Forces of nature

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The story goes that King Canute set his throne by the sea and rebuked his courtiers when the tide rose and wet his feet. Ordering the tide not to rise did not work. The truth of the story is lost in history, but the apocryphal message is that, however powerful men (and women, of course) may be, the forces of nature will always win.

Many papers of this issue share a common thread of response to inexorable change – the inevitable ageing of our population and the consequences of providing health care in an old fashioned health system structure, the evolution of healthcare education and health professions, and disparate patient views on preventive health care. Primary health care has always adapted to these, and similar issues. Hashim discusses the core, universal values of the medical part of primary health care.[1] Knowing that the foundation has remained stable for many years permits considerable, ongoing revision of the superstructure.

We have two papers in this issue reporting research into preparing GPs for 21st century general practice. Le Comte *et al.* report their evaluation of the new House Officer attachments in one region.[2] Although GPs, house officers, and patients all appreciated the educational value of these attachments, there were challenges in dealing with the financial costs to general practices. The funding model for 20th century house officer training is at odds with the ideals of house officer preparation for 21st century medical practice and solutions have yet to be found. Morgan *et al.* report on the ophthalmology exposure of 884 general practice registrars in Australia, providing a useful view of the common eye conditions registrars deal with and, by inference, providing information about where education should be targeted.[3]

A wellness-orientated health system serving a growing elderly population needs to embrace the inevitability of death. Llewellyn *et al.* conclude from their research that patients could benefit from healthcare providers being less coy about introducing discussions about death.[4] The keeping-people-alive goal of 20th century health systems has left healthcare providers ill prepared for such conversations outside of acute death events, and patients bereft of opportunities to express their fears, plans, and wishes.

Keating offers practical advice about how to improve the ethnic equity of the primary health care superstructure.[5] Meredith-Jones *et al.* identified one area of ethnic equity: in their study there was no significant difference between, Māori, Pacific, Asian, and European parents in their recognition of obesity in their children.[6] Our guest editorial discusses the concept of obesity or 'fatness', highlighting the four papers in this issue relating to nutritional issues.[7] Are we, as a society, in the grip of a 'moral panic' about the way we eat, our editorialist asks?

The research of Arroll, Ndukwe, Gauld, and Muller (along with their colleagues) provides further directions for 21st century primary health care revisions.[8–11] Antidepressant medication should be cautiously prescribed because their effectiveness studies may be biased, according to Arroll's updated systematic review of antidepressant effectiveness in primary care.[8] Similarly, the low participation rate in Ndukwe's survey gives plenty of scope for bias,[9] but the study at least makes a contribution to increasing knowledge of healthcare revisions appropriate to an aged population. The research suggests that antipsychotic medicines are not widely used in rest homes, but when they are, they are frequently associated with over-sedation and falls.[9]

At the other end of the age spectrum, the research of Gauld *et al.* relates to pregnancy.[10] By talking to young mothers, these researchers found that if mothers failed to receive pertussis

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vaccination in pregnancy, it was generally because of communication failure: they were unaware that they should or could be immunised.

Addressing an alternative communication method now available to healthcare providers, Muller's team found that text messaging between healthcare providers and patients is now quite common.[11] However, texting causes some disease among providers who are unsure of the confidentiality and privacy dimensions of texting. They want education.

GPs also want further education about nutrition, according to Crowley *et al*.[12] Not all GP participants in Crowley's study thought more detailed nutrition knowledge was their particular business, though. Some thought it more appropriate for practice nurses to upskill in this area. Like GPs, the pharmacists in the research by Gray and her colleagues report some ambivalence regarding their role in nutrition advocacy.[13] Beckingsale's team offers a solution: better integration of dietitians into primary health care teams.[14] Although this was a small interview study, its findings suggest that uncertainty about the best processes to deliver dietetic advice in primary health care is mostly what inhibits the availability of dietetic services, as dietitians are keen participants in general practice teams.

Martini can be relied upon to propose a natural solution.[15] This time, she discusses green tea as a natural appetite suppressant – or not.

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