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Editor's choice

Climate change emergency

It is good to see the climate change emergency highlighted in this article¹ and also in several other articles in the July issue of the *BJGP*.² Climate change and global heating are the biggest public health disaster that we have ever known, affecting everyone on the planet. Everyone working in health can play a part in reducing carbon emissions, whether at home, changing how they work or travel, by 'greening' processes in their workplaces, and by putting pressure on our elected governments locally and nationally to treat this issue as the emergency that it is.

Medical journals also have a huge potential to assist change. I propose that every article has a heading and a few words about the climate impact of the issue it talks about, in particular the effect on emissions. For example, the article about unnecessary measurements of inflammatory markers in this same issue suggests that in the study population many hundreds of GP and phlebotomy appointments and many referrals could have been avoided. That represents considerable emissions from transport, disposables, heating, and lighting. This important saving in emissions should be highlighted.

Almost everything we do in health care affects the wider environment. Let's hear about our impact and what we can do to reduce it in every edition of the *BJGP*.

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Artificial intelligence and diagnosis in general practice

As a triage and screening tool, AI could theoretically reduce the pressure on the medical system and allocate resources to patients who need medical help the most.¹ AI could be used as a replacement for tasks that are less complex but time intensive and labour intensive, allowing health workers to tackle more complex tasks. But the problem is of how to increase the trust of health workers and patients in AI. On the one hand, this problem involves the accuracy of AI's data analysis; on the other hand, it is also related to ethics. For the accuracy of data analysis, a larger and more comprehensive database needs to be established, which is something that technicians need to solve. But, ethically, who is responsible for the errors made by AI? On the other hand, is it not good for the harmonious development of the doctor-patient relationship to use a lot of tools to replace the labour in clinical work?

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Paediatric asthma care in the UK: continuity of care

As a retired GP and grandfather of a 3-year-old asthma sufferer I am troubled and not a little alarmed by the current standard of asthma care being offered today, as described in the article in this month's journal.¹

The theme running through the article was lack of continuity of care in general practice. I note one case of a 13-year-old with 47 asthma attacks in her last 4.5 years of life who was seen by 16 clinicians at her GP surgery on the 19 occasions she attended because of poor control.

The concluding analysis regarding the Finnish National Asthma Programme that stressed the effectiveness of instituting anti-inflammatory treatment from diagnosis was stark.

Surely this advice, coupled with a single named GP responsible for every child with asthma, would dramatically improve the outcome in these cases and could be established in every surgery. Continuity of care is one of the most precious aspects of general practice but I fear this crucial aspect of modern-day general practice is in decline.

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Correction

In the Clinical Intelligence article by Ong J *et al.* The investigation of chronic diarrhoea: new BSG guidance. *Br J Gen Pract* 2019; DOI: <https://doi.org/10.3399/bjgp19X702653>, Figure 1 showed 'FCP <50 µg/g' but this should have read 'FCP >50 µg/g'. In the Figure 1 caption and Figure 1 itself, reference 5 should have been reference 3. We apologise for these errors. The online version has been corrected.

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