# Preparation for catastrophe

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Our last issue, 1 September 2010, featured a seemingly prescient guest editorial 'Are we ready for the big one?'[1] At 4:35 am on 4 September, Christchurch was struck by a magnitude 7.1 earthquake.

The RNZCGP's annual conference was halfway through in Christchurch when the earthquake occurred. There were a plethora of GPs in town, myself among them. Dressing and evacuating from my hotel by the light of my iPhone, I joined my colleagues congregating in sub-zero temperatures. Googling 'civil defence' informed me that 'There are no declared civil defence emergencies in New Zealand'. 'Christchurch earthquake' was more helpful, stating that a 7.4 magnitude earthquake had struck (later downgraded to 7.1) with few apparent casualties. Fortunately there was little need for the assembled doctors to offer our services at the city hospital and emergency clinics.

The earthquake caused significant damage in Christchurch city and the Canterbury region, although there was no loss of life and few injuries. This was in dramatic contrast to the January 7.0 earthquake which devastated Port au Prince, Haiti, killing about 300 000 people, rending over a million homeless with after-effects including an outbreak of cholera now sweeping the country. It is a powerful reminder of the inequity existing between a poor and a developed country. The New Zealand (NZ) buildings largely withstood the earthquake, in stark contrast to Haiti's shanties. Power was quickly restored, resources mobilised and essential services such as water and sewerage systems either repaired or alternatives provided. There was a rapid, coordinated local and national government response, with advice and aid soon available on many fronts.

However the Christchurch quake and numerous aftershocks (2500 eight weeks post-quake) have taken their toll on many, with sleep disturbance and renewed anxiety as the jolts continue. People exposed to the effects of earthquakes are susceptible to post-traumatic stress disorder (PTSD) and trauma-focussed cognitive behavioural therapy (CBT) is the most effective intervention.[1] PTSD only can be diagnosed four weeks or more after exposure to the traumatic experience. Parsonson and Rawls have found that they can train professionals in key CBT trauma intervention skills in six weeks, who then can intervene successfully in both children and adults with rapid beneficial effects even in cases of severe PTSD symptoms 'so that symptoms such as avoidance, re-experiencing, insomnia and panic attacks became manageable, allowing normal functioning to be achieved'.[1]

While our Christchurch primary care services have coped admirably with the quake aftermath, the suggestion that NZ should have primary health care personnel trained to deliver CBT for trauma to be prepared for the effects of any major catastrophe seems sensible. This earthquake is likely to be more of a wake-up call than the 'big one'—our geographical location renders us potentially vulnerable to natural disasters. Our capital city sits on the Wellington Fault, a collision zone between the Australian and Pacific Tectonic Plates. The Auckland region has 49 volcanoes and with the last eruption about 600 years ago, another eruption is inevitable, although not necessarily in our lifetimes.

The Christchurch health sector certainly has been getting experience in collaborative responses to emergency. This issue includes a paper by Williams et al. describing the coordinated response of Canterbury's health services to the Influenza A H1N1 09 pandemic last year.[2]

This issue also includes several research papers addressing the theme of chronic disease and patient self-management. Cutler et al. report the evaluation of a primary care–based healthy lifestyle programme for overweight women,[3] and Lawrenson et al. explore the education patients with newly diagnosed type 2 diabetes receive to

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help them self-manage their condition.[4] Horsburgh and colleagues report on the feasibility of assessing the Flinders Program™ of Chronic Condition Self-Management[5] and surveyed NZ practice nurses trained in the Flinders model.[6] Although 500 nurses have received training, use of Flinders tools and processes in practices appears to be very limited. This has important implications regarding funding of training for complex interventions if the support and infrastructure are not available for the learning to be implemented and sustained.

A study by Rademaker and Oakley has found that melanomas detected by screening using whole-body photography and sequential digital dermoscopy imaging services are thinner than those diagnosed by traditional diagnostic methods.[7] It remains to be seen whether earlier detection through screening translates into improved outcomes. Another study involving cancer screening explored experiences of women with high familial risk of breast cancer gene mutations.[8] The researchers found that contrary to expectations, genetic testing, screening and prophylaxis may reduce rather than improve the women's peace of mind.

