

OPINION

'I could nearly see me – the real me': A transgender nurse shares their story from 'rock bottom' to rainbow educator

BY MEL MEATES

January 17, 2024

Having survived addiction and the darkest depression during a lifelong quest to claim their identity, Manawatū transgender nurse Mel Meates believes nursing saved their life.



Photo: AdobeStock

Disclaimer/warning: The writer does not represent any group or workplace, this is their own personal lived experience. It contains suicide ideation and other things that some may find upsetting.

Everything I heard about gay and transgender people as a child and teenager were messages that it is wrong, sinful, gross, disgusting, abnormal, sick and these people should be shunned to the dark corners of society.

For many rainbow people (rainbow is an umbrella term for lesbian, gay, bisexual, trans, takatāpui, queer, intersex and other LGBTIQ+ people), negative experiences can start in childhood — often before the person even knows they are

part of that community.

It can start with hearing homophobic and/or transphobic comments. I heard these at school, in sports teams, on TV and at home.

Everything I heard about gay and transgender people as a child and teenager were messages that it is wrong, sinful, gross, disgusting, abnormal, sick and these people should be shunned to the dark corners of society.



Mel Meates today.

At some point, these things — or least some of them — become “I” statements in one’s internal dialogue, even at a subconscious level: “I am wrong”, “I am sick” etc. This is called internalised homophobia and/or transphobia.

Imagine growing up and the only thing you hear about something you have no control over is constant negativity. This deeply affects people and it affected me. Of course, kids pick on those who are different, so add severe bullying into the mix. Not being able to relate to the other girls, I played sports and had no interest in “girly” clothes and such things.

I absolutely did not want to be a lesbian.

But then I began playing sports in teams with lesbians and realised they were just normal people, like everyone else. However, I was afraid I was going to tell someone when I was drunk and it would get out before I was ready.

I learned something that I believed has saved my life many times over ... if a person who wanted to kill themselves waited just 10 minutes or so, things probably would be okay again.

At 18, two weeks after I moved out of home, I finally opened up to a counsellor with the words I feared saying: “I think I might be gay.”

When I told my mum, she told me I could never return home. Even though I didn’t want to move back, this was a huge rejection.

I went on to do some group therapy over the next couple of years. I was depressed and sometimes had dark thoughts of not being here anymore. At one workshop on dealing with depression, I learned something that I believed has saved my life many times over. They said if a person who wanted to kill themselves waited just 10 minutes or so, things probably would be okay again — not necessarily fabulous but okay enough not to kill yourself.

I had my first girlfriend at age 19. The first time we walked down the street (in Wellington) holding hands, this group of young guys approaching us began yelling out abuse. I didn’t know if we were going to be attacked, but thankfully they walked on by, “just” verbally abusing us. This was the first, but certainly not my last, experience of direct homophobia.

The ‘gift’ of desperation

I was no rebel or trouble maker — I was a quiet shy introvert. But going to Wellington’s gay bars and nightclubs, I fitted right in, not only as rainbow, but for drinking in excess. Like many who have faced adversity and a lot of hurt, I self-medicated through addiction to alcohol and drugs. My whole year when I was 20 was one long rock-bottom.

When I was at my most desperate point (of which there had been many), I regularly broke down crying to the point of physically retching.

One day, I called the psychologist who had helped me with counselling when I first came out, to ask if could I go to (now-closed) Hanmer Springs' residential alcohol and drug treatment centre at Queen Mary Hospital, because I knew some people from my therapy groups had gone there.

I knew how the world saw and treated trans people and I didn't want a bar of it – no way, I didn't want to be a 'freak'.

I just couldn't go on the way I was. I knew the hospital was a safe place, they had counsellors, they would give me a bed and they would feed me. I arrived the day after I turned 21. The hardest thing I experienced at that time, was that my parents declined to come to family week. It hurt a lot. To make it worse, I still had to attend family week with no family present.

Writing this still makes my eyes well up and I feel sorrow and compassion for that young person inside me who never felt supported.

I had what they called "the gift of desperation", which means a person is willing to try a different way of life — one with honesty, open-mindedness and willingness. I embraced this new way of living which meant I could actually have a life — because I did not want to carry on living as I had been. I attended their 12-step peer support meetings, and still do, and am pleased to say that I am 28 years clean and sober. Thankfully, having this in my life gave me support, connection with others and numerous life skills

At age 22, I saw a documentary with a transgender man in it. This was my first exposure to a trans man and it freaked me right out because it resonated with me. I knew how the world saw and treated trans people and I didn't want a bar of it — no way, I didn't want to be a "freak". So this thought — "I might be trans" — became the deepest darkest secret in the back of my head.



I realised my depression had been on and off because who can possibly live their best life if they are not living as their authentic self?

Despite being committed to my recovery, I still suffered from depression on and off. I have had many, many days in my life where I have been unable to get out of bed. I have dealt with those dark thoughts many times. It is true that, when in that space, your brain can be telling you that the world, your family and friends are better off without you and they won't even really miss you that much at all.

Suicidal thoughts are not actually about dying, they are about not hurting anymore, not feeling the way you are anymore, and possibly being just exhausted from getting by day-to-day or even minute-to-minute.

It took two decades but I got to the point in my early 40s where I had to face it and come out as trans. As I'd heard in my addiction meetings: "When the pain of change becomes less than the pain of staying the same, we change".

The pain of not facing it was just too great. So seven years ago, I came out as transmasculine, non-binary (someone assigned female at birth whose gender identity is masculine but not necessarily male).

At first I felt like I was riding high on a hot air balloon — I now knew who I was, my life finally made sense. I realised my depression had been on and off because who can possibly live their best life if they are not living as their authentic self?

Health system 'hopeless' for trans people

Then I entered the health system as a trans person. Lack of knowledge and services and repeated rejection letters for health services such as surgery brought me crashing down. I finally knew who I was, but there seemed to be no hope of becoming that person.

When hope is taken away, one is literally left hopeless.

The first rejection letter for top surgery (double mastectomy and chest masculinisation) was from the nearest public plastic surgery unit, which said it was due to lack of resources.

For the first time in my entire life I could nearly see me – the real me, the person I was always supposed to have been.

The advice on the Ministry of Health website was that local hospitals should be doing top surgery within their existing budgets. But trans masculine people seeking top surgery go into a funding pool with people with breast cancer and we lose every time. I do not begrudge cancer patients but believe there needs to be a separate funding pool for gender-affirming top surgery, as there is for genital surgery (albeit with an extremely long waiting list).

There is a lot of systemic transphobia. Many health professionals continue to operate from old, debunked schools of thought, such as being transgender is a mental illness. It isn't and it never was.

These are the people who make decisions on whether they will fund gender-affirming surgeries or not. This is why they don't get funded — it is not seen as important and legitimate health care.

Hospitals send people to other hospitals, including private, all the time for treatments they cannot provide. There are many plastic surgeons around New Zealand who can do gender-affirming top surgery but transgender people are not

afforded the same treatment because the decision-makers do not want to spend the money on us. Yet we are citizens of New Zealand who are entitled to free health care, just like everyone else.

Five rejections in five years

For the first time in my entire life I could nearly see me — the real me, the person I was always supposed to have been — but the chest got in the way.

I had five rejection letters for top surgery over five years. Each time, I would have to deal with suicidal thoughts as my hope of becoming the person I now know I am was taken away. It was devastating.

What those rejection letters said to me was: "You are NOT important, you DO NOT matter".

Over the years, with testosterone hormone replacement therapy (HRT), my body had masculinised. Body fat had redistributed from feminine areas like hips, buttocks and thighs to the belly, and my hairline receded to a male hairline.



Meates performing in drag in Dublin 2004.



One nursing placement I was on required students to wear a smart, casual collared top rather than the student uniform top. While I was in a dressing room trying on a polo shirt and looking in the mirror, I just wanted to cry. For the first time in my entire life I could nearly see me — the real me, the person I was always supposed to have been — but the chest got in the way.

It was heart-breaking. Imagine being in your 40s and nearly being able to see yourself for the very first time.

The health system is actually really cruel. It will allow someone to start HRT, have masculinising physical changes (which in some cases includes the start of baldness) but still have breasts. This leaves one in limbo, neither this or that — an in-between person, feeling like a right freak and totally powerless to do anything about it.

For some, the sad reality is they can't live like that anymore and they end their life. I have known four people who took their own lives and three of them were members of the rainbow community.

I, too, found myself in that dark place again, feeling hopeless.

It was then I decided to become a nurse to try and make the health system better for people like me. I didn't realise it at the time but in making that decision, I was actually making an anti-suicide plan for myself as I knew I needed something in my life that was working towards a better future.

When I told my mum I was going to become a nurse, I said I could never see myself as a nurse previously because of its strong feminine image with a nurse in a female uniform — that was not me. But a transgender non-binary nurse — that I could see, because that is me.

Studying 'confronting'

It was actually really confronting doing the nursing degree. Apart from some classmates rolling their eyes when I spoke up on transgender health in class, it was challenging learning about things like social determinants of health and seeing how these were stacked against me growing up.

