in the practice market.

“But we’ve probably...particularly in comparison to the likes of Green Cross and Tend...maybe pumped the brakes a little bit and that’s been deliberate.”

Tāmaki is still buying. In 2024 it bought the 10,000-patient Durham Health practice in Rangiora, just north of Christchurch, bringing its Canterbury practices up to five. It also bought a 60 per cent share in Hillpark Family Medical Centre, a busy Very Low Cost Access practice in south Auckland where the vast majority of its practices, predominantly VLCA, are based.

The big focus, since Dr McCann took over as CEO two years ago, he says, has been on the quality of patient, clinician and team experience rather than growth for growth’s sake. Patient demand saw Tāmaki making headlines last spring for patients queuing before opening outside several of its south Auckland centres offering walk-in clinics.

A lot of effort has gone into filling vacancies in the very tight post-pandemic workforce market with the then new CEO in late 2023 telling *New Zealand Doctor* he wanted Tāmaki to be



Tāmaki Health’s owners have never balked at “digging deep” to ensure clinics stay open, says chief executive Lloyd McCann

the “most attractive” place to work, including “incredibly competitive” pay rates. Nursing recruitment and retention has improved, he says, with Tāmaki taking on 10 new graduate nurses this year, compared to more than 20 last year, as it had fewer vacancies. Doctor recruitment remains a “very tight labour market”, he says, but it had managed to close a number of long-standing vacancies and has about 10 GPPEP1 registrars in 2025.

Purchasing philosophy

When Tāmaki does consider buying a new practice, Dr McCann says, the first step is ensuring a “strong values” alignment with the provider’s commitment to equity and improving health

outcomes for some of New Zealand’s most vulnerable populations. The second is whether the practice is on board with Tāmaki’s team-based model of care, supported by its virtual health provider Bettr. “Then we can move on to talk about economics.”

Dr McCann is aware many view corporate acquisitions as getting the most bang for the shareholders’ buck.

“A lot of people are surprised that [values] is the first thing out of my mouth rather than: how profitable are you?...Can we lock you in with a five year contract? Blah blah blah...”

When *New Zealand Doctor* asks him whether the low number of purchases in recent years was policy, or Tāmaki being outbid, he says bidding wars

are not its usual practice. But if an organisation Tāmaki felt a “strong strategic and values alignment” with started talking to “other potential acquirers” then, he says, “yes we will put our best foot forward”.

That GP practice owners expect a “decent price” for their practice, given the time and effort they have put into building the asset, is a reasonable expectation, he says.

Tāmaki has a number of joint-venture practice partnerships with clinicians and sees offering ownership opportunities as a recruitment carrot. A lack of clinician owners with “skin in the game” has been linked to corporate practices facing greater struggles to retain GPs, nurse practitioners and

nurses to provide continuity of care.

Dr McCann believes creating a good organisational culture can see clinicians build an affinity and loyalty to the practice and the patients they serve, irrespective of having an ownership stake or not.

Cynicism and commerciality

In response to concern and cynicism about corporates in primary care, the doctor-turned-CEO says corporate ownership evolved to fill a pipeline and policy gap in not delivering enough GPs and other clinicians ready to buy out an ageing GP-owner workforce.

The pragmatist in him thinks the sector needs to accept “that’s where we [are at] – so how do we make the best of that?” And also accept the need for commerciality in healthcare.

“I think we as a health system need to become much more comfortable around being commercial in order to be sustainable.”

Alongside clinical imperatives to deliver excellent patient care, he believes, you need commercial imperatives to ensure health services are sustainable and “you can do the good work”.

A lack of commerciality at Health New Zealand Te Whatu Ora – given the recent Deloitte report which said the agency lost control of spending – saw it end up in an unsustainable position, causing “us a heck of a lot of

pain as a system”, Dr McCann argues.

Given the scale of the challenge of creating a new national agency it is understandable how the situation may have arisen, he says, but adds that even prior to Te Whatu Ora: “We haven’t been comfortable accepting that we operate in a resource-constrained environment and we need to be commercial in our approach to delivering healthcare.”

Asked about fears that commercial imperatives drive corporates to put shareholders’ returns before patients, he responds: “I don’t see the provision of excellent clinical outcomes, patient outcomes as mutually exclusive in relation to commercial outcomes.”

Tāmaki, he points out, has for “literally decades” supported primary and urgent care through “some very lean periods” and owners “had never baulked” at “digging deep” to ensure continuity of service.

“In a number of instances, [Tāmaki owners] have not blinked at the need to keep clinics open and ensure team members get paid, etc,” Dr McCann says. Health system leaders need to balance those commercial and clinical imperatives.

“And not shying away from that is probably going to become increasingly important because, again, that same tension exists for an individual general practice owner.” ■

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Backwards equity step ‘saddening’

A “little bit of a lurch” backwards on the equity discourse in New Zealand has saddened Tāmaki Health chief executive Lloyd McCann, who grew up in apartheid South Africa.

Dr McCann says he is proud to be one of the Health and Disability System Review Panel members who, in 2020, wrote an “alternate view” arguing for a fully-funded Māori health authority with wide powers to commission health services for Māori. Instead, the review led to the creation of Te Aka Whai Ora, which had some commissioning powers but was more about policy and monitoring; it was short lived being disestablished by the Coalition Government in 2024.

When asked how he viewed the country’s current equity direction he says clearly the equity discourse is “quite

weaponised and polarising” at present.

“It’s interesting for me as a child of the latter part of apartheid South Africa to come into an environment like this where there is...I’m sad to see, a little bit of a lurch, in my opinion, sort of backwards [in the equity discourse].”

Tāmaki Health has a “hugely strong focus” on equity and he says he focuses on fairness when framing the work the corporate continues to do in the equity space for the populations it serves.

“I’m keen to bring it back to fairness and, I think given the Kiwi mindset and the Kiwi mentality, a lot of people actually see that as not such a contentious area.” He is also heartened that people from all corners of the health sector are stepping forward to say equity is “incredibly important”. ■

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BEXSERO is contraindicated in patients hypersensitive to its active substances or to any of the excipients. The persons depicted are models used for illustrative purposes only. This content is intended for New Zealand Healthcare Professionals only. *See Pharmaceutical Schedule for full funding criteria.

1. Immunisation Advisory Centre (IMAC). Bexsero: A vaccine to protect against Meningococcal group B disease Fact Sheet. Available at: <https://www.immune.org.nz/factsheets/bexsero-r-a-vaccine-to-protect-againstmeningococcal-group-b-disease>. Accessed October 2024. 2. World Health Organization. Meningococcal meningitis. 2023. Available at: <https://www.who.int/news-room/fact-sheets/detail/meningitis>. Accessed October 2024. 3. GlaxoSmithKline NZ. BEXSERO Data Sheet 2023. Available at: <https://medsafe.govt.nz/profs/Datasheet/b/bexsero.nj.pdf>. Accessed October 2024. 4. New Zealand Pharmaceutical Schedule. 2024. Available at: <https://schedule.pharmac.govt.nz/2024/03/01/Schedule.pdf>. Accessed: October 2024

BEXSERO (Multicomponent Meningococcal group B vaccine) is available as an injection for active immunisation against invasive disease caused by *N. meningitidis* group B strains from 2 months of age. BEXSERO is a **prescription medicine**. From 1 March 2023, BEXSERO is funded as part of the National Immunisation Schedule for infants and children under 5, people aged 13-25 years in close-living situations, and for certain individuals considered at increased risk of meningococcal B. See Pharmaceutical Schedule for full funding criteria. BEXSERO is also available for private purchase – a prescription charge will apply. A single 0.5 mL dose contains 50 mcg of *Neisseria meningitidis* Group B Neisseria Heparin Binding Antigen fusion protein, 50 mcg of *Neisseria meningitidis* Group B Neisseria Adhesin A protein, 50 mcg of *Neisseria meningitidis* Group B Factor H Binding Protein fusion protein, 25 mcg of Outer membrane vesicles (OMV) from *Neisseria meningitidis* group B strain NZ98/254 (PorA P1.4). **Dosage and Administration: Deep intramuscular injection.** 0.5 mL dose in a pre-filled syringe. Infants (2-5 months): 2 doses (≥2 month interval), booster dose from 12 months (≥6 month interval between primary series and booster). Unvaccinated infants (6-11 months): 2 doses (≥2 month interval), booster dose from 12 months (≥2 month interval between primary series and booster). Unvaccinated toddlers (12-23 months): 2 doses (≥2 month interval), booster dose (12-23 month interval between primary series and booster). Children 2 years – adults 50 years: 2 doses (≥1 month interval), need for booster not established. When given concomitantly with other vaccines BEXSERO must be administered at separate injection sites. Prophylactic use of paracetamol (as per local guidelines) reduces the incidence and severity of fever without affecting the immunogenicity of BEXSERO. **Contraindications:** Hypersensitivity to any vaccine component. **Precautions:** Do not administer intravenously, subcutaneously or intradermally. This medicinal product must not be mixed with other vaccines in the same syringe. Ensure medical treatment is readily available in case of anaphylactic reactions following administration. Postpone vaccination during acute severe febrile illness. Prophylactic administration of antipyretics at the time of and closely after vaccination can reduce the incidence and intensity of post-vaccination febrile reactions. Antipyretic medication should be initiated according to local guidelines in infants and toddlers. Apnoea in very premature infants. Pregnancy: category B1. May contain latex and kanamycin. The safety and efficacy of BEXSERO in individuals above 50 years of age have not been established. As with any vaccine, vaccination with BEXSERO may not protect all vaccine recipients. BEXSERO is not expected to provide protection against all circulating meningococcal B strains. **Adverse reactions:** Infants, toddlers & children: eating disorders, sleepiness, unusual crying, headache, diarrhoea, vomiting, rash, fever (≥38°C), injection site reactions, irritability, arthralgia. Adolescents & Adults: headache, nausea, injection site reactions, malaise, myalgia, arthralgia. This is not a full list. **Before prescribing BEXSERO, please review the data sheet for information on dosage, contraindications, precautions, interactions and adverse effects available at www.medsafe.govt.nz**. Trademarks are owned by or licensed to the GSK group of companies. ©2024 GSK group of companies or its licensor. Marketed by GlaxoSmithKline NZ Ltd, Auckland. **Adverse events involving GlaxoSmithKline products should be reported to GSK Medical Information on 0800 808 500.** Date of Approval: **11 2024** Date of Expiry: **11 2026** TAPS DA2301 VL-FM-NZ-BEX-JRNA-230002

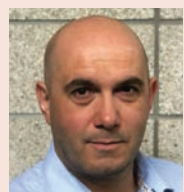
BEXSERO IS FUNDED
on the National Immunisation Schedule^{4*}

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Role Call

People on the move and gaining recognition in the health sector



Luke Bradford

RNZCGP medical director elected presidency

Luke Bradford will succeed **Samantha Murton** as president of the RNZCGP in July. The Tauranga-based specialist GP and current medical director of the college was the only nomination for the role, meaning an election process does not need to be held. Dr Bradford told *New Zealand Doctor Rata Aotearoa* he was “honoured and humbled” to be taking up the role.



Corina Grey

Pacific leader gets national role

Corina Grey has been appointed as director of public health following the sudden resignation of **Nicholas Jones** in February, RNZ reports (online 28 March). Dr Grey, a member of several public health groups and chair of the National Verification Committee, begins in the role on 5 May. Most recently, she was deputy secretary of policy and insights at the Ministry of Pacific Peoples.



Debbie Hughes

New leader for disability network

Speech-language therapist **Debbie Hughes** is the new chief executive of the New Zealand Disability Support Network, succeeding **Peter Reynolds**. Ms Hughes helped to set up Whaikaha – Ministry of Disabled People and most recently, was part of the Crown response to the Abuse in Care Inquiry, where she helped to ensure disabled people were acknowledged in the Government’s response to the Royal Commission’s findings.



Mark Shepherd

Northern chief executive resigns

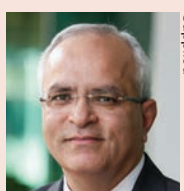
Mark Shepherd has resigned as deputy chief executive northern of Health New Zealand Te Whatu Ora after seven months in the role. In an emailed response, Te Whatu Ora interim chief executive Dale Bramley told *New Zealand Doctor* Mr Shepherd has stepped down to return home to his family in Australia and his last working day was to be 24 April.



Ming-Chun Wu

New chair for Pharmacy Council

Chartered director and teacher **Ming-Chun Wu** is the new chair of the Pharmacy Council, reports *Pharmacy Today*. Previously the deputy chair, Ms Wu replaces **Arthur Bauld**, who has served the maximum three terms. Ms Wu is also a board member and deputy chair of the Chinese Medicine Council of New Zealand and a Medical Council of New Zealand board member.



Rajiv Rattan

Former RANZCR dean makes president

Rajiv Rattan is the incoming president of the Royal Australian and New Zealand College of Radiologists. Dr Rattan, who has been an RANZCR board member and dean of the Faculty of Clinical Radiology, will succeed **John Slavotinek** and serve a two-year term beginning 1 January 2026. College leadership will work closely with Dr Rattan to ensure a smooth transition, a media release says.



Stephanie Whyte

NHC gets new culture lead

National Hauora Coalition has appointed **Stephanie Whyte** as culture and engagement lead. Ms Whyte, who has a background in learning, development and culture, has previously held roles at Waka Kotahi, Te Toka Tumai and Sky Television. She has been contracting at NHC for six months working on internal communications and events. ■

Role Call is collated by Zach Thompson. If you or a colleague would like to feature please send details to zthompson@nzdoctor.co.nz

News Making moves

New director-general arrives on fast track from transport

► **Barbara Fountain**

Wannabe directors-general of health were caught out last month when the role was filled without being advertised.

In early April, deputy public services commissioner Heather Baggott announced the “transfer” of acting director-general Audrey Sonerson into the role permanently, with a five-year term.

Ms Sonerson took up the acting director-general role on 22 February following the departure of Diana Sarfati a week after giving notice. At the time, it was indicated Ms Sonerson’s role was interim only.

That “transfer”, mentioned by Ms Baggott, refers to powers under the Public Sector Act 2020, which allow the public service commissioner Brian Roche to bypass the more traditional recruitment process for public sector chief executives, that is, advertising the role and appointing a panel to decide on a suitable candidate.

In 2013, changes were made to the then State Sector Act 1988, giving three options when filling chief executive roles: advertising the role and seeking applications, reappointing an incumbent, or transferring from another department.

These powers were used extensively in June 2018, when then-state services commissioner Peter Hughes appointed five chief executives in a single move, a sort of all-change, public service musical chairs.

The appointments covered vacancies that were to occur in the following 12



Director-general of health Audrey Sonerson

months and, in a media release at the time, Mr Hughes said he had decided on the package deal to “remove uncertainty and maintain momentum in key roles and portfolios”.

The law requires the transfer option to be in the “public interest”, and in the media release announcing Ms Sonerson’s appointment, Ms Baggott explicitly stated that any delay could risk the health reform process.

“A transfer was in the public interest and ensures a speedy appointment that will bring stability and effective leadership for the ministry at this critical time,” she said.

In the past 30 years, it has not been uncommon to have a director-general with no medical expertise, but aside from career public servant Andrew Bridgman – who acted in the role for six months from August 2010 – no one in that time has come into the role with no experience of the health systems.

Ms Sonerson has held several senior leadership positions, including deputy chief executive positions at the Ministry of Foreign Affairs and Trade and Ministry of Justice. She also held various manager roles at the Treasury. ■ editor@nzdoctor.co.nz

‘Relentless’ delivery officers sought for Te Whatu Ora

FOUR CHIEF DELIVERY officers were being sought by Health New Zealand Te Whatu Ora last month.

The positions, replacements for the four regional deputy chief executive roles, came with an expectation of turning around the problems confronting all aspects of the publicly funded health system – patient care, patient safety, workforce and health outcomes, and ultimately returning the system to a breakeven position by the 2026/27 financial year.

The five-page job description includes words like relentless, maximisation, unification, enhanced and the once-favourite, devolution.

It reiterates the high priority of

achieving the mostly hospital-focused health targets. But “faster access to primary care” is high up in the primary responsibilities list, with the expectation of an “unrelenting focus on improving outcomes and achieving results”. Iwi Māori partnership boards get a mention, along with possibly new entities, “integrated neighbourhood teams”.

Te Whatu Ora acting chief human resources officer Kate Coley confirmed that the roles are permanent positions replacing the “establishment” deputy chief executive roles, which were 12-month fixed term agreements. Applications were to close in mid-April. ■ editor@nzdoctor.co.nz

News

Stephanie Taylor seeks leadership role, shuns politics

► **Martin Johnston**

Stephanie Taylor hopes to find her way into another leadership role after resigning as clinical director of Green Cross Health’s medical division.

Dr Taylor doesn’t know where that role might be, but there is one thing she is certain of: it won’t be in politics.

New Zealand Doctor Rata Aotearoa had asked Dr Taylor, a specialist GP in Auckland, if she might follow another specialist GP and now National Party MP, Vanessa Weenink, into politics.

“No, no, definitely not politics,” she says emphatically.

The two of them were on the GP council of the now-dissolved New Zealand Medical Association, along with other GPs who have gone onto medical leadership elsewhere, and Dr Weenink was also deputy chair of the NZMA. Buzz Burrell chairs General Practitioners Aotearoa, Marcia Walker is secretary, and Luke Bradford is the RNZCGP’s medical director and will be its next president.

“As clinical director, she was a go-to person when things went wrong for a Green Cross practice”

While she finds her next leadership role, Dr Taylor plans to spend more time in her practice, and with her husband and three teenage daughters.

She is, of course, already in leadership roles as a minority shareholder – Green Cross holds the majority – in her practice, The Doctors St Heliers, and she is deputy chair of the General Practice Owners Association.

Reflecting on her more than three years in the clinical director role, Dr Taylor says one of the things it showed her is the great diversity in how primary care is delivered.

“I’ve learnt quite a lot from the commercial side, which, obviously, I didn’t know the background of when I started in the role.

“I think as a GP or any doctor – we’re trained from the medical aspect, but often and [problematically] for GPs, we’re not exposed to that business side of things.

“So, that’s been hugely beneficial to see the different approaches within different clinics on how to manage a business.

“I think it’s something that probably

Essentials

◆ Auckland specialist GP Stephanie Taylor was appointed clinical director of the Green Cross Health medical division in November 2021.

◆ Dr Taylor finished up in the role last month, on 10 April but continues to have a minority shareholding in a Green Cross practice.

◆ Though she has dismissed politics as an option, she hopes to find a new leadership role.



Former clinical director Green Cross Health Stephanie Taylor

needs more teaching to our registrars and others who are likely to become business owners in future...

“It’s more like a mentorship [that’s needed] so that the people that are already in that environment would be good to learn from.

“When I trained, which was over 20 years ago now, there was a little bit in that space but not at the level that you probably need.”

As clinical director, she was a go-to person when things went wrong for a Green Cross practice. She was also involved in updating guidance on inbox management and helped to establish the Green Cross deal with the Medical Protection Society to provide practice-level indemnity cover in response to the Supreme Court case on vicarious liability.

But despite swearing off politics, Dr Taylor seems magnetised to the advocacy side of medical leadership, which, in turn, is bound to funding issues.

“I think that when I started in the role, [advocacy] was definitely a trajectory that I saw as important because obviously without the funding, it’s really hard to retain staff. I think that’s got to be a key role for anyone in medical leadership at the moment – to ensure adequate funding for our workforce.” ■ mjohnston@nzdoctor.co.nz



STELLAR SUPPORTER PROFILE

Spark Health is sponsoring the Excellence in Information Technology or Telehealth Award in the 2025 New Zealand Primary Healthcare Awards | He Tohu Mauri Ora. **John Macaskill-Smith**, Spark Health CEO, tells us what it means to be a Stellar Supporter

Why is Spark Health sponsoring the primary healthcare awards?

Most of the action in the health sector – 90 per cent or so – happens in primary and community care. It’s the part of the health system that builds long-term, broad relationships with individuals, whānau and communities. Celebrating and supporting primary care’s key role is important in an environment where often all that is spoken about are the constraints.

What is Spark Health’s key area of involvement in primary care?

