Contents

NZLocums’ recruitment on target after third quarter of 2013 2
Tweets from the Chair 3
Five-day rural health conference bonanza 5
Taking a locum gap year a positive experience for family 6
The Year of the Black Snake 7
Wairarapa gets the thumbs-up as a rural immersion teaching centre 8
Christmas arrangements for the Network office 8
Scholarships awarded to medical students aspiring to a career in rural health 9
A day to remember for rural Nurse Practitioner 9
Getting connected in Opotiki – so far so good 10
Midland general practitioners (GPs) and hospital doctors have a new diagnostic tool at their fingertips, the Map of Medicine 10
GO Healthy – making a mark on the natural medicines front 11
Q and A with Kaitaia GP Lance O’Sullivan 12

Merry Christmas and a happy New Year
NZLocums' recruitment on target after third quarter of 2013

There are two components to the Ministry of Health’s recruitment contract managed by the Network: Rural Recruitment Service (long term) and Rural Locum Support Scheme (short term).

The following figures and bar graphs show NZLocums’ performance against recruitment contractual targets for the first three quarters of 2013.

- **Rural Recruitment Service** – the purpose of this service is to assist eligible rural providers (currently those with a rural ranking score of 35 or more) with recruitment of long term or permanent General Practitioners and Nurse Practitioners. Our target delivery for the third quarter of 2013 was 15 placements, against which we made 16 placements. This represents 7 percent above target for the quarter. Year to date delivery is 25% above the annual target.

- **Rural Locum Support Scheme** – the purpose of this service is to ensure that eligible providers (currently those with a rural ranking score of 35 or more, but excluding those in Northland) can access up to two weeks’ locum relief per 1.0FTE, per annum. Our target for the third quarter of 2013 was to complete at least 85% of applications received, against which we delivered 90%. Year to date the delivery rate is 96 percent against an annual target of 85 percent.

### Placements in Aotearoa for General Practitioners and NPs!

NZLocums is New Zealand’s only not-for-profit recruitment organisation. We have a range of locum, long-term and permanent positions nationwide and offer:

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- Stunning locations
- Welcoming communities
- Supportive, professional team managing the process.

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www.nzlocums.com
Tweets from the Chair
@opotikigp’s tweetbook

Between September 2 and October 10, 2013 Network chairman and avid Tweeter Dr Jo Scott-Jones posted 34 Tweets with the social networking site. He shares the best of them with readers and strongly encourages others to engage in the practice.

31 TWEETS
195 FOLLOWING
134 FOLLOWERS

Tweets

drjo @opotikigp
07:23 #nzrgpn Interesting article it is not often a medical conference goes by without someone mentioning Maslow. http://t.co/vdXVgKkBgQ

4 Sept

drjo @opotikigp
17:11 Opotiki telehealth launch Mark Eager and Ernie Newman leading the rollout of video medicine in NZ http://t.co/3rsSYnWWz7
17:59 The Ministers and Graeme Osbourne dialed in at the Opotiki telehealth launch http://t.co/XGdRtvFpQR
19:36 RT @NZDoctor_news @opotikigp How is the telehealth launch going? Here’s the story. http://t.co/KeHUXlwHE2 Thanks for your help.

5 Sept

drjo @opotikigp
08:40 21C version of doctor’s house call - Rural Communities innovate to deal with patient need vs system capacity #nzrgpn http://t.co/KSI7vY2VN
19:05 Judy Turner of RHAANZ meets Anders Johnsson Swedish MP and Paediatrician to discuss rural health #nzrgpn http://t.co/ocj5KQkys
19:10 #nzrgpn Anders W Johnsson Swedish MP learned about whanau ora from Te Ao Hou in Opotiki today. http://t.co/fZjvPAMnTi

6 Sept

drjo @opotikigp
03:53 http://t.co/wS4ikGgyv2 #rnzcgp #woncarural Just getting it out there shamelessly. Increasing respect for benefits of international networks.
14:09 http://t.co/SfNxBjy6OI #woncarural #nzrgpn Rural Telehealth
17:37 New Zealand’s Rural Health Alliance inaugural newsletter, #rhaanz #nzrgpn #woncarural http://t.co/ZqEHVeK1q1
07:46 Drjo @opotikgp  Make It Easy Minimally disruptive Medicine – great philosophy of care http://t.co/rlDZbjWB8B via @youtube •

14:48 Drjo @opotikgp  Doctors 'selfish on suicide' http://t.co/EWYcAr8AD via @nzherald - Do rural docs refer less because of lack of access? Is this better?

15:43 Drjo @opotikgp  Telemedicine rolled out in Eastern Bay of Plenty http://t.co/5KlWbKxuYP #radionz #nzrgpn #woncarural

10:01 Drjo @opotikgp  defining value in healthcare - http://t.co/J5U6GtW6ZP* #woncarural #nzrgpn we also need to define "quality" and measure teamwork….

