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Writing a while ago in the *BMJ*, Richard Lehman was making the case that we should no longer talk of heart failure, but replace it with 'cardiac impairment'.[1] The paper on page 393 takes this one stage further, with a plea to think in terms of 'ventricular wall stretch' indicated by the release of B-type natriuretic peptide (BNP). The authors argue that this is a better predictor of ventricular function than echocardiography, and in this study they used BNP levels to guide GPs' use of drugs.

The results make interesting reading: the bottom line an important reduction in overall BNP levels, mostly by switching from one beta blocker to another. But at the end, only 28% had BNP levels below the target threshold. This might be the best that anyone could achieve, and illustrates the folly of assuming that 'best practice' can be applied universally.

There is a comment about how many visits were made with no alteration to treatment, which sounds to me like real general practice. This kind of behaviour might now be labelled 'clinical inertia', a term with all kinds of negative connotations. It needs replacing with something that values taking one's time: cool and calm deliberation to be preferred over hasty decisions (almost) every time. As M Gwawr J David learnt on sabbatical 'some things can be completed at glacial pace without jeopardy' (page 442).

The editorial on page 387 explains why simply changing beta blockers is so effective. For one who has tended to dismiss claims of different effects among drugs of the same class as irrelevant, this piece is a salutary eye-opener. Quite apart from putting me right on the important differences between beta blockers, and pointing out that drugs may be classed together for different reasons, it left me feeling that my basic pharmacology knowledge is nowhere near as good as it could be.

For another take on classes of drugs, turn to page 417, where the claims of the 'Z' drugs (such as zopiclone) are put into context by patients. When compared with benzodiazepines they had, according to the patients, no better profile in terms of effectiveness or side effects.

Two papers on aspects of mental health take divergent approaches to characterising problems. On page 411 a computerised schedule was used to help nurses to make accurate diagnoses. The patients appreciated having all aspects of their mental health covered, and the model worked well when compared with diagnoses made by specialist psychiatrists according to ICD-10.

In contrast, the paper on page 403 adopts a very different approach, valuing 'complexity' of explanation against simple diagnosis. Here the authors argue that the more complex an explanation is the better that GPs are going to be at explaining the problems and helping patients to make sense of them. The commentary on page 409 is less sure, advocating the virtues of simplicity. This feels like another spectrum where we cannot indulge ourselves in the luxury of sticking to one end or the other, but will need to be able to decide which approach will best suit different patients. Better still, try to use both ends — the reductionist and the holistic — simultaneously.

On page 400 a study examines factors associated with hospital admission for lower respiratory tract infection. The ones identified (comorbidity, lack of social support, also previous admissions for COPD and courses of oral steroids) are what would be expected, but the surprise is that there wasn't any influence of socioeconomic factors over and above the medical ones. A high proportion of those admitted had died by the time of the study, which sounds like a tribute to the acumen of the doctors involved as well as a reminder of the awful prognosis for advanced COPD.

The leader on page 390 deals with end-stage COPD at greater length. A major problem of applying best practice is in identifying when patients are approaching the terminal phase, but the suggestions the authors make should be useful. On page 445 Chris del Mar reviews the collection of Iona Heath's essays on life and death, and echoes the study on page 403 when she emphasises the importance of helping patients find meaning in their lives.

Finally, John Frey has sent us another of his occasional pieces from the US, once again bemoaning the absence of any universal provision of health care (page 440). It is easy to read him in a mood veering between smugness and sheer bewilderment. But in the UK, as we watch the onward march of private capital as providers of health care, one phrase sounds a fateful warning: '… hoping that the public forgets that insurance companies, not doctors, run health care in this country.'

David Jewell
Editor

REFERENCE

1. Lehman R, Doust J, Glasziou P. Cardiac impairment or heart failure? *BMJ* 2005; **331:** 415–416.

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