Editor's Briefing

It's a mad world my masters! The BMA has led the profession into what I consider to be ill-judged and very badly timed industrial action, the senior academic in charge of the NHS Commissioning Board has attributed excess weekend emergency admissions to GPs playing too much golf, and other powers-that-be have instructed healthcare professionals not to use the word obesity in relation to fat patients — who presumably have instead, in the ghastly argot, 'weight management issues'. I once worked for a wonderful obstetrician who, in a soft brogue and with an admiring twinkle in his eye, could ask his patients 'And tell me Mrs Davies, how is it that a woman like you can have become so terribly fat?' without giving the slightest offence. But I recognise that the climate has changed. While I was always comfortable enquiring of a patient with alcohol on their breath at morning surgery if they had needed an eye-opener, or asking someone with a hacking cough and darkly nicotine-stained fingers to put two and two together, the approach to the obese was undoubtedly imperilled by a minefield of interpersonal sensitivities and political correctness. Obesity really is the elephant in the room — and with National Childhood Obesity Week looming, we have to work out ways to talk about being too heavy without upsetting everyone in sight. Suggestions please, and also let us have your views about strikes, pensions, austerity and, of course, golf.

In this month's *BJGP* our focus is on child health and we include a number of papers that touch on important topics for primary care clinicians, whose role is reviewed by Saxena *et al* in their leading editorial. Much of what we have to do in the care of children involves having the right degree of diagnostic suspicion for fairly rare events such as cancer, maltreatment, and mental health problems. In their important study of the coding of suspected child maltreatment in GP computer records, Woodman and colleagues argue that better electronic documentation will have a number of benefits in terms of flagging previous concerns, supporting regular review and quality assurance, and in the analysis of workload and other data. The contribution of practice computer systems could go much further than this. The computer knows far more about the patient sitting in the consulting room than the doctor does and is, consequently, able to generate prompts such as risk ratios and diagnostic hierarchies. Intelligent practice computing, which can't be far away, has the capacity to transform our ability to respond appropriately to symptoms which, unless seen against a patient's family and medical backgrounds, might be only a weak signal for serious illness. It also has the potential to raise suspicions of, for example, psychological problems or abuse in patients whose presentations might appear unrelated, but whose practice dataset points to potential problems, and to nudge the clinicians in the right direction.

In a special feature this month we asked five people, all with a major interest in the future of the NHS, to consider whether the Health and Social Care Act and GP commissioning really will lead to cost savings and improved quality. There has been an element of the triumph of hope over experience in much of the rhetoric we have heard so far, but there is cautious optimism in these personal views, about better use of resources as well as reduction in practice and quality variations. The concordance between some of the views of the NHS's Chief Executive and the CCG lead is striking, although their positive outlook is not shared by the chair of the RCGP's Patient Participation Group, who is sceptical about the prospects for raising standards and access across the board, and for smoothing out health inequalities. Multimorbidity, one of the great drivers of increased costs and management challenges for all health systems, along with equity and health inequalities, are discussed in a number of articles, including Jan de Maeseneer's James McKenzie lecture.

In her editorial about the Commission on Generalism, Amanda Howe highlights the key features of general practice and primary care that should equip us to tackle these demands in the years ahead. It is interesting to see how the pressures on health services are making us take a hard look at traditional professional roles and demarcations, as well as the RCGP work on generalism, the RCP has set up an analogous initiative, the Future Hospital Commission, which will examine five key areas: workforce and medical teams, information and records, patient pathways and the balance between generalist and specialist care, the organisation of diagnostic, support and community services, and 'patients and compassion': leadership, responsibility, and compassion on the wards and within multidisciplinary teams (see http://www.rcplondon.ac.uk/projects/future-hospital-commission).

We seem to have been saying too many goodbyes recently and it is now my sad duty to record the death, at the end of May, of Dr John Horder. He was one of the great heroes of general practice and a role model for many, and we are grateful to Iona Heath, President of the RCGP, for her appreciation on page 369 of the Journal. Farewell John, and thank you.

Roger Jones
Editor

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