On the second day of my nursing degree one lecturer said: "Put your hand up if you are here straight out of school." Many people put their hand up. I was suddenly (and unexpectedly) overcome with grief. I sat there trying hard not to cry. I was totally overcome with grief thinking when I was their age, I didn't stand a chance.

The health system ... leaves one in limbo, neither this or that – an in-between person, feeling like a right freak and totally powerless to do anything about it.

I have endured verbal harassment and abuse countless times over the years for simply being in public with my partner. I have experienced hate crimes — in Ireland on the housing estate I lived on, a group of young men urinated through my mail slot into my hallway. That was one of the worst.

There is so much more I could write about homophobic and transphobic experiences but I will wrap it up for now.

This is my story and I share it freely to help people understand what we in the rainbow community face. Everybody has a story and others' may differ — but the need for lift-up will be the same.

Unfortunately, mental health statistics for those in Aotearoa's rainbow community remain shockingly bad. [Research](https://static1.squarespace.com/static/5bdbb75ccef37259122e59aa/t/607cb8431453ca0b05c53bb8/1618786373138/Youth19+Brief_Transgender+and+diverse+gender+students+April2021.pdf) (https://static1.squarespace.com/static/5bdbb75ccef37259122e59aa/t/607cb8431453ca0b05c53bb8/1618786373138/Youth19+Brief_Transgender+and+diverse+gender+students+April2021.pdf) by [Youth19](https://www.youth19.ac.nz/) (<https://www.youth19.ac.nz/>) shows more than half transgender / gender diverse students report significant depression and self-harm.

More rainbow scholarships like [the one just launched](#) by the Universal College of Learning (UCOL) Te Pūkenga and Te Whatu Ora Midcentral would help someone have a better chance.

- *After graduating from UCOL Palmerston North last year as a registered nurse (RN), Mel Meates works as a rainbow education facilitator at Palmerston North Regional Hospital and as an RN in aged care. Meates and UCOL nursing senior lecturer Trish Morison also presented gender and sexual diversity workshops for the Nursing Council which has now included the promotion of diversity, equity and inclusion as a priority in its [strategic plan](#) ([http://To promote diversity, equity, and inclusion within systems of nursing practice, education, and regulation](#)).*
 - A glossary of gender diverse and transgender terms can be found [here](https://genderminorities.com/glossary-transgender/) (<https://genderminorities.com/glossary-transgender/>).
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NEWS

'Just a really good guy' – NZNO leaders mourn former kaumātua Richard Rangi Wallace

BY MARY LONGMORE

January 19, 2024

NZNO's Te Rūnanga members are mourning Richard Rangi Wallace, NZNO's former kaumātua and Māori Anglican pīhopa (bishop) o Te Waipounamu who died on January 6.



In May 2013, Richard Wallace (far right) at the powhiri marking NZNO's new co-leaders then president Marion Guy (second from right) and kaiwhakahaere Kerri Nuku. Te Rūnanga advisor Bill Stirling is on the left.

NZNO kaiwhakahaere Kerri Nuku said Wallace had been a key supporter of NZNO's new bicultural co-leadership model 10 years ago and had gifted NZNO its Māori name: Tōpūtanga Tapuhi Kaitiaki o Aotearoa.

"So he had a lot of influence in transforming [NZNO] to where we are today!"

Wallace died in Wairoa after travelling from Te Waipounamu (the South Island) to officiate at the funeral of Ngāti Kahungunu rangatira Norm Hewes. His body was returned to Wairewa Marae in Little River, Canterbury, with the help of an air force Hercules, for a tangi on January 11.

In 2013, Wallace gifted the titles of kaiwhakahaere and tumu whakarae (deputy) to the new NZNO Māori leadership roles. These roles were intended to work in partnership with the president and vice-president in a new bicultural structure.

The kaiwhakahaere and president roles both became full-time, paid positions for the first time under the changes, ushered in with a new constitution.

At the time, interim chief executive Susanne Trim said it was a new beginning for the organisation, along a bicultural pathway.

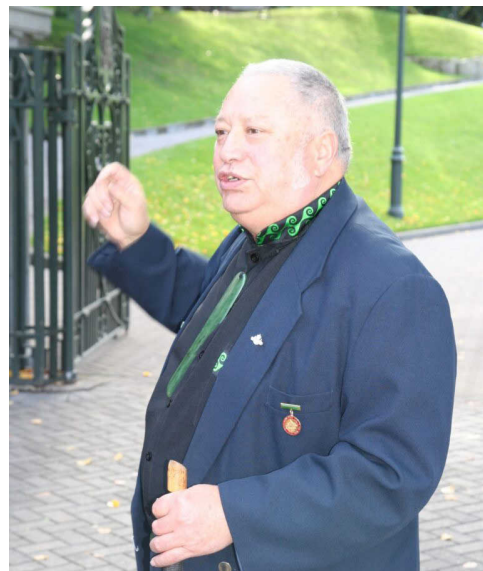
‘He was just a really good guy. He was funny – nothing was ever too much of a challenge.’

In his 10 years or so at NZNO, Nuku said Wallace was always very engaged with NZNO’s Māori governance committee, Te Poari, encouraging representatives to engage with their communities and make sure they took time to genuinely consult members.

“He wanted to embrace the whole ‘lost yourself in the service of members’, which meant being more proactive and doing that mahi,” she told *Kaitiaki*.

“He was just a really good guy. He was funny — nothing was ever too much of a challenge.”

In 2007, Wallace had also gifted the name Te Rau Kōkiri to a new tikanga-led bargaining process for Māori and iwi providers. This was intended to bring pay parity with other sector to nursing staff in these organisations — a fight which continues to this day.



Richard Wallace was influential in NZNO's bicultural leadership structure.



Kaumātua Richard Wallace hands over a Te Rau Kōkiri petition for pay parity for Māori and iwi health provider staff to then-Minister of Health David Cunliffe at Parliament in May 2008. Wallace said members had “come together in unison from the north, the south, the east and the west” to petition the Government.

Of Ngāi Tahu, Kāti Māmoe and Waitaha descent, Wallace was an aircraft engineer in the Royal New Zealand Airforce for many years, before joining the Anglican Church.

He was awarded the Queen’s Service Medal for services to Māori in 2009, and went on to hold various church roles in Nelson and Canterbury before becoming Pīhopa o Waipounamu in 2016.

‘The family is all about strengthening and giving back to community and that is just the epitome of what he is about.’

Wallace had served in the Māori Anglican church for more than 40 years. The Māori Anglican church has five dioceses or regions, each with its own pīhopa.



Kerri Nuku and then-president Marion Guy celebrate their new bicultural partnership in 2013.

Informal, intimate farewell

Nuku and other NZNO and Te Rūnanga representatives attended his tangi on January 11 in Little River, an event Nuku said was small and informal.

“It was more intimate and it was like we got a special last moment with him.”

She said they had tried to leave early to catch flights but their car wouldn’t start, “so we thought ‘okay, he doesn’t want us to go!’”

His wife Mere — who he met in the air force — was also active in Te Poari and a Te Rūnanga representative on the West Coast at the time.

The couple had three daughters and a whāngai (foster) son.

Daughter Susan Wallace said on social media that the death of her father had left whānau “bereft and heartbroken”.

One of their daughters, the late Angela Wallace-Swindells, worked at NZNO as a policy analyst in 2006/7. She passed away in 2014 from cancer at just 45.

Wallace’s daughter Maria Briggs is a nurse and NZNO member.

The whole family had been involved with the Māori Women’s Welfare League, Nuku said.

“The family is all about strengthening and giving back to community and that is just the epitome of what he is about.”

Wallace left NZNO in 2016 when he was appointed Bishop.

They eventually made their flights.



Richard Wallace as pictured on the order of service at his tangi.

LETTERS

‘Kerri Nuku needs to stick with nursing and leave history to the experts’

BY HELEN MCCROSTIE

January 15, 2024

Kerri Nuku needs to stick with nursing and leave history to the experts.

Her comparison (in the NZNO blog post [Seeds](https://blog.nzno.org.nz/2023/11/20/seeds/) (<https://blog.nzno.org.nz/2023/11/20/seeds/>)) of Israeli/Palestinian history with New Zealand/Aotearoa or South Africa is erroneous.

[NZNO-Tōpūtanga Tapuhi Kaitiaki o Aotearoa kaiwhakahaere] Nuku asks: “Why is Israel attacking Palestine?” Is she not aware it is the Islamofascist organisation Hamas that started this? It is a well-documented fact that Hamas is prepared to use its own civilians as human shields and accept the collateral damage of their own people for their sick Islamofascist aims.

What has Hamas done with all the international aid it has received over the years? They have built military complexes within the heart of civilian areas with no regard for their people.

And why blame the United States (US) for a situation created by the surrounding Arab states? These states benefit politically from having the festering sore of the Palestinians draining a Jewish nation that many in the Arab world would love to see annihilated. There is a lesson in genocide for her.

She regurgitates the same old post-colonial narrative with no regard for historical accuracy. Yes, we are all well aware of the broken promises and systematic dispossession and alienation of Māori under the British/colonial system.

However the fact remains, Māori are far better off now than what they were prior to the coming of the British. Māori population numbers are presently more than 800,000 compared to approximately 100,000 prior to the European arrival.

