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.

BRUCE CHARLTON

Division of Epidemiology and Public Health
University of Newcastle upon Tyne
Newcastle upon Tyne NE2 4HH

MICHAEL P KELLY

School of Social Sciences
University of Greenwich
London SE18 6PF

References

1. Kelly MP, Charlton B. Health promotion: time for a new philosophy? [editorial]. *Br J Gen Pract* 1992; **42**: 223-224.
2. Charlton B, Kelly MP. Paying for an off-the-peg life: positive health, like any other commodity, is subject to fashion. *Times Higher Educ Suppl* 1992; 22 May: 19.
3. Kelly MP, Sullivan F. The productive use of threat in primary care: behavioural responses to health promotion. *Fam Pract* 1993 (in press).
4. Davison C, Frankel S, Smith GD. The limits of lifestyle: reassessing 'fatalism' in the popular culture of illness prevention. *Soc Sci Med* 1992; **34**: 675-685.

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.

DENISE KENDRICK

Department of Public Health Medicine and Epidemiology
University of Nottingham
Queen's Medical Centre
Nottingham NG7 2UH

Reference

1. National Health Service Management Executive. *Assessing health care needs. A DHA project discussion paper (EL (91) 41).* London: NHS Management Executive, 1991.

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.

P G WEAVING

The Surgery
Brampton
Cumbria CA8 1NL

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

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.

HUGH A F MACKAY

5 North Lodge
Chester-le-Street
County Durham DH3 4BA

References

1. Marsh GN. Flourishing or floundering in the 1990s [editorial]. *Br J Gen Pract* 1992; **42**: 266-267.
2. Spence J. *The purpose and practice of medicine*. Oxford University Press, 1960: 273-274.
3. Pendleton D, Schofield T, Tate P, Havelock P. *The consultation*. Oxford University Press, 1984: 1.

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.

D M G GOODRIDGE

Warders
East Street
Tonbridge
Kent TN9 1LA

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.

JAMES AYLWARD

The Health Centre
Oliver Street
Ampthill
Bedford MK45 2SB

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.

DENIS CRADDOCK

36 Lackford Road
Chipstead
Surrey CR5 3TA

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.

JOHN L STRUTHERS

27 Kellett Road
Southampton SO1 2PS