natal and postnatal care is an essential or optional component of general practice. If it is essential, then well-directed training for it is also essential. Furthermore, such training is different from that needed for the practice of intranatal care. Another important recommendation is that arrangements for obstetric training and continuing education should be transferred to the Regional Postgraduate Medical Committees, and that clinical audit (exemplified by Dr Wood's paper) is both appropriate and feasible.

The question that all general practitioners and obstetricians must ask themselves is "What do our patients want and what do they need?" Are maternity welfare groups like the National Childbirth Trust "fuddy-duddy middle-class mothers" as Mrs Renée Short MP is said to have described them (1980), or are they right in objecting to Mrs Short's House of Commons' Committee which, inter alia, recommended that all births should take place in hospital, and that it should be mandatory that all women should be seen at least twice in their pregnancy by a consultant obstetrician? The College is discussing the whole question of obstetric care with the Royal College of Obstetricians and Gynaecologists; evidence, tempered by moderate doses of opinion, is needed to guide our negotiators, and readers are invited to send it to the Honorary Secretary of Council, whose letter appears on page 121.

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Everybody's business, nobody's responsibility?

THE phrase 'prevention is better than cure' turned into a colourless cliché so long ago that most of us have ceased even to think whether it might still be true; we have tended to throw it onto what George Orwell called that "huge dump of worn out metaphors which have lost all evocative power . . .." There is plenty of evocative power, however, in the three documents on preventive medicine which we publish today. Health and Prevention in Primary Care (No. 18), Prevention of Arterial Disease in General Practice (No. 19) and Prevention of Psychiatric Disorders in General Practice (No. 20) are first fruits of the Working Party on Prevention set up by the College in 1978. They help us to answer two big questions: does prevention work? and can general practice do it? The reports also suggest certain specific tasks for general practice in the fields of arterial disease and psychiatric illness.

Does prevention work?

This question directly tests the cliché, and it is perhaps inevitable that more answers are to be found in the report on arterial disease than in the one on psychiatric disorders. Several of the risk factors for arterial disease —cigarette smoking, raised arterial pressure and blood fats, obesity and physical inactivity—can indeed be altered, and there is evidence, some direct, some more circumstantial, that altering them will prevent or delay the appearance of stroke, myocardial infarction, sudden death, peripheral arterial disease, heart failure and renal and retinal damage. Probably about one half of all strokes and one quarter of all coronary deaths under the age of 70 are preventable.

The position is less clear with psychiatric disorders because their causes are so much less clearly definable. In Report number 20, however, the Working Party subcommittee present persuasive evidence that life events, or psychosocial transitions as they call them, produce psychological reactions and disorders for which the general practitioner is frequently consulted. The committee give many examples both from childhood (for instance separation from parents, home and school) and from adult life (marital breakdown, pregnancy, loss of job, or retirement), of times when the effects of severe stress can be partially relieved by good primary care. Anticipatory guidance has been shown to reduce the risks associated with major surgery, childbirth and release from prison; supportive intervention has been effective in improving long-term adjustment after bereavement. "It seems reasonable to assume," the committee go on, "that anticipatory guidance will be equally effective in preparing people for other types of predictable changes in their lives."

Can general practice do it?

Most doctors are probably already doing more prevention than they realize: it would be a very unusual day in the life of most general practitioners if there were no consultations for antenatal or postnatal care, family planning, cervical cytology or the immunization of children. Many primary care teams are also doing some

surveillance of the health of the children under their care; others are finding cases of hypertension by the methods of Hart (1970) or Howe (1980). The amount we are doing is increasing, and Report number 19 is able to list some outstanding successes. What it cannot do is to say what the total amount of prevention is: how many practices do no immunization at all, how many patients are helped to stop smoking, how many to become thin or take regular exercise? For answers to some of these questions we shall be looking to the efforts of medical audit groups. For instance, it will be a natural task for these to decide such things as the reasonable attainable percentage for child immunization against measles, and to see how near the standard each practice gets, repeating the count a year later to see if increased awareness or changes in practice policy have had any effect.

There is no lack of opportunity, as Stott and Davis showed (1979), for extending the traditional content of every consultation to include health education and health conservation. Van den Dool (1970) called this anticipatory care, and Hart (1978) called on general practitioners to extend their responsibilities from the care of individuals to the care of defined communities. British primary care, with its system of relatively continuous care of relatively stable populations, all registered with a general practitioner, offers an administrative framework far more suitable for prevention than is possible in most other countries. Nevertheless, other changes are needed, notably more administrative staff (particularly those able to handle small computers), more nurses and health visitors, and more doctors trained in clinical community medicine.

But are doctors doing enough to lead society in a more healthy direction? Do we promote health any more effectively than we prevent disease? Have we ourselves stopped smoking cigarettes; do we always wear our safety belts when we are out visiting by car? Doctors are influential people, but how much do we influence local and national governments, industry, trade unions, consumer groups and even our own few patient participation groups by constantly pointing out what pressures in society are healthy and what are damaging? And, as Report number 19 says, "prevention might be better taught by those in a position to act and perceive their success or failure in a defined population small enough to be a community in real terms. It would then become possible to use the clinical experience of diseases that still occur, and the memories of disease now overcome, to give motivation and urgency to prevention and anticipatory care."

Cynics and idealists

What will happen to these reports, and to the remaining ones, still to be published, on family planning and child health? Will there be polite murmurs of approval, a little action, a few research projects started, and then nothing? Will the profession divide into two groups, the cynics and idealists? The first group will be those who see prevention as not only expensive, but strategically unlikely: to alter the working pattern of doctors, nurses, health visitors and administrative staff will, they say, take more than the few thousand words of some worthy reports. Where will the extra money come from in these economically troubled times? Why should general practitioners do more unpaid work for fewer patients when it pays them to have a big list to whom they give the usual kind of episodic care? They will be answered by the idealists, who will point out that the Department of Health and Social Security already gives money for specific preventive work in primary care, that anticipatory care delivered by an enthusiastic and well co-ordinated primary health care team is enormously satisfying in a professional sense, and that (in the words of Report number 19) "if effective prevention must in some degree be personalized, then in this country it should in that degree become a task for general practitioners. We hope it is one we will accept, and that we shall insist on the resources needed to carry it out.

"Our decision may be as important for our own future, as for that of our patients."

The three reports are available now from The Royal College of General Practitioners, 14 Prince's Gate, London SW7 1PU, price £3 each, including postage and packing. Payment must be made with orders.

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The general practitioner research club

THE General Practitioner Research Club was founded in 1969 following a ten-day course at the College on research methods in general practice (Fraser, 1969). The course participants became the founder members of the Research Club and elected Dr John Fry as President and Dr Robin Fraser as Honorary Secretary. Its aims were identified as follows:

1. To bring together people who are interested in research in general practice, be they general prac-