Spark Health is a health system integrator. We bring global and local partners and scale to all corners of the health sector. Primary care’s superpower is that it is small and local. But it’s also one of its biggest challenges; leveraging the benefits of scaled procurement and accessing/adopting technology can sometimes be confronting. Spark Health is committed to ensuring that primary care is seen as the big player, not the second cousin.

What is it that interests you personally about the category Spark Health is sponsoring?

Every industry needs to learn and leverage from the past while adopting and forming its own future. Innovating in the new digital clinical space isn’t easy – funding and support can be hard to access – and the always on, fast-paced nature of clinical work leaves little time to adapt and experiment. As a part-owner of GP clinics

and someone who has spent years supporting primary care innovation, I know firsthand how tough it is when the health system remains fixated on hospitals.

What do you hope this sponsorship will achieve for the entrants in this category?

The health sector can be quick to criticise, making it tough for those who put themselves out there. We hope these awards help shift that mindset – encouraging individuals and teams to take bold steps, embrace innovation and keep pushing boundaries.

What is a great experience you have had in primary care that you can share with us?

I was lucky enough to work with 400 GPs and their teams across the Midland region for 15 years. We were brave, trying new and different approaches to operational and clinical models. Strong clinical leadership, a bigger vision, scaled support and digital tools all combined to drive massive improvements in health outcomes through to primary care innovation. Post-COVID, we need to reignite the “art of the possible”, supporting visionary leadership that goes beyond today’s constraints and helps to deliver health outcomes for the future.

How would you describe the sector in three words?

Solid, resilient, core.

If you were asked to name a popular song as the anthem for primary care, what would you choose?

We Didn’t Start the Fire (Billy Joel). ★



Spark Health

Strategy refresh a chance for tāngata whaikaha Māori

► **Zach Thompson**

A refreshed disability strategy presents an opportunity to share a Māori perspective, says advocate Tania Kingi.

The consultation process for an updated strategy was announced via a media release by the minister for disability issues, Louise Upston, at the end of March. The current 10-year strategy finishes in 2026.

“I don’t know if we’ve ever had this kind of political environment before, especially for Māori with disabilities,” says Ms Kingi, chief executive of Te Roopu Waiora, a group advocating for kaupapa Māori disability services, founded and governed entirely by those with lived experience.

The process offers an opportunity to register a Māori worldview with a government agency when many agencies have been “unsure [about] Treaty responsibilities, marginalised populations and how to respond to equity”, Ms Kingi says.

“This is our chance as both a disability community and a Māori community to help set the record straight.

“It’s now up to us to make sure that those distinctions between a Western view of disability and traditional Māori concepts are known,” she says, “because we haven’t had the opportunity as Indigenous peoples to really feed into a national strategy for disability quite the way that we should.

“It feels like we could possibly be doing that this time round.”

The transfer of commissioning powers to the Ministry of Social Development last August – following contentious funding restrictions in March 2024 – sparked significant backlash from the disabled community. However, Ms Kingi says it allows Whaikaha – Ministry of Disabled People to focus entirely on an improved strategy, “which is what we’re all hoping for”.

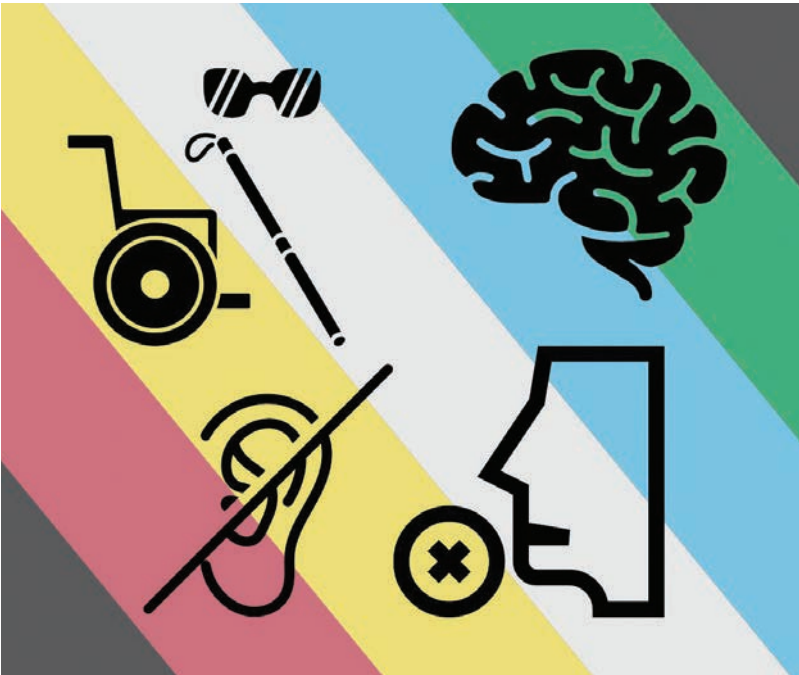
Whaikaha has received nearly 350 expressions of interest from disabled people to work with the Government on the updated strategy, Ms Upston says in the release.

Te Roopu Waiora has also received many emails from across the motu encouraging the group to be involved in any consultation.

“There’s a lot of hope in the community that this strategy is going to be meaningful, and [there is] an expectation [it will serve] more people than [other strategies] have in the past.”

The final document, intended to focus on education, employment, health, housing and justice, will be implemented for five years, Ms Upston says in the release.

Debbie Hughes, chief executive of the New Zealand Disability Support Network, says the updated strategy must



The current 10-year disability strategy is due to end in 2026



“This is our chance as both a disability community and a Māori community to help set the record straight”

TANIA KINGI

“One of the major issues raised about the initial review of Whaikaha was the lack of consultation with disabled people”

DEBBIE HUGHES

incorporate current efforts by MSD to make the sector sustainable.

It’s really important to align the Disability Support Services review with the strategy work, says Ms Hughes, who has recently taken over from Peter Reynolds at the network of not-for-profit and for-profit NGOs.

To get all of the focus areas right, disabled people often need the right support at the right time, she says, and combining these two big pieces of work will be important in achieving this.

One of the major issues raised about the initial review of Whaikaha was the lack of consultation with disabled people, Ms Hughes says. But the new approach represents an attempt to address that and is a really positive step forward, she says.

However, its success will depend on the Government genuinely listening to the feedback.

Ms Upston describes the approach, which will see Whaikaha engage with working groups from the disabled community, industry and government agencies, as an “exciting opportunity”.

The make-up of these working groups was announced today via a media release and includes 26 members from the nearly 350 expressions of interest.

A working group will be assigned to each focus area and have a chair. It comprises:

- **Education:** Grant Cleland
- **Employment:** Lorraine Toki
- **Health:** Josephine Herman
- **Housing:** Daniel Clay
- **Justice:** Paul Gibson.

“The draft strategy will go to the wider disabled community for further review later this year before being agreed by Cabinet,” Ms Upston says in the release. ■

zthompson@nzdoctor.co.nz

Timeline

- 2001**

The first New Zealand Disability Strategy is developed, laying the groundwork for advancing the rights and wellbeing of disabled people.
- November 2016**

The New Zealand Disability Strategy 2016–2026 launches, a renewed commitment across various sectors, including health, education and employment.
- March 2024**

Funding restrictions imposed by the Ministry of Social Development spark significant protests and criticisms from the disabled community.
- July 2024**

Whaikaha – Ministry of Disabled People was created to work with the disability community, Māori and Government to create more equitable outcomes for disabled people
- August 2024**

Commissioning powers for disability support services are transferred to the Ministry of Social Development, turning Whaikaha – Ministry of Disabled People into one of advocacy-based stewardship, and shifting its focus to strategy and system transformation.
- March 2025**

Minister for disability issues Louise Upston announces the New Zealand Disability Strategy will be refreshed using a collaborative approach.
- April 2025**

Whaikaha receives nearly 350 expressions of interest from disabled people to participate in co-designing the updated strategy.

New Zealand Doctor Rata Aotearoa

WRITE TO US

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GETTING IT RIGHT

We aim to ensure the information in *New Zealand Doctor Rata Aotearoa* and on nzdoctor.co.nz is accurate, but in the rush of daily publication, we can make mistakes. And we really appreciate if those mistakes can be pointed out so we can correct them.

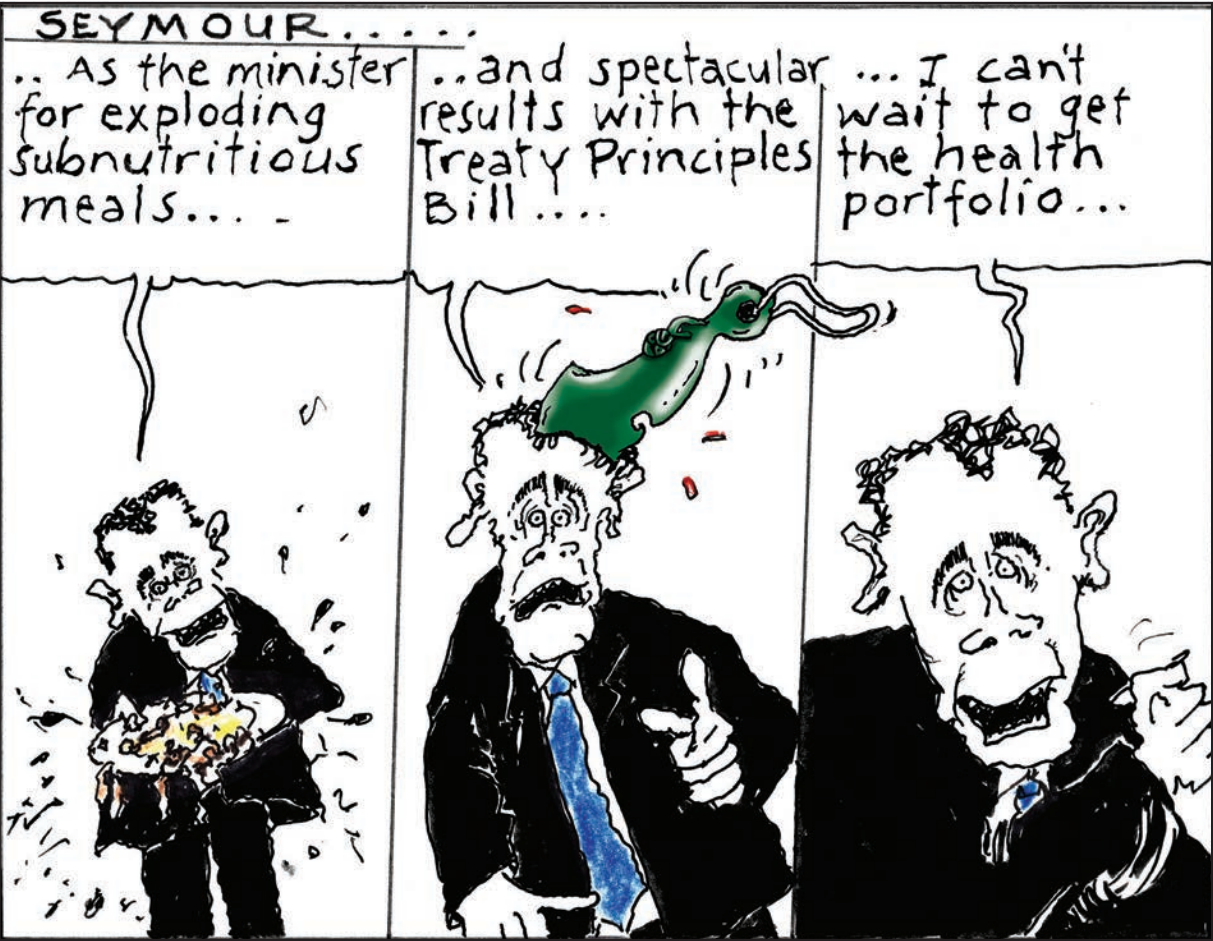
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Commentary ...ideas, letters, thoughts

Second opinion Malcolm Walker



PHOs: The glue binding primary care

Far from being just an administrative layer, PHOs drive population health, support providers and bridge the gaps between primary, secondary and community care, writes **Bryan Betty**

The long-awaited consultation document on the future of PHOs is expected very soon. It should deliver the direction we’ve been calling for since the beginning of the health reforms.

It comes at a time when some have raised questions over PHO structures and funding flows.

General Practice NZ acknowledges there is variation among PHOs. But we are unapologetically direct about the role PHOs play in our health system – this includes the expectation that the intention to enhance the role of PHOs remains despite a change of minister.

While much of the work of PHOs happens behind the scenes, without them, our primary health system would be much more fragmented, inefficient and less capable of meeting the needs of those who rely on it the most.

Beyond their visible role in contract management and funding distribution, PHOs perform four core functions: population health, provider support, primary-secondary integration and innovation, including data



and digital transformation.

PHOs are active players in addressing health inequities, co-designing and implementing solutions that align with Te Tiriti o Waitangi.

Without PHOs, many of these responsibilities would fall entirely on individual practices, undoubtedly compromising patient care. Commentators have called PHOs “the glue in the system” because of their key role in integrating – connecting with their communities, primary and community providers, secondary care, social care, iwi Māori partnership boards and iwi.

The relationships built and maintained across the vast primary care network are fundamental to making things work.

PHOs are not an “admin layer”, taking funding away from providers – it is time we appreciate they need to be funded for their crucial work.

Currently that funding is complex and poorly understood. PHOs collectively received \$1.56 billion in 2024/25 – 5.29 per cent of the total health budget.

These funds are then distributed to practices and used to support a wide

range of essential services.

PHO income includes capitation pass-through, along with funding streams for rural, nurse pay disparities, system-level measures, flexible funding and other programmes. Multiple independent audits consistently verify 100 per cent of capitation is passed through.

PHOs can receive income for coordinating contracts. However, when a fee-for-service approach is used, 100 per cent of that funding is passed through to practices.

PHOs also perform the “heavy lifting” when it comes to meeting the contract reporting and monitoring needs of the Government.

Our PHO members are keen to increase collaboration, building on what works and scaling.

We welcome the Government’s focus shifting to primary care – it is, after all, long overdue. We need to seize this opportunity to build on existing functions and leadership.

PHOs have more than proven their worth. It’s time to recognise they are the glue that holds our health system together and to unlock their full potential. ■

Bryan Betty is chair of General Practice NZ and a specialist GP in Porirua

This is an abridged version of the article appearing on nzdoctor.co.nz, 1 April

Māori health snapshot: Follow the data and target inequities

Gabrielle Baker is pleased to have the findings from the new *Tatau Kahukura* but is disheartened by health factors for Māori that are not improving, such as the life expectancy gap and problems with accessing healthcare

The other day someone mentioned to me that an updated version of *Tatau Kahukura* was online. I almost couldn't believe it. It has been 10 years since the last update, and I had given up hope that we'd see a new one any time soon.

Tatau Kahukura, the Māori health chart book, has, since the first edition in 2006, provided a snapshot of the health of Māori compared with non-Māori.

It was originally developed as part of the monitoring He Korowai Oranga (Māori Health Strategy) and as a response to calls for Māori to have access to a wide range of health information that could be easily accessed and easily understood.

Mita Rininui, the then associate minister with responsibility for Māori health, said in 2006 when the first *Tatau Kahukura* was released that, as an evidence-based report, it "can provide important clues to understanding the causes of disease and contribute to primary prevention initiatives".¹

The initial intention was to update the chart book every three years, but this never really panned out. The second edition was published in 2010 and the third in 2015. This fourth edition is dated December 2024. All up, *Tatau Kahukura* has been going for nearly two decades.

I was thrilled to know there was a fourth edition out in the world, even if it is a few years late. In addition to the data being useful for policy, research and service delivery, access to this data is also important to Māori whānau and communities. As Ngapera Riley wrote in 2023: "The Government holds a large amount of data about Māori that is used in decision-making by both the Government and by Māori. It's vital that this data continues to be accessible to Māori and that the quality keeps improving."²

And, as it has been 10 years since the last chart book, it was time to provide more up-to-date data. However, there has also been ample opportunity for the book to expand – perhaps including more comprehensive data or better reflecting whānau health aspirations. This new edition, with the exception of results from the Active NZ survey, actually provides less comprehensive data than previously because there is no updated data on disability.



You can read the chart book on the Ministry of Health website – as with the previous editions it is easy to scan and understand.³ But I do want to highlight some key results.

• **Population:** In 2023, Māori made up 17 per cent of the New Zealand population (up from 15.6 per cent in 2013, which is the data used in the previous edition). The Māori population is younger overall than the non-Māori population and is expected to reach over 1,000,000 people by 2030 (in 2023 there were just over 900,000 Māori in the country).

• **IMPB rohe:** The iwi Māori partnership board rohe with the largest Māori population is Te Taumata Hauora o Te Kahu o Taonui, which runs north from the Tāmaki Estuary to Te Rerenga Wairua, with 185,500 Māori (it is also the IMPB with the highest total population). The highest proportion of Māori is in the Tairāwhiti Toitū te Ora rohe, where Māori make up 56 per cent.

• **Discrimination:** Māori experience higher levels of racial discrimination than non-Māori. The new chart book reports that 36.5 per cent of Māori have experienced ethnically motivated personal attacks or unfair treatment on the basis of ethnicity. This is based on data from 2020/21 and is higher than the levels reported in 2015 (when only 27.5 per cent of Māori reported such discrimination). There is gender dimension to this too, with, for example, Māori women four times as likely to have experienced unfair treatment by a health professional as non-Māori women.

• **Life expectancy:** There remains an unfair and unjust life expectancy gap of 7.5 years for Māori males compared to non-Māori males and 7.3 years for Māori females compared with non-Māori females. In both cases this is a slightly bigger gap than was reported in 2015, so things are moving in the wrong (and, honestly, upsetting) direction.

• **Vaccination:** Things are also trending in the wrong direction for immunisation. Immunisation rates are down from 2015 when 88.9 per cent of pēpi Māori were fully immunised at eight months. Now, only 69.7 per cent of pēpi Māori are fully immunised at eight months and there's a widening gap between Māori and non-Māori babies (with 88.6 per cent of non-Māori babies fully immunised at the same age).



The question is, what to do with nearly two decades of data on Māori health?

It's not exclusively bad news, but the good news is not unambiguous. For example, smoking rates are down for Māori adults (15 years and older) with only 20.6 per cent (compared with 42 per cent in the 2015 book) identified as daily smokers. This needs to be interpreted with caution, though, as for the first time we have vaping rates in *Tatau Kahukura* and the vaping rate for Māori adults is 26.1 per cent, compared with 10.3 per cent for non-Māori.

When it comes to primary healthcare, there are consistent patterns of unmet need for Māori children and adults. While unmet need in general is similar for Māori and non-Māori children, Māori children are four times as likely as non-Māori to have

unmet need for a GP due to lack of transportation. And Māori adults are one-and-a-half times more likely than non-Māori to have unmet need for primary healthcare due to owing their clinic money, and are twice as likely as non-Māori to report not collecting their prescriptions.

Now that we have this data, so what? In addition to it being valuable to have a point-in-time record to hold government to account, this type of data can also be used in informing government policy and investment. This is particularly the domain of the Social Investment Agency, which seeks "to improve outcomes for people through the systematic, consistent, and rigorous use of data and evidence to invest earlier and more effectively".⁴ While I don't think the data in the chart book would by itself provide enough nuanced detail, especially without any disability data, it does give us hints about where to start further exploration (eg, addressing discrimination, improving access to primary healthcare, and increasing access to transportation).

For the Government, which has been clear that its social investment programme of work is meant to help tailor and target interventions "rather than waiting for the inevitable crisis",⁵ *Tatau Kahukura* is surely a reminder that it must not ignore inequitable differences in health status and outcomes for Māori compared with non-Māori. Such inequities require health and social sector responses that centre on Māori needs and aspirations. To do otherwise would be to fly in the face of the data-driven approach it claims to value.

With this in mind, I turn to a speech from minister for social investment Nicola Willis, speaking on that topic, from November 2024: "Those of you who interrogate the data know what we need to be focusing on and what we need to be trying, and you know how we should be thinking about what success looks like."⁶

Those who interrogate *Tatau Kahukura* will inevitably see that success looks like a vastly different snapshot to what we have had for the past 20 years. While everyone might suggest different areas of specific focus, it's hard to imagine that a one-size-fits-all approach, or one that is ignorant of the impacts of racism, will get us close to success. ■

Gabrielle Baker (Ngāpuhi, Ngāti Kuri) is an independent health policy consultant

The references for this article can be found with the online version on nzdoctor.co.nz

Contraception gets attention, but are real barriers being ignored?

