The dynamic steady state

In 1975, Dr David Penny and I gave a talk outlining arguments in the recently published book *The limits to growth*.[1] We showed that graphs of unlimited upwards trends described a phenomenon which is impossible in nature. In natural processes the rule is a dynamic steady state. The body's internal environment, the milieu interior, is kept constant in temperature and in chemical balance. Forests, plains, seas and even the planet itself all have been in a dynamic steady state.

Until about 200 years ago societies of the world were in a steady state. Human numbers remained constant because of high infant and maternal mortality rates plus the occasional war and epidemic. It was a closed society. There were no empty continents or new technologies to move into. Those who controlled the people's beliefs (the Church) kept the economy in check by forbidding usury. It must have been realised that to allow money lenders to charge interest on their loans would destroy the prosperity of the villages where most folk lived. Growth cannot be allowed in a closed system so people had to do their duty in that station of life where God had placed them, and 'neither a borrower nor a lender be.'

Now the world has closed in around us. The message of *The limits to growth* was that continuing to increase population, pollution, and exploitation of non-renewable natural resources will lead to a catastrophic collapse of human societies and populations. The even more worrying issue facing us in the 21st century—climate change—was not on the horizon in 1972 when *Limits to growth* was published.

Can we change our social structures and way of life to make them compatible with the way biology works? How do we make the dynamic steady state the ideal that rules economic theories? I think that we can do this and still make life interesting and exciting by turning to science and the arts.

The kinds of controls used during WWII could not be imposed from above in New Zealand today, but there are plenty of signs that ideas of conservation and restraint are beginning to gain ground. Maybe we will reach this goal by popular consent. One first step is to convince decision makers and politicians that the phrase 'Gross National Product' is a measure but nothing more. Making it bigger is not a valid goal.

Jim Hefford

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A lament for art in/of medicine

Who stole the pictures?—My first thought as I peruse the latest medical journal to trouble my otherwise innocuous mail delivery. The answer is soon clear, the same villain who stole the colours... The colours are missing, all but one... orange. Orange trying to fill the void, manifesting itself in various shades across the pages. There's even orange on orange.

In a fleeting moment of vocational responsibility and hope to keep abreast of developments, I scan the titles for an article that appeals... 'A patient-centred referral pathway for mild to moderate lifestyle and mental health problems: Does this model work in general practice?'... I move on, quickly...

'Prevalence of acne and its impact on the quality of life in school aged adolescents in Malaysia'... I understand the title, a good start. I make the prerequisite check on the number of pages... only five... and launch into an extraordinary demonstration of speed reading.

Happily I find I'm not so behind the cutting edge of research... I know and agree with the conclusion that we are already familiar with the psychosocial implications of a bad case of acne... However, usefully, the study also points out that health care professionals and school authorities should actively identify, manage and educate adolescents with facial acne. I ponder, for a moment, as to whether I already knew that too... perhaps, in fact, already do that? I think I do... but faced with a gauntlet born of quantitative research, I begin to doubt, and wonder if I need to audit my practice, to be sure.

The thing is, I have a love hate relationship with evidence-based medicine. Reassuring and validating at times, yet insidiously eroding the will to use my initiative, trust my instincts or permit a decision formed solely on the shaky grounds of common sense. Indeed, at times it seems irresponsible to do so without evidence based on statistically sound research.

Yes, yes, of course I see the value of the science, the EBM, but can't help but wish for a little more of the art of medicine. Art of medicine, art in medicine... in medical journals.

Bring back the colours; bring back the pictures.

Dr Black

Back to the future

Working as a rural doctor in the Hokianga I am very possibly one of 'the few rural colleagues' that you refer to in the first paragraph of your editorial and I thus feel com-

LETTERS may respond to published papers, briefly report original research or case reports, or raise matters of interest relevant to primary health care. The best letters are succinct and stimulating. Letters of no more than 400 words may be emailed to: **editor@rnzcgp.org.nz**. All letters are subject to editing and may be shortened.

pelled to comment. I don't think that we are so few, nor do I agree that 'those days' have passed.

It is unlikely that a family planning or sexual health clinic, a mental health unit, a sports medicine clinic, a hospice or an emergency department, to name but a few, will set up shop in our neck of the woods in the foreseeable future. Nor is it likely that large numbers of paramedics will be available to attend emergency callouts. Thus our daily work still covers all the areas you mention and more.

Primary health care for us means meeting the health needs of our community; thus we provide integrated and comprehensive care with limited human resources, across the primary –secondary interface: this is not nostalgia, this is reality. It is also very enjoyable work.

Whilst it may be the content of general practice which has fragmented in urban areas, in our rural area we have increasing problems gaining recognition for the provision of a broad range of services, i.e. in many rural areas it seems to be the funding, not the care, which is fragmented.

