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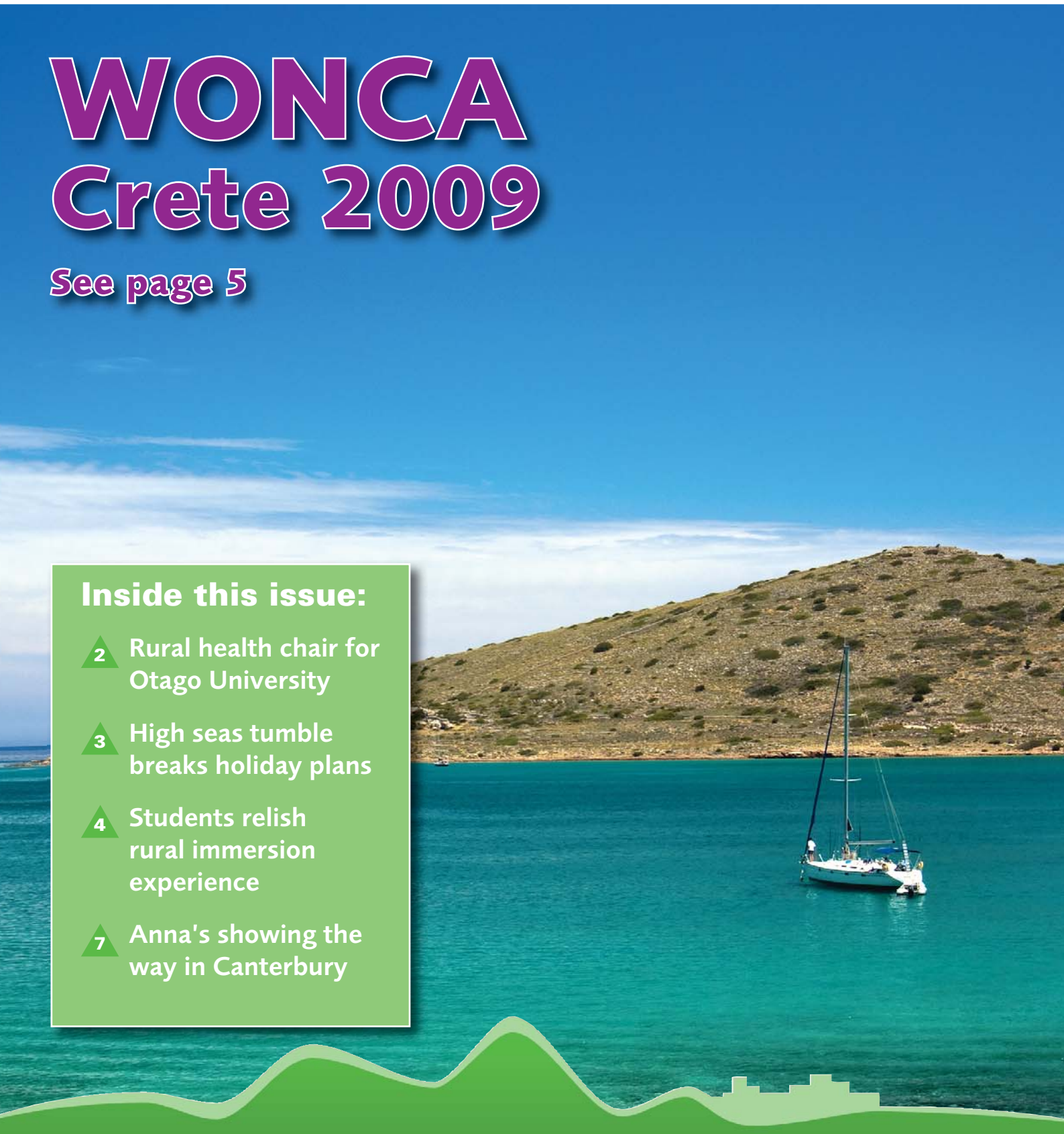

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Rural health chair for Otago University

Rural medical training has received a boost with the creation of a new chair at Otago University's Dunedin School of Medicine.

The search is now on internationally for the inaugural Professor of Rural Health at the school.

