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NZLocums recruitment targets for the year

New Zealand Rural General Practice Network holds the government contract to recruit General Practitioners and Nurse Practitioners for rural New Zealand.

There are two components to the Ministry of Health’s recruitment contract:

**Rural Recruitment Service** (permanent and long term placements)
**Rural Locum Support Scheme** (short term placements).

The following figures and bar graphs show NZLocums performance against contractual targets for 2014/15 year.

- **Rural Recruitment Service** – the purpose of this service is to assist eligible rural providers with recruitment of long term or permanent General Practitioners and Nurse Practitioners. Our annual target delivery for 2014/15 was 70 placements. During the year ended 30 June 2015 we made 67 placements, four percent below target.

- **Rural Locum Support Scheme** – the purpose of this service is to ensure that eligible providers can access up to two weeks locum GP relief per 1.0FTE, per annum. Our target for this year was to fill at least 90 percent of applications received. This year we delivered 98 percent, eight percent above target.

We’re all too aware of the ever-increasing need to rise to the challenge of maintaining a sustainable workforce in rural health. NZLocums experience during the last couple of years has seen an increasing number of practices expressing concern around the lack of succession planning, with an increasing number of GPs nearing retirement. It’s not uncommon for two or three GPs in the same practice to be all looking to retire within the next 12 months or so. So while we have seen a steady decrease in the number of “hotspot” practices over the last few years we continue to work hard to attract health professionals to consider rural New Zealand as their work place of choice.

Upcoming GP Locum Placements

As New Zealand’s government funded GP and NP recruitment organisation we have a range of locum vacancies nationwide:

- Wairoa - ASAP - 30 August 2015
- Katikati - ASAP - 4 September 2015
- Putaruru - ASAP - 4 October 2015
- Roxburgh - 31 August - 11 September 2015
- Motueka - 1 September - 16 October 2015
- Te Araroa - 7 September - 2 October 2015
- Marton - 7 September - 11 October 2015
- Buller - 28 September - 4 October 2015

Contact us to find out more
enquiries@nzlocums.com | 0800 695 628 | www.nzlocums.com
From the Chair...

One of the most difficult and ongoing challenges we face is sustainability and succession planning in rural general practice. It is a question I am often asked. I am also asked: why don’t we have more doctors, where can I get a Nurse Practitioner, how can I find an experienced registered nurse, whose is going to buy my practice, so I can retire, how can I get the DHB to listen to me, how will my interests be served on the alliance team?

We get bombarded with these and other questions and we look to our leadership to solve these problems for us.

However, it is we who hold the resource of knowledge in our areas. It is we who work with our people in our communities and who know the nuances of how they function. Therefore we are part of the problem and part of the solution.

If we start by looking at why we don’t have more doctors, Nurse Practitioners and experienced nurses, we need to look at the gap between their academic preparation and their placement into practice. The gap in medical training and preparation for practice is well-acknowledged and there are moves afoot by the Royal New Zealand College of GPs and Health Workforce New Zealand to address the issue.

Weis going to create. The discussion is no longer whether we should have senior or advanced nursing positions in rural general practice, the discussion is how do we achieve that?

Let’s start with Nurse Practitioners. So, how do you ‘grow’ a Nurse Practitioner?

First think about the gap in service provision that a Nurse Practitioner will fill. They are not cheap substitutes for medical doctors, however they can perform a significant part of the GP’s role but they will come from a different philosophy and will approach issues from a nursing perspective.

Relevant questions include: do some of the enrolled population have long-term challenges and chronic illness, are there same-day and out-of-town patients? Is there is a sub-population who relate better to a different approach, for example home or marae visits? Is a case management type of approach valuable for some people? Is there after-hours or emergency work? If so, a Nurse Practitioner will be a valuable resource within the practice. In other words is a Nurse Practitioner the best fit for your practice?

“There are also groups that can provide support for nurses on, or wanting to get on, the Nurse Practitioner pathway. They may also be aware of others who want to move to nurse practitioner scope.”

The integration into practice for experienced and advanced nurses is less organised and to date has been ad hoc. Rural practices by their nature, are not always capable of absorbing interns and trainees into their teams for a sustained length of time. There has been quite a variation in how this is done and how it is financially supported.

Consequently there is a dearth of people with the right skills and experience to fill the gaps in practice that our rapidly ageing workforce is going to create. The discussion is no longer whether we should have senior or advanced nursing positions in rural general practice, the discussion is how do we achieve that?

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…continued on page 15
National rural health conference 2016 update

Conference committee members met in Wellington in late June to start planning next year’s event – the dust having not long settled from the successful 2015 Rotorua event.

