NEW ZEALAND RURAL GENERAL PRACTICE NETWORK

NetworkNews

Autumn 2010 | Vol 14

Promoting the networking, support and advocacy of the rural general practice workforce

Conference 2010
One of the best yet

Inside this issue:

COVER PHOTO: Minister of Health Tony Ryall speaks to delgates at the conference's political session. (See page 6.)

Message from the Chairperson

New Board charged with fresh energy

Kirsty Murrell-McMillan.

First and foremost, I would like to warmly welcome the new Network Board and look forward to working with Members – new and old – in the year ahead. While new faces bring fresh ideas and energy, the wise heads who have departed will not be lost to the sector. On that note I want to acknowledge and applaud the establishment of the past chairpersons' group, which the Board formalised at its recent AGM in Christchurch. Their wealth of expertise and experience in rural health is invaluable and will be well-utilised in mentoring and supporting rural practices particularly with the challenges the sector faces.

One such challenge is the move to integrated family healthcare centres and already there is some considerable concern about bringing people together, who have not worked in a team. Bringing practices together that are separated by significant geographical barriers is another challenge. Our past chairpersons' "wise heads" and experience will be well-used in this respect, especially by those more isolated practices.

The Board is working to solve hard-to fill-positions around New Zealand. Its members are meeting regional PHOs and DHBs in conjunction with NZLocums to look at issues of recruitment and retention in some rural practices and communities. Several successful meetings have been held in Canterbury and on the West Coast of the South Island and have enabled DHBs, PHOs and practices to say how we can better support them. Board members Dr Martin London and Sharon Hansen have been involved in these visits, which are also designed to develop strong relationships with the respective parties. These visits and meetings are ongoing.

An important Network role is recognising and honouring the often unheralded work rural practitioners do. This year two practitioners were to the forefront: Dr Tim Malloy and the late Dr Pat Farry. Tim's contribution is significant in a number of ways: The development of a very successful PHO - Coast to Coast Healthcare; development of an integrated family practice based in Wellsford; the use of information technology and communication in the practice; the vision and work to support funding for rural practices during the past 15 years; mentoring of students, registrars and colleagues of all disciplines; encouraging them to work in rural areas and PRIME training. Tim put rural on the map within the general practice community by being a strong leader and has given rural practices a strong profile. He also proved to be a formidable opponent to any government trying to take away rural services.

Pat Farry was another icon in rural health who was an innovator in education. A trust set up in his name seeks support to develop a firm capital base to enable education scholarships in the rural health sector.

That trust was officially launched at conference and it was an honour that the Farry family came from all over the world to Christchurch and enabled the rural health sector to applaud the work that Pat did.

...continued on page 9

Landing the 'big one' in the Hurunui River

John Blunn holds an 8.5kg salmon he caught in the Hurunui River earlier this year. He and his partner, doctor Mary Philipsz, who hail from the UK, spent time in Hurunui where doctor Philipsz worked as a locum in January.

Dr Philipsz came to New Zealand through NZLocums, the recruitment arm of the New Zealand Rural General Practice Network.

The trip came about when her brother announced his engagement to his Kiwi girlfriend last year.

"The wedding was set for January 2010, so I considered my options: A three-week holiday in New Zealand or request a sabbatical and try to see the country properly. Once my sabbatical was accepted, NZLocums did all the rest."

The couple arrived in New Zealand on December 31. They spent a week in a camper van travelling from Christchurch to Milford Sound then up to Wellington for the NZLocums' orientation.

They were initially based in North Canterbury where Dr Philipsz worked in Rotherham and Cheviot Medical centres and "had our first taste of rural New Zealand life".

John, who had not fished since childhood, bought himself a lightweight telescopic rod and fishing licence in hope of a few trout on the Hurunui River. "After three hours of casting on our first day fishing, we were about to give up hope when the line went taut and a large tail fin flicked up. Twenty minutes later the 8.5 kg salmon was landed. The story even made the local Hurunui News."

Dr Philipsz also worked at Owaka in the Catlins and Darfield in Mid-Canterbury.

"We took advantage of being in the Catlins and walked the spectacular Hump Ridge track and the Catlins River walk. After finishing in Darfield, we then undertook the Grand Traverse, a combined Routeburn and Greenstone tramp, with stunning views during five sunny days in April.

Dr Philipsz said the New Zealand trip has also benefited her professionally. "My medical knowledge and experience have been enhanced and I have learned much from the excellent teams of rural nurses, paramedics and ambulance staff.