Recent changes, including full funding for Cerazette and proposed IUCD supply reforms, are welcome but fall short of meeting the needs of wāhine, argues Orna McGinn

On 11 March, Pharmac announced the contraception pill, Cerazette, would finally be fully funded from the beginning of April. Marvellous news – it has only taken since 2002.

Then on 8 April, the first five-yearly periodic *Review of Certain Matters under the Contraception, Sterilisation, and Abortion Act 1977* landed, assessing how well the updated 2020 abortion legislation is faring.

Remember those days? Abortion was decriminalised, aligned with other health services, and barriers were removed. The shift was seismic, and early medical abortions, now possible at home, have jumped from 38 to 66 per cent of all abortions.

However, an unintended consequence is a drop in post-abortion



access to contraception. Previously, many opted for an intrauterine contraceptive device (IUCD) at the time of the procedure. This is not possible with emergency medical abortions, which requires a separate in-person appointment a week later.

Follow-up and signposting to community contraception services are variable, and there is still no national patient-facing database of long-acting reversible contraception (LARC) providers. It is difficult to say exactly how poor access is as the act's reporting requirements don't "enable the ministry to collect sufficient data to comment in comprehensive detail on timely and equitable access to contraception".

This brings me to more contraception-related news: Pharmac's current consultation on a proposal to make

Mirena and Jaydess available on Practitioner Supply Order (PSO). This means a clinic could stock them directly instead of patients having to collect them from a pharmacy.

It's a good idea, and I don't want to sound ungrateful. Having a cupboard full of Mirenas, for me, is rather exciting. But almost two years after the publication of Aotearoa's first *Women's Health Strategy*, we should be seeing more than piecemeal announcements. It's starting to feel like almsgiving to the deserving poor – with clinicians wasting time responding to endless consultations on issues that should have been sorted out years ago.

Secondly, picking up their own Mirena is the least of the barriers facing women trying to access a Mirena for contraception, to arrest their heavy menstrual bleeding or as the progestogen component of HRT.

Before 2019, the main issue was the cost of an unfunded Mirena, around \$450. Once that was removed, usage rose by 50 per cent, most notably in

Essentials

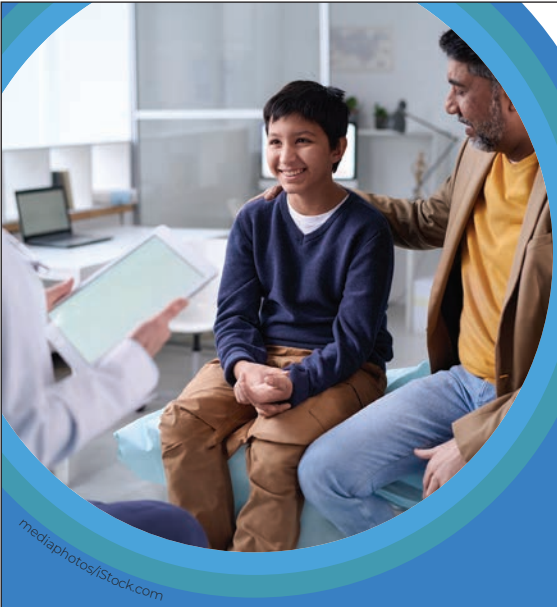
- ◆ Pharmac will fully fund the contraception pill Cerazette.
- ◆ Early medical abortion now dominates abortion care, but post-abortion contraception is falling through the cracks.
- ◆ Proposed PSO access for Mirena and Jaydess is welcomed, but the lack of trained providers and funding still blocks true access.

under 25s. This clearly demonstrated an unmet need.

The real barriers are the lack of access to trained providers and the insertion cost. These issues show no sign of being addressed, and in some cases, access to funding is worsening.

I was most gratified to have my own paper quoted in the Abortion Act

Continued on page 50 ►



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Fa’afetai lava Tamā Pesetā: Leaving legacy of family and friendship

At the funeral of 94-year-old Sāmoan ali’i matai Pesetā Misipati Iosefa, [Lucy O’Hagan](#) effects on the intertwining stories of two families – one Irish-Catholic, one Sāmoan – and the enduring friendship, faith and love that bind them across generations

I want to tell you a story about a man and two families, Iosefa and O’Hagan.

Yesterday, I went to the funeral of a 94-year-old Sāmoan ali’i matai, Pesetā Misipati Iosefa, or to his fānau, simply Tamā. Pesetā is the father of my lovely sister-in-law, Asimanogi Iosefa O’Hagan, whom we call Asi. It was a six-hour funeral, including a post-burial feast and the exchange of fine mats, tinned corned beef, boxes of frozen Tegel chicken and bulging envelopes.

Tamā Pesetā was a lay preacher who lived a life of faith in God, a prayer warrior full of warmth, kindness and love. Even when I met Pesetā 45 years ago, his English was hesitant, but in the past 10 years, he mainly spoke Sāmoan, weaving into his words verses from the Bible in English.

Last month, in the beautiful St Paul’s Trinity Pacific Presbyterian Church in Christchurch, we heard about Pesetā’s gafa or whakapapa. In the 1850s, two of his ancestors helped translate the Bible into Sāmoan and then followed many generations of faifeau/ministers.

I am remembering my own Irish-Catholic O’Hagan ancestors, who, in the 1850s, were half a planet away, escaping the potato famine. They got as far as Glasgow, where there was work in the coal mines.

Pesetā was born in Sāmoa in 1930, although his passport always said 1932. We heard that his family moved to Tuvalu in 1933, where his father was a missionary on the tiny atoll of Nanumea. We saw sepia photos of an idyllic village with a beautiful, ornate and very large church. Funds had been raised by sending the young men to work in the phosphate mines in Nauru and Banaba.

My father, John, was born in Wellington in 1931, the youngest of six. The O’Hagans had left Glasgow in



1926, travelling to a better life in New Zealand aboard the ship *S.S. Pākehā*. (It gets worse; it was later renamed the *Empire Pākehā*.)

World War II brought the Americans to Tuvalu. They mowed a line through the plantation in Nanumea to build an airstrip. Ten-year-old Pesetā and his friends climbed high up coconut trees to watch the Japanese bomb the American base.

During the war, my father was a small boy in Kilbirnie, probably an altar boy at the local parish and perhaps climbing the odd English oak tree. My grandfather, Patrick O’Hagan, was quietly pacifist. He had a good job as an electrician but sadly died of an asbestos-related cancer when my dad was 11. Luckily, there was a widow’s benefit.

Yesterday, we heard the love story

“They came from such different cultures and ways of being, but we were welcomed into the Sāmoan world and, in turn, could show the Iosefa family the strange ways of the Pālāgi”

of the young Pesetā and Utuvailagi Tuamasaga Ale. However, in the 1950s, it was forbidden for the high chief’s daughter to wed the minister’s son. There was a baby, an elopement, hiding out on a remote plantation, a secret marriage, a twin lost in a cyclone and, some years later, a fa’aleleiga/reconciliation between the aiga.

My father spent the 1950s surpassing the aspirations of his immigrant family. He was the first person in his family to attend university. When he graduated as a doctor in 1955, he joined the affluent professional classes as a GP in rural Southland.

▶ *Continued from page 49* review, noting that LARC access has been inequitable and hampered by cost barriers. In fact, a follow-up paper last year found that in addition to cost and workforce shortages, some areas apply strict eligibility criteria for funded contraceptives, which, in many cases, contravenes the WHO framework for contraceptive rights.

Funding is sometimes tied to factors including a history of drug use, an STD, a recent abortion, or “high

users of maternity services”, which presumably is open to interpretation – how many children are too many?

Even these funding streams are under threat; in at least one area, PHOs have withdrawn funding for LARC altogether. Without funding, the cost of an insertion is about \$220, beyond the budget of many, and, like cervical screening, yet another out-of-pocket cost visited on women.

An IUCD in the hand – or cupboard – may be worth two in the bush. But



New beginnings: John O’Hagan, Clare O’Hagan, Sean O’Hagan, Asi Iosefa O’Hagan, Lagi Iosefa and Pesetā Iosefa

In 1966, Pesetā and Utuvailagi moved their family from Sāmoa to Auckland, settling in that “Pasifika” suburb of Grey Lynn. They wanted education for their four children. Pesetā worked at the wharf and two

been a 45-year friendship between the Iosefa and the O’Hagan families.

They came from such different cultures and ways of being, but we were welcomed into the Sāmoan world and, in turn, could show the Iosefa family the strange ways of the Pālāgi. It is a testament to the four parents – John, Clare, Lagi and Pesetā – who all showed open-heartedness and willingness to transcend cultural differences with humour and affection.

Sean and Asi married in 1982 and had my beautiful niece Siobhan, who now has a three-year-old daughter, Tuileisu, named after her great-grandmother. Asi later fulfilled the dream of her immigrant parents, graduating as a doctor in 1993.

But, sadly, 40 years ago, my brother Sean stepped in to cross the Haast River on a tramping trip, lost his footing and was washed away, his body never found. Siobhan was 18 months old.

And so, the funeral of Tamā Pesetā, the last of that generation, was important. My brother Liam came from New York, and my sister Mary from Melbourne. It was poignant wondering how life might have been if Sean had lived. But also understanding the gift he left us, an enduring friendship with a family whose ancestors had come from a place half a planet away from ours. It is a reminder to us of the importance of embracing difference with curiosity and aroha.

Fa’afetai lava Tamā Pesetā for your warmth, your dancing, your Bible quotes, your graces before meals and for always remembering Sean. May you be in the arms of your saviour, Tamā, and I hope that you, Lagi, Clare, John and Sean have met again in that other place where good people go. ■

Lucy O’Hagan is a medical educator and specialist GP working in the Wellington region

This is an abridged version of the article appearing on nzdoctor.co.nz, 10 April



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[†]Reader’s Digest Trusted Brand Survey 2024. ^{*}Absorbed 25% faster than standard paracetamol tablets. [^]Greater pain relief than standard paracetamol tablets.

References: 1. Wilson CG, Clarke CP, Starkey YY *et al. Drug Dev Ind Pharm* 2011;37: 747–53 (GSK sponsored). 2. Panadol Optizorb Tablets/Caplets (paracetamol). New Zealand approved Product Information. Haleon Australia. Approved June 2023. 3. First of two consecutive assessments scored ≥2 on the VRS pain relief scale for some pain relief when taken at 1000 mg dose. (GSK Sponsored Study); Grattan TJ *et al. J Clin Pharmacol* 2004;44(10):1188.

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What do you reckon? Readers tell it like it is – rather glum

The year started with a flurry of health announcements – it was a lot to take in. Last month we published the results of our straw poll to gauge readers' reactions to the various funding initiatives, asking 'What do you reckon?' about the health minister's Primary Care Package, more formally known as the Primary Care Tactical Action Plan. But in addition to the figures, readers were keen to comment. Deputy editor [Patrice Dougan](#) takes a dig through the comments

Primary care staff are feeling more pessimistic about the future of the sector following health minister Simeon Brown's Primary Care Package announced in March; at least, the 102 survey respondents report the package did little to lift the weight from their shoulders. The short answer: very little.

Gloomy days ahead
 Asked how they were feeling compared with six months ago about the road ahead for general practice, 50 per cent of respondents said they were "more pessimistic" than before. About 20 per cent were "more optimistic", and 30 per cent described themselves as "neutral".

"The practice I am working in is starting to thrive – but it is the exception. And even then, it is dependent on GPs who are in their late 60s or reaching 70. So, not sustainable long term. All around us, practices are reducing service and access. Nothing I have seen so far from the Government will change that.

"I worry that within 10 years when I want to retire, I will be left with a practice I can't sell OR staff, which will have to close as I leave and turn the lights out.
 GP

"I see them [targets] as a potential to reduce funding rather than increase if they are used as sticks rather than carrots. I have no faith that capitation will be reviewed favourably and result in any great improvement. I see inequalities increasing and a government that doesn't understand and worse, I'm not sure they care. As an NP of nine years and over 35 years in primary care, I have never been so despondent and am now actively looking forward to retirement as I can't see how we will win this.
 NP

"Possibly the \$285 million might help but not so sure about the rest. Will wait and see.
 GP

"Increase funding to GP, not through all these programmes. Need to retain our workforce, allow primary care to fund their own projects.
 GP

"A practice manager says they have drawn up the budget for the next 12 months and "we will be struggling more than before".
 Practice manager

"The Government started with a tax cut and then immediately embarked on slashing everything. They even cut health IT at the very time they announce a nationwide system and when they want even more health data to make good decisions. This all smacks of incompetence.
 GP

Handed a 'shit sandwich'
 "If Mr Luxon wonders why we have no faith – we had a well-educated dedicated Māori GP as health minister who was handed a shit sandwich of smoking and dismantling of Māori leadership in healthcare delivery and given us in exchange our moronic current minister – this is "populist" and "lobbyist" policy over common sense. We have felt no benefit or support from the change. Nothing has been done for GPs, and we remain in a precarious position, which cannot be fixed by sound bites that replace decades of neglect.
 GP

"Can someone tell the Government and opposition parties that all of health needs to be pan-party agreement to changes and funding, etc? That way, we are not subjected to the mercenary roll of the dice every three years, and there would be a feeling of value and stability in the sector.
 GP

"The new health minister doesn't know how the health service works and has not got the necessary experience to be health minister.
 GP

"My practice ownership and management group has done the mahi ourselves to reduce reliance on a fickle and misinformed Ministry of Health. The cavalry died years ago and isn't coming. We are it, and we're accustomed to circling the wagons.
 GP

Looking to leave
 "Burned out, tired of fighting. There is no one to take over the gap I will leave in our community in a year or two.
 GP



"I am looking at any way possible to get out. I used to love my job. It has become so stressful due to increased demands, increased expenses, and the daily stress of paying the bills, let alone earning an income out of it. Now I hate it; wish I never went to med school; wish I never became a GP. I feel on the verge of tears going to and from work most days.
 GP

"I am 70 – cannot wait to get out of primary care in this present environment. By the time all the above takes effect, I will be having umbrella drinks, watching news about the excuses why the above didn't really work...they should have increased capitation and get those doubtful overseas doctors to come to NZ and not Aus.
 GP

"These plans do not help general practice as we have lost and continue to lose our older experienced workforce (including myself) that could have made a difference; these proposals are unfortunately well too late. Many of my colleagues and myself have early exit plans already drawn up and in motion...
 GP

On the plus side...
 "I feel very privileged and love my work and the team I work alongside. The people we care for are getting access to high-quality primary care.
 NP

"It is at least good to hear more about the lack of funding in primary care, but we need to start listening to everyone. We all know that \$1 spent in primary care saves \$14 in secondary. Let's turn things around and promote GPs as the specialists they are. Pay them and their teams in a manner to reflect this.
 Administrator

"A smidge more optimistic. But then I don't think that the Government will be retained unless they work some magic in health between now and the election.
 Chief executive, past clinician

"Political pressure is likely to mean much-needed investment is more likely.
 Advocate

On PHOs
 "There should be more longer-term funding contracts, and in many cases, these can be dealt with directly with general practice. The rural contracts with ACC are a case in point. We certainly do not need to be spoon-fed by a PHO organisation that, to us, is clearly over-staffed, underworked and actively encouraged to dream up ridiculous plans that simply don't work.
 Administrator

On parity
 "GPs are specialists and need to be paid as specialists or more, as patient[s] present with multiple problems they like us to fix in 15 minutes.
 GP

"You cannot expect doctors to want to work as GPs if they [aren't] paid similar amounts to hospital doctors. Increase their remuneration and doctors will be more likely to want to work as GPs. The same goes for nurses. Pay what they would get in the DHBs. All our nurses can pretty much walk straight into a DHB job without a problem. The same cannot be said for DHB nurses coming to work for us.
 GP

"Just action the Sapere report with adjustment for inflation. Get rid of PHOs that are top slicing the lifeblood out of general practice. Don't attach funding to stupid targets that will only create more demoralising bureaucracy. GPs are demoralised and sick of it and are being made sick by all these political manoeuvres. Well done, Simeon. In just a few short weeks, you were able to finally break this previously relentlessly optimistic GP. Hope you are proud. If you find this response puzzling, Mr Brown, you better find out why you don't understand in a big hurry. You have an awful lot to learn.
 GP

"I believe in our system of healthcare being a right, not a privilege you must purchase. I don't believe you can bribe any of us to try harder by offering pay for performance. We already give all we can.
 GP

"Simeon Brown has prioritised primary care, which is positive, but most initiatives lack long-term vision and sustainability. The funding decisions seem reactive rather than strategic, with many short-term interventions that do not address systemic issues such as workforce shortages, health equity and structural funding gaps...Capitation reform and sustainable workforce solutions should be top priorities, rather than fragmented funding pools and performance-based incentives that may create unintended barriers.
 GP

"General practice has struggled under successive governments since I graduated in 1980. Two simple suggestions: (1) Bond med students on a year-by-year basis to work in [general practice] and forgive their student loan for each year they agree to be bonded. (2) Increase the capitation, especially for rural areas to encourage GPs to work rurally.
 Sports physician and GP

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Analysis on renewing primary care system

Specialist GP Prabani Wood begins her lengthy paper on the problems of primary care and possible solutions with a gripping story of not being paid for probably saving a patient's liver from irreversible damage. Dr Wood, who established Cambridge Family Health in 2014, relates this incident in her paper, *The Heart of Healthcare: Renewing New Zealand's Primary Care System*, published by the New Zealand Initiative, a pro-market think tank at which she is a research fellow. The paper traverses the underfunding and understaffing problems of general practice and its "archaic fragmented IT systems" and also looks at some new models of care. It concludes: "Long-term cross-party agreement is required if any meaningful and sustainable improvements are to be achieved in primary care." **Read more: 'UPLOAD: Specialist GP's analysis on renewing primary care system' Delve into: *The Heart of Healthcare: Renewing New Zealand's Primary Care System***

Report on expanded primary care teams

A report by General Practice NZ finds primary care patients have benefited from government-funded schemes that expand the kinds of health workers operating in the sector. The number of disciplines working in primary care was already expanding, but this trend has been boosted by the Access and Choice scheme and, more recently, by the Comprehensive Primary Care Teams scheme. Access and Choice has funded health improvement practitioners, health coaches and other support staff to work in practices. CPCTs have involved care coordinators, kaiāwhina, physiotherapists, pharmacists and extended-care paramedics working in practices, pharmacies, PHOs and patients' homes. The CPCT funding of \$102 million over three years is due to end in June. **Read more: 'UPLOAD: GPNZ report finds benefits for access and outcomes in team schemes' Delve into: *GPNZ Extended Care Primary Care Teams Current state, future opportunities*** ■ **Read more on these stories and download the reports at nzdoctor.co.nz**



The cutting edge is a nice place to hunt for new music. Although nothing is really new, a formidable skill in recycling and a perpetually refreshing audience makes this matter little. Here are this month's favourites



No way to relax when you are on fire
Dora Jar
Made of Elves Inc, 2024
★★★★★

Comfortably self-declared weirdo **Dora Jar** has been on a lot of watchlists since her excellent 2021 EP *Digital Meadow* and a very solid tour as an opener for **Billie Eilish** (no mean feat) in 2022 and **The 1975** in 2023. She is very much an artist's artist. Eilish, **Conan Gray** and **Gracie Abrams** count her as a friend and an influence on their own music. Her voice is a skilful instrument. She sounds much younger than her 28 years and this works well for her, she brings a sense of wonder and naiveté that does not come across as contrived. Her songwriting has also solidified and, where the EPs have been playful teases at what she might become, the album is a more than accomplished debut. It is a compelling listen from go to whoa. Quirky opening track "This is Why" gives way to the chill groove of "Timelapse" which displays her versatility and confidence. Then "Debbie Darling" kicks up a notch and mines **Bowie** and **The Beatles** (and why not) and is a ridiculously strong song for what is technically a debut album. It also demonstrates her excellent taste in production and engineering. There isn't a bad song lyrically, and there isn't a bad song sonically. "Ragdoll" is next and riffs on reckless sex with an almost club beat. "She Loves Me" slaps like a **Wet Leg** song and is a deserving single. "Puppet" shows she can shred with



Dora Jar brings a sense of wonder to her vocals and has solidified the songwriting on her debut album, offering a compelling listen

St Vincent and "Behind the Curtain" that she can sequence like **Grimes**. So good.
GET THIS: Welcome and hail queen of the weird kids



Billboard Heart
Deep Sea Diver
Sub Pop, 2025
★★★★½
Seattle-based **Deep Sea Diver** hit 2025 with a phenomenal new album. They are new to me, via a heads-up from my adept younger brother. Singer **Jessica Dobson**, though, is not new, she has been playing in this incarnation since 2009. In a lengthy career, she has also played guitar for **Beck** and with **Conor Oberst** and **The Shins**. Well-travelled, and revered in Seattle, now it seems time for the rest of the world to switch on to the band. It isn't hard to get into the rhythm. "Billboard Heart" is a cracking opener and a compelling single. Plaintive vocals over echoing guitars and synth washes could certainly be sailing close to **Sharon Van Etten**'s sound, but there is ample room for both



Deep Sea Diver, with singer-guitarist Jessica Dobson, are revered in Seattle and their new album could get the rest of the world on side

when the output is this good. There is no let-up, with "What Do I Know" and "Emergency" both sharing the propulsive rhythm beloved by **Spoon** (who she has also played with) and nailing the brief. Next single "Shovel" builds on and exceeds this premise. By also conjuring some mid 1980s' grooves and not letting up on the vocal tension, this is a terrific cut – a favourite track of the year so far. "Always Waving Good-bye" betrays a winning **Beatles** sensibility. But "Let Me Go" is flat-out epic, twinning vocals with

folk/Americana singer **Madison Cunningham**, this crushes the emotional power-play. Superb. "Happiness is Not a Given" is also a phenomenal closer. There is more than a hint of **Radiohead** in the mix, and she shows her vocals can reach and mirror **Thom Yorke**'s fragile frequencies.
GET THIS: Better found late, than forever unheard ■

David Doig is a Havelock North GP. His email is nzdocmusic@hotmail.com

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*PAXLOVID reduces the risk of COVID-19-related hospitalisation or death by 86% when taken within 5 days of symptom onset^{1†}

†Efficacy compared with placebo through Day 28 in the EPIC-HR clinical trial (P<0.001; secondary endpoint)^{1,2}

Streamline PAXLOVID access for your high-risk patients with 3 simple steps at their next appointment:³

1 Consider an advance prescription for your eligible patients[^]

[^]Identified based on your judgment of clinical need and expected benefit.