The 2016 committee is Dr James Reid (Queenstown), Dr Stephen Hoskin (Te Anau), Dr Erin Turner (Rotorua), Kim Gosman (Turangi), Sharron Bonnaux (Hamner), Deb Lawry (Dunstan - NZRHN), Deb Jones (Oamaru), Sharon Wards (Dannevirke - RHAANZ), Katelyn Thorn (medical student Otago), Blair Mason (medical student Auckland), Rob Olsen (Network, Wellington), Terri Growcott and Charlotte Sloane (Conference Innovators).

The programme is currently being developed and should be live on the official conference website by September 1. The conference theme and logo is pictured bottom right.

The recently refurbished Dunedin Centre and town hall on the Octagon is the venue for conference 2016 to be held over four days from March 31 to April 3. Keep watching the Network’s website for updates.

New primary health care award category announced

The Network in partnership with the Health Promotion Agency (HPA) will present a ‘Leadership in Health Promotion’ award ‘Te Hīringa Hauora’ at next year’s conference.

The award is designed to highlight and showcase best practice in health promotion in a rural primary care setting, as well as to support and encourage others to implement health-promoting practices into their core business.

The award will be presented to the winning practice at the conference awards ceremony on Friday, April 1, 2016. The winner will be asked to give a short presentation on their successful initiative at the ceremony and also participate in a filmed presentation at the conference (courtesy of Mobile Health) to be used as a web resource to assist and encourage other rural practices to initiate similar programmes. Entries open September 14, 2015 and will be judged by a professional panel made up of medical, nursing, and other sector representatives. More detail will be available soon on the Network’s website www.rgpn.org.nz

The RHAANZ sponsored best rural practice as decided by the community will also be repeated in 2016.

Peter Snow Memorial Award 2016

Do you know of a medical or nursing colleague in rural health worthy of this accolade?

Nominations are now open for the annual Peter Snow Memorial Award to be announced at the next year’s conference.

The award was set up to honour the life and work of Dr Peter Snow who passed away in March 2006. Dr Snow was a rural general practitioner based in Tapanui.

For more information, nomination guidelines or to nominate someone, contact: Network communications manager Rob Olsen, email: rob@rgpn.org.nz or telephone 04 495 5887 or 021 472 556.

Fun Run and Walk to return to conference 2016

After a gap year the Pat Farry Trust Fun Run and Walk returns to the Network’s national rural health conference in Dunedin.

Pat Farry Rural Health Education Trustees last year decided to hold the event every second year to spread costs and use each alternate year to do something different to raise awareness and funds.

The run and walk will be held on Saturday, April 2, 2016 – 6am start. The route will be announced soon. Rest assured it will not be Dunedin’s notorious Baldwin Street.

And the range of activities on tap doesn’t stop there. The Network in association with the Pat Farry Rural Health Education Trust and Bike it Now are offering 2016 national rural health conference delegates the chance to experience the amazing Otago Rail Trail - on two wheels. As a special offer, conference delegates can experience a luxury or standard option, four-day/three-night Otago Rail Trail self-guided superior tour. Bike It Now will give 10 percent of any booking made through the conference to the Pat Farry Trust.

The tour dates are March 27-30, 2016 (Easter Sunday through Wednesday before the conference), with the conference running from March 31 to April 3, 2016. Initial expressions of interest to rob@rgpn.org.nz

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New Zealand Rural General Practice Network

National Rural Health Conference 2016

31 March – 3 April 2016
Dunedin Centre

In association with NZRHN and RHĀNZ

• Captivating and relevant programme
• CME accredited
• Numerous networking and social opportunities for you, your colleagues and friends
• Extensive industry exhibition, sure to impress

www.rgpn.org.nz

Rob Olsen
NZ Rural General Practice Network
T +64 21 472 556
E rob@rgpn.org.nz

Terri Growcott
Conference Innovators
T +64 3 379 0390
E terri@conference.co.nz

Mark the dates in your diary now
What is the rural health workforce view on EFTS funding limit?

BY KATELYN THORN AND BLAIR MASON

In the last issue of the Network News we commented on the seven year Equivalent Full Time Student (EFTS) funding limit for tertiary study and the potential issues which may arise for graduate entry medical students and the rural medical workforce. Since then, the issue has received some brief, but relatively widespread media attention. In addition to the numerous online, print, radio and television outlets that ran stories highlighting the issue, an online petition organised by the New Zealand Medical Students Association (NZMSA) attracted more than 20,000 supporters. Unfortunately, the response from government has been disappointing, with tertiary education minister Steven Joyce suggesting he is unconvinced a problem exists, and has instead opted for a ‘wait and see’ approach.