"The warmth, generosity and hospitality of everyone I have met since coming to New Zealand cannot be overstated."

Dr Pat Farry fondly remembered

Members of the Farry family gathered at the Network conference's Friday night cocktail function for the launch of the Pat Farry Rural Education Trust and scholarship established in honour of Queenstown-based Dr Pat Farry who died suddenly last October aged 65. Dr Farry was a founding Member of the Network, educator and fierce advocate for rural general practice.

Several hundred delegates heard tributes from his widow Sue and his brother John, who chairs the trust. Both shared moments of Pat's life - light-hearted and serious - with the audience – John making reference to Pat's "pathological lateness" for dinners and his frequent quips about lawyers. He also paid tribute to Sue "for her courage over recent months".

Sue said she had not fully realised the significance of the trust launch until asked the question by a journalist. There is very little in the way of rural scholarships in New Zealand, unlike Australia and the United State of America, she told those gathered.

It is a first, definitely for the South Island, and the potential to offer considerable assistance to students for study in the rural medical sector has been greatly enhanced, she said.

Setting up the trust had been a "healing experience," she added.

John thanked the Network for accommodating the trust launch at its conference. "I did not realise how much Pat meant to rural GPs and the Network."

Health Minister Tony Ryall announced that funding has been allocated for training another 20 GPs next year on the back of its pledge to increase medical student places by 200 over five years. This year the government provided another 60 additional medical student places.

The extra places will be earmarked in future for young people from rural New Zealand as part of an extension of the Rural Origin Medical Preferential Entry (ROMPE).

The move was in recognition of Dr Farry's contribution to rural medicine and this group of medical students next year will be officially known as the Pat Farry Intake.

The Pat Farry Rural Education Trust has so far raised more than $44,000. Donations can be made online by visiting **www.patfarrytrust.co.nz**

FAMILY AFFAIR: Dr Pat Farry's family (from left) daughter-in-law Anne Kulonen, son Ben, wife Sue, brother John, and sons Jude and Simon.

FONDLY REMEMBERED: John Farry shares a light-hearted moment with the audience.

One-third of rural hospital positions unfilled

A survey of 28 hospitals conducted by the New Zealand Institute of Rural Health has shown only two-thirds of rural hospital doctor jobs are currently filled. The survey results were presented recently at the NZRGPN conference in Christchurch.

These positions are predominantly staffed by International Medical Graduates IMGs). All the managers surveyed reported there was a shortage of doctors – most stating that the situation was either critical or severe. They noted that 25 per cent of positions were filled by locums and 9 per cent were vacant (66 per cent are FTEs). Fifty-one per cent of doctors surveyed said they had to do extra shifts in the previous month. All these findings confirm the concerns that have been expressed by the Royal New Zealand College of General Practitioners.

However, the positive finding from the survey was the support that respondents had for the Rural Hospital Doctors training programme and the belief that this was one of the initiatives, which would help improve the attractiveness of rural hospital medicine for medical students and more involvement of doctors in the leadership and governance of hospitals.

The authors believe that this survey is an important starting point from which to master the medical cover for this small but critically important part of the New Zealand public hospital service.

Bitten by the rural general practice bug

Not many jobs allow the luxury of mountain biking in the morning followed by coffee with friends then a picnic and a swim in the lake after a day's work in a general practice surgery.

That's exactly what Scottish-born GP Anne Hutchison from Queenstown Medical Centre can roll into her working day.

After three years in general practice in rural New Zealand Anne says it's a working lifestyle that's hard to beat.

The 32-year-old (pictured) did her pre-clinical training at St Andrews in Scotland and her clinical years in Manchester where she graduated. After completing her pre-registration year as a house officer in the United Kingdom she went to Cairns, Australia for 15 months before returning home "to do the sensible thing and get a career.

"I lasted for almost 18 months .... then a friend who wanted to do her OE suggested I go too. I was persuaded on the condition we came to New Zealand as I'd always wanted to return " Anne had previously visited New Zealand but never lived here.

She and her friend arrived in October 2006 and for the first six months worked at Middlemore Hospital in Auckland in obstetrics and gynaecology.

