

# Network*News*

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



## Stewart Island nurses receive QSMs

### Queenstown - winter wonderland

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# Astrid combines career and travel

German-born general practitioner Dr Astrid Bodendieck is passionate about both her profession and travelling the world and she has managed to successfully combine both.



*TRAVELLING GP: Dr Astrid Bodendieck took time out during her NZLocums' orientation in Wellington to look at the historic Bolton Street cemetery.*

She has also found time for another passion - making movies of places and people she encounters on her travels.

"I like to make movies, it relaxes me, switches off my mind and enables me to focus on other things and also to provide friends and family with a visual impression of what we are experiencing and enable them to experience what we are doing.

"People say 'why don't you do something with it or write a book' but that's not what it's about."

Astrid was in New Zealand during June and July and the Network News caught up with her during her orientation session with NZLocums in Wellington.

Originally from Hamburg, Astrid trained as a doctor in her home country between 1981 and 1988, treating her travel bug with a year's break in 1985 when she spent time in Brazil on an internship.

Astrid had her own practice in Germany for 10 years from 1997 to 2007.

She considered coming to New Zealand when she was still a student after hearing about other people's experiences. "I couldn't afford to come then, but it was always on my mind to come here."

In 2006 she visited the NZLocums' website to see what opportunities existed. Although she speaks several languages fluently her English was not good enough to allow her to come to New Zealand at that time, so she went to the UK in March 2006 to learn English.

Armed also with a degree in tropical diseases her goal was to travel the world and work in tropical countries, which has seen her based in the middle of Brazil's Amazon rain forest, the Philippines, Western Australia, and also Nepal – always in rural and remote areas.

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## From the Chair...

As I write this article I am aware there are a number of historical events that coincide with my focus as Chairperson of the New Zealand Rural General Practice Network (NZRGPN). My aim in rural health politics is to recognise, develop, and support rural teams and some of the remarkable work being done by them.



*Kirsty Murrell-McMillan.*

In June, New Zealand recognised Deborah Dillon and Martyn Pepers, two Stewart Island rural nurse specialists, with Queen's Service Medals. Their achievements highlight the work of many rural practitioners who have dedicated themselves to rural communities, often very isolated with small but seasonally inflated populations. Deb and Marty are inspirational heroes for the service they provide to their communities. So too are those we celebrate with the annual Peter Snow Memorial Awards, such as Drs Ron Janes, Garry Nixon, Tim Malloy and (the late) Pat Farry. Many others are also worthy of mention: NPs Anne Fitzwater and Amanda McCracken and Drs Andrew Costello, Graham Fenton, Eoin Park, Lewis Arundell and the energetic Janne Bills. Now is the time to recognise and celebrate how well we care for our rural patients and showcase our 100 year-old models of integrated care to the rest of New Zealand.

### Strategy

Late last year the NZRGPN Board met and examined the organisation's strategic direction for the next two years. That direction incorporated strategies such as growing membership; advocating for appropriate levels of funding for integrated rural general practice development and maintenance; measures to attract an integrated rural workforce, which included provision of scholarship and thesis, development of rural placements; integration of rural health education and training; the need to support the retention and sustainability of an adequately sized rural health workforce and to have sound corporate management for the Network's business arms - NZMedics and NZLocums.

Recently, we have received notice that the Ministry of Health, in keeping with Treasury requirements, will be putting the recruitment contracts – held by the Network since their inception, for recruiting doctors to rural areas - out to tender. Accordingly all management efforts are being directed at securing this contract.

Meanwhile, the Board's focus has been on providing advocacy and support to members by working with the Ministry of Health and DHBs to: determine an acceptable Rural Ranking Score; to champion the rural voice in the new environment where there has been consolidation of PHOs, as well as working hard towards next year's rural conference.

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# QSMs for island nurses

**Stewart Island-based clinical nurse specialist Deborah Dillon got the surprise of her life when a letter arrived informing her she'd received a Queen's Service Medal in the 2010 Queen's Birthday honours.**

Deb says her nursing colleague Martin Pepers, who also received a QSM, was "stunned" by the news. The honours were for services to the community and nursing.

Both Deb and Martin are employed by the Southern DHB to provide primary health and emergency care to the people of Stewart Island.

A member of the two-person team that is the Stewart Island Health Centre, Deb has worked full-time for 11 years at the centre and four or five years part-time before that. Prior to living and working on the island she was based at Glenorchy near the top of Lake Wakatipu, where she nursed part-time.

Deb is also on the way to becoming a Nurse Practitioner however, she must gain approval from the Nursing Council to clear the final hurdle. She is also studying for a post graduate primary health care certificate (Wellchild/Tamarikiora) with Whitireia Polytechnic.

Deb says she was "surprised and thrilled" to hear of her honour, which was totally unexpected until a letter arrived from the Prime Minister's office. She had to keep a lid on the news, which was embargoed until June 7.

There has never been a doctor based on Stewart Island, so the pair handle all situations and emergencies. "We deal with

lots of different things from dog bites to drownings basically."