Māori, as a Stone Age culture, readily embraced the benefits of European society. Take modern medicine for instance. As a nurse and leader of the NZNO, she needs to give credit to the “colonial power” for that. If you are wanting to look for instances of genocide, she does not need to go far in looking at the brutal tribal history of Māori society.

She is also sadly lacking in her knowledge of Middle East history and the history of the Jewish people and their defence of their spiritual and historical homeland from Islamofascists like Hamas or the Muslim Brotherhood. Just research the wars of 1948, 1967 and 1973. Each time the Arab states and Palestinians were the aggressors. Hence it is they who created the tragic refugee problem for the Palestinians.

Helen Mccrostie, RN,
Canterbury

Racial justice consultant Dr Heather Came replies:

Kerri Nuku is a well-respected international indigenous nursing leader, who has been representing Aotearoa on a global stage at a range of international fora for decades. She has strong indigenous networks and is deeply familiar with the power dynamics of colonisation and white supremacy.

Her credentials mean she is well placed to comment on the Palestine independence struggle and the current US-backed Israeli-led genocide which seems to be deliberately targeting hospitals, doctors and nurses.

The argument that Māori benefited from colonisation is fatally flawed. Māori land was systematically confiscated and alienated and there has been sustained attacks on te reo me ōna tikanga. Māori remain under-represented in senior decision-making roles across the public sector. Ethnic inequities persist across key social and economic outcomes particularly in health.

Māori population levels dramatically declined upon contact with Pākehā settlers due to the new diseases, weapons and legislation they introduced to Aotearoa. It took decades for the population levels to recover and expand.

The Waitangi Tribunal, a permanent independent commission of inquiry charged with investigating breaches of te Tiriti, in its Wai 2575 and COVID-19 reports, concluded that our health system (modern medicine) is failing Māori.

The Tohunga Suppression Act 1907 brutalised traditional rongoā practices within te ao Māori. The 1918 influenza epidemic saw Māori die at seven times the rate of non-Māori. Contemporary research shows that Māori whānau continue to receive poorer quality and quantity of care across our health system.

Colonisation always does considerable intergenerational harm to indigenous peoples. I encourage the letter writer to read the [United Nations Declaration on the Rights of Indigenous Peoples](https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf) (https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf) and anything ever written by [Moana Jackson](https://e-tangata.co.nz/comment-and-analysis/moana-jackson-decolonisation-and-the-stories-in-the-land/) (<https://e-tangata.co.nz/comment-and-analysis/moana-jackson-decolonisation-and-the-stories-in-the-land/>) and to reconsider their position.

— **Heather Came** (New Zealand Order of Merit) is an activist scholar at large. She is an adjunct professor at He Herenga Waka — Victoria University of Wellington and runs consultancy [Heather Came and Associates](https://www.heathercameassociates.com/) (<https://www.heathercameassociates.com/>), focused on pursuing racial justice. She is a founding member of STIR (Stop Institutional Racism) and the [Radical Sewing Circle](https://docs.google.com/forms/d/e/1FAIpQLSe21myDJldZAarijxFBLfu-8JZYdXVdgVsgw43nN-dPyG4qzA/viewform) (<https://docs.google.com/forms/d/e/1FAIpQLSe21myDJldZAarijxFBLfu-8JZYdXVdgVsgw43nN-dPyG4qzA/viewform>) social justice network, co-convenor of [Te Tiriti-based futures](https://givealittle.co.nz/cause/te-tiriti-based-futures-and-anti-racism) (<https://givealittle.co.nz/cause/te-tiriti-based-futures-and-anti-racism>) anti-racism series and member of the NZ Public Health Association. She was invited to respond by Kaitiaki co-editors.

See also Kerri Nuku's latest blog on te Tiriti o Waitangi: [Toitu Te Tiriti](https://blog.nzno.org.nz/2023/12/15/toitu-te-tiriti/) (<https://blog.nzno.org.nz/2023/12/15/toitu-te-tiriti/>).

Cultural safety, te Tiriti o Waitangi and Māori health guidelines for all nurses from Te Kaunihera Tapuhi o Aotearoa Nursing Council of New Zealand can be found [here](https://www.nursingcouncil.org.nz/Public/Nursing/Standards_and_guidelines/NCNZ/nursing-section/Standards_and_guidelines_for_nurses.aspx) (https://www.nursingcouncil.org.nz/Public/Nursing/Standards_and_guidelines/NCNZ/nursing-section/Standards_and_guidelines_for_nurses.aspx).

OPINION

'Please share your art of nursing with our graduate-entry students'

BY MICHELLE HONEY AND RACHEL MACDIARMID

January 26, 2024

Two nursing educators encourage clinical RNs to welcome graduate-entry students, and share their 'art of nursing' with them.



Nursing students give you the chance to share your knowledge with someone who really appreciates it. (Photo: Adobe Stock)

For many registered nurses (RNs) reading this, the pathway they took to registration in Aotearoa New Zealand was to complete a three-year bachelor's degree and sit and pass the Nursing Council state examination.

There is now an option for those who already have a degree to complete a shortened programme of study, while still meeting all the Nursing Council requirements and competencies. This is a graduate entry to nursing (GEN) programme.

GEN education started in New Zealand in 2014 and is now provided by eight schools of nursing. In alphabetical order, these are: Auckland University of Technology (AUT), Canterbury University, Massey University, University of Auckland, University of Otago, University of Waikato, Victoria University of Wellington and Wintec Te Pūkenga.

GEN programmes have been offered internationally since the 1970s and are recognised as an attractive option for those with a completed degree. Internationally, we know that those who complete a GEN nursing programme were looking for a satisfying career, work that had meaning and purpose and sometimes for a complete change in direction.¹

Proven ability to learn

As these people have already completed a degree, they have a proven ability to learn and most can manage the intensity of the two-year full-time (some schools of nursing have a part-time option) programme.

When they start, GEN students are much like other pre-registration nursing students, particularly in how nervous they can feel when faced with their first clinical experiences. We know a supportive clinical environment and good RN role models can really make a big difference to all students, and notably GEN students.

We know a supportive clinical environment and good RN role models can really make a big difference to all students, and notably GEN students.

While completing the same 1100 clinical hours as other programmes, as required by the Nursing Council, these GEN students do this within two years, while also completing assignments and other academic work at master's level.

GEN students are working towards the same end goal as undergraduate students. However GEN students sometimes face scepticism and questioning about their two-year master's programme, no doubt because GEN programmes and GEN students are still navigating relatively new ground in New Zealand.

Many will remember similar concerns with other changes in nursing education, such as the change away from "hospital training" and when degree programmes for nursing were first introduced.

It is worth clarifying that GEN students complete a different master's degree than RNs who are building on their existing practice. GEN students are at the early stages of developing their nursing knowledge and skills, while RNs who are completing a masters of nursing are practising at an advanced level.

GEN students sometimes face scepticism and questioning about their two-year master's programme ...

As the new year starts, you can expect to see nursing students, including some GEN students, in clinical placements. An American nurse wrote these five reminders of why nursing students are good for you.² These reminders apply to GEN students, but in fact all nursing students.

Why nursing students are good for you

1. Nursing students keep you on your toes.

Don't feel as if you're being scrutinised or tested; consider it as a way of showing off your skills and knowledge. And if you don't know, say so, but tell them how to find the answer. You can always ask that they share the answer with you on their next shift — which is helpful to you both.

2. Nursing students make you laugh.

It reminds you of where you started and how far you have come!

3. Nursing students give you a chance to share your knowledge with someone who really appreciates it.

Nursing students can't believe they'll ever become as competent and knowledgeable as you are. You'll never have a more attentive, appreciative audience.

4. Nursing students remind you why you became a nurse.

Watch a nursing student hold a hand, interact with a family, or get their first "thank you" from a patient. It

will remind you why you go to work every day.

5. Nursing students give you a chance to affect the future of nursing.

You're not just teaching students — you're also preparing your future colleagues.²

'Nursing students can't believe they'll ever become as competent and knowledgeable as you are. You'll never have a more attentive, appreciative audience.'

We who work in nursing education recognise the powerful effect clinically based nurses have in shaping future nurses. Please share your "art of nursing" — that magic that combines the science with your knowledge and experience, and that makes a difference with our patients and their whānau.

Then, the next time you're asked to help a nursing student, you may find it a mutually beneficial experience and perhaps you'll say, "I helped a student today — and I really learned from it."

* **Michelle Honey, RN, PhD**, is programme director of the master of nursing science programme at the University of Auckland.

* **Rachel Macdiarmid, RN, PhD**, is head of nursing at the Auckland University of Technology.

References

1. Macdiarmid, R., Turner, R., Winnington, R., McClunie-Trust, P., Donaldson, A., Shannon, K., Merrick, E., Jones, V., & Jarden, R. (2021). [What motivates people to commence a graduate entry nursing programme: A mixed method scoping review](https://doi.org/https://doi.org/10.1186/s12912-021-00564-9). (<https://doi.org/https://doi.org/10.1186/s12912-021-00564-9>) *BMC Nursing*, 20(1), 47.
 2. Kadis, J. (2002). Why nursing students are good for you. *Nursing*, 32(10), 32hn8.
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PRACTICE

Fostering resilience in patients with life-limiting illness

BY CAROL ROSE

January 23, 2024

A nurse and aromatherapist investigates what resilience means for patients who are facing the end of their lives, and provides a case study on how aromatherapy can be harnessed to improve resilience.



