general practice by peer review, which was published in 1987 in *The front line of the health service,*[4] has been dramatically highlighted.

History may yet show that the spring of 1988 marked a turning point in the process of the self-regulation of the largest branch of the medical profession. The issue of the implementation of minimum standards could not be avoided for ever. General practice has not waited for others to intervene but, in the educational world, has started through peer review to set its own house in order. This is medical audit in action.

Royal colleges

All Royal colleges exist to promote and at times to defend standards. The Royal College of Music defines minimum standards and assesses applicants individually. Medical royal colleges sometimes do the same. The Royal College of General Practitioners is bound to act in accordance with its royal charter and must 'encourage, foster and maintain the highest possible standards in general medical practice.'

All doctors understand the responsibility of taking decisions on national minimum standards. It is distressing to have to tell a patient who wants a licence to drive a heavy goods vehicle that they fail the national minimum standard for sight. Such patients often point out that the great majority of their bodies, perhaps all the rest of their bodies, may be fit and strong. They often say that the social consequences of the decision to them or their families may be severe. Nevertheless, failure in any one national minimum standard means that approval simply cannot be given.

This is a three word issue: 'national', 'minimum', and 'standards'. It is national because the national bodies have agreed that certain standards are expected in every training practice in the UK. It is about the minimum, because it refers to the lowest acceptable standards. Finally and most important it is about standards, because standards of care protect patients and training raises standards of care. All junior doctors in every region who choose a career in general practice are entitled to learn their craft from a trainer in a practice which has achieved the national minimum standards.

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Community nursing on the planning board again?

THE review of community nursing in Wales, chaired by Noreen Edwards,[1] was published in an atmosphere of controversy generated by the Cumberledge review of community nursing in England[2] and coincided with the publication of the government's white paper on primary health care[3] towards the end of 1987. It is likely, therefore, that readers of the *Journal* will have heard little about the Welsh review, yet, like the Cumberledge report, this report is not about community nursing alone. It contains an agenda which reaches to the hub of general practice and, if adopted, will pave the way for fundamental changes in our primary health care services. Many of the premisses upon which this report is based appear to stem from the evolution of health care in the underdeveloped countries, with primary health care being viewed as the key to attaining health for all by the year 2000.

The Edwards report starts with the claim that British primary health care services appear to lack an overall sense of direction and it deplores this 'at a time when primary health care could take on a new and more active role in the promotion of good health, and thus do much to combat inequalities in health between different groups within society'. The scene is thus set for a major shift in nursing towards health promotion and a much greater coordinating role in patient care.

If the proposals of the review are adopted, a new breed of generalist nurses in primary health care will also prescribe from a limited formulary items such as dressings and appliances and perhaps certain drugs; be directly accessible to their patients; hold regular consulting sessions at the primary health care team premises; have hand-held computers to help in the collection of data and radio-pagers for two-way communication; be part of an expanded out-of-hours nursing service; have more nursing assistants working under them; have time for unsolicited visits to dependent patients and their carers; and set aside time for pro-active work with homeless and itinerant families.

Community nurses are thus bidding for much clearer front-line roles in primary health care by modifying the traditional pattern of receiving patients referred after assessment by the doctor. The new community generalist nurses will also try to achieve coverage in two areas where health visitors and general practitioners have failed: routine visiting to patients who are disabled or dependent and the care of itinerant families. The legal, ethical and scientific grounds for these major changes in a community nurse's role are not addressed in the Edwards report and this will be a source of concern to others who work in primary health care. However, the proposals reflect changes which are already occurring in our society and in other parts of the world and they question the doctor's traditional monopoly of the diagnostic process at all levels of sophistication.

A major objective of the Edwards report which most general practitioners will welcome is that all members of the primary health care team should work from the same premises and that nursing staff should be permanent members of the team. Less well defined and more controversial are recommendations for primary care teams to have annual agreed objectives and for all team members to be consulted about selection of new members. These recommendations appear to intrude on the independent contractor status of doctors but could help to build up teamwork if sensitively handled by all concerned. Unfortunately both of these recommendations represent time-consuming activities and the system could break down if more aggressive team members use them as weapons rather than as facilitators. Nevertheless, both the suggestions deserve serious consideration and

experimentation in an increasingly complex team structure. Drawing the primary health care team together is a clear goal of the Edwards report, hence community psychiatric nurses, community nurses for mental handicap and midwives are all to be firmly embedded in one or more primary health care teams.