Both are also PRIME trained (Primary Response In Medical Emergency) and prior to PRIME worked as ambulance officers.

An air ambulance - a helicopter or fixed wing plane - is arranged if a patient has to be taken off the island for treatment, usually at Southland Hospital. That depends on the weather and sometimes patients have to be "managed" on the island until conditions improve enough for departure. The clinic has enough room to house two patients. "We have a lot of equipment, we are well geared up," says Deb.

Most deaths by accident are through drowning and not hunting accidents, she says.

Otherwise they look after everything and everyone from pre-natal and post-natal care through to the elderly who make up about a quarter of the island's population - about 100 people who are aged over 60 years.

"We are focussed on health promotion as much as anything. We are nurses and that's a nursing sort of thing. We work hard to keep people healthy."

Deb describes it as a challenging and a wonderful role with a lot of community back-up and support. "We are deeply



*SERVICE RECOGNISED: Deb Dillon and Martin Pepers have Stewart Island covered for its medical and nursing needs. The pair received QSMs recently for services to the community and nursing.*

engrained – embedded you might say – in our community. We work together. We are never short of help."

Life on the island is pretty interesting and offers lots of variety, says Deb. "People are pretty social but we work hard." Everyone says they want to come here for the lifestyle – hunting and fishing and that sort of thing – but there's not a lot of time for that when you're working."

Deb and her husband have five children and one grandchild. None of their children live on the island but they do like to visit.

The couple have no plans to leave Stewart Island in the near future. Deb says she will use the QSM after her name. "The community gave it to us to be used."

## 'If in doubt fly them out...'

**Stewart Island clinical nurse specialist Martin Pepers' rule of thumb is "if in doubt fly them out" an adage befitting the location and conditions he has worked in for the past 19 years.**

Martin and his fellow clinical nurse specialist on the island, Deb Dillon, were both recently awarded the Queen's Service Medal for services to nursing and the community.

"I was pretty much blown over by the award. It's great for nursing, great for medicine and great for rural practitioners all over the place really," said Martin.

The 51-year-old began his career in the military as a 17-year-old in the medical corps, then trained as an enrolled nurse in the 1970s, as a general nurse in the 1980s and then worked at Dunedin Hospital for 14 years mostly in acute ICU and acute medical. Towards the end of the 1999, Martin began his Masters studies, which he completed in 2006.

He came to Stewart Island in 1991 and was instrumental – along with Janet Hogan and later Deb - in building up the service from almost scratch.

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# New Nurse Practitioner has a focus on the elderly in rural areas

The nation's ability to care for its rapidly growing elderly population is paramount in the mind of newly certified Nurse Practitioner Rachel Hale.

Based at Matamata Medical Centre, Rachel's specialty is working with elderly people in the rural community.



*EFFORTS REWARDED: Rachel Hale has just attained Nurse Practitioner status however she believes more nurses need to follow suit.*

Amongst her busy work and study schedule, she also finds time to be a Member and Treasurer on the New Zealand Rural General Practice Network Board.

"The elderly get an "extremely raw deal", says Rachel.

"At Matamata we are more than an hour away from the tertiary hospital. If elderly people don't have a licence how do they get there to access specialist services?

"They don't have the range of home-based services now, except for services such as Access, the women's division of Rural Women New Zealand, but that's about all, and then they are means tested for all but personal care.

"If you live in Hamilton you could choose between five or six providers. In rural areas you get one provider if you are lucky."

This is a New Zealand-wide situation, she says.

With the so-called "Silver Tsunami" looming she believes rural New Zealand has an added problem – more city people are choosing to retire rurally.

She recently highlighted the issue in her presentation to the Nursing Council, as part of the process of becoming a Nurse Practitioner.

In the last census 12.5 per cent of the population in New Zealand was aged over 65. By 2050 the increase could be close to 20 per cent and one in four people will be aged over 65.

However, the last census also revealed that the over 65s in the Matamata area had already reached 15 per cent. An April check with WINZ revealed that anecdotally, Matamata had already reached the 20 per cent mark, says Rachel.

Some elderly people are selling up in urban areas and moving to smaller towns such as Matamata where housing developments tailored to their needs are springing up and they are "getting more bang for their buck".

It makes economic sense but it puts huge strain on health services in smaller rural areas, says Rachel.

"It is a growing trend. There's less traffic on the road, they can pop down to the shop, and the community is safer. In Matamata where it's flat they can use a mobility scooter if they can't drive."

Other groups such as the unemployed and the chronically ill are also attracted to rural areas, which adds to the strain on health services, she says.

Supporting infrastructure is not there either, she adds. There's one part-time taxi driver. The community and Red Cross have bought a health shuttle, which operates twice a day, to get people to their appointments.

Waikato DHB's Nurse Practitioner Champions group have identified rural, mental health and older persons as the main areas of need for Nurse Practitioners, says Rachel.