Otago University School of Medicine's Dr Pat Farry says the successful candidate will become head of the newly created section of rural health within the established department of general practice at Otago.

"The new person will have an overview of all existing rural programmes including the undergraduate rotational programme, the immersion programme and the post graduate programme in the form of the Rural and Provincial Hospital Diploma.

The creation of the new chair is the culmination of a few factors.

Te Waipounamu Rural Health Unit at Dunedin has been developing teaching programmes and doing research in rural health for some time. Both the rural hospital diploma and the fifth year immersion programme have been successful and now the university has managed to raise the funds for a professor of rural health to head the section. This will be a further boost for rural health teaching and research in New Zealand.

This move by the University of Otago is an indication of the importance placed on rural health, said Dr Farry.

Though the university raised some money, it came up a bit short of the required amount but considered it so important and decided to go ahead with the new position and advertise internationally. "That's a real plus," said Dr Farry.

The search for the right person to fill the chair is on with the aim of having the new section functioning before the end of the next academic year (2010).

Dr Farry described the new position as "a very exciting prospect". Support for the new chair was universal and "these things are not easy to get through".

The rural section might eventually become a department within its own right. "That's the hope in the not too distant future."

"It will depend on how hard the new professor pushes it. I've pushed as far as I can," he says.

The university is also advertising to fill the Elaine Gurr chair of General Practice in Dunedin.

Dr Farry was involved in setting up the first chair of General Practice about 25 years ago. The new chair of rural health will be based in Dunedin. It will not include the Otago schools of medicine in Christchurch and Wellington.

A breath of fresh air from Hobart

Northern Rural General Practice Consortium nurse Michael McGivern (pictured) recently attended the Spark of Life conference in Hobart. He says the experience has greatly assisted him in his role as a resuscitation training officer and he has a wealth of information to share with others.

In April of this year, I was very fortunate to be able to attend the seventh International Spark of Life resuscitation conference in Hobart. My visit was made possible by a generous scholarship that I received at this year's New Zealand Rural General Practice Network conference in Wellington.

The conference was privileged to have keynote speakers from countries such as the United Kingdom, the United States of America and Canada. The Don Harrison perpetual lecture entitled *Evidence based medicine, what does it really mean?* was presented by Dr Tony Smith, who is the national medical director for St John ambulance in this country. I must also acknowledge the lecture on Fluid resuscitation in children, given by Dr Richard Aickin, who is the current chairman of the New Zealand Resuscitation Council.

The conference was an excellent forum for health professionals in the field of resuscitation and to network and share knowledge and experience. I personally made several new professional contacts whom I am able to refer to for advice and guidance relating to the field of resuscitation. The conference provided participants with an excellent opportunity to view the latest medical products relating to emergency care at the large exhibition.

The greatest benefit for me in attending a conference such as this is to be able to bring back the latest knowledge and guidelines to share with clinical colleagues in rural and remote areas. My current position as resuscitation training officer for the Northern Rural General Practice Consortium requires me to provide clinicians with high quality training and guidance in the field of resuscitation. My attendance at the Spark of Life conference has greatly assisted me in this role.

If anyone would like to speak with me regarding any aspects of resuscitation training and advice, please do not hesitate to email me at michael@ruralgps.co.nz

Been to a conference recently? Want to share your knowledge with colleagues? Contact the editor: rob@rgpn.org.nz

High seas tumble breaks holiday plans

A pleasure cruise in Milford Sound turned out to be anything but plain sailing for visiting Dutch GP Paul van der Veer when a heavy swell hit the boat he was on, tossing him in the air and breaking one of his legs.

The freak accident happened last month at the end of a working holiday and saw Paul wheelchair-bound with a compound fracture of his right lower leg for the remainder of his New Zealand stay. His leg had to be pinned as a result.

Paul arrived in New Zealand in early February and spent 10 to 12 weeks as a locum through NZLocums at three locations around the country – Otorohanga, Marton and Westport. In early April he went to Auckland to pick up his wife Thea who flew in from Holland and the couple holidayed for several weeks.