16:24 Drjo @opotikgp  Congratulations to rural GP Dr Lance O'Sullivan named the Public Health Association's Public Health Champion for… http://t.co/QZGADm6W2Q*

16:25 Drjo @opotikgp  RT @NZMAchair Do we want health policy based on scientific evidence or scaremongering? Hear facts on fluoride from @NZMAchair, http://t.co/O1PEW9owP4

17:24 Drjo @opotikgp  RT @NZMAchair Fluoride debate: 'We're well past arguing about the science' - National - NZ Herald News http://t.co/co/bGnAm3tvW via @nzherald:

17:26 Drjo @opotikgp  RT @brookmanknight Six myths about vaccination http://t.co/LVtrdp4xB7 via @smh Nailing it @DrRachie

07:17 Drjo @opotikgp  RT @GPCareUK A really neat interactive timeline of the history of the #NHS by @NuffieldTrust http://t.co/4E42O2URBm

02:45 Drjo @opotikgp  http://t.co/QL2BwEI3pM #nzrgpn #woncarural models of care that work, because the culture is right.

03:29 Drjo @opotikgp  Farm safety 'not a problem'. Fed Farmers don't exactly say that more a reality check #nzrgpn #woncarural http://t.co/y9DzuEKpJu

07:20 Drjo @opotikgp  why HC is stuck & how to fix it. http://t.co/nLbjehRP0p even though the US system is different, I recognise every statement in a NZ context.

07:49 Drjo @opotikgp  Too Much Medicine Is Bad for Our Health http://t.co/979JPgIH92 This seems a call to Minimally Invasive Medicine - adding value by doing less.

07:51 Drjo @opotikgp  RT @glynelwyn RT to help patients find tools made to help them make better decisions ... https://t.co/2WP2dnqzXln

09:00 Drjo @opotikgp  Make It Easy http://t.co/rlDZbjWB8B via @youtube Minimally Disruptive Medicine - not only admirable but important philosophy of care.

17:41 Drjo @opotikgp  RT @mellojonny "Ownership [of your practice] encourages stability, upon which the doctor-patient relationship is moored" http://t.co/cJS94M6Qf2 #RCGPAC

18:27 Drjo @opotikgp  Green light for one RN prescriber model, amber for the other | Nursing Review http://t.co/JAVdEQk1Ba

03:42 Drjo @opotikgp  RT @bmj_latest: The 10 minutes belong to the patient, says GP Brunet... http://t.co/554Ac8uCVA* We must not let this happen here. #nzrgpn

04:01 Drjo @opotikgp  #WMHD2013 http://t.co/uUuHMEFqFa #woncarural #nzrgpn Rural communities have special mental health pressures. Access. Equity. Workforce.

04:08 Drjo @opotikgp  RT @lauren_dean6 @stephenfry this is a compilation that I thought covered it very well. http://t.co/uuyhX9B1lk #WMHD2013

04:48 Drjo @opotikgp  http://t.co/jcYtC30JxN A minimum practice income guarantee - sounds like a solution not a problem to me. #nzrgpn #woncarural

08:36 Drjo @opotikgp  WHO | Tables and Figures http://t.co/bEXPHbBiZR How are we doing? #woncarural #nzrgpn
Five-day rural health conference bonanza

Next year’s NZRGPN conference will focus on the "holistic" health of the country’s rural communities as the backbone of the nation’s economy.

The conference starts with the RHAANZ day (March 12) featuring keynote speakers and workshops.

The RHAANZ programme will focus more on aspects of the broader rural community and will conclude with an AGM and dinner.

A RHAANZ keynote panel discussion will also be held on Saturday afternoon (March 15).

The other four days of the conference will focus on the delivery of rural primary care health services and will include plenary sessions of interest for clinicians, health planners, managers and the broader rural community.

There will also be concurrent streams for GPs, nurses, rural hospital staff, practice management and research. Demand has seen six concurrent session streams included in the program across both Friday (March 14) and Saturday (March 15) of the conference. Delegates will have a wealth of topics and speakers to choose from.

Students, both nursing and medical, are catered for with a keynote session on the Saturday morning (Student and GP registrar multi-disciplinary report) while Northland GP Lance O’Sullivan will host a Q and A session for students as well as a practice model keynote.

Thursday (March 13) hosts various workshops including a PGGP teaching workshop, an insulin workshop (Sinofi Aventis), a clinical skills workshop (plastering, suturing, joint injections) and nurses’ forum (this is part one with part two a Saturday morning breakfast session). Several sector meetings will also be hosted on this day (please refer to the programme for more details).

Following a powhiri on Friday (March 14), a political forum featuring the Minister or associate Minister of Health and health spokespersons from the other political parties, hosted by former journalist now lawyer Linda Clark will tackle the big issues facing rural health and rural health practitioners.

A full social programme is also on offer with a doctors’ and nurses’ dinner (Thursday evening, March 13); welcome cocktail function and official conference dinner (Friday evening, March 14) and members-only forum (Sunday, March 16). A student breakfast forum will be held concurrently with the members’ forum.

The NZRGPN AGM will be held from 5.45pm to 7.15pm on the Saturday night (March 15) concluding with a cocktail function.
Taking a locum gap year ‘on the road’ a positive experience for family

By ROB OLSEN

When Rotorua-based GP Genevieve Matthews decided, with her husband, to take a year out to become a “roving locum” in the South Island, she had no idea how rewarding the experience would be for the entire family.

