TE PUAWAI

The Blossoming

The Professional Update for Registered Nurses

August 2015

TE PUAWAI

The Blossoming

Whakatauki

Kia tiaho kia puawai te maramatanga

"The illumination and blossoming

of enlightenment"

This whakatauki highlights the endeavours of the College of Nurses as an Organisation which professionally seeks enlightenment and advancement.

ISSN 1178-1890

College of Nurses Aotearoa (NZ) Inc

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Disclaimer

The College of Nurses Aotearoa (NZ) Inc provides Te Puawai as a forum for its members to express professional viewpoints, offer ideas and stimulate new ways of looking at professional practice and issues. However, the viewpoints offered are those of the contributors and the College of Nurses does not take responsibility for the view points and ideas offered. Readers are encouraged to be both critical and discerning with regard to what is presented.

Editorial

Professor Jenny Carryer
RN, PhD, FCNA(NZ) MNZM
Executive Director

I recently bought a book in an Australian airport bookshop entitled Nurses of the Outback and written by Annabelle Brayley (Penguin books).

My interest was sparked because I had just spent a week trekking in the Australian outback beside 10 camels, which kindly carried our food and swags and other gear. We struck an extremely cold week and felt very intrepid (and frozen) as we lay down in our swags each night on the rocky ground without the benefit of tents or shelter of any kind! So the outback was still on my mind alongside the need for a good "plane read" having exhausted everything available on my kindle.

The book provided the true stories of fifteen outback nurses including vignettes of events they had dealt with in the course of their clinical practice. The book was highly readable and quite thought provoking. I noticed how very much these nurses became key figures in their remote communities and how much they were called upon in the broadest way to provide support and care in social situations, to treat injured animals! to provide daily primary and preventative care, to manage social crises and to respond to the most severe events involving cars, helicopter crashes, guns, knives, fire and other trauma.

There was another recurring theme, which intrigued me. Most of these nurses had, at one time or another, because of various life events spent a period of time in a hospital setting or a more urban General Practice. They had, almost universally, hated it and the comment that cropped up most frequently was " I had no autonomy". They were relieved to get back to the remote areas and to take up their role as outback nurses

Despite the enormous responsibility they accepted in lonely and isolated situations with back up many hours away, they thrived on the feeling of being vitally needed and responsible and accountable for their own decision-making. And they seemingly thrived on their visibility. This was the case in a range of circumstances from the very minor to the quite extreme. The nurses enjoyed and valued the opportunity to know their community so well and to have the authority and autonomy to determine the nature of their own practice without having to seek permission or approval.

The book suggests that inland Australia literally runs on "nurse power".

I noted how these nurses grew and flourished personally and professionally in the context of that responsibility and authority. It made me think about the environments in which nurses more usually practice where they often seem constrained by the fear of overstepping some invisible mark and fearful of some kind of imagined retribution for working outside their "scope of practice". I note how often nurses especially in primary care settings so regularly make the statement "we are not allowed to do that" although no one is ever completely clear about who is withholding permission.

Such caution is in complete contrast to the outback settings where nurses are looked up to as substantial figures of authority and value in their community. I think the public more commonly see nurses (if they see them at all) as shadowy figures in the background unless they have had personally close encounters. This position is consistently enforced or reflected by the media who cite "doctors say" at every possible opportunity and rarely if ever seek or report a nursing opinion or view-point. Some level of public perception was conveyed in research we did with General Practice patients who used words such as "I don't think the nurse is allowed", "I think she would need to ask the doctor" and "of course I wouldn't ask the nurse about that".

There is a level of feedback loop operating here. Autonomy breeds confidence, authority, independence and visibility. Lack of autonomy or lack of clarity about autonomy fosters uncertainty, timidity, silence and fear. A profession which is often silent and fearful is easily rendered invisible and marginalised. There is much food for thought here. My imagined simple "plane read" led to some prolonged reflection. I began to think about how, without recourse to the Australian outback, we could confidently claim and assert the same level of autonomy over who we are, what we do and our right to determine exactly how it is done. There is a need to sever the feedback loop and I am still thinking about that…… there are clearly some nurses who have managed to do so but not nearly enough.

Long Acting Reversible Contraception For Teens: the case *against* a universal opt-out programme

Article Supplied by: George Parker, Strategic Advisor, Women's Health Action Trust

George Parker is Strategic Advisor at Women's Health Action Trust in Auckland and is also a Doctoral Candidate in the Department of Sociology at the University of Auckland. George's doctoral research is examining the politics of maternal body weight during reproduction through the lens of reproductive justice.

