Letters to the editor

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What do interns think about vocational training for general practice?

Dear Editor

Demand for places in vocational training for general practice has fallen from its peak in the mid 1990s to the current situation where demand does not meet the number of places available in all regional training providers (RTPs). Paradoxically the need for general practitioners and rural practitioners is probably even higher than then, with record numbers of international medical graduates working in rural communities and the extension of the GP shortage to urban areas. Suggested reasons for this collapse include confusion over competing colleges and the move of general practice training management to General Practice Education and Training (GPET).

We explored the apparent mismatch in the demand for, and supply of, training places in one successful regional training program.[1] All 31 interns in the three regional teaching hospitals were asked if they were interested in applying for general practice training in the near future. Fourteen (45%) responded in the affirmative and agreed to participate in a telephone interview. All but two were graduates of The University of Queensland, and half had attended the North Queensland Clinical School for the final 2 undergraduate years.[2]

All interviewees expressed an interest in general practice training, but about half were in no hurry, stating that they might not apply for 2, 3 or more years. None felt knowledgeable about the training program and only those who had attended the vertically integrated NQ Clinical School had heard of the local training program. Responders were also concerned about the level of supervision available from experienced teachers, tales of heavy clinical workloads, and isolation from educational resources, friends and support services in rural terms.

These findings suggest that interns may be relatively isolated from RTPs and GPET. While the new medical school at James Cook University will solve local supply problems from 2006,[3] other RTPs may need to re-think promotional strategies. The hesitation of recent graduates to apply for general practice training also requires further exploration. Are they simply trying to gain additional experience in order to obtain the broader skills required for rural practice? Are they unprepared for the relatively isolated nature of mandatory rural experience, or are they still unsure of their chosen career and seeking broader experiences before making a choice?

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Developing family health nurses and family nurse practitioners for rural and remote areas in Australia

Dear Editor

The September issue of *AFP* contained two articles about developing nurse practitioners for rural and remote areas in Australia in order to improve access to health professional care.[1,2] Highly skilled nurses in remote areas do amazing work, showing that with appropriate support and the fortunate tendency of the human organism to heal despite what we doctors and nurses do, many patients can be satisfied by either type of care. But there is a desperate shortage and high turnover of staff, largely because there are insufficient funds provided for rural and remote health care, given the higher cost of providing the service, and the greater level of needs.

However, we must be careful about extrapolating cost studies from other countries to Australia. First, it is important to assess what proportion of advanced practice nurse work needs to be reviewed by a doctor, thus duplicating the attention needed. Nursing practitioners tend to work slower than doctors, which explains their higher ratings on communication, but this will only be economically efficient if their rates of pay are much lower than those of doctors.[2] Given the low pay rates of Australian GPs and poor working conditions (long irregular hours without breaks, limited holiday and skills maintenance opportunities) it is unlikely that nurses who have gained high level skills will

want to work for a fraction of the per-patient rate of GPs. And, it is equally unlikely that sufficient funds will be provided to pay these extra people.

Furthermore, I am concerned about submitting rural people to such experiments. Why are rural people required to tolerate less qualified health care providers than those in the cities? Those who run the health care system are willing to allow part time anaesthetists, surgeons and obstetricians who have done 6 months or a year of training to work in rural areas, but if any of these doctors return to city practice they are seldom allowed to continue using their skills, even in the very hospitals that trained them.

Nurses who spend time learning advanced practice skills will no doubt have the same difficulties, thus forcing them to work only in remote areas and limiting their long term career development and personal opportunities. Is this what they want?

Perhaps to get more and better qualified health care staff in rural areas, we should educate more nurses to take over some of the tasks that specialists do, which require only a limited range of knowledge and skills.[4] Given the higher pay rates of specialists, this would be much more economically efficient. Such a change would free up many specialists to work in rural areas, or alternatively, fewer would be needed in the cities, allowing greater production of GPs and higher funding for rural health care. Surely, nursing schools should put energy into addressing this better answer to the overall workforce problem, rather than setting up turf battles in rural settings where all need to work together.

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GP counselling

Dear Editor

I read with interest the article by Grant Blashki (*AFP* Jan/Feb 2003) on counselling by GPs and the more recent article by Francis Macnab on the treatment of common life event traumas (*AFP* September 2003).[1,2] As a patient who has had first hand experience of GP counselling, I agree with the first author that the practice needs further investigation. If counselling is 'successful' then presumably all is well, but if it 'fails' the cost may be very high. The second author presents the view that GPs should play a role in managing the emotional trauma of life events, but in a more limited way.

I received assistance from two GPs during my 'marriage break up' several years ago. I attended consultations initially in the belief that the doctors were applying their professional skills in a rational manner to assist me to cope with my predicament. I was to be sadly disillusioned. One GP offered a diagnosis of 'depression', and suggested this was the cause of my marital problems, taking the side of my wife. The other GP gave no diagnosis as such, since the problem was not medical!