During that time they discovered the application process for GP training in the UK had changed meaning they would have to return home much earlier than planned. On the off chance, Anne enquired about doing her GP training in New Zealand assuming it wouldn't be a possibility as she wasn't a resident at that time. "I was told there was one spot left and I could have it. But it's in Dannevirke. Where the heck is Dannevirke? Jacqui Virtue said to me, 'it sounds like the world's you're oyster but maybe Dannevirke is your pearl!' I decided to go for it."

It was a good choice as it turned out. "They welcomed me warmly as a GP registrar on the PRIMEX programme and continued to encourage and support me throughout. The wide variety of cases and its rural setting made it an ideal practice to learn to be a GP. The combination of scope, freedom and support made for a steep learning curve."

After about 15 months Anne moved south to Queenstown where she worked as a doctor on the ski fields at Coronet Peak and the Remarkables; returned to Dannevirke for six months then back to Queenstown for another winter on the ski fields. Now she is a GP at the Queenstown Medical Centre.

Anne says she had no intention of specialising in general practice, especially rural when she began training. "Absolutely not, at university most people want to do the perceived exciting stuff – emergency, paediatrics, anaesthetics."

Although it was accidental that she ended up working in rural practice she reckons she'd be reluctant to work in a big city again. Although Queenstown doesn't feel too rural it is still a couple of hours from secondary care.

"In rural areas there is a wider scope of practice and greater flexibility in what can, and sometimes needs to, be done, especially in regard to hands-on medicine. You get right in there and do things including minor surgery and stabilisation."

In Dannevirke some of the more serious cases she treated were often farm-related – a farmer who had been pinned against a fence by a bull, for example, or large leg lacerations that would usually go straight to hospital in an urban setting. On the ski fields it's orthopaedic issues such as dislocated hips, fractured femurs and nasty spinal or head injuries. Some of which do need to be evacuated by helicopter, says Anne.

Though pay rates in New Zealand may be lower, the lifestyle and the incentives to work in rural areas definitely balance that out, she says. "This week the weather has been so lovely that in the morning I managed a mountain bike ride and a quick dip in the lake before work. Other days may see a hike to a mountain lake squeezed between clinics. I can't think of many places in the UK where you can achieve that balance without compromising on either collegial support or after work activities."

"Working in this kind of environment is great. You have a close-knit team, people are welcoming, friendly and very supportive. That's not to say that people in urban areas aren't all those things as well but the people you work with in rural communities are the community. They are passionate about providing care for their own and that means you too when you join them. My Dannevirke colleagues quickly became my family in New Zealand."

Anne says she has no intention of leaving rural practice. "I think it's where I'm supposed to be. I didn't exactly choose it but I'm in no rush to change it ..."

Nurse Practitioners want removal of legislative barriers

Rural Nurse Practitioners want urgent and immediate action to clear away legislation that often stops them from doing their jobs and treating patients effectively and efficiently.

That was the message given to Minister of Health Tony Ryall at the New Zealand Rural General Practice Network's recent annual conference in Christchurch.

For example, simply signing a WINZ form that enables patients' access to a disability allowance is not possible under existing legislation. Currently, a GP needs to sign-off a WINZ disability allowance form. Nurse Practitioners want this barrier removed as soon as possible in line with a move towards integrated family health care centres and the general practice team approach to primary health care delivery and patient care, especially in rural areas.

Nurse Practitioners at the Network conference in Christchurch spoke out strongly about this and other legislative barriers that often prevent them doing their job in rural and remote areas of New Zealand.

Nurse Practitioners are often the first line of health care and work in collaboration with, or in some cases in the absence of doctors, in many rural and remote areas of the country.

The inability to sign off a form that will give a patient access to not only treatment but services such as transport is causing severe disadvantage to vulnerable people in rural communities, Nurse Practitioners at the conference said.

Mr Ryall told the delegates gathered that he would go away and relook at the issue of legislation in this respect.

About Nurse Practitioners:

- A nurse practitioner is a registered nurse practising at an advanced level in a specific area of practice.

Nurse practitioners must have:

- Attained Master's level of education
- Been approved and registered by the Nursing Council of New Zealand as a nurse practitioner.
- The title is protected and may be used only by those nurses formally registered by the nursing council.
- Nurse practitioners were first introduced in New Zealand in 2000. It is anticipated that it will take a decade to fully implement the evolving model.

Nurse practitioners combine the roles of:

- Practitioner, mentor, teacher, researcher, administrator.
- Nurse practitioners must meet six core competencies to attain and maintain nurse practitioner status. At present nurse practitioners may chose to apply to be independent prescribers. Specific educational and practice requirements must be met for a nurse practitioner to gain prescriptive authority.