Will there be enough Nurse Practitioners by 2010? "No", she says. "I don't know exactly what my Nurse Practitioner number is but I'm somewhere between 75 and 80 New Zealand-wide. After many years' training Nurse Practitioners we haven't got to 100 yet."

Though she supports the Nurse Practitioner process she says it is extremely hard and daunting. "It's taken me 10 years."

The Masters-Nurse Practitioner-Masters pathway is also quite expensive costing about \$50,000.

"But if you get through the process ... you've got some good nurses out there."

Despite her best efforts Rachel did not pass the prescribing section of her Nurse Practitioner assessment at the Nursing Council. She intends to redo that section at some stage.

In the meantime she can carry out a broader range of practice including lab testing, ordering x-rays, making diagnosis, handling ACC cases, working collaboratively with GPs concerning medication requirements and medical certificates.

Rachel, who also has a clinical Masters, has always worked in the rural setting, except for four years of her 31-year nursing career where she was Charge Nurse for a unique hospital in-home DHB older person service. "I even trained in a rural hospital, Thames Hospital, qualifying in 1979."



# Student groups active in rural communities

By Darran Lowes

In my last column, I talked about three areas where student rural health groups are looking to make progress this year.

These areas were:

- 1) increasing rural student numbers
- 2) increasing rural exposure during training
- 3) influencing graduates to choose rural careers.

In this column I'd like to focus on the first area.

One of the strongest predictors for medical students going on to work in rural areas is if those students originated from rural areas themselves. For this reason, student rural health groups at the universities of Auckland and Otago have been developing rural school visit programmes to promote tertiary education and health careers to students in rural areas.

Matagouri, the student rural health group in Dunedin, has been developing their programme over several years. This year they will visit schools in Hurunui, Kaikoura, West Coast, Marlborough and Nelson. The school visit team is usually composed of medical, pharmacy and physiotherapy students. At each school, the team does a presentation on health professional courses, provides handouts and flyers and gives children a chance to play with clinical skills equipment. This year, the school visits team consists of university students who are interested in providing ongoing mentoring to secondary school students through their school years and their first year of university. It is hoped that this ongoing contact will keep the students interested in health professional careers and make it easier for rural students to access tertiary education.

Grassroots, the student rural health group in Auckland, is also developing a rural school visit programme. The format is similar to the Matagouri programme, with medical and nursing students visiting a range of secondary schools and promoting health professional courses. Last year, the Grassroots team visited six schools in rural

parts of Northland. This year, Grassroots has received funding which will enable the team to visit schools in the Waikato region, along with more schools in Northland. Grassroots is also in the process of setting up an ongoing mentoring scheme for secondary school students, similar to the Matagouri's scheme.

Both Grassroots and Matagouri are keen to hear from rural health professionals who would like to be involved with the rural school visits programme, such as through having secondary school students visit their practice. If you'd like to have more information or to make any suggestions, please contact me on [dlow041@aucklanduni.ac.nz](mailto:dlow041@aucklanduni.ac.nz)

The Boot and Country Scrubs, the student rural health groups of Wellington and Christchurch respectively, do not currently run school visit programmes, focussing instead on providing a huge number of services for university students. These services include skills workshops, information evenings, guest speakers and social events with a rural flavour. They also advocate for rural issues on behalf of rural students.

If you would like more information on the individual groups, or feel you could contribute your skills, time or experience in some way, please get in touch with the groups via the contact details provided below.

Each of the rural health groups is doing great work trying to increase the number of rural students enrolling in health professional programmes, but this is only part of the equation to bolstering the rural health workforce. Stay tuned for my next column where I will talk about the groups' work increasing students' exposure to rural health during their training.

#### Contacts:

**Auckland/Grassroots:** Lara Manson (President) - [Iman049@aucklanduni.ac.nz](mailto:Iman049@aucklanduni.ac.nz) - <http://www.grassroots.org.nz/>

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#### Christchurch/Country Scrubs:

Charlotte Kevern (President) - [countryscrubs@gmail.com](mailto:countryscrubs@gmail.com)

**Dunedin/Matagouri:** Helen Martyn (Co-President) - [matagouri@gmail.com](mailto:matagouri@gmail.com) - <http://matagouri.otago.ac.nz/>



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# Winter wonderland a hit with Australian family

**Crossing the Ditch to work as a GP has been a seamless procedure for an Australian doctor and her family who have temporarily traded the warmer climes of Perth for the cooler air of Wanaka.**

**Amanda Hall, her husband Scott and three children arrived in Wanaka in February and will be based there for another six months.**

Amanda was recruited through NZLocums, the rural recruitment arm of the New Zealand Rural General Practice Network. She is full of praise for the NZLocums' team who she says were "absolutely fantastic" from start to finish in the recruitment process.

"I can't speak highly enough of them, right from when I made the first email enquiry. I initially saw NZLocums on the Internet when I was looking at coming to work over here. I sent an email and their response was very prompt and efficient and they had all the information I needed. They just went out of their way to be helpful and accommodate the needs of our entire family."

Amanda was also full of praise for the two-day orientation course she did on arrival in Wellington.