Anecdotal evidence has long supported the relationship of positive personality traits with resilience in patients facing life-threatening illness.

(Photo: Adobe Stock)

Clinical research has recently brought the subject of resilience — a complex and often neglected aspect of patient care — into the spotlight. The focus of this interest lies in exploring the complexity of the human response to the challenges of ill-health, to explain why some individuals are better able to cope with adversity than others.

The concept of resilience has particular relevance for patients in palliative care, who are confronting their own mortality and the intense loss which accompanies a life-limiting illness. Resilience offers a means of protection, particularly against the negative impact of stress, at the same time supporting an individual's adjustment to their end-of-life care.[1](#), [2](#)

Fostering resilience requires a comprehensive understanding of the specific factors that underpin a person's innate capacity to cope and the unique combination with which each patient presents. This helps to identify those who may need additional support and enables practitioners to tailor aromatherapy interventions specific to the patient's individual strengths and needs.

Definitions of resilience



Resilience can be considered as an individual's ability to maintain or restore relatively stable psychological and physical functioning when confronted with stressful life events and adversity.

In his powerful memoir of life in Auschwitz, Viktor Frankl wrote, *"When we are no longer able to change a situation, we are challenged to change ourselves."*³ In the worst imaginable circumstances, his firm belief was that the human spirit can rise above any given situation. These early and striking observations of resilience are human realities which are difficult to define.

The concept of resilience has since continued to evolve with the focus of research extending beyond the individual to other areas of human experience. This includes palliative care, where a broader outlook considers the patient, their families, staff, organisations and communities. For definitions specific to these areas, readers are referred to the exceptional collection of writing in *Resilience in Palliative Care*.⁴

Resilience can be considered as an individual's ability to maintain or restore relatively stable psychological and physical functioning when confronted with stressful life events and adversity.⁵ This view aligns with the holistic nature of palliative care.

Resilience in the context of cancer

Resilience has predominantly been evaluated in patients receiving active forms of cancer treatment and survivors of cancer. Optimism, hope and early coping were identified as critical elements of resilience in a systematic review published in 2014.¹

Opportunities for personal growth and improved quality of life were evident in many who overcame cancer and its treatment. Importantly, the authors highlight that adversity presents itself across the entire cancer trajectory with each stage generating its own unique set of stressful challenges.

Optimism, hope and early coping were identified as critical elements of resilience.

However, not everyone reacts to adversity in the same way, raising questions as to whether clinical differences exist in how resilience manifests across the cancer spectrum and whether interventions to foster resilience need to be adjusted at each stage.

A recent large-scale review² examined factors which promote resilience and post-traumatic growth in patients across the cancer trajectory. Currently, limited evidence is available to support a reliable relationship between socio-demographic factors and resilience in patients with cancer, in addition to disease-related variables such as the time since diagnosis and the severity of the disease itself.

However, strong associations were identified in four common areas, as shown in Table 1.

Table 1: Common factors underpinning resilience in patients with cancer

- Personality traits
- Social circumstances
- Positive coping strategies
- Optimism, hope and spirituality

Personality traits

Anecdotal evidence has long supported the relationship of positive personality traits with resilience in patients facing life-threatening illness. Research-based findings have been more specific, identifying optimism, self-esteem, positive emotions and personal control as being central to an individual's resilience.²

Integral to positivity is laughter and the expression of positive emotions, including gratitude, interest and love, all of which have been shown to increase levels of resilience and improve quality of life.^{6, 7} Predominantly, this has been evaluated around the time of diagnosis or during cancer treatment.

Social circumstances

Supportive, meaningful relationships, where an individual feels loved, valued and esteemed, are considered strong determinants of resilience. Specifically important are sustainable relationships,² which enable patients to share and process their cancer-related experiences. These are an important means of support when adjusting to each stage of the cancer trajectory.

Patients with this level of social support generally report higher levels of resilience and lower levels of distress.⁸

Positive coping strategies

A critical element of resilience is the ability to employ coping strategies focused on problem-solving. Self-determination to overcome difficulties, self-efficacy, flexibility in adapting to change, positive reappraisal and social interaction are among several strategies used, where patients report less distress and experience improved quality of life.^{2, 9}

Optimism, hope and spirituality

In patients with cancer, optimism is consistently associated with better adjustment to the disease itself, an improved sense of wellbeing and reduced distress, and is positively linked to resilience and hope.² Strategies which tackle spiritual distress by fostering hope are also central to building resilience in this patient group.

Hope is considered a flexible experience which changes over time and is influenced by personality, relationships and social support.¹⁰



Optimism, self-esteem, positive emotions and personal control are central to an individual's resilience. (Photo: Adobe Stock)

Resilience in the context of life-limiting illness

Few studies have evaluated resilience in those with advanced-stage disease. For the patient group who meet entry criteria to be included in systematic reviews, high levels of social and psychological support, combined with optimism, hope and spirituality, are central to increased levels of resilience.^{1, 2}

Although resilience is under-researched in patients with life-limiting illness, parallels can be drawn with studies evaluating quality of life in these patients. A systematic review of qualitative data identified a broad range of domains which patients consider important to their quality of life.¹¹ These are summarised in Table 2, below.

Spiritual aspects were identified in all but one of the studies which met the robust selection criteria (n=24), closely followed by social and physical domains. When compared with Table 1, several similar threads exist. Therefore, it seems reasonable that fostering resilience in patients with life-limiting illness has the potential to positively influence several important aspects of their quality of life.

Table 2: Patient-reported aspects important to their quality of life

Aspect	Examples
Cognitive aspects	<ul style="list-style-type: none">• Mental alertness, ability to read, watch television, hold a conversation• Fearful of losing cognitive capacity
Emotional aspects	<ul style="list-style-type: none">• Optimism and positive thoughts considered important to combat negativity
Aspects of health care	<ul style="list-style-type: none">• Access, co-ordination, continuity of health-care services

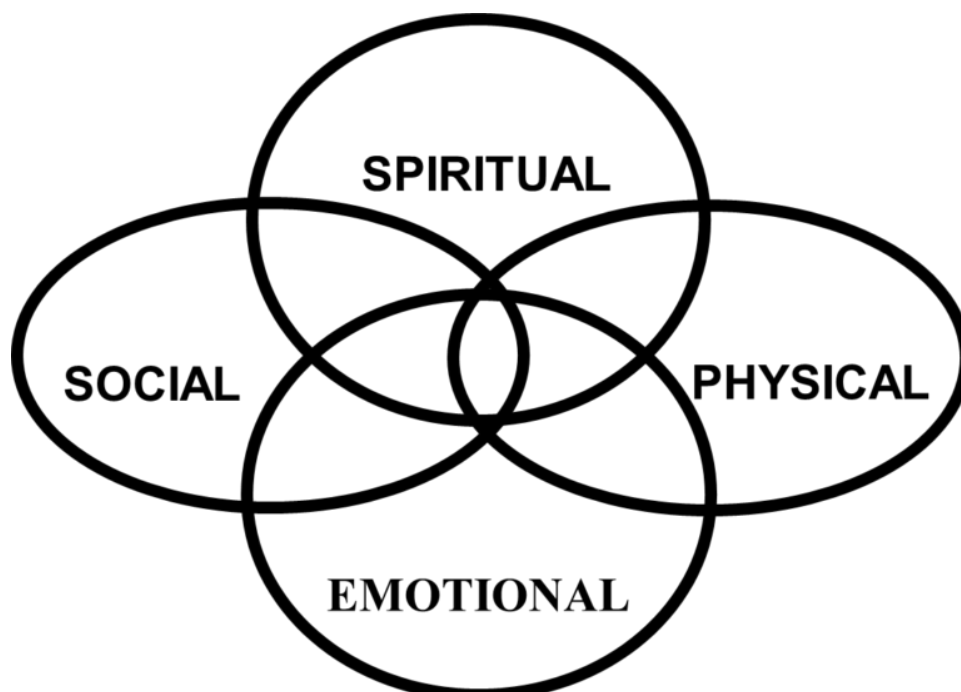
Table 2: Patient-reported aspects important to their quality of life

Aspect	Examples
Aspects of personal autonomy	<ul style="list-style-type: none">• Having choice, control• Maintaining independence contributes to normalcy• Loss of independence leads to loss of dignity and increased frustration
Physical aspects	<ul style="list-style-type: none">• Physical health• Strength and ability to get around, continue activities such as gardening• Uncontrolled symptoms impair quality of life
Preparatory aspects	<ul style="list-style-type: none">• Making preparations, organising finances, wills, funeral arrangements, delegating tasks, dealing with unresolved issues, saying final farewells
Social aspects	<ul style="list-style-type: none">• Relationships are critical to quality of life, including partner intimacy• Retaining social networks, role in society• Being treated with respect, feeling valued• Maintaining dignity and a sense of normalcy
Spiritual aspects	<ul style="list-style-type: none">• Hope, comfort, meaning and purpose were all voiced by patients• Organised religion for some patients• Environment (indoor/outdoor) influenced quality of life• Being in nature enhanced quality of life

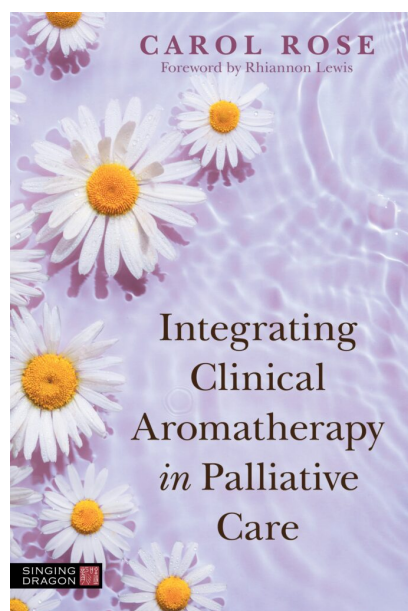
The holistic nature of resilience

Resilience is a complex concept, largely defined by the interplay of several factors, as summarised in Tables 1 and 2. These factors align with the holistic care model where an individual is considered an integrated whole, comprising physical, psychological, social and spiritual dimensions (see Figure 1, below). Each patient presents with a unique combination of these dimensions, relevant to their individual circumstances.

