Research Unit, which has also monitored enalapril, found that in the first year of experience of the drug in general practice 50% of prescriptions for enalapril were written by general practitioners who were involved in the pharmaceutical company's study.[2] The success of the company in recruiting 10% of general practitioners into their study resulted in useful information but the data was based on a selected group of patients. Furthermore, the scale of the study served to distort the population exposed to the drug in the early years of its general availability and this created difficulties for prescription event monitoring. These observations are not a criticism of Merck, Sharp and Dohme; the company took a responsible position in carrying out a large scale study and problems of selection would occur whoever conducted a prospective study. Similar difficulties occurred, for example, with the Medicines Surveillance Organization, set up by the College to conduct independent post-marketing surveillance of new drugs. Critics felt that doctors were persuaded to prescribe the new drugs being studied and the present inactive state of the Organization highlights the major problems involved in creating an effective monitoring system.

The irony of this situation is that the structure of general practice within the National Health Service should enable the UK to produce unrivalled information about the safety of new drugs. A very high percentage of the population are registered with a general practitioner whose prescriptions are collected centrally for pricing. The facility therefore exists for gathering information about symptoms associated with new drugs in a large defined population. Developments in computers may be the key to setting up a system of surveillance of new drugs in the UK which is both rapid and unselective. The use of computers centrally at the Prescription Pricing Authority will allow better feedback of information to doctors about their prescribing habits than the crude cost analyses which are currently provided. Computers will also shorten the time taken to identify prescriptions for new drugs and allow the Drug Safety Research Unit to request additional information from the prescribing doctor much sooner than is possible at present.

However, it is the introduction of computers into general practice which provides the most exciting opportunity for drug surveillance. Predictably, the initiative has been taken by the commercial sector. Companies who are offering free computer systems to practices can only do so because the pharmaceutical industry is willing to pay for the information which the systems will provide and the design of the systems will be influenced by these commercial considerations. If an effective and coherent system of drug monitoring is to be set up, it is essential that independent authorities have access to all available information about the use of new drugs. The Scottish Home and Health Department has taken a lead in developing a computer software system (GPASS) available to general practitioners. The guarantee of continuing support for the software by government has encouraged over 160 practices to invest in computers and there now exists in Scotland the possibility of a computer based information system about the adverse effects of new drugs. An unbiased system such as this — in which the profession and the government retain control — may be the only way to build up public confidence in the safety of new drugs and this Scottish initiative should be developed further and followed by similar schemes in England and Wales.

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# Primary health care and community medicine: a new approach

THE National Health Service in the United Kingdom has two major strengths. The first is an extensive and well developed primary care service, which has helped achieve a high standard of health in the population with the lowest expenditure on health care in the Western world. This is not to argue that expenditure does not need to increase, rather it demonstrates the efficiency of the primary care system in ensuring the most effective use of expensive resources. The second strength is the foundation of the NHS on the principles of public health, now in the form of community medicine. Community medicine has been severely damaged by successive re-organizations and is only now re-establishing its unique contribution to the health of the whole population.

Previously there has been no noticeable fusion of these two elements in the study, planning and development of health services. Now that the family practitioner committees have been constituted as independent authorities in England and Wales it is opportune to look at the possibility of greater collaboration between general practice and community medicine.

The most distinctive features of community medicine's approach to health care and health services are the overall view which community physicians take of the health of groups and populations and the skills which they can bring to bear through a detailed knowledge of the operation of the health care delivery system. In addition, experienced community physicians can understand and make use of the complementary skills and knowledge of a great many different professionals within the health care system and a knowledge of health economics can help to suggest solutions for the inequities which exist in the health and access to care of different groups in the population.

In submitting programmes to the Department of Health and Social Security for approval family practitioner committees need to follow the NHS planning cycle. The technical skills of community physicians could be of value to family practitioner committees at the different stages of this cycle: consideration of environmental changes, situation analysis, formulation of objectives, definition and implementation of an operational plan, and evaluation.

Monitoring is an essential accompaniment to the planning process. In departmental performance review community medicine has the most obvious monitoring role to perform. In this type of situation community physicians could deploy their skills in epidemiology, health economics, statistics, systems analysis, computing and information science most effectively.

