GPs – do we need to change our name?

What's in a name? Does it make any difference to who we are and what we do? Surely, as Shakespeare said, a rose is a rose by any other name. Anyway, we have been GPs, general practitioners 'forever' (although some of us prefer to call ourselves 'family physicians'). Everyone knows who we are and what we do.

Perhaps this is one of the few occasions on which Shakespeare was wrong. Indeed, everyone does 'know' what we are and what we do. But do they really? No doubt everyone assumes they know. Words not only convey meaning, they create meaning; they control meaning (think of the power of the term 'cultural safety'). Words can expand the understanding of the user. But words can also limit the understanding of the user to the confines of a word. The user brings with him or her a collection of baggage or assumptions that are, usually unconsciously, tied to a word.

Let's brainstorm around the baggage that goes with the term 'general practitioner':

- Generalist, i.e. not specialist;
- Less knowledge than a specialist;
- Only useful for certain tasks – the easy tasks;
- The lower status and less well-paid tasks;
- Cheaper (with all the connotations of that word in turn);
- Does not and should not charge as much;
- And what about calling ourselves family practitioners – that we see only families?

For many, the term 'family' has warm connotations that are valid and important. Unfortunately, as the controversy aroused by the family commission demonstrates there are others for whom this term is at best irrelevant and at worst they feel alienated by it.

In describing ourselves with the term 'GP' – to ourselves, our patients and our specialist colleagues – we are declaring what we are not: not a specialist. Surely it is better to declare who we are. We are specialists, but we need a new name to label our area of expertise.

We see all around us examples of people and professions who change their names or titles in an attempt to increase their own perceived status – perceived by both themselves and the public. We see nurse specialists in paediatrics, diabetes and oncology; we see dentists, chiropractors and others calling themselves 'doctor'. We already have medical specialists in cardiology, geriatrics and public health, but no one has yet claimed primary health care. That is for the very good reason that we are the specialists in primary care. We need to claim that term. Now.

Calling us primary care specialists will likely help morale and recruitment and retention. It may help raise our public status and therefore our political status. This is all the more important and even urgent in this day of the HPA and its areas of competence. We do not want to be reduced to a series of small competencies that we must prove and reprove. We do not want to have to renew two-yearly our certificate in taking blood pressure or giving injections. What is our area of competence? It is (the whole of) primary care.

We are fighting a long-term battle to be publicly acknowledged, accepted – better still, assumed – to be the experts in primary care. We cannot simply hope this will happen. The advertisers refer to 'branding' and consider a strong brand to be 'priceless' – something not even your plastic card can buy.

We do not want to lose the valuable connotations and history of the term 'GP'. I am still emotionally attached to the term. In many ways it is who I am. But I am also a primary care specialist. Indeed, we specialise in being generalists!

Tim Kenealy
GP and Primary Care Specialist

Response from Jonathan Fox

Tim's letter makes a lot of sense and I share his frustration at the lack of recognition of his higher training and expertise.

However we should be aware of how well known and loved the term 'general practitioner' is. Whilst not proving much, Google does gives us a clue. In response to 'general practitioner' it returns 29.4 million results; 'family physician' 4.1 million and 'primary care specialist' 13 900 only.

I love the name 'general practitioner' and am proud to be called one. What I want to see is the value of that title improved.

I want to see only those doctors with vocational registration or in the training scheme being allowed to use the name. We need to continue the work the College has been doing in this area and we will report progress on some matters later in the year.

I do not believe a name change will assist in gaining recognition of our specialist standing.

There have been some disastrous attempts to change names. In 2000 the UK Post Office decided to call itself 'Consignia' – two years of public confusion and worker rebellion and they reverted. The giant US firm Arthur Anderson became Accenture (for different reasons!) but fooled no one.

At present our nurses are seeking parity with their secondary care colleagues – so should we! We must work to get the true general practitioner their appropriate public and professional recognition.

As your president I say watch this space.

Huge seasonal and latitudinal variability in vitamin-D production from sunlight

Despite New Zealand and Australia having the world's highest death rates from skin cancer, many New Zealanders are deficient in vitamin D. This finding, by Tim Green and coworkers at Otago University, comes on top of growing medical literature about the possible beneficial role of ultraviolet (UV) radiation.[1] Insufficient UV exposure seems to be a factor in increased occurrence of bone fractures in the elderly, tuberculosis, rheumatoid arthritis, multiple sclerosis, inflammatory bowel diseases, hypertension, and many cancers. This poses the question of how to balance the benefits against the hazards of human exposure to UV. We show here that no conflict exists, just a need for better understanding of the effects of season, time of day, and latitude.

