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September Focus

Peter Toon shares my own views about the prophet Ezekiel — his visions speak all too clearly of mind-altering substances. On page 758 he compares the late David Widgery to the ancient prophets, to remind us how much we need those who are prepared to tell the rest of us uncomfortable truths. The comparison is always in itself uncomfortable, when we imagine how such prophets would be greeted today. Peter thinks that Jeremiah would attract the attention of the mental health team; in an eerie precursor of modern practice he found himself not in hospital, but thrown into prison by the authorities who found his preaching too much to take. It did them no good: he continued to preach from his cell and warn of the coming destruction of Jerusalem.

Luckily, trying to decide whether those with apocalyptic visions are inspired by God or mentally ill (or both) is not one that we have to grapple with very often. The simpler problems are quite difficult enough. Diagnosing brain tumours in those complaining of headache (page 695) is one such. Headache on its own is a poor predictor, and doesn't get much better even when accompanied by other neurological problems. Late onset epilepsy is a better predictor. Again (see last month's *BJGP*) it is interesting to note that the textbooks have been vindicated by careful research on very large numbers of patients, much larger than any one individual's clinical experience could possibly encompass.

This study also raises an interesting question about the relationship between primary and secondary care. The positive predictive value (PPV) of new onset epilepsy for a brain tumour is quoted as 1.2% (higher in older age groups). We could debate at what point we refer for a CT scan. At 1.2% we would expect 99 out of 100 to be reported normal. Would that be good medicine?

Similar questions are implied in the study of GP referrals to hospital out of hours (page 706). One of the factors distinguishing 'high' from 'low' referrers was a feeling of confidence, and we may expect that 'confidence' translates into an internalised sense of the level of PPV one wants to be working to. Too much confidence brings its own problems: there are always patients like Norman Gland to catch us out (page 756).

Such research is shedding fresh light on old problems. The drive to be more responsive to patients' own concerns is more recent. Nobody would want to argue against trying our best to provide a service that suits patients, but doubts remain of the best way of achieving this. In the UK we are all spending moderate amounts of time and money handing out, collecting, analysing, and responding to questionnaires.

Two papers this month (pages 737 and 741) question the validity of some widely-used questionnaires. There may be value in using them even if they are less than perfect. As one of these papers states: *'... it could be argued that there is virtue in engaging the primary care team in considering the patient's experience of care, and patient satisfaction surveys can act as the catalyst. Whether this alternative agenda warrants the time and resources put into surveys or is the most appropriate way to raise the profile of patient satisfaction is a matter for debate. If the data are to be used for comparison of practices, or of practitioners within practices, or to demonstrate improvements in patient satisfaction over time, then the validity and precision of measurement are hugely important.'* (page 739).

If we were setting out to compare experience in other European countries, then a different questionnaire is available (EUROPEP), and apparently not considered by the UK's Department of Health (page 691). Euroscepticism in Whitehall, perhaps? Surely not.

Nor is responding to patients' agenda that simple. Heinz-Harald Abholz points out that there is always a balance to be struck between looking after individuals and the public health agenda (page 693). Meanwhile, spare a thought for those struggling to establish primary care in China (page 754). With limited support from government, and high-tech hospitals competing for patients' custom, they face the kind of difficulties that GPs in the UK have not had to face — at least not yet.

David Jewell
Editor

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