The transition from one country to another has been easy for the couple and their children, aged four, nine and 11, who have settled in well to the Southern lifestyle and all it offers. It's all been very uneventful and they are all very happy. They have lots of friends now and have busy social lives. Everyone here has been very friendly and welcoming, Amanda says.

The Network News caught up with Amanda after the family had spent a weekend in Naseby (central Otago) lugeing, curling and ice skating. "It is just such a wonderful spot," said Amanda. "We have spent every spare weekend touring the South Island, mountain bike riding, tramping and relaxing in the beautiful mountain environment."

In Western Australia there is no snow, so the family does a lot of other water-based sports such as waterskiing, scuba diving, sailing and fishing.

In July last year they went to Falls Creek in Victoria, which was the first time the children had ever seen snow. "They absolutely loved it and said 'can we go back'. We thought it would be fantastic for us all to experience life in an overseas country different from our own.

We sought to combine the adventure with skiing and other snow and mountain based activities. This led us to enquiring about coming to New Zealand."

Working in Wanaka has also been a positive experience for Amanda. "I love it in Wanaka. I wanted something different and do more hands-on work and I've certainly had that, it's been great. All of the doctors here have been very supportive and have helped me gain experience with many minor surgical and orthopaedic procedures. "When you have practised in a city area for over ten years, with a major hospital only five minutes away, it is much easier and expected to refer to a tertiary hospital or specialist."

Because Wanaka is a PRIME site, Amanda was initially a little concerned thinking she would have to deal with major roadside trauma, which was "a little outside my comfort zone". The support from the other doctors in the practice, who have been attending to these situations for years, has been absolutely fantastic." (At the time of this interview Amanda was scheduled to attend a PRIME course in Mosgiel).

Amanda had previously done anaesthetics training in England and obstetrics in Tasmania, "so my anaesthetic training



*COOL FUN: Amanda, Scott and family (Brendan 11 years, Mitchell 9 and Rhys 4) enjoy some curling in central Otago.*

has been handy in terms of emergency management skills and I felt quite confident with that".

Amanda did her medical and intern training in Perth, spent two years in Tasmania doing the general practice training programme in rural areas and completing a diploma of obstetrics and gynaecology followed by 12 months in England where she completed a diploma in anaesthetics. She did more anaesthetics training and completed her GP training on return to Australia.

In Australia she worked in several locations – at two city-based practices; in a Bariatric clinic performing pre- and post-operative assessments and at a GP after-hours clinic. The after-hours clinic, she says, was similar to rural general practice because "you were on your own, there was no nurse, you had to perform minor procedures yourself, apply plasters, suture, take and interpret ECGs and triage all patients that walked through the door. That stood me in good stead to work where I am now."

Amanda says she always wanted to be a doctor and is currently really enjoying her rural GP posting. She encourages anyone who wants to get out of the big smoke and try something different to consider rural general practice in New Zealand.

# Technology has an important role to play in rural health

By Dr Stuart Gowland, Mobile Surgical Project

**The success of rural health services revolves around community access. Solving the difficulties of recruitment of health professionals for the rural sector is the biggest single barrier to achieving this success.**

**A lot of initiatives have been taken regarding recruitment and some have been successful, but there are other factors relating to the rural health environment that will work against recruitment in subtle but important ways. Technology can help in two areas:**

1. Reducing the perception for both patients and health professionals that there is still an important tyranny of time and distance relating to their care. This has to be led by the widespread availability and useful connection of video communication.
2. Enhancing available care to communities without the need to travel by having primary care teams that can safely and effectively use modern diagnostic technologies, often in the realm of the specialities, made affordable by sharing.

## Video communication

Promising so much and delivering so little is a reasonable assessment of the 25 years this technology has been available. The issues boil down to constraints of:

### 1. Bandwidth

Cost has been the single impediment to the use of television quality bandwidth. Rupert Murdoch's minimum bandwidth of three megabytes a second has been impossible to justify for non-broadcast users, but interestingly ranges between five and 10 times the bandwidth currently used in most video communications known as video conferencing. Fortunately Government initiatives are starting to work and it appears prices are starting to fall.

For novel connections we will always put up with poor quality, for example Skype, because it is just so great to see the grandchildren in London opening their presents on Christmas day. Unfortunately day in, day out communications make

this quality unacceptable. The picture is further confused by the plethora of video enthusiasts, the majority of who have politely walked away.

### 2. Live interactive contact

The majority of video conferences are simple one-to-one conversations. An example is a job interview with one or two people interviewing a single applicant at a different location. These simple video conferences are commonly known as "talking heads".