While the media attention was very useful, the $15,000 per year cost broadly quoted was inaccurate for many – and threatened to underplay the actual figure. This figure approximately represents course fees, but does not include living costs. There are a number of factors which influence living costs and we can’t speak for everyone without solid data, but a back of the envelope figure of $10,000 per year puts the estimated total at approximately $25,000 per year. This means that a student needing to cover two years of unfunded study will need somewhere in the vicinity of $50,000 cash. For those only needing to cover the trainee intern year, the $26,756 grant in our trainee intern year has the potential to cover this cost however, the timing of this payment considering the graduate entry medical pathway in the future.

We as authors feel it is important to note that this limit does not affect either of us, but we feel it is critical to advocate both for our classmates and the rural sector. Through discussions with classmates, we continue to understand the issue more deeply. Those who are able to, will likely turn to parents for financial assistance, however for many this is not feasible. Ultimately, the bottom line is this: there are a number of students who, under the current system, are unable to pay for their final year of study – and are continuing in the course in the hope that something will change between now and January 2017.

New Zealand’s funding of tertiary study is generous by world standards. It is egalitarian, and the loan bears no interest while the borrower is living in New Zealand. In response to critics, we also understand that student debt is climbing exponentially and we acknowledge that the model must be sustainable for future generations. To study medicine is a privilege, and the majority of us will earn a comfortable living in the future. We enjoy one of the healthiest graduate salaries and have good job prospects when we finish. We know we are on a good wicket – our main concern is about fairness, and maintaining equitable graduate entry pathways into medicine in the future.

So where to from here? 20,000 signatures and various coverage in the media has drawn important attention to the issue but this is going to need persistent support at a higher level. Without further impetus, the issue has probably done its dash in mainstream media. The feedback we have had from colleagues suggests that most are very supportive of this issue, and recognise the benefits of having an accessible graduate entry medical programme. Can the rural health workforce add more weight to this argument? Can rural health professionals approach MPs in rural centres throughout the country, expressing concern and advocating for change? Or, inequities aside – is it unlikely to have an effect on the future of the rural workforce? These are discussions we think need to happen around lunch room tables across the country.

We would appreciate any feedback or support, so please do not hesitate to contact us.

Blair Mason (blair.mason08@gmail.com) and Katelyn Thorn (katelyn.thorn@hotmail.com)

NZRGPN student representatives 2015.

“So where to from here? 20,000 signatures and various coverage in the media has drawn important attention to the issue but this is going to need persistent support at a higher level.”
Sitting or standing the work goes on

Has the standing desk craze hit your workplace yet? Seven Network staff took a new stance in the office with their recent introduction. The desks are adjustable so staff can sit also. Network staff member Louise Pert was the first to use a standing desk in the Network office. A prototype of her own design.

“My partner got a proper standup desk and said he enjoyed using it and found it beneficial, so I constructed my own desk and used it for seven months until we bought the real thing. Although it wasn’t aesthetically appealing it [the prototype] really worked well for me.

“My monitor sat on a small coffee table on top of my desk, my mouse on top of an Officemax box of paper and my keyboard on top of a file holder.

“However, when I needed to sit down it was a case of reverting to using my laptop, which sat on my desk for my screen and bringing my keyboard and mouse back to desk level. That wasn’t ideal.”

The real McCoy poses no such problems. “They are adjustable and easy to work with. There are some small adjustments such as getting the height of your monitor and keyboard right. There’s a website that you input your data and it calculates the heights for you.”

Louise says she used to sit at her computer from 8am to 4.30pm and would suffer sore quads from that position. “I don’t get that now.”

She stands in the morning and sits in the afternoon. “After four hours I get tired of standing.”

And the benefits from standing? “I feel more energetic and don’t suffer sore quads. I would not go back to a total sitting day.”

“STRAIGHT UP: NZ Locums Project Coordinator Louise Pert is pictured left with her improvised standing desk and right with the custom version.”

A soft padded floor mat is an added optional luxury, which Louise says is more comfortable than standing on a hard floor.

Other Network staff members tell a similar story. They feel more energized both mentally and physically and aspire to a 50-50 standing-sitting use of the desk.