Paul says the cruise on the sound turned sour when the vessel ventured out several hundred metres onto the Tasman Sea and ran into some swells. "The ship was going up and down and suddenly there was a big swell and the ship launched me from the front deck and dived deep into the next wave and I collapsed back on the deck and then I broke my right lower leg. That's the whole story really."

And it was a very nasty break … a compound fracture as they call it, so the bone was sticking out of my leg and I had to reposition myself [the leg] on the ship. So, I had to push the bone back and I had the three most terrible hours of my life, I think."

The first hour was the trip back on the boat to the harbour, the second was the wait until he stabilised and the helicopter arrived and the third was the trip from Milford Sound to Southland hospital in Invercargill.

The force of the fall was amplified by the wave swells, which saw Paul slammed to the ship's deck as the boat was rising back up to meet him. "About double or triple the impact," he said.

The experience was "very, very painful", says Paul. And with no pain relief available he just lay on the deck and concentrated on staying conscious.

"I just lay down on the front deck and concentrated on not fainting. I felt like fainting but I wanted to stay alert," something Paul says he achieved by breathing slowly and deeply, and talking to his wife and other people on the boat. His advice in that situation: "Don't panic, regulate your breathing and talk to people."

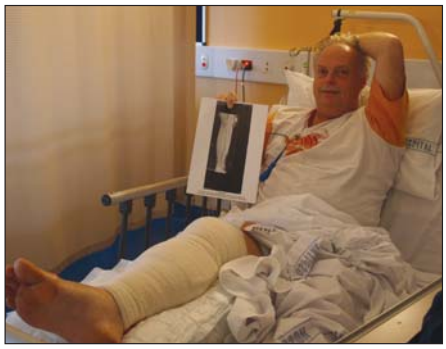
Relief was eventually at hand. "When I arrived at the hospital things were nicely organised. My leg was immobilised, I got pain relief, had surgery and things became better."

Paul underwent surgery the same night and spent a week in hospital while the fracture stabilised. The skin around the open wound was badly damaged and Paul agreed to stay in NZ to allow it to heal, and let the leg re-fuse. The leg was bandaged and Paul put into a wheel chair with leg elevated.

A week later the couple were in Wellington and Paul was told he needed another operation – the fourth – because the skin was not going to heal and a skin graft was required.

When contacted by the Network News Paul was in Rotorua enjoying the geysers, mud pools and some sunny weather, and being wheeled around by his wife.

The sudden break to his holiday aside, Paul says his New Zealand experience has been a good one. "I've seen everything so there is no need to come back."



LAID UP: Paul in hospital after his ordeal.

He qualifies the "no need to come back" comment: "It had nothing to do with the accident. There are so many nice things to do in the world."

Before coming to New Zealand Paul did a six-month stint in Australia as part of a year's sabbatical.

The couple had also planned to holiday in the Pacific before heading home but his accident put paid to that. "Thea deserves to express a lot of disappointment because we were to have a nice holiday after my work was done … but in two weeks I broke my leg … it's disappointing for her."

Paul and Thea have since returned to Enkhuizen in Holland.

While in Hospital in Invercargill, Paul was visited by New Zealand Rural General Practice Network board chairperson Kirsty Murrell-McMillan and by Network staff while in hospital in Wellington.

Students relish rural immersion experience

One of the highlights of the recent Rural Health Symposium in Wellington were presentations by medical students on their experiences working in the rural areas.

All three were entertaining but one in particular told a story with a difference. Kerry Anderson spent some time in South Westland working with Dr Martin London last year and what left a lasting impression on her was not the medical "moments of sheer terror and adrenaline" but the characters – both medical and patients - she encountered. One patient in particular – she referred to him as John – was living in a shack at the far end of Okarito Lagoon about 13 kilometres off the main road half way between Whataroa and Franz Josef.

When Kerry first met John in the Whataroa Clinic he was at his wits end with cataracts, which were making his life miserable.

This led Kerry to the door of his dilapidated but cosy corrugated iron shack – a disused duck shooting hut at the far end of the lagoon. His living conditions were basic. One wall of the hut was patched up with clear plastic, it was heated by a small fire, a small kerosene cooker was used to prepare food, there were two rusty spring bunks (one with a sleeping bag), a gas lantern supplied light and there was no refrigeration.

