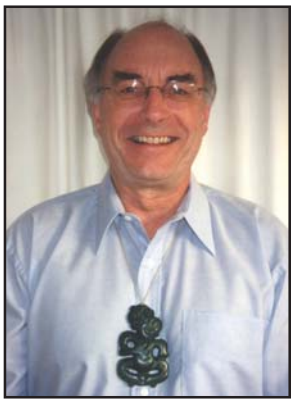
Editorial



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.

My relatives first arrived in New Zealand on the Charlotte Jane in 1850. My father, who was the first medical practitioner in our family, was a general practitioner obstetrician (they all were back then) for many years in Rotorua. Although he was known as the *'Father of Ngapuna'* I believe that this was metaphorical. As far as I am aware I have no Maori ancestry. However, in common with most New Zealanders, I have a strong Maori heritage. The papers in this issue by some of the members of Te ORA prompted me to reflect on this.

I started school at Rotorua Primary in 1949 and, as it was then, Maori culture was not part of our curriculum. We played stick games together, exchanged stories together and got into trouble together, but I did not know about the Treaty until I was much older. Maori language was picked up in the playground but not in the classroom.

Although I did a little general practice while I was a MOSS at Kawakawa, my first full-time general practice experience was working as a locum for a short while in Te Araroa, the birthplace of Sir Apirana Ngata. That was before electricity came to the town and twilight was heralded by the gentle thud of diesel engines powering up the generators all around the Medical Clinic.

House calls were often done on horseback as there were no roads to some of the houses across the rivers. The nearest colleague was 60 miles away in Te Puia Springs and the nearest hospital 100 miles away at either Opotiki or Gisborne. Nearly all of my patients were Ngati Porou and they welcomed me as a friend. I went fishing with them (we used crayfish as bait), I was invited into their homes, I joined in their traditional Maori party songs such as *'Hoki Hoki'* and *'Spanish Harlem'* and the local nurse and I treated their illnesses.

I left with some reluctance to set up practice in Rotorua. I started as a solo GP in Owhata, the home of Hinemoa, in 1974, and was joined by two colleagues in 1978. I have many stories from the twenty years that I spent in practice in Rotorua. Some I can tell and some I can't.

One of my patients was the local Tohunga. I would see him at his home, as he was clearly not too comfortable sitting in our waiting room. I would help him with his heart failure and he would send patients to me if he thought that they had a medical problem. He called me when his wife died, sitting up in bed reading a book, and then not long afterwards he also quietly faded away.

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Another woman I remember clearly was a Maori in her early 50s. She had had a peptic ulcer for many years, I guess she may have had Helicobacter pylori but we didn't know about that then. She came to see me one day to tell me that she was dying of stomach cancer. She was more convinced of this than I was, but I persuaded her to have a gastroscopy so that I might be more certain of the diagnosis. She returned after this and I informed her with a certain amount of disguised pleasure that her biopsy was clear. She replied that, with all due respect, she did not believe me and that she had prepared her family for her death. She went to die in a small town on the East Coast and her new GP contacted me when she died to see if I had the histology of her cancer for the death certificate. I told the GP that I thought that the patient had died of makutu but that I was not sure if this was acceptable for a death certificate!

The paper in this issue about attitudes towards immunisation reminds me of a young Maori woman whom I saw quite frequently as she had quite severe learning difficulties and life was not easy for her. She had a baby and not long after his three-month immunisation I was called as he had suddenly died in his mother's bed. She, of course, blamed the vaccine and didn't get her second child vaccinated. However her third child had a systolic murmur and when she was seen by a paediatrician, her mother and her partner were persuaded to have the child immunised. About a month later she was also found dead with no suspicious circumstances. There was nothing that we could do to convince the parents that the deaths were not vaccine related. I didn't see them very often after that.

One of my most treasured possessions is the tiki my partners presented to me when I left Rotorua for an overseas appointment in 1994. I wore it on many occasions while I was overseas, particularly when I was travelling, and it served to remind me of my roots. That reminder and the call of our family were the reasons that we decided last year to return to New Zealand to rural general

practice, despite having a teaching contract in the Middle East that continued to 2003. I had been away for seven years but I had endeavoured to keep in touch with the ever-changing New Zealand health care system.

There is no doubt that the health status of Maori is worse than non-Maori[1] and that this cannot be explained solely by socio-economic differences.[2] On the other hand, there is no evidence that a decade of health reforms has done anything to improve this situation. Indeed, some of the more noticeable outcomes of the reforms include an increasing fragmentation of primary health care with multiple and changing provider organisations, the demise of primary medical obstetric care, serious concerns about community mental health care prompting Auckland coroner Murray Jamieson to state that *'fragmented care is a short distance away from disintegrated care'*[3] and increasing difficulty in accessing some secondary health care services. Expenditure on health care management has exploded and the morale of health care workers has declined. Maori health care has not escaped the consequences of political interference. Although there may have been small improvements in some parts of the health care services, in general all is not well in Aotearoa.

I hope that the formation of a Maori Faculty in the College will help to address some of the health care concerns of our Maori patients. I hope that the new Faculty will suggest strategies to promote integration of health care. We all need help to understand why it is that Maori continue to have increased morbidity from potentially preventable illnesses.

It seems to me that the basic principles of general practice – patient centredness, continuity of care, comprehensive care, accessibility and teamwork, are essential elements for the provision of high quality primary health care whether it be to Maori or non-Maori. Somehow, in amongst all that has been going on, some of these principles seem to have been set aside.

As editor of this journal I will endeavour to publish original research with a high standard of scientific rigour, reviews based on sound evidence and viewpoints which stimulate debate and encourage evolution of general practice services.

Our previous editors have set high standards in this regard. Most recently Campbell Murdoch has continued to achieve a high quality scientific publication at the same time as over-seeing the transition of the journal to a fully College-based publication. These are big footprints to follow and I call on all of our readers to contribute to the evidence that underpins our discipline. Without your enthusiastic support we are a profession at risk.

References

1. http://www.tpk.govt.nz/maori/health/
2. Sporle A, Pearce N, Davis P. Social class mortality differences in Maori and non-Maori men aged 15–64 during the last two decades. NZ Med J 2002;115:127–31.
3. NZ Herald, 29th August 2002.