Figure 1: The holistic care model



Although the holistic care model is integral to the philosophies of several health disciplines, including palliative care, the deeply embedded root of the biomedical model often reduces the focus of care to the physical element. Specifically, this means the diagnosis of disease and the physical aspects of symptoms and their management.



This article is adapted from a chapter in Carol Rose's book, *Integrating Clinical Aromatherapy in Palliative Care*, published last year.

Consequently, insufficient attention is given to a patient's social, emotional and spiritual dimensions and their inter-connectedness.¹²

This is increasingly evident in patients with life-limiting illness, where studies evaluating psychological and spiritual aspects of care identified these symptoms as being frequently under-recognised by health-care professionals and consequently undertreated.^{13, 14, 15, 16, 17} This is likely to have a negative impact on a patient's level of resilience and quality of life.

The potential of aromatherapy

Interventions which foster resilience generally target spiritual and psychosocial distress. These areas are recognised aspects of successful aromatherapy intervention which are explored in chapters 5 and 6 of my book *Integrating Clinical Aromatherapy in Palliative Care*.¹⁸

Spiritual distress does not manifest as a set of pre-determined symptoms, rather a variety of expressions of distress which are unique to each patient. For some patients, it may influence how they experience and express the physical symptoms of their disease, particularly pain. For others, spiritual distress may cause greater concern than their physical symptoms.

A review of qualitative research found fear, insecurity and nervousness as predominant manifestations of spiritual distress.¹⁹ Associated increases in anxiety, depression, panic attacks, uncertainty and fear of the unknown were also reported. Spiritual suffering can be expressed through questioning the meaning of life, anger with God, or viewing illness as a punishment for life choices.²⁰ Additionally, feelings of guilt, shame or an inability to trust oneself, other people or God/higher being, can result in a lack of inner peace.²¹

Aromatherapy can help alleviate such distress by working with essential oils with properties that calm the central nervous system. With careful selection, these can be administered via aromatherapy inhalation sticks, rollerball applicators, aroma patches and aroma showers, as well as via skin absorption using appropriately diluted oils for relaxation massage, aromatic baths and footbaths.

Understanding the factors which underpin resilience (see Table 1) helps to identify patients in need of additional support and tailor interventions to address their unique capacities. The following case study demonstrates the beneficial effects of integrating clinical aromatherapy alongside conventional medical interventions.



CASE STUDY: Winnie's experience

Referral

Winnie presented to the specialist palliative care team with rapidly deteriorating health, with a complex range of symptoms arising from advanced cancer of unconfirmed sources. Clinical concern about her ingestion of essential oils prompted an aromatherapy referral by the nursing team to ensure safe integration with prescribed pharmacology.

Background

Throughout her life, this independent, erudite 69-year-old lady had used plant-based medicine to maintain her health and wellbeing. Although taking prescribed opioids for pain relief and anti-emetics for nausea, she preferred to use natural medicine alongside her conventional regime. She felt overly drowsy with prescribed pharmacology, particularly anti-emetics, which she had stopped taking because she felt it was easier to cope with persistent nausea than intense drowsiness.

Winnie was self-medicating by taking essential oils orally. Unfortunately, this was not based on the professional advice of a qualified aromatherapist and involved:

- *Boswellia carterii* (frankincense): 2 drops undiluted, sublingually (under the tongue) 3x daily
- *Copaifera officinalis* (copaiba balsam): 2 drops undiluted, sublingually 3x daily

Personal goals

Having experienced a complex pathway through the health-care system, Winnie's priorities were:

1. To be involved in all treatment decisions
2. To continue self-administration of essential oils
3. To live as well and independently as she could in the life she had left
4. To see her new grandchild, due to be born in a few months

Aromatherapy intervention

Many of the extended family were present at the first home visit and space was limited. Winnie was weak with fatigue, and largely confined to one room due to the limitations of her breathlessness, for which she required supplemental oxygen. Her oral mucosa was red and dry but intact.

We discussed her current ingestion of essential oils, which had been ongoing for several weeks, with no alleviation of her symptoms and further deterioration in her health noted.

Winnie described a spiritual and cultural connection with *Boswellia carterii* (frankincense) and enjoyed the aroma of the *Copaifera officinalis* (copaiba balsam). As such, it was suggested that she continue using both essential oils but change the route of application from sublingual to topical use (ie on the skin).

We considered other essential oils and base substances, with analgesic and anti-inflammatory properties, more suited to her current pain from the right kidney.

Mindful of her deteriorating renal function, we proposed a topical pain-relief blend starting at a concentration of 3 per cent, plus an aromatherapy inhaler stick formulated with her choice of essential oils from a selection designed to alleviate nausea (see Table 3, below).

Winnie was willing to try this combination and agreed to stop taking the essential oils orally.

Table 3: Winnie's aromatherapy interventions

Method of application	Botanical products <i>Botanical name (common name)</i>	Amount used	Directions for use
Topical blend 'Pain relief' 3%	<i>Boswellia carterii</i> (frankincense)	10%	Patient-assisted Apply THREE times daily After 1 week, review
	<i>Copaifera officinalis</i> (copaiba balsam)	25%	
	<i>Kunzea ambigua</i> (kunzea)	30%	
	<i>Lavandula latifolia</i> (spike lavender)	25%	
	<i>Zingiber cassumunar</i> (plai)	10%	
	<i>Calophyllum inophyllum</i> (tamanu)	40%	
	<i>Simmondsia chinensis</i> (jojoba)	60%	
Aromatherapy inhaler stick 'Nausea relief'	<i>Lavandula angustifolia</i> (lavender true)	4 drops	Patient-directed as required At each use, inhale 4-8 breath cycles
	<i>Citrus bergamia</i> (bergamot)	5 drops	
	<i>Zingiber officinalis</i> CO ₂ — total extract (ginger CO ₂)	4 drops	
	<i>Simmondsia chinensis</i> (jojoba)	1ml	

Within 24 hours, the clinical team reported that Winnie was less restless at night, with an associated reduction in pain intensity. One week later, at the next home visit, she described how she was sleeping

through the night, she no longer required supplemental oxygen and the nausea was easing.

By the third visit, again one week later, her breathlessness had totally resolved and the nausea was well-controlled with regular use of the aromatherapy inhaler stick. Her pain level had significantly reduced to the extent she had completely stopped her prescribed opioids. However, fatigue remained a persistent issue which we explored.

Winnie spoke of the exhaustion she felt from no longer being independent. This was not how she had lived her life. Conversations ensued between the multi-disciplinary team (MDT) and her close family members to determine how she could achieve her goal of living more independently.

Her pain level had significantly reduced to the extent she had completely stopped her prescribed opioids.

With improved physical symptoms, the support of a daily carer and the clinical team available via a 24-hour on-call service, Winnie was quickly able to return to independent living.

At the next aromatherapy follow-up, she attended the hospice day centre. She described how she had returned to her normal diet, was feeling physically stronger, less fatigued and sleeping well. This resulted in a further decrease in her level of pain intensity, with an associated self-reduction in the pain-relief blend to twice daily applications.

Reflection

From a patient's perspective, personal autonomy is a central aspect of palliative care.¹¹ In this case, autonomy was achieved by supporting Winnie's decision to integrate natural medicine within her end-of-life care and involve her in all essential oil choices and intervention options.

Central to the success of this approach is the cohesive nature of the MDT. Recognising and utilising the strengths of each discipline, together with timely intervention, provided a structure of holistic support for this lady.

This, in turn, fostered her resilience to the extent that she was able to return to independent living with a restored degree of "normalcy" in the life she had left. Winnie was also able to welcome her second grandchild into the world.

