Editor's Briefing

It's almost exactly half a century since Leonardo da Vinci made his beautiful drawings of the heart valves and almost figured out how turbulent blood flow works in closing the aortic valve — and, by extension, how blood circulates around the body. He was also the first person to describe atherosclerosis. Five hundred years on we understand the physiology and much of the pathophysiology, but the ways of stemming the tide of cardiovascular disease continue to elude us. This month's focus is on circulatory disease and vascular risk, and in papers and editorials we examine key facets of management including concordance with therapy, weight reduction, and other 'lifestyle' modifications and the diagnosis of ischaemic heart disease in primary care, take a close look at postural tachycardia syndrome, and provide tips for trainees working in cardiology. Inactivity, smoking, over-eating, and being overweight contribute massively to the burden of cardiovascular disease, and are often most problematic in the most vulnerable and least advantaged sectors of the community. In the lean financial times ahead, will we be able and willing to put health service money into prevention, and will governments be prepared to put time and resources into public health measures and private sector controls? Should smoking cessation and weight reduction be incentivised by payments — to doctors? To patients? Where does the locus of responsibility lie? Let us know what you think!

The UK's Medical Programme Board, which oversees specialist medical training, has recently accepted the educational case advanced by the Royal College of General Practitioners for an extension of vocational training for general practice to 4 years, aiming at implementation in 2014 at the earliest, and bringing the UK more into line with comparable European countries. This is extremely good news. In their editorial Rughani, Riley, and Rendel look at how the changing face of primary care creates the educational agenda for extended training, but there are bound to be debates about the where and the who, not to mention the money, and we would like to hear your views about the ways in which an extra training year could best be spent. For example, is there an argument for including additional hospital-based specialist training opportunities to equip GPs to take care of the increasingly complex tasks of chronic disease management and comorbidity? Are there opportunities to look again at the GPs with Special Interests initiative, that may fit well into models of integrated and intermediate care? And is there perhaps chance to re-examine the problems of academic careers in general practice and the need to find protected and remunerated time for clinical academic training?

In another happy coincidence, we are publishing a summary of a lecture given by Professor Tony Kendrick on generalism in undergraduate medical education which was named after one of the fathers of vocational training for general practice, Dr George Swift. Kendrick makes a strong case for further expansion of the curricular contribution made by general practice and primary care, and the importance of recognising the importance of generalism across much of the undergraduate teaching experience. The College's forthcoming report on medical generalism, responding to and building on the Commission on Generalism, will further raise the profile of this important debate, which has implications for teaching and training in all medical specialities and for the future relationships between generalists and specialists. We also report some interesting sex differences in knowledge among candidates for the MRCGP examination, and include a salutary perspective on the same exam from Malaysia.

We are publishing the first instalment of a 12-part series by Wilfred Treasure called *First Do No Harm*. Perhaps, like me, you thought that this apothegm, from the Latin *primum non nocere*, was lifted from the Hippocratic Oath? Not so, apparently, and etymological and medical historical opinion is divided between the introduction of the term by an US physician named Worthington Hooker and, more comfortingly somehow, its coinage by our own Thomas Sydenham, that giant of 17th century medicine. There is, of course, nothing new under the sun, and our current concerns about patient safety were clearly shared 350 years ago by Sydenham, who wrote: 'I have consulted my patients' safety and my own reputation most effectually by doing nothing at all'. Treasure's articles will lead you into a sophisticated and remarkably evidenced-based world in which he examines 'the insidious harms resulting from well-intentioned and apparently good acts' and proposes the antidote — 'an attitude of compassion and measured confidence; knowledge of science; and skills that enable us to help patients both by means of our relationship with them and by using appropriate technology'. That really is primary care for the 21st century.

Roger Jones
Editor

DOI: 10.3399/bjgp12X641654

© British Journal of General Practice 2012; 62: 281–336.

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2010 impact factor: 2.070

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PUBLISHED BY

The Royal College of General Practitioners,
1 Bow Churchyard, London, EC4M 9DQ.
Registered charity number 223106. The BJGP is published
by the RCGP, but has complete editorial independence.
Opinions expressed in the BJGP should not be taken to
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ISSN 0960-1643 [Print] ISSN 1478-5242 [Online]

PRINTED IN GREAT BRITAIN BY

HPM Limited, Prime House, Park 2000, Heighington Lane
Business Park, Newton Aycliffe, Co. Durham DL5 6AR.

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Carbon Balanced
paper

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CBP00048040504111835