In a highly publicised opinion piece in the British Journal of Obstetrics and Gynaecology (BJOG debate) this month, Senior Lecturers in Bioethics and Women's Health at the University of Otago have called on the New Zealand government to fund a free universal LARC (long-acting reversible contraceptive) programme to be made available to all teen girls *before* they become sexually active[i]. The programme, reminiscent of the New Zealand HPV Immunisation Programme[ii], would be offered universally to all teen girls, presumably in a school-based programme, and would be 'opt-out', meaning all teen girls would be assumed to participate unless they expressly declined. The scholars- Drs Neil Pickering and Lynley Anderson (Bioethics) and Dr Helen Patterson (Obstetrics and Gynacology)- argued that such a programme would be defensible, and indeed a good and logical Government investment, because of the effectiveness of LARCs in preventing pregnancy, the absence of evidence that insertion of LARCs in adolescent girls is harmful and poses risks to future fertility, and because of the high costs to both individual, state and society of teen pregnancy. The scholars defended the heavy-handedness of an 'opt-out' approach on the basis that it would support health equity by making sure all young people had access to the programme and weren't disadvantaged by a failure to opt-in.

The opinion piece, structured as a debate, was countered by an opposing opinion by Associate Professor Alison Edelman, an Obstetrician Gynaecologist and Co-Director of Family Planning Fellowship, USA[iii]. Edelman argued that the risks of harm from LARCs, including rare but significant adverse events, as well as unpleasant side effects (which have been shown to be higher in younger women), in the absence of certainty of benefit (ie. If the adolescent girl was not yet sexually active and had no plans to be) outweighed the potential benefit of preventing an unplanned pregnancy. Edelman emphasised the vital role of LARCs in 21st century contraceptive choices for women and the danger of generating a generation of young women who might be dissatisfied with their adolescent experience of LARCs and who may go on to hold a bias against this method into adulthood. Edelman concluded that on the basis of these risks a universal LARC programme for teen girls before they were sexually active could cause more harm than good.

While troubling, this debate may not have warranted further examination had it not been for the ensuing sensationalist and partial coverage of the issue by the New Zealand news media. The University of Otago's PR machine publicised the BJOG debate with a poorly constructed media release 'Long-acting reversible contraceptives for adolescents advocated' that presented the 'pro' side of the BJOG debate by the University of Otago scholars whilst ignoring the 'con' side presented by Edelman. The resulting flurry of headlines in major news media outlets including 'Opt-out contraceptive programme proposed to curb teen pregnancy rates'[iv], 'Long-term contraceptive for all teens in NZ? Working in Colorado'[v], and 'Free Contraception suggested for pre-teens'[vi] similarly failed to report on the 'con' side of the debate. In its coverage of the 'pro' side of the debate media reporting trumpeted the well-worn moral panic about teen pregnancies as significant social problems of such a scale that drastic measures are warranted to prevent them. For example, in 'Free Contraception suggested for pre-teens' which was featured on the front page of the print copy of the NZ Herald, the University of Otago scholars were quoted as saying 'the children of teen pregnancies do poorly in statistics related to poverty, imprisonment and teen pregnancy. In a worryingly large number of cases, pregnancy in the teenage years is bad for the teenager, is bad for the child of the teenager and it is bad for both of them during the whole pregnancy. Obviously that also impacts on society.'[vii]

This is the latest concerning example of a slew of recent proposals in New Zealand, some that have already been enacted in policy, intended to control who has babies, and when, by shaping women's contraceptive choices and other aspects of their reproductive lives. In 2012 we saw debate over the announcement of government funding for free LARCs for beneficiaries[viii], part of an unprecedented package of welfare reforms directly intended to regulate the reproductive choices of women in receipt of welfare, that also included the introduction of sanctions for women who had a subsequent child whilst in receipt of sole parent assistance[ix]. Women's Health Action opposed the funding of free LARCs for beneficiaries, not because we don't support access to free or cheap contraception for all women- we do! We opposed the funding because the principles of reproductive autonomy, informed consent, and gender equity dictate that women should not alone bear the responsibility for unwanted pregnancy and its consequences, and that state intrusion into women's reproductive bodies and choices is a slippery slope that history tells us results in the most punitive and unjust outcomes for those women already the most marginalised – the young/old, disabled, poor and women of colour. It was also our position that while LARCs are a very important addition to contraceptive choices, there is no one size fits all contraception and all women should have access to a full range of contraceptive choices and be able to make informed decisions about the method that's right for them. This is a tenet of 40 years of global feminist women's health advocacy.