Availability of a video terminal is an important factor. It really needs to be from your desk or even your belt, as is the case with the telephone and technology is already there to make this available. On the contents side there must be a perception that the collaboration that is about to be undertaken is useful. Examples of the types of collaborations are:

- You may be seeking advice on an acutely presenting patient with bad and on-going renal colic. Video communication allows you not only to show 'the x-ray' to the specialist, but also allows the patient to be seen and the patient to see the specialist in an interactive way. This has to be the best option on the need for an acute referral or not.
- An elective remote consultation is possible to a specialist clinic and the importance of this is that there may be up to a 30 per cent reduction in the need for referral in this setting with huge advantages to both patient and the DHB referral centre. Again the ability of the specialist to see the patient and vice versa is a world away from the sometimes-used telephone consultation.
- Multidisciplinary clinical meetings are becoming important in decision-making

and in the rural sector people involved may be from different towns. Video communication has the ability to bring them together, including specialists where necessary.

- Remotely being able to attend meetings was recently demonstrated at this year's New Zealand Rural General Practice Network conference, where Health Minister Tony Ryall's address was connected both to Dannevirke and Dargaville Hospitals. A similar connection is planned for this year's Australian Rural meeting, ACRRM, to be held in Hobart in October.
- Access to educational programmes often relating to CME and currently broadcast from different places, including the broadcast studio at MSS in Christchurch and the Rural Unit at the Otago Medical School.
- Remote supervision of training in various GP procedures.

## Local availability of diagnostic technologies

The technologies that, with care, will be appropriate for rural GPs have historically been in the realm of the specialists. The care will involve a program that involves initially the definition of a scope of practice followed by training and then credentialing, and probably regular recertification. Clearly, primary care staff utilising their skills with these technologies should be appropriately reimbursed.

In summary rural general practice and its associated communities have the same problems they have always had. Many solutions have been offered, some with significant success. Technology now has a role in advancing on those previous successes.

# Enjoying the sweet life on the coast

**Kaikoura-based practice nurse Deb Bailey loves working with bees and it's a passion she has been able to pursue as part of living and working in a rural community.**

In Hebrew Deborah means "queen bee", an insect she has had a long association with. American-born Deb has adopted the South Island -- Kaikoura specifically -- as her home and for the past year has been based at the Kaikoura Medical Centre in a dual practice nurse-district nurse role. She has been a nurse for five years after graduating from the Christchurch Polytechnic Institute of Technology with a Bachelor of Nursing degree from the school of nursing in 2005.

She first visited New Zealand in 1998 and returned in 2002 when she was invited to study veterinary medicine at Massey University as an international student. However, after one semester she decided not to continue, instead opting to study at the Christchurch school of nursing.

"I loved New Zealand, loved the South Island and I wasn't ready to go and I was accepted into the registered nurse degree programme."

Three years later she graduated with a degree in nursing.

Deb grew up in Delaware on the eastern seaboard of the US but she became interested in New Zealand and its outdoors and culture when living in North Carolina where she met a number of visiting Kiwis. It was here she worked for a white water rafting business and had a lot of contact with New Zealanders who said: "come visit".

Eventually she did just that.

Her beekeeping passion began back in North Carolina in 1995/96 through a friend of the family who kept bees. "One bee sting caused him to have an anaphylactic reaction, his wife found him unconscious on the floor and he had to give it up through fear of another reaction.

"He gave me three hives to have a play with. It took a few months to develop confidence and knowledge of what beekeeping was all about. I used to ring my neighbours and say 'I'm going in to work the bees, just so you know'. I was pretty nervous about the whole thing starting out myself. But I knew Deborah actually means queen bee, so I just thought, 'oh well, why not'?



*BEEKEEPER: In her spare time Deb still likes to work with bees. And yes, she does like honey.*

"Slowly I became more confident and got a little honey business going."

With the shift to New Zealand all the bees and equipment were sold. At its peak there were 20 honey producing hives.

But you can't hold a good apiarist down and during her summer breaks while studying nursing she found a job as a beekeeper's assistant. "He wanted someone to work in the processing plant but I said I preferred to work directly with the bees.

"I was in Christchurch and he was in Methven. That was the beginning of a nice working relationship for three summers while I did my degree. He had hives not just in south Canterbury but also on the West Coast. I just loved the West Coast and the bush and I couldn't have been happier really."

The commercial operation involved about 3000 hives.

There is a buzz to working with bees, according to Deb. Though she couldn't do it as a full-time job she says as a hobby it's neat to watch them toing and froing, "They all have jobs and you get to recognise what they are doing."

As a career Deb says she needed a bit more human contact.

"Getting stung is routine and although you get used to it, it's not that pleasant especially when one gets up your trouser leg or under your veil and stings you on your face, although you get to read that sort of thing and manage to squish them before they sting.





SMOKIN': A dash of smoke settles the bees for the beekeeper.

"If you feel them crawling up your leg you give them a bit of a pinch – they don't survive but it's either that or a rather unpleasant experience."

And bees have temperaments, says Deb. "You do get nice, cruisy, friendly ones or mean, angry ones and that can be dictated by the quality of the hive, whether they are wild or a backyard hobby [they tend to be more docile]. "The weather, available food and population of the hive can also make a difference to the hive's temperament. On the coast they can be quite cranky, possibly due to the changeable, wet weather, whereas in Canterbury where you have sunny, dry summer days they can be more docile."

