1996–2001
NZFP – looking back

Tessa Turnbull

Tessa Turnbull *is still in full-time practice, enjoying a rural lifestyle and juggling work, family and other interests.*

'SHORTAGE OF DOCTORS IN CITY CRITICAL' shrieks the headline of Tauranga's evening paper the *Bay of Plenty Times* this week. The lead article goes on to say that *'Tauranga doctors under growing demand are closing their books to new patients – eight of nine practices spoken to by the paper this week are unable to accept new patients.'*

This message had already been signalled by a couple of my patients who, in forsaking country life to retire to the city, found themselves unable to forsake their country doctor for a bright new city one for the time being. Instead, they found themselves joining a waiting list for their proposed new practice, a waiting list said to be up to a year, as patients from these practices moved on or out of this world.

Doctor shortages in 2008 in a city like Tauranga, famed for its appealing climate, close proximity to all the things that support a traditional Kiwi lifestyle, home to the Steamers and supporters of The Magic, might seem an anathema, a puzzle, an impossibility. Twelve years ago, the after hours service was well organised and co-operative in nature; rural GPs regarded this with no small envy. There was an active peer group culture, which had begun at least 15 years before led by Derry Seddon. Horror of horrors, Otumoetai Medical Centre had even signalled that capitation could be a good thing for both patients and doctors.

Looking back 12 years, could the looming problem of general practitioner shortage in Tauranga city have been anticipated and perhaps avoided? Certainly rural doctor shortages had been well flagged as an important workforce issue: doctors who came from all over the world propped up rural medical services. One way to do this is to scan the *NZFP* at that time, as the journal traditionally reflects the current interests and concerns of general practice and its practitioners. The College journal is a mirror of the times, as well as being a repository of peer-reviewed research.

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Round about 12 years ago I took over the reins as editor of the *NZFP* from a scholarly and highly regarded Rae West. Rae wanted to retire from the position and no one else put up his or her hand. I was happy to accept the challenge as an antidote to the downside of rural practice – i.e. a degree of professional isolation and grinding hours on night and weekend call. I duly made the trip to Auckland and collected various cardboard boxes and files and the tools of office, some College notepaper and envelopes and a couple of research papers poised at the peer review stage of their journey. And, of course, received sage words of advice from Rae as well as hospitality from his wife, Lillian.

It was a time of change for the *NZFP* as the decision was made by the College to move its publishing base from Southern Print in Dunedin. A bold alliance was about to be struck with *New Zealand Doctor*.

My first *NZFP* was published in Dunedin and, to celebrate, I got my practice partner Jeff Friis to make up a collage of our local Kaimai peer group for the cover page. Never one to stand back, Jeff ensured two pictures of himself were included!

The partnership with *NZ Doctor* brought assistance from their editorial team with layout and publication, although the *NZFP* editor still retained full editorial control. *NZ Doctor* was responsible for seeking advertising and joint distribution saved postage for us both. Another early focus of the association was market research – those pie charts were an amazing resource. The names Colin Abercromie, Chris McBride, Carmel Williams and Sanya Baker from *NZ Doctor* are indelibly printed on my memory as our partnership was forged and grew.

The relationship was very satisfactory for both partners and lasted many years. Advertising was an important source of revenue for the journal as the subscription base was too small to balance costs. It was a time when pharmaceutical advertising revenue was becoming leaner as the Pharmac grip on the previously free-spending companies started to tighten. Passing the task of seeking advertising on to Colin, who had vast experience in this area, was an enormous relief.

The College was attracting more members, but membership fees had to be balanced against many other College demands – all needing a budget from a finite pool at a time of expansion in the College history. This expansion is well reflected in the pages of the *NZFP* of those years.

In the College at that time there was solid support from members for what was considered to be traditional College business; that is, medical education and governance. They were forging links with practice nurses and managers and other medical and political alliances. Our position on The Terrace made many of these links much easier to develop.

Governance was not straightforward as the way the College delivered education both before and after vocational registration was being challenged. State funding provided to the College's Registrar Training Programme was shrinking, but was still seen as a juicy financial plum by universities facing financial constraint. They tried their best to persuade politicians that they were more capable of 'providing the goods' and training registrars destined for general practice. It took many years, many meetings and many determined College office holders to define the current registrar-training programme, which is still firmly based in College hands.

I had a capable and handpicked Editorial Board and we met annually to ponder on previous themes and develop new ones for the upcoming year. Thanks to Bruce Arroll, Marjan Kljakovic, Rose Laing, Ian Millward, John Richards, Jonathan Simon, Murray Tilyard and Les Toop for their input and support during my years as editor. We were an industrious group; Murray would always have at least one other meeting to attend to keep him busy on his trip north!

Looking at copies of the *NZFP* of the time, the maternity debate was in its infancy and much time and energy was spent reflecting the unheeded concerns of general practitioners. It is no great surprise to see the political and Ministry agenda to sideline GPs from maternity care fulfilled. The College predicted that maternity workforce fragmentation would occur, and it did; valuable skills and experience gained by GPs would be lost and that happened; and workforce shortages remain critical especially in rural areas. All this at a time when the concept of teamwork was being much trumpeted for its ability to deliver better patient care.

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In stark contrast to this has been rural general practice's association with the ambulance service through PRIME. In our rural area, we once went to every ambulance callout with the local volunteers, at times being tracked down by the women who ran the local telephone exchange. This dates me, as time wise this was over 25 years ago. The St Johns' staff subsequently became better trained, more professional and quite separatist in their view that their staff could cope with any and every emergency. Then came PRIME and ongoing joint training sessions. The outcome has been better care all around and true teamwork in practice has developed. PRIME is a wonderful initiative, which has been to everyone's benefit, not least our hapless patients.

