The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

EDITORIAL

The essence of primary health care research

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'. . . *research because we need practical answers to practical questions.*'[1]

We strive in this Journal to publish research that captures the essence of primary health care. That means that we look for articles that provide practical answers to practical questions arising from clinical practice in diverse primary health care environments.

In the busy-ness of everyday clinical practice, amid the bureaucratic burdens of providing healthcare, and with the goal of 'saving lives' firmly embedded in both lay and professional ideas of medicine, it is easy to overlook the bigger picture purpose of the patient-centred healthcare that clinicians worldwide are now expected to provide. This issue has an audit article prompted by one general practitioner (GP) taking stock, wondering if saving lives is what his patients really want of him, and seeking to understand what makes life worthwhile for them so that he can assist them to achieve as many 'best days' as possible.[2] Andrew Corin asked his patients what their best day looked like. The question was challenging for many patients and many of their answers surprising for our author. We invite you to consider whether a similar audit might be useful in your practice.

GPs are especially important to certain vulnerable groups of society, as McDaid *et al.* found in their analysis from the large cohort study Growing Up in New Zealand.[3] This study has previously shown that Pacific women are at higher risk of perinatal depression than other women in New Zealand.[4] The in-depth analysis of this earlier finding adds the new knowledge that having a regular GP before they become pregnant is a solution, reducing the risk of depression for the Pacific women in the study.[5]

Two articles in this issue focus on Māori. One uses a Kaupapa Māori approach in investigating the impact of osteoarthritis on the lives of seven Māori women.[6] This research identified both experiences that might be shared by osteoarthritic women of any ethnicity (pain, frustration, limitation of social activities) and an additional understanding of the effect of the disease on the wairua (soul) of study participants as it forces their abandonment of aspects of marae life that become impossible for their bodies to maintain. Osteoarthritis is predicted to affect around 17% of New Zealand adults by next year (2020)[7] and it is a condition that people live with, rather than die of, so it is time we made accessible some of the sustainable models of care that have already been developed by these authors and others.[8] The other paper reports on the achievements of a multidisciplinary programme run in Northland and aiming to empower patients to understand the prevention and management of gout.[9] This report provides practical lessons to the wider primary health care community, showing how known ethnic inequalities in one health issue can be systematically addressed by re-arranging health services to empower a whole team of health care providers. This careful evaluation showed that even after some years of effort, ethnic disparities, though reduced, remained – leading to plans for further adjustments to the intervention.

We also have an article about long-acting reversible contraception (LARC) for adolescents.[10] Duncan *et al.* explore the potential acceptability to GPs of a proactive approach, where they would routinely offer LARCs to adolescents requesting contraception. Along the way, the researchers found that their participating GPs were often unaware that LARCs are suitable for adolescents and consequently do not routinely offer this form of contraception.

EDITORIAL

Existential challenges are nothing new for the primary health care professions, whose specific and overlapping contributions to patient care may be poorly understood. In this issue we publish research about nurse practitioners and pharmacists working in primary health care. Each discipline has a distinct healthcare scope but there is, and should be, a blurred boundary between professional roles to ensure gaps in service provision are minimised. No professional group can entirely replace another but each can provide back-up to others. An interview study reports nurse practitioners striving to work to the top of their scope but facing difficulties in having their scope recognised in some parts of the country.[11] Haua found similarly variable integration of community pharmacists into primary healthcare teams[12] and Gauld *et al.* give a practical example of how community pharmacists can contribute to the better care of patients with insomnia.[13] It may be time for a high level robust appraisal of the entire primary healthcare workforce to provide models of efficient and effective inter-disciplinary practice to guide planning and funding decisions.

Community engagement is a core function of primary healthcare teams but the concept is poorly understood and may therefore often be poorly executed, despite the guidance available in New Zealand for advancing community participation in healthcare.[14] Rowes team identified both examples of well functioning community engagement processes and practical barriers to ongoing engagement.[15]

In general, this Journal does not publish articles about hospital-based care but we do recognise that some issues cross sector boundaries. Two such issues are domestic violence and self-harm or suicide. We have two research articles relating to these healthcare challenges and coming from a hospital perspective. One is an audit of a decade of youth self-harm presentations to a rural hospital's emergency department[16] and the other is a report of one tertiary hospital's efforts to understand how well it is doing in identifying and assisting people experiencing domestic violence.[17] As much excellent research tends to do, both articles raise as many questions as they answer. Importantly, both also signal some ways that health systems can do better.

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