NEW ZEALAND RURAL GENERAL PRACTICE NETWORK

New Network Board named

The New Zealand Rural General Practice Network elected a new Board at its AGM during its recent Christchurch conference.

Incumbent chairperson Kirsty Murrell-McMillan was re-elected unopposed. Longstanding Board member and past chairperson Dr Tim Malloy stood down from the Board as did regional representatives Dr John Burton and Dr Andy Minett, the latter resigning at the April 19 Board meeting. Dr Jo Scott-Jones takes over as deputy chairperson and Rachel Hale as Treasurer replacing Dr Stephen Graham. Dr David Wilson continues as Board Secretary.

Those elected were:

Chairperson - Kirsty Murrell-McMillan

Deputy Chair - Dr Jo Scott-Jones

Treasurer - Rachel Hale

Secretary - Dr David Wilson

Northern North Island - Dr Graeme Fenton

Western Middle North Island - to be confirmed

Eastern Middle North Island - to be confirmed

Southern North Island - Kim Gosman

Northern South Island - Sharon Hansen

Southern South Island - Dr Stephen Graham

North Island representative - Dr George Tripe

South Island representative - Dr Martin London

Rural Hospital doctors (honourary) representative - Dr James Reid

Student (guest) representative - Darran Lowes.

CME reminder

We remind all those who attended the Network's Christchurch conference in March to send in their CME points forms.

Please post your form to: New Zealand Rural General Practice Network, PO Box 547, Wellington 6140. Once received, a certificate will be issued and returned to the CME applicant.

For more information please contact Communications and Membership manager Rob Olsen on 04 495 5887.

Conference 2010 one of the best yet

The 2010 NZRGPN conference in Christchurch is being hailed as one of the best yet with almost 330 delegates attending, more than 40 exhibition stands and good support from sponsors.

The turnout and interest was testament to the high level of activity in rural health at both the coalface and political levels.

The opening day's political session saw Health Minister Tony Ryall front-up to delegates who questioned him on a range of issues from how to get funding from DHBs and will the Government fund dental care, to rural GPs' ability to provide emergency obstetrics cover in the middle of the night.

The latter was put to the Minister by Matamata GP and Network Board member Andy Minett who quoted personal experience, which saw him called one night and told that midwives were in trouble, could he assist? At the conference forum Dr Minett said while once upon a time he did a lot of obstetrics his skills now were evaporating, as he no longer provides such care; what should he do?

Mr Ryall said that the Government was focussing on a number of key areas in maternity to give better safety of midwives and babies.

Unsatisfied with this Dr Minnett said he has no choice but to be involved. The number of his colleagues with obstetrics' experience was getting less but babies were still being born, he said.

The political session was again beamed live to two provincial centres thanks to Mobile Surgical Services' technology and crew. This year Dannevirke and Dargaville featured courtesy of MSS and joined those who lined up to ask the Minister questions from the floor.

MC at this year's conference was the inimitable Dr Buzz Burrell who acquitted himself with aplomb and his usual mix of humour and tact.

The four-day conference featured the presentation of the annual Peter Snow Memorial Award, which this year went to Wellsford GP Tim Malloy (see story in this issue) and the launch of the Pat Farry Rural Education Trust – both held at the Friday night cocktail function.

Amidst the workshops, presentations and education sessions delegates also enjoyed a dinner and dance on the Saturday night at the convention centre (see photos in this issue).

The Network wishes to thank all delegates, presenters, sponsors, exhibitors, staff and others involved in this year's event.

Next year's conference will be held in Wellington from March 17-20. Keep an eye on our website **www.rgpn.org.nz** and fortnightly e-zine for details.

The Network wants input from spouses of rural general practitioners about the content of the spouses' programme at its annual conference. We welcome your ideas, feedback or input into this important section of the conference. Ideally we'd like someone to represent spouses on the conference committee, which meets via telephone conference – monthly in the lead-up to conference.

Please contact communications manager Rob Olsen on 04 495 5887, 021 82 2468 or email rob@rgpn.org.nz to register your interest.

Pragati Gautama, James Reid, Kati Blattner and Raelene Abernethy.

Kirsty Murrell-McMillan and Peter Foley.

Sabine James, Anne Hutchison, Sam Wilson, Jane Laver and Fiona Bolden.

Gill Godfrey and Iain Russell.