For some time I continued seeing both doctors, each with the knowledge of the other. In retrospect I can only wonder at my own gullibility, but a drowning man will clutch at straws. With all the pomp of medical authority I was given counselling and antidepressants, both of which were entirely useless. A great deal of unnecessary suffering in my life, and possibly the eventual destruction of my marriage, might have been averted by less incompetent treatment.

I ultimately found my way to two psychiatrists, both of whom offered highly professional help, the first giving effective emergency treatment for my acute anxiety (the correct diagnosis – not depression), the second giving me the invaluable benefit of a genuine understanding of the difficult and unfamiliar interpersonal situation in which I found myself, and the roles of the various parties involved.

Thanks to the psychiatrists I moved on, but my disillusionment with GP counselling remains – as do nightmarish memories of some of the worst of my sessions with the GPs I saw. In a gentle way, Blashki seems to be saying that GP counselling is of unproven value. My experience suggests that counselling is an ill defined procedure, that its use is not backed by good evidence, and that it is often done by people untrained or inadequately trained in its use. In the nineteenth century, this sort of thing was called quackery. What do we call it now?

Blashki's article suggests strongly that further research on counselling is needed, Macnab's that the scope for effective GP intervention is limited to listening, encouraging, reassuring, providing a broader perspective – a more grandmotherly role. But what is intuitively good is not necessarily so, and the possible human cost of these practices needs to be considered in the meantime.

In a more recent article, Blashki[3] and coauthors attempt to define a range of 'evidence based' approaches to psychological treatments in general practice, in recognition of the GPs 'ever increasing role as providers of mental health care' (*AFP* August 2003). But how many GPs conscientiously apply the principles of evidence to psychological treatment? It needs to be stressed, in my opinion, that when the GP resorts to unproven practices it not only puts the patient at risk, but it demeans the profession and destroys the confidence of the patient in the practitioner.

Stephen Due
Belmont, Vic

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Reply

Dear Editor

Mr Due is not alone in his experience of care. Three key themes identified in a national community consultation involving 1529 people whose lives were affected by depression were difficulty accessing family doctors with time, skill or commitment to mental health services, difficulty accessing specialist care for assessment, and, difficulty accessing nonpharmacological forms of care.[1]

The recent $120.4 million commonwealth

funded 'Better Outcomes in Mental Health Care' initiative begins to address some of these deficits through a number of strategies including supporting mental health training of GPs, supporting GP delivered evidence based psychological treatments,[2] and improving GP access to allied health providers of psychological care.[3]

Blashki's[4] call for more evidence based research of GP delivered psychological treatment is concordant with the most recent Cochrane Review on the subject,[5] and reflects that most studies have been conducted in specialist settings. Mr Due's conclusion, however, that counselling is an '... ill defined procedure' and '... not backed by evidence' is not consistent with the vast literature to the contrary.[6]

Nevertheless, Mr Due's experience is a reminder to GPs to clearly communicate their level of expertise before embarking on psychological treatment, and to refer to specialist care when the diagnosis is uncertain, or if the patient responds poorly to treatment.[7]

Grant Blashki, Jenni Parsons, Hugh Morgan, Ian B Hickie, Tracey A Davenport

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Pathways to care

Dear Editor

The recent article by Stain et al[1] (*AFP* November, 2003) is a timely reminder of the 'pathways to care' concept. However, it only provides a partial insight to how people with mental health problems go about seeking care. There are major difficulties in interpretation at two levels.

As indicated in an article quoted by Stain et al,[2] less than 50% of patients' first point of contact is the general practitioner; 23% of patients self referred to psychiatric services. By basing the study in general practice, this latter group of patients is missed.

A more significant flaw is in the number of people in the community with mental health problems who do not seek help from medical services of any type. Some seek care from complementary and alternative practitioners, some use lay counsellors or family members, but a proportion probably do not seek care from anyone. These patients are not picked up in studies based in general practice or other mental health services.

In mental health, 'pathways to care' analysis should occur from a community base. Otherwise, a proportion of those with mental health problems will be missed.

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Reply

Dear Editor

Ian Wilson is quite correct that a 'pathways to care' study in primary care can only give a partial picture of how patients reach treatment. Any study in general practice, of whatever diagnosis, will only consider the patients who come for care. However, primary care is a good place to start as three-quarters of Australians first seek help for mental health problems from GPs.[1] Of course, studies in general practice should be complemented by similar studies in psychiatric or community settings.

The aim of this article was not to give a comprehensive view of every possible route that someone might take to get to services, but test the feasibility of one particular method in one particular setting. We would also like to point out that conducting research in psychiatric and community settings is not without its difficulties. One of us (SK) tried on several occasions to obtain funding for a similar study in psychiatric settings only to be told that such a design was subject to referral bias, and should therefore only be undertaken in primary care. It seems that we are damned if we do, and damned if we don't! Undertaking a community survey would be a mammoth and expensive task, which I would be more than happy to do if I could ever raise the necessary funds.

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