It is for similar reasons that Women's Health Action opposes the proposal to fund a universal LARCs programme for teen girls prior to the commencement of sexual activity. We strongly support engaging young people in comprehensive culturally and age-appropriate sexuality education and sexual health services throughout their school years that includes information about positive body image, sexual pleasure and negotiation, consent and safety, and access to a range of choices for preventing sexually transmitted infections and unwanted pregnancies[x]. We have continued to call for the prioritisation of improvements to sexuality education on the back of the Education Review Office's 2007 report[xi] on the teaching of sexuality education in years 7-13 that found widespread failings and regional inconsistencies in how sexuality education was being delivered. However, we recoil from the proposal to single out young women before they are sexually active, and a single contraceptive choice- LARCs, as a strategy to prevent unwanted pregnancies. In addition to the important issues raised by Edelman relating to the risks of adverse outcomes and side effects without certainty of benefit, we believe there are a number of other flaws with the proposal from a public health and gender justice perspective. We believe that rather than engaging young women in sexual health decision making such a programme risks rendering them disempowered passive recipients of a contraceptive choice made for them before they are ready to even contemplate the negotiation of safe sex let alone make informed decisions about it. Not only does this undermine the ethnical principle of informed consent, it also ignores young men's role in the prevention of unwanted pregnancy altogether, and silos pregnancy prevention from other aspects of sexual health promotion. This is counter-productive from a public health perspective because it assumes and communicates heterosexuality and penetrative heterosex as "the normal" expression of teenage sexuality invisibilising less risky sexual expression, potentially adds to condom avoidance thus increasing the risk of sexually transmitted infections, and because it ignores overwhelming evidence of the vital connection between young people being informed and motivated about their sexuality and their ability to negotiate safe and consensual sex[xii]. In other words, like Edelman, from a public health perspective such a programme could pose more harm than good.

We also believe that that such a programme, by targeting only young women for unwanted pregnancy prevention, would contribute to and reinforce the gendered stereotype that sexual health and pregnancy prevention are "girls problems" and of young men as sexually irresponsible. This undermines efforts to promote egalitarian sexual and intimate relationships between young men and women and therefore the goals of gender justice. There is strong evidence that messages about sexual health responsibility are already highly gendered. In their analysis of sexual health messages in young adolescents' media, Hurst et al[xiii] found that the media typically portrayed boys and men in stereotypical ways as physically strong and mentally dominant, obsessed with sex and sexual performance, and disinterested in sexual health and their own or their partners pleasure. Teen fathers were routinely represented as absent. In contrast media represented teen pregnancy as a "girl's problem", and girls as solely responsible for contraception, STI prevention and for the children resulting from teen pregnancies. In the rare instances when condoms were discussed or depicted, boys had condoms as a kind of toy, whereas girls were more knowledgeable and more likely to have a condom when it was needed. Hurst et al conclude that given evidence of the important role played by the media as a source of information for young people about sex the mixed messages young men and women receive in the media about sexual health decision making are of concern. They argue that 'By reinforcing traditional gender stereotypes of males as sexually obsessed and females as responsible for access and consequences, such content may reinforce the cross purposes at which many young men and women approach their romantic and sexual relationships, especially for those adolescents who model their behaviour on such media portrayals'.

Troublingly gendered stereotypes about sexual health decision-making are not confined to the media. In their study of young peoples' views about the quality of sexual health services and education, DiCenso et al[xiv] found that young men and women were governed by different expectations and codes of behaviour based on gender stereotyping, with young women receiving the message that their sexual desires were mild compared to young men and that young women were responsible for being level headed and for using birth control. It is clear that sexual health initiatives are vulnerable to inadvertently reproducing gender stereotypes and bias.

Further, from a reproductive justice perspective, we must resist the notion that only particular kinds of women are able to be "good mothers" and are worthy of support and esteem. Reproductive justice was first articulated by women of colour and indigenous women in the United States, and is a framework that asserts, as women's fundamental human rights, the right to have children, to not have children, and to parent the children they have in a safe and healthy environment. It extends the notion of reproductive choice by pointing to the racial, economic, cultural, and structural constraints on women's power to control their reproductive destinies[xv]. From a reproductive justice perspective, young women should have the right, and means, to prevent a pregnancy, but should also be supported to mother should that be their choice and/or circumstances. A reproductive justice lens points to the role played by the social positioning of teen mothers including their subjection to isolation, stigma, discrimination and poverty as major contributors to the sometimes poorer outcomes attributed to them and their children.

