Editor
David Jewell, BA, MRCGP
Bristol

Deputy Editor
Alec Logan, FRCGP
Motherwell

Journal Manager
Lorraine Law, BSc

Assistant Editor
Soma Goswami, MSc, B Ed

Advertising Executive
Brenda Laurent

Advertising Sales Executive
Peter Wright

Design
Layne Milner

Editorial Board
Mayur Lakhani, FRCGP
Loughborough

Ann Jacoby, PhD
Liverpool

Ann-Louise Kinmonth, MSc, MD, FRCP, FRCGP
Cambridge

Tom C O'Dowd, MD, FRCGP
Dublin

Tim Peters, PhD
Bristol

Surinder Singh, BM, MSc, MRCGP
London

Blair Smith, MD, MEd, MRCGP
Aberdeen

Lindsay F P Smith, MClinSci, MD, FRCP, FRCGP
Somerset

Theo Verheij, MD, PhD
Utrecht, The Netherlands

Editorial Office: 14 Princes Gate, London SW7 1PU (Tel: 020 7581 3232, Fax: 020 7584 6716).
E-mail: journal@rcgp.org.uk
Internet home page: http://www.rcgp.org.uk

Published by The Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU.
Printed in Great Britain by Hillprint Ltd, Prime House, Park 2000, Heighington Lane Business Park, Newton Aycliffe, Co. Durham DL5 6AR.

May Focus

IN May 2001 we published a letter from a Hertfordshire GP, Richard Gallow, responding to a paper on the use of antibiotics in lower respiratory tract infection. He succinctly summed up the GP's dilemma: 'the problem lies with the fact that these presenting symptoms and signs are the same as those with community-acquired pneumonia … so one can only be confident of the natural history of LRTi if that is definitely the diagnosis'. He then went on to ask how we are to distinguish which infections will progress to pneumonia. Two years on, and the paper on page 358 supplies the first hint of an answer. A combination of symptoms, fever and high C-reactive protein was the best predictor; using the combination to predict those at low risk could avoid a substantial number of antibiotic prescriptions. This study also reminds us that no tests can ever be perfect: the paper includes an estimate of the risk of missing a case of pneumonia by applying the same prediction.

The same worry, of missing important diagnoses, surfaces in a study on page 378 of patients presenting to three primary care centres in Sweden with chest pain over a two-year period. Ischaemic heart disease was diagnosed in 8% of patients presenting with chest pain, though the authors also point out that the majority of patients with a diagnosis of ischaemic heart disease went directly to the local hospital. The primary care doctors in this study seem to be practising to a high diagnostic standard. However, as with the previous study, there is bound to be a false-negative rate. Five out of 281 initially thought to have had non-cardiac pain had been diagnosed with ischaemic heart disease three months after the initial episode. Again, this sounds like an acceptable error rate, but one wonders if the lawyers would agree.

Two other diagnostic puzzles are also discussed in this month's *BJGP*. A study on patients identified by deliberate self-harm episodes on page 365 confirms that many had consulted their general practitioners in the month prior to the self-harm episode, but provides encouraging evidence that the general practitioners are engaging with their patients' psychological difficulties. The authors acknowledge that 'the scope … for the GP to intervene and prevent DSH is limited'; one of the difficulties being the ability to pick out those at risk of self-harm from the others with depression. A related problem emerges from an exercise in accident surveillance on page 383. Here the difficulty is accurate labelling, with considerable variation between practices on what was labelled as an accident. There were lots recorded, but as with the Swedish patients with chest pain the more seriously affected patients were going elsewhere, presumably to local A&E departments. Seth Jenkinson struggles with different labelling, for sickness certification, on page page 417; and on the last page this month Saul Miller is struggling on an altogether different plane, doubting the very existence of the district valuer.

Finally this month, we return to more profound values. Research participants recruited to the long-running UK Prospective Diabetes Study were motivated more by the prospect of better clinical care, and less by altruism (page 394). Altruism may also be part of the motivation when parents are offered vaccination for their children where the main intention is to produce herd immunity (page 399) Any suggestion that altruism may be disappearing as a force in our society should worry researchers and policy makers — the whole NHS may become even more difficult to manage effectively. However, the accompanying editorial on page **355** points out that it's a slippery concept. Altruism often exists in what Tom Murray describes as a more 'rough and tumble' form, where it coexists with self-interest. One of the problems facing those who want to examine altruism is that we have difficulty expressing our motives: 'we are often, literally, better than we can say.' Surely a corrective motto for our cynical age?

DAVID JEWELL
Editor

© *British Journal of General Practice,* 2003, **53,** 353-357.