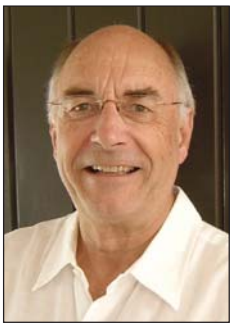
Editorial



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.

Special interests

Many of us, perhaps most, have special interests and these sometimes change throughout our professional career. I have run a family planning clinic, obtained a certificate in musculoskeletal medicine and in minor surgical procedures, and still enjoy these particular areas of medical practice. I have also been involved in teaching for many years and I practised obstetrics from 1974 to 1994 (in those days I would have considered obstetrics to be part of regular general practice, but it is no doubt now a special interest). Something draws us to those areas that we find more interesting or more relevant to our daily practice than others. We focus on these in our CME even though we should probably learn more about those areas in which we do not have a special interest. Some GPs become so involved in their special interest that it becomes their full-time practice.

I suppose that what is important is that these interests derive from primary care. The principles that are important for general practice also apply to the special interest (teaching is like consulting) but we develop more expertise in these areas and consequently need to refer less often and sometimes we are more adequately rewarded financially for our special services. Rightly or wrongly it appears that the narrower the specialty the more people are prepared to pay for our expertise.

For this issue of the journal I asked several GPs or ex-GPs to write a brief commentary on their area of special interest. The broad range of primary care special interests is not reflected in these commentaries, but they do give some insight into why special interests sometimes become the preferred practice for some GPs. Areas that are not covered include obstetrics, family planning, child health, adolescent medicine, sexual abuse care, care of the elderly, palliative care, psychological services, aviation medicine, travel medicine, research and teaching. I have also not included complementary therapies such as hypnotherapy, chelation therapy, homeopathy, meditation, neurolinguistic programming (I still do a little of this from time to time) and many other areas that some GPs become involved in. It was not the intention to be exhaustive but rather to contrast special primary care interests with our major discipline of generalism.

It is coincidental that two of the original research papers in this issue focus on psychological issues in general practice. One discusses the use of a screening tool for detecting psychological distress and the other casts doubt on the usefulness of psychiatric classification models for managing patients in primary care. I rarely use questionnaires or classification models to diagnose mental illness in my general practice patients. I am not suggesting that they do not have a place in medical practice, simply that I do not find them useful. I suspect that the spectrum of psychological disturbances seen in general practice is as different from those seen by most psychiatrists as the spectrum of musculoskeletal problems seen differs from the caseload of most orthopaedic surgeons.

In a pre-publication review of the paper authored by Steven Lillis, Graham Mellsop and Maureen Emery, a psychiatrist referee stated:

'Despite my caution about qualitative research, I did like this one. As a rule, useful qualitative research must lead to either generating an empirically testable hypothesis or open the door for a meaningful discussion about an important clinical or practice issue. This paper technically achieves both. However I would prefer that it (and I hope it will) leads to a wider discussion about the role of primary care in managing mental health problems. Of particular interest to me is the threshold/criteria for referring patients to a specialist psychiatric service (especially for those with symptoms of anxiety or depression). That is more of relevance to me as a psychiatrist, than the ability of a GP to make a diagnosis according to a formal classification system.'

The final paper that I would like to highlight in this issue is that written by Matt Harrison about his good friend Bill Pike who was injured in a

volcanic explosion on Mt Ruapehu. I was impressed at how people respond to unexpected tragic events in ways that I, after more than 30 years of general practice, have not encountered before. I asked Matt to share some of this with you.

This issue of the *NZFP* will be my last as editor. My first issue was October 2002. We have made a few changes over the five and a half years that I have been involved. We have introduced a section on 'Improving Performance' that allows those who have been involved in quality improvement activities in general practice to share these with others without having to follow the strict criteria for original scientific research. This initiative was triggered by comments from Ian St George and Bruce Arroll and has proved popular with respect to the number of papers received. We have tightened up our refereeing and competing interests criteria. I am indebted to many health professionals for their refereeing services during my time as editor. Their efforts mostly go unnoticed but my policy has been to ask referees to advise authors about how their papers might be improved rather than to reject them outright. We have developed guidelines for this and, I believe, this has enabled us to publish papers from authors who have not had papers published previously or who may have had their papers rejected by other journals. The Editorial Board members have been a tremendous help with regard to suggesting content, reviewing papers and exchanging ideas. I would also like to acknowledge the great support I have had from the College, in particular our CEO, Karen Thomas, manager Hugh Sutherland, Lee Sheppard and more recently Cherylyn Borlase and last but, for me, the most important assistant of all, Robyn Atwood, who typesets, keeps me on schedule, picks up my mistakes, helps with proofreading, finds the cover photos and puts it all together. I thank you all.

My greatest disappointment was that we did not manage to get the *NZFP* indexed on Medline. We are not given the reasons for this, but I suspect that the bottom line is that we are a small journal, from a small country with only a handful of primary care academics and that we produce a journal that we think our readers want to read rather than being a vehicle solely for the dissemination of sometimes relevant and sometimes irrelevant quantitative scientific research.

It is time for me to move on. A new editor will bring new ideas and a different perspective. The guest editor for the June issue of the *NZFP* will be Susan Dovey. I cannot think of anyone better to take on this task and I know that I look forward to reading an issue after it is published rather than before.