An experienced community physician is skilled in liaison with other organizations involved in the provision of health care; joint planning with local and health authorities is a good example. This is a crucial interface, where a closer working partnership with primary health care services can only enhance the quality of plans produced. Hitherto the joint planning process has taken little account of the interests of primary care. Similarly, the mutual interactions of health services and the general socioeconomic environment have been explored to only a limited extent and analysis in terms of primary care would reveal the extent to which the community makes use of health care and the relation of that pattern of use to social and other factors.

There are currently a number of fields of activity where a combined approach by community physicians and family practitioner committees could bring great benefits to the populations served in the form of improved availability and range of services and better access to them; examples include inner city services, community health care and information, all of which were referred to specifically in the College's evidence to the Royal Commission on the NHS.[1]

In looking at a possible synthesis of primary care and community medicine it may be helpful to highlight certain problem areas, correction of which could contribute materially to joint progress. Three crucial needs were set out by the working party of the Royal College of General Practitioners in its report on health and prevention in 1981:[2] (1) studies which examine what is being done already in general practice in specific activities; (2) further studies which demonstrate the benefits of prevention in terms of improved outcome — morbidity, mortality and satisfaction in both receivers and providers of care; (3) experiments which attempt to answer the question 'how can it be done?' — practice organization, delegation, suitable records and the use of computers must form elements in such studies.

Progress in these matters depends on a wide-ranging and sophisticated approach to the development of primary care. An experimental synthesis of primary care and community medicine should be attempted in selected districts. Some of the fields in which cooperation could be fruitful include: health promotion, rehabilitation, screening programmes, immunization and perinatal and related mortality rates. A useful way forward would be the part-time secondment of community physicians to family practitioner committees to work in the areas outlined above.

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# Voluntary organizations: an underused asset

GENERAL practitioners are a central part of local networks of health services in the community. Outside the conventional health and social services, however, there is a growing and vigorous voluntary sector which is unfamiliar to many general practitioners and is therefore an underused asset in patient care.

Voluntary organizations are already major providers of services to patients. Many of the familiar caring charities, such as Barnardos and Age Concern, are multi-million pound, nationwide operations. There are also myriads of small groups in every locality for all sorts of personal and health problems, offering everything from coffee-and-chat support to specialist advice and services.

Voluntary organizations are associations of people who come together by their own choice, so they vary in the way they provide services. Some use paid, professionally qualified staff, some make great use of part-time volunteers, others emphasize mutual assistance among people suffering from similar problems. They also vary in the way they structure their activities; some organizations aim to provide the same service in each area of operation while others encourage diversity among branches.

Doctors must take many factors into account when considering referring patients to voluntary organizations. First, the standard of service provided by individual self-help and voluntary organizations can be hard to judge. Information provided by the organizations may offer some basis for assessment, for example, to check if staff and volunteers are well prepared for their work or whether policies for managing services seem effective. Feedback from patients and professional staff can also assist, although, because of geographical variations, information about one branch of an organization is not necessarily helpful for evaluating another.

While each voluntary organization has its own distinctive style there is often overlap in the type of client they can help. Thus, for example, a stroke patient who becomes pregnant may benefit from contact with the Chest, Heart and Stroke Association, the National Childbirth Trust's Disabled Parents' Group, the Disabled Living Foundation and the Disablement Income Group. Depending on her interests she might subsequently like to contact the Society of One-Armed Golfers or the Uphill Ski Club. The particular style and membership of the local branch must also be considered; for example, an older working-class patient might not find congenial support in an organization made up of young middle-class people.

It can be difficult for doctors and patients to find out what groups exist to cover particular circumstances and whether these are available locally. As voluntary organizations become more important, in part as a result of government encouragement, patients will expect practices to have information about local groups which are concerned with health matters. Practices need to create an information system so that primary health care team members and patients can easily learn what is available.

The best course for identifying a local organization is often for the doctor, the patient or relative to contact the local authority's member of staff responsible for liaison with voluntary organizations. This person is normally to be found in the central office of the social services department, but is sometimes attached to the chief executive's or secretary's department of the authority. Many areas also have a voluntary organization with the job of coordinating the activities of others. In the shire counties this is called a rural community council; in most urban areas