2 Request a renal function test (if clinically appropriate)

3 Send advance prescription to chosen pharmacy, with these annotations:

- ✓ 'Advance prescription. Meets Pharmac eligibility criteria' (except current COVID-19 infection)
- ✓ 'Not to be dispensed until diagnosed with COVID-19'
- ✓ Patient's latest eGFR (if available)

IF IT'S COVID THINK PAXLOVID^{*1}

*PAXLOVID is indicated in high-risk patients ≥18 years with mild-moderate COVID-19, unless contraindicated. Review for drug-drug interactions. Commence within 5 days of symptom onset.¹ Pharmac restrictions apply.⁴

PAXLOVID® (nirmatrelvir 150 mg/ritonavir 100 mg) film-coated tablets

Indications: Treatment of coronavirus disease 2019 (COVID-19) in adults 18 years of age and older, who do not require initiation of supplemental oxygen due to COVID-19 and are at increased risk of progression to hospitalisation or death. **Contraindications:** Hypersensitivity to active ingredients or excipients, severe renal and severe hepatic impairment, potent CYP3A inducers, highly dependent CYP3A inhibitors. See Data Sheet for details. **Precautions:** CYP3A inhibitors or inducers may increase or decrease PAXLOVID concentrations; severe, life-threatening, and fatal adverse reactions due to drug interactions have been reported; co-administration with calcineurin inhibitors and mTOR inhibitors; anaphylaxis, other hypersensitivity reactions, toxic epidermal necrolysis and Stevens-Johnson syndrome have been reported; use with caution in patients with pre-existing liver diseases, liver enzyme abnormalities, or hepatitis; low dose ritonavir may risk HIV-1 resistance to HIV protease inhibitors; contains lactose; pregnancy; lactation. See Data Sheet for details. **Interactions:** The drug-drug interactions for this medicine are extremely complex. See Data Sheet for details. **Adverse Effects:** **Common:** diarrhoea, vomiting, dysgeusia, headache. **Uncommon:** myalgia and hypertension. **Post-marketing experience:** anaphylaxis, hypersensitivity, nausea, abdominal pain, malaise, toxic epidermal necrolysis and Stevens-Johnson syndrome. See Data Sheet for details. **Dosage and Administration:** 300 mg nirmatrelvir and 100 mg ritonavir tablets taken together orally every 12 hours for 5 days. Mild renal impairment, mild and moderate hepatic impairment, elderly: no dose adjustments. Moderate renal impairment: 150 mg nirmatrelvir and 100 mg ritonavir taken together orally every 12 hours for 5 days. See Data Sheet for details. **Medicines Classification:** Prescription Medicine. PAXLOVID is a funded medicine – Restrictions apply. Before prescribing, review Data Sheet available from Medsafe (www.medsafe.govt.nz) or Pfizer New Zealand Limited, Auckland, (www.pfizermedicalinformation.co.nz) or call 0800 736 363. ® Registered trademark. V11223

References: 1. PAXLOVID Data Sheet. 2. Hammond J, et al. *N Eng J Med*. 2022;386:1397–1408. 3. Te Whatu Ora. Advance Prescriptions for Oral COVID-19 Antiviral Medicines. Available at: www.tewhatauora.govt.nz/assets/For-the-health-sector/COVID-19-Information/COVID-19-for-all-health-professionals/V5.0-Guidance-Advance-Prescriptions-for-COVID-19-Oral-Antiviral-Meds.pdf. Accessed 4th April 2025. 4. Pharmac. COVID-19 antivirals: Access Criteria. 1st Feb 2024. Available at: https://pharmac.govt.nz/news-and-resources/covid19/access-criteria-for-covid-19-medicines/covid-antivirals. Accessed 4th April 2025.

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The Clinical Quiz

Test yourself on this issue's clinical content



Gain CPD credits reading
New Zealand Doctor Rata
Aotearoa – see below

Educate

Educate Online

In April's **How to treat** feature, respiratory physician Lutz Beckert considers chronic obstructive pulmonary disease management, including the prevention of COPD, the importance of smoking cessation and pulmonary rehabilitation, and the lifesaving potential of addressing treatable traits. He also discusses the logic of inhaler therapy, moving from single therapy to dual and triple therapy when indicated, as well as other aspects of management.

In **First time**, specialist GP Jo Scott-Jones discusses health economics and considers whether cost–utility analyses could help plan for the workforce needed for our burgeoning population.

In **Heartbeat**, consultant cardiologist Chris Ellis discusses a case of cardiac ischaemia, including the various investigations and treatments required.

In **Pharmacotherapy**, pharmacist prescribers Linda Bryant, Penny Clark and Leanne Te Karu review a potentially significant drug–drug interaction between the antiepileptic lamotrigine and combined oral contraceptives.

In **Sexual health**, sexual health specialist Massimo Giola reminds you to keep an open mind as he describes an unusual case of a young man allergic to his own semen.

In **Travel medicine**, members of the New Zealand Society of Travel Medicine Nicky Burwood and Joan Ingram examine travellers' knowledge of rabies and different schedules of rabies pre-exposure prophylaxis.

Goodfellow Gems #237 looks at exercise for Parkinson disease.

PEARLS #765 asks whether antidepressants are effective for people with generalised anxiety disorder.

Medicolegal



Cottonbro Studio on Pexels

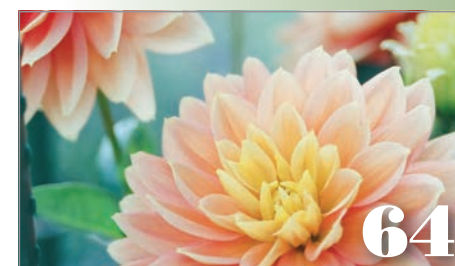
1. Botulinum toxins are among the most toxic poisons known. **True/False**
2. Use of social networking sites has been shown to increase the acceptance of cosmetic surgery. **True/False**
3. Fourteen days is required between the initial consultation and the performance of a cosmetic procedure where there is cutting beneath the skin. **True/False**

Sexual health



1. Recommended first-line treatment of gonorrhoea is ceftriaxone 500mg intramuscular injection plus azithromycin 1g orally. **True/False**
2. People can die of gonorrhoea if not treated. **True/False**
3. Clinicians do not need to notify ESR of cases of gonorrhoea. **True/False**

Older people



1. Living in a house with stairs reduces life expectancy. **True/False**
2. Shiny surfaces that create glare should be avoided in the home environments of older people. **True/False**
3. For people with dementia, having neutral decor in similar colours and hues is important. **True/False**

Clinical update: MHT



1. Approximately half of postmenopausal women over age 60 experience genitourinary symptoms. **True/False**
2. Transdermal menopausal hormone therapy is not associated with an increased risk of venous thromboembolism. **True/False**
3. MHT should be stopped 10 years after menopause onset or at age 60. **True/False**

Answers on page 68

+Educate | Capture your CPD credits



0.5 CR

Each Practice article has been endorsed by the RNZCGP and has been approved for up to 0.5 credits for continuing professional development purposes. Learning reflection questions are available with the articles online. Simply go to nzdoctor.co.nz and either click on Educate or use the search function to find the relevant article. The Capture button at the end of each article allows you to record your time spent reading and your reflections. To claim your CPD credits, log in to your Te Whanake dashboard and record these activities under the appropriate learning category.

A sideline in Botox? Top tips to keep yourself safe



Wellington barrister **Gaele Phipps** examines the risks of cosmetic procedures and how to prevent legal ramifications when providing them

It was a gathering of medical friends. A Kiwi visiting home from the US commented on how struck and impressed she was by the naturalness of New Zealanders – no Botox or lip filler in sight. This was significant to her. Then, silence.

One of the group – a GP – spoke out, “But wouldn’t it be lovely just doing that all day? Limited paperwork, delays won’t kill your patients, they choose whether to come back, and if they don’t, there is no need to chase them for follow-up; they are active and well and positive.”

It all sounds rather appealing, but is this reality?

Risks for patients and doctors

It has been opined in one paper that doctors who perform cosmetic procedures face relatively high risk of malpractice claims and complaints.¹ Plastic surgeons were fifth highest at risk of malpractice claims in one study,² but a 2022 review from Australia recommended caution in drawing conclusions from notification data.³

The only New Zealand GP ever charged with medical manslaughter (though he eventually pleaded guilty to the lesser charge of failing to provide the necessities of life) was a doctor

“Always have a cooling off period, such as sending the consent in advance of the procedure, then revisiting consent at the time of the procedure, to avoid the patient feeling pressured”

whose patient died from a cardiac event while he was carrying out a cosmetic procedure – an exoderm facial peel. Ian Scott Little was convicted in the High Court and District Court for his conduct on the same event. In 2002, he was disciplined by the Medical Practitioners Disciplinary Tribunal, with the outcome being censure and removal from the register of doctors. His crime was in viewing the procedure as very safe and omitting to have continuous cardiac monitoring, resuscitative drugs and emergency equipment on hand.⁴

In an article, it was said, “botulinum toxins are among the most toxic poisons”.⁵ However, the authors noted the rarity of serious events. Fillers have been known to cause complications such

as granulomas, infections and even permanent blindness.⁶ So, these procedures do have some health risks.

Legal disputes often involve the informed consent process for cosmetic procedures (eg, failure to explain risks or potential lack of benefit). Why patients complain has been put down to various other factors, including unrealistic patient expectations, commoditisation of medicine, and promotion of aesthetic norms.¹ For example, a recent study found a strong relationship between social networking site use and acceptance of cosmetic surgery. The authors suggested that social networking site use leads to fixation on appearance dissatisfaction.⁷

For doctors, motivation by commercial rather than therapeutic considerations can be an aggravating factor. Notably, in the 2002 tribunal decision, it is stated, “The tribunal is satisfied that Dr Little was motivated to carry out the procedure by commercial considerations and he failed to turn his mind to keeping his patient safe.”⁴ This case also highlights the increased risk of severe penalty when things go wrong in cosmetic procedures.

Top 10 tips

So, how do you keep yourself legally safer when performing cosmetic procedures?

1. Always under promise – unmet expectations increase the risk of complaint.
2. Do not overstate your qualifications or ability.
3. Ensure you are practising in scope.⁸
4. Consciously recognise and address the conflict that exists between recommending a procedure that does not improve physical health and the financial benefit you will receive from that recommendation being agreed to.
5. Pre-procedure assessment should include assessing motivation, mental and physical health.
6. Do not proceed without psychologist/psychiatric assessment if a patient has a mental illness associated with body image issues.⁹
7. Remember, you can decline to carry out any procedure and should do so at the whim of a scenario where the patient has had repeated procedures and expressed dissatisfaction, has high expectations about how lifechanging results will be, is hesitant or appears to be pushed by the interests of a third party, or heaps praise on you as if you are a God/superstar – you can never live up to such adoration.
8. Have formal, written, robust, highly informative consent processes that frankly state any risks associated with the procedure.
9. Always have a cooling off period, such as sending the consent in advance of the procedure, then revisiting consent at the time of the procedure, to avoid the patient feeling pressured.
10. Be familiar with the Medical Council of New Zealand *Statement on cosmetic procedures*.⁸

Gaele Phipps is a barrister with Lambton Chambers in Wellington. If you have a request for this column, email gphipps@professionallaw.co.nz

The references for this article are available with the online version on nzdoctor.co.nz

PEARLS #766

Practical Evidence
About Real Life Situations

Adding medication to psychosocial interventions for alcohol use disorder

Clinical question

What is the effectiveness of combined pharmacological and psychosocial interventions for alcohol use disorder in adults?

Bottom line

Results indicate that adding pharmacotherapy to psychosocial interventions may benefit people with AUD. Compared with psychosocial interventions alone, combined interventions probably reduce heavy drinking and may lower the risk of alcohol consumption during abstinence. This is supported by reductions in craving severity and alcohol-related consequences.

However, they probably do not affect the rate of abstinent days and may not reduce heavy-drinking days or the number of drinks per drinking day. There was no increase in the number of serious adverse events, dropouts, or dropouts due to adverse events compared with psychosocial interventions alone.

Any benefits of combined interventions compared with pharmacotherapy alone, no intervention or treatment as usual are less clear.

Caveat

The review primarily focused on the combination of naltrexone and cognitive behavioural therapy, with few studies evaluating other pharmacological and psychosocial combinations. Studies were conducted in the US, Canada and Europe, and participants were mainly middle-aged men without comorbid mental disorders, limiting generalisability to other populations.

Context

AUD increases mortality and morbidity, causing acute risks such as intoxication and injury, and chronic issues such as cancer and heart disease. It impacts individuals and societies, leading to disability, premature death and economic costs.

Psychosocial interventions include behavioural therapies, motivational interviewing, mutual help groups, 12-step facilitation, psychodynamic therapy and social network therapy. Medications used for AUD recovery include disulfiram, naltrexone and acamprosate. Combining medical and psychosocial interventions may address both immediate and long-term AUD risks.

Cochrane Systematic Review

Minozzi S, et al. Combined pharmacological and psychosocial interventions for alcohol use disorder. *Cochrane Database Syst Rev* 2025;3:CD015673. This review contains 21 trials, representing 4746 participants.

PEARLS are summaries of Cochrane Systematic Reviews, developed for primary care practitioners by the Cochrane Primary Care Field and Cochrane New Zealand, funded by the Ministry of Health. They are written by Vanessa Jordan, an associate professor and the New Zealand Cochrane Fellow based at the University of Auckland. New Zealanders can access the Cochrane Library free via nz.cochrane.org

Threat from the past looms as gonorrhoea develops resistance



Sexual health specialist **Massimo Giola** looks at the increasing resistance of gonorrhoea to treatment options and the need to notify cases and contact trace

Is gonorrhoea becoming untreatable (again)?

Geoff is one of the young men who comes to our sexual health service infrequently, but when he does, there is definitely something interesting going on. He self-referred on a Tuesday morning, and as we had a free slot in the afternoon clinic, I was able to see him the same day.

The diagnosis was not an issue; he knew he had gonorrhoea as he had had it before, and I quickly confirmed on examination that there was indeed a lot of “gonadal flow” (which is the Greek etymology of gonorrhoea). Oh well, at least there was plenty of pus to sample, not only for PCR detection but also for old-fashioned culture and sensitivities.

I gave Geoff a shot of ceftriaxone (500mg) and two tablets of azithromycin (1g) for synergistic effect, as per the Aotearoa New Zealand STI Management Guidelines for use in primary care (tinyurl.com/STI-gon).¹

I then proceeded to ask for further epidemiological information to use for contact tracing/partner notification. It turned out that Geoff was pretty sure when and where he got the infection (the previous Saturday at the sex-on-site venue in our city) but could not name any contacts as they were all anonymous.

Darkrooms ‘101’

Not only Auckland, Sydney and the likes have sex-on-site venues, but also some regional cities. In this case study, it is a darkroom at the back of an adult shop, where men are admitted on paying a fee, and then have sex with each other, potentially anonymously (formal introductions are not essential).

For the uninitiated, sex-on-site venues (sometimes abbreviated SOS) have been around in gay culture for a long time. They can be more or less sophisticated, and sometimes include saunas and other amenities, but the common etiquette includes anonymity and lack of traceability for obvious reasons. They fulfil a positive purpose in giving to men who might not be openly “out” a safe location, far from the public eye, to sexually express themselves.

If we did not have or allow any SOS venues, men would be forced to have sex in public parks or toilets (the English slang word for that is

Key points

◆ Keep actively screening for gonorrhoea, particularly in the most affected communities.

◆ Ideally, every time there is pus, also send a further swab for culture as only this can give antibiotic resistance information; in 2022, only 24 per cent of the almost 7000 cases of gonorrhoea in New Zealand were cultured.

◆ Culture should be performed before any antibiotics are given.

◆ Always follow the Aotearoa New Zealand STI Management Guidelines when treating gonorrhoea.

◆ Notify all gonorrhoea cases and do your best to contact trace.



Sex-on-site venues in Aotearoa are legal but the venue owners are obliged to supply free condoms

“cottageing”), as it happened for centuries until the sexual revolution in the 1970s.

SOS venues in Aotearoa are perfectly legal, but I understand there is an obligation for the owner to offer a supply of free condoms and to put some information posters on the walls about sexually transmitted infections and how to get an STI check. (That was the case when I sat on the board of the New Zealand AIDS Foundation – now Burnett Foundation Aotearoa – and we had our social marketing team reaching out to all of them.)

As a practical tip to clinicians, I noted the infection was acquired at an SOS venue in my notification form, and I followed up with an email to our public health unit to request an educational intervention by their health protection officers to the owner of the SOS venue (offering support from our service, of course).

Bad news follows culture

The day after treating Geoff, my clinical diagnosis was confirmed by PCR, and after another couple of days, the culture also came back positive. The bad news was that the strain of *Neisseria gonorrhoeae* was resistant to both azithromycin and ciprofloxacin, and borderline between intermediate and completely resistant to tetracyclines too.

Luckily, it was still susceptible to ceftriaxone – but if Geoff was allergic to beta-lactams, we would have been left with no evidence-based, easily available option. Also, I felt distinctly uncomfortable thinking we were only one antibiotic away from disaster, and out in the community, there were at least six to eight men with whom Geoff had sexual contact during that Saturday at the SOS venue, and who could be either the index case or the contacts of his difficult-to-treat gonorrhoea strain.

I partially placated my anxieties by asking Geoff to come back early (four weeks after treatment) for a test of cure to make sure that, at least for him, the 500mg of ceftriaxone had been enough to eradicate the infection.