There is now growing evidence that poor maternal-child outcomes associated with early childbearing have been overstated and may be explained by teen mothers' childhood disadvantage and adversities[xvi]. In other words, teen mothers and their children tend to do about as well or as poorly as mothers and children who are older but from similar backgrounds[xvii]. Further, because mothering is so often the core of a young mother's identity it can actually be a catalyst for reducing risky behaviour, and teen pregnancy and parenting represent opportunities to validate teens' strengths and aspirations offering something of a turning point in their lives[xviii]. SmithBattle[xix] argues that what matters profoundly is the "frame" that society holds about teen mothering: 'The frame that teen mothering is a disaster for mothers and their children correlates with stigmatizing practices and misguided policies. Reframing teen mothering as an opportunity to support teen mothers' emerging identity, new sense of purpose, and reduced risk taking are worthy ends that deserve to be heard and reinforced by clinicians, educators, and sound social policy.' In order to achieve reproductive justice for young women we must be alert to, and address, representations of teen mothers as risky subjects that are a scourge to society and look for opportunities to represent a more positive and empowering frame which can sit alongside and reinforce knowledgeable and empowered sexuality and sexual decision making including contraceptive choices.

Finally this debate is a lesson on the need to broaden discussions about women's sexual and reproductive lives beyond the logics of biomedicine and to incorporate critical social and health science perspectives. This will help ensure gender aware and equitable sexual health proposals and policies that address the need for all sexual partners, regardless of their gender and age, to share responsibility for sexual and reproductive matters. This will also help reframe the persistent negative framing of teen pregnancy and mothering improving the life chances for young women and their children. This will bring us closer to the important public health goal of positive sexual health for young people as well as progressing gender and reproductive justice for all.

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[i] Pickering, Neil, Lynley Anderson, and Helen Paterson. "Teens and young adults should be started on long-acting reversible contraceptives before sexual activity commences: FOR: An opt-out programme would avoid teen pregnancy and associated costs." *BJOG: An International Journal of Obstetrics & Gynaecology*122, no. 8 (2015): 1052-1052.

[ii] Parker, Christy. "One for the girls?: Cervical cancer prevention and the introduction of the HPV vaccine in Aotearoa New Zealand." *Women's Studies Journal* 24 (2010): 25-39.

[iii] Edelman, Alison. "Teens and young adults should be started on long-acting reversible contraceptives before sexual activity commences: AGAINST: Pre-emptive use without need or benefit may cause more harm than good." *BJOG: An International Journal of Obstetrics & Gynaecology* 122, no. 8 (2015): 1052-1052.

[iv] http://www.stuff.co.nz/life-style/parenting/big-kids/tweens-to-teens/69838572/optout-contraceptive-programme-proposed-to-curb-teen-pregnancy-rates

[v] http://www.stuff.co.nz/life-style/parenting/pregnancy/conception/69985709/longterm-contraceptives-for-all-teens-in-nz-its-working-in-colorado

[vi] New Zealand Herald, 30th June 2015, retrieved from: http://www.nzherald.co.nz/lifestyle/news/article.cfm?c_id=6&objectid=11473471

[vii] Ibid

[viii] Retrieved from: http://www.workandincome.govt.nz/individuals/a-z-benefits/sng-contraception.html

[ix] Retrieved from: http://www.workandincome.govt.nz/individuals/benefit-changes/dpb-sole-parents.html

[x] Allen, Louisa. "Young People and Sexuality Education: Rethinking Key Debates." *Palgrave Macmillan* (2011).

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[xiv] DiCenso, Alba, Vicki W. Borthwick, and Catia Creatura. "Completing the picture: adolescents talk about what's missing in sexual health services." *Canadian Journal of Public Health* 92, no. 1 (2001): 35.

[xv] Why is reproductive justice important to women of colour? Retrieved from: http://sistersong.net/index.php?option=com_content&view=article&id=141

[xvi] SmithBattle, Lee. "Reframing the risks and losses of teen mothering." *MCN: The American Journal of Maternal/Child Nursing* 34, no. 2 (2009): 122-128.

[xvii] Ibid

[xviii] Ibid

[xix] Ibid pg. 128

Welcome To New College Board Member

Kia ora koutou katoa, it is our great pleasure to welcome Lorraine Hetaraka-Stevens to the College of Nurses Board. Lorraine joins the Maori Caucus and replaces Margareth Broodkoorn who will step down in October. Lorraine brings a wealth of experience particularly in primary health care and Maori workforce development. No reira, e te tuahine…nau mai

Lorraine Hetaraka-Stevens, Ngāti Kahu, Ngāti Ranginui, Te Arawa.

