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The adequacy and safety of out-of-hours general practice services in the UK has come under intense scrutiny in recent months, following a number of instances of seriously unsafe practice, often involving doctors with little training in general practice, and little familiarity with the patients for whom they were responsible or with the medical systems in their locality. In this issue of the Journal we report the findings of a qualitative study of out-of-hours services in Wales, (page 164) and this is accompanied by a trenchant article by John Campbell, (page 155), who argues for tougher oversight and governance and a more resolute professional commitment to reasserting responsibility for patients at night and at weekends. His proposals will undoubtedly strike a chord of sympathy among the general public and, I imagine, among many GPs, but others may be concerned about returning to an unsociable commitment which they were happy to relinquish.

Although the problem is principally about patient care, non-engagement with out-of-hours services, particularly in the wider context of the European Working Time Directive, has significant implications for training. It is difficult to see how new generations of doctors can be trained to be competent in out-of-hours assessment of seriously ill patients without seeing any and, indeed, how new entrants to general practice are going to obtain sufficient hospital and community-based experience of the care of acute illness. Clinical judgement, the recognition of serious medical problems, informed and appropriate referrals and hospital admissions, and accurate telephone triage are all likely to depend on having been exposed to a sufficient intensity and duration of clinical encounters. There must be real concerns that, as well as abandoning what Campbell describes as the 'moral authority' derived from assuming 24-hour responsibility for patient care, the quality of clinical practice in primary care may itself be under threat.

Terry Pratchett's recent Dimpleby lecture — given by Tony Robinson because Pratchett himself is unable, because of his posterior cerebral atrophy, to read accurately, will undoubtedly do more to raise the profile of Alzheimer's disease and other forms of dementia in the UK. The National Dementia Strategy, launched a year ago, comes under intense, and possibly somewhat premature, scrutiny by Greaves and Jolley, (page 193), who argue that not only is more effort required to implement the strategy but that excessive reliance on secondary care services may itself delay implementation. They argue for a more community-based and collaborative model, in which families, carers, and primary care providers will play an important role. Beattie

(page 197), challenges this assumption, and is concerned that we may be over-claiming for the ability of primary care and the fabric of society to absorb this extra load. She argues that a coordinated national approach, with national levers for change, is more likely to lead to effective implementation. The diagnosis and care of dementia seem to be an area which is ripe for the development of some innovative, collaborative primary/secondary care working.

The richness of patients' medical records as a research resource is emphasised in two papers and an accompanying editorial. The General Practice Research Database and the QRESEARCH Database contain information on very large numbers of patients seen in general practice over an extended period. The research potential of the GPRD, in particular, was originally recognised not by UK researchers but by Hershel Jick and colleagues in the US and Luis Garcia Rodriguez and colleagues in Spain, so that it is particularly fitting for Garcia Rodriguez to have written about the database in this issue (page 160). Over the last decade, however, not least because of the MRC's funding of licenses for research groups to access the GPRD, a steady stream of papers derived from the analysis of large datasets has appeared in the literature. These have alerted us to the dangers of prescribing, such as the association between NSAIDs and cardiovascular disease, the changing pharmacoepidemiology of drugs, the associations between physical diagnoses and psychiatric disorders, and the links between alarm symptoms and other early manifestations of disease and the subsequent diagnosis of cancer and serious illness. Subject to well-recognised caveats, and with linkage to other databases such as cancer registries, these large datasets offer an extremely valuable resource for future research.

2009's William Pickles Lecture given by Amanda Howe (page 207), re-examined the meanings of 'family practice' and 'family medicine' and identified the enduring importance of keeping the personal and interpersonal aspects of our work at its absolute centre. Pickles recognised the anxiety brought to every consultation by his patients. At a time of potential fragmentation of continuity, personal care and partnerships, it is more important than ever that concentrating on process and performance does not get in the way of empathy and kindness.

Roger Jones*Editor*

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