What the experts say

The key findings of a June 2015 British Journal of Sports Medicine’s Report on Sedentary Workplaces included:

Initially progress towards accumulating at least 2 h/day of standing and light activity (light walking) during working hours, eventually progressing to a total accumulation of 4 h/day (prorated to part-time hours). Seated-based work should be regularly broken up with standing-based work and vice versa, and thus, sit–stand adjustable desk stations are highly recommended [BJSM, 2015]

Similar to the risks of prolonged static seated positions, so too should prolonged static standing postures be avoided; movement does need to be checked and corrected on a regular basis especially in the presence of any musculoskeletal sensations. [BJSM, 2015]

Those individuals new to adopting more standing-based work could expect some musculoskeletal sensations and some fatigue as part of the positive adaptive process. If such sensations cannot be relieved either by an altered posture or walking for a few minutes, then the worker should rest, including sitting, with a posture that relieves the sensations. If discomfort does persist, then seeking appropriate medical advice is recommended. [BJSM, 2015]

Epidemiologist Steven Blair, professor of public health at the University of South Carolina headed up a study that looked at adult men and their risk of dying from heart disease. Those who did more than 23 hours a week of sedentary activity had a 64 percent greater risk of dying from heart disease than those who reported less than 11 hours – many regularly exercised too.

“We’re finding that people who sit more have less desirable levels” of cholesterol, blood sugar, triglycerides and even waist size, Blair says, which increases the risk of diabetes, heart disease and a number of health problems.

Other reading:

Sitting All Day: Worse for you than you might think:
www.npr.org/2011/04/25/135575490/sitting-all-day-worse-for-you-than-you-might-think

Standing up for health (Stuff):
www.stuff.co.nz/business/7779501/standing-up-for-office-health

Sitting down increases women’s risk of cancer – study (NZ Herald)
www.nzherald.co.nz/health/news/article.cfm?c_id=204&objectid=11481511

Now standing is bad for your health (NZ Herald)
www.nzherald.co.nz/lifestyle/news/article.cfm?c_id=68&objectid=11482166

Standing desks at schools: The solution to the childhood obesity epidemic? (NZ Herald)
www.nzherald.co.nz/health/news/article.cfm?c_id=204&objectid=11485750
If drinking alcohol during pregnancy is 'socially pervasive', what can we do about it?

A recent study published in the British Medical Journal reports that alcohol use during pregnancy is 'prevalent and socially pervasive' in New Zealand.

The results of this study confirm what we already know. Approximately 50 percent of New Zealand women drink alcohol in early pregnancy before they know they are pregnant, inadvertently exposing their developing baby to risk. While most women stop or reduce their drinking when they find out they are pregnant, between 10 and 30 percent continue to drink alcohol throughout their pregnancy and around 10 percent report binge drinking during pregnancy.

The public health message about alcohol use during pregnancy is clear: Stop drinking alcohol if you could be pregnant, are pregnant or are trying to get pregnant. There is no known safe level of alcohol consumption during pregnancy. This message is supported by the New Zealand Rural General Practice Network and a range of other key health sector agencies, including the Royal New Zealand College of GPs, the New Zealand College of Midwives, the New Zealand Nurses Organisation and the Ministry of Health. This message also underpins the Health Promotion Agency’s (HPA’s) new programme of work to reduce alcohol use during pregnancy.

Don’t know? Don’t drink is HPA’s new alcohol and pregnancy campaign launched last month. It focuses on young women, letting them know that alcohol can harm developing babies even before a woman knows she is pregnant and if they ‘don’t know’ whether they are pregnant then ‘don’t drink’. The campaign involves video content and banner-ads appearing in a range of digital environments and posters in bars.

Along with the campaign, HPA is developing tools and resources that support health professionals to routinely and consistently advise women not to drink if there is any chance they could be pregnant. Health professionals have a key role in providing this advice as well as the ideal opportunity to do so. Women want and expect health professionals to give advice. They see health professionals as having expert knowledge on the issue and they trust their advice.

Pregnancy is a time when women are open to making changes, including around alcohol, and health professionals are well placed to support women to make these changes.

HPA has developed the following resources for health professionals:

- **ABC Alcohol for Pregnancy** - a practical guide to help primary care health professionals address alcohol use in pregnancy in their conversations with women.
- **Pregnant? Maybe? Don’t drink** - a pamphlet that health professionals can give to women as part of that conversation.
- **Don’t know? Don’t drink** - posters – that can be displayed in health settings and other environments young women frequent.

These resources and the Don’t know? Don’t drink campaign (available at [www.alcoholpregnancy.org.nz](http://www.alcoholpregnancy.org.nz)) have been developed with the advice and guidance of a health professionals advisory group. This group includes the New Zealand Rural General Practice Network and representation from other key health professionals and agencies working with pregnant women.

Over the coming months HPA will continue to work with primary health care and its health professional advisory group to identify additional ways it can support health professionals to respond in a routine, effective and consistent way to women who are drinking while they might be pregnant, are pregnant or are planning to become pregnant.