It may interest you to know that in rural NZ there are moves afoot to broaden the scope of general practice and that we are starting to see the re-emergence of generalism. This is in line with current medical career thinking and may have played no small part in the recent setting up of rural programmes at both of our medical schools as outlined in the guest editorial by Peter Crampton in the same issue of your journal.

As rural doctors we too are facing changes, but our problems and thus solutions vary hugely depending on our locality and are almost certainly different from big city ones.

We are, however, also part of modern general practice.

I did enjoy the first issue of the journal, but would be delighted to see some articles and/or dialogue with rural perspectives in future issues.

Katharina Blattner, GP, Hauora Hokianga

REPLY: Apologies to rural colleagues who felt denigrated by my editorial comments grieving the loss of the comprehensive care and the fragmentation experienced in many urban general practices where patients may self-refer to a plethora of other providers. That rural GPs routinely provide the breadth and depth of primary health care services is a great selling point for our graduating doctors to choose rural general practice as a career. *JPHC* welcomes contributions from our rural sector. —Editor

Acupuncture

Unlike your correspondent Dr John Welch, I have greatly appreciated the inclusion of acupuncture papers within the *NZFP* Journal Review Service. As one who continues to observe the value of acupuncture within my practice, I am aware that this is a time when there are considerable advances in our understanding of both the biomedical and biophysical mechanisms that lie behind its successful clinical application. In my 28 years of practice, I have had the good fortune to meet many doctors and research scientists involved in the practice and study of medical acupuncture internationally. In general, they are well aware that many of the studies have been poorly funded and designed; but there is now more than ever, within their ranks, a determined call for excellence.

The biophysical property of connective tissue is one area of research where such excellence is being achieved, shedding light both on the mechanisms behind acupuncture, and the limitations of 'sham' studies.[1,2] Simply put, the cytoskeletal network is omnipresent within the body; hence placing a conductive needle anywhere is likely to produce a physiological effect. This goes some way to explaining why sham acupuncture (using points other than known acupoints) also produces positive results, and can no longer be used as a valid control in RCTs.

But this is also an important time for the recognition of medical acupuncture in a highly practical clinical setting. From March 2009, the US Air Force is training military doctors to take ear acupuncture to the war zones of Iraq and Afghanistan. This 'battlefield acupuncture'[3] is used for rapid pain relief for those wounded in conflict. The US Navy has begun a similar pilot programme to train its doctors at Camp Pendleton in California.

So as the science and practice of medical acupuncture become increasingly more sophisticated and recognised, it is important that the *Journal of Primary Health Care* caters for those experienced and informed doctors who continue to use acupuncture effectively in their practices.

Dr Robin Kelly FRNZCGP, Past President Medical Acupuncture Society (NZ)

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Use of psychoactive drugs in children

As a GP who has been working in child psychiatry for some eight years now, I would like to comment on Barry Parsonson's guest editorial in *JPHC* Vol.1, No.1, March 2009.[1]

I would say that contrary to the asserted 'increased moves to pathologise children's behaviour' we are extremely careful when making a diagnosis in this age group. Environmental factors are not missed.

Bipolar illness does occur in children. The reality is that the buck stops in the end with the psychiatrist/psychologist team and medication carefully prescribed can transform absolute chaos. Psychological work can begin when there is some insight.

ADHD: Stunted growth on therapeutic doses of stimulants is a rare problem and weight and height charts are kept over time. Hypertension and stroke is not something that I have ever encountered. With the high degree of ADHD comorbidity it is a difficult area for any clinician. Behavioural intervention may not be enough.

CBT is not enough in selective mutism, in OCD-type symptoms which freezes the kid to the toilet seat in the morning, or in acute generalised anxiety where your child is screaming with terror and trying to exit the window of the car in peak-hour traffic.

ASD: ASD symptoms and OCD are not one and the same. A small dose of a psychotropic agent can transform the situation for a distressed child who is being bullied, or is into bullying, and tenure at school is threatened.[2] Medication can be withdrawn over time as psychological intervention gets underway and the child grows older.

Attachment Disorders: It is not 'pathologising' a child of four presenting with a history of major neglect, and abuse, who is peeing in the bedroom, hiding food and faeces, to say that they have a reactive attachment disorder.

Mood Disorders: More lives are saved by a prescription of Fluoxetine than otherwise[3] and the use of SSRIs has coincided with a falling suicide rate in many countries.[4]

Many of us would wish for the return to the days of Huck Finn. Sadly our kids are over protected.

Thank you Barry for beginning this important dialogue and raising questions. There needs to be more research to fill the gap between educational journals, research articles, and the realities of clinical practice.