Genevieve, her accountant husband Stuart and their two pre-school children, were “well ensconced” in their lifestyle in Rotorua where Genevieve says she had been in and out of the workforce since having children. “I had no commitment to a practice, so when the prospect of a locum year looked possible, I thought, ‘we’re off to the South Island’.”

That was in 2012 when the children were aged about 18 months and three years. It was quite good timing because the children were not yet at school, which was a major consideration, says Genevieve. Stu decided to resign from his job and become a ‘house dad’ for the year. The couple decided to buy a caravan and travel from place to place with two to three-month locum stints. “That would enable us, especially the kids, to settle in to a community for a decent period of time. We arranged accommodation in houses while I had locum work”. Overall they spent approximately 10 weeks in the caravan travelling between towns and heading away for long weekends.

On December 20, the family hit the road. After a holiday in Golden Bay, in New Year 2013 they headed to Motueka for a two-month placement, then to Westport for six weeks, to Alexandra for three months, followed by six weeks off in Queenstown for some skiing, then to Gore for four weeks before heading back to Alexandra for a final four weeks and the “beginning of the end” of the journey, says Genevieve.

“Our year away has been an incredibly rewarding experience for us as a family, for Stu and I as a couple and parents, and for me professionally. I’ve had the privilege of working with some exceptional rural practitioners. In particular, teams of nurses who practise to a very high standard within their scope. Rural practice tends to be well supported by specialist colleagues in the cities. For the most part they were only too willing to give advice by phone, and treated me as a valuable GP colleague who has a valid opinion, somewhat refreshing compared to some past experiences.

“In being able to ‘design’ our year away to include lots of long weekends exploring, a few weeks on the road between placements, as well as leaving behind the ‘busy-ness’ and commitments of life back home, we’ve enjoyed lots of quality time together as a family and countless memorable adventures in all sorts of places in this incredibly beautiful country.

“I’m really proud that my children have developed the willingness and skills to meet new people, get to know new places, and try new things, and I hope this will benefit their development and growth as young people. As a couple and as parents, Stu and I have been able to truly slow down and smell the flowers along this journey – sometimes literally as our children bumbled their way along some beautiful forest track in a national park.”

Genevieve says they could not have successfully undertaken the locum stint without the assistance of NZLocums, the recruitment division of the New Zealand Rural General Practice Network that organised the locum placements.

After seeing an advertisement in New Zealand Doctor for NZLocums, Genevieve decided to get in touch when she started planning her year away.

“NZLocums just made it so easy. It’s been amazing. An NZLocums’ relationship manager was ‘in charge’ of me and totally got what we wanted to do. With that in mind, she matched me with suitable practices and sorted out all the details. It’s worked out so well.
The Year of the Black Snake

By Network CE Michelle Thompson

Financial pressures

Looking back on the last five years of penning Christmas columns, my opening comments have tended to reflect on the current year being “busier than usual.” 2013, the Year of the Snake, has not disappointed and has been the busiest and most challenging year yet. Interestingly, 2013 is actually the year of the “Black Snake” - years which are historically seen as financial milestones. Ensuring the sustainability of our organisation has been a key focus of the board and management over recent months and it would be fair to say that our financial situation is the tightest yet.

In September the strategic decision was made to cease trading under the “NZMedics” brand by the end of the year. This arm of the business was focused mainly on hospital specialist recruitment as well as some urban general practice recruitment. Recent consolidation of back-office functions by DHBs - while good for the whole of system – has made it increasingly difficult for commercial medical recruitment agencies to survive. NZLocums - our brand delivering rural general practice recruitment services – will be able to pick up urban general practice and hospital specialist recruitment opportunities should they present themselves in the future.

Membership and recruitment services

Providing advocacy and expertise at a national level is an expensive business and the costs of doing this well have consistently outweighed the revenue received for these purposes. Providing a national rural GP and NP recruitment service is our biggest operational activity and is becoming an increasing challenge. While much of this activity is government funded (in recognition of the fact that market forces do not work, so a level of central intervention is needed) we are still required to operate in the commercial recruitment world in order to attract quality locums. This is becoming increasingly tough as we vie for the same pool of professionals.

In the New Year – as a result of new government procurement rules - our recruitment contract will again be put out for public tender. We hope that you will both support the continuation of this national contract and NZRGPN as the holder.

While it may seem from an individual rural general practice perspective your recruitment needs are being met, perhaps by a variety of local short term solutions, at the time of writing we are aware of 41 permanent GP vacancies across rural general practice – that’s 20.5% of all rural practices. This percentage has remained fairly steady over the past four years. However, it is important to note that these are not the same practices; rather it is a constant churn of professionals across the country. Some practices have more than one vacancy, 6 are deemed critical and two have been on our books for three years or more. It is critical the government continues to fund a rural GP and NP recruitment service and this in turn depends on the demand and utilisation evidenced by rural general practice.

Workforce planning

In the last fortnight we ran a brief survey to ascertain the current state of permanent Full Time Equivalent (FTE) nursing vacancies across rural practices. From the responses to date, 25% of rural general practices have a nursing vacancy of which: 38% are for registered nurses; 23% are for rural nurse specialists; 15% are for enrolled nurses, 15% are for newly registered nurse graduates and 1% is for a nurse practitioner. The areas of common workforce shortages for both doctors and nurses appear to be Whakatane, Wairoa, Waimate, Oamaru and Putaruru. Three of these practices were deemed to have “critical need” as at end of September 2013. More in-depth research through a national workforce survey is required to better understand the current workforce situation and most importantly the future pressure points. We are working with a number of organisations, including the Ministry, to make this survey a reality in 2014.