The most radical and important proposal in the report is the creation of new primary health care authorities responsible for both family practitioner services and community health services in all districts. This entirely logical proposal begs the question whether the new authority should be based on an expansion of the present family practitioner committee or of the district health authority community unit. The report sensibly avoids this contentious point but it gives indirect evidence of the committee's favoured view in the recommendations which deal with the interim arrangements before the new primary health care authorities are established. Here Edwards recommends the formation of community units within all existing district health authorities, the establishment of liaison committees and a clearly defined primary health care budget for each health authority. There is no recommendation for concomitant strengthening of the present family practitioner service planning and management budgets, despite the recognition that family practitioner committees have been grossly underfunded for these new activities since legislation changed their role in 1985. We must conclude that a properly resourced community unit of a health authority and an underfunded, hard pushed, cash limited family practitioner committee are not intended to be equal competitors in the race for leadership in the new primary health care authorities.

The United Kingdom Central Council for Nursing and Midwifery may be upset by the recommendation for generalist nurses in primary health care rather than specialist nurses, the proliferation of which we have been witnessing in recent years. A service based on generalists but supported by a smaller number of specialists is the model upon which medicine has operated since the advent of the National Health Service. If nurses adopt the same structure continuity of care will be greatly enhanced and administration will be more flexible.

Our society needs more professional input to chronic and continuing care as well as support for acute crises in young single parent families and the elderly living alone. It is therefore appropriate for the Welsh nursing review to recommend a far greater role for well trained generalist nurses working in primary care teams. However, two issues cause disquiet in this otherwise forward-looking report. First, a major shift towards health promotion in a profession already short of staff must lead to a reduction in some other activity. Is it the nurse's traditional role of caring for the sick that will be discarded? Secondly, the long term goals of this report have implications for family practitioner services which extend to the structure and function of their premises, contractual and legal responsibility for patients, financing of services and inter-professional relationships. It is hoped that these will be properly addressed during the consultation process with representatives of the medical profession. Without such consultation the primary health care team will stagger into the next century in its fragmented form instead of achieving the integrated approach proposed by the review of community nursing in Wales.

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Management of drug misuse in general practice

MOST general practitioners are unsure and apprehensive about their role in the management of drug misuse. Drug misusers, in common with all our patients, are entitled to the full range of primary health care services. It is entirely appropriate that we should concern ourselves with their general medical problems and also with the problems associated with their drug misuse.

The general practitioner is well placed to see addiction in its true perspective. It is not just a condition which affects the primary sufferer alone. There are many equally important secondary sufferers who badly need help — parents, partners, siblings, children and other relatives and friends. These family members often suffer more serious and longer lasting harm than the addicts themselves. General practitioners are frequently approached by concerned family members seeking help for the addict. The family may be misguidedly paying fines incurred by the addict or protecting him in other ways from the legal and social consequences of his criminal activities. Some relatives go to the lengths of procuring drugs for the addict, either by illegal means or by manipulating the general practitioner or consultant psychiatrist to prescribe. This behavioural pattern of shielding a person from the natural consequences of his actions is known as 'enabling' — it enables the addict, the alcoholic and the compulsive gambler to remain addicted. Families which practise enabling do great damage to themselves as well as to the addict.

Other problems arise because mothers and fathers often disagree on how best to 'manage' their addict child. This can lead to irreparable damage within the marital relationship. Brother and sisters resent the amount of time and effort spent on the 'black sheep' and because of the problems within their dysfunctional family they often fail to achieve their potential in life. The distress of the spouse or partner is extreme and readily understandable. The problems and distress of the children of addicts and alcoholics are insidious and long term. Such children have to compete with the drugs for parental attention and approval. They grow up sometimes as high achievers but suffer from great insecurity and loneliness.

It is perplexing that so few professionals recognize the dimension of the family problem. It is best tackled by voluntary self-help groups: there is no need for a professional 'empire' to be set up. Most people will have heard of Alcoholics Anonymous and its associated fellowship for family members, Al-Anon. The fact that Narcotics Anonymous has an associated fellowship for families called Families Anonymous is less well known. Families Anonymous groups are being set up all over the country. Their goal is to assist the family member to find serenity. They do not set out to solve the problems of the addict or to give advice