For resources or more information about HPA’s alcohol and pregnancy work visit [www.alcoholpregnancy.org.nz](http://www.alcoholpregnancy.org.nz) or contact Cath Edmondson (c.edmondson@hpa.org.nz).

View the 30 second video here: [https://youtu.be/W93GgAE1e0U](https://youtu.be/W93GgAE1e0U)


[www.alcoholpregnancy.org.nz](http://www.alcoholpregnancy.org.nz)

MISSED A PILL? MAYBE?

If there's even a chance you could be pregnant, don't drink. Alcohol can harm a developing baby at any time - even before you know you're pregnant.

For more info visit alcoholpregnancy.org.nz or talk to a health professional.
From the Chief Executive...

One word seems to be on the lips of many in rural health and indeed the health sector at large these days - “Workforce”.

In fact “workforce” echoes throughout the regions whether it be in health, farming, agriculture, horticulture, viticulture or tourism.

Right now, the pressure is on the entire rural workforce physically, mentally and economically and it’s a workforce that needs to be looked after, nurtured and future-proofed because our country will depend upon it.

Statistics show a looming and somewhat alarming number of ageing GPs set to retire in rural communities. Data shared by the Royal New Zealand College of GPs at their recent conference in Hamilton reveals that 36 percent of GPs nationwide intend to retire within the next 10 years. It’s common to hear of rural practices with a number of GPs who are all within 5 to 10 years of reaching retirement, sometimes sooner.

New Zealand’s population has risen by 16 percent between 1999 and 2012 and the number of GPs per 100,000 population has reduced from 84 to 74 (12 percent reduction).

The number of hours GPs are working is decreasing too. The recent College of GPs survey found, many GPs in the 45-plus age group are looking to restrict their hours for family reasons.

"Access to reliable broadband is another key component on the rural health infrastructure wish list."

It is acknowledged that the situation in rural is more critical than urban New Zealand. There are almost half the number of GPs in rural areas compared to urban; rural doctors are more likely to be male, older and International Medical Graduates (IMGs).

The Network is at the rural health coalface – it has been for almost three decades and workforce has long been high on the agenda – amongst other issues. Our NZLocums recruitment division, supported by a Ministry of Health contract, has been able to keep a steady supply of locums flowing into rural practices since the early 2000s. NZLocums consistently over-achieves in this area. It also recruits longer term and permanent doctors to fill gaps and replace some of the retiring rural medical workforce. Ideally we wouldn’t need to continue to recruit so many overseas trained doctors but until such time as we are “growing enough of our own” we will continue to do so.

The reality remains, that for a variety of reasons the demand for locum GPs in rural communities is ongoing. It will never be completely addressed by recruiting overseas or international doctors. We need to attract, encourage and train more home grown GP specialists to work in rural New Zealand. We need to give medical students great experiences during their training which will encourage and inspire them to be ‘generalist specialists’ in rural areas.

This home grown approach must be a priority and in the mix of solutions. We must also look at ways to attract more female graduates to the regions and to retain older GPs in the workforce longer – either working part time or in roles to mentor or supervise.

The Government is making extra training places available in our medical schools to train more doctors, some of who will filter through to rural practices and communities once they have gained the required skill and experience.

The Network is instigating a distance learning mentoring programme that will enable rural practices and medical and nursing students to collaborate and foster careers in rural New Zealand. More than 20 practices have indicated willingness to be involved to date. Initiatives like this and other long standing programmes such as the universities’ schools of medicine rural immersion and training programmes are also integral components towards creating and maintaining a sustainable rural health workforce in the future.

Another changing area of the primary care workforce is nursing. We have an increasing number of nurses working to the top of their scope including a growing number of Nurse Practitioners who are helping to change the way we deliver our health service.

Health Minister Jonathan Coleman recently announced an extra 20 training places for Nurse Practitioners in 2016. This announcement was welcomed by the Network. They are set to play an increasing role in the rural health team in future and will to some degree offset the demands on GPs as a result of their high level of training and their ability to prescribe in certain settings.

The move towards an integrated rural health workforce is another key component to a sustainable rural health workforce. Rural nurse specialists, district nurses, midwives, pharmacists, managers, medical and nursing students, alongside GPs and NPs will make up the rural primary health team. It is this team approach that will ensure high professional standards and good support within practices and great health services and outcomes for communities.

Access to reliable broadband is another key component on the rural health infrastructure “wish list”. In this digital day and age the need to have accessible and reliable broadband for practices to function and embrace e-health initiatives and other IT advances is critical. Without that access health professionals, their patients and communities are on the back foot. Outside of practice, good broadband is also essential to practitioners’ families be it for lifestyle or professional reasons. It is crucial that rural New Zealand has parity with urban on this front. Not having good broadband can be a disincentive to those considering working and living in a rural community. Progress has been made here but more is needed to ensure rural-urban parity.