Gerard Vaughan, Anne Hawker and Tom Morris.

Deb Panckhurst, Andrew Panckhurst, Rosie Eager and Mark Eager.

Amiria, Ivan and Leonie Howie.

John and Sue Burton.

Sabine James, Marta Kroo, Sam Wilson, Pauline Blackmore, Jane Laver and Rochelle Murphy.

One man, one road, one cycle

Roger Honeybun has cycled more than 1000 kilometres from Christchurch to Auckland to raise awareness of poor asthma control in New Zealand.

The intrepid and energetic cyclist took to road to raise awareness of the issue after his great nephew, Sean Hedley, tragically died from an exacerbation of asthma at just nine years old.

The *One Man, One Road, One Cycle* awareness campaign took place from March 13 - 21 and saw Roger travel along State Highway One during nine days to raise awareness about asthma control and to help raise funds for Asthma New Zealand.

He called in to the Network's annual conference at the Christchurch Convention Centre on March 13 where a talk entitled "What's the score with asthma control and management" was given by Professor Shaun Holt.

After Professor Holt's presentation Roger was introduced to those who attended the breakfast session by Asthma New Zealand's Linda Thompson.

"Sean's death was devastating for our family, but I wanted something positive to come from it. I am lucky enough not to have suffered from any sort of infirmity in my life and I was amazed that, in this day and age, children like Sean are still dying of this incredibly common affliction," said Roger.

New Zealand has the second highest prevalence of asthma in the world affecting one in four children and one in six adults. It is estimated that it costs the country more than $1 billion annually.

Furthermore, research shows that more than half (54 per cent) of those with Asthma in New Zealand are under-treated and do not have control of their asthma.

"Many people with asthma think they have their condition under control when they don't – they have just accepted the symptoms as part of life," said Linda.

"If someone is using their asthma reliever more than twice a week then this indicates that their asthma is not under control. If asthma is well managed it shouldn't interfere with an individual's quality of life or daily activities.

"Because asthma is a chronic disease a perception exists that it is not all that serious, but it is. It is a disease that can kill and it currently kills more than 100 New Zealanders each year. Treatments exist to achieve asthma control and it's upon us to ensure New Zealanders are aware of this and know how to best manage their asthma."

TAKING A BREATHER: Linda and Roger and the mobile Asthma clinic outside the Christchurch Convention Centre. Soon after Roger began pedalling to Nelson. PHOTOS: Rob Olsen.

ASTHMA UPDATE: Professor Shaun Holt spoke to delegates about asthma control at the Network's recent conference.

As part of the *One Man, One Road, One Cycle* asthma control campaign, Asthma New Zealand is running a TXT campaign until May 30 where people can make a $3 donation by texting "ASTHMA" to 4711 or donations can be made online at www.asthma-nz.org.nz

Bike Barn, Bunnings and GlaxoSmithKline supported the *One Man, One Road, One Cycle* challenge. Roger and Asthma New Zealand have also set up a Facebook page outlining his journey.

Students set to make their mark in rural health in 2010

By fourth-year University of Auckland medical student Darran Lowes

"As the Grassroots Rural Health Club and Aotearoa Rural Health Apprentices (ARHA) political representative, I work with the New Zealand Rural General Practice Network Board. I'm excited to be involved with others who are passionate about rural health.

This year we are aiming to make progress in three areas: Increasing rural student numbers, increasing rural exposure during training and influencing graduates to choose rural careers.

It has been shown in overseas studies that students from rural areas are more likely to go on to work in rural areas. Rural health groups across the country are now running rural school visit programmes aimed at promoting health careers to rural secondary school students. What we'd really like to add to these programmes is ongoing mentoring for students who show interest in health careers. So, we'd love rural health practitioners to get on board with this mentoring; perhaps by speaking at schools or having students come and visit their workplaces. Stay tuned for more updates on this.

With ever-increasing student numbers, it's getting harder and harder to give medical students a truly 'rural' GP placement. Likewise, most nursing and allied health students from Auckland have no rural exposure during their degree. This is a problem because it has also been shown that positive experience during rural placements has a strong influence on graduates' career decisions. This year we intend to work closely with the New Zealand Rural General Practice Network to find more rural general practices that are keen to host students. Again, watch this space.

Influencing medical, nursing and allied health graduates to work in rural areas is a difficult task that requires a coordinated effort from student groups, organisations such as the Network, individual DHBs and the Ministry of Health. The introduction of the Voluntary Bonding Scheme was a great step however there are some ongoing issues that need to be resolved.

