NEW ZEALAND RURAL GENERAL PRACTICE NETWORK

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

Christchurch wired for rural health in 2010

Merry Christmas

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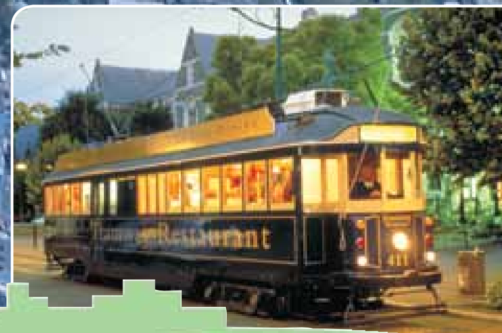
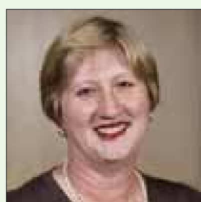


Message from the chair – Kirsty Murrell-McMillan



Over the past eight weeks it feels like the primary health care sector has taken on an air of excitement. The Expression of Interest (EOI) process has generated the belief that we should be bringing out all our ideas and dreams, and how we would do things better. The current health environment, whilst sending the messages that we need to trim our sails and make best use of resources, has an air of permissiveness to redesign the sector to work smarter.

Through the EOI process, we were given a really good push to be creative and show innovation. There were 72 expressions of interest that came from that push. Although only nine were selected to go forward with the Ministry's blessing, this does not mean the balance is wasted, far from it in fact. There is no reason why those ideas can't be progressed and even put into practice independently.

What implications does that have for us – the Network – in future? Part of our role will involve forming a broader base of relationships with a range of health professionals outside of the parameters we now operate under.

One thing is certain; we can no longer afford to operate the way we have in the past. And I believe that if we keep doing the same things we will get what we have always got. Changes afoot in the sector in both funding and resources are challenging us to think hard about what it is we are actually doing and how we are doing it.

Traditionally, general practice has been small and owner-operated businesses. Our challenge remains in how we support the smaller rural and remote practices when the emphasis of government and district health boards is on the development of larger integrated health centres.

But this is a hardy annual, it is easy to promote a "hub and spoke models of practice" where there are few geographical constraints but challenging to us where there are communities who are geographically isolated or communities where the nature of the areas are not attractive to new doctors or nursing teams. These two scenarios throw up some real challenges. However it is up us to think through and find the solutions rather than to have them imposed on us. We need to be thinking about and planning for this new direction for rural health and rural general practice.

The health sector is undergoing radical change that will undoubtedly affect rural general practice and health practitioners. It is my belief is that the rural areas are the thermometer of the country. Whilst the country's health sector is in a fever of innovation, many may have sub-normal temperatures from the reality of not being able to recruit workforce to their areas and increasing gaps where there are no health providers anymore. It is time to look in the mirror and address some of the real reasons why these exist.

As part of the Government's *Better, Sooner, More Convenient* health care initiative and the drive to reduce long hospital waiting lists, the challenge for us now is how is to look at how we are providing services and how can we trim our sails? In my view, part of the solution lies in general practice working more collaboratively with itself and possibly integrating other disciplines into the traditional team. In some cases this may mean working differently or working in bigger teams in future be it face to face or virtually.

More than ever it is important that we are one unified voice and that there is a body that is dedicated to looking after the needs of practitioners who serve rural patients. So I urge all those who are not Members to join and be part of that unified voice for rural health.

Conference is a real opportunity to come together to share ideas with colleagues, take up CME or CPD, get involved in a political forum, look at how other rural general practices deal with issues both administrative and clinical, and generally network. The breakfast forum for example – which was hugely successful in Wellington this year – gives delegates the opportunity to talk together, air their views and take away ideas .

The Minister of Health Tony Ryall has again been invited to attend our conference and will spend an hour or more talking to and answering delegates' questions. Let's fill up the auditorium and the workshops in Christchurch next year. I urge all rural general practices and practitioners to plan to send one or two people to conference next March. There has never been a greater need to work together and support each other, and establish a stronger voice for rural general practice.

This year we have lost a number of figureheads of rural general practice. Some have died and many have fallen ill. Some have retired.

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Christmas arrangements for the Network office

The Network office will be closed for the Christmas break from December 25, 2009 to January 4, 2010. We will be back at work from Tuesday, January 5, 2010.

Locum payments

We wish to remind all our locums who are working during this period that the final day for you to submit your time sheets and invoices to be paid before Christmas is Monday, December 21, 2009.

All invoices submitted after this date will not be paid until Wednesday, January 6, 2010.

Network staff and NZLocums' and NZMedics' teams would like to wish you all a very Merry Christmas and Happy New Year and thank you for all your support during the past year.

Network conference 2010

Christchurch is the venue for the Network's 2010 conference – March 11-14. The theme is Rural Health – No.8 Wired. For more details and to register visit www.rgpn.org.nz

Don't miss our early bird registration offer and the chance to win tickets to the Ellerslie Flower Show.

Visit our website for more details: www.rpgn.org.nz

Wellsford – showing the way for rural health

Does the future of effective and efficient rural health care lie in Wellsford? In a world where the health dollar is ever-more scarce, where smaller rural practices are faltering, where GP succession is a major concern and greater cooperation between professions is required, the Northland town's family-based healthcare model might just be the way ahead.

Dr Tim Malloy's Coast to Coast Health Care north of Auckland looks to have set a new direction for primary care in the rural sector. He spoke to Rob Olsen about the successful practice and business model.

It involves six clinics with the Wellsford Medical Centre as the hub. In essence the practice is a decentralised system with multiple sites that take services to the people. Developed in the late 1980s and early 1990s, the so-called "hub and spoke" system has embraced the wider community and provided a health service that is effective, efficient and all-encompassing. It also works closely with Coast to Coast PHO whose chief executive Nancy Malloy has been involved in health management since arriving in Wellsford in the late 1980s with her husband.

Coast to Coast serves a population of just less than 14,000, employs eight to 10 doctors plus trainee registrars and house surgeons, 25 nurses and medical staff such as radiographers and nurse specialists. Not only are there nurses specific to each site but also those who shift across six sites, an acute care team doing practice nursing and a chronic care management team dealing with long-term conditions. There is some cross-over of nurses between teams. On the administrative side there is a business manager, account and nurse managers, and a part-time administrative assistant. Tim's role includes 7/10ths general practice and two-tenths as clinical director of the PHO, with half a day off a week. In his spare time Tim manages an 1100 acre beef and sheep farm.

When I spoke to him at 6pm he had just finished putting strainers in the ground for a new stock yard. He was on his way home so he talked on his mobile while walking. After getting off the phone he planned to go down to the PHO base to see what had been going on during the day and then see what had been happening at the community garden. He describes himself as "driven -always" – a type A personality.

TRAIL BLAZING: Wellsford doctor Tim Malloy sees big changes ahead in the way health is delivered to the community.