Just as a reminder, the latest edition of the Aotearoa New Zealand STI Management Guidelines has removed the early test of cure in most cases and replaced it with a test for reinfection three months after treatment.¹

For gonorrhoea, the remaining indications for

an early test of cure are gonorrhoea in pregnancy and pharyngeal gonorrhoea. However, I would argue (and I will propose for the next edition of the guidelines) that antibiotic resistance to two or more of the main agents normally used for gonorrhoea treatment is also a valid reason to perform an early test of cure.

Notifications needed

Please do your best to complete contact tracing and partner notification – as of March, the public sexual health clinics do not have any dedicated contact-tracing full-time equivalents and are able to help only in limited and selected circumstances (eg, during pregnancy).

Also, please do notify all gonorrhoea cases (ESR data show >50 per cent of cases are not notified) and add as much epidemiological information as you can. ESR only gets very limited information from the laboratories (site of infection, age, gender and ethnicity) and is completely dependent on notifications by clinicians to fill the gaps.²

If ever we find ourselves in the situation of having pan-resistant gonorrhoea with no antibiotic options left, we know from historical case series that people can die of it. The natural history of untreated (and untreatable?) gonorrhoea includes a 3 per cent risk of disseminated gonococcal infection, causing sepsis, septic arthritis and aortic valve endocarditis.

Before the antibiotic era, most patients with gonococcal endocarditis died of valve incompetence and acute heart failure within six weeks. Looking at its incidence from another perspective, a surprisingly high proportion (26 per cent) of all bacterial endocarditis cases were due to gonorrhoea before 1938 – and the threat might well come back if we are not careful with our antibiotics.³

Details changed to protect patient confidentiality
Massimo Giola is an infectious disease and sexual health physician, and clinical lead of the sexual health services for Health New Zealand Te Whatu Ora Hauora a Toi Bay of Plenty and Te Whatu Ora Lakes

The references for this article are available with the online version on nzdoctor.co.nz

Simplifying urinary tract infection management and prevention

Clinical writer **Noni Richards** summarises the assessment, treatment and prevention of urinary tract infections



Urinary tract infections are among the most common bacterial infections, affecting individuals across all age groups but disproportionately impacting women.¹ They occur when bacteria, most commonly *Escherichia coli*, colonise and infect the urinary tract. Uncomplicated UTIs include acute cystitis occurring in healthy, non-pregnant women with no urinary tract abnormalities or comorbidities. Complicated UTIs involve structural or functional impairments that reduce treatment efficacy, such as urinary obstruction, immune suppression or recent urological procedures. Kidney involvement (pyelonephritis) or UTIs during pregnancy are also classified as complicated.²

UTIs can be acute or recurrent. Recurrent UTIs are defined as at least two infections in six months, or three or more in a year.²

Presentation

The classic symptoms of an uncomplicated lower UTI include dysuria, urinary frequency, urinary urgency and suprapubic discomfort. Systemic symptoms such as fever, chills, nausea, vomiting or flank pain suggest an upper UTI (pyelonephritis) or systemic infection. Red flags that warrant further investigation are listed in the panel.^{1,3,4}

Testing

Routine urine culture is not necessary for most cases of uncomplicated cystitis in females. Empiric treatment is usually sufficient without the need for laboratory confirmation. However, urine culture (preferably from a mid-stream urine sample) is warranted in specific situations – for example, in patients with lower UTI symptoms and any of the following factors:^{3,5,6}

- child under 14 years
- male
- urinary tract abnormality (either anatomical or functional)
- renal transplant recipient
- poorly controlled diabetes
- pregnancy
- recurrent or persistent UTI symptoms despite treatment
- suspected pyelonephritis or upper UTI.

Dipstick urinalysis can support diagnosis when UTI symptoms are unclear but should not be used in catheterised patients. Classic UTI symptoms alone predict infection more reliably (90 per cent probability) than a positive dipstick result. While dipstick testing is sensitive, it lacks specificity – if nitrites or leukocytes are positive, UTI probability increases to about 80 per cent. Dipstick results should be used alongside clinical assessment rather than as a standalone diagnostic tool.⁶

Management

Current guidelines recommend nitrofurantoin as the first-line empiric treatment for uncomplicated lower UTIs due to its effectiveness and low resistance rates.^{3,6,7} The standard regimen is nitrofurantoin 100mg modified-release capsules

Red flags and complicating factors³

Suspected pyelonephritis or systemic infection – symptoms such as fever above 38°C, rigors, flank pain, nausea and vomiting suggest an upper UTI or systemic infection.

Pregnancy – pregnant patients with UTIs may require referral for medical assessment and treatment due to the increased risk of complications, including preterm labour and pyelonephritis.

Recurrent UTIs – patients with recurrent UTIs (defined as two or more infections in six months or three or more within a year) should be referred for further investigation to identify underlying causes, such as anatomical abnormalities or kidney stones. Patients who have had unsuccessful antibiotic treatment within the

past two weeks also require further investigation (including urine culture).

Older patients – older people may not present with classic UTI symptoms and are at increased risk of complications such as urosepsis.

Pre-existing conditions – other high-risk groups include those with diabetes, immunosuppression or renal impairment, as they may have atypical presentations or a higher likelihood of complications.

Men – lower UTIs can occur in males with normal anatomy and be treated similarly to females. However, UTIs are less common in men, requiring consideration of urethral or prostatic infections. Older men with possible prostatic hypertrophy or recurrent UTIs should be further evaluated.⁴

twice daily for five days. Seven days of nitrofurantoin is appropriate for uncomplicated UTIs in men and pregnant women, but it should be avoided after 36 weeks' gestation.⁸

Nitrofurantoin is generally well tolerated, but patients should be advised of possible side effects, such as nausea and gastrointestinal discomfort. It should be avoided in patients with significant renal impairment (creatinine clearance <60ml/min) due to reduced urinary concentrations (and increased risk of treatment failure) and increased toxicity risks.⁸ Cephalexin (500mg twice daily for five days) is a recommended alternative option.

Trimethoprim also remains an alternative option, prescribed at 300mg once daily for three days.^{3,6,7} However, rising resistance rates have reduced its reliability as an empiric treatment. Recent surveillance data from Auckland, Northland and Canterbury show approximately 25 per cent of *E. coli* isolates are resistant to trimethoprim.^{9,10} Trimethoprim should be avoided in the first trimester of pregnancy.

Note that the urinary alkaliser Ural is no longer routinely recommended for acute UTI treatment as increasing the urinary pH may reduce antibiotic effectiveness, particularly for nitrofurantoin. Instead, NSAIDs can be used alongside antibiotics for pain relief if needed.³

An uncomplicated lower UTI may resolve on its own. Routine treatment of asymptomatic UTI is not recommended, except in pregnant people, who should be screened at their first antenatal appointment.

Prevention

Preventing recurrent UTIs is a key aspect of management, particularly for patients with frequent infections. Lifestyle modifications that may help reduce recurrence include:

- maintaining adequate hydration (at least 2.5L per day) and not delaying urination, to promote urinary flow and bacterial clearance
- practising good perineal hygiene, including wiping from front to back

- urinating after sexual intercourse to reduce bacterial introduction into the urethra
- avoiding spermicide-containing contraceptives, which can disrupt normal vaginal flora

• consuming cranberry products, which may have a role in reducing UTI recurrence in some patients, though evidence remains mixed.¹¹

Most women with recurrent UTIs can be effectively managed in primary care through the non-pharmacological strategies described above. Other recurrent UTI management options include the following:

• **Vaginal oestrogen therapy** – can help reduce UTI recurrence in postmenopausal women, particularly those with vaginal atrophy.⁶

• **Low-dose antibiotic prophylaxis** – this is typically trialled for six weeks to six months. Patients should be monitored for adverse effects, particularly with prolonged nitrofurantoin use. If an infection occurs despite prophylaxis, the prophylactic antibiotic should be stopped, the patient treated with a full course of antibiotics, and then prophylactic use reassessed.⁶

• **Methenamine hippurate (Hiprex)** – the ALTAR trial showed this agent is non-inferior to nitrofurantoin for preventing recurrent UTIs in women.¹² It maintains urinary acidity to inhibit bacterial growth and requires periodic liver function monitoring. ■

Noni Richards is a registered pharmacist and a senior researcher at Matui

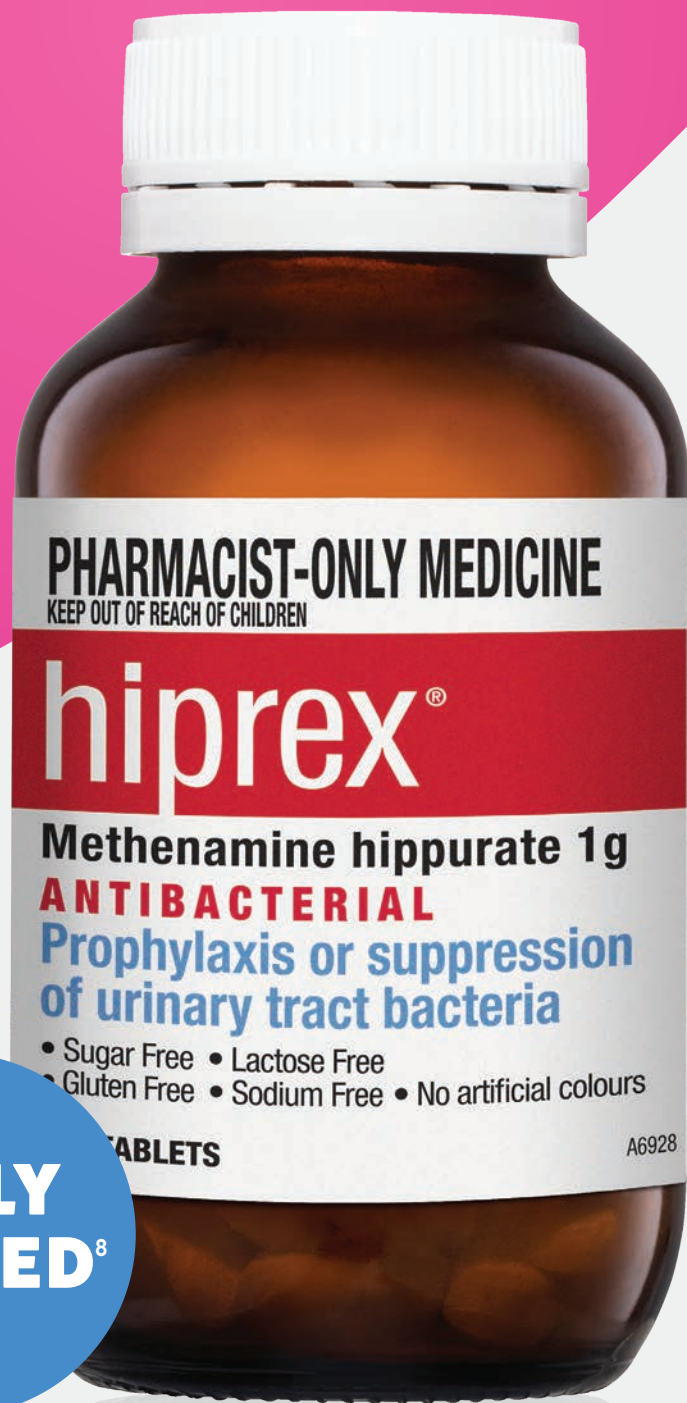
The references for this article are available with the online version on nzdoctor.co.nz

Up to
1 IN 4
WOMEN

who experienced a UTI in their life, will go on to suffer a recurrent UTI*¹

Indicated for prophylaxis or suppression of bacteriuria associated with recurrent infection of the urinary tract.²

100 tablets
FULLY FUNDED⁸



Prescribe Hiprex for your female patients to help protect against recurrent* UTIs

- Effective[‡] protection against recurrent* UTIs.^{3,4}
- No known risk of antimicrobial resistance with long-term use.^{3,4}
- Generally well tolerated.^{6,7}

Antimicrobial resistance (AMR) is one of the top global public health and development threats.

WORLD HEALTH ORGANIZATION⁵

‡p<0.01, vs placebo over 1 year of treatment with two 6-month Hiprex treatment periods in a 2-year double-blind crossover protocol.³ 11 cases of cystitis in women treated with Hiprex (n=11) vs 41 cases in women on placebo (n=10).³

[†]100s fully funded on prescription

*Recurrent UTIs: ≥2 in 6 months or ≥3 in 12 months¹

REFERENCES: 1. Geerlings SE et al. *Infect Dis Clin North Am* 2014;28(1): 135–47. 2. Hiprex Data Sheet. 3. Cronberg S et al. *Br Med J (Clin Res Ed)* 1987;294(6586):1507–8. 4. Lo TS et al. *Expert Rev Anti Infect Ther* 2014;12(5):549–54. 5. Antimicrobial resistance. (2023, November 21). World Health Organization (WHO). <https://www.who.int/news-room/fact-sheets/detail/antimicrobial-resistance>. 6. MIMS Full Prescribing Information: Hiprex. 7. Australian Medicines Handbook Pty Ltd. 2019. 8. <http://schedule.pharmac.govt.nz/2024/06/01/Schedule.pdf> HIPREX is a Pharmacist Only Medicine for the prevention or suppression of urinary tract bacteria associated with recurring urinary tract infections. Contains: Methenamine Hippurate 1g per tablet, available 20 and 100 tablet bottles. 100 tablet bottle is a fully funded medicine, a prescription charge will apply. Dose: adults and children 12 years and older 1 tablet twice daily. Do not give to children under 12 years. Contraindications: severe hepatic impairment; severe renal failure; severe dehydration; metabolic acidosis; gout; acute parenchymal infections. Pregnancy: Category A. Interactions: alkalinising agents; sulphonamides. Adverse Effects: nausea, upset stomach, dysuria, rash. Radiant Health, Auckland. Prepared May 2024. NZ-2024-05-0029 NP21020.

~25%
of local
E.coli
isolates are
resistant to
trimetho-
prim

EARN
CREDITS



Details on
page 57

Making changes to substance use can be difficult, but the right support makes all the difference.

Just a Thought have launched three new alcohol and drug support courses to help you empower patients to make meaningful changes to their substance use.

Accessible, practical support at the click of a button

The three courses are designed to support people experiencing harm from their substance use - whether they're thinking about making changes, ready to take action, or seeking support after a lapse or relapse.

Grounded in proven therapeutic approaches

- Motivational Interviewing
- Acceptance and Commitment Therapy
- Cognitive Behavioral Therapy

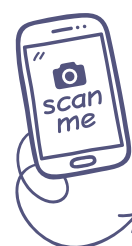


Guided by real people with real stories of change and recovery.



For more information or to sign up and start prescribing these courses, go to:

justathought.co.nz/drugandalcohol



Harnessing ambivalence as tool in recovery from substance harm

This article discusses how to effectively approach ambivalence in people experiencing substance harm, to support their recovery

► Anna Elders

Ambivalence is a complex emotional state we experience when faced with contradictory positive and negative feelings about a situation. Commonly experienced during challenges or transitions in life, ambivalence can cause great discomfort as people sit with the uncertainty of what they should do next. However, it can play a crucial role in decision-making, prompting reflection, information-seeking, and weighing-up of options to help us make more informed choices.

The intensity of ambivalence increases with the complexity of decisions, especially when losses are possible. This can lead to indecision and inaction, fuelling distress and avoidance through fear of making a "wrong decision".

For health professionals, ambivalence presents daily challenges in the work we attempt to do with people, particularly when patients must make behavioural changes for their health that involve sacrificing something they value. Success in such interventions often depends on our ability to effectively work with ambivalence, just as much as it does our clinical reasoning skills.

Ambivalence and addiction

Ambivalence is a key concept in addiction and substance harm. According to Prochaska and DiClemente's Stages of Change model, individuals experiencing significant ambivalence are thought to be in a contemplative stage of change. While this stage can create obstacles, people are often more open and motivated to consider reasons for change and possible solutions.

Conversely, ambivalence often intensifies as the risk for lapse or relapse increases, or relapse occurs. Maintaining recovery from addiction is challenging, and feelings of ambivalence towards abstinence or harm-reduction efforts are natural.

During the increased period of risk for lapse and relapse, people often experience a range of internal and external triggers, including "permission-giving thoughts" that attempt to justify substance use. This period is marked by distress and conflict, as the desire to use clashes with the awareness people have of the associated risks of going back into harmful behaviours.

Despite its challenges, ambivalence does not have to be a major barrier for wellbeing. When approached thoughtfully and with the right support, it can serve as a tool to help people reflect on their personal values, future aspirations and the necessary self-care actions required to ensure forward momentum.

While ambivalence can support positive change, it becomes more of a problem for those with lower self-awareness and self-confidence and who have difficulties committing to their values in life. Low self-confidence and unclear values can lead to a cycle of uncertainty and inaction, compounded by the stigma of addiction.

This inertia can foster feelings of hopelessness, powerlessness and shame, making it even harder to initiate change. As distress and self-doubt grow, isolation follows, further deterring help-seeking behaviour.

“Despite its challenges, ambivalence does not have to be a major barrier for wellbeing”



Just a Thought offers three free courses for people struggling with addiction and harmful substance use

Utilising benefits of ambivalence

To overcome these barriers, a healthier approach to ambivalence is essential. This involves fostering awareness of, and commitment to, what matters most.

Recognising ambivalence as a normal part of the recovery journey allows it to become a powerful tool for reflection. This is incredibly supportive for people struggling with harmful substance use, where the anxiety of uncertainty creates a major barrier for change.

Supporting people to foster a more open, curious and flexible approach to the conflicts present within their ambivalence, allows them to better process their own internal experiences and arrive at more thoughtful decisions. This can build greater self-confidence, but it also creates more willingness to experience distress, reducing the likelihood of them turning to substance use and other unhelpful coping mechanisms as a way to tolerate emotional pain.

Facilitating this process through open discussions helps individuals address the potential losses and difficulties associated with change. Such conversations also allow people to identify necessary supports, increasing their motivation for change and reducing acceptance of harmful substance-use patterns.

Building a kete of skills

Techniques from motivational interviewing, cognitive behavioural therapy (CBT) and acceptance and commitment therapy (ACT) can help. These psychological approaches use Socratic questioning to help individuals gain insight into their stuck points, focus on goals, and build motivation and action.

Questions to explore ambivalence:

- What do you like about your substance use and what are the downsides?
- What impacts does it have on what matters most to you?
- What risks do you see if you don't change?
- What benefits would change bring?
- What makes it difficult to decide what to do about your substance use?
- What would help you to make a decision?

Questions to promote reflection and commitment to change:

- What future do you want for yourself and your loved ones?
- How would changing your substance use

help you to reach those goals?

- What difficulties would change bring?
- What supports and skills would you need?
- What could you focus on when things get tough?
- What's one thing you could do this week to move closer to your goals?

Useful digital courses

Just a Thought (justathought.co.nz) has just launched three new free courses for people struggling with addiction and harmful substance use: *Thinking About Change*, *Taking Action*, and *Getting Back on Track*. Each course is tailored to different stages of change (contemplation, action and relapse), teaching essential skills, providing information and sharing stories of hope from real people with lived experiences of recovery.

Built around the most helpful aspects of motivational interviewing, CBT and ACT, the courses support people to make changes to their substance use while increasing self-awareness and overall wellbeing. Although people can register independently, research shows adherence and outcomes increase when people are prescribed a course by their healthcare supporter.

Another evidence-based digital tool made in New Zealand is the Headstrong app for young people (headstrong.org.nz). Its Change course focuses on treating and minimising harm related to both behavioural and substance addiction.

Other international digital tools to support substance-use recovery are in use in some parts of the country (eg, CHES Health at ches.health). Other apps can be used to track alcohol use but do not offer comprehensive support (healthify.nz/apps/a/alcohol-use-apps).

We need a wide array of digital tools to provide choice and ensure they can be woven into face-to-face services and support.

Ambivalence is less problematic when viewed as a normal part of life. By staying focused on what matters, individuals can harness ambivalence to support thoughtful action. Health professionals play a vital role in this process by maintaining non-judgemental, trusting partnerships and employing tools and techniques that foster reflection, confidence and resilience. ■

Anna Elders is a mental health nurse practitioner in Tauranga, an honorary teaching Fellow at the University of Auckland, and the clinical lead for Just a Thought

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Details on page 57

Thoughtful housing design helps better ageing through life stages



Specialist GP **Ngair Kerse** looks at healthy home design and the positive impacts this can have for older people, whether living independently or in care

Where we live and what we live in makes a difference to our health and wellbeing. As our society ages (the ageing demographic transformation), the “age-friendly city” movement attempts to ensure public spaces, public transport, amenities and developments are accessible, easy to navigate, safe and well lit.

