

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