

From the patient's perspective

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Health care services will not be effective if they do not suit patients or if patients have difficulty accessing them. This issue contains a number of research projects conducted from the patient's perspective. Scrymgeour and colleagues examine patients' satisfaction with components of a project aimed at improving cancer care and patient access to services.¹ On a similar theme, Slater et al. explore the factors that might facilitate or inhibit access for Maori patients and their whanau to cancer care services.² Lee and North focus on Maori sole mothers and the barriers they may encounter in accessing primary health care services.³ On a different tack, Fraser et al. look at patients' perceptions of their general practitioner (GP) as a healthy role model, especially with respect to their weight, and whether this impacts on the likelihood that they follow their GP's advice.⁴

Health care services will only be effective if they also have 'buy-in' from primary care staff. McKernon and Azariah evaluate a pilot programme aimed at implementing the chlamydia management guidelines.⁵ They identify areas of difficulty encountered by all members of the primary care team, highlighting the need to include staff input when designing programmes.

In both New Zealand and Britain, the goal is for 50% of medical graduates to train as GPs, a target we are a long way from reaching at the moment. So how do we ensure that we select medical school students with the inclination and attributes for general practice? In our lead paper this issue, Poole and Shulruf researched whether student demographic variables or selection scores correlate with propensity to general practice.⁶ Concerningly, they found the only association was an inverse relationship with the aptitude test (UMAT) used at The University of Auckland, with lower scores on this tool predicting

stronger interest in general practice. Our guest editor, Dr Anne Stephenson, Director of Community Education in the undergraduate medical programme at King's College, London, reflects that if this finding is reproduced with similar aptitude tests used at different universities, we may need to reconsider how we select medical students, lest we exclude from training the very ones we need.⁷

The last two studies are community-based. Dewes, Scragg and Elley look at the role church-going plays for Pacific peoples with respect to diet, physical activity and obesity.⁸ Church attendees were more likely to have unhealthy eating behaviour and be inactive; hence, the church may be an important venue and change agent for weight management interventions. The study of sleep disorders by Fernando and colleagues was conducted in high schools.⁹ They found that sleep difficulties were common in adolescents, often occurring in conjunction with depression, anxiety and substance misuse, something for GPs to consider with their younger patients.

The *Back to Back* column this issue is on whether New Zealand water should be fluoridated. I chose this topic early in 2013, with no real knowledge of the evidence for or against the moot. While I suspected the evidence supported that community water fluoridation (CWF) leads to reduction in dental caries, I wondered about the potential for harm from mass treating a population whose consumption of water differs, leading to a variable dose of fluoride ingested. Events have overtaken me, with this topic hotly debated in September as to whether fluoride should be added to Hamilton water. The city voted in favour.¹⁰

In our *Back to Back* column, Professor Murray Thomson argues cogently that CWF is a safe and

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effective public health intervention.¹¹ Mr Mark Atkin counters that CWF does not reduce tooth decay and cites a number of potential harms.¹² What has convinced me in favour is, firstly, evidence that CWF appears to be an effective means of preventing dental caries, especially of benefit to Maori and Pacific children who carry the greatest health burden from rotting teeth, and secondly, the fact that New Zealand water supplies have very low levels of natural fluoride. CWF increases this to 0.6–1.1 mg/L, which is lower than the naturally occurring levels in some countries, including China, India, and parts of Africa, and the potential risk of harm is at far greater concentrations. I invite you to read and decide for yourself.

Finally, Wee and colleagues outline the second part of their treatise on dynamic consent (Part 1 was the *Ethics* column in the September issue¹³), a concept developed to manage the use of health-related information and samples.¹⁴ They address using the dynamic consent approach in the context of international online initiatives and how these fit within New Zealand's regulatory framework. While managing the ever-growing volume of personal health information available digitally has technical and technological challenges, ultimately it is the ethical considerations that need to be addressed.

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