So it looks like it should be a pretty interesting year. I'm looking forward to being involved with each of the rural student groups and the Network working towards a better rural health workforce.

Please feel free to contact me at dlow041@aucklanduni.ac.nz if you have any ideas or questions.

One final note: If you happen to be around Queenstown during the weekend of May 21-23, keep an eye out for more than a hundred young people wearing dark sunglasses, clutching a packet of Nurofen Plus in one hand and a bottle of Powerade in the other. These will be medical students attending the NZMSA Conference 2010. Rural health groups from each medical school will be out in force promoting rural careers to these impressionable young, future doctors."

... continued from page 2

New Board charged with fresh energy

The Network is working with the Ministry of Health and DHBs on future rural funding and will engage the heads of the schools of nursing and medicine to ensure that the needs of students in terms of rural experience are met. Some student feedback at conference was to the contrary, so the Network is committed to seeing they get to work in rural locations.

Closer ties with rural hospital doctors have been forged and the Board has met with a delegation to discuss how the Network can support them in future. The Network is very keen to walk the road to rural hospitals and has agreed to be their advocates.

A firm strategic direction for the next nine months has been developed by the Network focussing on the keys areas of advocacy (rural funding), recruitment (working with hard-to-fill areas regarding doctors, developing relationships with DHBs and PHOs), growing and developing membership, and strengthening the Network and its business arms (NZLocums and NZMedics).

Finally I want to acknowledge the successful Network conference in Christchurch in March. There were a number of excellent clinical sessions and I particularly enjoyed Sharon Hansen's opening keynote practice session.

Is there a place for Apple iPad in your healthcare organisation?

By Simon James, Editor of Pulse+IT

Along with every IT journalist on the planet, the inevitable announcement of Apple's iPad in late January did not go unnoticed by the author. Having received even more pre and post announcement hype than the iPhone a few years prior, even the most technologically uninterested reader will have no doubt stumbled across at least a mention of the device in the mainstream media.

The iPad went on sale at the end of March 2010 and has only been provided to a select number of developers since it was introduced at the start of the year. The amount of pre-release discussion amongst clinicians and other participants in the healthcare sector has all but ensured the device will be reviewed for potential adoption by Health IT software developers and users of Health IT software alike.

WHAT IS IT?

While Apple does not use the term explicitly, the iPad fits best into the "Tablet PC" category. As with tablet PCs made by Motion Computing and other companies thereafter, Apple has not included a physical keyboard on this device. However unlike the vast majority of tablet PCs currently on the market, the iPad does not ship with a stylus pen and instead relies on a finger sensitive "multi-touch" screen to receive the user's input.

In what represents an even greater departure from the status quo, Apple has shipped the device with a derivative of its iPhone operating system as opposed to its more feature laden MacOS X computer operating system. While this will make it more difficult for developers of Microsoft Windows and even MacOS X products to bring their applications to the iPad, it does provide iPad users with instant access to over 150,000 iPhone applications, over a thousand of which are designed for clinicians (albeit US-based clinicians in many cases). As with the iPhone, users launch applications on the iPad by simply tapping on a prominent "app" icon using their finger. Once launched, the user can interact with an application by tapping on buttons or into fields, typing using an on-screen keyboard, rotating the device, or by using the device's microphone in some instances.

By announcing the iPad prior to launch and releasing a software development kit for the device, Apple has given its existing iPhone developer community a few months to prepare their existing applications to take advantage of the iPad's larger screen real estate and faster processor.

WHAT IT HAS

The iPad weighs in at 700 grams with a height and width around an inch slimmer than the page you are now reading. The iPad is 13.4mm deep at the thickest part of its curved back, which encloses the device's circuitry and non-removable battery. The screen has a resolution of 1024x768 pixels and a diagonal size of 9.7 inches. A 20mm black bevel surrounds the screen's viewable area, allowing fingers to grip the side of the device without interfering with the touch screen sensors.

Like the iPhone, the device has a large "home" button below the screen, with volume controls and a button to put the device into sleep mode positioned on its top right hand edge. A dock connector port is included at the bottom of the iPad underneath the home button, with this port used for charging the device's battery, synchronising data with a computer, or connecting the device to other peripherals such as keyboards, speakers, external monitors, cameras, and memory card readers.