National locum payroll

As Christmas 2013 looms we have the highest number of GP locums in the country than ever before, and while this is a wonderful achievement, managing a national locum payroll system is placing increasing financial pressure on us. Some fortnights this can amount to $250,000 and while practices are required to reimburse these amounts there can be a lag time between our paying the locum and receiving reimbursement from the practice. As a consequence, we have had to increase the nominal payroll administration fee by 2% effective from January 1, 2014. Again, from an individual practice level, we appreciate that you may feel you are able to process a two-week locum through your own payroll cheaper than this. However, these doctors commit to being in our country for three months or more and during this time they need certainty of placements and income. Therefore, in order to ensure consistency and security for our locums it makes sense for the associated payroll system to be managed at a national level. Please support us in these endeavours and rest assured we make no profit from these charges – it is purely a contribution to the costs of providing the service. Another option we could consider is requiring payment within 7 days and charging a penalty (i.e. use of money) fee for late payments. We’d be interested in your thoughts on this.

Co-CE role

As from January 2014 I will be sharing the role of Chief Executive with Linda Reynolds. This is to help spread the workload and to enable me to devote more time to my farm in the Hawke’s Bay. Many of you will know Linda, she has been with the Network for nearly 10 years and has an incredible knowledge of rural general practice in New Zealand. In this regard she is a unique treasure and I am very much looking forward to working alongside her next year.

Happy Christmas

As part of contemplating what I might do with some spare time on my hands (have no idea what this might feel like), I sat down to read one of my favourite non-work related magazines NZ House & Garden where I stumbled on a lovely phrase by Mary Ellen Chase:

“Christmas is not a date. It is a state of mind.”

Here’s wishing you all a wonderful Christmas and restful New Year with your loved ones.

Ka kite ano
Michelle
Wairarapa gets the thumbs-up as a rural immersion teaching centre

By RILEY RIDDELL

As I have very recently finished my fifth year exams and am in the process of shifting to Hastings for Trainee Intern year, I thought this would be a great opportunity to reflect upon my year, and share some highlights from the Rural Medical Immersion Programme (RMIP).

I was sent over the hill to Masterton, which, after having spent the summer in South America, seemed like a Kiwi paradise. Grass, big mountains, rivers. I remember it didn’t rain in the Wairarapa for a month after we got there and that knocked the hell out of our lawn. I invested in an inflatable whale paddling pool to curl up in after a run.

Two men and two women were sent to the Wairarapa and we all flatted together in the nicest lodgings that I have ever experienced and for half the rent I paid in Newtown.

Our year was split between the local hospital and GP placements in the region. We would alternate every couple of weeks. In the hospital we did orthopaedics, medicine, paediatrics, psychiatry, obstetrics and gynaecology, and emergency. All but one of the hospital consultants were trained overseas, so I really got an international education. House surgeons and consultants were all keen to teach. I found the psychiatry and paediatrics to be a bit quiet but I got to see more of that in general practice. The weekly clinical society meetings served as great lectures for our upcoming exams and the hospital library had all the good books.

I did GP placements at Greytown, Carterton, the behemoth Masterton Medical Centre, and Whai Ora. These placements could get repetitive when you were spending your fifth week with the same GP and there were no rooms for you to see patients. General practice is where I got the most experience seeing patients, which set me up well for the big fifth year Observed Structured Clinical Examination and I have no fear of starting in general practice in a couple weeks.

Each Wednesday we would have a teaching session with our GP coordinator in Carterton (baking compulsory) and the afternoon off for study. There were regular video conferences with the boss [Branko] who would teach on a big topic. We were assessed each term with a day of tests and some assignments to hand in.

I joined the Masterton Athletic Football Club at the sage advice of a physician. We had an abysmal season in the local league and often played with nine men, but I scored a couple goals and got surprised with the most dedicated player award. We had a steady supply of elective students to keep us company, which was a real bonus. The RMIP sent us up to the students’ surgical conference in Auckland where I presented some research I did a couple of summers back.

My conclusion is that the Wairarapa is the best clinical medical school in New Zealand. I was lucky to get this opportunity and would recommend it to anyone. It only works because we have these keen teachers, so a huge thank you to those who made room for students in their practice this year.

Riley Riddell is a student representative on the Network Board.
Scholarships awarded to medical students aspiring to a career in rural health

The 2013 Pat Farry Rural Health Education Trust Travelling Scholarship has been awarded to two University of Otago School of Medicine students who will travel to India, Nepal, Gibraltar and the Falkland Islands to further their rural health education.

John Farry, chairman of the Pat Farry Rural Health Education Trust, has announced that David Neynens (pictured above) from Glenorchy and Rebecca Craw (pictured right) from Tauranga will both receive NZ$5000 to assist their elective travel in the first term of 2014.

"The Pat Farry Rural Health Education Trust Travelling Scholarship assists young people to spend valuable time in innovative and challenging overseas situations, to return, and to become the next generation of idea generators here in New Zealand," said Mr Farry.

