strapped councils has to be changed if we still want to have our bins emptied, as well as care for frail older people.

The challenge for GP partners, as the power brokers in this, is to take action and make their practices ready now for integrated care; waiting for the next contract to sort it out will not make us fit for purpose quickly enough.

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Health inequalities in primary care: time to face justice

I read Dr Moscrop's review article regarding health inequalities in primary care¹ with interest. It is an excellent article that clearly distinguishes differences between inequities and inequalities. However, although the article attempts to raise awareness of health inequality to GPs in the wake of the Marmot report of 2010,² it did not highlight the 2-year update published by the UCL Institute of Health Equity in February 2012 which found that health inequalities had widened in most areas of England.³

The Equality Trust has been set up by authors of *The Spirit Level*⁴ to 'gain the widest public and political understanding of the harm caused by inequality'. The striking messages are that members of more equal societies tend to live longer, have less mental health illness, less illegal drug use, less obesity, and higher levels of trust, with lower rates of homicide, and childhood violence.⁵

People are not oblivious to rising inequality — a *Harris/Financial Times* poll in July 2007 found that 78% of responders felt that the gap between rich and poor was getting larger in Britain.⁶ I feel the challenge is to engage people to tackle the issues — my suggestion is that by ending the article with 'GPs (and GP leaders) surely have an obligation to take on ...' is vague, political rhetoric, and an abstract idea for most GPs.

In Scotland, work assessing ways to reduce inequalities includes the asset-based

approach, which combining social and health care, aims to improve the sense of control a person has over their life by empowering individuals and communities; data are being gathered that may provide evidence for the effectiveness of this approach in the longer term.⁷

I believe to narrow the unjust gap of health inequities the solution lies with the whole of society. Initially raising awareness of health inequality issues is important, this has partly been done by previous national press coverage. With greater public awareness it is likely that developing and implementing government policies to tackle underlying socioeconomic problems would stay a priority: this fundamentally needs to be addressed to solve this problem.

It has been written that 'Many of the policies and strategies designed to reduce inequalities appear to be beyond the scope of individual practitioners'.⁸ I suggest that individual GPs can tackle health inequalities by continuing to provide accurate tailored health promotion messages, signposting patients to local community groups and other relevant agencies (such as Citizens Advice Bureau). A job that I believe is done extremely well by the majority of dedicated GPs.

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Outside the Box: why are Cochrane reviews so boring?

Trish Greenhalgh asks why Cochrane reviews are so boring.¹ Strange that she should ask such a question on this particular platform. Many colleagues ask me the same question about the *BJGP* (identified as I am as the local RCGP stooge because of my varied faculty activities during the course of my career). My answer in both contexts is the same: of course they are boring to practitioners because the job of practitioners is (no surprises) to practice. Both Cochrane reviews and the research articles appearing in the *BJGP*, nevertheless, are essential to the progress of practical medicine. We turn to them when we need them.

To answer another question, I have read Cochrane reviews. Let me give the most recent occasion because the narrative illuminates the synergy between trial evidence and complex decisions. Faced with high rates of referral and surgery for carpal tunnel syndrome, our commissioning consortium sought to explore the alternatives. Many issues had to be taken into consideration: the influence of local expert opinion, secondary-care behaviour in the market, GPs' knowledge of the condition, whether GPs possess the skills for injection and last, but not least, whether splints and injections are effective and safe. My interpretation of the Cochrane reviews on the subject was that the evidence for the effectiveness of non-surgical interventions is weak. But they are safe. So what to do? In this complex situation, the decision to offer non-surgical intervention first line (with safety provisos for those with advanced disease) is sensible. Had the evidence been that non-surgical interventions only delayed surgery or were useless, such a decision would not have been sensible. The evidence was only one part, but a vital one, in the decision.

I do not find Greenhalgh's suggestion of a database of opinions and ideas at all 'outrageous' or even radical. It already exists, it is called the World Wide Web. You can use your favourite search engine to find opinions

and ideas on many health matters. I guarantee that some of them will be outrageous.

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21st century health services challenges for an ageing population

Advance care planning should be added to Oliver's 10 challenges for general practice for an ageing population.¹ Many of the scenarios he describes, such as, multiple conditions, dementia, and repeated hospitalisation, are in fact prognostic markers for end-of-life care. Prognostic indicator guidance is available to assist doctors to identify patients approaching the end of life.²

We know that patients at the end of life with non-cancer diagnoses are less likely to be included in practice registers. Timely identification allows for more systematic care based on patient preferences.

The General Medical Council³ also emphasises a broad non-disease based definition of end of life. Systematic identification of people who are approaching the end of life and advance care planning⁴ can be the 'game changer' that is being looked for.

The issues that Oliver has identified are a massive challenge to general practice. At present, it is difficult to see where the solutions are going to come from, with current approaches best characterised as 'fire fighting'. But a way forward must be found with better models of care. The advent of clinical commissioning groups affords the best opportunity for a strategic approach to systematically improve care. Key to this will be how geriatricians and GPs work together, and how general practice capacity and capability increases.⁵

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Pharmacovigilance on the turn? Adverse reactions methods in 2012

I was interested to read in the August edition of *BJGP* that there are proposals to involve patients in reporting drug side effects.¹ It is now 30 years since I suggested that patients should be allowed to report suspected side effects of medication to the Committee on Safety of Medicines (CSM). In my proposals any patient prescribed a drug within 1 year of that drug being granted a licence should receive a pre-paid postcard advising them of the novel status of that drug, and advising that they should notify the CSM of any untoward incident or occurrence within a specified period after taking that product. This would extend to reporting any concerns about a child born subsequently, should the patient have been pregnant when taking the drug. In tandem with this, any doctor prescribing a drug within 1 year of licensing should be obliged to report all medical events experienced by the patient during the following 12 months.

Undoubtedly such an arrangement would generate a great deal of spurious

information. However, with the use of computer analysis, common patterns would be easily identifiable. One of the problems with reporting suspected drug side effects is the natural preference of reporting effects that are already known to be associated with a drug. The aim of pharmacovigilance should be to identify quickly unsuspected adverse effects, for example, dry eyes that occurred with beta blockers. During research and development of new drugs there is a tendency for negative attributes of a product to be suppressed, or if developmental trials are abandoned then this is never published. Even in phase 3 trials the follow-up surveillance is often limited in scope and may not identify atypical reactions.

The more general collection of data, as I propose, would include the known reactions, which may be easily filtered out, as well as events that may or may not be of significance. Patterns of recurring similar events could flag up the possible need for more careful scrutiny. The added responsibility on the prescribing doctor may also encourage reflection before using a me-too product introduced at the expiry of a drug patent with little or no advantage over the established and less expensive product.

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Looks vestibular: irrational prescribing of antivertiginous drugs for older dizzy patients in general practice

Although there is little evidence for the effectiveness of antivertiginous drugs (AVDs) for dizziness of vestibular origin and no evidence for the effectiveness of AVDs for non-vestibular dizziness,¹ prescribing drugs for dizzy patients in general practice is still common practice. Recent publication of the updated Beers Criteria for potentially inappropriate medication use² stimulated