deal appropriately with the vicissitudes of life without recourse to drugs.

I am not sure how this process can be adequately recorded or audited, but it is an important aspect of a drug misuser's rehabilitation and needs to be observed, and to be part of the research agenda.

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Sir,

Leaver and colleagues (November *Journal*, p.465) found that 14 of their 29 patients on a methadone programme missed at least one booked appointment over a 26 week period while none of the non-drug using controls missed any. This is at variance with a survey performed in my practice in which heroin addicts (those smoking and/or injecting heroin) were followed up for a 13 week period from November 1990. At the time of the survey, the practice had 4860 registered patients, with three partners and one trainee. The addicts were seen by only two of the partners. Over the period only three appointments were missed out of a possible total of 59 by the 11 addicts (5.1%). This compares with a 5.2% non-attendance rate among all patients not known to be heroin addicts who made appointments over the same period.

The addicts in my practice were well motivated to attend regularly in order to receive their methadone prescriptions. The guidelines issued prior to treatment state 'If you fail to attend, or are late for appointments, no further prescriptions will be issued.' It is surprising that in Lever and colleagues' study none of the control patients failed to attend but this may represent a different practice population compared with that of my practice. Prior to my survey it was thought that heroin addicts receiving methadone were less likely to attend booked appointments than other patients, but this was not confirmed. Attendance may depend on how flexible the treatment programme is: if addicts know that failure to attend will result in them being removed from the treatment programme, their incentive to attend may be greater despite their, at times, chaotic lifestyle.

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Medical certification

Sir,

Dr Toon presents an unjustifiably adversarial view of medical certification (November *Journal*, p.486). The value to an employer of a medical certificate is to confirm that the sick employee has sought medical care. It carries the assumption that adequate and appropriate treatment is being provided. The employer's primary concern is that the employee recovers and becomes fit to resume work as soon as possible. The production of a certificate is not an end in itself. A main objective of a national primary health care service is to maintain a fit and efficient working population.

As a National Health Service manager I demand and expect priority care for any sick members of my own department so that they can return to their caring roles with the minimum of delay. I am sure all doctors would intervene similarly on behalf of their own staff. However, this raises some pertinent questions.

Should the general practitioner and specialist services of the NHS afford priority care to all sick employees in order to ensure their rapid recovery and return to work? What criteria should a general practitioner use in determining the period of time for which the medical certificate is valid? What degree of liaison should exist between general practitioner and occupational health physician in deciding upon optimum care for those in the working population who become sick?

These are questions of concern to all who believe that the *Health of the nation* refers not just to the physical and mental wellbeing of the community but to the existence of a fit and economically productive workforce without which the NHS itself will founder.

A CRAWFORD

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Sir,

Dr Toon's excellent discussion paper on the ethics of medical certification (November *Journal*, p.486) makes a timely contribution to the subject given the proliferation of third parties requesting information on patients.

The problem of role conflict needs to be addressed further. The present situation, where general practitioners allow themselves to act as patients' advocates at one point and as third party agents at another, makes a mockery of the issue of confidentiality. Although the patient's consent is sought before any information is disclosed, the service that a patient might require from a third party would not be obtainable without surrendering the rights to confidentiality between doctor and patient. The complacency of our profession in taking on two conflicting roles is somewhat surprising and is in contrast to the attitude of other institutions. The Catholic church, for example has made confidentiality in confessionals absolute. Similarly, journalists and the police go to great lengths to protect their informants.

Most medical certificates are only a bureaucratic exercise. One solution to the problem would be to place the onus on patients to provide their own certification and for third parties to contact doctors only if verification or clarification were required. This would then be similar to the Inland Revenue's attitude to tax assessment which places the onus on the individual to provide accurate information and an investigation is only conducted if fraud is suspected.

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Flourishing or floundering in the 1990s

Sir,

Marsh's article[1] and the correspondence from both Taylor and McCormick (letters, November *Journal*, p.492) reflect two of the more familiar arguments for the future face of general practice. But attention should be paid to, and debate directed at, the ethical conflict created by our apparent ready acceptance of our new role as businessmen within the new market-driven health care system.

This tacit acceptance by the profession is regrettable. There has been a wealth of published material from the longest running experiment in market force driven health care, the United States of America, that should make all doctors wary of mixing medicine with business. The editor of *The New England Journal of Medicine* initiated the discussion in 1980 by recognizing 'the new medical–industrial complex.'[2] Eleven years later Relman commented 'Today's market-orientated, profit-driven health care industry therefore sends signals to physicians that are frustrating and profoundly disturbing to the majority of us who believe our primary commitment is to patients. Most of us