



Research and education in clinical training

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The clinicians who are the readers of this Journal have achieved their position in the healthcare system by completing both education and training in their discipline (dentistry, medicine, nursing, pharmacy, physiotherapy, social work and others). Education happens in universities and sometimes polytechnical institutions where healthcare providers learn the basic principles of their discipline and core academic knowledge underpinning its practice. To some extent this core academic knowledge is the same for all of the health professions – anatomy, physiology, biochemistry, ethics and an understanding of human emotions, societies and communities – albeit with different emphases in different disciplines. Part of this education, crossing all disciplines, is the development of inquiring minds and research skills so that education is not just received, but embedded. Research, if successfully learned during the initial education phase of clinician development continues to be developed during the training and practice phases, when asking questions and finding ways to answer them becomes more urgent because people's lives may hinge on competency in these skills. 'Research' tends to be narrowly interpreted as something that requires advanced mathematics or writing skills: often these are part of researchers' skills sets but not always and not only.

Research is often under-emphasised in the training of clinicians because practical imperatives in providing healthcare may steal time from the deep thinking needed for research – and because the skills may not have been previously well modelled or taught so emerging clinicians have not learned its importance. Most medical specialties specifically incorporate research requirements into their vocational training programmes but not the general practice speciality, with patchy exceptions internationally. In my most recent university position in the Middle East, I taught research concepts and methods as part of the general practitioners' (GPs') vocational programme: completing and publishing a group research project was required to qualify for Fellowship as a general practitioner (GP).

Nevertheless, even in countries without such requirements general practice is not bereft of clinicians for whom research skills have become embedded and who wish to further develop these skills during and after their initial training. Lacking defined opportunities for research development, they seek them out anyway.

Our guest editorial relates the sputtering history of general practice research training opportunities in New Zealand (NZ), written by GPs who have sought research training.¹ In contrast to NZ, many Australian GP registrars have the opportunity to learn and embed a research culture during their vocational training as they contribute to a large and valuable research database of clinical experiences. In this issue we publish research from this database showing high levels of GP registrars' antibiotic prescribing for infective conjunctivitis, an important issue relating to antibiotic stewardship.² The 2333 registrars saw 1580 new cases of conjunctivitis and prescribed antibiotics for 74% of these cases, which is probably over-prescribing for a condition minimally benefited by antibiotics. The good news from this research report is that it also shows that senior registrars prescribed antibiotics less and were more likely than junior registrars to prescribe them according to clinical guidelines.² This is important objective evidence of the impact of GP vocational training in assisting higher standards of clinical care.

In the sense we use it in healthcare the word 'equity' means fairness or freedom from bias. Equity is a strong value of egalitarian societies like ours. It means there should be equal access and engagement for everyone in every sector – health, education, industry, housing and so on. There never is, except in utopian ideals. There are many other examples of inequality between different population groups. In this issue we have several research papers documenting inequalities between people of different ethnicity in NZ and offering suggestions for redressing the inequalities they uncover.

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A systematic review of the literature about the pre-diagnostic period for bowel cancer in NZ shows more delayed care and poorer cancer outcomes for Māori than for non-Māori in NZ, and for NZ overall in comparison with other countries.³ The authors suggest that the current focus on elderly people for colorectal cancer screening disadvantages Māori, who develop cancer at a younger age. Kaupapa Maori research from an urban marae general practice provides a strong example of how current pay-for-performance measures exacerbate Maori disadvantage.⁴ Survival of this Very Low Cost Access practice requires concentration of its resources on targeting care to the performance measure conditions instead of to gout that disproportionately affects its mostly Māori patients: the practice does not have enough time and people to care for patients with gout the way they would like to and they need the money that comes from performance payments. An article from the National Hauora Coalition Primary Health Organisation (PHO) explains why the routine collection of iwi data is important information for healthcare providers and that there is no standard way of collecting it, as there is for most other demographic patient data.⁵ The authors report that only 9 (27%) clinics in the PHO use a specific Iwi question on their enrolment and this was asked in 6 different ways. They suggest standardisation and routine collection across NZ. In another article, data from 15 general practices in the Waikato show diabetes prevalence being higher for Māori (8.6%), Asian (7.0%) and Pacific peoples (9.1%) than Europeans (5.0%).⁶ Many clinical measures failed to meet target ranges, signalling inadequate diabetes management.

Further clinically oriented papers in this issue are about using the Mirena Intrauterine device (IUD) for treating endometrial cancer,⁷ calls to the National Poisons Centre about medication errors (where do you think most happened?),⁸ and a remote rural nurse practitioner shares important lessons for the clinic from implementing an updated point-of-care laboratory testing system.⁹ Choi and Oakley provide a useful review of referrals to a virtual dermatology clinic.¹⁰ They suggest that most conditions prompting these referrals did not need dermatologist care, providing photographs to show the sorts of lesions that can be well managed in primary care. The electronic Case finding and Help

Assessment Tool (eCHAT) is being developed as a safe process for screening people who might have mental health issues unknown to their care team. It has been trialled for different types of user.^{11,12} In this issue we publish a report of the development of VeCHAT, the tool targeted for use by military Veterans and developed in partnership with the Ministry of Defence and Veterans Affairs.¹³

We hope you find plenty to interest, stimulate and challenge you in this issue of the Journal.

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