Information technology in general practice had passed its infancy in 1996 and was teetering into childhood or towards adolescence, depending on whether you were an early or late adopter. There were several companies offering their packages and First Class was up and running at the College headquarters. Twelve years of emerging information technology in general practice has been a whirlwind. Just think of advances such as fully computerised practices – 12 years ago most practices had office packages and some were using electronic prescriptions and records. Some GPs still used those ubiquitous A5-sized cards! We have progressed to electronic transfer of results and referrals, practices with web pages and now Best Practice. Best Practice, paper-based and electronic, is one of the better things to happen in general practice lately, bringing clinical guidelines to the desktops of general practice in a succinct and practical way. Thank you Murray; to think we mourned the passing of PreMec and doubted your ability to deliver a finer product!

Sub-branches of general practice were another theme in the College and *NZFP* in 1996. The *NZFP* featured several GPs with special interests who combined these with 'normal' general practice. General practices have tended to get larger and better organised over the last 12 years, assisted by information technology and trained practice managers. Special skills are easily utilised within the variety of a large general practice. And new initiatives such as the surgical skills programme have been win-win for DHBs, general practice and patients, once again having battled past some opposition from our specialist colleagues.

The College has played a critical role in the progress and definition of general practice since its inception, and no more so through practice accreditation. This was in its infancy 12 years ago with its central document *Aiming for Excellence* going through validation. The *NZFP* reflected the many issues relating to practice accreditation and from 1996 provided articles to help practices through the processes.

Competence to practice was another developing theme through the early1990s reflected in the *NZFP*. 'Reaccreditation' was the given name and 'cohorts' of GPs were required to detail their required number of points to be passed on to the Medical Council. The Quality Assurance Unit has been the glue that has melded everything together. The Unit developed powerful and effective resources and some of these were published or given publicity in the *NZFP*. Reaccreditation survived revolution from College members and later became MOPS with its own ongoing evolution.

The College surveyed its members in 2001 to find out what they believed should be core College business and the results were published in the *NZFP*. It is not surprising that GPs strongly felt that training, education and professional development through PRIMEX and MOPS were the highest priority. However, advocacy also rated highly.

Well, back to Tauranga. I began my journey as a rural GP nearly 30 years ago when I forsook my shiny city practice and close friends and colleagues in Island Bay, Wellington, to practise medicine in Katikati. I settled into a struggling rural town 45 minutes' drive along winding rounds with several one-way bridges to the city of Tauranga. I was just the third doctor to arrive in town and, like the first two, never left. It has been a fascinating journey and being editor of the *NZFP* for four years was part of that journey.

What of the evolving *NZFP*? A journal of, and for, team-based primary health care? We have not achieved team care in maternity care but we have achieved it through PRIME. Best Practice is cool and Care Plus is struggling. There will always be a need for a paper-based journal to read at leisure and to reflect the paradigms and issues of the day. The news, current themes and debates and peer reviewed research.

Smoking, exercise, and health care costs

'Several lifestyle variables are strongly correlated with the likelihood of using outpatient and inpatient care services, and the related costs, in many cases. For instance, former smokers are found to have higher probability of using medical care and incur higher medical expenses. The predicted outpatient and inpatient medical expenditures are found to be much higher for an average former smoker. Also, there is a significant link between the exercise variable and the likelihood of outpatient and inpatient care services usage, and the related costs, in most models. People with exercise habits are less likely to use inpatient care services, and they incur lower inpatient expenses. As a consequence, healthcare policies that promote physical activities and non-smoking would be a good policy instrument for the government to curb rising healthcare expenditures in Taiwan.'

Lin T-F. Modifiable health risk factors and medical expenditures – The case of Taiwan. Soc Sci Med 2008;67:1727-36.

Doctors' strikes

'We identified 156 articles, seven of which met our search criteria. The articles analyzed five strikes around the world, all between 1976 and 2003. The strikes lasted between nine days and seventeen weeks. All reported that mortality either stayed the same or decreased during, and in some cases, after the strike. None found that mortality increased during the weeks of the strikes compared to other time periods. The paradoxical finding that physician strikes are associated with reduced mortality may be explained by several factors. Most importantly, elective surgeries are curtailed during strikes. Further, hospitals often re-assign scarce staff and emergency care was available during all of the strikes. Finally, none of the strikes may have lasted long enough to assess the effects of long-term reduced access to a physician. Nonetheless, the literature suggests that reductions in mortality may result from these strikes.'

Cunningham SA, Mitchell K, Narayan KMV, Yusuf S. Doctors' strikes and mortality: A review. Soc Sci Med 2008; 67(11): 1784-8.

The QOF tackles health inequalities

'Tackling health inequalities has been a consistent part of the political rhetoric in the UK for more than a decade, with primary care seen as a key player in improving life expectancy in areas with the worst health record and highest deprivation... High blood pressure is the most important risk factor worldwide for developing cardiovascular disease, a condition that contributes greatly to the gap in life expectancy between deprived and affluent areas. The problem of reducing blood pressure is now being tackled more effectively in practices across the land. Perhaps the greatest contribution that the quality and outcomes framework has made to changing practice will therefore be the largely unintended consequence of generating more equitable health care.'

Lester H. The UK quality and outcomes framework: Has improved quality of care reduced health inequalities? BMJ 2007;337:a2095.