toms and cause abdominal pain similar to peritoneal irritation.[4] Our case highlights the afferent arm of the reflex (located in the external meatus) and the efferent arm of the vagus innervating the cardiac plexus; causing noticeable cardiac deceleration–asystole. It must be noted here that a diet-controlled diabetic patient could well have diabetes-induced dysautonomia which could have enhanced the above mentioned symptoms.[5,6]

Asystole is a quite common and dreaded complication in emergency. The common mnemonic of 6Hs and 5Ts are a useful reminder (Table 1). This case was unusual in the sense that the patient already had a hyper-responsive vagus nerve but was not investigated for it.

This case highlights the fact that there is no procedure with zero risk and, albeit in some cases patients describe symptoms vaguely, one must be wary that rare cases are unusual, but they do occur.

WHAT GAP THIS FILLS

What we already know: Ear sunctioning or syringing is a commonly performed procedure in primary health care to remove ear wax which is causing symptoms such as discomfort, tinnitus or hearing loss.

What this study adds: Even the most common and benign of medical interventions can have serious adverse effects or cause fatality.

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LETTERS TO THE EDITOR

Nurse and medical (general) practitioners

Dr Bill Douglas's letter[1] requires correction of a number of misconceptions. I hold a National Minimum Data Set for New Zealand (NZ) Nurse Practitioners (NPs) collected when the total number of NPs was 50 (now 65). Only four had original registration in the US, thus clearly refuting the assertion that many NZ NPs are US-trained and rendering irrelevant many of the comments made. There is similarity between the two countries: both regulate the role of NP and require the full Master's degree and relevant clinical training. Clear data on other aspects of NZ NPs is also available.

Production of NPs in NZ is of variable duration depending on how each nurse takes that journey and how much support is given. Dr Douglas's suggestion of 10–12 years of personal and employer cost is inaccurate. All nurses undertake a self-and tertiary-funded three-year Bachelor's degree, before commencing paid contribution to the health sector. Within one to two years they may choose to commence the two-year Master's degree; most do this as part-time students over four to five years while building clinical hours in paid practice. Master's course fees are paid either by the Clinical Training Agency (CTA), occasionally by employers and often by nurses themselves. Some candidates apply immediately, some wait longer but all are practising as registered nurses (RNs) throughout the entire period. The full-time study equivalent is five years and clinical preparation is completed while contributing to the sector as an RN.

Letters may respond to published papers, briefly report original research or case reports, or raise matters of interest relevant to primary health care. The best letters are succinct and stimulating. Letters of no more than 400 words may be emailed to: **editor@rnzcgp.org.nz**. All letters are subject to editing and may be shortened.

Dr Douglas is correct in asserting that the process has not been simple. Difficulties have been exacerbated by widespread ignorance and failure to adopt the immense potential inherent in the role. Lack of guaranteed employment following successful authorisation is a disincentive to NP candidates. As time goes by, we see a slow improvement in awareness and support, a greater number of employers providing the needed encouragement and the number of NPs is gathering momentum.

Suggesting that interested nurses fast-track into medicine misses the essential point motivating every NP candidate. They are all passionate nurses and plan to utilise the additional skills to improve patient and client access to nursing care. Australasian research[2,3] found that NPs regarded additional skills as enabling them to provide the full episode of care in a valuable blend of skills. NPs are very cost-effective to produce and offer a transformative model of service delivery much needed by many consumers of current services.

Professor Jenny Carryer

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Support for men's health initiatives

As rightly identified in the December 2009 issue, men's health is an important area largely ignored in this country to date. As such I applaud the leadership shown by the Journal's editorial team in dedicating an issue to this important topic. This is a significant contribution to the almost nonexistent New Zealand–specific literature on the topic.

Despite the minimal focus given to this topic from within government and the health sector formally, there is a genuine groundswell of activity nationally with some excellent and innovative initiatives. Although briefly noted within Lannes Johnson's guest editorial, it is important to draw attention to, and acknowledge, the many champions, grass-roots innovations and leader organisations that exist. They offer us the opportunity to further develop the awareness, understanding, evidence base and effectiveness needed to improve men's health in New Zealand.

Examples include the first Tane Ora Maori Men's Health Conference last year and subsequent developing body. Canterbury University is entering its third year in providing a postgraduate paper in men's health and is developing an endorsed Master's degree in the subject. Christchurch is an area where services for men are really developing, in part through the coordination of the Canterbury Men's Centre. I recently saw that the Wairarapa DHB will be hosting a Men's Mental Health Promotion Symposium shortly also.

