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EDITOR'S CHOICE

Open wide

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NHS England's new medical record database, care.data, is currently taking a bit of a battering. The scheme will link patients' GP records with information already collected from hospital trusts through hospital episode statistics. Data will be "pseudonymised" and shared with approved users for commissioning, planning, and research. It's not surprising that so many questions have surfaced: How will patients' privacy be ensured? Can pseudonymisation be "undone"? Who can access the data? How much will it cost? Jon Hoeksma explains the nuts and bolts of the scheme, how it should work, and how it could affect patients and clinicians and, importantly, relationships between them (doi:10.1136/bmj.g1547).

Campaigners argue that holding patients' data on a national database could increase the risk of breaches of privacy. Last week the Royal College of General Practitioners called for the roll out to be slowed down until a "crisis of confidence" in the plans had been averted (doi:10.1136/bmj.g1566). And this week a risk analysis by the NHS concluded that care.data could undermine patients' trust in the confidential nature of the NHS, leading patients to withhold information from their clinicians (doi:10.1136/bmj.g1624). If patients can't trust and open up to their clinicians then their healthcare will suffer.

But are the criticisms fair? Clare Gerada, former chairwoman of the Royal College of General Practitioners, doesn't think so and says that they are fuelled by "endless scaremongering about groundless allegations." In a *BMJ* blog she says that the scheme will be "transformational to our NHS, to research, and to improving quality of care" (http://bit.ly/1cVeHrY). John Appleby, chief economist at the healthcare think tank the King's Fund, also reminds us in a blog that hospital episode statistics have shown over the past 25 years that the "risks can be minimised (to zero it would seem) to allow us to enjoy the benefits"(http://bit.ly/1fvxefg). Whichever side of the fence you're on it looks uncertain whether the national roll out in May will go ahead as planned.

Three clinical articles are about asking patients to open up in a more literal sense: they all link to conditions of the mouth or throat. The first is a 10-minute consultation with a 58 year old woman who has a six month history of feeling a lump in her throat (doi:10.1136/bmj.f7195). Foden and colleagues discuss what you should ask, look for, and rule out (including red flag features). In the absence of an underlying cause, globus pharyngeus can be diagnosed.

The second is a clinical review on trigeminal neuralgia, which is not something you might associate with mouth problems (doi:10.1136/bmj.g474). But Zarkrzewska and Lindsay say that the condition is often mistaken as a tooth problem because of its presentation in the lower two branches of the trigeminal nerve. Patients often have unnecessary and sometimes irreversible dental treatment before trigeminal neuralgia is diagnosed. The authors describe the latest approaches to diagnosing and managing the condition, including what to do in a "crisis."

And finally Minerva has a mouth related offering. The picture illustrates the case of a woman with painful mouth ulcers, then painless ulcers in the eyebrow and arms over an eight month period. The initial diagnosis was pemphigus, but this turned out to be wrong. I can't say more without giving the diagnosis away, so take a look for yourself (doi:10.1136/bmj.g1540).

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