way, central government has acquired increased control over the way practices are run and even the way doctors practise. This reached a peak of populist appeal last December with the health minister's announcement of his plan to encourage patients to rank their GPs' competence and bedside manner on the NHS Choices website. He hopes this will do for health care what Amazon has done for the book trade. It is debatable whether this market approach is appropriate for general practice, which prides itself on the therapeutic relationship between health care professional and patient, rather than on any commercial transaction involved or ranking of quality by the consumer. It seems unlikely that such a shift in ideology will encourage a flourishing future for UK general practice, which is still run mainly as a small independent enterprise at the friendly, local bookshop level, rather than at the multi-national supermarket level.

NZ should be cautious about importing the UK model (which has also cost the UK Government much more than anticipated) without taking these factors into account.

It is a relief to be spared all that and, overall, work in NZ seems more fun, varied and satisfying than in the UK. I hope that we can protect this by resisting the temptations of performance-related pay here.

View from the edge

Emma Storr MB BS Lond., MRCGP

Time is different in New Zealand compared to the UK. There seems to be more of it in general practice, both for appointments and for paperwork. As a result, work is generally much less stressful and I actually get to eat my lunch, talk to colleagues and attend occasional midday meetings. Fifteen-minute appointments are luxurious and, with any time left over, I usually ask the patient if there are other issues they want to talk about. This is so different to practice in the UK where I was always running behind and wondering how I could 'squeeze' in the extras, before rushing out to do home visits. I never asked the patients if there were other things to be discussed. I was always trying to close the 10-minute consultation, not prolong it.

Perhaps it is not fair to compare the busy, inner-city practice in Leeds where I worked for 11 years with the mere 20 months I have spent at Student Health in Dunedin, dealing mainly with healthy, young people. My former practice was full of patients with multiple social and medical problems, many of whom did not speak English and whose health needs were very complex. I used the telephone interpreting service constantly and communication was often far from adequate. At Student Health, my role is simpler and often preventive. Contraception, sexual health counselling and screening for STIs take up many appointments, as well as treating minor injuries. These are often caused by the Dunedin students' insistence on wearing jandals all year round and stepping on the numerous broken bottles strewing the streets. There is alcohol abuse of course and a fair amount of psychological distress, but with seven counsellors on site and an in-house psychiatrist available, there is plenty of expertise to help. It is a far cry from seeing destitute refugees and the lonely, poor elderly in Yorkshire, where the problems were often overwhelming and exhausting for both the patients and the doctors.

And the downsides of general practice here? It seems very strange to have to charge patients for seeing me after working in the socialist NHS which prides itself on free access for all. It certainly influences my decision to ask patients to see me again 'to check how things are going.' I have learned to have a lower threshold for suspecting meningitis or rheumatic fever as both are much commoner here than in the UK, particularly among the Maori population. I find the fewer medicines available frustrating and the need to apply for special authority or consultant approval slightly humiliating. I hate the ACC paperwork.

Many problems are common and familiar to both New Zealand and the UK. It takes months to arrange a non-urgent ultrasound scan. ENT,

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gynaecology, dermatology and orthopaedic outpatients have long waiting lists. On the other hand, when I ring the hospital or pathology laboratory, the staff are charming and helpful. Everyone uses first names and seems anxious to help, instead of interrogating you at great length about your request for admission or information and making you feel a nuisance and unworthy of attention.

What do I miss? Not the pressure and time constraints, not the mounds of repeat prescriptions and not the annual appraisal system. I miss the patients I knew for years, their stories, humour and the even bigger mix of nationalities I came across working in Leeds. I miss the camaraderie between colleagues that comes from working in adversity. But overall I think the Kiwi approach is refreshingly honest, good humoured and the standard of medicine extremely high. I am grateful to be working in such a system and to have been welcomed here with such enthusiasm.

A type of lady's corset?
Support for older people

Ruth Allen MA (Hons) Psych, MA (Hons) Eng, PGDipJour, PGDipClinPsyc, MNZCCP; **Janine Wiles** BA (Hons) Geo, MA, PhD

ABSTRACT

'Older people need support.' What sense do older people themselves make of this apparently simple statement? Comments drawn from qualitative research underway with older New Zealanders highlight the gulf between the language of older people and the well-meaning assumptions of primary health care professionals about support needs. These thought-provoking vignettes show it is crucial to delicately negotiate the ways that support is offered and delivered to people who have long achieved the autonomy and self-sufficiency prized in Western societies.

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Support for older people. 'What on earth is it? A woman's corset?' says the 75-year-old ever-single woman. 'Smothering,' say the over-70s focus group members, discussing what support can mean for older people. 'Propping someone up,' they add. 'I hate it when someone grabs my arm as if I can't manage. I'll ask for help if I need it!' says Lois, 86. 'You lose your ability if too much support is given,' says Maggie, who at 93 moved out of an eldercare 'serviced apartment' because she didn't need the mandatory cleaning and laundry services provided; she could do her own.

Busy physicians are supposed to ensure patients have adequate support, as well as to deal with all the difficulties of the ageing body before them. Ample research has provided evidence for the necessity of 'good social support' to buffer morbidity associated with loneliness and social isolation. But our recent research is showing a yawning gap between professional and lay views on the idea of needing 'support', highlighting what an emotionally-laden and socially-difficult concept it is. We suggest this has significant implications for health practitioners, and that recognising and understanding these complexities may bolster our abilities to enhance the well-being and resilience of older people in our communities.

What support have you given or received in the past week? 'None,' says the 86-year-old childless man who lives alone. Later, he speaks about the neighbour with whom he exchanges the daily newspaper (so she would take action if he didn't appear), his 'mate's wife' who visits weekly, the godson who helped him buy a new car, and the man who comes to mow the lawn (which was 'organised by the doctor').

Another focus group shares stories of 'maintaining their independence'—the daughter who helps them out, the grandson who does the garden and the son who tackled that useless tradesperson are