

# Editorial

*Tony Townsend has been a general practitioner for 30 years. Although he has dabbled in medical politics, medical ethics, community-based teaching, university-based teaching, quality improvement and assessment, his passion remains clinical general practice. He is currently a full-time general practitioner in Whangamata.*



## Advancing technology

It is 190 years since Laennec invented the stethoscope in 1816 and 100 years since Nikolai Korotkoff described the use of the stethoscope with a sphygmomanometer to measure blood pressure. The first otoscope was used in 1841 followed by the ophthalmoscope in 1851. Although these latter two instruments have been refined with modern engineering, the stethoscope and sphygmomanometer have changed very little. Our clinical examination still depends on the use of these century old diagnostic tools to help us in the office assessment of the health status of our patients. In the Hippocratic tradition, we continue to rely very much on our ears, eyes, touch and sometimes our sense of smell<sup>1</sup> to help us decide what might be the cause of our patient's dis-ease or to make an estimate of their risk of ill-health. On the basis of our clinical evaluation we use pattern recognition, mental algorithms or some sort of individualised cognitive search system to make assessments; pathognomonic, probable, possible or no idea. This is done with very little in the way of sophisticated technology, although computerised resources are being used by some GPs to help in their assessments.

We are now able to order an increasing array of laboratory inves-

tigations and to send our patients for imaging, but these tools are not usually much help in our initial diagnostic office evaluation. Unlike doctors in the hospital setting, we cannot easily access CT, MRI or PET scans for the majority of our patients. I recently had a patient who had an x-ray of her thoracic spine. An abnormal shadow showed up in her chest and it was suggested that she have a CT scan to sort this out. In order to get a CT scan covered by her insurance company we had to refer her to a specialist who simply authorised the scan, which turned out to be normal. Another, uninsured middle-aged man, had to wait for six months for a publicly funded CT to confirm that his exophthalmos was caused by an invasive retro-orbital neoplasm. On the other hand, there is a disturbing trend, noted in an earlier editorial, for using whole body CT for screening in asymptomatic patients. As expected, false positives requiring further evaluation are relatively common! So, whether or not limiting our access to these technologies is a good thing or a bad thing is debatable, but that is how it is.

Now, in the early part of the 21st century, we may be on the verge of change. Technology has finally entered the consultation room in the

form of monitors and keyboards (some colleagues would use the term intruded) and some of our patients think that this is great while others think that it interferes with the personal relationship that they have with their doctor. But we are about to go a step further. In this issue of the journal we have contributions that describe the virtual consultation and how this can be used for both diagnosis and for management, even for the management of cardiac arrest. Portable ultrasound and handheld echocardiograph devices are now available. Mark Billingham and his colleagues describe the development of their exciting, new, virtual interface tools. I have had the opportunity to play with an early version of Tangible Teleconferencing and can confirm that it is almost like being there. I can easily imagine sitting in my consulting room with a patient while holding a virtual consultation with a consultant without the patient having to travel out of town.

It seems to me that what is important is that we learn how to use this new technology to enhance patient care. It will not, in the near future, replace good history taking and physical examination skills but it may save patients time and money and help us to resolve some aspects of our uncertainty.

### References

1. Bomback A. The physical exam and the sense of smell. *New Engl J Med* 2006; 354:327-329

# What is new in NZFP in 2006

Most readers appear reasonably happy with the format and content of our journal and we do not intend to make any major changes to this in 2006. We have, however, introduced two new sections and, in response to comments from readers, are now asking every author to complete a statement of competing interests and to allow publication of an e-mail address for correspondence. We continue to welcome correspondence through 'Readers write', but sometimes a direct response to an author is more appropriate.

## Competing interests

Declarations of competing interests have become common in most international medical journals. A competing interest exists when professional judgment concerning a primary interest (such as validity of research or a patient management review) may be influenced by a secondary interest (such as financial gain or professional status). For us to make the best decision on how to deal with a paper, we need to know about any competing interests that authors or referees may have. We are not aiming to eradicate competing interests as they are almost inevitable. Neither will we reject papers or opinions simply because there is a competing interest, but we would like to know about it and, more importantly, we would like our readers to know about it. From time to time a com-

peting interest may result in a bias that is sufficient to warrant rejection, but we hope that this will most often be sorted out at a very early stage of the editorial process.

## Improving quality

In the last few years, in response to a variety of stimuli, including consumer demand, government decrees (such as the HPCA Act), IPA and PHO development and, most importantly, the genuine desire of general practitioners to improve the quality of the service that they provide (most of us do care about what we do), quality improvement activities have developed to the extent that they are now an everyday part of our practice. From time to time we have been sent papers describing these activities, but it has been difficult to know how best to deal with these. They usually do not meet the criteria of original scientific research and they are not CME. We have sometimes published these as 'Issues' papers but most of this work goes unpublished and the changes in practice that have led to improvements are therefore not available for use by other primary care practitioners. This has been recognised in the international literature and some of the reasons that quality improvement reports are rarely disseminated have been outlined by Professor Richard Thomson.<sup>1</sup> Davidoff and Batalden consider that part of the reason for the gap between

quality improvement activities and the publication of the results reflects the reality that most people who do the work of quality improvement are more interested in actually improving care than in writing about what they do, but they also acknowledge that there are barriers to publication. They list examples of elements and criteria to be considered in reporting guideline items<sup>2</sup> and these will be helpful for authors to follow in the preparation of a quality report paper. The first of these reports is published in this issue of the journal and we welcome contributions from any of our readers.

## GP Browser

There are a multitude of web pages available for those of us who work in primary care. The problem with this is to know what is useful and what is best ignored. We are introducing a page that we hope will help with this. What we would like from you is a brief note describing your favourite web site with a comment about why you have found this useful. Bruce Arroll has set the ball rolling with a fairly comprehensive list in this issue. Please send your comments by e-mail to the editor at [tonytownsend@xtra.co.nz](mailto:tonytownsend@xtra.co.nz).

## Acknowledgement

The editor is very grateful to Professor Bruce Arroll for suggesting these initiatives and for providing the background reading.

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## References

1. Thomson RG. Consensus publication guidelines: the next step in the science of quality improvement? *Qual Saf Health Care* 2005; 14:317-318.
2. Davidoff F, Batalden P. Toward stronger evidence on quality improvement. Draft publication guidelines: the beginning of a consensus project. *Qual Saf Health Care* 2005; 14:319-325.