Geographically, Wellsford was the right place for the hub, says Tim who studied the local geography and demographics extensively to work out where the greatest needs were before he bought into the practice. "We always knew that Wellsford was central to the lower Northland area."

About 17 per cent of the area's population is Maori and the majority of the rest European with a sprinkling of other ethnic groups. About 40 per cent of Wellsford's population is Maori and relatively poor, says Tim.

"Although there are six clinics there is only one management team so the back office function of the business is very cost-effective. Compared to a solo practice, which has a doctor and a nurse and a practice manager for example, we have a doctor and a nurse at each clinic but one person doing the accounts for the whole system. The same person, who does the payroll, does the accounts and the billing and so on. With modern IT, running the administrative side of 14,000 people is no different to running it for 1400.

"In essence what we ended up doing was focussing not so much on what we could do to influence income but rather how could we reduce our overheads and become more efficient by reducing costs.

"If there was any one single driver it was that we became a collective of doctors in particular but also nurses, which gave us the capacity to manage our on-call demands more effectively."

All sorts of opportunities have come from the system including shifting resources - both physical and human - around to meet a particular need or demand at that time.

How did the model come about? "Necessity is the mother of invention," says Tim. "The initial driver was the fact that we were burning out, there were three of us [doctors] doing a one in three in Wellsford. That number was going down to two and we had 6500 patients. We made a conscious decision to get bigger or burn out and die ourselves, so we got bigger."

Other towns around Wellsford were all solo or one or two doctor practices and the reality was that they were falling over too. They were invited to join the Wellsford doctors.

"At least initially we could salvage the day time cover in their town."

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Colleagues and friends pay tribute to a great man

Dr Patrick Joseph Farry - 17 March 1944 – 9 October 2009

The sudden and unexpected death of rural GP and educator Dr Pat Farry has left a huge void in rural health that will be difficult to fill.

Dr Farry (NZOM, FRNZCGP Dist.) passed away on Friday, October 9 in Twizel where he had been working as a locum.

A founding member of the New Zealand Rural General Practice Network, Queenstown-based Dr Farry was made a Member of the New Zealand Order of Merit earlier this year for his services to rural medicine.

Born and raised in Gore and a student at St Kevin's College in Oamaru, Dr Farry (pictured) graduated from Otago in 1967. He began practising medicine in Queenstown in 1971 and in 1976 opened the Queenstown Medical Centre, one of two medical centres in New Zealand at the time.

Dr Farry was also involved in the education of young GPs, was a former regional director of the Royal New Zealand College of GPs' registrar training programme, a former chairman of the college's education committee, was on the board of the college's rural faculty, was their representative on the Education Advisory Committee and was a Fellow and Distinguished Fellow of the College of GPs.

He also served on the editorial board of the Journal of Primary Health Care.

Dr Farry (65) was also the first rural health director for the South Island, a role that enabled him to push at political level for improved services for health practitioners and their communities, during which time he helped establish Otago University's Te Waipounamu Rural Health Unit, which he was director of.

He became a Lecturer in the Department of General Practice at the University of Otago in 1980, and a Senior Lecturer in 1990.

Dr Farry and others successfully obtained specific funding for the recruitment and retention of rural GPs and the reasonable roster fund, helping to keep many in the sector. He also helped establish the locums service funded by government (now under the auspices of the NZRGPN). Dr Farry helped establish the Otago University Diploma in rural and provincial hospital practice and in 2007-08 helped establish a vocational pathway for rural hospital doctors under the auspices of the College of GPs. His enthusiasm eventually led to the establishment in 2007 of the rural immersion programme to train rural doctors.

He was awarded the Peter Snow Memorial Award in 2008 by the Network. In 2006, New Zealand Doctor also recognised his efforts, awarding him the Buzz Lightyear Award for GPs who go "To Infinity and Beyond" in the line of duty.

Dr Farry also taught fifth-year rural medical students at Monash and Flinders universities in Victoria, Australia and he also lectured and gave presentations at WONCA conferences, including this year's Crete conference, which he participated in via a live link from the Rural Health Symposium in Wellington.

Dr Farry's funeral was held at his home – Punatapu at the head of Lake Wakatipu on October 15 and was attended by several hundred colleagues, friends and family. Dr Farry is survived by his wife Sue, sons Simon, Ben and Jude, three daughters-in-law and two grandchildren.

An education trust has been set up in honour of Dr Farry. Donations can be made to Pat Farry Rural Education Trust, PO Box 1252 Queenstown.

Friends and colleagues pay tribute to Pat Farry:

New Zealand Rural General Practice Network chairperson **Kirsty Murrell-McMillan** said Dr Farry made a significant contribution to rural health in New Zealand and internationally.

"He lobbied governments for rural health funding and had the vision, foresight and ability to bring people together. "He was totally dedicated to working in rural health.

"He died doing locum work and supporting a rural community which did not have and could not find a doctor."

She described Dr Farry as a "warm and open colleague who was extremely supportive and encouraging. He always had time for people and for me.

"He was always a gentle, plain spoken and kind friend and I will miss him very much."

Network board member, **Dr Graeme Fenton**, described Dr Farry as a "leading light" in rural health and said his death is "a very sad loss".

Dr Fenton was associated with Dr Farry "on and off over about 20 years but specifically when we were rural directors, he in the South Island and me in the North Island". The pair also worked together as directors of Rural Health Directors Aotearoa (RHDA) along with Dr Martin London, Jean Ross and Kim Gosman.

"I respect him tremendously because he kept on pushing the training of rural GPs and he got the rural immersion school going ... he was into things all the time, getting house surgeons into general practice, things like that."

He had great letter writing skills, said Dr Fenton.

The pair also worked together on the rural implementation of the Primary Health Care Strategy at the Ministry of Health in Wellington in 2000-2001.

West Coast GP, long-time associate and Network board member, **Dr Martin London**, said Dr Farry leaves a huge legacy to rural health and a gap that will be very hard to fill.

"Pat was always the leader. It's extraordinary. In many ways he put together the ultimate thing we had both been driving towards but he really picked it up and went with it in a big, big way – the rural immersion education for undergraduates. He was the initiator of the programme and the person who made it all happen and looked after the quality aspects of it.

"He leaves a huge gap and it is going to take many, many people to do what Pat did and at the emotional and inspirational level no-one will fill it.

"He is the ultimate doyen of rural practice in New Zealand, I would say.

"I'm just going to miss him so much personally in terms of, he has always been my mentor in this thing. If ever I got stuck in a difficult practice or patient situation Pat was usually the person I would ring. He was always wonderful and stunningly supportive."

Nurse, midwife and Network board member **Kim Gosman** described Dr Farry as "passionate and committed to rural health and the well-being of rural communities". He was also committed to ensuring that GPs in rural communities were provided with ongoing post graduate programmes and upskilling.

"Pat was absolutely committed as a GP and with a post graduate diploma in obstetrics he also tried hard to maintain shared services with midwives in rural communities."