The Pat Farry Rural Health Education Trust was established in 2010 to support the sustainability and quality of health services to rural communities.

The medical students have spent the last year in Balclutha (David Neynens) and Greymouth (Rebecca Craw) as part of the University of Otago School of Medicine’s Rural Medical Immersion Programme established by the late Dr Pat Farry in 2007.

"By supporting the learning experiences of medical students like David Neynens and Rebecca Craw, the Pat Farry Rural Health Education Trust continues my brother’s instinct for finding and mentoring rural general practitioners of the future," said John Farry.

To read more, click HERE.

A day to remember for rural Nurse Practitioner

Nurse Practitioner and New Zealand Rural General Practice Network deputy chairperson Sharon Hansen (pictured below) has vivid memories of one – not untypical - day on the rural on-call frontline.

She reflects on events as they unfolded:

"I was on-call in Twizel, which covers the Mckenzie district. The first case of the day was an early one; a very sick child who was not responding to medication, so I made the decision to send the patient through to Timaru by ambulance, courtesy of the Twizel-based crew.

The next call came in just after I had finished my shower and breakfast. It was a patient with chest pain, about 25 minutes away. I went up there, assessed him, put in an IV, gave him some morphine and set off with him to meet the ambulance crew coming back from Timaru after taking the first patient to hospital. The heart attack patient would change ambulances three times before he got to hospital. I would accompany him until Fairlie.

Meanwhile, a palliative care patient had died and because I cannot declare life ‘extinct’ I had to find a doctor who would do it for me and arrange transport for the patient to get to the doctor who was in Timaru. There was no one closer. I had to ring the doctor during the ambulance transfer. I later returned to be with the family of the deceased woman.

The patient’s death was expected and the family were respectful and supportive of having her go to Timaru to the doctor and then to the undertaker.”

Photo credit: Emilia Hansen.
Getting connected in Opotiki – so far so good

The national Telehealth Demonstration Project in the Bay of Plenty has been in operation since March 2013 and launched its Opotiki Telehealth Community in September. Parties involved say they are happy with progress to date.

ROB OLSEN reports.

The project is a joint initiative between the Bay of Plenty District Health Board, the Ministry of Business, Innovation and Employment and the National IT Health Board. Chorus, Ultra Fast Fibre and the Rural Broadband Initiative are also integral to the project.

In Opotiki three GP practices and six or seven doctors, health centres, aged care and palliative care facilities are involved in a project designed to build on telehealth work already underway across the Bay of Plenty. It will eventually be expanded across the Midlands Region before going national.

Telehealth is the delivery of health services and information via telecommunications technologies. In its simplest form it involves a camera and monitor in two separate geographical locations. The connection allows doctors to make patient assessments which often dispense with the need for long and costly journeys or after-hours visits.

The technology lends itself, in particular, to serving rural and remote communities.

Key areas include: care of aged people and those with chronic conditions in the community; mental health, with a focus on child and adolescent care; virtual visits by GPs to aged care facilities; speech language therapy; and emergency departments.

Telehealth Project Facilitator for the Bay of Plenty Health Board Ernie Newman says he is “quietly satisfied we are on the right track”.

“I am happy but not ecstatic with progress to date. The jury is still out but indications are positive that the technology is good for rural or isolated communities. It’s exciting and at a go-forward stage but we don’t want to trip over our own feet. It is better to have a small sustainable outcome initially.”

Diagnostic tool at doctors' fingertips

Midland general practitioners (GPs) and hospital doctors have a new diagnostic tool at their fingertips, the Map of Medicine.

“The Map of Medicine has pathways for hundreds of health conditions. The web-based software works like an online flowchart, guiding health professionals as to what the best treatment options are for patients,” says Health Minister Tony Ryall.

Mr Ryall, joined by local MPs Tim Macindoe and David Bennett and Waikato DHB staff Jo-Anne Deane, Graham Guy and Jan Adams.

Bay of Plenty, Lakes, Tairawhiti, Taranaki and Waikato District Health Boards (DHBs) are part of the Midland region grouping of DHBs that are using Map of Medicine. MidCentral DHB also introduced the tool in 2012 where it is working very successfully.

Story supplied by MOH
GO Healthy – making a mark on the natural medicines front

By ROB OLSEN

If you’ve attended the Network’s conference you couldn’t help but notice the crew from GO Healthy New Zealand. They’re the ones who gush smiles, enthusiasm and product like there is no tomorrow.

They are not alone in that respect but perhaps what sets them apart from most others at a medical conference is their product – a natural health range that you won’t find in supermarkets or online, or on prescription for that matter.

As company director Lisa South readily acknowledges, they are not mainstream or conventional medical products but “supplements” complementary to medicine.

The company was established in May 2008 by Lisa South, Kurt Renner and Greg Driscoll and in September that year they launched their first products. “We had five reps on the road from day one. The reps had customer lists including health stores and pharmacies and they went cold calling and that’s how it started,” says Lisa. GO Healthy only supply to Pharmacies and Health Stores in the New Zealand market. They believe in the advice channel and consumers will not get this in a supermarket or from an online business.

“The key thing is we set out to ensure that customers got quality support and product. The market had not seen anything new for some time. The three of us were very keen to bring something to the market.