Lorraine is Nursing Director at ProCare, Aotearoa's largest network of general practice teams. ProCare's members deliver care to more than 800,000 enrolled patients across Tāmaki Makaurau. Its diverse network is made up of over 600 nurses and 600 GPs. Lorraine is also a Nga Manukura o Apopo graduate from the leadership programme cohort one.

Photo credit: Aerial Vision for Nursing Review NZ

Prior to her appointment Lorraine held the position of Associate Director of Nursing Māori at Auckland District Health Board, a joint appointment with the University of Auckland. She is a Fellow and Board member of the College of Nurses Aotearoa (NZ) and a member of the Nurse Executives of New Zealand (NENZ). Her areas of interest are primary care, workforce development and improving Māori health outcomes.

Nga mihi,

Taima Campbell, RN, MHSc (Nsg), PG Dip Bus (Māori Dev)
Board Co Chair (Maori)

NURSEPRENEURS - Taking The Leap And Being Bold - A Nurse Led Business To Build Resilient Youth - Today

Article Supplied by Pat Mitchell and Maria Kekus, Co-Directors, Health Connections

Health Connections is a small business focused on building resilient youth - today. We believe healthy, well connected youth are key to a positive future for Aotearoa, New Zealand. Health Connections provides services to empower youth, their families and whanau and key agencies to enhance the health and wellbeing of young people.

Health Connections is a partnership between 2 nurses - Pat Mitchell, RN, MN and Maria Kekus, RN, MN, NP.

Maria Kekus, RN MN NP

Maria is a Nurse Practitioner for Child and Youth with experience of working for many years in the primary health care sector both in the UK and NZ. What drives Maria is pushing the sector to look at different models of care that are responsive to the health needs of our youth, including supporting health and allied health professionals to work effectively with young people. Maria not only brings the clinical expertise but also a strategic approach to the business.

Pat Mitchell, RN MN

Pat's journey has navigated a range of youth health clinical settings both in the UK and NZ. These have included working with young people who offend, specialist drug and alcohol services, mental health and youth health services. A post graduate nurse leadership course gave Pat pause for thought which resulted in working in quality improvement; using change management skills to effect change on a wide scale. Pat's experience includes operational management and the design and development of services for young people.

Between the two of us we bring different skills but the same passion for improving the health and wellbeing of young people. Nursing has provided us both with the core knowledge and skills we use in the business. These include clinical, operational and leadership. Our diverse nursing experience has provided the foundations for the business credibility and growth.

Having worked together before we recognised how our complementary skills leant towards innovative methods and approaches to improving outcomes for young people. We believed that a private business would allow for greater scope for us to use these approaches and methods.

Our journey began with a simple conversation, after a hellish day of health politics, clinical complexity and operational frustrations. What could be achieved outside the ‘system’? What could we do differently and what would it mean to us, our families and of course outcomes for young people.

And we dreamed – we dreamed of a world without contracts and limits; an environment in which all things are possible. We knew we were armed with clinical skills and experience and had developed a network which had always been supportive.

So, feeling brave and being bold, we explored a nurse led business. The dreaming stopped and the bright light of harsh reality shone in; a world of seeking contracts, revisiting networks and building business credibility. As in all good stories though, the original dreaming overrode and we leapt the abyss from the safety of paid employment to a nurse led business.

A priority for us was acquiring a business mentor we trusted and who fitted with our values. The first question posed by our mentor whilst we were exploring a nurse-led business was framed as ‘why are you playing at being business owners – take the leap or leave’. This was an eye opener for us. Yet it gave us the motivation to be brave and take the leap.

Being open and transparent with each other and exploring the eternal question of ‘are we on the same page’ was key to our bold leap. We revisited nursing leadership and business literature and invested a lot of time formulating our vision and values and understanding our goals, both personally and professionally. We have always had a true belief in our vision of improving outcomes for young people as well as believing that this can be done in partnership with agencies wanting to be innovative, able to stretch the boundaries and take risks. We looked into the legal perspective of business ownership exploring the hard ‘what if..?’ questions. In doing so we learnt a lot about each other, ourselves and ultimately our business.

Together, we also tested the water with our networks – Should we? Would you? Will you contract us? And, with nods and positive encouragement, we rode the initial wave of seeking our first contracts and learnt a huge amount along the way. We learnt quickly that we needed to rebrand ourselves as Health Connections and invested a significant amount of time in rebuilding our networks, building trust as business owners and credibility for Health Connections.

