New Zealand
Rural General Practice Network

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

network news

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From Wisconsin to the Wairarapa – Nancy takes transition in her stride

A nurse practitioner's position advertised on-line saw American woman Nancy Williams go from a large family clinic to a small country medical centre but it's a move that hasn't fazed the 56-year-old.

Nancy has been in New Zealand for the last eight months working at the Martinborough Medical Centre alongside Dr Steve Philip and his team of two practice nurses, a business manager, two full-time equivalent receptionists and casual diabetic and lab nurses.

The change from the US centre to its smaller Kiwi counterpart has been immense but the warm welcome from the local community has helped smooth the transition. "Everyone was welcoming straight away, everyone went out of their way," says Nancy.

Her hometown of Oshkosh, Wisconsin has a population of about 60,000 residents. There, she worked in a clinic that boasts 140 physicians - including specialists in areas such as paediatrics, radiology and haematology, and about 14 family doctors.

"The beauty of it was, you could call on this or that specialist immediately," says Nancy.

It was a big corporate clinic – owned by Milwaukee-based Aurora Healthcare - but it had a real collegial atmosphere, no-one really pulled rank, she says.

Nancy began her career as an undergraduate in the early 1970s, went to graduate school in 1990 and graduated in 1993. After that she worked in the family practice area for about 13 1/2 years. The role saw her taking care of all ages from newborns to 99 year-olds, with a range of health conditions. In the US she is known as a family nurse practitioner and while they are a familiar part of the medical landscape over there, not so here, especially in rural areas.

The US has had nurse practitioners since 1965 - 75 per cent of them are family nurse practitioners while others fill paediatric, geriatric and cardiac roles. In New Zealand they cover roles including primary, diabetic, wound care, youth health and rural nurse practitioners. They have practised in urban New Zealand since about 2001 and in rural areas for about a year.

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NURSE TO NURSE: Working in the Martinborough rural general practice has been "really refreshing. It was easier to learn the little things you have to learn [in the practice] such as where ACC and Pharmac fit in and where to refer patients", says Nancy. She is pictured with New Zealand Rural General Practice Network board chairperson Kirsty Murrell-McMillan. *PHOTO: ROB OLSEN*

Rural life, rural health – look what we've got!

March 2009 sees the capital host the New Zealand Rural General Practice Conference for three days from March 27 to 29.

The network's showcase event of the year will feature a range of workshops and discussions, as well as informative keynote speakers, and plenty of CPD for the whole team, culminating in a conference dinner on Saturday night. This year's venue is the Wellington Convention Centre and the theme is "Rural life, rural health – look what we've got!" There's no shortage of things to see and do in the cultural capital, so why not make it a longer break – bring your partner … bring your family … and enjoy the sights, shopping and sumptuous cuisine Wellington offers. Children's and partners' programmes are also available. Visit www.rgpn.org.nz for more information or contact communications and membership manager Rob Olsen on 04 472 3901.

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Rural health set to benefit from technology

By ROB OLSEN

Electronic referrals, e-prescribing and better access to patient status updates are benefits that will flow-on to rural general practices as part of a revamped initiative to encourage technology in the health sector.

The initiative, announced recently by Health Minister David Cunliffe, has seen the Health Information Strategy Advisory Committee (HISAC) revamped to provide improved sector-wide information and communication technology.

Rather than working from the bottom up, encouraging individual health IT projects, HISAC will, in its new form, provide advice direct to the minister. Decisions made at ministerial level will then be the responsibility of the ministry to implement across the health system, working in partnership with DHBs and other health providers.

The sector has been great at identifying pockets of innovation but needs new mechanisms to achieve a fast and decisive roll-out across the sector, Mr Cunliffe said.

The initiative will help achieve the Government's vision of a fully connected health sector, where patients' health information is available where and when they need it, he says.

HISAC will continue to provide independent advice on the Health Information Strategy and on investments in sector-wide health information solutions.

HISAC manager Dougal McKechnie says technology such as electronic referrals and management of them, e-prescribing and lab results are areas the advisory committee would be focussing on and would be of particular interest to GPs and practices in isolated rural communities.

The idea is to try and automate some of those practices and move away from referral or correspondence by letter, or "snail mail", which is very slow, says Mr McKechnie.

Urban GPs usually have a great relationship with hospitals but that's often not the case in rural areas where isolation is a major factor, he says.

The technology has been trialled in the Hutt Valley and GPs using it for referrals and information updates report it has been "immensely beneficial", says Mr McKechnie.