An eeler and fisherman, John's diet consisted mainly of fish. He had a quad bike to get around on but apart from the basics, he had none of the trappings of modern-day living. In fact he shunned them. It was a lifestyle he had chosen to live for the past 30 years.

John was having an ongoing battle with the Department of Conservation regarding his lifestyle and his livelihood – eeling and fishing – DoC wanted him out. John was reluctantly considering buying some land closer to town on which to live if he lost the battle with DoC. But the idea of living in a "house" was something that John didn't fancy.

Cataracts aside, John was "fighting fit", said Kerry. He was also a "very personable, friendly and eloquent man and a fascinating person to talk to". He had been to university and studied forestry but had opted to go bush instead.

He has since had one cataract removed and is thinking about forking out for a second operation.

"I guess for me this case wasn't really about medicine. It was far more about seeing a totally different and yet acceptable way of life," said Kerry.

"John exemplified in the extreme what the rural immersion experience was for me. It reinforced my belief that the medicine is a vehicle for getting to know people and that being a doctor puts us in a privileged position of being let into people's lives."

Fellow students Brad Stone and Olivia Hill spoke of their experiences while based at Queenstown, also in 2008.

Brad worked at Wakatipu where he said he "got very involved and did not feel like an observer" during his time there. He said the training he received from St John and the Fire Service placed him in good stead for real accidents that followed, which included a four-wheel drive vehicle versus cyclist in the early hours of the morning on a country road.

Olivia described her experience as one from "the shop floor". A 65-year-old man was found in his home cold and sweaty and was transported by St John Ambulance to a rural hospital. He was having an acute coronary attack and was initially unresponsive. Airways were checked. CPR done and the crash trolley readied. Still he was unresponsive. More CPR was carried out. An ICU team was called in and the man was transported by air to Dunedin Public Hospital where a stent was put in. He survived. That was one of two cardiac arrests Olivia encountered in two weeks.

As part of their year in rural areas the students rotated around Southland rural hospitals including Queenstown, Gore and practices in Matuara and Lumsden.

Before the students' presentations Dr Pat Farry spoke of the success of the Rural Medical Immersion Programme, which he helped establish in 2007. He said the academic success and the career paths indicated by students pointed to the programme's overall success.

The RMIP students have four term assessments during the year and all sit the same common fifth year examination at the end of the year.

- All students passed the final examination in 2007 and 2008
- At graduation '08 one of the first intake of students (2007) took the Otago prize in Obstetrics and Gynaecology
- In 2008 four students achieved distinctions and almost all of the group improved their class ranking
- first, second and fourth places in the fifth year class of 240 students were taken by RMIP students in 2008.

The RMIP was evaluated externally by Professor Paul Worley and Dr Lucie Walters at the end of the first year.

2009 saw the third annual intake of students in the programme offered by the Otago Faculty of Medicines. Twenty students selected from all three Otago medical schools are based in six teaching centres at Southland, Clutha, Westland, Marlborough, Wairarapa and Tararua.

The students spend their entire fifth year of study based at the rural teaching centres with short visits to tertiary centres for residential workshops or to accompany their patients who are transferred to tertiary care.

Each teaching centre has a regional coordinator and a group of teachers comprising the local general practitioners, rural hospital generalists and specialists, visiting consultants, midwives, pharmacists, nurses, Maori health providers, mental health teams and public health personnel.

WONCA '09 exceeds expectations

This year's rural WONCA conference in Crete was hot in more ways than one, Network board chairwoman Kirsty Murrell-McMillan tells Rob Olsen.

"It was very hot, perhaps a little too hot for me, going from Invercargill to 36 degrees. The summer clothes I wear in Southland and the summer clothes required in Crete are two different things. The North Islanders were fine, they were perfectly prepared.

"I went to WONCA in Seattle some four years ago and what I was really impressed with this time was the number of New Zealanders who were there. There were about 12 that we knew of, that's quite a significant bunch."

Presentations by three New Zealanders were very well received, says Kirsty. Otago University's Dr Pat Farry presented a full session on rural immersion, as did Dr Jim Reed on chronic obstructive airway disease, and West Coast doctor Martin London did a 10-minute presentation on getting specialists into rural areas.