The leap into business was closely aligned with our personal challenges for a greater work/life balance, a challenge for most nurses. We wanted to have a greater flexibility to manage work around family as opposed to the opposite.

Our greatest gift has been the involvement of a Kaumatua who has guided our work culturally and who has supported our growth in confidently partnering with diverse cultures. This has also been the catalyst for growing the Health Connections network who work with us and includes youth health practitioners and other youth professionals.

Our partnership approach is designed to develop a true collective impact. Practically this looks like a triad of expertise, young people and the agency contracting us, with Health Connections as a central reference point. Our partnership approach up-skills all participants and leaves a sustainable model with the contracting agency and young people for their continued use in the future.

Partnering with agencies that want to work differently has been hugely empowering for us as a small business. Interestingly these partnerships have been with NGO, philanthropic agencies and Iwi providers rather than public sector. It is unclear why the public sector does not take the opportunity to partner with potent and responsive private sector businesses to improve outcomes for the populations they serve.

Using outcomes for young people as the first and last part of conversations with agencies that contract us is a key and pivotal difference for being in business. Being embraced for our skills, experience and knowledge in these partnerships has been refreshing.

We have faced a few challenges along the way including the use of social media to spread the word; a medium that we have both used personally and are now rapidly learning to use effectively to promote Health Connections.

Selling our ‘product’ and pricing for our services has been one of our biggest learnings. Whilst we have provided ‘pro bono’ work, it has not always been as smooth as we would have anticipated – for example what we were able to offer pro bono as oppose to what was expected from the agency. We reflected that often in our previous salaried roles we provide a significant amount of work and expertise that is never accounted for in terms of budgets and yet is often expected by the sector, planners and funders, operational managers and colleagues. This has also meant managing relationships within our networks and their expectations of us.

Letting go of the systems we wanted to work outside of has taken some time. We adopted some of the most restrictive systems, for example having a sense of accountability to statutory funders as opposed to the communities we are serving. By losing the restrictive systems, we are more confident business owners with young people at the centre. Embracing the challenge and truly being bold in our decisions has been an area for growth and learning. On reflection, we have perhaps been somewhat conservative and reserved in our approach to business decisions and profiling our products as we started the business journey.

We are passionate about continuing to develop our business whilst maintaining our core vision and values. Central to everything we do is the ‘added value’ question of ‘does this improve outcomes for young people?’

Sharing our nursing and business expertise as widely as possible is important to us. Health Connections as a business demonstrates that nurses can be business leaders and are well placed to drive change and improve outcomes for their clients. Bring on more nursepreneurs!

We are looking forward to partnering with more innovative agencies and sharing our expertise. You can find out more at www.healthconnections.co.nz and sign up for our updates, or follow us on Twitter @HealthConNZ and Facebook.

NOTICE OF

ANNUAL GENERAL MEETING

for

College of Nurses Aotearoa (NZ) Inc.

to be held

5.30pm
Wednesday, 7th October 2015

at the

Executive Suite
Massey University
Wellington

followed by speaker -

Professor Jenny Carryer

Executive Director, College of Nurses

Learning From Workshops Held
With Emerging Primary Health Care Leaders
Considering The Current Health Strategy Refresh

College of Nurses members please RSVP to the College office -

email - member@nurse.org.nz

AGM Remits: Individuals or regional groups may submit remits for consideration at the Annual General Meeting. Remits must be in writing and received at the College office no later than **7th September 2015.**

A copy of the College rules is available on the website

www.nurse.org.nz

Nursing Praxis Becomes An e-Journal

The Editorial Board of Nursing Praxis in New Zealand advised in the March edition of Nursing Praxis that from the July 2015 issue, Nursing Praxis will become an e-journal. There will no longer be print copies mailed to Nursing Praxis subscribers.

All College of Nurses members will continue to receive Nursing Praxis as part of their College membership, but now as an e-journal. You will have full access to current and past editions of the Nursing Praxis journals.

College members will be notified of the release of each new issue via e-mail.

To access the Nursing Praxis e-journal you will need to log on to the Nursing Praxis website www.nursingpraxis.org

The **User Name** and the **Password** have been advised to College members via e-mail. When logging on for the first time you will be asked to change the password to one that is personal to yourself by following the links on the website. You will then have full access to Nursing Praxis journals at all times.

For those College members who have already had online access to Nursing Praxis, no change will occur.

Moving House or Changing Job

Please remember to update your contact details with the College office.

Email: admin@nurse.org.nz

Diagnosing Cancer – Turtles, Birds or Rabbits?

