

treatment options? What would happen if I did nothing? Perhaps if patients did ask such questions, or specialists and generalists did, a more scholarship-based medicine approach would follow.

Reeve thus develops a model, which, if it is to be truly effective for patients, should not just be the preserve of the generalist, but of doctors. A more ambitious approach may be not to redefine generalism, but remove criticism of others (not typical of GPs), and ensure that the prospect of generalist-led medicine is made more realistic.

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A complex consultation

It was interesting to read Clare Gerada's editorial 'Doctors and suicide'.¹ The majority of doctors manage their health alone for several reasons: neglectfulness or denial, self-prescribing, the desire to present a picture of good health to others,² fear of causing their colleagues difficulty,³ or fear that medical confidentiality will not be respected.

Questions on intimate subjects such as sexuality or addictive behaviours are rarely approached, or not at all.⁴ This is also true of clinical examination,⁴ often because the question of knowledge or hierarchy between the treating doctor and the doctor-patient comes into play.

We carried out a survey of 375 GPs who treated doctor-patients, using an online self-administered questionnaire based on elements identified in the literature as likely to affect management. The three main barriers to the relationship between treating doctors and doctor-patients from the perspective of the treating doctors were the difficulty in making the doctor-patient accept the patient role, the fear of error and of being judged, and competency in another specialty. The three facilitators were confidence shown by the doctor-patient, an equal level of medical competency, and the relaxed atmosphere of the consultation.

Medical management of doctors is a problem that is common to all countries, and one on which there is currently no helpful consensus. According to the British Medical Association,⁵ a doctor-patient must be treated just like any other patient. The creation of dedicated health services would seem also to be a possibility. Canada and Spain are leaders in this field. A joint European initiative has been set up through the European Association for Health Physicians (<http://www.eaph.eu/>) and shows the need for research to aim for optimised and coordinated management.

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Corrections

In the Online First article by Smith SG *et al*. Prescribing tamoxifen in primary care for the prevention of breast cancer: a national online survey of GPs' attitudes. *Br J Gen Pract* 2017; DOI: <https://doi.org/10.3399/bjgp17X689377>, the author Andrea DeCensi was incorrectly listed as Andrea de Censi. The online version has been corrected.

DOI: <https://doi.org/10.3399/bjgp18X699029>

In the article by Mordecai L *et al*, Patterns of regional variation of opioid prescribing in primary care in England: a retrospective observational study, *Br J Gen Pract* 2018; DOI: [10.3399/bjgp18X695057](https://doi.org/10.3399/bjgp18X695057), the Figure 2 caption incorrectly stated: 'Total opioids prescribed in equivalent mg morphine per capita per month from August 2010 to February 2014 ($r = 0.48$, $r^2 = 0.23$)' but should have stated 'Total opioids prescribed in equivalent grams of morphine in England per month from August 2010 to February 2014 ($r = 0.48$, $r^2 = 0.23$)'; additionally the y-axis of the figure incorrectly stated 'Opiate total in equivalent mg morphine per capita per month', but should have been 'Total equivalent grams of morphine prescribed nationally' with the axis label 'Months'. The online version has been corrected.

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