Ms Gosman also worked with Dr Farry on the rural implementation of the Primary Health Care Strategy as part of Rural Health Directors Aotearoa.

Dunstan-based rural hospital doctor and senior lecturer **Garry Nixon** also lauded Dr Farry's achievements. "Pat was a central figure in rural medical education in New Zealand, both at undergraduate and postgraduate levels. Importantly for us he was instrumental in obtaining recognition for the scope of rural hospital medicine and in the setting up of the division."

Dr Farry and Martyn Williamson started the University of Otago's Postgraduate Diploma in Rural and Provincial Hospital Practice. In 2005 Dr Farry organised the national meeting of rural hospital doctors that resulted in the formation of the working party and eventually the RNZCGP Division of Rural Hospital Medicine. While he understood the urgent need for a professional pathway for full-time rural hospital doctors, Dr Farry also recognised the equally important need to support rural GPs in their hospital-based practice. This vision has underpinned the division and is the reason it sits within the RNZCGP, said Dr Nixon.

"Pat had boundless energy and enthusiasm and a tireless passion for the cause of rural health. Many of us have lost a very supportive colleague and friend and are greatly saddened by his death."

Stu Gowland was in the same medical class as Dr Farry at Otago School of Medicine in the 1960s. "We really got to know each other during the first part of our surgical exam – the fellowship – there's a thing called the primary and in those days what appeared to be the only way you could pass the thing was to become an anatomy demonstrator.

"So we were working 20 hours a week in the anatomy department. There were six of us including Pat and we really got to know each other then."

In the late 1970s Pat appointed Stu the visiting urologist at Queenstown, a job he did for quite a few years. "We would catch up then."

Pat was always expansionary and built what was really quite an exotic thing at that time – the Queenstown Medical Centre – the first in Queenstown, says Stu.

"It had everything in it … I went to consult there one time and I couldn't pull the curtains across for the patient. I didn't realise it had electric curtains … highly advanced.

"We probably got to know each other most once the surgical bus project started. I wanted to learn a lot about rural primary care, stuff I didn't really know much about, and Pat became a bit of a guiding light.

"Pat first taught me about the value of using actors to act-out different symptoms. Of course surgeons would say, 'hell we'd never do that sort of thing' but in actual fact we introduced the Australian-New Zealand urologists to exactly that concept in early 2000s and that all came through Pat.

"He also travelled a lot internationally, which we think is absolutely critical for this country. He spent a lot of time with Australians, Americans, Canadians … he knew people in the UK and he was picking up new ideas that were coming through.

"One of those things was treating knee injuries using telescopes to look into the knee and how you can operate through them. Being a urologist I've been using telescopes since the start of time. We said yeah, that's absolutely logical and what must happen. Down in Christchurch they thought it was the most ridiculous thing they had ever heard.

"The rural immersion programme was another example. Pat had a knack of bringing things like that in. It's that networking that gets new ideas in," says Stu.

"Pat will go down as one of the greats and we are all annoyed that he went down at this time. We are all dispensable in the end and we all understand that … it's going to be very hard to replace him.

"I have lost a major sounding board for ideas. It's certainly hard to think how it will be filled."

Wellsford GP **Tim Malloy** described Pat Farry as "inspirational". "He was kind, friendly and also driven. He was single-mindedly driven towards rural health and he saw the future and pathway probably sooner than most of us for rural health through education.

"His contribution to the exposure of medical graduates from the school of medicine and the University of Otago, especially in the Dunedin clinical school, but all of them in fact, was just absolutely immeasurable.

"It was Pat who first set the systems which enabled the sector to demonstrate that from the students' perspective the most enjoyable part of their whole medical training was their rural primary care run and Pat was largely responsible for that.

"Pat was unique, absolutely unique. He had a rural perspective but he also had the emotion and passion for the work … it's just hard to describe."

Road to nurse practitioner status long but worth it, says Sarah

Nurse and mother Sarah Waldron has done the hard study yards to become a nurse practitioner. The final hurdle is approval from the Nursing Council of New Zealand, which she hopes to attain by mid-2010.

She talks to Rob Olsen about the road to higher qualification.

Forty-six-year-old Sarah is a hospital-trained, registered obstetrics nurse. She did her training in Whangarei in 1984 and then had a "very short spell" working at Greenlane Hospital in Auckland.

"Then I went overseas, you know, the big OE", where she did a lot of private hospital and agency work in the UK. "I travelled around Europe and worked in between times, said Sarah, who returned to New Zealand at the beginning of 1990 with an English husband and a two-year-old daughter Holly. Sarah initially started doing shift work at the Bay of Islands Hospital then worked with a doctor at Paihia and at the local hospital. She has worked full-time at Bayview Health Centre for 13 years.

In 2004 Sarah applied, and was accepted, for a rural nurse scholarship and was in the second group to complete the post graduate diploma in rural health (advanced nursing through the NZ Institute of Rural Health). She also holds a Masters degree in nursing from the University of Auckland from which she graduated in October 2009.

Though her bid for nurse practitioner status began in March 2005 (she graduated with her diploma in May 2007), she had the rest of the year off from study because she couldn't get funding to complete her masters. "I couldn't have done this without funding ... women of our age with mortgages, children, my children are at university now, and it would be too much to take on a student loan plus the mortgage."

Luckily Sarah's was part-funded through the DHB (via the Ministry of Health), which she had to apply for. "I had to say

MASTERING THE PRACTICE: Paihia-based nurse Sarah Waldron is one of a group of about six Masters graduates to present their portfolios to the nursing council in June 2010. There are less than 70 nurse practitioners in New Zealand.

Sarah graduated with Honours. She has two daughters – Holly, now 20 and Sophie 16.

what I wanted to do and where I wanted to go, where I saw the qualification taking me and how that was going to improve the health of people I was going to be working with."

Then the hard work began. "You have to be quite motivated to get through the programme," says Sarah who spent on average 15 hours a week studying – on top of a 40-hour working week. Some time was given towards study leave but not a lot – about eight days.

"You have to work every night and some weekends, all weekend but otherwise at least one day of the weekend I'd be studying.

"It was very hard-going and looking back I sometimes wonder how I did it. Last summer, because of the way the papers were structured, I had to complete my dissertation, so over the semester when I was supposedly not studying, I worked ... all over my Christmas and New Year holidays, but it was worth it."

She admits there were days when she thought "what have I taken on".

The Masters programme, which Sarah describes as "very good", also involves a variety of clinical assessments, which were pretty intense. Because she would be prescribing she was required to do three papers and worked with a clinical mentor who had to be a prescribing doctor.

"Once you are a nurse practitioner you see patients who are within your scope or you see them to a point and then you might refer them to a GP if there was something you are not comfortable with. That's why it's good working in a general practice.

"A lot of things can be handled by a nurse practitioner such as common skin infections, upper respiratory tract infections, urinary infections; things people have normally seen a GP for can be handled by a nurse practitioner.

"The biggest plus is the follow-though of patient care and not just doing a little bit and passing it on to somebody else – seeing the patient, evaluation, diagnosis, the correct management and seeing an outcome you have helped to achieve.

