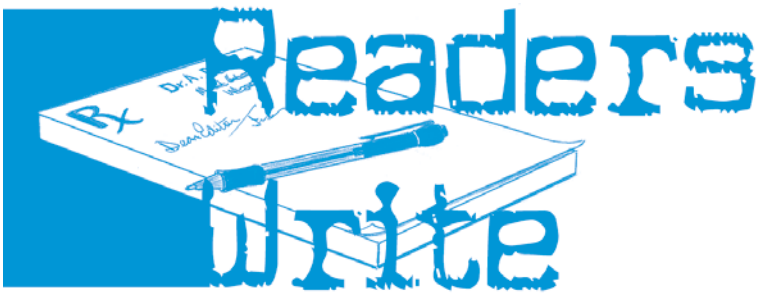

Readers may have noticed that the Readers Write *section in the last two issues of the journal has included some rather lengthy letters. This is because the editor has decided that the submitted material was more suited to this section than any other section of the journal. It is not a precedent for lengthy letters, which generally should not exceed around 500 words – Editor*

Traditional slide Pap smears are not out of date

The partners at the Papanui Medical Centre recently debated the place of different cervical smear technologies – the usual slide method over newer liquid-based technologies. This came about after the representatives of a respected laboratory had given a presentation on cervical cytology and one of the liquid technologies. We wondered if we should adopt it for routine use. To resolve the issue, we consulted Dr Anne Richardson, an epidemiologist from the Christchurch School of Medicine and Health Sciences.

She discussed the research difficulties of comparing different systems, and why apparent superior results with liquid technologies were less convincing to her. She was able to discuss why some communities had adopted the liquid technologies as a preferred method, but for the New Zealand situation there was not enough high quality evidence that more lives would be saved than with conventional smears.

She also drew our attention to a New Zealand HFA-funded systematic review of the literature on cervical smear screening technology published by the New Zealand Health Technology Assessment Clearing House (NZHTA) in 2000, which came to the same conclusion.[1]

The Australians are about to release a more to up to date review of their own. There is a prediction that it will have a similar conclusion, so keep an eye open.

In the meantime, a well taken, mid-cycle, instantly fixed smear is just fine for the usual situation. The Ministry of Health's (National Screening Unit) sponsored smear-taker training is still along these lines.

I mention that because I recently received a flyer from the marketers of one of the liquid-based technologies. It included a full colour copy of Ministry correspondence offering smear-taker training. I have confirmed with the Ministry of Health that this was carried out without their knowledge and does not imply sponsorship of training in these newer technologies. Nor has the Ministry at this stage changed its position from that expressed in the independently researched opinion published in the NZHTA report.

Calder Botting
GP at the Papanui Medical Centre and Department of Public Health and General Practice, Christchurch

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Regarding Paul Harper's 'Controversies and questions in the management of deep vein thrombosis', NZFP February 2003

I would like to say how useful I found this article – it is clear, concise, well laid out and specific in its detail and recommendations, unlike many articles whose purpose is to update GPs in a specific area of diagnosis and management. The topic is also well chosen, since standard management has recently changed in this field. (And getting DVTs past registrars can be difficult – I get told all sorts of dross, and because I'm aware management has changed over the last three years or so I'm at a disdvantage in a discussion). Thanks for this; more of this standard on changing medical topics would be wonderful.

Anne Lear
Wellington

A reply to Dr Ian St George

I read with interest (dictionary in hand) Dr St George's article[1] describing why he chooses to be irked by 'rural apologists'. He suggests that (a) we have a low opinion of urban general practice, and think we are 'nobler', and (b) we are about to 'force' students from rural areas into rural general practice. He projects his ideas and opinions onto rural apologists, and then argues against them. I believe both of his assertions are incorrect, in fact he offers no evidence of any kind to back them up, and I will discuss each in turn. His article was, however, amusingly educational – I learned that rural apologists are egocentric, nonsensical, mono-cultural, not person-centred, possessive, narrow-minded, narcissistic, and prepared to use emotional blackmail. I know all of New Zealand's rural apologists, and this description doesn't fit any of them.

