Editorial

Susan Dovey works half-time for the Royal New Zealand College of General Practitioners as Advisor to the Chief Executive, and half-time for the University of Otago, as Associate Professor in the Department of General Practice, Dunedin School of Medicine. She is a general practice researcher.

Celebrating heterogeneity

Heterogeneity is an interesting term because it is widely used in a variety of scientific and social contexts, to describe a group of things comprised of individuals with different characteristics. In its technical use it is often a term with a vaguely negative flavour: as in genetics, where heterogeneity refers to multiple origins causing the same disorder in different individuals; or in statistics, where tests for heterogeneity (most importantly, its absence) are used to make sure that the differences in the populations or methodologies of studies in meta-analyses do not reduce their comparability and call into question the overall conclusions. The opposite of *heterogeneity* is *homogeneity*, or similarity in every ingredient of a group.

This edition of the *New Zealand Family Physician* celebrates the heterogeneity of general practice and primary care. It draws attention to the fact that the things that we call 'general practice' and 'primary care' are each comprised of disparate (and overlapping) individual ingredients. There are no negative connotations to be seen here. Primary care is distinctly different from health care in hospital settings due not only to the environments in which health care is delivered and the type of health services provided there. As well, health professionals generally have less control over care management and delivery in primary care than in the more continuously monitored hospital admission, and more than one site is often required for an episode of care (having implications for patient and information transfer). Sites where primary care is provided are not necessarily designed for this purpose (for example, patients' homes, providers' cars, on roads, or anywhere else, in fact) and episodes of primary care may extend over very long time frames – sometimes years. In my own research on patient safety, these defining characteristics have made the translation of hospital-based solutions into primary care settings both challenging and (often) inappropriate. The upshot of this situation is that research that has any real chance of being used in general practice and other primary care settings really has to be generated in those same settings. This reality has yet to dawn on many of our health policy makers and planners.

The things that we call 'general practice' and 'primary care' are each comprised of disparate (and overlapping) individual ingredients

This year is the 30th anniversary of the World Health Association's Alma-Ata Declaration[1] and we could not let this important anniversary slip by unnoticed. Why is it important? Mainly because previously health care was officially assumed to be a hospital-based activity and for the first time the Declaration gave the world the internationally agreed definition of primary health care – at the same time officially acknowledging its existence. The definition is provided in point VI of the Declaration of Alma-Ata. It is: '*... essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community...*' Although each country interprets the concept a little differently (more heterogeneity!), it is generally agreed that primary health care describes the activity of health care providers who act as a first point of health system contact for all patients and who are based in a community, rather than in a hospital.[2] We are privileged in this edition to have a reflection from George Salmond on the meaning of the Alma-Ata Declaration for New Zealand, from one who was there. Accompanying this is a paper contributed by Wellington GP and academic Sue Pullon, drawing together the threads of discussions from workshops at the RNZCGP annual conference and at the national

Alma-Ata symposium held at the School of Population Health, University of Auckland, in September.

The real strength of a heterogeneous general practice and primary care sector is in its adaptability. There is an argument that medical specialties that are based around a homogeneous technology, such as radiotherapy, or a homogeneous philosophy, such as psychiatry, will have no longitudinal reach, whereas medical specialties like general practice that are complex, confused, diverse, and chaotic, will ultimately survive intact for this very reason. With their complexity comes adaptability. Yet socially and politically we seem to be motivated in the 21st century by ideas of homogeneity – reducing inequalities, cutting out variability, and removing differences. Perhaps there has always been this tension: perhaps it is part of the human condition. GPs are constantly urged to be both patient-centred (implying unequal time commitment, variable service, and different 'inputs' and outcomes) and evidence-based (implying 'averaging' and homogeneity in all the above dimensions). Obviously these two values conflict, but maybe it's all a matter of degree.

GPs are constantly urged to be both patient-centred... and evidence-based... Obviously these two values conflict, but maybe it's all a matter of degree

Maybe we can tolerate differing interpretations of even the definitions of 'general practice' and 'primary care', if we all share a general understanding of more or less what we're talking about. In this journal, US family physician Professor Rich Roberts writes a very elegant essay about New Zealand GPs. In it, he roughly equates Kiwi GPs with US family physicians and, even more broadly US primary care physicians. Most of us would agree that that's OK, even though family physicians in the US, on average, do slightly different things (more obstetrics and hospital-based care, less measuring and politics) and even though primary care physicians in the US include different medical specialties from primary care in New Zealand. In his capacity as current WONCA president-elect, Professor Roberts gets to see a lot of the world and its primary care and general practice groups. This bird's eye view enables Roberts' thoughtful consideration of where general practice might be heading in New Zealand.

The real strength of a heterogeneous general practice and primary care sector is in its adaptability

Jenny Carryer and her co-authors also refer to heterogeneity within the general modus operandi of New Zealand general practice. This is an interesting piece of research for its identification of patients' perceptions of nurses in general practices – busy but subsidiary. In the context of a Primary Health Care Strategy that emphasises the importance of nurse-led care for the very sorts of patients involved in the Carryer study, they highlight the dominance of doctor interactions in patients' perceptions of their general practice care. Obviously this will apply more in some practices than in others, but the authors suggest that the underpinning political environment supports doctor dominance, even though the political rhetoric expounds otherwise. Both Carryer and Pullen draw attention to the way our complex funding models act as barriers to application of different health professional skills in general practice.

As well as the Alma-Ata papers, we have in this journal some papers coming out of the research stream of this year's RNZCGP annual conference. Ben Gray writes of a dimension of cultural competence we don't hear much about – the competence to provide good care to patients who come from other countries and need translation services to communicate with their health care providers. Melissa Ge and colleagues provide a review of vitamin C use and its (mainly) beneficial properties. We also include a selection of vignettes prepared by general practice registrars in their Stage 1 programme. Skills in critical inquiry are actively promoted in general practice vocational training and these vignettes demonstrate some of the clinical challenges this year's registrars have dealt with. You will see more from our registrars in the December edition of the journal. Finally, I am privileged in this journal to publish one of the finest pieces of general practice prose I have ever seen. Clare Ward, a rural GP for many years, reflects on death. These will resonate with many of you, but the extraordinary element of this piece is how Clare has located the work firmly in New Zealand general practice. Whatever you do, don't miss this.

References

1. Declaration of Alma-Ata. In International Conference on Primary Health Care. Alma-Ata, USSR: World Health Organization; 1978.
2. Starfield B. Primary Care: Balancing Health Needs, Services and Technology. New York: Oxford University Press; 1998.