Reprinted with the kind permission of the Auckland Women's Health Council Newsletter

In an article entitled "Overkill" in the 11 May 2015 issue of the *New Yorker* Atul Gawande describes how an avalanche of unnecessary medical care is harming patients physically and financially, and asks what can we do about it. (1) Atul Gawande, a surgeon and public health researcher, has been a *New Yorker* staff writer since 1998. He was in New Zealand at the Auckland Writers' Festival in May this year talking about his latest book "Being Mortal."

In his lengthy article Atul Gawande refers to the latest book by H. Gilbert Welch, a Dartmouth Medical School professor, who is also an expert on overdiagnosis. In his book "*Less Medicine, More Health*," (2) Welch explains the phenomenon in this unique and unforgettable way:

"We've assumed that cancers are all like rabbits that you want to catch before they escape the barnyard pen. But some are more like birds—the most aggressive cancers have already taken flight before you can discover them, which is why some people still die from cancer, despite early detection. And lots are more like turtles. They aren't going anywhere. Removing them won't make any difference.

We've learned these lessons the hard way. Over the past two decades, we've tripled the number of thyroid cancers we detect and remove in the United States, but we haven't reduced the death rate at all. In South Korea, widespread ultrasound screening has led to a fifteen-fold increase in detection of small thyroid cancers. Thyroid cancer is now the No. 1 cancer diagnosed and treated in that country. But, as Welch points out, the death rate hasn't dropped one iota there, either. (Meanwhile, the number of people with permanent complications from thyroid surgery has skyrocketed.) It's all over-diagnosis. We're just catching turtles.

Every cancer has a different ratio of rabbits, turtles, and birds, which makes the story enormously complicated. A recent review concludes that, depending on the organ involved, anywhere from fifteen to seventy-five per cent of cancers found are indolent tumors—turtles—that have stopped growing or are growing too slowly to be life-threatening. Cervical and colon cancers are rarely indolent; screening and early treatment have been associated with a notable reduction in deaths from those cancers. Prostate and breast cancers are more like thyroid cancers. Imaging tends to uncover a substantial reservoir of indolent disease and relatively few rabbit-like cancers that are life-threatening but treatable.

We now have a vast and costly health-care industry devoted to finding and responding to turtles. Our ever more sensitive technologies turn up more and more abnormalities—cancers, clogged arteries, damaged-looking knees and backs—that aren't actually causing problems and never will. And then we doctors try to fix them, even though the result is often more harm than good.

The forces that have led to a global epidemic of overtesting, overdiagnosis, and overtreatment are easy to grasp. Doctors get paid for doing more, not less. We're more afraid of doing too little than of doing too much. And patients often feel the same way. They're likely to be grateful for the extra test done in the name of "being thorough" – and then for the procedure to address what's found." (1)

The story of one of Atul Gawande's patients, Mrs E provides a telling and very insightful example of the human cost of all this testing.

Mrs E, a woman in her fifties, had had surgery for a thyroid lump. The biopsy revealed that the lump was benign. But the pathologist examining the specimen found a pinpoint "microcarcinoma" next to it. It was just five millimetres in size. Some experts argue that we should stop calling these microcarcinomas "cancers" as they are very unlikely to turn into dangerous cancers.

The surgeon told Mrs E about the tiny cancer that had been found and ordered regular ultrasounds every few months to monitor her thyroid. When another five millimeter nodule was found he recommended removing the rest of her thyroid. When the surgeon had to cancel the planned surgery Mrs E was referred to Atul Gawande. He advised her that she really didn't need surgery and the operation posed a greater risk of causing harm – vocal-cord paralysis and life-threatening bleeding – than any microcarcinoma she had. Removing her thyroid would also result in the need to take a daily hormone-replacement pill for the rest of her life. She would be better off being monitored with regular scans.

But Mrs E was too fearful of the tiny "cancers" she was told she had, and opted for surgery. "Given that the surgery posed a greater likelihood of harm than of benefit, some people would argue that I shouldn't have done it," Atul Gawande writes. "I took her thyroid out because the idea of tracking a cancer over time filled her with dread, as it does many people. A decade from now, that may change. The idea that we are overdiagnosing and overtreating many diseases, including cancer, will surely become less contentious. That will make it easier to calm people's worries. But the worries cannot be dismissed. Right now, even doctors are still coming to terms with the evidence."