Even if it's just simple things like skin infections – you know the right thing to do.

"There is a great deal of satisfaction in that. People come in to see me rather than the doctor. They think, 'oh Sarah can sort that out' and that's nice. They have the confidence in you."

The uncertainty of future employment as a nurse practitioner is another big hurdle, she says.

Because there are not many job opportunities for nurse practitioners, Sarah says it was also a bit discouraging not knowing where she was going once she'd completed her study. "That's probably what put me off going straight on to my Masters after the diploma in rural health.

"I think the uncertainty of the future puts a lot of nurses off doing further study. A lot of my friends have said they don't know if they would get a job at the end so what's the point.

"We sort of have to create our own role and I've been very lucky in that Te Tai Tokarau PHO have been very supportive and that they are looking for some work for me in the area of Cardio Vascular Disease (CVD) screening and management."

Sarah believes funding to primary health care has to be addressed by Government because GPs hold the funds for their practice nurses and if they want to upskill the money for salaries is coming out of the GP purse.

"My doctors at work have been helpful, although sometimes I wonder if it's a monetary threat, the thought of paying a nurse practitioner's salary out of their bulk funding. Even though you are taking on more responsibility it's a little off-putting for them. But they have been very supportive of my role and my assessments and that sort of thing. The main discrepancy seems to be extra money."

And there are GPs out there who aren't sure what nurse practitioners can do but they usually haven't worked with nurses with advanced skills and they are probably a bit scared that nurse practitioners don't know what they are doing, says Sarah, who believes that will improve over time.

"It's really about getting nurse practitioners into mainstream and general practice in the regular team. It'd be nice to see GPs, nurse practitioners and practice nurses working in the one team with each of the team understanding what role each has. I think that's where things will go but it will take the best part of 10 years to be accepted in general practice."

And where to from here? Sarah wants to remain in the clinical role and nurse practitioner is about as far as she can go in that guise. "I don't want to be a doctor. It's a totally different focus."

She will continue to do clinical, acute condition management in general practice and wants to work with CVD prevention, which she covered in her dissertation for her Masters, and was published in the Journal of Primary Health Care. "That's something that will be useful towards gaining nurse practitioner status," says Sarah, who has to develop a portfolio that includes case studies, evidence of research skills and work on primary health care gains. Sarah's specialty is Cardio Vascular Disease.

"That's an area that has always interested me. My father died at 57 from a heart attack caused through his asthma. He died young but he smoked. In those days you didn't really know about CVD prevention and I dare say that if he was around today we'd be doing more for him and it's quite likely he'd be living.

"It's a satisfying area to work in because you see people who finally get the message and start making good health changes. It's a huge cause of death in this country."

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

Nurse practitioners must have:

- Attained Master's level of education
- Been approved and registered by the Nursing Council of New Zealand as a nurse practitioner
- The title is protected and may be used only by those nurses formally registered by the nursing council

Nurse practitioners were first introduced in New Zealand in 2000. It is anticipated that it will take a decade to fully implement the evolving model.

Nurse practitioners combine the roles of:

- Practitioner
- Mentor
- Teacher
- Researcher
- Administrator

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

For more information see

www.nursingcouncil.org.nz

www.moh.govt.nz

Nurse Practitioner Advisory Committee of New Zealand (NPAC-NZ)

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You can't beat the country practice

The difference between working in primary rural health and secondary urban health is, you are the ambulance at the top of the cliff, not the bottom, says Wellsford nurse manager Cherry Phillips.

Cherry has been at Coast to Coast Medical Centre in the Northland town for five months after living and working in Auckland for 34 years. She was a clinical nurse specialist and a nurse manager for the Auckland DHB.

Nursing, says Cherry, has been a life-long passion.

She was attracted to rural health by several factors: the chance to break away from secondary urban health and the hustle and bustle of city living, the more proactive role that primary care offers and the lifestyle.

Cherry bought a lifestyle block about five years ago and was commuting from Auckland in the weekends and eventually decided to turn that around and do the commute back to Auckland in the weekends. Her city home is now on the market.

"You still have reasonably close access to the city. It's 40 minutes to Whangarei and an hour and 20 minutes to Auckland."

The work is different too. "It's very challenging for me coming from secondary care, which is primarily hospital-based care to primary health care. It's very different. The learning curve has been very steep for me.

"You are dealing with people in the community, stopping them from going into hospital, so the systems are different. The whole process is different. You are trying to keep them as well as possible in the community, as opposed to treating them in hospital where you are almost the ambulance at the bottom of the cliff.

"In primary care you are like the ambulance at the top of the cliff. It's more of a proactive role. When people are in secondary care in hospital it's very much how good your discharge planning is as to how well they stay out in the community in terms of support you can put in place.

"Here it's putting the support in first so you can keep them out of hospital. It is a big challenge."

GREEN FIELDS: Coast to Coast nurse manager Cherry Phillips (left) and administration assistant Lisa White enjoy the rural aspect their Wellsford location offers.

The administration systems are different too, compared to secondary care, which has also been a learning curve for Cherry. "All the IT and clinical records systems are very different and processes such as community follow-up are quite different. Here you are trying to organise it from day one whereas in the secondary it comes after hospital care."

Overall the work is very rewarding especially being able to keep people in their own homes, says Cherry. "They are there because they want to be there, because they have farms and that's their livelihood.

"It's important for the community that they get to stay well in that environment."

Although she is based at Wellsford Medical Centre her role as head of nursing services sees her go out to the six other practices that are part of the Coast to Coast practice.

"That's not always easy with a busy practice in Wellsford. I do try to get out to each practice every two to three weeks." She also goes to the various practices if problems arise.

In fact Cherry covers a lot of nursing roles in any given week including professional development, orientation and training for nursing staff and she works clinically; she has a role in the management team and is involved in strategic planning. Her hours too can vary. It's a bit different to working in the city. "You don't just do a Monday to Friday, 8am to 5pm ... you just do what needs to be done [in rural practice]."

Primary rural health is an exciting area to work in, says Cherry. "There is a variety of different complaints as you can imagine, it being a vast area to cover. You get a multitude of things that you'd probably only get in emergency departments in secondary health. It's quite exciting nursing.

"You also get to be quite autonomous in your practice. A lot of nurses have gone on to specialise in certain aspects of their profession like chronic care management in cardiovascular care and prevention, breast screening and vaccination, smear screening and older people's health. We also do PRIME here in the rural setting. All the staff does PRIME courses. It's a well rounded area of practice but you get to specialise if you want to."

Cherry says it's a well-supported environment to work in.

Rural women to benefit from local breast cancer research

In November 2009, Associate Professor Susan Dovey from Te Waipounamu Rural Health Research Unit at the Dunedin School of Medicine, University of Otago was awarded one of five 2009 New Zealand Breast Cancer Foundation Research Grants.

The grant covers two years: $46,000 in 2009 and $17,000 in 2010.