Firstly, he asserts that we *'claim special status'*, that we think our calling is *'nobler'*. He claims we think urban practice is *'effete'*, *'less worthy'*, and implies we also consider it uninteresting and unchallenging. Ignoring the highly emotive nature of the discourse, his assertions are simply wrong. It is the individual practitioner who decides for themselves what is fulfilling and gratifying. Another GP can at most say that they didn't find a particular practice personally fulfilling. What however does differentiate urban from rural (and makes rural practice harder), is that urban GPs have options and choices unavailable to their rural colleagues. Urban GPs can choose to live in the neighbourhood where they practise or elsewhere, perhaps in a more affluent area, where they will enjoy more anonymity. They can choose to do oncall, or sign out to an after-hours centre. They can more easily limit their practice size and can choose to have a part-time special interest (e.g. sports medicine) or even do it full-time. Dr St George has chosen to do a shift at the after-hours clinic 'every fortnight or so', whereas my (non-optional) oncall is one night a week and one weekend in five (and I consider myself lucky to have such a luxurious oncall schedule). Because rural areas do not have emergency departments, hospitals with house staff, and advanced paramedics, rural GPs must maintain emergency care knowledge and skills that are optional for GPs in cities. With more oncall, responsibility in emergencies, difficulties with locums, and fewer options about practice size, *rural general practice is harder* than urban practice. The current workforce crisis further accentuates these difficulties. Rural GPs want their realities, stresses and training needs acknowledged, not denied. Acknowledging rural general practice's specific issues does not *demean* urban general practice.

In contrast to Dr St George's rural start, I was born in urban St John's (Newfoundland) and raised in an even more urban area (Montreal; population: two million). My general practice career has included working in urban (Auckland, Toronto), provincial, rural and remote general practices. I have talked with urban GPs who have worked in rural areas and rural GPs who have worked in urban practices. The vast majority (if not all) of them do not agree with Dr St George's claim, that rural is *'no harder'* than urban. I know of no rural GP who, to escape the stress and workload of urban general practice, has shifted to a rural location – the flow is unidirectional. Although stating *'I would not claim to know what being a country doctor is like'*, this article clearly suggests Dr St George *believes* he does understand rural issues, a misconception common to urbanites.[2]

Secondly, Dr St George wades into the area of recruitment. He asserts that there is a *'monoculturalism in the country that only country people can know country people well enough to be effective general practitioners there'*. This is the first time I have heard this assertion from anyone. It is certainly not a view held by rural apologists. Rural communities are desperate for GPs and will welcome virtually anyone – urban or from a completely different overseas culture. The majority of rural GPs in NZ are overseas-trained.[3] What rural apologists do say, is that to fully appreciate all that living rurally has to offer, you actually have to live in a rural area for a period of time – you can't evaluate it from a distance or by simply having a holiday in the country. The evidence clearly shows that a combination of selecting rural origin students into medicine and providing all medical students with undergraduate and postgraduate exposure to rural areas and rural role models improves recruitment.[4–12] None of the proposals currently being looked at in New Zealand, to my knowledge, will *'force country kids to go home'*. In fact, the approach that is being planned is to assist rural students to aim higher than they might otherwise have planned – to consider a medical career. And once in medical school, to at least have the opportunity to consider a fulfilling and gratifying career as a rural GP.

When Dr St George describes being greeted by his patients on the streets of Wellington, he seems to imply that just like in rural areas you are not anonymous in the city. My Wairoa patients too have greeted me on the streets of Wellington. New Zealand is a small country. But the lack of anonymity that exists rurally is a magnitude of order different from that which Dr St George describes. Over 25% of my area's population count me as their family doctor. As a rural GP, you are truly *'a visible presence in the neighborhood'*[13] in a manner far different from a city.

While rural GPs don't bump into specialists on a daily basis, they are readily available over the phone for

advice, possibly more so than in the cities where registrars and house surgeons act as intermediaries. In most rural areas you can now enjoy long blacks and short whites, and they have video stores that if they don't have a particular movie in stock can order it in. In NZ you can live rurally but be in a city within a number of hours (driving or flying) to spend a weekend enjoying all the other amenities of which Dr St George speaks, but without the daily hassles of traffic jams, pollution and overcrowding.