The device features Bluetooth technology, which will allow the iPad to interface with other devices wirelessly. Wireless networking is also included with all popular iterations of the 802.11 standard included, namely A,B,G and N.

At the time of writing, Apple hasn't released its pricing information for New Zealand, however a rudimentary conversion from the pricing announced in the US will see the entry level 16GB configuration of the device debut at around $699. Models sporting 32GB and 64GB of storage capacity are likely to retail for a little over $150 and $300 more than the base model respectively.

The optional cellular network functionality, which allows the user to access the Internet where ever they can get mobile phone reception, will add around $200 to the cost of the iPad. As with other mobile broadband devices, ongoing data charges will apply.

As with the iPhone, customers may not always be able to access mobile broadband at 3G speeds, particularly

outside of major metropolitan areas. This is because the 3G mobile broadband components built into the iPad do not operate at 900MHz, a frequency favoured by some New Zealand telcos in regional areas. Data access will still be available in these areas via these networks, albeit at reduced speeds.

WHAT IT DOESN'T HAVE

Much has been made about what has been omitted from the iPad, typically by commentators making comparisons with tablet PCs costing several times as much as what Apple is asking for the iPad. Nevertheless, some of the omissions are worth noting as they will serve to limit the utility of the device in some healthcare scenarios.

Firstly, the iPad does not include any standard USB ports, though a USB adapter can be added to the dock port. While this adapter is being marketed by Apple as a means for people to synchronise their photos directly from their camera to the device without first having to transfer them to a computer, it is unclear what other roles this or other similar adapters may play in the iPad's future.

Secondly, the iPad lacks a user-facing video camera for video conferencing, and in fact has no camera whatsoever. The lack of a camera represents a departure from how Apple has configured its laptops, iPhones and even its diminutive iPod Nano devices, with cameras having been a standard feature on such technology for many years. That said, the prospect of taking a photo with a magazine-sized device or attempting to video conference using a piece of hardware that would usually be operated from an orientation that faces directly up the user's nose does not sound as exciting to the author as some must envisage the process would have otherwise been.

Thirdly, the iPad was developed primarily for use by consumers and not for specific fields such as healthcare. As such, the device lacks many of the specialised pieces of hardware included in devices adhering to Intel's "Mobile Clinical Assistant" (MCA) reference design. These include RFID and barcode readers, multiple hot-swappable batteries, a handle for easy portability, and an outer shell designed to withstand both regular disinfection and occasional rough treatment. Only costing around 15 per cent of the price of a typical MCA however, the iPad's price-point may be enough to overcome these specialised technical limitations, particularly for organisations looking to perform large-scale rollouts of tablet PC technology.

Finally, and perhaps the most debilitating omission, is the lack of multitasking support for applications not developed by Apple. That is, while you will be able to, for example, receive email and listen to music at the same time as browsing the web, users will be unable to run multiple clinical applications on the device simultaneously. While the author expects this limitation — inherited from the iPhone — will be overcome in a future software update, it is worth noting that if the device is used simply as a Terminal Services or Citrix client, then all the multitasking functionality inherent in the server-side operating system will be instantly available to the user. Indeed, it is in this configuration that the author expects the device will be most attractive to healthcare organisations looking to untether their clinical and nursing workforce from desktops, laptops, computers on wheels (COWS), and of course paper-based record systems.

CONCLUSION

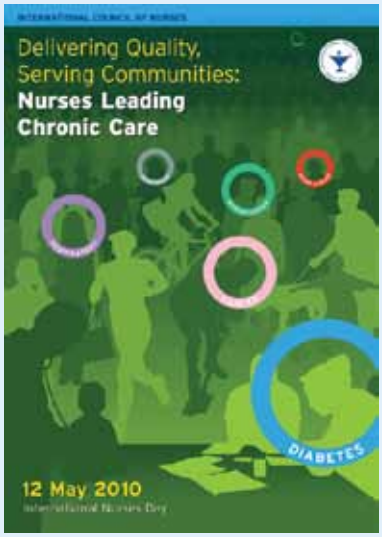
The iPad is unlikely to replace any category of computer currently deployed in a medical practice or larger healthcare facility, but it does have the potential to act as an adjunct to existing IT infrastructure in many scenarios. Ward rounds and home visits would appear to be obvious tasks that can be aided by the presence of a mobile device that provides access to patients' electronic health records for the purposes of both review and real time updating. The form factor of the device and its positioning in the consumer market as a viable eBook reader also opens up the potential for clinicians to collect and subscribe to a myriad of clinical resources and have these presented in a fashion that makes accessing them efficient.

