age of general practice. If this golden age is to be maintained the central role of the consultation must be continued for the benefit of patients, and to make best use of the doctor's training and skills. No amount of delegation, use of ancillary staff or introduction of paramedical disciplines into primary medical care must be allowed to interfere with the primary role of the general practitioner — to listen to the patient, to examine and to give advice.

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## Primary health care authority

Sir,

John Noakes' editorial on the case for a primary health care authority (September *Journal*, p.355) ignores some of the fundamental changes at work within the National Health Service. By April 1993, about 70% of district nurses and health visitors will be employed by NHS trusts. These provider units will either be combined trusts working to achieve seamless care between the acute and community sectors or separate community trusts. The community services are likely to be monopoly providers and higher quality services will be achieved by purchasers setting standards.

A primary health care authority under the philosophy of the reorganized NHS would only be a purchaser, and one of its remits for those who are not fundholders could be to purchase community services. Management of community services could logically only be done by NHS trusts, or if there was a change in legislation, by general practitioners. This would only work, however, where a number of practitioners joined together, and it ignores the difficulties of the employment and pension rights of community staff.

District health authorities are tending to combine, and as purchasers are naturally liaising better with family health services authorities. There will be increasing pressures for the two types of authority to coalesce, and as purchasers, they will be interested in commissioning high quality, cost effective, appropriate and accessible services for their resident population. The correct balance between acute and community services will naturally follow from these objectives. A primary health care authority integrating health care delivery in the community setting would have been much easier to develop prior to 1991.

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## General practice advice to purchasers

Sir,

In his editorial (November *Journal*, p.450) Richard Maxwell rightly identifies the importance of advice to purchasing health authorities from general practice at district level.

In north Bedfordshire, an advisory group of general practitioners was established by the district health authority in December 1991. This group is well placed to influence purchasing on behalf of all the non-fundholding practices of north Bedfordshire, and has been successful in gaining for those practices many of the perceived advantages of fundholding. This model of purchasing has the advantage of greatly reducing the amount of negotiation required by both purchasers and providers, and enables the health authority to press for improved services while avoiding the destructive effects of unhealthy, unbridled competition.

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## Research in general practice

Sir,

I was disappointed to note that, in the excellent article by Richard Baker (October *Journal*, p.415) only 14% of the 287 practices assessed were involved in individual research and 9% in collaborative research.

Perhaps many general practitioners fail to realize that worthwhile research in general practice is possible without any expertise in pure research. My own interest in research in general practice came from a desire to obtain an MD. Having created an age–sex register I was able to follow up a group of obese patients for between five and eight years and compare them in various respects with a control group. Reading the relevant literature added further interest to the project. As most practices now have age–sex registers this type of research is relatively easy. The satisfaction afforded to me by this simple research encouraged my involvement in various small and interesting research projects, both collaborative and individual, over the next 30 years. Administrative problems and unusual clinical conditions are other areas which can be explored with benefit.

Research in general practice not only adds interest and enjoyment to one's work but improves the status of our branch of medicine in the eyes of doctors in other disciplines. I hope that my experience will encourage others to take up the challenge. Help with reviews of relevant literature and with statistical problems is readily available from the Royal College of General Practitioners.

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## Medical certification

Sir,

Dr Toon's discussion paper (November *Journal*, p.486) touches a field in which a number of doctors show themselves in a bad light, that of writing certificates for courts. Every certificate provides information about somebody, to somebody, for some particular purpose. If a general practitioner gives a certificate to a manual labourer advising him or her 'to refrain from work' a copy of it is little use to a court that wants to know why that person did not walk a quarter of a mile to come and give evidence. Similarly, a certificate stating that the defendant has arthritis or has never lied to the doctor has no bearing on the question of whether he or she went shoplifting and very little bearing on the severity of the sentence. Worst of all is the certificate that no one in court can read.

Most general practitioners believe that their patients can do no wrong, even though the average general practitioner has approximately two patients who are actually in prison. However, the carelessness and lack of imagination of some of us in writing certificates for courts is liable to be interpreted as incompetence and rudeness on the part of general practitioners in general. It is clear to me as a magistrate that it is not only the ethics of certification that are worthy of attention.

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