Wouldn't it be nice if the house we live in during early and mid-life is still fit for purpose in late life? Accessible housing design achieves this, and while Kāinga Ora – Homes and Communities uses accessible, healthy design standards (one of the justifications for increased building costs), many newer developments don't. Retrofitting for accessibility is much more expensive than starting out with an accessible design. Inside the house, the layout, decor and functionality of spaces become more important as people age. The negative impact of health and social needs is reduced by age-friendly housing.

Age-friendly environments

The senses change with age. As the eyes' rods and cones lose sensitivity, colours fade and contrasts and brighter lighting become more important. Glare also becomes difficult for older people, so shiny surfaces facing the sun need to be avoided (eg, by using tablecloths to cover shiny tables). Dual sensory impairment is more debilitating than hearing or vision impairment alone. Age-friendly design enables ongoing independent function by accommodating both sensory and physical disability.

Stairs are good for longevity – those who reside in houses with stairs live, on average, five years longer than those who live in houses without stairs. However, stairs can become a barrier, and a downstairs toilet becomes more desirable with age. The size and shape of furniture also makes a difference. For example, low couches that you sink into may be difficult to get out of for those with low mobility.

Older people with sensory, functional or cognitive impairments living in accessible or usable home environments have better health, are better able to accomplish everyday tasks, are less likely to fall, and have less fear of falling than those with impairments living in conventional or unmodified home environments.

Perceived difficulty in performing activities of daily living inside and outside the home was

Key points

◆ Older people with sensory, functional or cognitive impairments living in accessible or usable home environments have better health and ability for everyday tasks.

◆ For people with dementia in care homes, having familiar items, easily identifiable and home-like spaces, no clutter and good lighting are helpful features.

◆ Within a GP practice, design and function make a difference to how things flow, for both patients and staff.

shown to improve two months after home modifications for older adults with impairments. This included increased confidence in managing disability and increased safety, especially in tasks related to self-care.^{1,2}

So, think about that as you upsize, downsize, renovate and relocate. Use age-friendly design advice, think about the interior design and live in that house through older and advanced age. Fill the house with those who need accommodation, and when you pass it on, the next family will be able to live in it through their stages of life. Lifemark has universal design standards for all ages, stages and abilities, and they are great to engage with (lifemark.co.nz).

Dementia-enabled environments

The built environment around people living with dementia and their whānau carers makes a difference on top of age-friendly design. Think about the changes related to dementia and it is not rocket science to work out some things that will help.

There is quite a lot of information available about care facilities: care homes built like a home are easier to live in; shared spaces that look like a home lounge with comfortable, supportive seating and contrasting furnishings are easier for people with dementia to enter and participate in; having a visible kitchen area with the ability to take part in food preparation encourages social interactions around tea-time; having the toilet easily identifiable, locatable and well-lit encourages continence; and long corridors with mirrors promote distress and confusion.

Personalisation of each resident's room with a photo and name on the door, as well as a personal item from home outside the door, makes it easier to find, and having familiar things inside the room is also good for people with dementia. If there is an inviting area outside the door, with other people, things to do and somewhere to sit, residents are more likely to come out, interact and participate, thus preventing further cognitive decline.

Wayfinding becomes more important when people have dementia. Rooms should be easily identifiable with their function explicit. Signs must be in an easily readable font – sans serif is the best with good contrast between letters and background. Lighting is interesting – track lighting along corridors (like in a plane) and around doorways prevents falls in care environments and helps people with dementia get around. Lighting is currently lower than it should be in aged care facilities, especially at night!

A lot more information is available, including on the Victoria Department of Health website (tinyurl.com/dementia-friendly-env).

The care home considerations described above apply to private housing as well. Contrasts in colour and hue become more important – for example, different colour and hue on architraves and skirting make doors and walls easier to identify. Proximity to, and visibility of, the toilet, including a different-coloured toilet seat, promotes independent continence even in own-home situations. Having the toilet lit and in line of sight from the bed promotes continence at night. Clutter and busy environments can be



Ma Ito on Unsplash

Having easy access to gardens and safe places to walk can improve quality of life

confusing, some colours increase agitation, and too many colours at once (the LSD experience) make people with dementia withdraw. Clear, well-lit hallways, without clutter or anything to trip over, prevent falls and encourage independent mobility for people with dementia.

Also think about finding the door handle, the light switch and the way in and out of rooms. The size, shape and colour of these things make a difference for the person with dementia.

Having easy access to the outside, gardens to participate in and places to safely walk improve quality of life. Exercise and some cognitive challenge every day can be facilitated by the inside and outside environments.

In your practice, the built environment impacts patient health, as it does yours, and practice design and function make a difference to how things flow. We all need healthy homes, and as society changes to have greater numbers of older people, we need age-friendly and dementia-friendly homes and urban environments. Let's transform the environments within our societies. ■

Ngair Kerse is president of the New Zealand Association of Gerontology and the Joyce Cook Chair in Ageing Well, University of Auckland

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Abbreviations: GSM, genitourinary syndrome of menopause; HCP, healthcare provider; MHT, menopausal hormone therapy.

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Weighing up risks and benefits of menopausal hormone therapy

Menopause can be a challenging time of life, with distressing symptoms that affect quality of life. Endocrinologist **Susannah O'Sullivan** describes how to tailor treatment to each individual, with a focus on menopausal hormone therapy

Menopause is considered to be the end of a woman's reproductive life and occurs with the final menstrual period at a median age of 51 years. In New Zealand, most women around the age of menopause report some menopausal symptoms, but many do not seek medical assistance.¹

Although Māori and non-Māori women experience menopausal symptoms with similar frequency, Māori women are half as likely to ever use menopausal hormone therapy (MHT; 54 per cent for non-Māori versus 24 per cent for Māori).¹ Active screening and engagement of Māori women may help identify those who would benefit from treatment.

Menopause and the menopause transition (perimenopause) are associated with a number of symptoms of varying severity, from relatively untroublesome to those that significantly affect quality of life. An initial assessment of the menopausal woman determines which of these are present:

- **Vasomotor symptoms** – (hot flushes and night sweats) are the classic symptom of menopause and are an almost universal experience.
- **Sleep disturbance** – tends to begin in perimenopause and increases in a linear fashion during the transition to menopause.
- **Mood changes** – are another common feature of menopause. Studies suggest there is an increased risk of new-onset depression and anxiety symptoms in menopausal women when compared with premenopausal women.²

There is a significant interaction between sleep, mood and vasomotor symptoms.

- **Cognitive symptoms** – many women also describe new cognitive symptoms with menopause, with forgetfulness being the most common symptom reported.
- **Genitourinary symptoms** – oestrogen deficiency associated with menopause leads to atrophy of the vaginal lining, resulting in vaginal dryness, itch and dyspareunia. Vaginal symptoms appear relatively early in perimenopause and become more persistent with progression through menopause.

Independent of these changes, menopause is associated with a lowering of sexual desire and decreased arousal.

The epithelium of the urethra is also oestrogen dependent, and some women experience urinary symptoms.

- **Other changes** – joint stiffness or pain is commonly reported by women during middle age, and there may be an association with menopause.

Key points

- ◆ The management of menopause requires a careful assessment of the benefits and risks for each individual.
- ◆ Initiation of menopausal hormone therapy in women older than 60 or more than 10 years from menopause onset requires careful consideration.
- ◆ Menopause is an opportunity to institute screening and management for diseases that increase in prevalence during midlife.



Lifestyle modifications benefit overall health as well as menopausal symptoms

Weight gain has also been attributed to menopause, which does contribute to an increase in total body fat and a redistribution of fat to the abdomen.

Many women describe worsening fatigue during menopause, most likely from a disrupted sleep pattern along with other non-hormonal stressors of middle life.

Management

Management of menopause involves an assessment of the individual's needs, and determination of the risks and benefits of treatment in each individual case. In addition to addressing troubling symptoms, it is important to discuss midlife health considerations, including cancer risk and screening, cardiovascular risk and osteoporosis. This can provide an opportunity to discuss lifestyle modification, such as weight management, exercise, smoking cessation and reduction in alcohol intake.

For women with mild menopausal symptoms, lifestyle measures may be sufficient; they can also be used in conjunction with medication for more severe symptoms. These include:

- weight loss in women who are overweight
- regular exercise
- managing the environment to optimise cooling
- avoiding triggers (eg, smoking cessation, decreasing alcohol intake)
- relaxation techniques.

A range of non-pharmacological measures can be used to manage vasomotor symptoms and sleep issues (eg, cognitive behavioural therapy, yoga, hypnosis), while recognising that studies have shown variable effectiveness.

Genitourinary symptoms

Genitourinary syndrome of menopause is a common condition, with epidemiological data showing approximately 50 per cent of postmenopausal women over age 60 experience symptoms such as vulvovaginal dryness, burning, itching, dyspareunia, frequent urination, urge incontinence and recurrent urinary tract infections.³ Pelvic floor exercises are important

to improve some of these symptoms.

For women who principally have mild genitourinary symptoms (or when any form of oestrogen is contraindicated), non-hormonal vaginal lubricants and moisturisers are an option:

- Lubricants are typically used to coincide with sexual activity and may be water, oil, silicone or hyaluronic acid based, but may also contain other ingredients.
- Moisturisers are usually used on a regular basis, and may contain a bioadhesive polycarbophil-based polymer, which attaches to mucin and epithelial cells on the vaginal wall and retains water.

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For those with moderate to severe symptoms, vaginal oestrogen without additional progesterone is the mainstay of treatment. Vaginal oestrogen is administered as a pessary (500µg oestriol) or cream (0.1 per cent oestriol) in a loading dose of nightly administration for two weeks, followed by a maintenance dose of two nights per week. In addition to improving vulvovaginal symptoms, topical oestrogen therapy may improve urinary incontinence and prevent recurrent urinary tract infections.

The recommendations for duration of use vary between preparations, but vaginal atrophy is a chronic condition and will recur on cessation of treatment. In light of reassuring safety data, women who experience benefit from treatment can continue long-term use of topical oestrogens.

Safety and timing of MHT

In 2002, the report of increased risks of breast cancer, cardiovascular disease, stroke and venous thromboembolism (VTE) by the Women's Health Initiative study led to widespread concern among clinicians and women about the safety of MHT.⁴ Since then, other studies and reanalysis of the data has led to changes in the understanding of the risks and benefits of MHT.^{5,6}

International guidelines support the use of MHT when initiated before the age of 60 or within 10 years of menopause onset in women with symptoms, and for those at risk of bone loss or fracture, who do not have any of the following contraindications:^{4,7,8}

- hormone-dependent cancer, including breast and endometrial
- unexplained vaginal bleeding
- acute cardiovascular or cerebrovascular event
- acute venous thromboembolic event
- severe liver disease.

Caution is recommended with the following conditions:

- high risk of breast cancer
- past myocardial infarction, transient ischaemic attack or stroke
- high risk of venous thromboembolic event
- active liver disease.

“The use of transdermal MHT has not been associated with increased venous thromboembolism risk”

Most guidelines agree that there should be no mandatory stopping time for MHT, but that initiation of MHT in women older than 60 or more than 10 years from menopause onset requires careful consideration as there may be greater absolute risks of coronary heart disease (CHD), stroke and VTE. In such cases, lower-dose transdermal oestrogen could be considered, but in those at high risk, non-hormonal options (not covered here) are preferable.

Breast cancer risk – most women are concerned about the potential for an increased risk of breast cancer when taking MHT, but the absolute risk is less than one case per 1000 woman-years with combined oestrogen and progesterone. For women taking oestrogen only, there is a decrease in breast cancer incidence. For women with a high risk of breast cancer, even those with *BRCA* mutations, there is no evidence of a greater increase in risk with MHT than in the general population.⁹

Cardiovascular risk – increased risk of CHD and stroke depend on the type of MHT, age and time since onset of menopause. There is no increase in risk of CHD or stroke in young

Menopausal hormone therapy formulations available in New Zealand				
Oestrogen (Use with a progestogen if intact uterus)				
Formulation	Brand name	Low dose	Medium dose	High dose
Oestradiol gel	EstroGel	0.75mg (1 pump)	1.5mg (2 pumps)	2.25mg or 3mg (3 or 4 pumps)
Oestradiol patch (applied twice weekly)	Estradot* Estradiol TDP Mylan*	25µg per day	50µg per day	75µg or 100µg per day
Oestradiol valerate tablet	Progynova	1mg	2mg	
Oestradiol tablet	Estrofem	1mg	2mg	
Conjugated equine oestrogen tablet	Premarin	0.3mg	0.625mg	
Progestogen (Use with an oestrogen if intact uterus)				
Formulation	Brand name	Use with low-dose oestrogen	Use with medium-dose oestrogen	Use with high-dose oestrogen or in cyclical regimens
Medroxyprogesterone acetate tablet	Provera	2.5mg	5mg	10mg
Micronised progesterone capsule	Utrogestan	100mg	100mg	200–300mg (limited safety data)
Norethisterone tablet	Primolut N	¼ of 5mg	¼ of 5mg	½ of 5mg
Levonorgestrel intrauterine device	Mirena	20µg per day	20µg per day	20µg per day
Combined regimens				
Formulation	Brand name	Dose		
Oestradiol + norethisterone tablet	Kliovance Kliogest	1mg + 0.5mg (low dose) 2mg + 1mg (medium dose)		
Oestradiol + norethisterone tablet (cyclical regimen)	Trisequens	2mg + 0mg, 2mg + 1mg, 1mg + 0mg		
Conjugated equine oestrogen + bazedoxifene tablet	Duavive	0.45mg + 20mg		
Tibolone tablet	Livial	2.5mg		
Fully funded products are in bold * A global supply issue is affecting oestradiol patches. From December 2025, Pharmac is proposing to fund these two brands of oestradiol patches but expects Estradot will not always be available for everyone who wants it. Until then, the oestradiol patches currently funded will be available (schedule.pharmac.govt.nz)				

women in the absence of established disease.¹⁰ Women older than 60 and initiating MHT more than 10 or 20 years since menopause onset may have increased risk of CHD and stroke. Observational data suggest transdermal oestrogen and oestrogen-only regimens may confer lower risk.⁵ **Venous thromboembolism risk** – MHT is associated with a small increased risk of VTE of two cases per 1000 woman-years. The risk of VTE is increased by smoking, increasing age, obesity and with use of oral MHT. The use of transdermal MHT has not been associated with increased VTE risk and is recommended for women with risk factors for VTE (including thrombophilia), and it could be considered for those with previous VTE.^{5,11,12}

Women with contraindications – a challenging area is the management of menopausal symptoms in breast cancer survivors (who often experience premature and/or increased severity of menopausal symptoms as a result of treatment), due to concern about the risk of recurrence. In breast cancer survivors with mild or moderate symptoms, lifestyle modifications or non-hormonal approaches are recommended. In

those with severe symptoms with a significant impact on quality of life, MHT might be considered with informed consent and shared decision-making.¹³

MHT is not recommended in women with active CHD or stroke but might be contemplated in women with a history of these conditions and persisting vasomotor symptoms despite non-hormonal therapy; low to medium-dose transdermal oestrogen could be considered.¹⁴

In women with VTE, decisions regarding use of MHT depend on the setting in which that VTE occurred as well as the severity of menopausal symptoms; those who experience provoked VTE have a much lower risk of VTE recurrence than those with unprovoked VTE. If MHT is considered, transdermal oestrogen is preferred.¹²

Tailoring MHT

The risks and benefits of MHT differ with the individual woman, and treatment should utilise the most appropriate MHT type, dose, formulation, route of administration and duration of use for that individual. The MHT regimens available in New Zealand are shown in the table.

When deciding on an appropriate MHT regimen, the following aspects need to be considered:

- whether the woman has a uterus
- the woman's age and time since onset of menopause
- the presence of any contraindications or increased risk.

Oestrogen – the choice of oestrogen is governed predominantly by the presence of risk factors for metabolic conditions, vascular disease and VTE, and by patient preference. Transdermal oestrogen is recommended in women with controlled hypertension, hypertriglyceridemia, gallbladder disease, migraine, increased risk of stroke and VTE, and in those who are obese.⁵

Progestogen – women with a uterus require treatment with a progestogen as well as oestrogen (combined MHT). Combined MHT can be cyclical (intermittent progestogen use, leading to a four-weekly or three-monthly withdrawal bleed) or continuous (no withdrawal bleed). Cyclical MHT is recommended for women with less than 12 months of amenorrhoea. If desired, this can be changed to continuous combined MHT after 12 months.

The choice of progestogen is determined by the presence of risk factors for breast cancer and VTE, and by patient preference. Medroxyprogesterone acetate may increase breast cancer risk, whereas micronised progesterone may be safer than synthetic progestogens.¹⁵ Medroxyprogesterone acetate and norethisterone may increase the risk of VTE with oral oestrogen. Intrauterine progesterone reduces exposure to systemic progestogen. **Other treatments** – for women with a uterus who wish to avoid progestogens, tibolone and bazedoxifene are other options.

Tibolone is a synthetic steroid that can bind to oestrogen, progesterone and androgen receptors. Studies show an increased risk of breast cancer recurrence, and an increased risk of stroke in older women.¹⁶

Bazedoxifene is a selective oestrogen receptor modulator that is combined with conjugated equine oestrogens to make up the tissue-selective oestrogen complex Duavive. This compound is comparable to traditional MHT for management of vasomotor symptoms, and contraindications to its use are similar to MHT but without long-term data on safety.¹⁷

Monitoring MHT

Before prescribing MHT, women should be assessed for contraindications, cardiovascular risk, and for participation in breast and cervical screening programmes. Baseline measurements of BMI and blood pressure should be performed.

After prescribing MHT, a review should occur at three months to assess the effectiveness and tolerability of treatment. Then, reviews should occur at least annually for measurement of blood pressure and assessment of effectiveness, side effects, metabolic health and risk factors, with the regimen adjusted as needed.

The main side effects of MHT include breast tenderness, abdominal bloating, mood changes and uterine bleeding, and an elevation in blood pressure with oral oestrogens. If troublesome breast tenderness occurs, the oestrogen dose can be reduced. If unscheduled bleeding occurs, the dose of progestogen can be increased or intrauterine progestogen administration may be considered, after assessing whether further investigation is needed.

Duration of use

In women with frequent vasomotor symptoms, the average duration of symptoms is 7.4 years, but some women experience symptoms for more than 13 years.¹⁸

MHT need not be routinely stopped if the patient has been advised that risks of MHT increase after age 60, she continues to have troublesome symptoms, and if benefits outweigh risks.^{5,7,8} However, the need for ongoing MHT should be reviewed regularly, and the dose, type of MHT and mode of delivery may need to be adjusted.

Stopping MHT may lead to recurrent symptoms in up to 50 per cent of women, and more than 20 per cent of women experience moderately severe symptoms.¹⁹ There are no studies to guide discussions about the safety of restarting MHT. There is also no clear evidence on the optimum method of discontinuing MHT, but gradually tapering the dose may reduce the short-term recurrence of symptoms.