The iPad also has potential patient-facing uses, with tasks such as the completion of patient enrolment forms, patient surveys, and the provision of educational material to aid in the obtaining of informed consent all possibilities.

Ultimately however, it is impossible to predict all the work flows that devices such as the iPad will facilitate. As one GP told me: "I don't yet know what I'll use it for, but I definitely want one!"

This article first appeared in the March 2010 edition of Pulse+IT, available in electronic form at: http://www.pulseitmagazine.co.nz/march2010

Pulse+IT is distributed in hard copy every second month to Health Informatics New Zealand (HINZ) members and subscribers to NZ Doctor magazine.



International Nurses' Day

Nurses in New Zealand and around the world will celebrate International Nurses Day on May 12, the anniversary of Florence Nightingale's birth. The day, which has a different theme every year, has been celebrated since 1988 when it was Safe Motherhood.

The IND theme for 2010 is: Delivering Quality, Serving Communities: Nurses Leading Chronic Care.

The International Council of Nurses commemorates this important day each year with the production and distribution of the International Nurses' Day (IND) Kit. The IND kit 2010 contains educational and public information material, for use by nurses everywhere.

The content of this year's kit, including the poster image are downloadable documents for use by individual nurses, associations, health ministries and health institutions at **http://icn.ch/indkit.htm**

Far North GP gets Peter Snow Memorial Award

Wellsford GP Dr Tim Malloy is the 2010 recipient of the Peter Snow Memorial Award.

The award, which honours former Tapanui GP Peter Snow, was presented to Dr Malloy at the New Zealand Rural General Practice Network's annual conference in Christchurch on March 12.

Dr Malloy accepted the award on behalf of the rural general practice sector and said it was an "award for rural medicine" and an "incredibly humbling experience".

He also acknowledged the important role played by spouses and families in supporting their partners in their work.

Dr Malloy paid tribute to the late Dr Pat Farry, who was a previous award recipient. Dr Farry died suddenly last year while working as a locum in Twizel. "This conference is also in memory of a colleague and friend, Dr Farry."

Dr Malloy has been actively involved as a member of the New Zealand Rural General Practice Network for 15 of his 22 years as a rural general practitioner and has made a valuable contribution of his time, expertise and business acumen by holding the Chairmanship and deputy Chairmanship of the Executive Board in recent years. He stood down as the latter and resigned from the Board at the conference AGM.

He assisted in the establishment of the rural faculty of the RNZCGP and in the development of the NZRGPN's Incorporated Society status. Dr Malloy was an advocate for state funding for the establishment of a rural locums scheme and the dedicated rural funding now received by all rural ranked GPs. Dr Malloy is a Fellow of RNZCGP, having completed part II in January 2006. He is an enthusiast for training in general practice of medical students; within his own teaching practice, Coast to Coast Healthcare, he provides training for fourth year and sixth year students, PGY2 and Registrars.

Dr Malloy owns and operates Coast to Coast Healthcare north of Auckland, a successful practice and business model that involves six clinics with the Wellsford Medical Centre as the hub. The practice is a decentralised system with multiple sites that take services to the people. Developed in the late 1980s and early 1990s, the so-called "hub and spoke" system has embraced the wider community and provided a health service that is effective, efficient and all-encompassing.

Coast to Coast Healthcare serves a population of just less than 14,000, employs eight to 10 doctors plus trainee registrars and house surgeons, 25 nurses and other staff such as radiographers and nurse specialists. Not only are there nurses specific to each site but also those who shift across six sites, an acute care team doing practice nursing and a chronic care management team dealing with long-term conditions. There is some cross-over of nurses between teams.

WELL- DESERVED: Dr Tim Malloy of Wellsford with the Peter Snow Memorial Award and certificate presented at the Network's conference cocktail function last month.

About Dr Peter Snow

Dr Peter Snow (1934-2006) was a former Tapanui GP and champion of rural health. He was the sole GP in West Otago for 35 years and raised a family while practising, teaching (through the Otago Medical School and RNZCGP), and farming.

A past president of the RNZCGP (1998 and 1999), he was awarded the College's Distinguished Fellowship in 2001. He was a member of the Otago Hospital Board and later the Otago District Health Board for many years. He gained international attention as the first doctor to identify "Tapanui Flu".

Last year's recipient was Dr Garry Nixon.