Smoke is often used to settle the bees. It makes them think they are being invaded and they gorge themselves with honey and are less bothered by the beekeeper.

But bees don't really bother anyone, says Deb. They just do their own thing. It's wasps that give bees a bad name.

The varroa mite invading New Zealand is a huge threat, she says. The mite feeds on the bees' larvae and they are born usually with deformed wings and can't do their thing. Ultimately the hives' bee population dwindles in numbers.

In her clinical role as a nurse Deb works on average four days in the Kaikoura Medical Centre and one day as a district nurse. She also does a health promotional role for the practice, which involves diabetes education, B4 school checks, CVD risk assessments, spirometry and sleep apnoea study.

Kaikoura Medical Centre is a practice owned by four GPs, which contracts to the District Nursing Service. It shares the same building with a DHB-funded hospital and maternity service.

Deb is involved in post graduate studies having received her PGCert in Health Science and is now working towards a diploma. She is keen to obtain Nurse Practitioner status, but at the moment is taking one day at a time and is absorbing as much clinical knowledge as possible.

How far down the Nurse Practitioner path is she? "How long is a piece of string?" she asks.

For Deb, working in rural "was a no-brainer".

"I didn't grow up in rural, although I lived in a semi-rural area in upstate New York where we were surrounded by farms and sheep until I was about 10 or 11 years old. It was very, very similar to New Zealand's South Island, so it was in my blood really."

Deb also enjoys running and the great outdoors: She's completed one full marathon and six or seven half marathons and often runs mountain trails, which are usually 25 kilometres long. "I prefer the hilly trail runs where we're not so bunched up and you can see countryside and hear birds."

She doesn't do much white water rafting these days, although she'd like to pick it up again at some stage.

Deb is also a member of the Network's 2011 conference planning committee.



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## Board focus on advocacy and support

The Board is coming together for an annual face-to-face meeting in late October/early November for further discussion on rural funding models.

### Rural funding overview

Rural funding to general practice in New Zealand has traditionally flowed to where it has been needed, directly to the practice. It has long been recognised that to practise in rural and remote areas there has to be access to: adequate training to meet the challenges and diversity of rural clinical work; extra equipment that urban general practice may not need because of proximity to secondary hospitals and time out for training, peer review, mental health breaks and holidays, which means being able to employ a suitably trained locum. Rural practitioners are a precious commodity and retention of these practitioners needed to be incentivised. It was for these reasons that the rural recruitment and retention funding and the rural bonus were established.

With the devolution of funding to DHBs and PHOs there has been some variability as to how these funds have been utilised around the country. Some PHOs have viewed the recruitment and retention funding as "theirs to use" requiring general practice to submit applications in order to access funds or to support special projects. Other PHOs have passed the funding directly on to practices. There is also differing views across the country as to the importance of sustainable rural general practice. To this end the NZRGPN management and Board have been meeting with DHBs and PHOs to raise the profile of rural general practice around New Zealand.

When the NZRGPN negotiated the funding for rural after-hours some two years ago, we did so with the view that practices needed resources in order to reconfigure themselves to sustain after-hours. There was recognition that the days of doing after-hours, as well as long and arduous day time practice was no longer acceptable and was becoming a deterrent in the recruitment of new clinicians to rural areas. But not providing after-hours in a remote rural community is not a reality for most practitioners. Many practices have used this funding to change the way they work and there are some good examples throughout

the country where this additional funding has relieved the burden of after-hours in various ways.

Typical discussions between NZRGPN and DHBs have focussed on the hardy annual topics of replacing retiring or sick general practitioners, recruiting for hard-to-fill areas and retaining practitioners. Nevertheless we now face the greatest number ever of vacancies for GPs in rural New Zealand. Health Workforce New Zealand (formerly CTA) has put out a new report predicting dire shortages of rural nurses. Workforce problems continue to grow despite our best efforts.

On the positive side much has been achieved over the years including: the establishment of a rural locum scheme that enables every rural GP to have a two week mental health break each year, voluntary bonding for general practice, rural emersion medical training, rural interdisciplinary training and rural streams in undergraduate health education, rural bonus for remote and isolated practices, rural after-hours funding, rural pre-hospital care in PRIME, rural retention and recruitment funding and rural reasonable roster funding.

### Current state of play

Earlier this year NZRGPN, the Ministry of Health and DHB staff met to forge greater understanding of rural issues and to revisit the Rural Ranking Score. NZRGPN members presented a revised Rural Ranking Score that was practice-based, allowed for influxes of visitors, recognised service delivery in rural settings, as well as other rural factors. We achieved little in convincing or influencing our DHB colleagues at this meeting and returned for a later meeting to discuss high level principles for providing care to rural communities. It appears that some DHBs want to do away with the Rural Ranking Score as a method for allocating rural funding on the premise that it does not give enough flexibility to make changes in a particular region. DHBs are signalling their desire to bring the \$20M currently flowing through the PHO Agreement back into the centre and to devolve it down to Alliance Leadership Teams (groups charged with overseeing the implementation of the nine Eol business cases) so they can determine the optimal allocation for their regions. This

model in principle should focus on high level principles and trusting relationships between clinicians and funders. It assumes that clinicians know best where funding needs to go and can control and monitor the effective use of monies. While we continue to explore this model and believe its intent should empower rural practitioners to direct funding to where it is most needed, we are aware of a number of areas where there is huge pressure for funding to be cut. Several DHB CEOs are facing enormous pressures to reduce their budgets, which may make moving towards alliance based arrangements risky business for rural general practice. Every week we see examples of rural services being whittled away and the potential for rural patients to suffer the constraints of their geographical location.