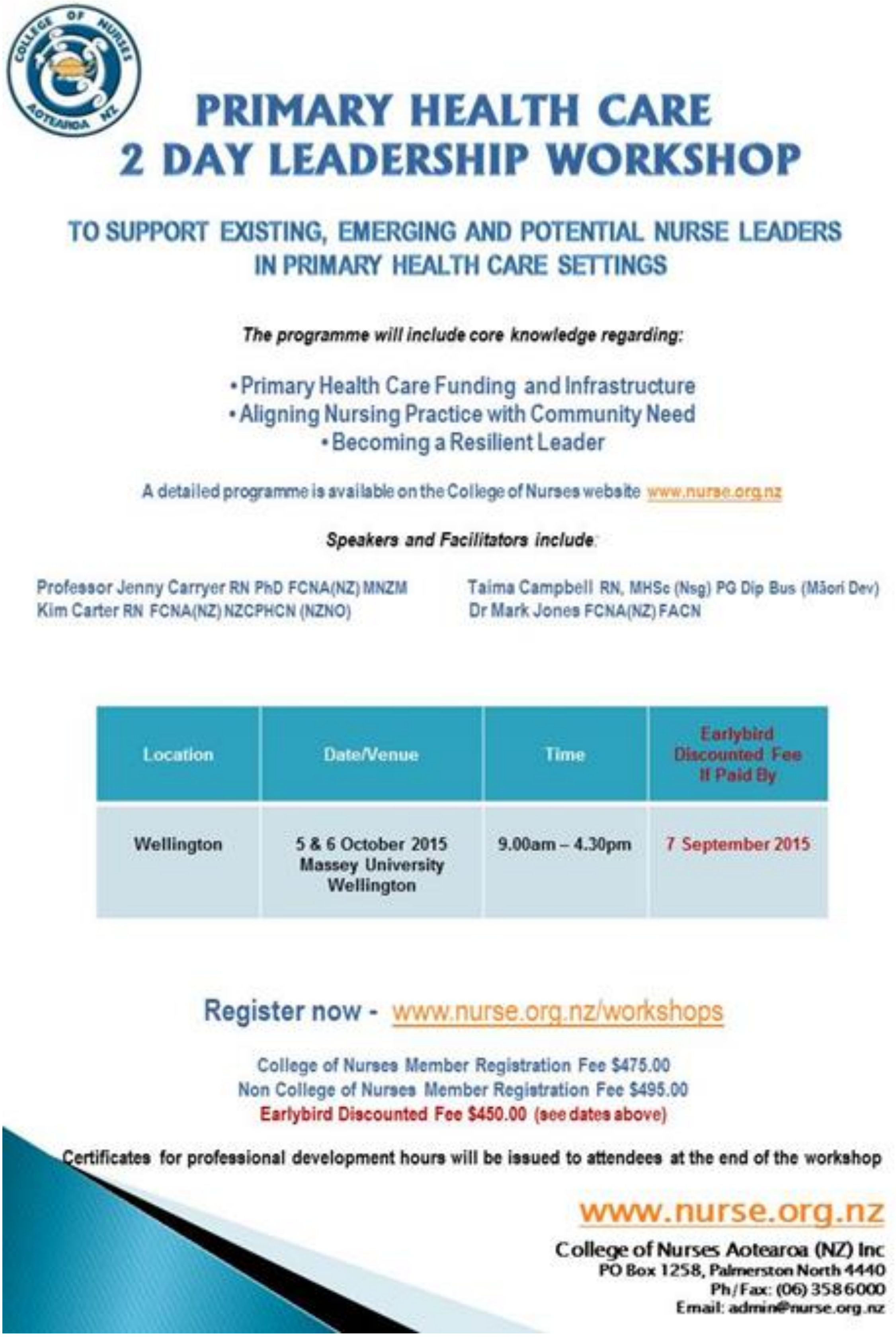
Mrs E had post-surgery complications. Two hours after the operation she began to bleed and had to be rushed back into the operating room to find and fix the cause of the bleeding. While she suffered no permanent harm and made a full recovery, she had to take a pill for the rest of her life.

She was also extremely grateful. "She thanked me profusely for relieving her anxiety. I couldn't help reflect on how that anxiety had been created. The medical system had done what it so often does: perform tests, unnecessarily, to reveal problems that aren't quite problems to then be fixed, unnecessarily, at great expense and no little risk."

However, these issues are now starting to be addressed. The third international conference on preventing overdiagnosis will take place in Washington in September. (3)

References

1. http://www.newyorker.com/magazine/2015/05/11/overkill-atul-gawande
2. H. Gilbert Welch. "*Less Medicine, More Health*." Beacon Press 2015.
3. http://www.preventingoverdiagnosis.net/?p=830



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