With about 600 delegates and presenters from around the world there was much of interest and to learn about rural medicine, says Kirsty.

"What was really different this time was, even though it was a group of family physicians coming together, there were many other health and allied professionals, and they were all presenting, or looking for similar things. It was that connection to rural and that this was the world's rural [medical gathering] that was different to what I had seen at previous rural WONCAs."

The conference's main themes were: Inequalities and inequities in health, technical suitability for rural settings, island medicine and health services for immigrants.

"Each day one of those themes was featured and there was a significant amount of research being presented, again a big increase on what I had seen in Seattle," something Kirsty puts down to the coordinator Christos Lionis, the University of Crete and the Greek universities.

KIWI CONTINGENT: (from left to right) Kathy McDonald, Martin London, Monique Leerschool, Mia Carroll, Ross Lawrinson, Ivan and Leonie Howie, Adele Robertson and Kirsty Murrell-McMillan.

A presentation by a Scottish group was one of many highlights. "They talked about the way we decide a community's health needs. The needs are examined, the community is given the budget and outlines all the skills required and then they decide on the appropriate health professional. I saw that as being useful."

Also significant was work by the WONCA rural working party on developing recruitment and retention policy and similar work by the World Health Organisation.

New Zealand's problems with recruitment and retention are similar to those experienced in other countries although there are many areas much worse off, says Kirsty.

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Recruitment, retention and avoidance of entrapment – the pitfalls of rural general practice

The days of solo rural general practitioners owning and running their own businesses are almost over, says Waikari GP Richard McCubbin.

He cites growing business responsibilities and administrative burdens as the main reasons for his flight from solo practice to life as a roving locum.

Dr McCubbin has been at Waikari for twenty-two and a half years. He arrived in 1986 from the UK with his wife Deborah and two young children, although he had been to New Zealand twice prior to that – in 1979-80 as a registrar and again in 1985 for a six-month GP practice exchange.

He trained at Oxford University, qualifying in 1976 and decided to specialise as a General Practitioner.

"In 1986 I had no idea of what I was doing in terms of management, especially coming from the National Health Service in the UK where you are mostly protected from that responsibility.

CHANGE OF DIRECTION: Richard McCubbin and wife Deb will retain links to Waikari, though Richard will take on the role of wandering locum here and in the UK.

"I really had very little idea how to run a business … if I knew how hard it was I may have hesitated to take it on."

The model at Waikari is that the GP is the solo owner/operator of the business, so Dr McCubbin owns the business as well as operates the practice clinically. The administrative burden has increased exponentially since he started. Luckily his wife Deborah started as practice manager in 1995. "Without her help and support I probably would have gone long ago."

His good friend and colleague, Dr Slassor works at the practice one or sometimes two days a week and for the last couple of years he has had a registrar as well, but there is no regular partner. The registrar works nine months of the year and Dr McCubbin says the practice has been lucky to have had some very competent registrars. "But I am responsible for them as a teacher, so it's not the same as working with a fully-fledged GP.

"I am also very fortunate in having very supportive colleagues in neighbouring practices and a fantastic practice team at Waikari but at the end of the day the buck stops with me.

"Basically, the model of a privately owned solo rural practice has become too much of a burden for Deb and me to carry on with. When we advertised to sell the practice there was no response. We discussed the possibility of setting up a trust with a community group but they felt the task was beyond them. We ended up accepting the friendly offer from our neighbouring practice in Amberley to take over the business from July 31 this year.

"All of this confirms my impression that the days of the solo owner-operated rural practice are over. We have had to accept that there has been no monetary goodwill value in passing on the practice although we never really expected there would be."

Yet the practice was slightly bigger than the average of its kind in rural New Zealand. With about 1650 patients it certainly is a going-concern with a friendly, stable and very supportive community, an opportunity to practice excellent traditional family medicine, only one hour from Christchurch and a good on-call roster (one in three to four during the week and one in five in the weekend), says Dr McCubbin.

So what's the problem you might ask?