In Winnie's words: *"The most important part is being listened to and being heard. It's about being supported in how I want to do things. The positivity this [hospice] team brings is allowing me to do that and to live my life well."*

Acknowledgement

This is an abridged version of the chapter, "Fostering resilience in patients with life-limiting illness" taken from Carol Rose's book, *Integrating Clinical Aromatherapy in Palliative Care*, published in 2023 by Singing Dragon. She can be contacted at carol@thearomary.co.nz

Carol Rose, RN, BSc(hons) palliative nursing, Dip Aroma, registered massage therapist, is an RN, clinical aromatherapist, educator and author. She works as an RN in specialist palliative care, North Haven Hospice, Whangarei.

References

1. Molina, Y., Yi, J., Martinez-Gutierrez, J., Reding, K., Yi-Frazier, J., & Rosenberg, A. (2014). [Resilience among patients across the cancer continuum: diverse perspectives.](https://pubmed.ncbi.nlm.nih.gov/24476731/) (<https://pubmed.ncbi.nlm.nih.gov/24476731/>) *Clinical Journal of Oncological Nursing*, 18(1), 93-101.
 2. Seiler, A., & Jenewein, J. (2019). [Resilience in cancer patients.](https://doi.org/10.3389/fpsy.2019.00208) (<https://doi.org/10.3389/fpsy.2019.00208>) *Frontiers in Psychiatry*, 10(208), 1-31.
 3. Frankl, V. (1984). *Man's Search for Meaning: An Introduction to Logotherapy*. Simon and Schuster. (Original work published in 1946).
 4. Monroe, B., & Oliviere, D. (2009). *Resilience in Palliative Care – achievement in adversity (2nd ed)*. Oxford University Press Inc.
 5. Bonanno, G., Westphal, M., & Mancini, A. (2011). [Resilience to loss and potential trauma.](https://pubmed.ncbi.nlm.nih.gov/25521911/) (<https://pubmed.ncbi.nlm.nih.gov/25521911/>) *Annual Review of Clinical Psychology*, 7, 511-535.
 6. Manne, S., Myers-Virtue, S., Kashy, D., Ozga, M., Kissane, D., Heckman, C., Rubin, S., & Rosenblum, N. (2015). [Resilience, positive coping, and quality of life among women newly diagnosed with gynaecological cancers.](https://pubmed.ncbi.nlm.nih.gov/25521911/) (<https://pubmed.ncbi.nlm.nih.gov/25521911/>) *Cancer Nursing*, 38(5), 375-82.
 7. Tugade, M., Fredrickson, B., & Barrett, L. (2004). [Psychological resilience and positive emotional granularity: examining the benefits of positive emotions on coping and health.](https://pubmed.ncbi.nlm.nih.gov/15509280/) (<https://pubmed.ncbi.nlm.nih.gov/15509280/>) *Journal of Personality*, 72(6), 1161-90.
 8. Somasundaram, R., & Devamani, K. (2016). [A comparative study on resilience, perceived social support and hopelessness among cancer patients treated with curative and palliative care.](https://pubmed.ncbi.nlm.nih.gov/27162423/) (<https://pubmed.ncbi.nlm.nih.gov/27162423/>) *Indian Journal of Palliative Care*, 22(2), 135-40.
 9. Eicher, M., Matzka, M., Dubey, C., & White, K. (2015). [Resilience in adult cancer care: an integrative literature review.](https://pubmed.ncbi.nlm.nih.gov/27216362/) *Oncology Nursing Forum*, 42(1), E3-16.
 10. Li, M., Yang, Y., Liu, L., & Wang, L. (2016). [Effects of social support, hope and resilience on quality of life among Chinese bladder cancer patients: a cross-sectional study.](https://pubmed.ncbi.nlm.nih.gov/27216362/) *Health Quality of Life Outcomes*, 14, 73.
 11. McCaffrey, N., Bradley, S., Ratcliffe, J., & Currow, D. (2016). [What aspects of quality of life are important from palliative care patients' perspectives?](https://pubmed.ncbi.nlm.nih.gov/27216362/) (<https://pubmed.ncbi.nlm.nih.gov/27216362/>) *Journal of Pain & Symptom Management*, 52(2), 318-328.
 12. Youngson, R. (2012). *Time to Care*. Rebelheart Publishers.
 13. Austen, P., Macleod, R., Siddall, P., McSherry, W., & Egan, R. (2016). [The ability of hospital staff to recognise and meet patients' spiritual needs: a pilot study.](http://DOI:10.1080/20440243.2016.1158453) (<http://DOI:10.1080/20440243.2016.1158453>) *Journal for the Study of Spirituality*, 6(1), 20-37.
 14. Balboni, T., Paulk, M., Balboni, M., Phelps, A., Loggers, E., Wright, E., Block, S., Lewis, E., Peteet, J., & Prigerson, H. (2009). [Provision of spiritual care to patients with advanced cancer: associations with medical care and quality of life near death.](https://pubmed.ncbi.nlm.nih.gov/19354444/) *American Society of Clinical Oncology*, 28(3), 445-452.
 15. Edwards, A., Pang, N., Shiu, V., & Chan, C. (2010). [The understanding of spirituality and the potential role of spiritual care in end-of-life and palliative care: a meta-study of qualitative research.](https://pubmed.ncbi.nlm.nih.gov/20440243/) *Palliative Medicine*, 24(8), 1-18.
 16. Epstein-Peterson, Z., Sullivan, A., Enzinger, A., Trevino, K., Zollfrank, A., Balboni, M., VanderWeele, T., & Balboni, T. (2015). [Examining forms of spiritual care provided in the advanced cancer setting.](https://pubmed.ncbi.nlm.nih.gov/26440243/) *American Journal of Hospital Palliative Care*, 32(7), 750-757.
 17. O'Connor, M., White, K., Kristjanson, L., Cousins, K., & Wilkes, L. (2010). [The prevalence of anxiety and depression in palliative care patients with cancer in Western Australia and New South Wales.](https://pubmed.ncbi.nlm.nih.gov/20440243/) *Medical Journal of Australia*, 193(5), S44-47.
 18. Rose, C. (2023). *Integrating Clinical Aromatherapy in Palliative Care*. Singing Dragon.
 19. Edwards, A., Pang, N., Shiu, V., & Chan, C. (2010). [The understanding of spirituality and the potential role of spiritual care in end-of-life and palliative care: a meta-study of qualitative research.](https://pubmed.ncbi.nlm.nih.gov/20440243/) *Palliative Medicine*, 24(8), 1-18.
 20. Richardson, P. (2014). [Spirituality, religion and palliative care.](https://pubmed.ncbi.nlm.nih.gov/25521911/) *Annals of Palliative Medicine*, 3(3), 150-159.
 21. Speck, P. (2011). Spiritual/religious issues in care of the dying. In J. Ellershaw and S. Wilkinson (eds) *Care of the Dying: A pathway to excellence*. Oxford University Press.
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FEATURES

It's cool to kōrero – January 2024

BY KATHY STODART

January 12, 2024

Hipi — sheep



The first four photos here show shearers and wool-handlers from the Peter Lyon gang, shearing Merino wethers at Patearoa Station in Maniototo in the South Island in November. (Photos: Barbara Newton)

it's cool to
kōrero





Haere mai and welcome to the first “It’s cool to kōrero” column for the year. “Hipi” is the common word in te reo for sheep, an introduced animal which has played a major part in the New Zealand economy for more than a century.

After European settlers first brought hipi here, Māori were quick to establish themselves as expert shearers, first with blades, and then with electric shearing machines.

Māori continue to be a strong presence, as shearers, rousies and wool-classers, in shearing gangs that work on sheep farms and stations across New Zealand and Australia.

Kupu hou (new word)

- **Hipi** (sheep) — pronounced “hee-pee”
- **Kia kutikuti hipi e rua rau ia rā, e taku tungāne.** — My brother can shear 200 sheep a day.

More words related to *hipi*:

- **hipi toa** – ram
- **kātua** – ewe
- **hipi tame raho-poka** –wether
- **reme** – lamb
- **hōkete** – hogget (year-old sheep)
- **huruhuru hipi** – wool
- **wūru** – wool
- **weu wūru** – wool fibre
- **kirihipi** — sheepskin
- **kutikuti** — shearing
- **kaikuti** — shearer
- **hīpō** – “sheep-o”: person whose job it is to fill the pens with sheep for shearing
- **piriho** – “fleece-o”: person who picks up shorn fleece and tosses it on table for wool-skirting and classing

E mihi ana ki a Titihuia Pakeho rāua ko Mairi Lucas.

Sources

1. maoridictionary.co.nz
(<http://maoridictionary.co.nz>)



Weu wūru — wool fibre: parting the fleece of a Merino sheep shows its fine texture, which is in demand for the manufacture of clothing. (Photo: Adobe Stock)



Ewes (kātua) and lambs (reme) on an Aotearoa farm. (Photo: Adobe Stock)



A mob of sheep are driven along a country road near Fiordland, in the South Island.