Otago Polytechnic nursing school and students collaborate with rural practice

A mental health screening tool for use in rural general practice has been developed by a group of year-two Otago Polytechnic nursing students and their tutors in association with Pleasant Point Medical Centre.

The project involved students Olivia Connor, Savanah Brady and Katheryn Campbell while on their clinical primary health care placement at the South Canterbury practice and was supervised by their lecturer Anna Wheeler, the polytechnic’s, principal lecturer Jean Ross and medical centre co-owner and Nurse Practitioner Tania Kemp.

“The desired outcome is the early intervention and referral of any patients in need of mental health support within the time constraints of general practice.”

The project also set out to demonstrate to both student nurses and rural communities, that when nurses work in collaboration with community residents and academic organisations they are in a strong position to improve health care, that is responsive and sustainable to local demand.

A second tool was also developed on smoking cessation in shearing gangs, which Tania would also like to see used in rural practices.

In developing the tools their research centred on the south Canterbury town of Pleasant Point with a population of 1278. The most common occupational group in Pleasant Point is “labourers” who include farm workers, some rural contractors and shearers.

Adverse events such as drought and extreme storms have a significant effect on the mental health of farmers and there is extensive research to support this statement, along with the realisation that farmers do not regularly access health services.

“We have developed an effective and opportunistic mental health screening tool, to be used at general practice level, to determine the mental health well-being of this group in our community,” says Tania.

The tool is designed to quickly screen all patients with a rural address or known rural connection regardless of the primary reason for visiting the practice. The desired outcome is the early intervention and referral of any patients in need of mental health support within the time constraints of general practice.

A flow chart of community organisations with contact details for easy access and referral for the Pleasant Point Medical Centre has also been developed, as well as a generic poster to help highlight the issue of mental health for this population group to place in the waiting room. “We anticipate this will provide patients with a comprehensive list of community resources that can help with mental health and rural support,” says Tania.

To view the full report click www.rgpn.org.nz/Network/media/documents/Rural%20Networker%202015/Pleasant-Point-Community-Project-Final.pdf
Roving rural GP discovers the artist within

By Rob Olsen

Opotiki-based GP Dr Peter Conolly has a calling aside from medicine – art.

Dr Conolly trained in Dunedin graduating in 1971. “I was in the same class as [Sir] Peter Gluckman.”

Dr Conolly’s career has taken him to many and varied rural locations around New Zealand and beyond. Although he grew up and began his working career in hospital and surgical settings in Auckland, he says his passion has always been for rural New Zealand.

“I like rural, the people are more down to earth and I’ve always been a bit of a loner and prefer solo practice, in fact I try to avoid working in big practices – I suppose you are a small fish in a big pond there.

“It’s easier to be yourself in a rural practice and you don’t have to wear a white coat.”

Following his Auckland stints Dr Conolly went to the Hokianga for a couple of years where he worked as a GP in a small hospital as an anaesthetist. That was followed by a year in Te Puia and then three years in Opotiki in private practice, with a young family in tow. He was also doing anaesthetics and obstetrics in the local hospital. “There are a few people around now in their 30s who I delivered including the local bank manager and a young doctor.”

In 1980 Dr Conolly and family went to Te Kaha where at that stage there was no doctor – the doctor from Opotiki used to visit once a week – and set up practice there. He recalls that in those days people still paid in kind. “You might have got a crayfish as payment for treatment.”

He also remembers getting a special visit from then minister of Health Dr Michael Bassett. “The area I covered – from the Motu River to Cape Runaway and 1500 people – was deemed a special area. It was basically one long 100 mile road. I did that on my own and there were nurses who helped me. I also ran the pharmacy.”

There were also locum stints on Pitcairn and the Tokelau Islands (amongst other islands) followed by another five years in Te Kaha – in fact 15 years in the latter in total.

Australia has also beckoned – Dr Conolly spent six years there including locuming on Groote Eylandt Island (or Groot Eiland) in the Gulf of Carpentaria, northeastern Australia. The island hosted manganese mining and Dr Conolly was employed by the mining company along with one other doctor. “It was very isolated and you had to fly in and out, which was expensive. Spear injuries weren’t uncommon and if the patient died you had to watch a spear wasn’t thrown your way. I spent a couple of years there.”

The following three years were spent in New Zealand’s South Westland based in Whataroa, where nurses played a big role in primary health care, something Dr Conolly says he became used to and encouraged.