An early study on this topic[2] showed that in Boston (42°N), at similar northern latitude to the mean southern latitude of New Zealand, vitamin D production from sunlight remained zero for several months over the winter. This is important because the biological half-life of Vitamin D is at most a few weeks (12–19 days according to Zitterman[3]).

The National Institute of Water and Atmospheric Research (NIWA) studies solar UV as part of a global effort to understand the causes and effects of ozone depletion, and its interactions with climate change. Further, NIWA provides UV information to the public over summer, using the internationally accepted UV Index (UVI).

We have calculated variations in the availability of radiation necessary for the production of vitamin D (UVvitD) in human skin in the region, assuming the action spectrum of MacLaughlin et al.[4] The results are summarised in the table below, and show that there is strong latitudinal and seasonal variability.

The factor of 30 difference between summer UVvitD in Auckland and winter UVvitD in Invercargill may surprise. Strong atmospheric absorption and scattering of UV for low sun make its intensity strongly peaked around solar noon and the summer months.

Table. Geographical and seasonal variability in daily vitamin D production by solar UV radiation, calculated for clear sky conditions (relative to the summer in Auckland).

City	Latitude (°S)	Summer	Winter
Brisbane	27.0	1.1 ± 0.1	0.25 ± 0.05
Auckland	37.0	1.0	0.08 ± 0.02
Invercargill	46.5	0.9 ± 0.1	0.03 ± 0.01

In contrast, visible light under clear skies shows a much smaller contrast between summer and winter.

Humans cannot see or feel UV radiation, making it difficult to gauge exposure for good health. Continued public advisories of UV intensities throughout the year, rather than just in the summer, are needed to educate the public. The use of UV sensors would also be helpful, especially under cloudy conditions when UV intensities can be greatly reduced. Further work is also needed to verify the action spectrum for vitamin D production.

For general practitioners, in the front line of advice to the public on health issues, the strong contrasts in UV intensity are an important consideration. During winter, especially in the south, some UV exposure should be recommended for natural production of vitamin D. It will need to include the midday period; the same time that exposure to the sun should be avoided in summer.

The issues discussed above will be a focus of the UV Workshop planned for 19–21 April in Dunedin (see: http://www.niwascience.co.nz/rc/atmos/uvconference/)

R McKenzie
P Johnston
B Liley

Reference

1. Lucas RM, Ponsonby A-L. Ultraviolet radiation and health: friend and foe. Medical Journal of Australia 2002; 177: 594–598.
2. Webb AR, Kline L, Holick MF. Influence of season and latitude on the cutaneous synthesis of vitamin D3: Exposure to winter sunlight in Boston and Edmonton will not promote vitamin D3 synthesis in human skin. Journal of Clinical Endocrinology and Metabolism 1988; 67(2): 373–378.
3. Zittermann A. Vitamin D in preventive medicine: are we ignoring the evidence? British Journal of Nutrition 2003; 89(5): 552–572. DOI: 510.1079/BJN2003837.
4. MacLaughlin JA, Anderson RR, Holick MF. Spectral character of sunlight modulates photosynthesis of previtamin D3 and its photoisomers in human skin. Science 1982; 216(28 May):1001-1003.

The Royal New Zealand College of General Practitioners

The Royal New Zealand College of General Practitioners'

PRIMARY MEMBERSHIP EXAMINATION

PRIMEX

CLOSING DATE FOR APPLICATIONS: FRIDAY 9 June 2006

FEES (GST inclusive)	FULL FEE
Current Associate Primex Fee	$2,812.50
Applicant joining as an Associate Primex Fee and Associate Fee	$3,287.82
Non Associate Primex Fee	$4,000.00

EXAMINATION DATES

Written Examinations	Saturday 14 October 2006
Clinical Examinations	Saturday 4 November 2006

ENQUIRIES

Any enquiries concerning the Primex examination in 2006 should be addressed to **Rebecca Wilson:**

Tel: 04–915 4937 Fax: 04–496 5997

Email: rwilson@rnzcgp.org.nz

Becoming a physician

'While I am busy treating the bodies of my patients, I try to remember to treat the patients as well – to touch them in small ways as well as large. It is critically important to treat the hypertension, the diabetes, or the heart disease skillfully, but when I remember to treat the patient as well, I experience the essence of being a physician. Caring for my patient as a person provides a comforting connection for both of us – the doctor and the patient facing the fears and managing the problems together. I know this alliance is at the heart of our calling, of why we went to medical school all those years ago.'

Treadway K. Becoming a physician: Heart sounds. New Eng J Med 2006; 354:1112-1113.