Peter Strang MBChB, Dip Obst, PG Cert [Trav Med], FRNZCGP, FACTM

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REPLY: First, I would like to thank Dr Strang for his letter and for his acknowledgement of the importance of challenge, dialogue and research in this area. I will not attempt any specific responses to his various comments, but my experience in practice is somewhat different from his. I see a number of children who are, in my opinion, misdiagnosed, inappropriately medicated and/or whose behaviours are attributed to psychopathology rather than to wider and evident contextual variables, such as social, familial or environmental factors impinging on their lives. I have a long experience of effectively applying behavioural interventions (e.g. cognitive behavioural therapy and applied behaviour analysis) with children displaying behaviours of the types he describes and thus would challenge some of his contentions. Equally, I would not like it thought that I am entirely antagonistic to medical interventions when behaviour is highly problematic, when an urgent response is required or when all else has failed. I have, however, tried to argue that medication should neither be the first nor the only intervention in many instances. I agree with him that the most important issue is that we begin a dialogue in respect of the issues that both he and I raise.— Barry Parsonson

'How can I help?' may be a risk to rapport

'How can I help?' is often used by doctors when seeing a new patient. Consideration should be given to more appropriate open-ended questions, such as 'What would you like to talk about today?' or 'What brings you in today?' These are the recommended questions in the evidence-based Calgary-Cambridge Guides used to teach consultation skills in over half of British and many North American medical schools.[1]

The start of the consultation is very important in establishing understanding the relationship. 'How can I help?' risks impeding rapport for the following reasons:

1. 'How can I help?' falls more toward to the doctor-centred end of the doctor- to patient-centred spectrum. The subject of the question is 'I' (the doctor), whereas the subject of 'What would you like to talk about?' or 'What brings you in?' is 'you' (the patient).
2. 'How can I help?' unnecessarily taints the start of the consultation with power dynamics. It may evoke subtle thoughts and feelings of inferiority in the patient—the 'authoritative powerful doctor' is here to help the 'poor dependent patient.' Some patients will be more sensitive to this possibility, particularly those with experiences of disempowerment related to ethnicity (e.g. Maori and

Pacific Islanders), gender (male–female issues and sexual orientation), disability, socioeconomic status or previous abuse. 'What would you like to talk about?' or 'What brings you in?' are implicitly more respectful of patient autonomy.

3. 'How can I help?' risks evoking parent–child dynamics between doctor and adult patients. Teenagers are particularly sensitive to parent–child dynamics. They are usually establishing their own psychological space through separating from parents and other parental figures and often have low thresholds for resisting authority, including the authority of the doctor. GPs should keep consultation dynamics with teenagers on an adult-to-adult footing to facilitate rapport and compliance.
4. 'How can I help?' risks disjunction when patients do not know how the doctor can help or, worse, feel stupid that they cannot answer the doctor's question.
5. 'How can I help?' risks patients thinking that the doctor really only wants to hear about things he or she can fix, discouraging some from sharing their problems and unburdening themselves by talking.

While some of these issues are subtle they are important. With the average full-time GP having over 5000 consultations a year there will be many consultations where these issues subtly, or not so subtly, affect rapport. 'What would you like to talk about today?' or 'What brings you in today?' are patient-centred questions that are open-ended, less restrictive and avoid potential threats from power and parent–child dynamics. They imply greater respect by the doctor for the patient's life world.

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The health beliefs of cultural minorities

I have argued that adhering to the principles of good patient centred medicine is of more importance than knowledge of 'generic culture specific' material.[1] Two articles in your first edition focused on the health beliefs of cultural minorities.[2,3] The main points of the Bennett article are listed below with some quotes from each section:

- Ascertain the self defined cultural identity of your patient
- Patient and whanau views of the illness: *What do they think is wrong? Is there a name for it? What may have caused it?*
- Support and safety: *When Maori present to the consultation alone they should be asked if they would like to have another Maori present*
- The impact of culture: *A 'chat' before getting onto the presenting problem is helpful. It is important that the patient is given time to tell his story in his own way and time*
- Language: *Do not take it for granted that words and expressions in English mean the same thing for you and your patient. Be a good listener. Always be respectful*

This article was written by a Maori psychiatrist from a Maori perspective about Maori. In my view the lessons to be learned from this article are more generic and apply to any cross-cultural consultation. If we consider psychiatrists to be part of an unusual cultural group who understand the world through DSMIV it could be argued that the large majority of their consultations could be described as 'cross-cultural'.

The article by Norris was research on Samoan people, but again I think it has much wider relevance.

- Samoan people use antibiotics in ways that are not consistent with Western scientific beliefs
- Samoan people frequently attribute colds and flu to environmental conditions rather than microbes
- There was some difficulties in translating the terms 'bacteria' and 'virus' into Samoan
- It cannot be assumed that patients share Western scientific understandings about which illnesses are caused by microbes.

This article demonstrates the large gap between how 'we' (Western doctors) and Samoans understand illness and its treatment. My experience is that it is the norm that my patients do not share my understanding and that the process described in Bennett's article combined with 'Do not assume...' applies to not just identifiable cultural minorities, but to many groups... in fact to anyone who is different from me. The skills needed for a good cross-cultural consultation will enhance every consultation.

Ben Gray, GP

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