“We spent a lot of time talking to customers about what was important to them and the link between medicines and natural health.”

Providing a high-quality, high-margin product was also a priority.

“After five and half years we sit at number one or two in the market.”

The Petone-based company has blossomed during those years to employ 22 staff and their product range now covers 12 categories – general health, women’s health, men’s health, joint health, healthy oils, immune system, sleep/nervous system, weight management, specialty range, active energy, children’s health and Manuka Honey.

“We saw a gap in the market for VegeCaps [vegetable capsules as opposed to gelatine capsules] and where possible we use that product, which appeals to a range of people and groups in the natural health sector including vegetarians, those who are against practises such as animal testing and some religious people or groups.”

The added advantage with VegeCaps is that they are more readily absorbed by the body as well.

Head office and freighting is in Wellington, while manufacturing is done in Auckland because that’s the point of entry for some ingredients. The bottles are made in Auckland too. “We could get them made in China for a fraction of the price. The labels are made in Wellington. As well as keeping the business here it also gives us control over the quality of the product.”

Being owner-operators has advantages too. “We work in the market and are constantly involved in what’s going on … we are up with the science and what’s happening in the world with health and illnesses, conditions, medications and side-effects.”

An annual must-attend event is staged in Las Vegas – the Supply Side West Expo. “We go to lots of trade events but that’s the biggest. You can spend a day walking the trade stands and another two days gathering technical data and attending seminars on new ingredients and the science to support these.”
Q and A with Kaitaia GP Lance O’Sullivan

Network News: Where are you from originally?
Lance: East Auckland. I grew up in Highland Park. I went Hato Petera where I had a fabulous experience.

NN: Are you married or single.
Lance: I am married to Tracy, a nurse who is working in our practice.

NN: How many children do you have and how old are they?
Lance: We have seven children, five boys and two girls, aged 20, 17, 15, 12, 8, 6 and four.

NN: What are your qualifications/achievements?
Lance: I’m a doctor, a Fellow of the Royal New Zealand College of GPs, Rural Hospital Medicine Fellow, 2013 Maori of the year, recipient of the 2013 Sir Peter Blake Award and the PHA Public Health Champion.

NN: When did you decide you wanted to study medicine?
Lance: I was in the seventh form at Hato Petera College when I decided on medicine as a career. An auntie invited me to a Hui featuring traditional Maori healing and a young Maori doctor there talked about traditional and contemporary medicine and this inspired me to pursue a medical career.

NN: What brought you to rural practice?
Lance: The health needs, especially of the rural Maori population, were a big factor and I believe we are making progress, especially with the patients I see. I was inspired to pursue a career in rural health by Murupara GP Bernard Conlon whom I trained under. We in turn are also encouraging and hosting younger doctors to work here and inspiring them to enter rural general practice.

NN: What do you see as the biggest challenge facing rural communities in health?
Lance: Recruiting New Zealand-trained doctors to rural medicine is the biggest challenge we face. There is an aversion to getting involved in rural general practice which actually offers a huge variety of medical practice, challenges and rewards for young doctors.

NN: What motivates you politically in rural/primary health care?
Lance: The disparities. We have a double whammy here with isolation and a high needs Maori population, so disparities are hard to address and I am in a good position to make political comment, and I have a lot to say. I am mindful of the fact that a lot of health issues we are dealing with are strongly influenced by political will and policy, and a lot of us are dealing with that [the politics] in high needs areas alongside issues of health, housing, poverty and education. I guess I have got a political voice and Maori health issues are influenced by politics.

NN: Do you have any political aspirations with local or central government?
Lance: If I can avoid getting involved in politics at a higher level I will, but that’s probably where I could end up heading. I have no firm ideas or aspirations yet but I won’t rule out getting involved politically especially if it could affect change in future health outcomes for high needs rural populations and health professionals who work in rural health.

NN: What do you do in your spare time/what are your interests outside of medicine?
Lance: Whanau, multi-sport and a lifestyle block keep me occupied.

NN: Which New Zealander do you admire the most?
Lance: Sir Apirana Ngata, as a Maori leader (prominent lawyer and politician) who had a selfless approach to his work.

Lance: The best would be those times when people can live or die and you help them live and that’s pretty powerful. Being able to sit back and reflect “I did a good job and someone lived”. The worst would be trying to work with compassion and skill in an inflexible health system.

Lance: The discrepancies. We have a double whammy here with isolation and a high needs Maori population, so disparities are hard to address and I am in a good position to make political comment, and I have a lot to say. I am mindful of the fact that a lot of health issues we are dealing with are strongly influenced by political will and policy, and a lot of us are dealing with that [the politics] in high needs areas alongside issues of health, housing, poverty and education. I guess I have got a political voice and Maori health issues are influenced by politics.
A day to remember for rural Nurse Practitioner continued…

The law says nurses cannot declare or certify someone dead. All rural nurses have this problem, but it will change, says Sharon.

“The wind on that day was a howling nor’wester with icy, horizontal rain, which was seriously swaying the ambulance on the road, and cell phone coverage was cutting in and out. The wind was so bad that police were advising motorists not to travel and had closed the canal roads. The ambulance must have been a nightmare to drive as it was getting buffeted and I get car sick.