He then returned to Australia for two years working for the Aboriginal Medical Service in Walgett, northern New South Wales. “I was there for two years and it took the locals six months to become friendly.”

On his return to New Zealand Dr Conolly worked through NZLocums and “loved it”. After roaming far and wide for many years he decided he needed to be closer to home.

Papamoa was his next port of call, where he worked for the Maori health service for a year. The people were great but Dr Conolly says he “hated” working in a town, being a rural GP at heart. So it was back to Opotiki where he worked for the Whakatohea iwi who owned the local practice.

“I was there for four years and was looking after 2500 people on my own and eventually decided I’d had enough. I was 65 then and am 67 now. I’m now doing locums all over New Zealand – some in the South Island in places like Roxburgh, Rakaia, and Westport and in the Chatham Islands where I am job-sharing with a South African doctor. I do two months and he does four. I think I’ll do that for the couple of years.” Dr Conolly also plans to work in Whakatane.

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‘Leadership in Health Promotion’ award

‘Te Hīringa Hauora’

The Health Promotion Agency and the New Zealand Rural General Practice Network in association with the New Zealand Rural Hospital Network and the Rural Health Alliance Aotearoa New Zealand are pleased to announce a new award category at the 2016 National Rural Health Conference, Dunedin.

The award is designed to highlight and showcase best practice in health promotion in a rural primary care setting, as well as to support and encourage other practices to implement health promotion into their core business.

Entries will be judged by a professional panel made up of medical, nursing, and health sector representatives.

More information will be available on the Network’s website www.rgpn.org.nz soon, or alternatively contact:

Rob Olsen
Network communications manager
Phone: 021 472 556
Email: rob@rgpn.org.nz

Entries are open from September 14 and close on November 30, 2015.
By Judith Martin

Major Simon Ainsworth remembers well nursing an American soldier who had had his legs blown off by a bomb in Afghanistan. It’s not the trauma or the enormity of the situation he particularly recalls — most of his patients during that deployment had multiple traumatic injuries.

It was a newspaper cutting from the soldier’s hometown several months later that showed he was learning to walk again.

“That type of story is very rewarding for me as a nurse. I remember many of the patients I dealt with in Kandahar and Bagram who were very badly injured – I was pleased to have been there to care for them but always wondered how they were doing.”

Those sentiments seem to epitomise the reasons the majority of New Zealand Army nurses give for why they enjoy and value their career.

“Seeing people injured when on deployment is never easy but it is a privilege to be able to care for people injured in conflict.”

Major Ainsworth has been a member of the Royal New Zealand Nursing Corps for 12 years. “I had always been interested in joining the Army and with my background in emergency nursing it seemed like a place that I could use my skills.”

And those skills were put to good use when he deployed to Tonga in 2006, Samoa (after the Tsunami) in 2010, and three times to Afghanistan (TG Crib 5, TG Manaka in 2008/09 based at the Role 3 Hospital in Kandahar), and with the Mission Closure Team based at the Bagram, Role 3 in 2012/13.

“My tours based in Kandahar and Bagram are my stand-out deployments with regard to nursing as I was based in their trauma teams. As such I cared for a wide variety of patients that had been injured through combat. This type of trauma is very different from what you experience in New Zealand.”

On Crib 5 he worked with the RAP team based in the PRT at Kiwi Base, and in Tonga he lead the medical detachment in support of Op Vivendi Tango.

In Samoa he flew with 3 Squadron, RNZAF as one of their AME team.

When posted to Ohakea he was part of the RNZAF Search and Rescue team. “The back of an Iroquois is a very different environment to nurse out of and I always remember the missions when you would winch down to rescue people.

“This is a very rewarding experience and something that very few nurses are lucky enough to be involved in.”

Nowadays he can be found in Linton where he is Officer In Command of the Role 2 Light Manoeuvre (OIC R2LM), previously known as the Forward Surgical Team.

“My job is focused on leading the specialist staff posted to the R2LM and we are currently focused on the introduction into service of the new surgical tented platform.”

Would he recommend his career?

“As a civvy nurse your focus is on competence and you need to have both nursing and military competencies. The military lifestyle offers opportunities to train and experience things that you don’t experience as a civvy.

“I don’t think it takes a different type of nurse just a different sort of mind set in that you have to be prepared to work in any environment (and often at short notice). It’s not just about being good at nursing but being able to utilise your military training to maximise the effect you are trying to achieve.

“Enjoy the people I get to work with and the variety that comes with being in the military.

“Having the opportunity to serve as a military nurse is a great reminder of how lucky we are to live in a country like New Zealand.”

Article and photos courtesy Army News.

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From the Chair...