I can only speculate that for those who grew up rurally with parents wanting them to be a rural GP, not to live up to that expectation might cause some unresolved guilt which could manifest as anger towards rural GPs. Was Dr St George one of those rural boys who couldn't wait to escape 'the country' for the big city life? He obviously would not have wanted to be 'forced' to work as a rural GP. It appears that he now feels compelled to speak up for all those other rural students currently out there that he believes are 'at risk' of conscription and blackmail. Rural communities do not want a conscripted, disgruntled labour force and neither do the 'rural apologists'. But we are aiming much higher than Dr St George's suggestion of simply getting more 'overseas doctors to want to spend some time there'. Our goal is to see New Zealanders, appropriately trained and with a clear career pathway, choosing to work rurally because of all it has to offer, both professionally and in terms of lifestyle.

Both urban and rural GPs hold Dr St George in high regard for his considerable work with the Medical Council of New Zealand and the Royal New Zealand College of GPs. If the opinions expressed in this article were simply those of an out of touch urban GP then they would be of no consequence or even mildly amusing. However, they are the opinions of the Medical Advisor to the Medical Council of New Zealand and of the recently retired Chairperson of the Board of Studies of the College. It is very concerning that he appears to have little understanding of the issues affecting rural GPs and the current plans to address these issues. I am compelled to ask, *'Are his views about rural GPs held widely within the College hierarchy?'* Helen, Jim, Claire, Councillors – is this your view of us? To have the very reality of our working life dismissed by such an influential and highly placed GP is staggering. We have struggled to have our issues even acknowledged by politicians – have one or more of our urban colleagues been undermining our efforts the entire time?

Let's stop the name-calling and emotive diatribes. At least we agree that general practice, irrespective of geographic location, provides an opportunity for both emotional and intellectual challenge, as well as a fulfilling career. I (and others), however, contend that rural general practice is a sub-speciality of general practice, defined by varying degrees of geographic isolation from secondary and tertiary health services, that therefore requires an additional rural set of knowledge, skills and attitudes. This does not mean we are superior, only that we have specific additional training needs, as well as workforce issues. We require a (yet to be created) career pathway so that future rural GPs can more easily and earlier obtain the necessary training. By denying these training needs and workforce issues, Dr St George, it appears, would deny us our career pathway. It is up to rural GPs to define themselves, we do not need the assistance of well-meaning urban GPs for this task. However, for the career pathway we definitely need the assistance of a professional College.

Ron Janes
Associate Professor of Rural Health

PS. As a daily user of both for many years, I still think Macs are superior to PCs.

Disclaimer: The views expressed are those of the author alone, and do not necessarily reflect the policies of either the Institute of Rural Health, Hamilton, or the Department of General Practice and Primary Health Care, University of Auckland.

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Constant focus on rural sector

The Royal New Zealand College of General Practitioners has supported rural general practice by initiating new programmes, spearheading new directions and direct advocacy.

Promoting and working for rural general practice remains an integral part of the work of the College. The current public promotion of general practice that began late in 2002 has emphasised this and also provided further opportunity to extend our message.

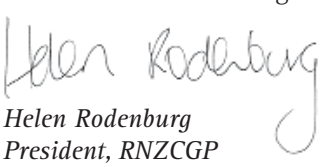
With the assistance of the Clinical Training Agency, targeted funding for programmes like the Postgraduate Year II (PGY2) mentoring is starting to show results. We have also provided specific educational assistance where the need has been identified – as in the East Coast seminar programme last year.

Research to support the continuation of these programmes is being carried out, and there are other rural-specific initiatives budgeted for fiscal 2003.

Many of these are in the Stage I GPEP programme, but there will also be development work on a rural MOPS module, and our AVE facilitators continue to assist rural candidates meet requirements for Fellowship and vocational registration.

The College has worked very hard to ensure the editorial and academic freedom of *New Zealand Family Physician* as the flagship publication for all members. Each issue carries, however, the formal disclaimer that views expressed are not necessarily those of the College, the editor or the editorial board.

We believe members wish *NZFP* to be a journal of robust debate, open to the views of any Fellow, Member or Associate of the College.



Helen Rodenburg
President, RNZCGP