BJGP

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PUBLISHED BY
The Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU.

PRINTED IN GREAT BRITAIN BY
Hillprint Media, Prime House, Park 2000, Heighington Lane Business Park, Newton Aycliffe, Co. Durham DL5 6AR.

ISSN 0960-1643

April Focus

The study of patients with type 2 diabetes on page 298 should make uncomfortable reading for many UK GPs: 'Although participants felt that the lifestyle advice they were given was sound, many spoke about it with a sense of weariness and felt that health professionals overestimate the impact making such changes could have on measurable outcomes such as weight, blood sugar, and blood pressure. You could use a manual when you go back and listen to them "watch your diet, watch your salt" the answer is not where they seem to think the answer is.' The authors report widespread scepticism about the diagnosis of raised blood pressure, and of the advice about diabetes. It's not obvious how we should respond to these findings. Should we despair of our patients' unwillingness to change, or applaud them for their resolute scepticism that we can do them any lasting good?

Suicidal behaviour is another area where our effectiveness to influence events poses difficult questions. The idea that GPs may be able to prevent suicides has been around for a long time, and continues to exercise researchers. The paper from Australia on page 269 focuses on older patients with depressive symptoms. Many older patients had high levels of psychological distress, few presented with psychological complaints. On page 261 the accompanying leader emphasises the sceptical line taken in the Stewart paper above: 'While all of us could usefully finetune our skills in recognising and responding to the hopelessness that makes suicide acceptable to some older people, we do need to understand our limitations.' Neither is finetuning such a simple matter. The study of GPs' decisions in the treatment of patients with depression revealed that our ability to assess the severity of depressive illness still leaves a lot to be desired. Mike Fitzpatrick, who on page 327 picks up on John Berger's *A Fortunate Man* from last month's *BJGP*, worries that our preoccupation with psychological labels has brought more aspects of human behaviour into the realms of psychological distress, 'resulting in a process of enduring suffering doctors are now more likely to intensify than alleviate.' Part of the problem that the leader brings out is the stigma of all mental health problems, which encourages patients not to be completely open when they consult, and this may apply particularly to older patients. In the same way, symptoms attributable to stress were less likely to be seen as legitimate reasons for consulting GPs by black African or Caribbean patients than by white British patients (page 274). Studying another disadvantaged group, homeless injecting drug users, the paper on page 263 explores the impact of a diagnosis of hepatitis C. The lesson is to remind us not to allow any preconceived notions to influence clinical behaviour. This group of patients revealed exactly the same degree of shock and horror at the diagnosis that any of us would feel.

The debate on revalidation of UK doctors that has figured in the last 2 months of the *BJGP* will rumble on for a while longer, at least until after the CMO completes his review. On page 318 Paul Thomas attempts to broaden the debate and get us all to consider the context in which revalidation should operate in the future, as part of a bigger educational and developmental picture. Amid all of the rather gloomy material in this month's *BJGP* he strikes a much more optimistic note: 'Different and innovative windows should be encouraged, including audio and video analysis, peer consultation audit, 360° appraisal, knowledge questionnaires, audit and research projects, written papers, significant events, student teaching and leadership of team-learning. These should be presented not as defensive posturing, but as proud celebration of personal growth.'

DAVID JEWELL
Editor

© *British Journal of General Practice* 2005; **55:** 257–336.