areas for change.[9] This is the assumption behind the Prescription Pricing Authority statistics which are provided to each general practitioner.

The same system could be applied to the referral habits, the care of chronic diseases and the preventive care of general practitioners. However, little evidence is available to demonstrate an alteration in clinical behaviour from general feedback of this kind. This lack of evidence may further increase the trend towards using information as a means of regulating the profession. We are all aware of the variation in the standards of care which patients encounter but the profession has been unable to identify unacceptable practice because the data has not been available. Information gathering in general practice will increasingly highlight practitioners whose performance fails to match objective criteria and the profession will be faced with a challenge: respond to this information with education and professional regulation or have external controls imposed.

Here lies the nub of the issue. Bearing in mind the reluctance to date to define and enforce minimum standards of care, will the profession become prepared to do so in the future on the basis of information supplied by external sources? If we appear reluctant to impose and police minimum standards because we doubt the validity of the information, it is possible that pressure from government and from patients for externally imposed standards will become intense.

Furthermore, the DHSS will no doubt wish to use the information to establish guidelines for identifying general practitioners who refer patients frequently to hospital, have high prescribing costs and achieve low rates of immunization. It is their clear intention[3] to use such information to implement a performance related contract. Both minimum standards and a performance related contract might therefore be imposed using information derived from data of unknown quality and analyses of unknown integrity.

General practitioners will be vulnerable unless we can check the quality of the original data and monitor its conversion into information. The imposition of inappropriate performance criteria will distort our professional work in a way which will not necessarily be in the interests of patients. In the long term, external controls will weaken the concept of self-regulation, which has been the hallmark of professions in the past.

There are only two realistic alternatives. General practitioners, through their representative bodies, must either purchase the raw data and be in a position to monitor its validity, or set up an independent data gathering system. Either of these two courses would be expensive both in money and in time, but the risks of passivity are quite profound. The message in Bacon's aphorism appears as clear today as it was in 1619.

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Rediscovering the role of the pharmacist

SELDOM is the pharmacist considered part of the primary care team, yet both the Nuffield report[1] and the government's green and white papers on primary care[2,3] recommended an increase in the role of the community pharmacist, especially in the now eroded activity of advice giving. Certainly the functions of general practitioners and pharmacists overlap, but the pharmacist should be portrayed as providing a complementary rather than competitive service to the general public. There is sufficient need for accessible, professional health care at all levels in the community for the pharmacist to perform an important and valuable role. General practitioners should welcome the pharmacist's contribution, and the burden it may lift from their own workloads. As Taylor pointed out previously in this *Journal,*[4] inter-professional rivalry should play no part in the debate about community pharmacists and primary care. Indeed, it is the patients' needs and views which must be heeded.

It is now well known that general practitioners only see the tip of the illness iceberg,[5] and that many people react to symptoms without consulting their doctor. Traditionally people have resorted to 'home remedies' of various types, and in pre-NHS days many will have used the local pharmacist for both advice and treatment. While the advent of free health care for all led to a change in the main function of pharmacists, their role in the community still retains some of its traditional basis — this has tended to remain unacknowledged, ill researched and poorly remunerated. Today lay responses to illness often involve the purchase and use of over-the-counter remedies: for example, research into the lay management of children's illnesses has shown that these form a large part of treatment for minor symptoms.[6] Indeed these replace traditional home remedies as the common response to minor illness. Although not everyone uses proprietary medicines, for many people they nevertheless play an important role, both before and instead of going to see a general practitioner. They may also, of course, be recommended by the general practitioner.

A community pharmacist can be used for advice on 'differential diagnosis', as an alternative to the doctor and as a stepping stone to the doctor. In addition to this there are potentially numerous fleeting contacts when a person purchases the over-the-counter medicine that they have already decided upon. It would seem that although pharmacists today have lost some of their traditional functions they have retained others: they are seldom required now to compound their own medicines, yet their role as the givers of advice and treatment for minor ailments remains significant.

There are many positive aspects to this situation from the patient's point of view. The pharmacist enables people to cope with their own and others' minor symptoms, without necessarily seeking the attention of a doctor. Pharmacists provide an external source of advice, and may help people to come to appropriate decisions about care themselves. A considerable strength of the community pharmacists' role is that they form a convenient part of existing lay health resources. For many they are accessible, informal, helpful and responsive. They are in a unique position

to provide an important link between lay and professional responses to illness.

The existing use made of pharmacists also has the potential for further development of their services to the community. There is scope for health education, again in an informal setting, responsive to the needs and requests of individual members of the public. A range of advice can be and often already is provided — from foreign travel to family planning. The community pharmacist could usefully contribute in a broad way to the health of the community, with advice about over-the-counter medicines as only a small part. Rather than detracting from this, the retailing that many pharmacists are involved in is pertinent to their wider role — issues of diet, hygiene or baby care, for example. This would mean that those in the community who are reluctant to seek the advice of a pharmacist because they do not like using non-prescribed medicines would benefit from their wider engagement in health advice.

However, in stressing the positive aspects of developing further an advisory service that already exists in an *ad hoc* form, the problems should not be overlooked. Pharmacists may be a useful source of advice or of pharmaceutical products, but there is still a good deal of ambiguity about the extent to which they should be treating illness. Recommendations to expand their role have to be thought through seriously. Issues of training and remuneration must be taken up, and steps taken towards increased cooperation between pharmacists and general practitioners at a local level in order to provide a good service for all. Furthermore, these developments may result in better use of proprietary medicines by the public and may lessen the unsupervised sale of such medicines although there remains the question of the appropriateness of many over-the-counter medicines for the treatment of minor illness. Cooperation between doctors and pharmacists should lead to more systematic and clearly defined recommendations. From the patient's point of view there may remain the issue of the cost of treatment: there will need to be some arrangement devised whereby, in appropriate circumstances, the cost of treatment recommended by a pharmacist can be defrayed.

An expansion of the role of the community pharmacist in the manner suggested above would not necessarily lead to a drug oriented society. Pharmacists already exist as part of the lay response to illness, and a development of their professional contribution to primary care can only enhance the standard of that care in the community.

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