general practice and in district hospitals, where most of the work goes on; thus the people who are faced by these issues, and who should be identifying the research needs, are general practitioners and district hospital staff, including nurses, physiotherapists, occupational therapists and other paramedical workers. Yet the regional research committees receive few applications — and even fewer acceptable ones — from these sources.

The problem is partly a lack of information on the existence of these funds. More fundamental difficulties include lack of training in research methods, lack of time, and professional isolation. To help with these difficulties, in the north west Thames region we have recently widened the guidelines for Locally Organised Research Scheme support. Within the limits of our funding we are now able to offer training fellowships which enable NHS staff to acquire research skills through courses or secondment to an academic centre; to pay the cost of research sessions; and to support collaborative research. These new facilities are additional to the usual research project grants.

The opportunities now exist (at least in this region) to widen the base of NHS research and to link it more closely with clinical practice: the need is to make the opportunities known and for all branches of NHS professional staff to recognize and use them. Further information can be obtained by writing to the secretary of the regional research committee at your regional health authority.

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General practice or primary health care?

Sir,

Linda Mark's excellent editorial (January *Journal,* p.1) is timely, and if we are to be serious about the role of general practitioners in achieving health for all it is necessary to be clear about the terms used. I would suggest, however, that there are three distinctions to be made: general practice, primary medical care and primary health care.

General practice is found in a variety of professional settings (for example law and architecture) and it involves the provision of a service on demand to those who request it and can pay for it; in the case of general medical practice in this country payment is mostly via taxation and is made by the state. Historically, general practice has not been concerned with the population who do not seek help, nor is it very interested in prevention, multidisciplinary working, information systems, management skills or evaluation.

Primary medical care is a bolder concept which accepts a responsibility to a defined population. It is concerned with prevention as well as treatment and aims at multidisciplinary working. Proper skills and information systems are an integral part of primary medical care. However, it tends to draw the boundary of medical work around clinical or doctor-like activities, for example immunization, family planning, child health surveillance and hypertension screening. Individual consultation, prescription or procedure define the limits of medical work.

Primary health care, as defined by the World Health Organization, is a much wider concept. At its most extensive it includes everybody because everybody has the possibility of influencing and affecting their own and other peoples' health, particularly that of family members. Managers of supermarkets are primary health workers because of the impact which they can have on peoples' health by their stocking and marketing polices; clearly the workers in the water supply industry and in education and housing departments are primary health workers as is the taxi driver who makes his taxi a no-smoking area. The responsibility of medically trained workers in primary health care is to establish links with these people in the settings of home, school, work, transport and recreation and support their work for health by making knowledge and expertise available to them.

Clearly we have a long way to go. But once we have a conception of the task we can begin to undertake it effectively. This will not happen while the three terms continue to be used interchangeably and little effort is made to achieve the transition from general practice through primary medical care to primary health care.

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Preventive care card

Sir,

I read with interest the article on a preventive care card for general practice by Drs Grundy and Dwyer (January *Journal,* p.15). I agree fully with the authors' comments that an adequate record of preventive activities is needed, especially in the age of computerization where suitable data is needed prior to transfer to computer records. However, I feel that the authors' comments that records developed by other practices will be incompatible when the records are transferred from practice to practice is a somewhat false argument since the same objection can be raised about their own preventive care card.

In our practice we have been using summary cards and database cards designed by ourselves for efficient record keeping and preventive care in practice.[1] Like the authors we feel that our cards are eminently suited to our own needs and practice organization. However, we do have criticisms about their preventive care card.

One of the main areas of contention is the lack of available space on Grundy and Dwyer's card for new developments in preventive care. For example, there is at present no space for human immunodeficiency virus status, which in future may be screened for at antenatal clinics, and travel immunization is not mentioned at all. On the reverse side of the card in the prevention section the card does not allow for more than five results to be entered and we feel the results would be difficult to read.

If the Department of Health is to be urged to produce a new card that will suit all practices in all areas then the General Medical Services Committee should encourage those interested practitioners who have taken the time and effort to improve their records to submit cards they have designed. Then finally one or a combination of the best should be chosen as a final template for future records of all general practitioners.

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References

1. Downey PF, Rogers AJ. Database and summary cards. *Update,* 1988; **137:** 232-233.

Sir,

In Scotland, if not a majority certainly a substantial number of practices use A4 folders, and it may be of interest to Scottish general practitioners to know that a suggested revision of the current A4 sheet 'Immunisations and screening investigations' (GP11H), very much along the lines of the card proposed by Grundy and Dwyer, was submitted to the Scottish Home and Health Department in June 1988 by the Lothian area medical committee's general practice sub-committee. Action is still awaited.

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