Susan's research project was selected as it demonstrated that it has the potential to generate findings that will be of significant importance to the further understanding and management of breast cancer in New Zealand.

The title of Susan's research is A comparison of treatment modalities and outcomes of treatment for rural and urban women in New Zealand who have been diagnosed with breast cancer.

Her research aims to:

- Determine whether in Otago and Southland, rural and urban women have different treatment for breast cancer.
- Establish the reasons rural women with breast cancer opt for the treatment choices they do.

Susan explains the significance of this research:

"Overseas research suggests that the treatment choices rural women opt for impacts on their long-term survival and the reasons for these choices needs to be well understood before the choices themselves can be influenced. By identifying reasons rural women make decisions about treatment choices, recommendations can be made to rural general practices and hospitals to promote best practice and ultimately achieve improved outcomes for rural women and their families. For example, some rural women chose more extensive surgical therapies than urban women, and treatments such as radiation therapy, were less likely to be chosen because of pragmatic challenges such as travel time".

NZBCF Executive Trustee Heather Shotter is pleased to be able to fund this original and much needed study.

"This research meets NZBCF's mandate to improve survival for New Zealand's rural/remote women diagnosed with breast cancer. By understanding the reasons rural women make the treatment decisions they do, hopefully in the future, it will increase their survival in both physical and psychosocial contexts".

This year saw the Foundation increase its financial support for New Zealand-based breast cancer research by an additional $200,000. The increase in funding was made to enable a greater number of research grants to be awarded, and as a result of the funding increase, the number of applications received was high. The Foundation is pleased to report that there was a wide variety of applications, and many were of a very high quality.

Most importantly, the increase in funding is part of the Foundation's three-year strategy to expand services and programmes to advance the New Zealand five-year survival rate of breast cancer – currently close to 85 per cent at five years from initial diagnosis - and improve the quality of life for New Zealanders affected by this disease.

Research grant applications are reviewed and awarded by the Foundation's Medical Advisory Committee and Board of Trustees. The Medical Advisory Committee is chaired by breast surgeon, Dr Belinda Scott, and includes clinicians and researchers across a wide variety of breast cancer disciplines.

To date, the New Zealand Breast Cancer Foundation has distributed well over $1,000,000 for breast cancer research and medical grants in New Zealand. Ms Shotter says the Foundation is committed to funding research into the prevention and successful treatment of breast cancer, which will provide those affected by the disease with hope and enable our doctors to save their lives.

NZLocums

Need a locum?

Or maybe you'd like to do some locum work yourself?
Give us a call to find out how we can help.

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Or email: enquiries@nzlocums.com

www.nzlocums.com

Make it a date in Christchurch 2010

Attending the Network's 2010 conference in Christchurch should be amongst the top two or three items on your New Year's resolution list.

Why? Dubbed *Rural Health – No. 8 Wired*, the conference programme is one of the best ever with a good balance between clinical-management-workshop-political and practical keynote sessions.

The conference committee has been hard at work formulating a programme and theme to cater for all-comers from rural general practice including nurses, rural hospital doctors, GPs, practice managers, with politics, AGMs and social and networking events built into the mix. So, there's something for everyone with a greater emphasis on the rural general practice team.

The programme is a four-day one with Thursday and Sunday featuring pre and post conference workshops such as ultra-sound and teaching workshops. The main programme starts on the Friday with registration and official welcomes followed by Minister of Health Tony Ryall talking to delegates then fielding questions. Two keynote practices will present their unique experiences with the afternoon covering concurrent sessions including wilderness medicine, home nursing care, medico-legal issues and pain management. Saturday sees five workshop streams including supporting and resourcing grieving families and the rural nurse practitioner as themes. The ever-popular and innovative student doctors make a welcome return and to round-off the afternoon there's an emergency transport session aptly named "Trip Wired" followed by "Get it off your chest", a hot topics forum. For a more relaxed look at the world author and social commentator Joe Bennett takes to the stage.

The conference dinner and dance and the highly successful Sunday morning Breakfast Forum are other highlights. Partners are urged to follow the road to Christchurch with the Ellerslie Flower Show an added attraction as part of the Garden City experience.

What: New Zealand Rural General Practice Network Conference

When: March 11-14, 2010

Where: Christchurch Convention Centre.

Early bird registrations go into the draw for flower show tickets. Visit our website to register and view the conference programme: **www.rgpn.org.nz**

New Zealand in Lonely Planet's Top 10 for 2010

New Zealand's made the cut to be named in Lonely Planet's prestigious Best in Travel publication for 2010.

New Zealand was picked by Lonely Planet authors, staff and travellers as one of the Top 10 Countries to visit in 2010.

Also featured on the list are El Salvador, Germany, Greece, Malaysia, Morocco, Nepal, Portugal, Suriname and the USA.

Lonely Planet pokes fun at itself for recommending New Zealand as "too obvious, right?"

"But there's wisdom in the old saying, 'If it ain't broke, don't fix it', and last time we checked the land of Māori and hobbits it certainly didn't need repairing," the guide says.

It lists New Zealand essential experiences as being 'as strong as ever', from spectacular landscapes and wildlife to Māori culture and food and drink. It also singles out New Zealand for praise in spearheading eco-travel and for its ethos towards responsible travel.

"Being singled out as one of the Top 10 Countries for 2010 by Lonely Planet is an astonishing result for New Zealand, given the competition out there from established and emerging tourism destinations," Tourism New Zealand Chief Executive George Hickton said.

Lonely Planet's Best in Travel 2010 also features its top 10 regions and cities for the year ahead, as well as other travel lists including:

- Top 10 super cycling routes - the Otago Peninsular route is named as the number one ride for its mixture of 'scenery and sweat'
- Top 10 places to walk your dog - Dunedin makes the cut for its 'network of dog-friendly trails' around the city
- Top 10 for twitchers - the Otago Peninsular is singled out as one of New Zealand's hot attractions because of the region's birdlife.

Earlier this year, readers of the prestigious travel magazine Condé Nast named New Zealand as one of their favourite destinations.

"New Zealand's ability to continue to compete with hot new destinations is a testament to the country's desire to deliver a great tourism experience, its innovation in creating new tourism products and its drive to improve its environmental performance," Mr Hickton said.

Read more

http://www.tourismnewzealand.com/tourism_info/media-resources/media-releases/new-zealand-in-lonely-planet-top-10.cfm

From The Hague to Otaki – with a helping hand from NZMedics

A move to the opposite end of the world was made easier for Dutch GP Bente Roberti-Ongkiehong thanks to professional assistance from NZMedics, the New Zealand Rural General Practice Network's urban medical recruitment agency.

ROOM WITH A VIEW: From left, Hanne, Bente, Hans and Martin Roberti-Ongkiehong have found a new lifestyle in the hills behind Otaki.

Bente came here after attending a promotional evening on work opportunities in New Zealand at its embassy in The Hague. Interviews with NZMedics staff followed and they handled all the necessary paperwork, immigration, and qualification and medical council requirements needed to come here.

