The challenging and complex nature of primary health care

Felicity Goodyear-Smith MBChB, MGP, FRNZCGP, Editor

Last issue our *Back to Back* debated whether retinal and subdural haemorrhage and encephalopathy in a baby with no signs of impact trauma is likely to be due to natural causes rather than shaking.[1,2] This has elicited a strong response in the form of *Letters to the Editor*, all of which express concern that natural or non-traumatic causes of death may be overlooked when the automatic assumption is made that abuse has occurred.[3] The argument is extended to the case of the Kahui twins, with the suggestion that the bleeding and fractures suffered by these three-month-old babies could be the result of Barlow's disease (infantile scurvy). Given that these were surviving twins from triplets born prematurely at 29 weeks gestation and bottle-fed with formula, the possibility that they were severely vitamin C depleted seems plausible. This question could be answered by plasma ascorbic acid analysis, had this been done. The argument is clouded by the extravagant claims for mega-doses of vitamin C as a panacea in people who are not vitamin C deficient, but certainly the idea that some cases of bleeding and fractures in young babies may be due to infantile scurvy rather than abuse is food for thought.

This September issue advances a number of other challenges. *Back to Back* raises the issue of whether primary care services should be provided free, with patient fee-for-service abolished. Main, a general practitioner (GP) employed in the special medical area of the Hokianga, argues strongly for salaried GPs,[4] whereas Marshall counters equally forcefully that removal of patient co-payment is neither desirable nor affordable.[5] In Vaikoloa, Fa'alili-Fidow acknowledges that encouraging Pacific families not to co-sleep with their babies as a measure to reduce sudden infant death does not deal with the reality that they may lack a cot, warm bedding and a heated room.[6] In our *Ethics* column Wee presents the interesting dilemma of whether or not patients' information from genetic testing should be passed on to their genetic relatives.[7] What is our duty to warn, and how should a patient's rights to confidentiality and privacy be balanced against potential gains to third parties from disclosure of this personal information? In three disparate *Viewpoint* pieces, Bryant reviews the literature and concludes that none of the current interventions to get people to comply with taking their medications appear to be very effective,[8] Scahill argues that the community pharmacist needs to join the doctor and the nurse as the tripartite core of the primary care team,[9] and Sullivan outlines the mental health challenges ahead from the ongoing re-traumatisation of earthquake-shaken Christchurch residents, both patients and their primary health care providers.[10]

These challenges exemplify the breadth and the complexity of our discipline, where anything that may affect the health or happiness of our patients and their families potentially falls within our realm.

These challenges exemplify the breadth and the complexity of our discipline, where anything that may affect the health or happiness of our patients and their families potentially falls within our realm.

CORRESPONDENCE TO:
Felicity Goodyear-Smith
Professor and Goodfellow Postgraduate Chair, Department of General Practice and Primary Health Care, The University of Auckland, PB 92019 Auckland, New Zealand
f.goodyear-smith@auckland.ac.nz

Original research in this issue is similarly diverse. Hassink-Franke and colleagues report on preliminary findings suggesting that simple problem-solving treatment provided by GP registrars may be effective in reducing patients' emotional symptoms.[11] In our *Guest Editorial*, Chris Dowrick, a British professor of general practice with a distinguished career in mental health, views this as a promising alternative to what he identifies as our other options: taking patients' emotional burdens upon our own shoulders, prescribing our favourite antidepressant, or relegating the problem through referral to psychological services for which the patient may face a lengthy wait, should these actually be available.[12]

On a very different tack, Reti and colleagues have explored the access and literacy with the Internet of diabetic patients in a Northland general practice.[13] They found that rural Maori with diabetes have a surprisingly high Internet access. This opens the door for online health interventions for Maori with diabetes. Educational initiatives to improve their IT literacy could make use of their extended-family living situations and networks, with the younger IT-savvy members of the whanau assisting their elders to use online tools and resources.