While we encourage members to become involved with Alliance Leadership Teams and their sub-groups, Service Level Alliance Teams, we ask that you do not commit to any changes to rural funding streams at this point. We are working hard to understand the national implications of the new environment and hope to be able to come up with some national guidelines soon.

We have recently conducted a survey to gauge current levels of understanding and comfort with the Eol processes and PHO configurations occurring around the country. Indicative findings show that there is limited understanding amongst responders as to the risks and opportunities associated with the *Better Sooner More Convenient* environment. We will be disseminating results to members in the next few weeks.

In the meantime, each DHB should continue to work with practices on calculating Rural Ranking Scores. We are aware there have been some regional changes that have not been agreed on nationally. Some DHBs have not calculated practitioners' Rural Ranking Scores for nearly three years, some have modified it by calculating funding per FTE and some have just cancelled contracts to PHOs for whole chunks of rural funding. In each of these areas the NZRGPN is working hard on your behalf to right these errors and to restore funding. Rural practices and rural clinicians (doctors, nurses, pharmacists, physiotherapists and dieticians) remain

## Working on your behalf

vulnerable, as do their patients. We remain on our quest to raise awareness of what it is to work in a rural community and keep showcasing our examples of truly integrated family health care practice.

As we move through the next six to 12 months it will be important we stay in touch with each other to share experiences, issues and concerns. We are also exploring ways to make our networking more efficient through mediums such as the website, Twitter and electronic surveys. We are here to support rural general practice and to advocate on your behalf and to do this effectively we need to know what the issues are – preferably before they hit crisis point. Please contact any of the following:

Current board members are:

**Chairperson** – Kirsty Murrell-McMillan  
kirstymm@rgpn.org.nz

**Deputy Chairperson** – Dr Jo Scott-Jones  
drjo@opotikigp.co.nz

**Secretary** – Dr David Wilson  
davidwilson.mbmc@gmail.com

**Treasurer** – Rachel Hale  
rachelghale@gmail.com

**Northern North Island Representative** –  
Dr Graeme Fenton – gffenton@clear.net.nz

**Western Middle North Island Representative** – Dr Fiona Bolden  
fionabolden@hotmail.com

**Southern North Island Representative** –  
Kim Gosman – kim.gosman@xtra.co.nz

**Northern South Island Representative** –  
Sharon Hansen – HansenSR@xtra.co.nz

**Southern South Island Representative** –  
Dr Stephen Graham  
stephen@fiordmed.co.nz

**South Island Representative** –  
Dr Martin London – londonz@xtra.co.nz

**North Island Representative** –  
Dr George Tripe – gctripe@ihug.co.nz

**Rural Hospital Doctor Representative** –  
Dr James Reid – james.reid@sdbh.govt.nz

**Student Representative** – Darran Lowes  
dlow041@aucklanduni.ac.nz

Or contact

Michelle Thompson, Interim CE,  
C/- Nina Klauke on nina@rgpn.org.nz

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## Stewart Island nurses receive Queen's Birthday Honours

"There was no ambulance or clinic here back then. I started working on building a clinic with Janet Hogan, a district nurse at the time. Then I introduced the ambulance role to the island because I thought we needed to be ambulance officers as well."

The original clinic was a house and the mode of transport a four-wheel-drive Suzuki Samurai, there was no ability to stretch a patient, no ambulance, no crash room, no defibrillator, no ECG; there was nothing. We had to start from scratch pretty much.

"We got a lot of community assistance, a lot of assistance from the Heart Foundation and from the district health board. Deb has also played a big part in developing the service we have today.

"It's a major challenge keeping it running at the standard we have at the moment. We are advanced clinical nurse specialists but working in the rural setting is a constant challenge."

Martin and Deb work seven days on, 24 hours on-call, weekabout. They can access expert medical advice by phone and call in aircraft to evacuate a patient if necessary.

"We regard ourselves as an outpost of Invercargill Hospital and the Southland District Health Board.

"The bottom line is we do everything, we are Johnny on the spot. We also make decisions such as evacuating a patient because at the end of the day, the person on the phone is not the one looking at the patient.

"Depending on the problem, I will discuss it with the appropriate registrar or on-call senior house surgeon. But at the end of the day if you are sitting in my clinic and I think you are having an MI and the guy on the other side doesn't think you are, I will evacuate you. I have the authority to get you on a plane and get you into a hospital.