"It was so helpful having the support of NZMedics during the process involved in coming to New Zealand," says Bente who worked closely with NZMedics relationship manager Kate Van Echten for more than three months leading up to the family's departure for New Zealand.

"Kate was very good. She helped and worked closely with me on everything. I was very lucky to have the support, especially with the paper work in matters such as immigration.

"It's quite demanding and it's good to have someone there to support you and give you all the necessary information."

Bente says it was also helpful working with one person through the entire process.

When the family arrived in Wellington early last year stormy weather meant their flight had to be diverted to Christchurch where they spent the night.

Settled weather the following day allowed them to fly into the Capital but it wasn't the ideal way to start their new life in a completely new country.

However, a year and a half later, Bente, husband Hans and their two children Hanne (12) and Martin (9) are living their dream in the hills behind Otaki - a lifestyle choice.

Bente and Hans, an environmental scientist, and the children live on 52 hectares of land they recently bought.

It's a totally new way of life for the family who are used to a more conventional and crowded lifestyle in their homeland. Their Otaki house, because of its isolation, is powered by solar panels and a wind turbine. They also have a generator for those times when neither of the aforementioned can supply their electrical needs.

"It is a new, exciting challenge as we have always been easy going with power and electricity," says Bente, who grew up in Norway and studied in the Netherlands.

"We are getting used to being aware of what power we use with the children being the most energy-conscious half of the family and reminding the other half constantly to turn off the lights."

And it's been a bit of a sharp learning curve. On the third day in their new house the family awoke to no power and just a few candles to light the house. But the biggest challenge, says Bente, was getting the car out of the garage, which had an electric door with a jammed manual opener.

"Eventually we managed to get it open and we learnt from this and bought a generator, candles and torches, so we are now slightly better prepared."

The views from their new home are spectacular overlooking the river, gorge, farmland and coast, as well as views of Mounts Taranaki and Ruapehu further to the north.

Their land is mainly native bush, hills and valleys with plenty of native birds and rabbits and possums. They have as yet no plans to keep stock on the land but horses might be an option later.

Bente worked in Upper Hutt for a year but now works in practices based in Levin and Wellington.

The family came to New Zealand because they wanted a new lifestyle and space and heard about New Zealand being a good place to live. They also looked at other options but the opportunity to go to New Zealand where both had good possibilities for jobs close by each other appealed to them.

"We wanted to travel, get away from Europe and change our lifestyle. Europe is quite crowded."

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Rural call long and loud for Northland GP

The Far North freezing works town of Moerewa might be a far flung corner of the country to practice medicine but for long-serving GP Graeme Fenton it's proven to be an enduring choice.

Graeme established Moerewa Medical Services in Northland in 1967 and has looked after generations of families. However, his Moerewa connection came about purely through a chance visit: "I never planned to come north. I just came up to see a friend of mine and they were desperately short of doctors, so I ended up staying here. I was going to stay a month and ended up staying a year just to help out."

The year morphed into a lifetime of work. A decision to buy a farm in the area sealed Graeme's future and 42 years later he is still busy and involved in the community he came to shortly after graduating from Otago school of medicine in 1965.

"I was accepted into the community fairly quickly because they were desperate," he quips.

Moerewa's population is about 80 per cent Maori and in the lower socio-economic decile and while this has produced some health-related challenges Graeme says the area has been a good and rewarding one to work in.

"Some areas have reputations that don't exist in reality and there has been a bit of a problem with people pre-judging this place and its people. In reality people around here are very friendly and they know what it's like not to have a doctor. Everyone [doctors] who comes seems to be very happy," he says.

"The people are lovely, they are friendly and they are good to work with. They are really what you would call the unworried unwell. It's a different environment to those who can afford to be more in the bracket of the worried well."

Diabetes, heart disease, obesity and immunisation of children are some high priority health issues Graeme and his team deal with. The immunisation rate is up around 90 per cent now and is something Graeme has been "hard-nosed" about. He believes childhood immunisation should be compulsory before children go to school.

Sector issues are no different to many other rural areas – the usual suspects in fact – such as recruitment, retention, after-hours and succession.

The basic issue with recruitment and retention in Moerewa, has been doctors and not nurses. says Graeme. "Retaining nurses has not been a problem, we have been very lucky. I have always had very good staff, professional, very supporting – and we are all getting old together."

Prior to the formation of the Northern Consortium and the New Zealand Rural General Practice Network (in the late 1990s) getting locums was a serious problem. Though things have improved with GP and locum recruitment, the problem remains a long-term one, he says.

While recruitment and succession remains a problem common to rural health, Graeme believes the whole ethos and attitude from Government and the medical fraternity is changing, which will flow into rural medicine. "You go back to the early 1990s, the attitude was 'rural, what rural problem?' Whereas now a whole lot of things are being done in rural areas such as bringing students in as part of their training. There's a whole raft of rural health initiatives that will gradually but surely help rural health as time goes on."

Rostering of doctors through a centralised after-hours service has largely solved the on-call issue, says Graeme.

His practice is one of three – two in Kawakawa and one in Moerewa – that work together with other practices in the area. The Moerewa and Kawakawa practices serve a total population of about 6000 people. The entire Bay of Islands' combined after-hours service operates out of 20 bed "cottage" hospital in Kawakawa, which caters for about 35,000 people. That involves about 19 doctors and provides a 1 in 18 roster for the GPs involved, says Graeme. Prior to February this year on-call was about 1 in 4 to 1 in 8. If a solution had not been found there were a considerable number of local GPs that would pulled out of after hours.

The success was due to every GP being involved, local PHOs support and a very

GRASS ROOTS: Graeme Fenton has lived and worked in the Northland town of Moerewa for the past 42 years.

enlightened supportive attitude from the Northland DHB and this has continued.

Communicating with the local community and keeping people informed has been key to implementing that service.

"Local Maori were concerned because of the lack of visiting for certification etc, but once discussed with the local Kaumatua they had a better understanding of the issues . I just put forward the reasons why, the problems involved, and the real possibility of losing after-hours call. It's a matter of the people feeling comfortable with what's happening."

There were also discussions with the ambulance service, police, rest homes, says Graeme.

Health funding from the Ministry of Health has also slowly improved. "When they first brought in capitation they made no allowance for deprivation or Maori population with GP income but then they brought in low access funding and that's helped and allowed us to do a lot more things, such as Outreach and Careplus."

It wasn't that practices weren't providing those sorts of health services but rather they could cover it so much better with extra funding, says Graeme.

Though his community links have been mainly medical Graeme has also found himself involved in unrelated ways. "Sometimes I'm a bit of a lawyer ... you tend to do a lot of things that go outside the medical, more so than in urban areas I should think."

Though he has been very involved in the community on a professional basis there has remained a degree of separation on a personal level, which he believes there has to be. "This is an area where I think rural doctors have to be quite careful."