NURSING NEW ZEALAND

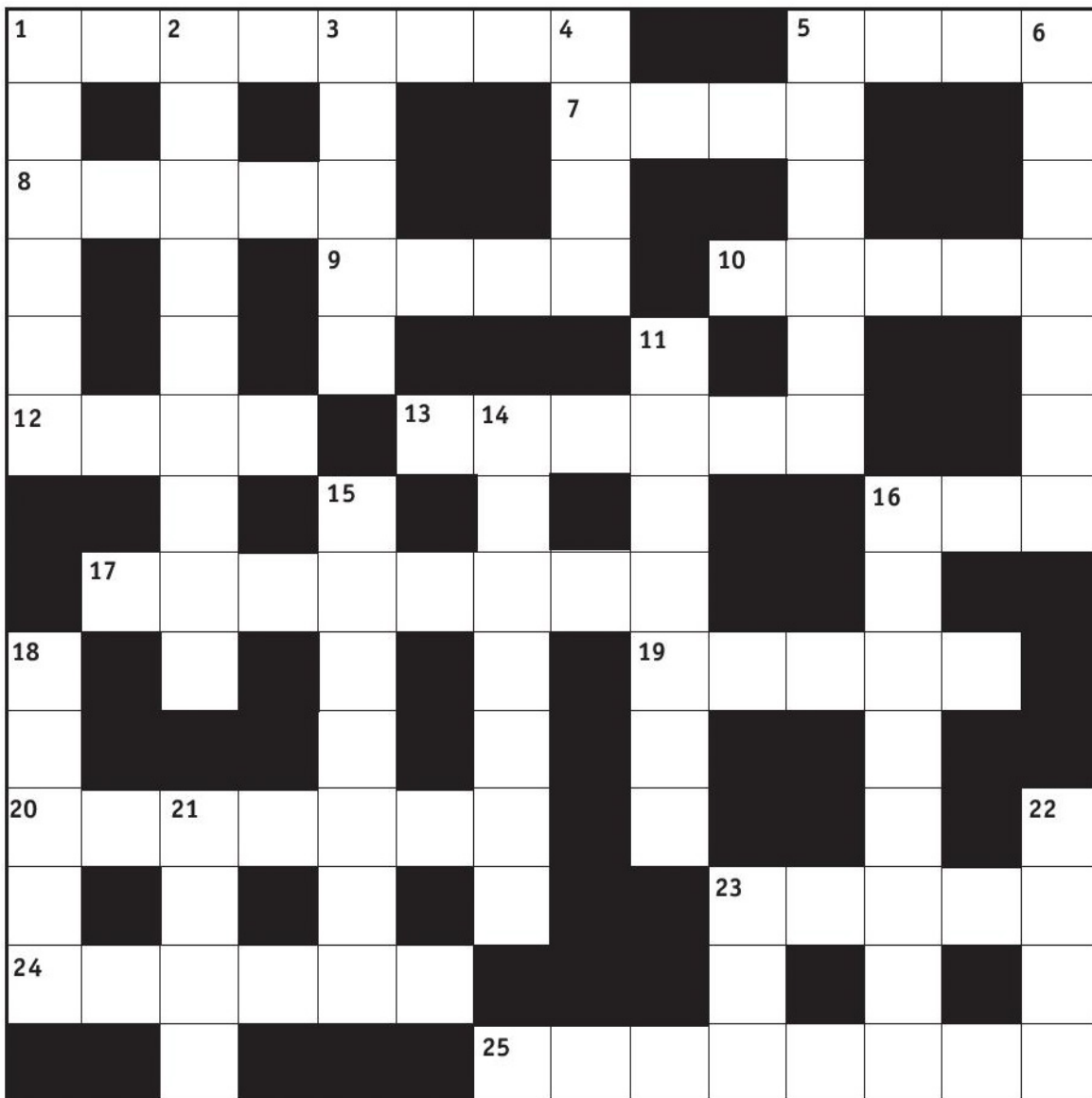
PUZZLES

JANUARY 2024 crossword

BY KATHY STODART

January 18, 2024

Print out the grid (using PRINT tab at the bottom right of this page) and use the clues below. December answers are below the clues.



ACROSS

- 1) Addictive drug in cigarettes.
- 5) Mark of old wound.
- 7) Female relative.
- 8) Painful muscle contraction.
- 9) Way out.
- 10) Boredom.
- 12) Biblical woman's name.
- 13) Ideal of masculine beauty.
- 16) A cow chews this.
- 17) Grandchildren (Māori).
- 19) Rips.
- 20) Long-necked mammal.
- 23) Diet forbidding animal products.
- 24) Profoundly.
- 25) Keep going.

DOWN

- 1) Tui's diet.
- 2) Government of more than one party.
- 3) Used a keyboard.
- 4) Where sun rises.
- 5) Small tubes used to keep blood vessels open.
- 6) Ended working career.
- 11) Prisoners.
- 14) Percussionist.
- 15) Optimistic.
- 16) _____ Bay, NZ's most famous racehorse.
- 18) Inflexible.
- 21) Stink.
- 22) Largest joint in body.
- 23) Large wine container.

December answers

ACROSS: 1. Penicillin. 7. Moth. 8. Budget. 10. Embark. 12. Eyeball. 13. Stud. 14. Tease. 15. Solo. 17. Sin. 19. Creche. 22. Solid. 23. Soar. 24. Amateur. 26. Storm. 27. Fasted. 28. Ngeru.

DOWN: 1. Patient. 2. Courage. 3. Legal. 4. Intent. 5. Coma. 6. Whakarongorau. 9. Decade. 11. Beds. 13. Sons. 16. Old. 17. Seafood. 18. Flea. 20. Root. 21. Corset. 24. Amen. 25. Tsar.

Menopause: getting it right for your patients



BY HE AKO HIRINGA

January 29, 2024

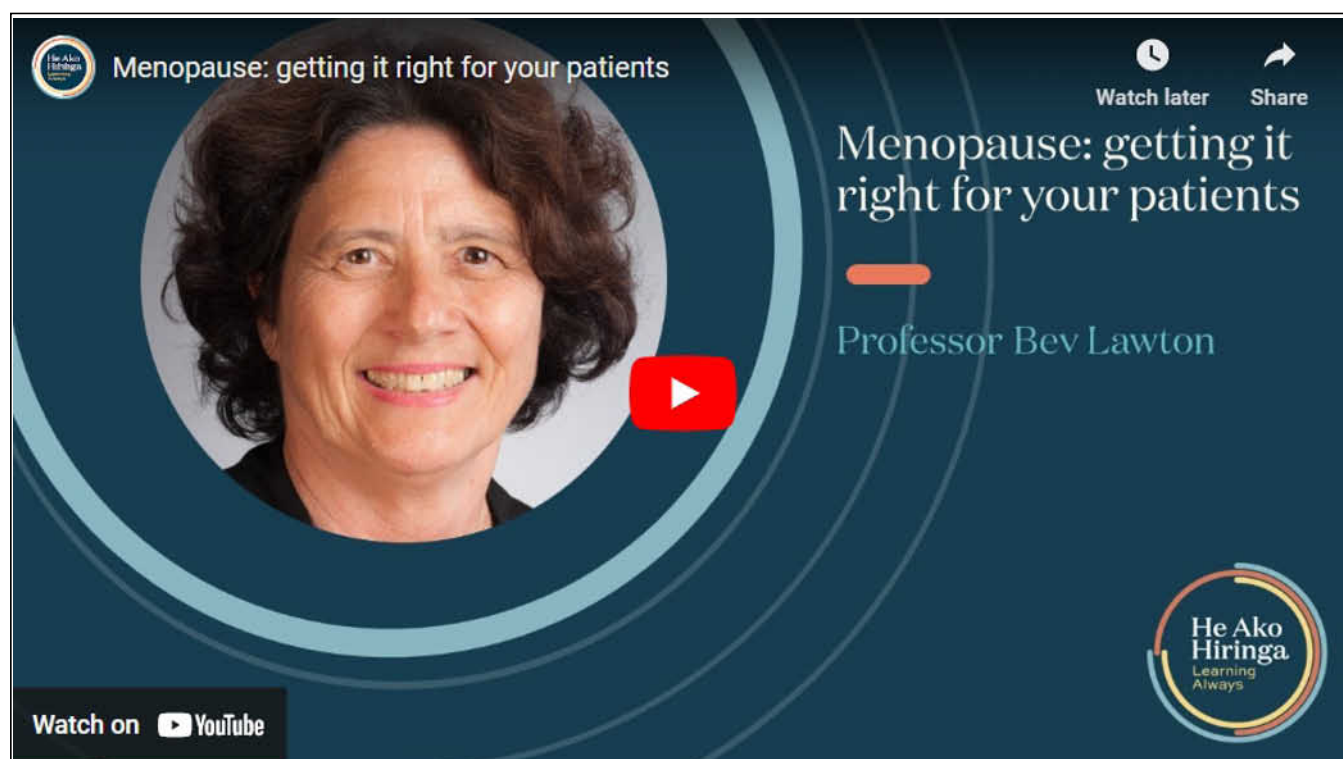
In this webinar, Professor Bev Lawton discusses menopause and how to get the best outcomes for your patients.

Presented by Professor Bev Lawton, this webinar discusses menopause and how to get the best outcomes for your patients. This presentation explores:

- Perimenopause symptoms and treatment options
- The benefits and risks of using menopause hormonal therapy (MHT)
- Treatment disparities for Māori and Pacific women
- Having conversations with women about their symptoms
- Genito-urinary and vaginal health.



This video is a recording of a live webinar hosted by Mobile Health on September 11, 2023. It is suitable for all primary care health professionals.