Contraception

Women who are sexually active need to be counselled that MHT is not a contraceptive. In those using MHT, menopause can be assumed in the majority of women at age 55, but it is important to be aware of a family history of late menopause or an absence of menopausal symptoms. ■

Susannah O'Sullivan is a general and reproductive endocrinologist at Greenlane Clinical Centre, Auckland

The references for this article are available with the online version on nzdoctor.co.nz

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References: 1. Kim HK, et al. The Recent Review of the Genitourinary Syndrome of Menopause. Journal of Menopausal Medicine. 2015;21(2):65-71. 2. Managing Menopausal symptoms. Royal Australian and New Zealand College of Obstetricians and Gynaecologists. September 2020. Available at: <https://ranzcg.edu.au/wp-content/uploads/Managing-Menopausal-Symptoms.pdf>. 3. Faubion SS, et al. The 2022 hormone therapy position statement of the North American Menopause Society. Menopause. 2022 Jul 1;29(7):767-94. Ovestin (estriol) Cream 1mg/g and Ovestin Pessary 0.5mg are fully funded Prescription Medicines for atrophy of the lower urogenital tract related to oestrogen deficiency. Dosage & Administration: For use women with/without a uterus. For intravaginal use. Ovestin Vaginal cream: one application using applicator at night for first weeks then maintenance dose. Ovestin Pessary: Insert one pessary at night for the first weeks, then maintenance dose. Contraindications: Pregnancy; history or suspected breast cancer or oestrogen-dependent malignant tumours; undiagnosed genital bleeding; untreated endometrial hyperplasia; history/current venous thromboembolism; thrombophilic disorders; arterial thromboembolic disease, history of or acute liver disease; porphyria; hypersensitivity to any ingredients in Ovestin. Adverse effects: Fluid retention, nausea, breast discomfort/pain, postmenopausal spotting, cervical discharge, application site irritation, pruritus, flu-like symptoms. Warnings and Precautions: Assessment of risk/benefit should be undertaken. See data sheet for a full list of conditions which need supervision or for immediate withdrawal. Before prescribing, please review data sheet available at www.medsafe.govt.nz. Trademarks are owned by or licensed to the Aspen Group of companies. © 2024 Aspen Group of companies or its licensor. All rights reserved. Aspen New Zealand, C/O Pharmacy Retailing (NZ) Ltd, Auckland. TAPS NP22392-MAR25.

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References: 1. Archer DF et al. Menopause 2012;19(6):622-629 2. Archer DF et al. Menopause. 2003;10(6):516-521 3. Linda Dear, Menosurvey 2023

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In women with an intact uterus, it is recommended to add a progestogen (e.g. progesterone) for at least 12 days each month, in accordance with the manufacturers' recommendations. **For treatment of menopausal symptoms:** The usual starting dose is two pumps (2.5 g gel) once daily, which may be increased up to a maximum of four pumps (5 g gel) daily if effective relief is not obtained after one month's treatment. Only continue Estrogel for as long as the benefit outweighs the risk. Use the lowest effective dose for the shortest duration. **For prevention of osteoporosis:** The minimum effective dose is 2.5 g of gel once daily for most patients. **Method of administration:** The correct dose of gel should be dispensed and applied to clean, dry, intact skin e.g. on the arms and shoulders, and/or inner thighs. The area of application should be as large as possible. Do not apply Estrogel on or near the breasts or on the vulval region. Please review the data sheet for full instructions on Estrogel application. **Contraindications:** Known hypersensitivity to the active substances or to any of the excipients; known, past or suspected breast cancer; known or suspected estrogen-dependent malignant tumours (e.g. endometrial cancer); undiagnosed genital bleeding; untreated endometrial hyperplasia; previous or current venous thromboembolism (e.g. deep venous thrombosis (DVT), pulmonary embolism (PE)); known thrombophilic disorders (e.g. protein C, protein S, or antithrombin deficiency); active or recent arterial thromboembolic disease (e.g. angina, myocardial infarction); acute or a history of liver disease, known or suspected pregnancy; lactation; porphyria. **Warning and Precautions:** Before initiating or re-instituting HRT, assess personal and family medical history. Periodic check-ups are recommended. Advise patients to report changes in their breasts. Closely supervise patients if any of the following conditions are present/have occurred previously: Leiomyoma (uterine fibroids) or endometriosis; risk factors for thromboembolic disorders or estrogen-dependent tumours, e.g. 1st degree heredity for breast cancer; hypertension; liver disorders (e.g. liver adenoma), diabetes mellitus with or without vascular involvement; cholelithiasis; migraine or (severe) headache; systemic lupus erythematosus (SLE); a history of endometrial hyperplasia; epilepsy; asthma; otosclerosis. Discontinue therapy in case a contraindication is discovered and in the following: jaundice or deterioration in liver function; significant increase in blood pressure; new onset of migraine-type headache; pregnancy. Endometrial hyperplasia and carcinoma: In women with an intact uterus, the risk is increased when estrogens are administered alone for prolonged periods. Addition of a progestogen cyclically for at least 12 days per month/28-day cycle or continuous combined estrogen-progestogen therapy in non-hysterectomised women helps prevent the excess risk associated with estrogen-only HRT. Increased risk of breast cancer dependent on the HRT treatment duration. Slightly increased risk of ovarian cancer in women which becomes apparent within 5 years of use and diminishes over time after stopping. HRT is associated with a 1.3 – 3 fold increased relative risk of developing venous thromboembolism (VTE), i.e. DVT or PE. Patients with known thrombophilic states have an increased risk of VTE. HRT is contraindicated in these patients. The relative risk of coronary artery disease during use of combined estrogen+progestogen HRT is slightly increased. Combined estrogen-progestogen and estrogen-only therapy are associated with an up to 1.5-fold increase in risk of ischemic stroke. Estrogens may cause fluid retention, patients with cardiac or renal dysfunction should be monitored. Monitor women on thyroid replacement as their thyroid therapy may require adjusting. Use in women older than 65 years is limited. Not recommended in children. **Interactions:** Treatment with surface active agents/drugs which alter barrier structure/ function, could remove drug bound to skin. Avoid use of strong skin cleansers and detergents, skin care products of high alcoholic content, and keratolytics. Avoid use of concomitant skin medications which alters skin production at the site of Estrogel application. **Adverse Effects: Common:** headache, nausea, abdominal pain, breast swelling/pain, breast enlargement, dysmenorrhoea, menorrhagia, metrorrhagia, leucorrhoea, endometrial hyperplasia, weight change, water retention with peripheral oedema. **Uncommon:** depression, mood swings, vertigo, migraine, venous thromboembolic disease, flatulence, vomiting, pruritus, benign breast neoplasm, increased volume of uterine leiomyoma, vaginitis/vaginal candidiasis, asthenia. **Rare:** glucose intolerance, change in libido, aggravation of epilepsy, arterial hypertension, liver function tests abnormalities, skin discoloration, acne, galactorrhoea, anaphylactic reaction. Data Sheet July 2024. Estrogel is a funded medicine. There are no restrictions on distribution. Pharmaco (NZ) Ltd, Auckland 0225BES105 TAPS DA2409MM

Fending off your own moral injury while patients languish on wait lists



Specialist GP Jo Scott-Jones discusses how GPs want to provide optimal patient care, but are at risk themselves from repeated dealings with a struggling health system

Imagine knowing that when you ask for an x-ray, you will get to see the film and have a formal result in 48 hours. This used to happen, and maybe still does in your area, especially if someone is seen privately.

Unfortunately, it is increasingly common for GPs not to be able to view the pictures (we used to struggle to find shelves big enough to hold the x-ray films, mind you!) but also for it to take weeks, or in some areas months, for the investigation to happen, and then months for the formal report.

The impact of this is obvious to those of us caring for a known community who know us.

My patient was an older Māori man who was proud to say he hadn't missed a day's work in his 60 years, but his hip was making it hard to get off the quad bike now, and he couldn't walk without a limp – the young ones were calling him “Lefty”.

Examining his hip, I wondered how he was able to get dressed with the limited range of movement, early morning stiffness and Heberden nodes; this was barn-door osteoarthritis, literally with knobs on.

The usual pattern of progression had been happening for years before he gave in and sought medical attention. Unravelling the symptoms, I confirmed his daughter was helping him to get dressed, he'd rigged an elevated toilet seat, he used a mix of cannabis and alcohol for the pain at night – paracetamol and ibuprofen “didn't do shit” – and he had been sent home from the farm because he was too sore to work.

“It's time to do something, doc.”

You can guess the story – I knew the orthopaedic team would not see him without an x-ray. Even after the x-ray, they would not see him for another four to six months, then they would try to engage him in physiotherapy, before they would put him on the six to 12-month waiting list for an operation.

What is moral injury?

Moral injury occurs when someone engages in, fails to prevent, or witnesses acts that conflict with their values or beliefs.¹ Moral injury occurs in soldiers on a battlefield, ordered to make sure all the enemy are dead, so it isn't something to claim lightly.

In healthcare, moral injury can be acute – making the life-and-death decisions in a mass casualty event when every choice is a bad one, for example – but it can also be chronic.

Witnessing, day after day, a health system that

is unable to meet our expectations of basic human kindness and care due to resource constraints is a source of moral injury. When “we” fail to do something that is in line with our beliefs – and harm results – we are at risk. When this happens day after day in multiple ways, the risk of moral injury increases.

Moral distress shows itself as guilt, shame and anger. It may have a lasting impact on our thinking and behaviour. I often think it underpins the most negative comments you see on medical social media.

Dealing with system failures

“First, you save yourself,” says it all.

Understand where the locus of control actually sits. We are mostly perfectionists, we think we can influence and control events, and we take on responsibility for the failures of the system that are not our failures. This is a deep internal belief we need to be aware of, and manage, not a superficial dismissal of our role in the system.

Understanding and addressing an imbalanced locus of control takes repeated practice to overcome. Mindfulness and discussing with your peer group helps, but accessing professional supervision is ideal.

It can be hugely satisfying to send an angry email to everyone in authority, from the Human Rights Commission to the local mayor. However, you can easily get labelled as a “lunatic” and you rapidly run out of whatever credibility you might have had.

The Medical Council of New Zealand has clear guidance on how we should react in a resource-constrained environment.² Where

deficiencies in a service are “serious”, we have to inform the people responsible, in writing, but this can be stressful in itself. Who do you talk to?

Your medical indemnity provider is a key resource to you. They will provide sage advice and ensure you are not breaching any rules as you share your concerns. Simply having someone look over the way you are expressing your concerns can be golden.

It is protective to have a clear idea of the escalation path that allows you to share what you are seeing. Rational elevation of concern will vary from situation to situation. The table provides a guide to consider. At any point, you should be able to hand over the concern to one of these colleagues and expect to be kept informed about an outcome, but otherwise trust they will do their job.

Finally, inform the patient. You may think it is kinder not to involve them as you work on their behalf in the background; you may want to avoid providing false hope. In this era of “open disclosure”, you need to let the patient know when there is a mismatch between standards and reality, and what is being done about it. ■

Jo Scott-Jones is medical director for Pinnacle Midlands Health Network, has a general practice in Ōpōtiki and works as a specialist GP across the Midlands region

References:

1. Watson P, Norman SB, Maguen S, Hamblen J. Moral injury in health care workers. US Department of Veterans Affairs, National Center for PTSD. tinyurl.com/moral-inj
2. Medical Council of New Zealand. *Safe practice in an environment of resource limitation*. September 2018. tinyurl.com/resource-const

Concern elevation guide

Who	What	Notes
The provider of the service	Case details and the mismatch between guidance or best practice	If unresolved or unhappy with response, take the next step
GP liaison/clinical integrator with hospital and specialist services	Case details as above, plus the response from the service provider; seek support	Expect the liaison to resolve the issue; they know the people. If it is a system issue, they will struggle but will support you as this elevates further
PHO clinical director	Case details, plus response from hospital liaison support	Inform your PHO of what is happening; they will support you and may have more influence at a system level
Chief medical officer	Case details, plus response from hospital liaison support	If not already achieved by the above supports, then involving the clinical person leading the team concerned can help
Medical Council	If the issue is a personal professional conduct concern	Your PHO clinical team can help, but if the concern is a professional one about a person, the council has the statutory ability to investigate
Health and Disability Commissioner	If the issue is a service issue and can be aligned with a breach of the Code of Health and Disability Services Consumers' Rights	Your PHO team can help, but if the issue is a breach of patient rights, the HDC has the statutory ability to investigate



For more on moral harm see page 22

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Details on page 57

How to treat

Do you need to read this article?

Try this quiz

1. Most thyroid cancers only present as a thyroid nodule. True/False
2. All patients who present with a thyroid nodule should have thyroid function tests and an ultrasound scan of the thyroid. True/False
3. Ultrasound guidance is not usually required for fine-needle aspiration of easily palpable thyroid nodules. True/False
4. All patients with FNA cytology reported as Bethesda III and above should be treated surgically. True/False

Answers on page 76

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This "How to treat" has been endorsed by the RNZCGP and has been approved for up to 2 credits for continuing professional development purposes (2 credits per learning hour). To earn your CPD credits, complete the assessment at nzdoctor.co.nz. Click on the Educate button.

Francis T. Hall is head of the department of otolaryngology, head and neck surgery at Te Whatu Ora Counties Manukau and has a private practice in Auckland specialising in thyroid surgery. If you have any questions or comments, email francis@drfrancishall.co.nz



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Thyroid nodules

Otolaryngologist, head and neck surgeon **Francis T. Hall** discusses the evaluation of thyroid nodules, which primarily aims to determine the likelihood of malignancy. He then reviews the treatment of thyroid nodules and thyroid cancer, including recent advances in management

Thyroid nodules are very common. They are more common in women, with some estimates of palpable thyroid nodules occurring in 6 per cent of the female population and 1.5 per cent of the male population. Thyroid nodules are evaluated to determine:

- the likelihood of malignancy
- the likelihood that the nodule is the cause of symptoms.

While thyroid nodules are extremely common, thyroid cancer is a lot less common. Most patients with thyroid nodules do not have cancer. Ultrasound detects thyroid nodules in 19 to 67 per cent of the population, with 5 per cent being malignant.

Thyroid nodules in children are less common and more likely to be cancerous when compared with thyroid nodules in adults. About 20 per cent of solid thyroid nodules in children are cancerous, compared with only 5 per cent of thyroid nodules in adults.

Thyroid cancer

Thyroid cancer accounts for 1 per cent of all cancers in New Zealand, the incidence is 13 cases per 100,000 persons per year, and about one 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:

- 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. However, several variants of papillary thyroid carcinoma (tall cell, columnar cell, hob nail, diffuse sclerosing, solid, and telomerase reverse transcriptase promoter variants) have a worse prognosis.
- Follicular thyroid carcinoma is the second most common type of thyroid cancer. Even though it may spread to the lungs, it also has an excellent prognosis.
- Medullary thyroid carcinoma is less common. It sometimes runs in families and has an intermediate prognosis. Serum calcitonin is a very useful marker to diagnose medullary thyroid carcinoma and to assess response to treatment.
- Anaplastic thyroid carcinoma is a very aggressive thyroid carcinoma with very poor prognosis.

Other less common types of thyroid cancer include primary lymphoma of the thyroid, squamous cell carcinoma of the thyroid and others.

Red-flag symptoms

Most thyroid cancers only present as a thyroid nodule. Only the more advanced or aggressive thyroid cancers have red-flag symptoms.

Thyroid nodules associated with any of the following require urgent referral:

- rapid growth of the thyroid nodule/mass

A big **thank you** to everyone who downloaded the updated 2025 Everybody Patient Sheets.

And a special congratulations to **Dr Tom Gudsell** from **NorthCare Thomas Road** in Hamilton, the winner of the \$500 Prezzy Card in our giveaway contest!

"Being able to provide a full explanation of diagnoses and treatments can be challenging within a short consult, so I value having reliable information sheets on hand."

Dr Tom Gudsell



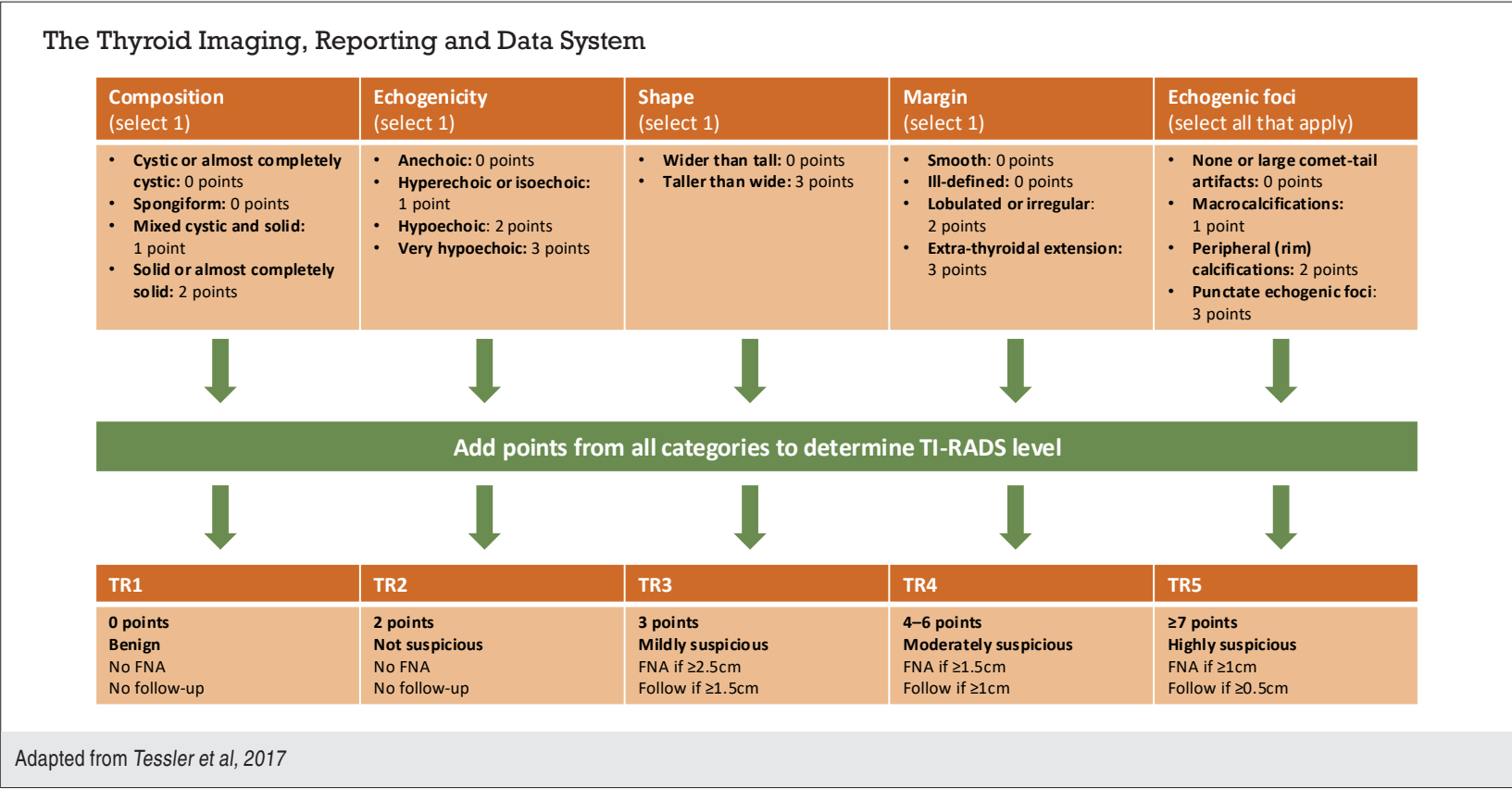
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Everybody Patient Sheets are written by New Zealand health professionals for New Zealand health consumers. The sheets are simple, easy and in a format patients love. **Try them out!**



- hoarse voice (from involvement of the recurrent laryngeal nerve)
- cervical lymphadenopathy.

Thyroid nodules Symptoms

Generally, the larger the thyroid nodule, the more likely it is to cause compressive symptoms, such as a feeling of pressure, tightness or a lump in the neck. Thyroid nodules frequently do not cause any symptoms, particularly those less than 2cm in size.

The position of a nodule within the thyroid may also contribute to symptoms. Some experts believe nodules in the posterior part of the thyroid are more likely to cause a globus-type feeling of something in the throat than a similar sized nodule in the anterior part of the thyroid.

If a nodule gets very large, it may cause compression of the trachea, resulting in shortness of breath on exertion and when lying down. Large thyroid nodules may also cause superior vena cava syndrome, with restriction of venous drainage from the head and neck. This is most noticeable when the arms are raised in such activities as hanging out the washing. Patients may go red in the face when doing such activities (positive Pemberton sign).

Investigations

The main goal in evaluating a patient with a thyroid nodule is to determine whether their nodule is cancerous. To do so, ultrasound and fine-needle aspiration (FNA) cytology of suspicious thyroid nodules are the mainstays of investigation.