He believes couples are ideally suited to rural general practice. "I think you have to be enthusiastic, idealistic, have skills across the board and want to do real general practice. The lifestyle is also an attraction. There are many outdoor activities, you don't have to dress up and have the ability to work from home with technology available today."

Graeme enjoys a spot of fishing when time allows, reading and he is becoming a "graduate of gardening", of which his wife Joan is a keen practitioner. Shooting the odd rabbit is a task that falls to Graeme too.

The Fenton's have three children, none of whom have gone into medicine.

The 67 year-old says he plans to retire but the issue of a replacement remains.

"You can't walk away from it. As long as my health holds up and I'm not pushed too hard I'll be fine."

Graeme and Joan own a 100-acre farm, which he describes as a "little side line". While medicine has consumed his life over the years, horses have been a passion for Graeme too. He has educated and raced harness horses for a decade during the 1980s and raced about 30 winners during that time.

He was also president of the Northland Trotting Club for about four years. He is still involved on the periphery of the sport.

Graeme was made a Distinguished Fellow of the Royal New Zealand College of General Practitioners in September this year. He served on the RHA Board in 1997 and was Director of the Institute of Rural Health from 2000-2001. He established the Northern Rural General Practice Consortium and has served as Deputy Chair of the Te Tai Tokerau PHO Board since 2003. Recently he has been involved in improvements to the after-hours service in the Mid-North. He has tirelessly worked in the background to improve access to healthcare for rural communities.

He is on the Rural General Practice Network's executive committee.

Just what the doctor ordered

NZLocums relationship manager Jenni Rutherford went the extra mile assisting an American locum settle into his Kiwi tour of duty.

Dr Mike Debevec and his wife Annie, who hail from Minnesota, arrived in New Zealand recently for a six-month locum stint in Balclutha.

Jenni, who recruited Dr Debevec, knew he was interested in playing piano and that he wanted to buy an electric keyboard when he arrived. Jenni asked him what style of music he played and he said jazz. He told her he had produced a couple of CDs and was quite particular about the type of keyboard he required and could not find one anywhere. As it happened Jenni had a Roland weighted keyboard, in her garage, which belonged to her sister Jann, a former Sydney-based jazz pianist who died of cancer several years ago.

"I told him he could borrow it while he was in Balclutha. He was ecstatic," said Jenni.

"I also sent him some copies of my sister's CDs which he loved. He said it was a privilege to use her electric keyboard.

"My sister would rather see the keyboard used than sitting idle in my garage."

Jenni said the Australians claimed her sister as "one of their best jazz pianists" and set up the Jann Rutherford Memorial Award for the Most Outstanding Female Jazz Musician.

She was aged 38 when she died.

From The Hague to Otaki – with a helping hand from NZMedics

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"It was a difficult decision to immigrate because it was me who was moving my family. I had the job, my husband did not. He came with his CV under his arm and was lucky to find a good job within the first weeks after moving.

"I went through stages thinking 'have I done the right thing? Am I and my family happy?'"

But the family is here to stay and is settling in well, especially the children who are fast coming to grips with the English language and the Kiwi way of daily life. Hanne and Martin both attend schools in the Capital, Wellington. "It was a big shift for them especially with the language and leaving their family and friends behind."

The children enjoy their schools and especially the sports they're able to play – Hanne hockey (above and underwater) and equestrian and Martin touch rugby and athletics, being a champion last year.

Hans has also taken up hockey after a break of some years and Bente is a runner and recently completed the 10-kilometre section of the Harbour City Marathon.

One of the best things about moving to New Zealand has been the many outdoor activities the family has been able to do such as tramping, rafting, and water sports.

Overall they have found New Zealanders very friendly and welcoming and the relaxed lifestyle here makes settling a pleasure, says Bente.

Family members have already visited them in New Zealand and more are planning to come as they are very inspired by their stories.

Bente believes patients are the same the world over with regard to health problems and complaints. Though she has found the health system here similar to Europe, it has its challenges such as bureaucracy and paperwork.

Provisional immigration adviser accreditation given to NZMedics manager

The New Zealand Rural General Practice Network has a new string to its recruitment bow thanks to NZMedics manager Julie Wilson.

Necessitated by a May 4 law change that requires anybody in New Zealand providing immigration advice to be licensed, Julie has recently acquired a provisional licence as an accredited adviser from the Immigration Advisers Authority, which falls under the auspices of the Department of Labour.

NZMedics is the urban medical recruitment arm of the Network and NZLocums is the rural equivalent. Both agencies have historically offered immigration advice to doctors wanting to work in New Zealand. The recent law change meant that without the appropriate accreditation, NZMedics' and NZLocums' clients would have to have been referred to another agency on immigration issues.

"After a lot of discussion with IAA and given the advice we provide our doctors it was deemed necessary for the Network to have a licensed immigration consultant and that's where I came in," says Julie.

There are three levels of adviser accreditation: Full, limited or provisional. Full accreditation should take about 12 months, says Julie.

"The Network could have recruited doctors and got immigration advice elsewhere but that would have brought in a third party and slowed the process down and it's a service that goes hand-in-hand with recruitment, so it is a natural move for us to take on the immigration advice service."

The availability of immigration advice through the Network makes the process seamless and offers a one-stop shop for doctors coming here from abroad to work in urban and rural settings, says Julie.

Doctors are able to use another immigration advice service if they desire.

Gaining the accreditation has seen Julie immersed in familiarising herself with immigration processes and protocol during the past few months. That included setting up a new service or business model from scratch and required her to show processes, procedures and how to conduct an application. The IAA wanted to know what sort of information or advice should be given to clients under certain circumstances and it presented a variety of scenarios. Processes must be transparent with the most up-to-date advice given to the client, says Julie.

Accuracy of information is extremely important. An adviser's license can be revoked by the IAA under certain circumstances.

Julie has already taken up the role as a preliminary licensed immigration adviser and is working with her first official case. Every application and query has to be run through a licensed supervisor until full accreditation is granted.

The names of those accredited or licensed as immigration consultants can be found on the IAA website: **http://www.iaa.govt.nz/**

Two students awarded John McLeod Hauora Māori Scholarships

Two medical students have been awarded the prestigious John McLeod scholarships this year for demonstrated academic excellence.

Courtney Hore (Ngai Tahu, Te Arawa) and Aroha Si'ilata (Ngāti Raukawa, Tuhourangi, Samoa, Fiji) were chosen amongst 579 students who have been granted Hauora Māori scholarships this year.

Scholarship grants were awarded to 579 of the over 800 students who applied under the Ministry of Health's Hauora Māori Scholarships programme this year. The Hauora Māori scholarships, of which the John McLeod Scholarships are a part, are awarded to help Māori students continue their studies in a range of health areas, including nursing, pharmacy, medicine and dentistry.

Ms Hore has just completed her studies in medicine and surgery at the University of Otago's Christchurch School of Medicine and Health Sciences. Her interests are in oncology, haematology and surgery, and she plans to undertake research alongside medical practice in the future.

