The path towards perfect practice

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In our lead paper this issue, Mitchell and colleagues look at the clinical severity of illness in children in a community outbreak of measles and find that those who have been vaccinated previously have significantly less severe illness despite inconclusive measles serology.[1] This indicates benefits from immunisation despite the apparent vaccine failure. In our guest editorial, Mary Ramsay, Head of Immunisation for Public Health England and her colleague Kevin Brown are of the opinion that such secondary infections from waning immunity are not very contagious and unlikely to contribute to further measles transmission, therefore probably will not impede strategies towards global measles control.[2]

For many years New Zealand has funded the annual 'Get Checked' (now the 'Diabetes Care Improvement Package') general practice review of patients with diabetes. It has proved challenging to maintain patients within the programme, although research has shown that once patients have had two or three reviews, they are more likely to continue participating. A study by Keenan and colleagues found that younger patients (<60 years) and Maori are less likely to participate, but practice characteristics also play a part, with increased participation from patients in practices with a higher practice nurse to general practitioner (GP) ratio.[3] A phenomenological study by Janes et al. of the lived experience of people with diabetes casts some light on why patients may not take up the offer of free check-ups.[4] Barriers to good diabetes care may include patients' fears, unscientific beliefs, expectations and misunderstanding about diabetes. Clinicians need to comprehend these and adopt a patient-centred approach to enable their patients to gain glycaemic control.

Clarity of communication is not simple. A study which conducted in-depth interaction analysis of video-recorded consultation and post-consultation interviews with GPs and patients found instances of communication mismatch, even when the GPs knew they were being recorded, GPs and/or patients were unaware that these misunderstandings had occurred, and both patient and GP thought that the consultation had gone well.[5] Communication is far more problematic with patients who are not proficient in English, and Seers and colleagues found that less than 1% of general practice consultations in Canterbury involving non-English-speaking patients used interpreter services.[6] Getting it right—both the process of a consultation and the ensuing health outcomes—is, of course, important. Our *Ethics* column this month explores the various New Zealand agencies tasked both prospectively and retrospectively with holding doctors accountable, to inform patients about actions and decisions, to justify these, and to suffer punishment should evidence be found of misconduct.[7]

Achieving best practice is challenging. Two studies this issue address the practical implementation of guidelines. One area with little room for error is identifying patients having transient ischaemic attacks (TIA) who have a high risk of imminent stroke and initiating best medical treatment, in accordance with the New Zealand TIA Guidelines,[8] the same day wherever possible. A pilot study has found that GPs using a primary care electronic decision support tool provided appropriate and safe early management for such patients, and a randomised controlled trial of the tool is now underway.[9] Another pilot project trialled the implementation of the Chlamydia Management Guidelines,[10] using a nurse-led approach to increase opportunistic testing.[11] While the project did produce a large increase in testing, research has yet to be conducted to demonstrate whether this is sustainable and cost-effective.

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In a *Viewpoint* article this issue, Savage explains that, as well as GPs following evidence-based practice, their practice may also inform evidence—for example, when they report adverse drug reactions observed in their patients to the NZ Centre for Adverse Reactions Monitoring (CARM) database.[12] Such cases may identify previously unknown serious adverse reactions, or generate hypotheses to be tested in formal trials.

Other research in this issue addresses the timeliness and safety of a locally provided abortion service in a high-deprivation community,[13] the suitability of the location where medications are stored in NZ households (warm and humid conditions in kitchens and bathrooms may speed medicine degradation),[14] and a health promotion perspective identifying the need for mental health initiatives to include services appropriate to the high-needs gay, lesbian, bisexual, transgender and intersex subpopulations.[15]

Finally, our *Back to Back* debate reveals the delicate balance needed between counselling people to avoid sun exposure to prevent skin cancer and adverse cosmetic effects (John Kenealy[16]) and ensuring people, especially elderly Europeans, receive sufficient sun exposure to create vitamin D and maintain bone strength (Ian Reid[17]).

With so many competing interests, there is no one sign-posted pathway to best practice. General practice requires the continuous weighing up of benefits and harms, of actions and inactions, the ongoing two-way conversations between patients and their health providers. While we may strive to attain it, 'perfect practice' is unachievable.

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