“By the time we got the heart attack patient to Fairlie and swapped him over to the Timaru paramedics it was 2pm and the ambulance crew had had no breakfast and no lunch, because they had responded to my first call of the day and had been on the road for hours.”

Sharon “sings the praises of the amazing Twizel ambulance crew”, who she says are the “real heroes of rural prime practitioners”.

Then there’s Murphy’s Law: If it can happen it will.

“We stopped at Lake Tekapo on the way back for a coffee and I accidentally dropped the keys to my car, which I had left on the side of the road when meeting the Twizel ambulance at the Mount Cook turnoff. Not realising that my keys were missing, I found myself locked out of the car and had to get the tow truck from Twizel to bring it back for me. The spare car keys were in the manager’s office in Dunedin. It was a memorable morning.

“I don’t do on-call up there now, but the nurses there say it’s much the same.

We would do 63 hours solo over a weekend, starting at 5pm on a Friday and finishing at 8am on Monday morning. That can be very tiring and quite challenging.”

Sharon’s on-call duty now sees her doing a one in nine roster in the Temuka/Geraldine area, which is a lot closer to the base hospital than the Twizel on-call situation.

“I won’t have to worry about whether the Bourke Pass is open or other roads are passable.

Another plus will be no night calls, as a phone triage service applies, so it’s not so exhausting.”

There will however be a bigger population to service – about 10,000 people compared to 1500. Temuka-Geraldine is a larger rural area to cover with open roads and farming, as opposed to the tourist-related accidents such as fall injuries, common in Twizel, which is a holiday area – although the population can swell to 7000 in the peak season.

Sharon started doing on-call work in July 2007 when she became a Nurse Practitioner, the same year and month she became a Network Board member.

She says on-call is “the real edgy part of practice as a nurse and rounds you out and gives opportunities to get to know the community”.

Taking a locum gap year a positive experience for family continued…

“I can’t speak more highly of the service, it takes all the stress out of the process and all the negotiating and contracts are done.”

As the year on the road draws to a close, Genevieve says the family is looking forward to going home to Rotorua.

“I think it’s going to be strange at first but I have locum work sorted for the summer so that’s a good start.’

Their eldest child will be starting school next year, so this is the time to “settle down”.

Her husband is also looking forward to returning home. While he did not mind being a “house dad” for a year, he did miss friends and the people—contact his profession enabled. “I got to see people every day but he struggled sometimes not having regular contact with people and friends. Although he found ways: in Alexandra he hooked up with a group of fellow mountain bikers and went for regular rides. We also enrolled the children into preschool or day care for a few days a week in each town we lived in so they had some social contact with their peers, and Stu could sneak some time to himself. The children really enjoyed it and coped surprisingly well”.

“It’s been an amazing experience. We didn’t really know what we were in for, especially with little children, but it has far exceeded any expectations of living and locuming in rural or semi-rural locations. We have had the chance to explore so much of the South Island. I’ve fallen in love with New Zealand again.”

Genevieve grew up in Christchurch and attended Auckland School of Medicine from 1998, graduating in 2004.

Five-day rural health conference bonanza continued…

Fun Run

The Pat Farry Fun Run returns for the third year with the Wellington waterfront hosting this event that has grown in popularity from year to year.

For further programme details click HERE to visit the conference website.

Practice discount for Network Conference 2014

A special offer to practices that want to send delegates to the conference has been developed for 2014. Send two delegates and get the third at 50 percent off the registration fee.

For further details click HERE.
Getting connected in Opotiki – so far so good continued...

In the medium to long term the goal is certain: “We would like to see it move to daily use and become routine daily practice. The video camera should become as ubiquitous in health premises as the stethoscope.”

Mr Newman says the project has been lucky to involve clinicians who see the potential in telehealth and Opotiki is an excellent site because of its isolation.

“The alternative to having no video link in an isolated community can mean no treatment at all, especially if there is no doctor and the patient can’t drive anywhere.”

Or there is a long drive to an ED in a bigger town.

He cites the example of Opotiki GP Jo Scott-Jones working as duty doctor in the town. He has taken calls from the assessment room at the local community health centre and saved the need for such a trip because he was able to speak with the health centre nurse and patient by video.

So what’s involved? A lap top and a Cisco Jabber camera and associated software – the cameras are provided free by the project, give excellent subject/image definition and are especially useful when diagnosing wounds and rashes, for example. They are not the sort of high-end camera you would find in corporate board rooms and you can’t tilt or rotate them, but for telehealth they have a very high degree of utility.

Every clinical situation is different. In mental health it’s more important to pan and zoom the camera and see the body language; in dermatology it’s more important to have higher definition images. In pediatrics children see themselves on camera and become a bit more animated, which aids assessment/diagnosis, says Mr Newman.

Every doctor in Opotiki has a camera [and laptop] in their surgery and the local hospice too. They will also eventually be rolled out to district nurses, who are out in the community and may need to talk to the doctor about a condition or assessment.

The use of iPads is also being discussed however the advantage of a separate camera is it can be moved independently, but technology is moving all the time, says Mr Newman.

Where to from here? Mr Newman says eight different projects of one kind or another are being worked on in the Bay of Plenty at the moment, some based on location and some on a particular cohort of patient.