"I think the issue is that younger GPs or doctors don't want the responsibility of running a business and when you take on a General Practice business there are huge responsibilities. There are the obvious financial responsibilities and also those around employment law, health and safety, staff and administration, etc."

The clinical workload is on the one hand challenging and exhausting, and on the other hand enormously rewarding, but younger doctors can be apprehensive about what they see as professional isolation in rural practice, he says.

When Dr McCubbin arrived in 1986 there were about one to two hours a week management work. Now Deborah and another staff member work as one full-time equivalent practice manager/ administrator.

"The burden and complexity of administration seems to grow exponentially. We now hold about separate contracts with the Ministry of Health and the DHB for delivery of medical services.

"I've lost count of the number of changes that have happened. There were health boards, CHEs DHBs ...it just goes on and on. You open your mail and every day there are new proposals, requests for information, audits, etc.

"At the cutting edge we're probably not doing a lot different at GP-patient level but the management requirements for reporting, recording and claiming, and how we get our money ... the burden gets heavier and more complex year by year.

"As well as that I had reached a stage of life where I had to develop an exit strategy. I'm in my late 50s now and had a mild heart attack last year, which definitely gives you a tap on the shoulder."

He is not sure that the stresses and strains of work caused the heart attack – his family history is not good – but they certainly did not help, he says.

He sums up the problems with rural general practice as: recruitment, retention and avoidance of entrapment. The last one is perhaps the most important, meaning that no matter how much you enjoy the community and practice, that once you're in it's very difficult to get out."

"In my situation it's a case of, 'I bought this practice and I know I can't sell it, so how do I leave?'"

Dr McCubbin says he could have walked away but only as a last resort or if his health had forced him to.

"It will be sad for Deb and me to leave the practice but it will be a huge burden off our shoulders too, and the prospect of change is exciting."

The problem of attracting young doctors to that sort of practice remains.

Young doctors have a huge student loan to pay off, so they can't afford to service a business loan and a mortgage, and take on the huge responsibility of running a business too. Registrars love medicine but I don't think they would want to take on the responsibility of running the business, he says.

He believes salaried employment for solo rural GPs is the way of the future, with good conditions of service and the ability to leave when they think it's right.

Dr McCubbin plans to "go walkabout" doing rural locums in New Zealand and the UK while retaining home base at Waikari. Deborah may look at taking on project and contract work in practice management.

The couple have three children, none of whom have entered the medical profession – one is a lawyer, one an actor and the other training as pre-school teacher.

He says he would have loved them to have chosen the medical profession but maybe they decided that one having doctor in the family was enough.

In spite of the trials and tribulations in solo practice, Dr McCubbin believes that rural general practice is a fabulous profession to be in but reiterates that it will only attract doctors if they "can do medicine and not a lot of management".

Anna's showing the way in Canterbury

Qualifying as a Nurse Practitioner has opened up a whole new world in the profession, explains Canterbury nurse Anna Higgins.

An Oxford Community Health Centre nurse, Anna has recorded a first for Canterbury by becoming the only primary health care Nurse Practitioner in the region with the ability to prescribe.

The 54 year-old mother of two adult children, who has a Masters degree in nursing, becomes only the sixth Nurse Practitioner in the South Island.

There are 53 Nurse Practitioners New Zealand-wide, however only 33 can prescribe.

Where did it all begin for Anna? "Oh, about 100 years ago ... I kid you not!," she says. A nurse for 36 years – 33 as an RN - Anna did her training at Southland Hospital, Invercargill in 1973, gaining registration in 1976.

Anna's achievement is all the more impressive when you consider that she gained approval from the Nursing Council of New Zealand to prescribe first time around. Some achieve Nurse Practitioner without prescribing status and they have to go back at a later date to complete the process, says Anna.

"Thank goodness I did not have to go back."

Before final approval by the Nursing Council to become a Nurse Practitioner you must attain a Master of Nursing degree, which Anna did between 2003 and 2007. "Then I had a wee rest because I was so sick of studying."

Then, last October Anna put together a portfolio in evidence of the six competencies of a Nurse Practitioner of which one is prescribing.

Her portfolio then went to the Nursing Council for a desk audit to see if it "ticks the boxes" as to what the competencies should cover. Then Anna was interviewed by a panel convened by the council.

