First, alternative medicine is seen by many patients with chronic disease as a new hope for cure, a clear and attractive alternative to the caring contract that has been offered at the local health centre. The prevailing publicity about acupuncture, homeopathy and osteopathy concerns their successes, often after years of failure of conventional treatment in the hands of the NHS. When will this vulnerable group of chronically ill patients hear about the failures of alternative medicine? Secondly, when alternative medicine exists outside rather than within the primary health care team, seeking help elsewhere is bound to disrupt the therapeutic potential of the patient's relationship with the doctor and with other professionals, which has been built up over many years within the primary health care team. This cannot simply be dismissed as an example of professional jealousy since most general practitioners would be delighted if their patients could find cures elsewhere as easily as this. What tends to happen is that the alternative therapies do not help or bring only transient improvement or can no longer be afforded, with the end result that the patient returns to the general practitioner and the whole caring contract and relationship has to be re-established.

General practitioners, more than any other group in the health service, can tolerate uncertainty. They know that many illnesses cannot be described by existing diagnostic taxonomies and that the success of care does not always depend on explaining or understanding the detailed mechanisms of health problems and their treatment. The apparent success of many of the currently popular alternative strategies could be of great value to many of the patients seen in general practice. This is more likely if such strategies are seen as alternative treatments within the context of primary health care teams rather than as 'alternative medicine'. The emergence of the concept of 'complementary' rather than 'alternative' medicine bodes well for the future.

CHARLES B. FREER

Senior Lecturer,
Department of Primary Medical Care,
University of Southampton

Performance review: contribution from the family practitioner committees

THE RCGP, through its quality initiative, has made performance review one of its main activities for the next few years. Family practitioner committees (FPCs) also have a role to play in making performance review a normal part of a general practitioner's work.

In March 1982 the Department of Health and Social Security (DHSS) issued advice about the National Health Service (NHS) planning system.[1] The guidelines recognized that district plans should cover all primary health care and not only those aspects of community care which are the direct responsibility of health authorities. The NHS now recognizes the need for information systems which can highlight areas of poor performance. Advice about operational requirements and guidelines for 1985–86[2] have now been issued to FPCs and they have been asked to consider the format of their annual programmes. FPCs will wish to take careful note of the views of the medical profession when preparing their proposals for change and development. While in no way wishing to dilute the statutory role of local medical committees in advising FPCs, the Council of the Society of Administrators is keen to foster the links that have been developed with the Royal College of General Practitioners (RCGP) and it has been suggested that the next step might be for local links to be forged between FPC administrators and the College faculties. Such a forum could provide an ideal opportunity to relate relevant parts of the quality initiative to a particular local situation. It would also present administrators with an opportunity of explaining their Committee's own proposals.

The key to collaboration between FPCs and family doctors over performance review and to collaboration with district health authorities (DHAs) lies in unlocking the vast store of information FPCs hold, not only about patients but also about a whole range of services provided by family doctors. The introduction of new technology will help FPCs to improve and extend the assistance they can give to general practitioners and to the rest of the NHS. During the coming year it is likely that half the FPCs will computerize their patient registration data. The remaining FPCs should follow over the next few years. The DHSS is also developing, in consultation with FPCs, computer finance packages which will enable FPCs to make payments more efficiently. As the registration system and the finance system are developed it should be possible for FPCs to provide a range of information to family doctors about their practices and also to compare practices in the same area, district and region. This will need to be done in consultation and agreement with the profession. Several examples spring to mind: the provision of more sophisticated and up-to-date prescribing information, including costings; the analysis of lists of patients by age, geographical location and sex; the analysis of night visit, temporary resident, maternity and other items of service claims and rates of vaccination and immunization. FPCs are ideally placed to assist in implementing screening programmes in primary care. At long last positive steps are being taken to introduce effective computerized call and recall arrangements for cervical screening. It will be a comparatively simple matter for FPCs to develop other screening programmes in consultation with the profession. There is a need for flexibility in the introduction of new developments. Neither the profession nor FPCs should wait until national schemes have been agreed. The RCGP and the Society of Administrators should encourage local initiatives.

The DHSS has raised the issue of making wider use of the personal registration data held by FPCs.[3] The exchange of information which does not breach confidence is not a problem but the fact that the personal data held by an FPC was given solely by a patient seeking to register with a doctor, must be respected. Nevertheless, it ought to be possible for DHAs and FPCs to agree on the exchange of a range of information which could be channelled back to general practitioners as part of a general information exchange.