Speaker:



PROFESSOR BEV LAWTON

Professor Bev Lawton (Ngāti Porou) is the founder/director of Te Tātai Hauora o Hine (the National Centre for Women's Health Research Aotearoa). She previously worked as a general practitioner in Wellington for 17 years and co-founded the Wellington Menopause Clinic. Professor Lawton has a strong interest in answering the many questions relevant to women's health and inequalities.

Options for recording your CPD activities and hours include:

- the Nursing Council's [MyNC](https://www.nursingcouncil.org.nz/MyNC/MYNC/Sign_In.aspx?WebsiteKey=940918e5-df3e-4c60-9746-7312cd202474&LoginRedirect=true&returnurl=%2fMYNC) (https://www.nursingcouncil.org.nz/MyNC/MYNC/Sign_In.aspx?WebsiteKey=940918e5-df3e-4c60-9746-7312cd202474&LoginRedirect=true&returnurl=%2fMYNC) "continuing competence tab"
 - the council's "professional development activities template" (you can download a PDF from [this page](https://www.nursingcouncil.org.nz/Public/Nursing/Continuing_competence/NCNZ/nursing-section/Continuing_Competence.aspx?hkey=6542ac27-9b56-4e89-b7ae-db445c5cb952) (https://www.nursingcouncil.org.nz/Public/Nursing/Continuing_competence/NCNZ/nursing-section/Continuing_Competence.aspx?hkey=6542ac27-9b56-4e89-b7ae-db445c5cb952))
 - the app "Ascribe" which can be found on [Google Play](https://play.google.com/store/apps/details?id=com.ascribe.pdrp_diary) (https://play.google.com/store/apps/details?id=com.ascribe.pdrp_diary) or the [App Store](https://apps.apple.com/nz/app/ascribe/id1667199802) (<https://apps.apple.com/nz/app/ascribe/id1667199802>).
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NEWS

New scholarship for rainbow nursing students embraces diversity

BY MARY LONGMORE

January 17, 2024

A new scholarship for rainbow nursing students is an “immense” step towards a safe and inclusive nursing workforce that celebrates diversity, say NZNO — Tōpūtanga Tapuhi Kaitiaki o Aotearoa student leaders.



Mel Meates

Universal College of Learning (UCOL) Te Pūkenga and Te Whatu Ora Midcentral have recently launched a [\\$1500 rainbow nursing scholarship](#)

(<https://www.ucol.ac.nz/ScholarshipDocuments/MidCentral%20Rainbow%20OScholarship%20Form.pdf>) — the brainchild of UCOL Palmerston North nursing graduate Mel Meates.

Meates said it was a “huge” step for rainbow or LGBTTTQI+ [lesbian, gay, bisexual, transgender, takatāpui, queer and intersex +] nursing ākonga (students) in Aotearoa. “This is the first time that a scholarship specifically for LGBTTTQI+ nursing ākonga has been established in the entire country.”

As someone who couldn’t find any scholarships when they were a student, Meates knew what a difference one could make.

Like Māori, Pasifika and women, rainbow people often faced discrimination — many from their own families — which could create an economic as well as psychological disparity, Meates said.

‘It can start as a kid. Kids are cruel when anybody is different.’

This created not only economic but broader psychological challenges for rainbow people — who endured worse mental health and addiction rates than non-rainbow people,¹ said Meates, who has struggled with depression and addiction.

“If you’re struggling with trying to find a safe place to live or are depressed and can’t even get out of bed, then you’re not going to be looking at doing any further study.”

Homophobic abuse and hate crimes had also been a feature of their life over the years, said Meates, who shares their experiences in [I could nearly see me — the real me](#).

After coming out as transgender seven years ago, Meates found it hard dealing with the challenges of both transitioning and studying as a mature student. Student allowances are only available for three, rather than five, years and coming out as transmasculine, non-binary (after identifying as a lesbian for more than 20 years) was also challenging.

Transmasculine, non-binary is someone assigned female at birth whose gender identity is masculine but not necessarily male.

“At 42, coming out trans, I have to go get on a different bus which was worse than the one I started on, and start at the back of the bus again.”

NZNO national student leaders Shannyn Bristowe and Stacey Wharewera said the scholarship “not only provides invaluable financial support for individuals within our rainbow community to pursue nursing education, but also holds immense significance in fostering a responsive and inclusive nursing workforce in Aotearoa”.

NURSING ‘HIGHLY GENDERED’ PROFESSION



Rainbow student nurse
Elliott Pepper

Third-year UCOL rainbow nursing student Elliott Pepper said nursing was still an “old school” and biased profession when it comes to gender

diversity.

“Nursing as a workforce, is really aware of cultural safety but it is still very much one of the old school professions in that it’s still highly gendered, still highly hierarchical,” Pepper told *Kaitiaki*.

“So as a rainbow student you’re in these very cis-normative, heteronormative hierarchies.”

Elliott said in his experience, discrimination was definitely there, even if people didn’t realise it.

“I don’t think any nurse is going to be explicitly homophobic or transphobic but everyone is subject to unconscious bias. I definitely think within the profession there is that unconscious bias present.”

Rainbow students like Mel Meates who had gone before and succeeded were very important role-models for him, said Pepper, who is a queer trans man.

“If it wasn’t for them, honestly I would have found it really hard to be myself and feel like I fit in within nursing as a whole, as a student.”

Pepper said his experiences of discrimination usually sprang from ignorance rather than hostility but could be “jarring”.

“Then there are things like being uncertain about which bathroom I should use at uni, not knowing what



Shannyn Bristowe

Making it easier for rainbow students to access training, also helped create a health-care environment that embraced diversity, they said.

"Investing in locally trained nurses through this scholarship ensures that we cultivate a culturally and clinically safe workforce, further enhancing the quality of healthcare delivery and promoting a holistic approach to patient care."

UCOL Te Pūkenga's Ashwini Patel, who runs the scholarship programme, said it was a "no brainer" to fill this gap in the community after being approached by Meates.

'That was one reason I wanted to become a nurse - to make things better for people like me.'

"We've heard from a few ākongā who had been looking for rainbow scholarships at UCOL, so it was on our radar."

In Meates' experience, the health system was not safe for trans people — which had made the former orderly, support worker and cleaner want to become a nurse.



Stacey Wharewera

"So many health professionals just don't know how to be culturally safe with trans people. GPs don't know how to write a referral letter — or where to send one. There's just a lack of knowledge, lack of services. That was one reason I wanted to become a nurse — to make things better for people like me."

Meates is now a registered nurse in aged care, and also a rainbow education facilitator at Palmerston North Regional Hospital

people's beliefs are about the rainbow community — being seen as different, which sometimes means I find it hard to fit in," Pepper told *Kaitiaki*. "All these small experiences add up to a bigger picture of feeling like an outsider."

UCOL itself had always been very supportive of Pepper's rainbow identity over the past three years, and he was pleased to see it supporting one of the few scholarships specifically for rainbow students.

Not only would it send a message of acceptance, but it would provide practical help to the rainbow community whose transgender members experienced higher levels of homelessness and other financial disadvantages. Some had to hide their identity because they relied on their family for financial support but knew they would not be accepted.

"But it's mostly an incentive for rainbow students to stick it out and to contribute, see their value in the community — and see themselves as a valued member of the profession."

It also sent a message of "solidarity and inclusivity" to rainbow people at a time where there is a lot of anti-trans pushback in places like the United States, he said. "This is a message that it's okay as a patient to talk about, be open about your rainbow identity."

While Aotearoa was "pretty inclusive" there remained a persistent fear of being discriminated against — evidenced by Burnett Foundation research suggesting in Aotearoa [50 per cent of gay and bisexual men haven't disclosed their sexuality to their GP](https://www.burnettfoundation.org.nz/articles/culture/why-straight-people-shouldnt-throw-around-the-f-word/) (<https://www.burnettfoundation.org.nz/articles/culture/why-straight-people-shouldnt-throw-around-the-f-word/>).

"So this is a great tactical way of breaking down that stigma and letting patients know it's okay to be who you are, it's not something that you have to hide when you're seeking healthcare." Humanity's very strength was in its diversity, he said.

who does diversity training for UCOL and MidCentral Te Whatu Ora staff.

'I really believe strength is in diversity and that's our main strength as humans.'

"I really believe strength is in diversity and that's our main strength as humans – we're all different and that's really good, we all have our own perspectives on things."

The scholarship aimed to support nursing ākonga who are part of the rainbow community and need support with course-related costs or financial support during a placement. It was a "first step" to ensuring nurses met the needs of everyone in the community — and Meates hoped it would take off nationally.

"I'd love to see a knock-on effect, with more rainbow scholarships popping up."

Applications for the June 2024 scholarship are open now, until April 30. Details can be found [here](https://www.ucol.ac.nz/ScholarshipDocuments/MidCentral%20Rainbow%20Scholarship%20Form.pdf) (<https://www.ucol.ac.nz/ScholarshipDocuments/MidCentral%20Rainbow%20Scholarship%20Form.pdf>).

References

1. [Counting Ourselves](http://countingourselves.nz) (<http://countingourselves.nz>). (2022).
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