She submitted her portfolio in February and was interviewed in April 2009. She was also assessed clinically by an associate (usually a doctor) as part of her Masters degree.

Though Anna is based at the rurally ranked Oxford Community Health Centre about 60 kilometres northwest of Christchurch, she will also be employed as an NP at the Pegasus Health 24 Hour Surgery in Christchurch city, an accident and medical clinic.

"We have a totally nurse-led after-hours service at Oxford. GPs are available on the phone but they don't physically do on-call."

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WONCA '09 exceeds expectations

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"There were things I discovered, like where you recruit from and who you recruit. There are areas of greater deprivation and to recruit from Africa is not a good idea because of that country's deprivation, so there are some real messages around that."

WHO also believe health professionals need to start thinking broadly about service provision, says Kirsty.

"We need to stop thinking in silos around how we address providing health care services to rural communities and start looking at bundles of initiatives and the kind of initiatives.

"We tend to think in terms of, if we address the workforce by increasing education [in rural areas], this will solve the workforce problem. The message is the workforce problem is much more complex than that.

"It might well be staffing, accommodation or access to peers but we need to start thinking in total packages and in each place the bundle will look slightly different."

A wide range of topics were covered under health inequalities such as health policy, disease management, maternity care and mental health. People used the conference as a place to showcase their programmes, says Kirsty.

Immigration and emigration are big issues for Europe and the health of migrant groups in rural areas. "It is something we need to be much more aware of in rural because we haven't been before."

Demographics in rural areas also came up for discussion. In many countries there are a lot of elderly people left in these areas, so the problems of providing care for them are significant. "We heard from places like Norway where there are up to 60 per cent older people in the northern regions."

"For me, some of the presentations from Scandinavia were some of the closest aligned to New Zealand and some of the areas where we should do more work and have a greater understanding. They had much more integrated health systems, it was of course all government funded and they had fairly successful models. They also had some incredible packages that kept practitioners working in remote areas."

In some areas governments compelled graduates to stay for up to a year after registration and there didn't seem to be any objection. "It was just policy and people did it.

"What also struck me was that now in general practice, there is the need for GPs to look outside the patient-doctor relationship and to look towards community assessment and community diagnosis. A good number of heath care problems are about addressing issues in the community. An example was a doctor in Belgium who helped address obesity among children in a community by getting behind a project to build a playground in an area that had none. "It was about making a diagnosis on what is actually going on in the community and rectifying it. The gem about rural is, that is much easier to do in that sort of community," says Kirsty.

Overall, the conference enabled the New Zealanders who attended to meet like-minded people from around the world who live in rural communities and with whom there was a common language. This was a great gathering of academics who were pushing for rural education programmes for medicine.

"My critical voice says that there is a danger that academics in rural areas will drive practice and what I didn't hear enough of were practitioners driving practice."

An example was a session on rural teams led by a professor and at no time was the word nurse mentioned, says Kirsty. "From my point of view, given the huge number of people who were there, that was hugely disappointing."

Anna's showing the way in Canterbury

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Her new status will mean a more efficient service for patients. "Previously I have had to get scripts signed during day-time clinics ... I do acute presentations, chronic disease management, accident and medical emergencies because I am PRIME trained.

"As a Nurse Practitioner you are autonomous, so you can have your own case load and you manage your own patients in collaboration with GPs."

When the nurse-led clinics were first started at Oxford there was one doctor. "You could not get anyone to work out here; you know what GP retention is like, they didn't want to do after-hours. And then we started the nurses doing after-hours and now we have three doctors."

And after all these years she says she still loves what she does.

"I really enjoy it. It's such a good career to be involved in ...you can do it around your children because of the shift work."

In 36 years she has only had one year off and says she has no plans to change career, now that "I have jumped this final hurdle".

Anna paid tribute to her medical colleagues and her family describing her husband Paul as "absolutely amazing" in terms of the support he has given her with her career. "He deserves half of my Nurse Practitioner registration. I think he feels he's involved in nursing. You can't do something like this without your family's support.

"It's been a huge commitment on everyone's part ... it's not a solo flight that you do."