The Government has taken the opportunity presented by the change of status of FPCs to strengthen links between community health councils (CHCs) and FPCs[4] although many FPCs and CHCs have already established good relationships. New regulations place FPCs on the same footing as DHAs with regard to their relationships with CHCs. FPCs will now have to consult CHCs about matters affecting the provision of family practitioner services and will be required to meet CHCs formally as well as informally at regular intervals.

Performance review is at an embryonic stage. FPC administrators are keen to take part in an agreed and planned system of performance review but only as a contribution to the College's quality initiative. FPC administrators must be careful to avoid any question of forcing performance review on unwilling family doctors. Such reviews must not be seen as some sort of disciplinary stick with which to beat the profession and, in fact, the whole subject will only be successfully implemented if it is seen in a positive light by the profession as contributing to patient care and as value for money. Having said that, the Council of the Society of Administrators wholeheartedly shares the view of the Chairman of the College, when launching the quality initiative, in hoping that FPCs will adopt a more vigorous stance in administering the contracts of family doctors. In this connection the majority of FPCs already have plans to visit practices, providing an opportunity to explain the schemes that exist to assist family doctors in improving premises and to talk over other matters of particular local concern, for example, the effectiveness of nursing attachment schemes, the employment of additional ancillary staff, the use of age–sex registers, general relationships between the practice concerned and the FPC and relationships with the other family practitioner professions.

CLIVE W. PARR
Administrator, Cheshire Family Practitioner Committee

References

1. DHSS Circular HC(82)6. *The NHS planning system.* London: DHSS, March 1982.
2. DHSS Advance Circular. *Management arrangements for FPCs.* London: DHSS, April 1985.
3. Anonymous. The wider use of personal registration data held by FPCs. *The Family Practitioner Services Journal.* 1985; May: 75.
4. DHSS Circular HC(85)11. *Community health councils.* London: DHSS, March 1985.

Biotechnology: implications for general practice

SEVERAL advances in molecular biology have occurred in the last 15 years which promise great clinical improvements and the likelihood of intense ethical and moral dilemas. As general practitioners we must look to the future if we are not to find ourselves taken unawares by events. This issue of the *Journal* contains the first of two articles reviewing biotechnology, the implications it holds for general practice and why it is important to start thinking about these innovations now.

Biotechnology has been defined as the application of biological organisms, systems or processes to manufacturing or service industries. As such the term embraces traditional activities, for example brewing, but here refers to today's advanced genetic technology.

In the last 10 years our ability to manipulate the DNA molecule — whether of viral, bacterial, plant or human origin — has been radically extended. It is now possible, for example, to isolate from human tissue the DNA sequence that is the gene for manufacturing insulin and insert the DNA fragments into *E.Coli* bacteria so that the bacteria utilize the gene and produce pure human insulin in commercial quantities.

Such technical virtuosity might seem just another esoteric advance on the road to human enlightenment. But we must face the fact that advances in genetic engineering will have serious implications for all branches of medicine. The wide range of problems presented to general practitioners and their place as mediators between the patient and the technically complex medicine of the hospital means that the innovations and the dilemmas arising from biotechnology will have great impact in primary care.

The articles are concerned with two aspects of bioengineering. The first article reviews some of the technical methods, such as recombinant DNA techniques, which enable particular genes to be isolated and then utilized in bacteria. Initially this is likely to permit the production of physiological substances, such as interferon, calcitonin and endorphins, and perhaps in the future derived compounds for use as drugs. There follows an outline of genetic probes, which are tools that locate particular genes on the DNA molecule and which will greatly increase our understanding of the genetic component of many diseases. One likely outcome will be the ability to screen both the fetus and the adult for those genes associated with particular diseases. Combining these approaches signals the distant approach of gene therapy — the attempt to use human DNA itself as a therapeutic agent. The second article takes a wider view of the social and ethical problems that biotechnology presents to general practice.

It is extremely difficult to predict the timescale of advances in biotechnology. Many of the developments hold immense commercial possibilities and new academic and business arrangements for research deliberately enforce a degree of secrecy unprecedented in the medical sciences. In the next few years, therefore, general practitioners may find themselves suddenly presented with startling new clinical opportunities.

The promise of the advances is tremendous but if we are also to avoid the ethical and practical pitfalls, an informed medical and lay audience is essential. We hope that these two articles will contribute to an awareness of the power of the biotechnological revolution that is now beginning to affect us all.

PAUL HODGKIN
EDWARD YOXEN