

more pleasant and the evidence certainly shows they increase patient safety and well-being.

It has been a significant pleasure to sense the small, but growing, and more genuine collaboration at team and practice level. The next challenge is to lift that collaboration to the policy and legislative table and I do not think nursing would be averse to harnessing the historically greater lobbying power of medicine towards such beneficial goals. If primary health care teams are to work as effective teams, and if people are going to have the access to services needed, a few key changes will release the potential of nursing to deliver on these goals. Medicine and nursing could collaborate powerfully

to direct the reduction in legislative barriers, increase the funding and accessibility of nursing postgraduate education, increase understanding about the value of the nurse practitioner role and fast track nurse prescribing legislation. The large-scale establishment of nurse practitioner roles in primary care teams and in residential care or gerontological settings is also long overdue. The key beneficiaries would be patients and they are the goal we share above all others.

References

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1998 vision for year 2003 for members of Pegasus Medical Group

In 1998 **Les Toop** anticipates general practice in the year 2003

You arrive at 0800 to begin the week with the team meeting. Coffee and croissants and 45 minutes to review the tasks ahead for the week. Then on and into your consulting room—you sit down, switch on your workstation and survey the week ahead. The first screen has the week's visits (looks like a quiet week ahead)—to the hospital on Monday and Thursday for lunchtime ward rounds to see longstay patients and any of your flock who are in having elective surgery, a couple of rest homes and tennis on Wednesday. Next, you check email and voicemail from the weekend. There are a series of questions requiring your input—Can Mrs X be safely discharged home? Mr Y doesn't quite have enough points to have his cataracts done, but if you think it is *really* important he will be done anyway but it might not be until next month. Next, the patients who attended the After-Hours over the weekend flick up with the picture of the patient and a medical summary in the corner of the screen to

remind you who they are. Next, up flicks the screen with the utilisation of labs, radiology and pharmaceuticals in the last three months. It looks scary and you decide to view this later in the week (in fact much later). Discharge summaries flash up next and after flagging the necessary follow-up actions are filed electronically on the patient records along with the x-ray and laboratory reports. A paper discharge letter from Australia provides a touch of nostalgia and you tut to yourself at the inconvenience of having to pop it into the scanner before shredding. The important lab and x-ray reports are next and there is an interesting report of someone with an arachnoid cyst. Never having seen one before you double click on the wee icon in the corner and the digital image of the scan pops up in a small window. 'Fascinating,' you think, and make an electronic note in your 'education to learn' folder. Interestingly it won't save, and a message pops up that you must allocate more storage space to this ever-expanding file.

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Mrs X is the first patient and she asks if you could help. She is feeling awful and doesn't know why. This consultation takes 40 minutes and turns out to be quite complex. Realising you are going over time at 20 minutes (the usual consultation length) you nonchalantly stroke the clock icon on your screen (which incidentally is set into your desk to be less obtrusive) This alerts the receptionist of the likely delay and she then phones the third patient to tell them not to rush. As part of the consultation, it turns out that there are major lifestyle problems for Mrs X and her periodic health review is long overdue. You agree to book her in for a 30-minute appointment with one of the nurses later in the week and prescribe some tricyclic antidepressants (which have come back into vogue as the addictive potential of the SSRIs became apparent around the turn of the century, when one in four of the developed world ended up taking them). The prescription is ordered by voice onto your computer, checked and then sent on to the pharmacy (which is an annex to your building and was built as a joint venture in conjunction with the local pharmacist following deregulation two years ago).

Onto the next patient—a pre-anaesthetic check—followed by a difficult diagnostic dilemma of a patient with dizzy spells and a multitude of medical problems. You are able to bring up on screen a new diagnostic algorithm for dizziness, which you read about when browsing the International Family Practice Intranet. It seems that the probability of an acoustic neuroma is somewhere between 10% and 15%, with an 80% chance of the symptom being related to 'old age'. You have a discussion with the patient on the relative uncertainty and between you decide that some imaging would be useful given that level of risk. You are quietly surprised to find that this man is one of the few superannuitants left with medical insurance and you are able to arrange one of the new Digital Oversampling Gamma Globulin Image or DOGGI scans. A simple click online allows an appointment and patient instructions to be printed out.