"If in doubt we fly them out," that's what I tell all my relievers.

"You've got a thing in medicine called Murphy's Law and if you ignore Murphy's Law you'll be in trouble."

The clinic has access 24 hours a day to fixed wing aircraft (Britain Islanders) and an extremely good backup service with South East Air. Helicopters can be called if needed – there's a search and rescue helicopter on the island and medivac helicopters are based either at Te Anau and Dunedin.

The worst situation Martin has had to deal with was a head-on car collision where he had four status three patients, one status two patient and he was by himself.

Probably the most challenging and rewarding situation he has had was when a man put an axe through his foot and he couldn't be flown out.

"I had 20 clamps in his foot ... I just clamped everything until the bleeding stopped and repaired the injury on the island. I was told they wouldn't have been able to do it any better at the other end, so I was quite happy about that.

"It was a very sharp axe and took out all the tendons and arteries. There was a lot of blood and it needed a lot of suturing, IV morphine, and IV antibiotics ... the works."

The man was on a fishing boat up an inlet in bad weather and was taken to the clinic where Martin spent two or three hours "repairing him" and kept him over night. The patient was flown to hospital the next day.

"I learnt a lot from that and it gave me confidence in repairing small to moderate traumatic injuries, which I quite enjoy doing.

"It's very rewarding to patch someone up and send them out the door knowing you've fixed them."

Martin does have a life outside work. His wife and child live in Dunedin and "I very much enjoy going up to Dunedin once a month. It's difficult at times and I miss being with my daughter."

# New skills enable Amanda to aid rural health shortfall

Tuatapere-based nurse and New Zealand Rural General Practice member Amanda McCracken is the latest in a growing number of her profession to attain Nurse Practitioner status.



**After five years' study Amanda (pictured) gained approval from the New Zealand Nursing Council as a Nurse Practitioner with full prescribing rights.**

The 42-year-old mother has worked as a nurse in western Southland for about 18 years, initially graduating as a Comprehensive Nurse in 1989 after studying at Southland Polytechnic (now the Southland Institute of Technology).

Currently based at the Tuatapere Medical Centre, she intends to stay in the

small town where she says her services are most needed.

After a stint travelling overseas she returned to Southland and worked at Otautau for about eight years and returned to Tuatapere last year.

"In 2005 I decided that with big issues here with recruitment and retention of GPs, becoming a Nurse Practitioner was probably the best way I could provide my nursing services."

She started studying to become a Nurse Practitioner in 2005, which included gaining a Masters qualification.

"There's an awful lot of work that goes into it, about 2500 hours of study. But it has been absolutely worth it. I am delighted."

"I knew where I wanted to be and what I wanted to do, so I worked hard to gain the Nurse Practitioner qualification."

Originally from Nelson, Amanda and her family moved to Southland when she was four years old. The family initially lived in Tokanui in eastern Southland. Amanda relocated to western Southland shortly after graduating.

If you have a story relating to events, achievements or issues in rural general practice, give Rob Olsen a call on 04 495 5887, 021 82 2468 or email: [rob@rgpn.org.nz](mailto:rob@rgpn.org.nz)

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## Astrid combines career and travel

Astrid has worked in primary care, in emergency (caesarean sections, appendectomies) and also in community health education during her travels. Malaria, TB and parasitic infections in children, chronically ill people and vaccinations were amongst her usual workload.

She has also worked in all sorts of terrain and conditions – in the Philippines access to rural areas was by four-wheel drive vehicle to attend to patients in remote areas who could not get access to health care or facilities. Based in a main centre, she was driven into these areas as part of a team of health professionals that also included a dentist. There were no facilities to admit patients.

In 1990 she worked in Nepal for about eight weeks. During an earlier visit there to see her brother, Astrid was asked by a mid-wife if she'd look at some of her patients, which saw her ultimately return to the tiny country sandwiched between China and India. The conditions there were "fourth world" and saw her work in a room with no power for two hours a day – conditions similar to those she found in Brazil.

Working in Western Australia was quite civilised compared to some conditions she has experienced in other countries. In Port Headland, which has a large Aboriginal population, she worked in a practice that had access to a base hospital, did x-rays and had visiting specialists.

In Ravensthorpe, where she was the only doctor, there were x-ray facilities, transport to both secondary and tertiary hospitals and the flying doctor service if needed.

The practice, which dealt with about 3000 patients, had difficulty recruiting doctors. She was there for eight to nine months in 2008-09 and had support from a community nurse and access to a hospital.

She then travelled around Australia in a campervan for six to seven months visiting most areas in that time apart from those that could only be accessed by four-wheel drive.

In June this year, Astrid finally arrived in New Zealand where she was first based in Balclutha and then in Otaki. Her partner, cat and dog joined her in late July to travel around New Zealand.

Astrid is also a keen amateur musician; she plays the flute and tenor sax. Kayaking is another interest.

Astrid has recently accepted a permanent GP position in Balclutha.