The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

EDITORIAL
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Primary Care Pivots

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According to the Free Dictionary, the noun 'pivot' refers to '*the central or crucial factor*' and the verb, 'pivoting' is '*the act of turning on a pivot; a dramatic change in policy, position, or strategy*'.[1] I looked up this word because it appears quite frequently in the College's Manifesto of 26 May, and I wanted to be sure of its meaning.[2] For years now the New Zealand health system has been stretched, struggling to accommodate 21st century needs for healthcare in a delivery model that has remained essentially unchanged for nearly 100 years.[3,4] Despite claims of patient-centredness, the bricks and mortar of healthcare institutions up until this time have been the main health system focus. Yet, as the Manifesto points out, it was not these institutions but the often overlooked primary care community that adapted most nimbly to meet the needs of the New Zealand people during the SARS-CoV-2 (COVID-19) pandemic. If any good thing is to come out of this pandemic experience, may it be that it becomes a catalyst for real change in the health systems of hospital-centric countries. The pressures for change are adding up. In this issue Askerud *et al.* discuss the rise of multimorbidity, arguing that '*the primary care system is no longer a good match for the population it serves.*'[5]

Before COVID-19 changed everything, we had planned to focus on research for this issue. It is too soon to be able to publish primary research about COVID-19 but not too soon to plan, to start, or to ponder lessons from the experience. We have four COVID-19-related papers sharing experiences[6,7] and drawing attention to things readers need to know[8,9] and further papers reporting how pharmacists dealt with another public health emergency[10] and how to plan research.[11,12]

Nine doctors (and one medical student) working in rural New Zealand hospitals and general practices describe a wide range of experiences during the COVID-19 lockdown, including the influence of the 1918 flu pandemic, Fellowship exams, being too busy and not busy enough, under- and over-supplied with materials to meet pandemic needs and suffering information vacuums.[6] Always devastatingly honest and elegant in her writing, Lucy O'Hagan reflects on telehealth consulting.[7]

Equity across many social domains is critical for peaceful and productive societies, and events such as the COVID-19 pandemic starkly expose equity gaps, most recently expressed globally in the Black Lives Matter demonstrations. A group of primary care academics has followed discussions about equity issues arising during and from the management of the pandemic, and present their observations in the Guest editorial.[8] The psychological effects of quarantine on both patients and their healthcare providers is discussed by another editorialist.[9]

Public health emergencies are not new to New Zealand. In August 2016, 6500 people in Havelock North experienced the world's largest campylobacter outbreak and four people died. We seldom hear about the primary care clinicians who have critical roles in alerting public health authorities and protecting population health. In this issue we publish research describing the activities undertaken by pharmacists working through this outbreak.[10] This paper is relevant to post-pandemic considerations about re-structuring the health system, providing lessons that primary care providers can and do keep society functioning in these events, constraining the need for care from hospitals to manageable levels.

The Journal has made a decision to publish research protocols as part of a strategy to develop primary care research. The planning stage is often overlooked as a critical part of the research process, but without good planning the end result of research risks being useless. In this issue we publish two quite different research protocols but both are clear about their research question, why their question is worth answering, and how they propose to answer it. These are the key ingredients of a good protocol.

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One protocol comes from a group of doctors working in New Zealand's rural hospitals and general practices and seeks to test whether the point-of-care tests they have access to are sufficient to safely diagnose heart attacks.[11] The other comes from Canadian authors and is about using published literature to develop a framework to describe the development of access barriers to primary care for refugees.[12] We welcome more protocol papers, which go through the same rigorous review processes as original research reports, and hope that they will be used as models for emerging primary care researchers.

The original research reports in this issue relate to medical education[13,14] and clinical issues (chronic obstructive pulmonary disease (COPD)[15] and diabetes[16]). The messages from the medical education papers are sobering. Intercalated degrees are courses of study that allow students (especially medical students) to take a year or more from their medical studies to complete a research project. Al-Busaidi analysed a database of 14 years of intercalated degrees by medical students and found that more than 2/3 chose to do laboratory-based research for their intercalated degree and only 16% ended up in general practice as their later career choice.[13] This suggests that general practice may not be adequately modelled to undergraduate medical students as a research-based discipline. In universities, academic work in teaching and research is supposed to take equivalent time so that teaching is research informed. A good research question might be: how often is that obligation realised? The second education paper comes from a team of north American researchers who compare three methods of measuring research outputs from academic departments of family medicine.[14] Although no method revealed very adequate research productivity, this paper refers to the considerable efforts and funding that the family medicine profession in north America has devoted to research development in the past 20 years or so. Another good research question might be: how does the research productivity of local academic departments compare?

Stokes *et al.* identify the need for health-care providers to be proactive in identifying and managing the unmet health needs of patients with severe COPD.[15] This qualitative research has many more clinically useful insights into the lives of these patients. Another paper provides evidence of health gains for patients with type 2 diabetes who are encouraged to go for a walk after breakfast, lunch, and dinner.[16] No duration or length of walk need be specified, making this a very simple message for patients. Our case report in this issue is about Paget-Schroetter syndrome, or effort thrombosis, a rare condition but one our reviewers felt that readers would be interested in.[17] Related to COVID-19 issues, the Cochrane Corner reviews the evidence about remote healthcare using telehealth technologies[18] and as we move into winter, the Potion or Poison column provides up-to-date information about Vitamin D.[19]

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