Numerous NGOs are forging ahead and developing a strong men's health presence within their social marketing campaigns. The Families Commission has been supporting innovative research. A groundswell of community activity is also developing, with each community fostering different initiatives to meet an increasingly apparent need. Men's Sheds are taking off in New Zealand, building on models in Australia and elsewhere, and their first conference is planned for April this year. Internet-based and general information sources (for example DIYfather.com) are increasingly present, providing men with access to vital information and support.

My challenge to all involved in men's health is to no longer wait for the Government or Ministry; to build on the leadership shown to date by many and to come together in developing a national body for advancing men's health in New Zealand. I challenge larger organisations to work together in leading such efforts and supporting the diverse and valuable grass-roots activity already underway in establishing such a forum. Well done RNZCGP for your valuable contribution and I hope your continued support of men's health development in New Zealand will be forthcoming.

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Pharmacist prescribers

Non-medical prescribing is currently a hot topic in New Zealand and Australia. In New Zealand midwives and optometrists have been authorised to prescribe within their professional practice and most recently nurse practitioners were granted authorisation to prescribe specified medicines within their scope of practice.[1] The Ministry of Health is also consulting on designated prescribing authority for podiatrists. In Australia optometrists can prescribe specific medicines;[2] the first Queensland nurse practitioners have been authorised to prescribe;[3] and several pilot studies of physicians' assistants are underway.[4]

Prescribing is a role for which the pharmacy profession is preparing itself, as part of an advanced scope of practice. Designated prescribing authority for pharmacists was proposed by the Pharmacy Council of New Zealand (PCNZ) in 2007.[5] Stakeholder feedback to this regulatory framework for advanced practitioners was positive; however collaborative practice was identified as the preferred model; pharmacists participating as prescribers within a multidisciplinary health care team.[6] Other research exploring feedback on the *Ten-year vision for pharmacists in New Zealand: 2004–2014* also found that pharmacists were positive in their agreement about undertaking enhanced clinical and collaborative roles alongside the more traditional roles.[7] However, significant barriers to a future role extension by pharmacists included a perceived lack of leadership and a unified pharmacy voice.[8]

With little Australasian evidence, the initial emphasis for implementing pharmacist prescribing must be on the accrual of evidence to support this new role, and the development of robust, credible methods to produce competent and fit-for-purpose practitioners.

In August 2008, an informal teleconference was initiated between individual pharmacist practitioners across Australia and New Zealand currently working on the advanced scopes of practice. Prescribing is a major component of that scope. The teleconference served as a useful forum for interaction, sharing ideas, projects and progress. Based on the collaboration developed over subsequent teleconferences, the group agreed that a face-to-face workshop was needed to explore issues further.

A two-day workshop at the University of Queensland was held in January 2009. Thirty people attended with interests in academia, clinical pharmacy and regulation from New Zealand and Australia. The workshop focussed on pharmacist prescribing models, pilot studies, practitioner competencies and training. It became evident from presentations that pharmacist prescribing pilot studies were using different models, methodologies and evaluation frameworks. As a result, the attendees agreed that a consistent 'evaluation framework' was needed. The framework could act as a guide for future pharmacist prescribing research and enable the alignment of research outcomes and for small studies to be combined as a more substantive evidence base. Without professional unity and such an evidence base, wider adoption of pharmacist prescribing models would be faced with ongoing scepticism.

Participants felt there was a need to continue a forum for professional interaction and consensus. In the absence of more formal mechanisms, it was proposed that this trans-Tasman collaboration continue, providing an opportunity for an aligned approach to introducing pharmacist prescribing and overcoming the many issues and barriers. For example, a lack of information on the potential role of advanced pharmacists in mental health was identified and New Zealand participants proposed to explore this further over the coming year to inform the local evidence base. The collaboration can also provide informal support and feedback as the PCNZ prepares to lodge an application with the Ministry of Health for a new scope of practice (the Pharmacist Prescriber) in the latter part of 2010.

For the pharmacy profession to adopt such an advanced scope of practice, the profession will need to speak with one voice, yet address many different models of care. The call for professional unity from the workshop was strongly supported.

We would like to acknowledge the vision and dedication of all teleconference and workshop participants. The New Zealand participants also acknowledge support from The University of Auckland and the Mental Health Pharmacy Special Interest Group to attend the workshop in Australia.

Dr Amanda Wheeler, Mr Andrew Hale, Miss Maree Jensen, Dr Ian Coombes, Dr Julie Stokes, Dr Danielle Stowasser, Dr Lisa Nissen

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