She cited that her involvement in Kaupapa Māori Research in the Māori/Indigenous Health Institute at the Christchurch School of Medicine and Health Sciences has given her an invaluable appreciation for, and understanding of, the health realities for Māori.

"My research experience with the Institute has given me insights into what is lacking in our communities to address Māori health inequalities and how I can use this knowledge in my future practice," she cited.

Ms Si'ilata has just finished the third year of her medical studies at the University of Auckland. She was Head Girl at Auckland Grammar School in 2006 and a leader in her Kapa Haka and Pacific Island Dance performing groups. She also represented Aotearoa at the annual All Pacific Prayer Assemblies from 2004 to 2007. This year, she mentored two first-year pre-med students.

"I am interested in dermatology but I haven't done a lot of practical work yet. I don't know what area I will specialise in yet because there are so many possibilities and opportunities in medicine. What I am committed to, though, is working for Maori and Pacific communities," Ms Si'ilata said.

The John McLeod scholarships are named after Dr John McLeod (Ngā Puhi), who was well-known nationally and internationally for his work in public health and his significant contribution toward improving Māori health. More than 25 students have been awarded this scholarship since it was established in 2000.

Message from the chair – Kirsty Murrell-McMillan

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With the busy and often stressful Christmas holiday period ahead of us, I urge people to look after their health and plan for extra staff cover where possible. For rural areas the next two months are more a wind-up than wind-down in work rate, especially with an influx of tourists and holidaymakers to certain areas of the country.

Finally, I would like to wish everyone a very Merry Christmas and a safe and happy New Year. I ask you to spare a thought for those friends and colleagues who have been rural practitioners who are no longer with us, in particular Dr Pat Farry, Dr Pat Ngata, and Dr Neville-Lamb.

Wellsford – showing the way for rural health

...continued from page 3

This evolved and each practice and town came on board at different stages. "It didn't happen overnight," says Tim.

Under the Primary Health Care Strategy the Coast to Coast PHO function has been to allow the practice, in particular, a means to interface with other providers and with the community, and as a facilitator of the engagement with the community it has been an excellent medium, he says.

The PHO aspect has brought Tim and Nancy in contact with their community in the broader sense. There's a community garden, weaving group, kuia and kaumatua feedback, hui and the recent purchase of the local community rest home by the PHO trust, to name a few.

"The owners of the rest home were going broke and they were going to close it. We had to take it over. In the responsible sense of a PHO we could not allow our community to be without a residential aged care facility and if they shut the doors what were the 12 people in there going to do? It was an ethical obligation on our part given that is our mandate, to look after the health of our community. Following due diligence it was the right thing to do," says Tim.

Another goal, in conjunction with the local district health board, is to establish a purpose-built student lodge as part of a health campus in the district. Students from a variety of disciplines come to Wellsford for about a month and learn and live together across the disciplines. "It teaches them to be respectful and to learn something about the other disciplines they may work with in the future and have knowledge and understanding of where their colleagues come from philosophically," says Tim.

"One of the objectives is to expose them to rural practice and medicine. Rural practice by its very essence requires us to work in teams across our professions. We do intrinsically what other people aspire to do in the urban setting. This learning is in a rural setting and we hope to encourage them to consider that option."

They run two programmes – one a multi-disciplinary team programme and the other as a trial site for post graduate education in primary care for nurses. One of their student nurses is applying to come back as a post grad trainee next year. "That's the first tangible outcome of the programme so far, returning someone to a rural setting where they would not have had the exposure otherwise."

Succession

The perennial issue of succession is something that is constantly on Tim's mind. "I think about it all the time and I don't have a simple solution. The fact that we haven't had any workforce development that has encouraged young doctors to come into the rural workforce for the last 30 years means that we have this big gap in the generation that would have followed me. We are starting to see some of the youngsters come through now and I am hoping that will ultimately pay off in some sort of succession planning."

Because the system has failed to deliver on the medical workforce Tim believes that the models of service in the future will not be entirely dependent on GPs seeing patients. "We are going to have to alter the expectations of the public, in my opinion, because their contact will be with a team. It may be that they see a nurse or another health practitioner rather than their GP in the future. The GP might take some sort of overview of the clinical governance role.

"If you present to my practice acutely right now the first person you will see is a nurse and they will undertake an assessment and determine the probable outcome of your care, which may involve a doctor but may not and in the future is less likely to involve a doctor."

Why rural medicine?

Tim was educated at Auckland Grammar School, graduated from Auckland School of Medicine in 1980 and after working in urban hospital medicine in both the Waikato and Auckland regions, entered general practice on January 1, 1987. He says he never thought about going specifically into rural health but wanted to go to a place that was "furthest away from a base hospital in Northland" because he wanted to move away from hospital medicine.

"One of the things that rural medicine does is gives you the chance to utilise all of your skills. Because I was an experienced doctor who had worked in hospitals and trained in paediatrics for something like five years I knew that the very reason for going into generalist medicine was to utilise every aspect of my skills that I had acquired in the course of my training.

"When I looked at urban practice I felt that there were many aspects of care that were missing such as minor trauma and obstetrics that were exiting general practice and these were part of my skill base that I wanted to explore and not lose."

The future

Tim says he will "almost certainly" spend his working life in the Wellsford practice. "It's a job unfinished. There will be aspects of my work that will alter, meaning that the component of clinical medicine is already altered. "I did 9/10ths for 19 years, all general practice but I am involved in health administration as a clinical director of a PHO, as well as the business side of my own practice and I am looking at an academic-type post as well in due course as part of the activities we have been involved in multi-disciplinary team teaching programmes."

He is also interested in change management in health and believes that the health care delivery systems in use now will not be there in 10 years from now. The issue is how will health care evolve and into what?

Perhaps he already has the answer.

NEW ZEALAND
RURAL
GENERAL PRACTICE NETWORK

Hear Ye! - NZRGPN Conference 2010

The New Zealand Rural General Practice Network's annual conference will be held in Christchurch, from March 11-14, 2010.

The theme is "Rural health – No.8 Wired" with a focus on the entire rural general practice team featuring workshops, education and plenary sessions and exhibition area.

Thursday features pre-conference workshops including rural hospital and rural GP teaching and employment workshops.

Friday morning sees the official conference launch followed by keynote practice, political and concurrent sessions (including pain management and prevention, frontiers in nursing communication, fracture management and wilderness medicine).

Saturday features workshops on transport, nursing, supporting and resourcing grieving families and "Hot Topics - Get it off your Chest".

Come and network, learn and have some fun with your colleagues. Come to the cocktail function and/or the dinner.

Partners! Come along and visit the Ellerslie Flower Show on the same weekend or just take in the sights of Christchurch.

To register visit www.rgpn.org.nz
Telephone Rob Olsen on 04 495 5887
Or email: rob@rgpn.org.nz

Take advantage of the Early Bird rate available until January 31, 2010 and go into the draw to win 1 of 10 tickets to the Ellerslie Flower Show.

www.rgpn.org.nz