A couple of initiatives by NZ general practitioners (GPs) are reported. Use of a standardised protocol by practice nurses to request International Normalised Ratio (INR) tests and adjust warfarin dosage was found to be more efficient than the usual ad hoc GP method, without compromising patient care.[9] A Dunedin practice replicated Lawton et al.'s intervention for increasing opportunistic screening for chlamydia.[10] Although they managed to increase their screening and detection rates substantially, post-intervention audit revealed that these had dropped back to baseline levels.[11] This was similar to Lawton et al.'s findings, and barriers to sustaining opportunistic screening are discussed. We invite other practices to share their experiences on this issue.

In a *Viewpoint* article about improving health outcomes for our children and achieving low or no-cost funding for New Zealand under–six-year-olds, the authors encourage debate on whether free child health care, including after-hours care, can be realised.[12] Again *Letters to the Editor* are welcome.

Other topics in this issue include a review of requirements by different countries for medical registration, recommending that increased flexibility would help address workforce shortages.[13] Two doctors go *Back to Back* on whether patients over 75 years with ≥15% five-year risk of a cardiovascular event should receive statins.[14,15] The *Ethics* column explores whether public funding of treatments such as bariatric surgery for obesity (a condition which the patient may be considered to have 'allowed to occur' in some way) essentially harms others by unfairly laying claim to shared resources.[16] Along with our other regular columns, there is plenty here for your summertime reading.

**References**

1. Parsonson B, Rawls J. Are we ready for the big one? Lessons from a brief war that could apply to New Zealand primary health care services following a major disaster. J Prim Health Care. 2010;2(3):180–2.
2. Williams D, Begg A, Burgess K, et al. Influenza H1N1 2009 in Canterbury: a case study in pandemic response co-ordination. J Prim Health Care. 2010;2(4):323–9.
3. Cutler L, King B, McCarthy N, Hamilton C, Cook L. Appetite for life: an evaluation of a primary care lifestyle programme. J Prim Health Care. 2010;2(4):281–7.
4. Lawrenson R, Joshy G, Eerens Y, Johnstone W. How do newly diagnosed patients with type 2 diabetes in the Waikato get their diabetes education? J Prim Health Care. 2010;2(4):303–10.
5. Horsburgh M, Bycroft J, Mahony F, et al. The feasibility of assessing the Flinders Program™ of patient self-management in New Zealand primary care settings. J Prim Health Care. 2010;2(4):294–302.
6. Horsburgh M, Bycroft J, Goodyear-Smith F, et al. The Flinders Program™ of chronic condition self-management in New Zealand: survey findings. J Prim Health Care. 2010;2(4):288–93.
7. Rademaker M, Oakley A. Digital monitoring by whole body photography and sequential digital dermoscopy detects thinner melanomas. J Prim Health Care. 2010;2(4):268–72.
8. Crump R, Fitzgerald R, Legge M. 'Going-to-have-cancerness': a study of living with increased risk of BRCA1 and BRCA2 mutations for six South Island women. J Prim Health Care. 2010;2(4):311–7.
9. Wright K. An audit of two methods of anticoagulation monitoring in a general practice. J Prim Health Care. 2010;2(4):318–22.
10. Lawton B, Rose S, Elley C, Bromhead C, McDonald J, Baker M. Increasing the uptake of opportunistic chlamydia screening: a pilot study in general practice. J Prim Health Care. 2010;2(3):199–207.
11. Lawless S. Letter to the Editor: Sustaining chlamydia screening is difficult. J Prim Health Care. 2010;2(4):347.
12. Fancourt N, Turner N, Asher I, Dowell T. Primary health care funding for children under six years of age in New Zealand: why is this so hard? J Prim Health Care. 2010;2(4):338–42.
13. Leitch S, Dovey S. Review of registration requirements for new part-time doctors in New Zealand, Australia, the United Kingdom, Ireland and Canada. J Prim Health Care. 2010;2(4):273–80.
14. Wells S. All people over 75 years with a five-year CVD risk of >15% should be treated with statins unless specifically contraindicated—the 'yes' case. J Prim Health Care. 2010;2(4):330–2.
15. Mangin D. All people over 75 years with a five-year CVD risk of >15% should be treated with statins unless specifically contraindicated—the 'no' case. J Prim Health Care. 2010;2(4):333–5.
16. Jonas M. Obesity, autonomy and the harm principle. J Prim Health Care. 2010;2(4):343–6.