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Doing the 'bread and butter' of general practice well in uncertain times

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It is uncertain times in Aotearoa New Zealand (NZ) for those of us who wish to see the country to continue to move forward to address health inequities, to uphold Te Tiriri o Waitangi (Toitū Te Tiriti)[1] and to value and support primary health care. NZ's new coalition government has just pushed through a 100-day plan which repeals evidence-based legislation of international significance (Smokefree Aotearoa 2025)[2] leading to worsening health inequities.[3] Another issue of major concern is the disestablishment of Te Aka Whai Ora (Māori Health Authority) a mere 18 months after it was set up.[4] Progress is also still awaited on the urgent need to deliver a fit for purpose funding model for primary health care following last year's Sapere report on capitation funding.[5]

Moving on to this issue of the journal, our focus is very much on the 'bread and butter' of general practice and primary health care. Our first group of research papers looks at learning in the consultation in vocational training for general practice. General Practitioner (GP) specialist training in Australasia occurs within an apprenticeship model using in-practice supervised practice. A key feature of this approach is the use of feedback and reflection on GP registrars' clinical practice. In Australia, the Registrars' Clinical Encounters in Training (ReCEnT) study, an inception cohort study, has been collecting consultation-based clinical and educational experience of GP registrars since 2010.[6] This issue features three ReCEnT research studies. Klein and colleagues[7] surveyed registrars, supervisors and medical educators regarding the effectiveness of ReCEnT as an educational tool for registrars to enhance reflection and influence change in practice. They found that ReCEnT can prompt self-reflection among registrars, leading to changes in clinical practice, learning approaches and training plans. Bentley and colleagues[8] build on these survey findings[7] by using qualitative methods to further explore participants' perceptions of ReCEnT's utility. They conclude that for ReCEnT to achieve its goal of being an assessment *for* learning (as opposed to an assessment *of* learning) requires effective engagement between registrars, their supervisors and medical educators. Sturman and colleagues[9] used a cross-sectional study of GP registrars to determine if the presence of previously reported barriers to GP registrars seeking assistance from their supervisor (concern about patient impressions of their competence and discomfort presenting to supervisors in front of patients) was associated with a reduction in the frequency of registrar in-consultation assistance from their supervising GP. They found no such association. The consultation is also the focus of Jefferies and colleagues'[10] qualitative study exploring the collection and utility of the family health history, which was used to varying degrees in four areas – risk ascertainment, patient engagement with a diagnosis, social context and building relationships.

Our second group of research papers addresses Type 2 diabetes (T2DM) which is one of the most prevalent chronic conditions diagnosed and managed in primary care, affecting over 300,000 people in NZ. Listening to and learning from our patients with T2DM is a must if we are to provide high quality care. In a qualitative study, Crosswell and colleagues[11] interviewed patients about the provision of education and delivery of care they received at the time of diagnosis. They found three overarching barriers to providing high quality care: ineffective provision of resources and education methods, poor communication from healthcare practitioners, and the NZ health system. They conclude that patients with T2DM require more information and support at diagnosis, and timely engagement with healthcare practitioners who can assist with setting patients up for effective self-management in the future. Ju and colleagues[12] in their qualitative

study explore patients' perspectives on the barriers to diabetes care once a diagnosis has been established and the patient is attending annual diabetes reviews (ADRs). They identified three barriers to attendance: healthcare-associated factors (eg not having a consistent GP); patient-related factors (eg co-morbid health conditions); and systemic factors (eg travel distance to the practice). They conclude that it is important to incorporate patients' views when planning the delivery of the ADR. One important aspect of T2DM diabetes management is ensuring greater access to medication, and this could be facilitated by increasing nurse prescribing capability. Short and colleagues[13] performed a rapid systematic review to investigate the influence of nurse prescribing on health care delivery for individuals with diabetes in NZ and in other countries with comparable health systems. They conclude that clinical outcomes are the same for both nurse and medical prescribers and that patients viewed nurse prescribing as safe and acceptable. T2DM also features as a letter to the editor from Hawkins and Zinn,[14] who argue that NZ has been slow to recommend carbohydrate-reduction in T2DM. In her invited commentary Hall[15] points out that while very low carbohydrate diets do work in the short-term, they are not a long-term solution for a long-term condition, and that what is most important is to address the underlying causes of inequity in T2DM management.

Skin conditions are also commonly diagnosed and managed in primary care with specialist assessment and management as clinically indicated, though there is a shortage of dermatologists nationally, particularly in the public sector. Kivi and colleagues[16] report an analysis of referrals made by a large general practice in Palmerston North to an onsite private dermatology clinic. They found this collaboration between GP and dermatologist acted as an effective triage service with the majority of patients not requiring referral on to secondary care. Tirado-Perez and colleagues[17] evaluated an excision pathway for keratinocytic cancers diagnosed by teledermatology following a GP e-referral for suspected skin cancer. This allowed for lesions to be removed by GPs in a timely manner. We end our research papers with a look at the treatment gap and the screening gap. The treatment gap is a focus of Lillis'[18] study of prescribing data for the use of psychostimulants in the management of Attention deficit and hyperactivity disorder. Lui and colleagues[19] in their scoping review of determinants of cancer screening participation among target groups in Queensland explored reasons for non-attendance using a behavioural change model.

We feature two viewpoints relating to prescribing. Norris and colleagues[20] argue that inequities in medicines use are probably much worse than we thought, and Jerjes and Harding[21] discuss the importance of de-prescribing. Our back-to-back series continues with Holt-Quick[22] arguing for the proactive use of AI-based technology and Bradford[23] arguing against. The issue concludes with a *Cochrane Corner* on whether decision aids improve clinical practice[24] and a *Charms and Harms* exploring the benefits and harms of *Ashwagandha* root (long used in Ayurvedic medicine).[25]

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Conflicts of interest. Tim Stokes and Felicity Goodyear-Smith are Editors in Chief of the Journal of Primary Health Care.

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