Why not monitor our patients for adverse effects of drugs?

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NINETY per cent of prescribing is done in the community by general practitioners, but we have little good information on the incidence of adverse effects of drugs in general practice. The 'yellow card' reporting system introduced by the Committee on Safety of Medicines is the central effort in the United Kingdom to obtain information on a large scale regarding drug side-effects, but the CSM itself estimates that less than one per cent of all adverse drug reactions that occur are reported. The yellow card system fails to reflect accurately the total burden of drug-induced disease in the community because it is a voluntary system—voluntary in respect of the patient having to act on his or her own initiative in deciding whether to report to the family doctor a symptom occurring during the course of treatment. If the general practitioner considers the symptom to be drug induced, he or she makes a decision whether or not to complete a yellow card. Failure to report a potential adverse drug effect by the patient to the doctor, or by the doctor to the CSM, results in an inaccurate estimate of drug-induced disease in the community.

A community-based drug surveillance network would greatly increase our knowledge of the nature and incidence of adverse effects of the drugs we prescribe, both of relatively new and of established preparations. Unlike a voluntary system, where information is incomplete and haphazard, such a network should undertake intensive surveillance of the population under study. Patients should be actively sought and questioned about symptoms that are potential side-effects which may have arisen during the course of treatment. A suitably trained drug monitor would interview patients, using a standardized questionnaire or data sheet, or possibly an 'event' record (a record of symptoms or signs present at the onset of illness and prior to treatment, and all events developing during the course of treatment). This information would be collected in a central data recording system. Events might be given a weighting as to whether they were 'certainly', 'probably', 'possibly' or 'unlikely' to be drug related. Of course, any such recording system must be confidential, but this should not be difficult. Although one may criticize symptom or event checklists because of the inherent risk of suggestibility, this method has been shown to be of value in large hospital-based drug monitoring programmes, for example the Boston Collaborative Drug Surveillance Programme.

As a first step in setting up such a programme, 20 practices might be asked to undertake the kind of monitoring service outlined above. If one takes an approximate 10,000 patients in a practice of four doctors, 20 such practices would provide an at risk population of 200,000, which should be large enough to permit evaluation of intensive monitoring over, say, a three-year period. Ideally such practices would be chosen at random, with an urban/rural mix, but it is likely that inclusion would be by self-selection and that participating practices would be atypical. The practices might be restricted to a sample within a particular region and, if the initial results were valuable, a wider, perhaps national, community drug surveillance programme might be introduced.

The key figure in a drug-monitoring study is the drug monitor. He or she would have to be trained in the techniques of event recording and in the use of standardized questionnaires or data sheets. It is unlikely that funds would be available for additional staff to do this work, but why not train health visitors or district nursing staff already in interested practices to become drug monitors? Iatrogenic disease and its prevention is, after all, a legitimate and very relevant aspect of health care. The additional work need not be great, particularly if within a practice only a random sample of patients given drugs are monitored. In Darley Dale over the last year we have successfully trained a health visitor in drug monitoring techniques and have employed her for a survey of all our patients over the age of 65 who are receiving drugs.

Why not introduce intensive surveillance for adverse effects of drugs in the community on a larger scale?

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