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


EDITORIAL

# Aspirations, innovations and reality

Susan Dovey, PhD, MPH, FRNZCGP(Hon)

editor@rnzcgp.org.nz

J PRIM HEALTH CARE
2019;11(1):1–3.
**doi:10.1071/HCv11n1_ED1**
Published 03 April 2019

Memories, I am convinced, are held as pictures and one or two-lines in one's brain, rather than full-length episodes. One such snippet that I hold is of being on a car journey with two north American professors of family medicine and hearing their discussion of a new medical school soon to be started in Northern Ontario. They were puzzled with, but not disparaging of, the establishment of this school. As I recall, they first saw no need for another medical school in north America; second they thought even if one was needed that Northern Ontario was a peculiar place to put it due the expansive emptiness of the Northern Ontario geography and its shortage of major population centres; and they had difficulty imaging how a standard medical curriculum could be delivered by this new school, on account of the challenges of location and a shortage of clinical teachers. Beyond this, I cannot remember the details of their conversation. Now in this issue we publish the reflections of a New Zealand rural general practitioner (GP) and educator as he thinks about his time recently spent visiting the Northern Ontario School of Medicine.[1] Addressing the first two concerns of my professor friends, this school proudly calls itself 'No Ordinary Medical School'. It did not set out to deliver a standard curriculum, but to facilitate medical education in a completely different way that specifically focuses on patient-centredness, a concept too often honoured in the breach in most western health systems. John Burton writes these reflections in the context of ongoing discussion about the possible establishment of a new medical school in New Zealand. Many people in New Zealand have similar responses to this idea that my American and Canadian friends had about the idea of establishing the new school in Northern Ontario: do we need a new medical school? Where should we put it if we do need one? Do we have the capacity to deliver our standard medical curriculum in an additional medical school or should we make an opportunity to do something out of the ordinary?

A second memory is of a Minister of Health a few years back saying '*Rural doctor shortage? What rural doctor shortage?*', raising eyebrows in his medical audience. Our guest editorialists recount the known challenges to providing rural health care in the present and future in New Zealand.[2] We have an ageing rural medical workforce and through many changes of government over the past decades, continued political reluctance to recognise rural workforce challenges in the context of a dearth of evidence that rural people suffer because of this. Nixon and Lawrenson, like the founders of the Northern Ontario Medical School, have a vision of a new medical school with a completely different structure and operational model from the existing medical schools, as an essential part of reducing health disparities for rural New Zealanders. They may be right about the advantages of training medical students in rural locations for rural workforce retention, although in my view the jury is still out on the idea that this will ensure a continuing stream of doctors willing to work in the rural areas. I find more compelling the contention that medical education in diverse communities simply provides better educated doctors than ordinary medical education in closed hospital corridors.

Rural healthcare providers have a reputation for innovation in the education space but often it goes undocumented. We therefore publish an important Improving Performance paper, documenting the trauma simulation training Gutenstein had colleagues have been delivering to rural interprofessional trauma teams.[3] The problem that was being addressed was the high number of trauma cases in rural settings and low access to trauma training while urban-based trauma teams have better access to training and comparatively fewer (and arguably different) trauma cases. Participants in the course were teams of rural hospital workers who provide trauma care to patients. The course was team-based and

EDITORIAL

evaluated highly by participants but, like many valuable healthcare innovations, faces sustainability challenges.

Two other papers in this issue also relate to healthcare education. Both these papers investigate and value the 'non-cognitive' aspects of doctors' and potential doctors' approaches to patient care. Moyo *et al*. studied how students' values influence their clinical decision-making[4] and we have a short report from Lillis and colleagues about using the Multiple Mini Interview format to inform the selection of doctors into general practice vocational training.[5]

Young adults are the population age group least likely to consult in general practice[6] and while in general this may be because they are also the population age group with the least need for health care, in study following up a cohort of very low birthweight (VLBW) babies at 2729 years of age Darlow and colleagues found a reasonably high level of unmet need for general practice care.[7] These researchers suggest that knowing the birthweight of their registered young adult patients might be helpful in sensitising general practices to the health needs of all young adults, and especially patients who started life as VLBW babies, many of whom have a surfeit of ongoing health issues.

