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EDITORIAL

What's in this issue

The General Practice Airways Group (GPIAG) has played an active role in the development of respiratory General Practitioners with a Special Interest (GPwSIs) [1—3]. This issue of the PCRJ includes the latest proposal for accreditation by portfolio of respiratory GPwSIs [4], and details the evidence that might be required for a GP wishing to work in this field. In the absence of current appropriate qualifications, these working party proposals provide an excellent framework for the training and assessment of respiratory GPwSIs. While formal evaluation of these proposals will be required, their implementation should ensure a high level of care for patients with respiratory disease. In her editorial, 'Connecting rhetoric, reality and research' [5], Professor Helen Smith places these proposals in perspective and discusses the issues related to their implementation. She eloquently describes the arguments for and against respiratory GPwSIs, and stresses the urgent need for generating and evaluating evidence on GPwSI effectiveness and cost-effectiveness.

Underdiagnosis and delayed diagnosis of asthma, which was highlighted in the UK over two decades ago [6—10], has persisted as a constant problem in primary care. Whilst there have been clear improvements in care, with reduced death rates due to asthma, it appears that some health professionals remain unaware of the presenting features of asthma, and that treatment is sometimes initiated in the absence of a clear- cut diagnosis [11]. Østergaard [12] presents a qualitative study to investigate the reasons for delayed diagnosis in a selected sample of parents of 30 asthmatic children, as well as 15 general practitioners, in Copenhagen. A third of the children were diagnosed with asthma two to eight years after their respiratory symptoms started. As in the case of the definitive study by Speight et al. [6], these children were not all suffering from mild asthma; indeed, a third of the total were acutely hospitalised more than five times for respiratory problems before asthma was diagnosed. This study provides further evidence that unnecessary delays occur in diagnosing asthma, probably related to inconsistent terminology and understanding of respiratory symptoms by both patients and health professionals. Similarly, a large survey [13] published in this issue involving interviews of over 4000 parents comparing diagnosis and treatment in German and Dutch children with asthmatic symptoms, found significant differences in approaches to diagnostic labelling between the two countries. Østergaard [12] suggests that we should be more rigorous in diagnosing asthma, especially if children present to a health professional with three or more episodes of asthma symptoms (cough, wheeze or shortness of breath) lasting over two weeks.

COPD has been included as one of the qualifying clinical areas for payment under the Quality Outcomes Framework of the new GMS contract in the United Kingdom. Two editorials and a commentary in this issue address some of the more controversial questions raised by the new contract [14—16]. Of particular interest is the heightened level of media awareness and concern related to contractual aspects of COPD management—in particular, whether the diagnosis of COPD requires an FEV1 below 70% or 80% predicted. Spirometry is essential for diagnosing COPD, yet it is not included formally in the undergraduate teaching curriculum in almost all medical schools, according to the review by Yawn and Yawn [17] in this issue. In addition, Lwin and McKinley [18] present a cross-sectional quantitative postal questionnaire survey of all 147 general practices in Leicestershire in 2002; less than 45% of

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those healthcare professionals carrying out spirometry were trained to do so, and only 4% of practices met strict criteria for the provision of a spirometry service.

The News section includes a report from the new Chief Executive of the GPIAG as well as a statement from our new Chairman.

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Mark L. Levy FRCGP (Editor-in-Chief)
GPIAG, Edgbaston House
3 Duchess Place
Edgbaston
Birmingham B16 8NH, UK
Tel.: +44 (0) 121 454 8219
fax: +44 (0) 1461 207819
E-mail address: marklevy@animalswild.com