Dr Scott-Jones has had high definition cameras in his surgery prior to the project, used mainly to teach students. The nurse led after-hours service has a camera and this system has worked well, he says.

Overall he is comfortable using the cameras in on-call situations to assess a patient. “I get the impression the nurses are delighted and feel supported and confident about the decisions being made and it definitely makes the after-hours service more sustainable.”

On the birth of his youngest child Dr Scott-Jones decided not to sleep in the hospital when on-call and be based at home, 25 minutes away, a decision based on a previous personal tragedy.

“I’d always felt guilty about that decision and the reduction in service to the community as a result. The nurses and ambulance staff do a wonderful job in lieu but having a doctor there is better. Having the cameras has been a huge step up in ability as an on-call GP to assist the nurses assess and treat in an after-hours situation.

He recalls the patient assessed by camera (referred to by Mr Newman in this story) thought to be having an asthma attack. Assessment via the camera established the patient was hyper-ventilating.

Dr Scott-Jones says in a 1 in 3 on-call roster the cameras are used “pretty much every time he is on duty and four or five times over a weekend”.

Where to from here? “After a few more months’ consolidation, tracking and assessing progress and results and DHB assessment we will look at what other functions can be installed such as consults by specialists on-line, which would be incredibly helpful.

“We are providing a much better service than we were, which is personally satisfying and offsets any angst about not being there in person and I can be at home with my family.”

On the downside there is a need to consider charges to patients because although the practice gets an after-hours payment, Dr Scott-Jones does not, outside of on-call duty. “That will have to be looked at. We would have to pay a locum for cover.”

In the future he can see situations where the doctor or nurse would want cameras with better peripheral vision to look at moles with more accuracy or in patients’ ears or throats, for example. Cameras with better tilt and zoom capability – it’s all doable, he says.

Chorus, is involved in the Rural Broadband Initiative (RBI) delivering fibre to schools, upgrading the rural network with fibre cabinets and broadband equipment and delivering fibre to the new Vodafone mobile sites that will deliver wireless broadband to rural communities.

Chorus head of industry relations Craig Young says the Opotiki telehealth project roll-out has gone smoothly from an infrastructure (copper and fibre) perspective with only one site he is aware of not having fibre available at the front gate – simply because the health centre was further back from the main road.

That site was installed by Chorus by request from the project utilising the RBI pricing, which caters for rural health centres and provides for some discount on the normal going commercial rate.

“We are using fibre where it is available for the RBI and this one site was not on the RBI list but we were able to use existing infrastructure to build to the site.”

Chorus is about to update its MAPS showing where fibre is located nationwide.
Lisa believes their products are gaining gradual acceptance from the medical fraternity, not as replacements for conventional medicines but as complementary products.

“We get a lot of interest from professionals at the rural general practice conference, for example. We’ve only ever had two or three who have said they are not interested in natural products. But that mindset is changing because of the clinical evidence now available. Where you have clinical data to support your product and it works well with conventional medicines to reduce side-effects, it’s a win-win situation.”

Lisa says they can’t track the data because their products are not prescribed but they are doing more and more work with GPs in Tauranga and Hamilton areas. This will extend to other areas in New Zealand next year.

“The idea is that our products work alongside medicines, it’s complementary.”

Lisa cites numerous examples where their products can alleviate conditions such as high cholesterol, digestive complaints, sleep issues, aches and pains, and cramps.

GO Healthy provide a medicine interaction chart for all of their products to assist health professionals when asked if products are safe for consumers to take with medicines.

GO Healthy have the exclusive rights to HOWARU Restore, a blend of five clinically trialled probiotic that they source from DuPont who are the world leaders in probiotics. Evidence is very important to GO Healthy.

GO Healthy are not advocates for replacing medicines, their products are there to support medicines where appropriate, says Lisa.

New Zealand Rural General Practice Network chairman and Opotiki GP Dr Jo Scott-Jones says there is wider acceptance of alternative medicines amongst GPs in New Zealand but also a high degree of anxiety.

“My feeling is and many GPs say it is good to keep an open mind about complementary medicines but we get anxious when people start talking about replacing or stopping conventional medicines for alternative ones.

“We [GPs] are coming from a science background and like to believe there is good evidence supporting what we offer in terms of medication and treatment.

“There are complementary medicines such as probiotics and there is a little bit of evidence that they do help certain conditions but you really need to look closely at studies done – and there have been studies done on probiotics – what’s in them, how are they prepared, is it the same product as examined in the studies?

“There are some exaggerated claims made around alternative medicines too,” says Dr Scott-Jones.

The cost of alternative medicines to patients is another concern, he says.

About 30 percent of people nation-wide are taking herbal medicines. On average he has about one or two patients a week ask if it is okay to take them. “If I am starting someone on a new medicine I ask are they taking something over the counter and I will tell them if it’s okay or not.”

“I try to keep an open mind and recognise there are probably more things in people’s lives that have not been extensively studied by conventional scientific medicine.

“A lot of people ask if it [an alternative medicine] is safe and that’s a valid question.”

Medicines New Zealand, the industry association representing companies engaged in the research, development, manufacture and marketing of prescription medicines, says any claims regarding medicines – conventional or alternative – have to be evidence based.
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