Other research in this issue explores issues around community pharmacists' knowledge of NZ health disparities,[14] identifies that pharmacists dispose of most unused liquid and class B controlled drugs into the sewerage system with potentially harmful environmental consequences,[15] examines reasons why patients and practices may choose not to be involved in a study of medication adherence,[16] and looks at the educational value of peer groups to GPs.[17] A small exploratory study finds that families living with an addicted member have strategies to cope, but do not demonstrate positive components of resilience such as the ability to persist and thrive in the face of these adverse circumstances.[18] Lastly, in our *Improving Performance* section, Gregg and colleagues report on the outcomes of an interdisciplinary rehabilitation programme from chronic low back pain that can be used in a primary care setting.[19]

We welcome thoughtful and lively discussion about these issues through our *Letters to the Editor.*

References

1. Rorke-Adams L. The triad of retinal haemorrhage, subdural haemorrhage and encephalopathy in an infant unassociated with evidence of physical injury is not the result of shaking but is most likely to have been caused by a natural disease—the 'no' case. J Prim Health Care. 2011;3(2):159–64.
2. Squier W. The triad of retinal haemorrhage, subdural haemorrhage and encephalopathy in an infant unassociated with evidence of physical injury is not the result of shaking but is most likely to have been caused by a natural disease—the 'yes' case. J Prim Health Care. 2011;3(2):159–64.
3. Galaznik J, Wojcik D, Godfrey M. Letters to the Editor: Response to the Back to Back debate about the effects of shaking a baby, in the absence of any impact trauma. J Prim Health Care. 2011;3(3):252–4.
4. Main S. Co-payments must go!—the 'yes' case. J Prim Health Care. 2011;3(3):228–30.
5. Marshall T. Co-payments must go!—the 'no' case. J Prim Health Care. 2011;3(3):230–1.
6. Fa'alili-Fidow J. Vaikoloa: Pacific SUDI and stillbirth prevention. J Prim Health Care. 2011;3(3):234–5.
7. Wee R. Disclosure of genetic information to at-risk relatives: the Privacy Act and professional guidance in New Zealand. J Prim Health Care. 2011;3(3):237–9.
8. Bryant L. Medicines adherence—evidence for any intervention is disappointing. J Prim Health Care. 2011;3(3):240–3.
9. Scahill S. Community pharmacy does not appear as part of the collaboration discourse within New Zealand primary care. J Prim Health Care. 2011;3(3):244–7.
10. Sullivan S, Wong S. An enhanced primary health care role following psychological trauma: the Christchurch earthquakes. J Prim Health Care. 2011;3(3):248–51.
11. Hassink-Franke L, van Weel-Baumgarten E, Wierda E, et al. Effectiveness of problem-solving treatment by general practice registrars for patients with emotional symptoms. J Prim Health Care. 2011;3(3):181–9.
12. Dowrick C. Beyond the prescription pad. J Prim Health Care. 2011;3(3):180.
13. Reti S, Feldman H, Safran C. Online access and literacy in Maori New Zealanders with diabetes. J Prim Health Care. 2011;3(3):190–1.
14. Aspden T, Butler S, Moore B, Sheridan J. New Zealand health disparities—pharmacists' knowledge gaps and training needs. J Prim Health Care. 2011;3(3):192–6.
15. Tong A, Peake B, Braund R. Disposal practices for unused medications in New Zealand community pharmacies. J Prim Health Care. 2011;3(3):197–203.
16. Chang S, Horsburgh S, Norris P, Braund R. Recruitment and retention of primary care patients into a research study investigating medication adherence. J Prim Health Care. 2011;3(3):204–9.
17. Lillis S. The educational value of peer groups from a general practitioner perspective. J Prim Health Care. 2011;3(3):218–21.
18. Moriarty H, Stubbe M, Bradford S, Tapper S, Lim B. Exploring resilience in families living with addiction. J Prim Health Care. 2011;3(3):210–7.
19. Gregg C, Hoffman C, Hall H, McIntosh G, Robertson P. Outcomes of an interdisciplinary rehabilitation programme for the management of chronic low back pain. J Prim Health Care. 2011;3(3):222–7.