The other clinically-oriented papers in this issue relate to pneumococcal disease,[8] mental health,[9] exostoses in surfers,[10] and dermoscope-guided surgical procedures in general practice.[11] Descriptive epidemiology such as the approach presented in the article by Eichler *et al*.[8] is sometimes regarded as rather pedestrian by our public health colleagues but for people working in primary healthcare and delivering vaccines it is both useful and reassuring to have access to this sort of analysis. This paper documents changes in vaccines to cover increasing numbers of pneumococcal serotypes and demonstrates how vaccinating preschool children has produced indirect herd immunity for the elderly, reducing the incidence of pneumococcal disease in both population groups. Alas, ethnic disparities remain.

Shah *et al*. document the implementation of an electronic tool adapted to screen Asian patients for mental health problems.[9] The New Zealand vernacular excludes people from the Middle East from our definition of 'Asian'. Recent events suggest this is probably not a helpful exclusion. Nevertheless, even with the abbreviated definition, this study shows that an electronic tool can be useful as an aid to identifying mental health issues among people who may be unwilling to talk about such things (and this is not an issue restricted to Asian cultures). Reality throws in the funding problem: identifying new health issues brings an obligation for treatment, and treatment takes healthcare time and resources which are already very stretched in the mental health domain.

As a non-surfer, I have always thought that surfers must be exceptionally healthy people so I was surprised and interested to receive a paper about a particular health problem disproportionally affecting surfers (exostoses).[10] I hope readers will find this paper interesting also. Our other clinical paper uses a case-control approach to investigating the usefulness of dermoscopy in general practice surgical procedures.[11] This scientific approach is accessible to primary healthcare professionals and dermoscopy, which may be unfamiliar to most readers, is defined along with an explanation of how the GP author uses this tool in his clinical practice. We are interested to hear what readers think of this innovation.

This Journal publishes case reports that describe snippets of the diverse clinical challenges facing primary healthcare providers. From 2019, we will label our published case reports with a number to help easily identify them. In this issue we publish a case report providing insight into challenges in diagnosing and treating syphilis and showing the importance of team-based care.[12] Finally, our regular columns summarise the latest update from the Cochrane Collaboration on iron supplementation[13] and we learn of medicinal uses for rosemary.[14]

## References

1. Burton J. Experiencing a rural medical school. *J Prim Health Care* 2019;11(1):6–11.
2. Nixon G. Lawrenson R. Failing to thrive: academic rural health in New Zealand. *J Prim Health Care* 2019;11(1):4–5.
3. Gutenstein M, Kiuru S. Withington S. Development of a rural inter-professional simulation course: an initiative

EDITORIAL

to improve trauma and emergency team management in New Zealand rural hospitals. *J Prim Health Care* 2019;11(1):16–23.
4. Moyo M. Shulruf B, Weller J, Goodyear-Smith F. Effect of medical students' values on their clinical decision-making. *J Prim Health Care* 2019;11(1):64–74.
5. Lillis S, Lack L, Mbita A. Using the Multiple Mini Interview for selection into vocational general practice training. *J Prim Health Care* 2019;11(1): 75–79.
6. Fryer GE, Green LA, Dovey SM, et al. Variation in the ecology of medical care. *Ann Fam Med* 2003;1(2):81–9. doi:10.1370/afm.52
7. Darlow BA, Martin J, Horwood LJ. Unrecognised and unmet physical health problems in a national cohort of very low birthweight young adults and controls. *J Prim Health Care* 2019;11(1):32–38.
8. Eichler N, Reynolds E, Jackson C, et al. Invasive pneumococcal disease and serotype emergence in the Auckland region during the vaccine era 2009-16. *J Prim Health Care* 2019;11(1):24–31.
9. Shah K, Corter A, Bird A, Goodyear-Smith F. A primary care programme to improve identification and stepped-care support of Asians with mental health and lifestyle issues. *J Prim Health Care* 2019;11(1):39–46
10. Simas V, Remnant D, Furness J, et al. Lifetime prevalence of exostoses in New Zealand surfers. *J Prim Health Care* 2019;11(1):47–53.
11. Chuh A, Zawar V, Sciallis G, Fölster-Holst R. Outcomes of dermoscope-guided surgical procedures in primary care: case-control study. *J Prim Health Care* 2019;11(1):54–63.
12. Kim J, Ussher JG. Ocular syphilis: connecting the dots. *J Prim Health Care* 2019;11(1):12–13.
13. Jordan V. Intermittent iron supplementation in women can reduce anaemia and has less side effects than daily supplementation. *J Prim Health Care* 2019;11(1):80–81.
14. Walsh P. Rosemary. *J Prim Health Care* 2019;11(1):82–83.