The HISAC initiative will eventually be rolled out across the entire health sector. The ministry is already working with eight DHBs around the country with Waikato also running a pilot for electronic referrals. The majority of the 21 DHBs nationwide should be set up for e-referrals within the next two years, with e-prescribing phased in after that, says Mr McKechnie.

Who has time for sex?

By JANE MORGAN, consultant sexual health physician

You've heard it all before - doom and gloom about New Zealand's sexually transmitted infection statistics. What's to be done? Ideally, every consultation is an opportunity to discuss sexual health risk-taking behaviour, advice on risk-minimisation and offer STI testing. Back in the real world, with ever-increasing and competing demands on primary care, is there a sexual health KISS (Keep It Simple Strategy) that might be useful, that might help identify those most at risk?

Not surprisingly, there's no perfect single question that will quickly identify who to test, and hence detect, for each and every asymptomatic chlamydia infection.

However, if we choose just one biological marker to determine risk of exposure to STIs, age ranks uppermost. Adolescents (under-25 years-old) are at high risk of STIs. This is due in part to the biological predisposition of the immature female cervix, if exposed to infection, as well as to an increased likelihood of engaging in riskier sexual behaviour. An estimated 10 per cent of teenagers have chlamydia. In 2007, 72 per cent of chlamydia, 61.6 per cent of gonorrhoea and 62.3 per cent of genital warts cases seen at New Zealand sexual health clinics were amongst those under 25 years. For those aged more than 25, a significant STI risk factor is a younger sexual partner.

This creates a further challenge in that adolescents do not access health services in the same way as adults and have lower GP attendance rates. Are your services perceived as "youth-friendly"? Do you offer opportunistic testing for STIs during adolescent consultation? If so, well done, you're already a world-leader. Honestly. Recent studies from Australia and the UK found chlamydia testing rates by GPs equate to less than 15 per cent of adolescents seen each year. Also, their collated feedback suggests you're not alone if you think you don't have enough time or energy for all this sex stuff.

So how about considering a more focussed approach? Being more proactive around addressing adolescent sexual health concerns might not be a panacea for New Zealand's STI woes but it's a good starting point.

■ Jane Morgan is based at Waikato Hospital's Sexual Health Clinic.

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City doctor had country roots

Long-time and prominent Wellington GP Ashton (Ash) Fitchett might have spent 32 years based in the Wellington suburb of Brooklyn but his career began in remote Karamea on the South Island's West Coast.

In fact his rural roots stretch back to the hills around the Wellington suburb - Dr Fitchett's great grandfather owned a Brooklyn West farm known as Fitchett's Farm.

Dr Fitchett (OBE) died, aged 82 after a massive stroke on October 11. His funeral was held on October 14. Dr Fitchett was a past president of the Wellington division of the New Zealand Medical Association and a member for 56 years. He was the first member of the Royal New Zealand College of General Practitioners and its president from 1984-85. He retired from his practice in Brooklyn after 32 unbroken years in 1990. He studied medicine in Dunedin where he met his wife Ruth.

After finishing medical school Dr Fitchett, Ruth and two young children spent a year at Karamea on the north of the West Coast. "It was a choice between Tolaga Bay or Karamea. We chose Karamea … I don't really know why we didn't go to Tolaga Bay … perhaps someone else got it," says Ruth.

After finishing medical school and as part of your bursary you had to "give your country back a year" and serve in a hospital or in a "special area", she says.

"Ash had done two years in a hospital and had to pay back the country by working for a year wherever they sent him."

It was a chaotic start to a medical career, Ruth recalls. There was a long trip from Wellington to Christchurch and on to the West Coast with a baby in arms. A flat tyre on the way didn't help. The electricity supply in Karamea was limited. "The power was privately owned and it would go on at 8pm and off at midnight, so electrical appliances were of no use."

The Fitchetts had two young children at the time – 20 months and a two-week-old baby. "It was heavy-going," says Ruth. "There was a copper [for washing], a hand wringer and a very smoky coal stove. It was back to basics."

The telephone would also go off at 8pm. Patients' relatives would sometimes have to come in at night and rouse the doctor to get treatment.

There was a small maternity hospital nearby but any patient needing surgery or emergency treatment had to be taken by car "over the bluff" to Westport, says Ruth. "A city council road worker had a car that was converted to carry a stretcher and he and Ash would take the patient to hospital in it," she says.

BACK IN THE DAY: Ruth and Ash Fitchett in 1962. PHOTO: Courtesy John Riordan.

The surgery was a shared affair, a bit like a little garage – a small waiting room, dispensary, surgery – and the house was opposite. Tank water was the order of the day.