The next step is to do the sums. Can training and ultimately employment be sustained? The time and cost to attain Nurse Practitioner level qualification is significant and then there’s the question of whether a practice can afford to employ a Nurse Practitioner?

DHBs have Nurse Practitioner champions and they are the first person to contact for information on training and support for Nurse Practitioner candidates. The universities that offer the clinical masters degrees are well versed on the educational requirements for registration.

There are also groups that can provide support for nurses on, or wanting to get on, the Nurse Practitioner pathway. They may also be aware of others who want to move to Nurse Practitioner scope.

The Council also has online resources and guidelines for nurses compiling their portfolio. It is the area of internship and mentorship that is so difficult for many nurses and this is where they need the help and support of authorised prescribers either medical or Nurse Practitioner. This experience is invaluable and absolutely necessary. Nurse Practitioners need to be working in their area of expertise for at least four years, not necessarily in the same workplace.

At the end of this process is the development of the portfolio and the trip to Wellington for the oral examination which is a nerve-wracking experience for most candidates. The preparation for the visit is best done within the Nurse Practitioner support group.

It should be noted that nurses cannot call themselves Nurse Practitioners until they have registered in the scope with the New Zealand Nursing Council.

More money for training Nurse Practitioners welcomed

One of the things that NPs need is good collegial and peer support and good structures around them, and that’s ongoing.

“The devil will be in the detail about how that is going to pan out and the Network has a pivotal role to play here. We are in a great position to assist in this area. We have a membership that has the ability to support these nurses during and after their training.”

Ms Hansen says she is often questioned about ‘where and how do we get a Nurse Practitioner, we want one’. “So we need to have the connectivity between training, trainees and primary care practices in rural to make this happen’.

Employment of NPs in rural practices is another area of concern, she says. “We need to think about how that happens and support practices in doing their sums to make it happen. Nurse Practitioners will bring in their own funding sources through things such as co-payments and through existing payment schemes. We are not looking at new money, but we are looking at helping practices grow their business models.

‘Nurse Practitioners will play a valuable role in the new and evolving model of primary health care in rural centred on the needs of patients and their whanau and we have to think about that in a sustainable way,” says Ms Hansen.

The University of Auckland and Massey University have designed a new education programme for the 20 new Nurse Practitioner trainees. It will offer more supervised practice time and require employer support to ensure graduates can practise in their advanced roles as soon as they qualify and register as Nurse Practitioners.

As at March 31, 2015, 145 Nurse Practitioners were registered by the Nursing Council of New Zealand.

Nurse Practitioners are experienced nurses with a clinical Master’s degree. They work in a range of settings from hospitals and aged care facilities to general practices.

Roving rural GP discovers the artist within

Looking back on his varied career, he says he has been “a bit of a wanderer, a gypsy, rural and solo GP. A lot of my life has been with Maori health. I’ve lived with Maori for 40 years. I can’t speak Maori but I know how they think”.

And so to art: “The art started about three years ago when I began painting the faces of friends. I started with one person in the practice and painted her in different colours and genres. I was just experimenting. I just got hooked from there.

“I admit that not everyone likes my paintings because they are not necessarily realistic. Some like them, some don’t, but it’s something I enjoy doing.”

Dr Conolly likes to paint intuitively. “If I see someone I want to paint I go up to them and ask if I can take their photo because I want to paint them. Then I put the photo aside unless I have to refer to it. I also warn them it’s not going to be a realistic painting, rather an abstract interpretation.”

He likes to give the portraits to his subjects. The reactions range from shock to delight, he says. “Some say ‘that’s not me, you have not painted me’ and others hang them on their walls.

“I think some people are just polite – it depends. People will see things in the paintings that I don’t see.” He says he has some “good critics” around him and that’s helpful.

Dr Conolly estimates he has completed between 300 and 400 painting in three years – 200 of them portraits. “Faces are what I like painting. Certain faces stand out and I just want to capture them.

“I do my art fairly quickly and I paint every night, sometimes three or four at a time. It’s not fine art but it’s more than a hobby. It’s part of me and I can’t stop, I don’t want to stop.”

Not all his face paintings are portraits. Some feature faces with animals and fish. “I’m getting more abstract and I love using colour.”

Dr Conolly describes himself as “slightly new-age”. I’m not heavily into alternative medicine though. My upbringing was a cross between science and religion.

“I’m constantly looking for new ways to express myself.”

He believes everyone has creative talents. “I’ve just found mine late in life and I have more time on my hands now.”

He paints in acrylics and is “self-taught”, has exhibited locally and sold one painting. His work is also on Facebook.

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Have an overseas GP/Nurse joining your team?

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