As you sit down to a well-earned cup of tea (weak, black with double antioxidants) your colleagues join you and you start up a conversation

about a difficult problem the whole practice has with a patient who is requiring regular opiate injections for migraines. Heated debate ensues and it is concluded that the best way to resolve it is to seek the advice of the opiate police—a branch of the Ministry of Health. You fire up the video-phone and have quite a fruitful discussion with one of the men from the Ministry who miraculously (in fact due to recurrent altitude sickness) was at his desk and not on an aeroplane. The rest of the morning consists of a shared antenatal clinic with yourself, one of the nurses and one of the new partnership midwives. Much hilarity ensues as a series of hale and hearty mothers-to-be come and see the team, much collegiality is in evidence. Interestingly, last year, you and your partners set up a profit-sharing arrangement with the nurses in your practice and this is working really well, with improvement in everyone's job satisfaction, work performance and income. The suggestion has now been made that physiotherapists, midwives and others be offered the opportunity to buy into the structure. This has started a lively debate on what constitutes the core versus the extended primary health care team.

Anyway, time marches on and you all have some house calls to do. Both the doctors and nurses set off on their rounds. You arrange to meet with one of the nurses who is having great difficulty with a patient's varicose ulceration. The three of you discuss the options and decide that it is very unlikely that this ulcer will heal without some varicose vein surgery. The patient finally decides that he will use the last of his retirement savings to have these done privately. A couple of quick phone calls has everything arranged for next Tuesday and the surgeon agrees to do these under local anaesthetic using a new laser technique for nothing as long as the patient signs a disclaimer. You make a voice memo to your laptop computer reminding you to visit the patient the following day if he is unlucky enough to still be in hospital.

The following afternoon, a Tuesday, is given over to an annual two-hour practice planning session with an agenda that includes how to best integrate the teaching of the general practice registrar and the nurse vocational training trainee who are

both attached to the practice. Other agenda items include the future financial structure for your organisation, how to deal with the number of requests to join the practice team. The premises yet again are becoming too small and decisions must be made about how big to grow. An offer is being made by one of the local banks to re-finance at an interest rate of 4%, which will allow you to pay off the building over the next three years not five. The practice policy on screening periodic health review and Well Child checks is also due for annual review and the practice manager has produced some statistics and options for the team to consider.

Tuesday night is your monthly Pegasus meeting, which is to cover the topic of the pros and cons of smart cards as well as a clinical topic. Three months ago when this topic was suggested you felt that this was not of great interest. However, last week you read of a colleague who was fined \$50,000 for breaking the privacy legislation when somebody hacked into his smart card reading machine. This is the last meeting before Christmas, and it has been decided to have a small group meeting in a new tax-deductible restaurant which has been set up as a sideline to the ever inventive after-hours multidisciplinary health care facility.

This Wednesday happens to be your fortnightly mid-week day off and you indulge in a day of constructive recreation and have an early night. Thursday seems to zoom by and the end of the week is nigh. Friday morning starts with a 30-minute round-up team meeting, followed by 10 minutes with the accountant by video link (it's cheaper) and a browse through the educational opportunities being offered by the multiple tertiary educational providers competing for your time and dollar.

The first three patients you see jointly with the nurses. The first has been referred to you for your input, the second you brought back to ask the nurse's advice and the third is an antenatal patient who couldn't make it to the clinic. The next patient doesn't attend and you spend a few minutes reviewing the practice immunisation and recall rates. This shows a pleasing response

with a few flagged non-attenders who need to be followed up. After lunch, you spend 15 minutes chatting to the chap who has come to install the new interactive computer used for patient education. Apparently, there is some new, highly interactive software available that you may wish to use with the virtual reality glasses and gloves! You are particularly interested in one on minor surgery. Friday afternoon is the usual last-minute rush, in the middle of which is a patient with a very unpleasant, but quite difficult to diagnose rash that you have now seen three times and neither you nor anyone else in the practice can recognise. You grab your brand new digital camera to take a picture, downloading it onto Dermnet for an opinion, which it is promised should arrive within two days. If this works it will save the patient an invasive biopsy.

Unfortunately it is your turn to run the late Friday evening surgery, a tradition your practice has carried on since the 1960s. Most surgeries now run similar late surgeries and this, together with the extended range of services and continuity provided by teams like yours, has been the final nail in the coffin of the entrepreneurial massproduction centres characterising the late 1990s.

A final check of your email before you leave has a couple of blanket invitations to weekend pharmaceutical-sponsored social functions, and a personal invitation to join another committee of the Transitional Regional Agency for Subsidisation of Health (TRASH for short) which succeeded the ill-fated HFA branch of the Treasury (which was wound up two years ago when it was realised that the average half-life of senior management was shorter than their period of notice and that the transaction costs of employment and redundancy were exceeding salary costs).

You can't help but laugh out loud; 'get real' you think as you turn out the light and tell your computer to shut down. Its random salutation generator responds seemingly instantaneously in its usual dulcet tones, 'Good night my friend, have a great weekend, see you on Monday. [Pause] Don't forget you promised to pick up a takeaway on the home.'