Thyroid function tests

Occasionally, thyroid nodules become autonomous (also referred to as “toxic” or “hot”) and

produce too much thyroid hormone, resulting in hyperthyroidism (anxiety, difficulty concentrating, fatigue, tremor, heat intolerance, etc). A toxic multinodular goitre contains one or more nodules that are no longer under control of thyroid-stimulating hormone (TSH). A suppressed TSH and normal free thyroxine (fT4) level (compensated hyperthyroidism) is often the first indication that a multinodular goitre or thyroid nodule is becoming autonomous.

Thyroid function tests should be requested for all patients with a suspected nodule in the thyroid gland. Most patients will be euthyroid. If a patient is hyperthyroid, referral to an endocrinologist and/or starting them on carbimazole is usually appropriate. A radionuclide thyroid scan can be helpful in elucidating the function of the nodule(s).

Patients with normal thyroid function tests are sometimes surprised when the diagnosis of papillary thyroid carcinoma is made as they may believe a normal thyroid function test means they will not have thyroid cancer. This is not true. Neither is it true that patients with hyperthyroidism do not have thyroid cancer, although thyroid cancer is very uncommon in patients with thyroid nodules and hyperthyroidism.

Ultrasound scans

An ultrasound scan is required for all suspected thyroid nodules. It is used to categorise thyroid nodules according to the Thyroid Imaging, Reporting and Data System (TI-RADS) developed by the American College of Radiology.^{1,2} The risk of malignancy increases with a higher TI-RADS classification, as follows:

- TR1 – 0.3 per cent
- TR2 – 1.5 per cent
- TR3 – 4.8 per cent
- TR4 – 9.1 per cent
- TR5 – 35 per cent.

TI-RADS categorises nodules according to their composition (eg, solid, cystic), echogenicity (eg, hypoechoic, isoechoic), shape, margin and echogenic foci (calcification). Points are given for

each of these characteristics to determine the TR level. For example, calcification is divided into three categories: coarse calcification (1 point), rim calcification (2 points) and microcalcification (punctate echogenic foci; 3 points). Punctate echogenic foci are commonly seen in thyroid malignancy and need to be distinguished from comet-tail artefacts that are associated with benign colloid nodules.

Recommendations for FNA and ultrasound surveillance are made depending on the size of the thyroid nodule and its TI-RADS classification. For example, FNA is recommended for a 1.5cm TR4 nodule, while ultrasound surveillance is recommended for a 2cm TR3 nodule. A 4cm TR2 nodule requires no follow-up. It is important to remember these recommendations are for asymptomatic euthyroid patients.

The figure above gives a good overview of TI-RADS and recommendations for subsequent management.

Ultrasound-guided FNA

It is recommended that FNA of thyroid nodules is performed under ultrasound guidance. Multiple studies have shown a lower non-diagnostic rate with ultrasound-guided FNA compared with freehand FNA, even for thyroid nodules that are easily palpable.

FNA cytology results are classified according to the Bethesda System for Reporting Thyroid Cytopathology,³ as shown in Table 1.

Molecular analysis

The American Thyroid Association (ATA) guidelines recommend three options for the management of patients with Bethesda III thyroid nodules:⁴

- diagnostic hemithyroidectomy (also called diagnostic thyroid lobectomy)
- close observation (with ultrasound)
- molecular analysis.

Approximately 10 per cent of thyroid FNAs are reported as Bethesda III (atypia of undetermined significance) and a further 10 per cent are

Table 1. The Bethesda System for Reporting Thyroid Cytopathology		
Diagnostic category	Description	Risk of malignancy (%)
I	Non-diagnostic or unsatisfactory	12
II	Benign	2
III	Atypia of undetermined significance	16
IV	Follicular neoplasm	23
V	Suspicious for malignancy	65
VI	Malignant	94

Table 2. Effectiveness of molecular testing techniques for diagnosis of malignancy when thyroid nodules have indeterminate cytology ^{5–8}				
	Sensitivity (%)	Specificity (%)	Negative predictive value (%)	Positive predictive value (%)
Afirma	97	88	99	65
Idylla ThyroidPrint	92	82	96	66
ThyroidPrint	91	88	95	78
ThyroSeq	94	82	97	66

reported as Bethesda IV (follicular neoplasm), but only about 16–23 per cent of these patients actually have thyroid cancer.² However, it is common practice to offer surgery to patients with Bethesda III and IV cytology, in the form of a diagnostic hemithyroidectomy. Although this approach detects and treats thyroid cancer in 16–23 per cent of people in this category, 77–84 per cent of people have an operation with no or little therapeutic benefit.

To help further determine which patients are more likely to have cancer, molecular analysis of FNA specimens can be performed by testing the DNA and RNA of the cells obtained. These tests look specifically for mutations in genes associated with thyroid cancer.

The prevalence of some of the common genetic mutations are listed below.

Prevalence of genetic mutations in papillary thyroid carcinoma:

- BRAF* – 45 per cent
- RAS* – 15 per cent
- RET/PTC* – 15 per cent.

Prevalence of genetic mutations in follicular carcinoma:

- RAS* – 40 per cent
- PAX8/PPARG* – 40 per cent.

In the US, Afirma and ThyroSeq are two of the common molecular tests that look at genetic mutations in thyroid cancers. Afirma looks at 593 genes associated with thyroid cancer. Using Afirma, two-thirds of patients with Bethesda III and IV nodules are reclassified as benign.

ThyroSeq looks at 112 genes associated with thyroid cancer. Similarly, ThyroSeq is able to stratify patients with Bethesda III and IV nodules into low, intermediate and high risk of

having thyroid cancer. Low-risk patients can be observed. Hemithyroidectomy is recommended for intermediate-risk patients, and total thyroidectomy is recommended for high-risk patients with aggressive types of thyroid cancer.

In New Zealand, ThyroSeq molecular analysis is available, but only if the FNA specimens are sent to Sullivan Nicolaides Pathology in Brisbane, which in turn sends them to Sonic Healthcare in New York, US. The turnaround time is about four to seven weeks, and the cost to the patient is approximately \$2300, which is not covered by health insurance.

In the near future, Idylla ThyroidPrint molecular analysis of FNA specimens of thyroid nodules will be available in New Zealand, with results available in 24 hours. Idylla ThyroidPrint looks at 10 epithelial and stromal cell target genes associated with thyroid cancer. It stratifies risk into low (observe) and high (operate).

Table 2 shows the diagnostic performance of different molecular tests.^{5–8} It is important to realise that as the prevalence of a disease increases in a population, the positive predictive value increases and the negative predictive value decreases.

In summary, molecular analysis of FNA specimens is a useful adjunct in the evaluation of thyroid nodules for malignancy, which needs to be considered alongside the history, examination findings, thyroid function tests, ultrasound findings and FNA cytology. It is particularly useful when deciding the most appropriate management strategy for patients with indeterminate cytology (Bethesda III and IV) and may reduce the number of diagnostic hemithyroidectomies performed.

Key points

- Urgently refer patients with thyroid nodules if there is rapid growth of the nodule, hoarse voice or lymphadenopathy.

- Patients with palpable thyroid nodules require thyroid function tests (TSH and fT4 levels) and a thyroid and neck ultrasound to determine the TI-RADS level.

- Patients with TR3 nodules ≥2.5cm, TR4 nodules ≥1.5cm and TR5 nodules ≥1.0cm require ultrasound-guided fine-needle aspiration to determine the Bethesda category.

- Bethesda III nodules are frequently treated surgically, Bethesda IV nodules are usually treated surgically, and Bethesda V and VI nodules are always treated surgically (with rare exceptions).

- Patients with Bethesda III or IV nodules are suitable candidates for molecular testing; if they are then deemed low risk, they may be followed with serial ultrasounds.

- Benign symptomatic thyroid nodules may be treated with either thyroidectomy or radiofrequency ablation.

- Patients with thyroid cysts are treated with aspiration; if the cyst recurs, they are good candidates for ethanol ablation.

Special populations

Pregnancy – thyroid nodules and goitres may grow significantly during pregnancy, and in some cases, cause airway obstruction by compressing the trachea. Thyroid nodules in pregnancy are evaluated the same way as in non-pregnant people – with thyroid function tests, an ultrasound and an ultrasound-guided FNA for selected nodules. Obviously, radionuclide thyroid scans are not performed during pregnancy.

Thyroid nodules in the setting of a multinodular goitre – an ultrasound scan in a patient with a goitre involving both thyroid lobes may be reported as showing multiple nodules. Some of these nodules may meet criteria for FNA due to their size and TI-RADS classification. If the patient is symptomatic, there is little to be gained by performing an ultrasound-guided FNA if they are to undergo surgery anyway (discussed below).

Treatment

Thyroxine

Most patients with thyroid nodules are euthyroid (normal TSH and fT4). The treatment of thyroid nodules with thyroid hormone (thyroxine; ie, TSH suppressive therapy) is not recommended in euthyroid patients. Both the ATA and the European Thyroid Association guidelines for thyroid nodule management recommend that

Advances in management

- ◆ Molecular analysis of thyroid nodules has reduced the number of patients needing surgery.
- ◆ Ethanol ablation for cystic thyroid nodules and radiofrequency ablation for selected solid thyroid nodules are now acceptable alternatives to surgery.
- ◆ The treatment of thyroid cancer is more selective than it was 20 years ago.

patients with benign thyroid nodules should not be treated with thyroxine.^{4,9} The ATA guidelines state, “Though modest responses to therapy can be detected, the potential harm outweighs benefit for most patients.”¹⁴

Hyperthyroidism

Patients with thyroid nodules and hyperthyroidism (low TSH and high fT4) are initially treated medically, usually with carbimazole.

Operating on hyperthyroid patients is contraindicated due to the risk of a thyrotoxic storm (tachycardia, hypertension, heart failure, arrhythmias, high temperature, severe agitation, etc) and the mortality associated with this. Once the hyperthyroidism is under control, they may be considered for surgery.

An autonomously functioning thyroid nodule may be treated with radioactive iodine, hemithyroidectomy or radiofrequency ablation (RFA). A toxic multinodular goitre is best treated with total thyroidectomy.

Thyroidectomy

Patients with significant compressive symptoms usually benefit from surgery, no matter what the TI-RADS and Bethesda classifications of the thyroid nodule are.

Asymptomatic patients with thyroid nodules are treated along the following guidelines:

- **Bethesda I** – consider ultrasound-guided core needle biopsy and treat according to result.
- **Bethesda II** – no treatment.
- **Bethesda III** – consider molecular testing and surgery (especially if high TI-RADS level). Some patients may elect to be followed with serial ultrasound examinations.
- **Bethesda IV** – usually offered surgery.
- **Bethesda V** – surgery.
- **Bethesda VI** – surgery.

Thyroidectomy may involve removing either half (hemithyroidectomy/thyroidlobectomy) or all (total thyroidectomy) of the thyroid. If half the thyroid is removed, it is very uncommon to need thyroid hormone replacement therapy.

Hypocalcaemia due to damage to the parathyroid glands or their blood supply, causing hypoparathyroidism, may occur after total thyroidectomy. Hypocalcaemia is not seen after hemithyroidectomy.

Risks of thyroid surgery include injury to the recurrent laryngeal nerve, resulting in voice change if unilateral and a tracheostomy if bilateral. Injury to the external branch of the superior laryngeal nerve will result in change in pitch of the voice. Postoperative bleeding will result in a return to theatre. Nearly always, the incision heals well, although occasionally a hypertrophic scar may develop.

Radiofrequency ablation

Most doctors are familiar with thyroidectomy, but many are not aware of the option of RFA,

which is an effective, approved treatment for some patients with thyroid nodules.

RFA is a non-surgical, scarless procedure performed under local anaesthesia as an outpatient procedure. A 19-gauge radiofrequency probe is inserted into the targeted nodule under ultrasound guidance. Using a “moving shot” technique, all areas of the nodule are targeted. Hydrodissection may be performed at the same time to create a fluid barrier between the nodule and any important structures.

The radiofrequency causes ions within the tissue to oscillate, which results in heating of the targeted tissue to 60°C. This heat is sufficient to cause necrosis of the targeted tissue. Over the subsequent few months, the thyroid nodule shrinks dramatically in size.

All patients require the following investigations before RFA: thyroid function tests, ultrasound scan of the thyroid, and FNA of the thyroid nodule.

Not all thyroid nodules are suitable for RFA. Benign thyroid nodules that are causing symptoms, such as a feeling of pressure in the lower neck or of a lump in the throat, are suitable for this procedure, preferably if they are less than 6cm in size. Some patients with benign thyroid nodules may choose RFA for cosmetic reasons. Thyroid nodules that are making too much thyroid hormone (autonomously functioning thyroid nodules) are very suitable for RFA. Very small thyroid cancers measuring less than 1cm in size (called microcarcinomas) are also suitable for RFA.^{10,11}

“Patients with significant compressive symptoms usually benefit from surgery, no matter what the TI-RADS and Bethesda classifications of the thyroid nodule are”

An advantage of RFA is that only the thyroid nodule is treated. There is no damage to adjacent thyroid tissue and thyroid tissue is not removed. Therefore, there is no need to take thyroid hormone tablets after the procedure.

Another advantage is the fast recovery time. Patients with an office-based job can return to work the following day. Patients who do heavy manual work can return to work two days after the procedure. Following RFA, there may be some discomfort, which is easily managed with paracetamol and ibuprofen.

Ethanol ablation

Ethanol ablation is the treatment of choice for thyroid cysts, which are usually benign nodules that have filled with fluid. The European Thyroid Association guidelines recommend ethanol ablation as the first-line treatment for pure cysts or dominantly cystic thyroid lesions.⁹ The ATA guidelines state “recurrent cystic thyroid nodules with benign cytology should be considered for surgical removal or percutaneous ethanol injection based on compressive symptoms and cosmetic concerns”.⁴

Most (80 per cent) of thyroid cysts recur after aspiration, while over 90 per cent of thyroid cysts do not recur after drainage and ethanol ablation.

Ethanol ablation is performed under local anaesthetic and ultrasound guidance. Patients with an office job can return to work the same day. Patients who do heavy manual work can return to work the following day.¹²

Treatment of thyroid cancer

Differentiated thyroid carcinoma is the term given to encompass both papillary thyroid carcinoma and follicular thyroid carcinoma. The ATA has guidelines on the treatment of DTC,⁴ which are generally followed in New Zealand. These guidelines tend to be updated every five to 10 years, with an update expected this year.

The 2009 ATA guidelines divided patients with DTC into a three-tiered risk system: low, intermediate and high risk. In the 2015 guidelines, this three-tiered risk system was further described as a continuum of risk.^{4,13}

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 and a suppressive dose of thyroxine. Nowadays, treatment of DTC is more selective and guided by the level of risk.

Many patients are now treated with hemithyroidectomy and without either radioactive iodine 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. 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. The dose of thyroxine is monitored with serial TSH and fT4 measurements. 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 0.5–2.0mU/L (low end of normal range), and for the highest risk patients, it is <0.1mU/L.

Patients with DTC are followed clinically and with ultrasound. Patients with DTC treated with total thyroidectomy are also followed with tests for serum thyroglobulin and thyroglobulin antibodies. The thyroglobulin level is interpreted in conjunction with the TSH level (stimulated or unstimulated thyroglobulin level). With good treatment, patients with DTC usually have an excellent prognosis.

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 with or without lateral neck dissection. In addition to clinical and radiological follow-up, serial calcitonin measurement is an important part of follow-up. Usually, medullary carcinoma has a less favourable prognosis than DTC.

Finally, the ATA has separate guidelines for the treatment of anaplastic thyroid carcinoma. This has the least favourable prognosis of the four main types of thyroid carcinoma, with very few people achieving long-term survival. ■

The references for this article are available with the online version on nzdoctor.co.nz

Quiz answers

1. True 2. True 3. False 4. False



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▶ **Auckland, New Lynn, Looking for dynamic GPs to join our west Auckland team!** HNL is looking for GPs to join us! 0.4 to 0.8 FTE roles available for permanent salaried/contractor. GPEP 2/3/3+, Fellows & GPwSI. Hybrid available. More info on our website: healthnewlynn.co.nz/careers. Contact Yasha Chepuri, Health New Lynn. Phone 09 827 8888. Email yasha@healthnewlynn.co.nz

▶ **Auckland, GP wanted to Join Pukekohe South Doctors.** GP wanted 1–4 days/week, flexible hours. No after-hours, weekends, or holidays. Supportive team, great pay, paid breaks. NZMC reg required.

Somerville, Epsom Medical Centre. Phone 021-242 3668. Email admin@asmedical.co.nz

GENERAL PRACTITIONER
9-MONTH SABBATICAL COVER - WHANGANUI



We're looking for a GP to hit the ground running and provide sabbatical cover from **1st September 2025 to 1st May 2026**. We are happy to be flexible, but ideally you'll be interested in working 8 sessions per week. Each of our sessions is 4 hours with 1 hour admin time and 12 x 15 minute appointments.

Our team operate in 5 hubs, and you will be in our McKenzie hub working with the same, amazing nurse every day to support you.

While this is a sabbatical cover, there may be a possibility to extend depending on team fit and availability.

For more information about us and about Whanganui go to our website <https://wicksteedmedical.co.nz/join>

GP needed for rural practice
A Kaupapa Māori rural practice in Tauranga who seek a full or part time GP.



We are willing to discuss availability to suit. The medical centre has approximately 1750 registered patients and is part of Ngā Mataapuna Oranga PHO. We offer excellent facilities, are accredited under the Royal NZ College of GPs, operate Indici PMS, and work within a Māori model of practice.

For more info and to apply, please contact Donna Motutere
E: manager@pirirakauhauora.org.nz P: 07 552 4573 extn 701
pirirakauhauora.org.nz

Full-time & Part-time GP Positions
LEAMINGTON, CAMBRIDGE, WAIKATO

Join our supportive team that values you as much as our patients. We are a growing practice with 6 GPs, 2 Nurse Prescribers, and a Physician Associate. Support services on-site: Pathlab, X-ray, Ultrasound, Pharmacy, and Physiotherapy. Enjoy a flexible work-life balance with negotiable hours, a great team spirit & strong peer support.

Please contact David at Leamington Medical Centre
DeBeer@leamingtonmc.co.nz | 021 917 775
<http://leamingtonmc.co.nz>



General Practitioner/Nurse Practitioner
KAPITI COAST



A great opportunity for a GP or NP to join a well-established practice on the Kapiti Coast, just 40 minutes from Wellington. Options include locum with a view to partnership, or long-term locum if partnership is not on your radar. Opening is for a minimum of 4 sessions and up to 9 sessions per week. No after-hours work.

You would work alongside 3 job share partners, locums and associates, with the support of a clinical pharmacist prescriber, health improvement practitioner and experienced nurses in a Health Care Home Practice.

Expressions of interest please send CV with contact details to our Practice Manager: applications@coastalmedical.co.nz
<http://www.coastalmedical.co.nz>

▶ **Southland, Invercargill, GP wanted for maternity cover.** Available for 6–12 months? Waihopai Health Services require a GP locum starting ASAP, working 4–8 sessions per week. We offer competitive remuneration and are a friendly and supportive team! Contact Bryan Stout, Waihopai Health Services. Phone 021-145 1190. Email stouties@gmail.com

▶ **Southland, Invercargill, Opportunity for long-term GP (or GPEP).** Waihopai Health Services in Invercargill wish to expand their amazing team! Medium to long-term GP required, with possible ownership opportunity. Work 4–8/10 with no on-call. Come and join us! Contact Bryan Stout, Waihopai Health Services. Phone 021-145 1190. Email bryan.stout@waihopai-health.co.nz

▶ **Wellington, Long-term associate GP wanted.** GP wanted for 3–4 sessions per week to join supportive team at our small, friendly, family focused practice in seaside suburban Wellington village.

Contact Emma Watson, Seatoun Medical. Phone 021-025 97909. Email practicemanager@seatounmedical.co.nz

AUCKLAND FACULTY RNZCGP

Join the Auckland Faculty of the RNZCGP!

Are you a GP in Auckland? Discover the support and opportunities waiting for you at our Auckland Faculty!

We focus on:

- **Education:** Access tailored professional development and local events.
- **Connection:** Join our gatherings to foster community and network with fellow GPs.
- **Advocacy:** We represent your concerns and ensure your voice is heard.

Connect with us today at aucklandfaculty@rnzcgp.org.nz to learn about upcoming events or to get involved.

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