The Fitchett's older child would be up at the window pulling faces at patients as they came down the path.

"You knew when the whitebait were running because patients would leave the waiting room and go down to the river … you'd go out for a walk and come back and find a jar of live whitebait."

Karamea was predominantly a forestry and dairy farming area and animals such as dogs and pigs would also be brought in for treatment, and at times Dr Fitchett was called out to treat sick cows.

Overall, it was a "wonderful experience" and "really enjoyable," says Ruth.

Many years later the Fitchetts returned to Karamea to walk the Heaphy Track.

Dr Fitchett is survived by his wife Ruth and three adult children.

Crisis looming in rural aged care

A burgeoning elderly population, rural rest home closures and government under-funding mean the elderly in rural areas will miss out on care and an aged care crisis will occur if the situation does not change, says Martin Taylor CEO of Health Care Providers NZ.

The reality of the situation has already been accepted by Otago and Southland DHBs, which have acknowledged that the bed situation was "tight" and that people were waiting for beds, he says.

"HCPNZ members are saying that there are no hospital or dementia beds in Dunedin or Invercargill, which is causing considerable stress on the elderly and their families. They just don't know what to do, the care is needed but no one can provide it", said Mr Taylor.

However, New Zealand Rural General Practice Network chairperson Kirsty Murrell-McMillan says it's not just beds that are tight in rural Southland in particular and Otago. "There is an under-recognition of the need for support people in the community. We simply do not have – we've got a major shortage of – people wanting to provide home care [for the elderly]."

In some rural areas there is one person able to give personal or home care to the elderly in the community, they get paid the minimum wage and they have to pay for fuel to drive themselves, often into rural areas, which is a big disincentive.

"So … until something is done about the recognition of servicing rural people in their communities and in their homes we have got real problems."

Elderly people who come out of hospital and need personal care should be able to stay close to their families and communities. They often need just a little bit of home help and housekeeping. But there is such a major shortage of these caregivers, says Ms Murrell-McMillan.

Government philosophy about keeping people close to their communities and homes was just not a reality because it was not adequately funded and there are no incentives.

"This again points to the fact that we need a strategic way of looking at health for rural communities … we need a proactive approach to the care of the elderly. It's not acceptable that people in rural communities have to move 200 kilometres to a town or provincial centre because they are incontinent and need support in their homes and that's what is happening."

There are some community-driven success stories. Balclutha and Roxburgh have done it well, says Ms Murrell-McMillan. Balclutha has a small rural hospital that provides rehabilitation care and an aged care facility. In Roxburgh a small rest home has been successfully established and taken the burden off rural GPs ten-fold. People can keep their houses and go into care, and stay within their communities. "It was an extremely successful model funded entirely by the community; they raised the funds, they operate on an extreme amount of goodwill … my concern is that the Government has not taken any responsibility for anything called elderly."

About 200 of the country's smaller aged care providers are located in rural communities or suburban areas.

From Wisconsin to the Wairarapa – Nancy takes transition in her stride

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To become a nurse practitioner in New Zealand a nurse must complete five years' service after registration, complete a masters (clinical) and demonstrate a range of expertise across their practice. "You have to show you can practise at the level of a nurse practitioner without being a nurse practitioner," says Nancy.

There are 47 nurse practitioners New Zealand-wide including three who are rurally based, according to the New Zealand Nursing Council.

Nancy describes the role as practising at the advanced level of a registered nurse, with expanded duties such as seeing patients, diagnosis, treatment and follow-up care. Ailments range from diabetes to chest and abdominal pain. "We can see 90 per cent of patients," says Nancy.

Another aim of a rural nurse practitioner is to identify and assess those at risk in the community and how the practice addresses those issues, she says.

Her special areas of interest are women's health promotion and depression, and anxiety counselling, although she says she has not done much of that here.

Nancy came to New Zealand to fill a specific need – it's quite hard to get rural GPs in south Wairarapa and creating a nurse practitioner's position was designed to help, although not solve, that situation, she says. Another goal is to show doctors and nurses how nurse practitioners operate and hopefully recruit more of them. Nancy is supporting another nurse in Carterton in her quest to become a rural nurse practitioner. "There are not a lot of us here."

Her three-year New Zealand stint is being funded through the South Wairarapa District Health Board, which applied for funding through the PHO under the Rural Initiative Funding Scheme.

Nancy says New Zealand's health system is better in some ways but not in others, compared to the US. "Not everyone is guaranteed health care over there as you are here."

New Zealand has a huge focus on cultural awareness compared to the US, although the US has begun a huge push in that area of late, says Nancy.

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