health checks, screening for early disease, and unsolicited advice ought to take second place, and only then if underpinned by proper sociological and psychological techniques.

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Health care needs assessment

Sir,

I am writing in response to Gillam's thought provoking editorial on the general practitioner's contribution to health care needs assessment (October *Journal*, p.404) and agree that a more coherent approach is needed.

First, a working definition of need must be reached. It seems most useful to define need as a capacity to benefit. Therefore if a person cannot benefit from a treatment or service they do not need it.[1]

Secondly, a distinction has to be drawn between assessing primary and secondary health care needs. District health authorities and purchasing consortia, along with the Department of Health, are attempting to assess needs for secondary health care, mainly by using the approaches outlined in the National Health Service Management Executive's discussion paper on needs assessment.[1] This is involving large amounts of work in determining the incidence and prevalence of disease and the effectiveness of treatment options. The conclusions reached are being used to influence purchasing decisions. However, general practitioner fundholders operate outside this system. If general practitioners are purchasing care without information on incidence and prevalence of disease or effectiveness of treatment options, how can they hope to improve the health of their practice population or use their budgets efficiently? Communication between district health authorities or purchasing consortia and fundholders must ensure the sharing of such information, especially as district health authorities are purchasing for dwindling populations. Fundholders must resist the temptation to purchase services or treatments whose effectiveness has not been adequately evaluated.

Thirdly, there is the issue of primary health care needs assessment. Increasing numbers of district health authorities and family health services authorities are providing information at a practice level for practice based needs assessment. Caution must be exercised in using such information. Even in large practices the number of people dying from common conditions will be small, consequently the confidence intervals around standardized mortality rates will be wide. Seemingly high standardized mortality rates may, in reality, not be statistically significant. If this point is not understood resources may be directed inappropriately.

While I agree with Gillam's assertion that numeracy and awareness of local services, negotiating skills and common sense are important in needs assessment, the most important key to the process, communication, seems to have been overlooked. Excellent communication between district health authorities or purchasing consortia and local practices will be needed regarding incidence and prevalence of disease and effectiveness of services, as well as information on appropriate methods of needs assessment at a practice level and the appropriate interpretation of data.

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X-rays and pregnant women

Sir,

Dr Edoman describes the case of a young pregnant woman sustaining a fracture of the radial head and being denied radiological examination (letters, October *Journal*, p.440).

Dr Edoman's report raises two points. First, since the treatment of a radial head fracture is simply to rest the arm in a sling and gradually mobilize the elbow as symptoms permit, this patient was not managed wholly inappropriately. In the rare event of complications, which would be diagnosed clinically and not radiologically, excision of the radial head is the preferred treatment and this should not be done until two or three months after the original injury because of the risk of myositis ossificans.

Secondly, this patient could have been spared a great deal of unnecessary pain and anxiety if someone had said to her that it was quite likely that she had a fracture of the radial head, it did not need an x-ray but that she would need to be kept under review to make sure no complications arose and that if they did, they would be treated appropriately. This poor woman was clearly the victim of a collusion of anonymity compounded by radiological uncertainty.

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Flourishing or floundering in the 1990s

Sir,

I read with great interest the stimulating editorial by Geoffrey Marsh.[1] He described the sweeping changes imminent in general practice, and foresaw large community health centres covering the widest aspects of primary health care, in which the general practitioner was the central coordinator. As would be expected, the article was argued persuasively and was well supported by references. I have no doubt it is a reasonable forecast of what our health planners have in mind and Marsh has done a signal service in drawing our attention to this prospect.

One omission seemed strange — the word 'consultation' was mentioned only once and almost incidentally. It is clear that with all the other duties mentioned consultation has been given a low priority in this vision of the future. Perhaps Marsh will recall a famous saying of one of his most distinguished teachers: 'The essential unit of medical practice is the occasion when a patient who is ill or thinks he is ill seeks the advice of a doctor whom he trusts. This is a consultation and all else in the practice of medicine derives from it'.[2] Nor has time altered the truth of this aphorism. In 1984 Pendleton and colleagues stated 'The consultation is the central act of medicine. To doctor and patient alike the general practice consultation is the medium through which medicine is most frequently practised'.[3]

Recently Stuart Carne, lately president of the Royal College of General Practitioners, referred to the 1980s as the golden