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.

Sports medicine

Along with most GPs in New Zealand, particularly those working in suburban and rural areas, I see a steady trickle of sports related injuries. Almost all of these are sustained in recreational sporting activities rather than professional sport. In our practice the predominant sports injuries are skateboard trauma, mainly upper limb damage, and surfboard slashes, mostly involving the lower limbs and face, sustained by contact with either a fin or the nose of the rider's own or someone else's board. Not surprisingly, most of these patients are young, although we do have a subpopulation of experienced ageing surfies who require suturing from time to time. We also see quite a few fishhook injuries and we do have a pair of bolt cutters in the treatment room for those large, tempered steel hooks that cannot be satisfactorily extracted with a string loop. A detailed explanation of fishhook removal, published in the *American Family Physician*, can be read at http://www.aafp.org/afp/20010601/2231.html.

When recalling the sports injuries that I have seen over the years it tends to be the more unusual presentations that come to mind. I have seen humeral shaft fractures in two arm wrestlers, both of whom were middle-aged men no doubt nearing the end of their arm wrestling careers. A healthy young woman sustained a spiral fracture of her humerus while swimming in the surf. I have never seen gamekeeper's thumb in a New Zealand rabbit killer but the acute version is not uncommon among snow skiers. I have read that it also occurs in break-dancers, but I don't get to see too many of them. I clearly recall the guy concerned about his penile paraesthesia. I was able to reassure him that this was bike seat neuropathy rather than any other serious neurological or sexually related disorder.

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I have had occasion to refer to the list of prohibited substances for sports people listed in *New Ethicals* (before it became MIMS). A professional athlete with an upper respiratory tract infection wanted treatment a week before an important event. It was helpful to be able to refer to this list as there is no way I could remember all of the banned substances referred to by Dave Gerrard in this issue of the journal. I suppose that it should be no surprise that some professional athletes want to cheat, as the rewards for top performers are substantial. We are frequently reminded that some top businesspeople cheat; lawyers, accountants, school prinicipals and even doctors have been reported to cheat, so it is hardly surprising that some athletes use banned substances to try to improve their competitiveness. What is surprising is the strategies that some of those involved in professional sport use to try to avoid detection.

It has often crossed my mind as to whether or not I am giving the best possible advice to patients who have been concussed. Steve Targett summarises the best evidence management for this and, although this applies primarily to professional athletes, the same advice should be given to any sportsperson who has sustained even relatively minor brain trauma. In the CME section of this issue we continue the sports medicine theme with a contribution from Rob Campbell outlining the modern management of tendon injuries and another from Chris Milne who takes us through the causes of anterior knee pain, a common problem presenting in general practice.

On a completely different CME track Calder Botting suggests ways

of improving the use of inhaled respiratory drugs for patients in rest homes.

Leaving practice

It is unusual to have a contribution to a medical journal from a doctor who has left medical practice for an unrelated profession. The author of the paper published in this issue wishes to remain anonymous and we have respected that request. Doctors change careers for a number of reasons. In the US these include disillusionment with medicine, third party interference, doctor's own medical problems, financial considerations, threat of increased litigation and political and economic factors.[1] These could all equally apply to New Zealand GPs although the threat of increased litigation might be replaced by the threat of disciplinary proceedings. It takes considerably more courage to change careers than to remain in practice disillusioned and disgruntled. In New Zealand, as in the US, it is likely that most doctors who have changed careers from the practice of medicine take on management roles, most often remaining within the medical arena, but some, similar to our contributor, move into totally unrelated areas. In 2002 it was reported that low morale 'continues to affect New Zealand general practice', with 60% of GPs rating their morale as average to very poor and more than half rating their stress levels as high or very high.[2] It will be interesting to see whether or not recent changes to the organisation of the delivery of medical care in New Zealand are associated with a change in the number of GPs switching careers.

Disciplinary matters

This issue contains two contributions from the Health and Disability Commissioner illustrating the difficulties associated with obtaining expert advice. A letter from the Commissioner comments on the relationship between the risk of embolism in women who have a history of superficial thrombophlebitis and who are taking oral contraceptives. I found it quite difficult to obtain evidence-based information concerning this and the best, up-to-date guideline that I could access recommends that the benefits of COC and POC outweigh the risks in women with varicose veins and superficial thrombophlebitis.[3] In the Commissioner's Comment the case discussed not only reminds us of the difficulties involved with diagnosing ovarian cancer but also shows the dilemma the Commissioner has when experts do not agree. It is interesting to note the Commissioner's statement that *'in the areas of assessment, diagnosis and treatment, we will naturally tend to defer to expert clinical opinion. But in areas such as communication, referral, and follow-up, we are prepared to question accepted practice, to see if it reflects custom rather than care'*.

We look forward to publishing papers in 2005 that are interesting and useful for GPs, but to do this we rely on your contributions. Editorial assistance is available for those who have not previously submitted a paper. We will continue to support research and commentary that fosters the discipline of general practice.

References

1 Balagot M. Leaving the bedside. Chicago, Ill.: American Medical Association, 1992. p 118.

2. Dowell AC, Coster G, Maffey C. Morale in general practice: crisis and solutions. NZ Med J. 2002;115(1158) http://www.nzma.org.nz/journal/115-1158/102/content.pdf

3. RCOG Guideline No 40. Revised October 2004.