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.

PETRE T C JONES

149 Altmore Avenue
East Ham
London E6 2BT

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.

DAVID M COOMBS

Bedford Avenue
Rock Ferry
Birkenhead L42 4QJ

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

Department of Community Dental Health
Mauldeth House
Mauldeth Road West
Manchester M21 2RL

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.

K R BISHAI

Chigwell Medical Centre
300 Fencepiece Road
Ilford
Essex IG6 2TA

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

believe we are parties to a social contract, not a business contract.'[3]

Already the first wave of enthusiastic fundholding practices have embraced the purchasing and selling of patient care by the creation of services owned by these practices, and have pointed to the resulting improvement of care for their patients. But there are losers. My practice has 6000 patients, too few for fundholding under the current Department of Health guidelines (Oxfordshire Family Health Services Authority, personal communication). My patients now suffer from a two tier system, and do not always receive the best medical care, not for lack of perceived medical needs but for business reasons — lack of fundholding money. This state of affairs was explicitly admitted to by our local medical committee (Oxfordshire local medical committee, minutes of meeting held 22 October 1992). To accept that by managing this market place, we as general practitioners will be able to create a just distribution of good health care seems, therefore, to be without foundation.

Holland, when commenting upon the approach of the Netherlands to their health care crisis, noted that the problems 'cannot be solved by structural change and, least of all, by introducing a market that has no underlying philosophy' and continued that 'The Dutch approach of accepting that in a market situation the losers will be those procedures that are inadequate or inappropriate, rather than the weak and the disabled, is a salutary lesson to us all.'[4]

The drive for change came partly from the growing awareness that at some point rationing has to occur, a process that implicitly results in the practice of non-voluntary euthanasia.[5] The ethical principle that demands to be applied to this social dilemma is justice, not market forces. We as general practitioners are advocates for each of our patients as individuals, not for populations, a responsibility which lies with society. It is as members of our society that we should lend our voices to the debate on rationing.

ANDREW BROWN

The Surgery
Burford
Oxford OX18 4LS

References

1. Marsh G. Flourishing or floundering in the 1990s [editorial]. *Br J Gen Pract* 1992; **42**: 266-267.
2. Relman AS. The new medical–industrial complex. *N Engl J Med* 1980; **303**: 963-970.
3. Relman AS. The health care industry; where is it taking us? Shattuck lecture. *N Engl J Med* 1991; **325**: 854-859.
4. Holland W. Choices in health care. *J R Coll Physicians Lond* 1992; **26**: 390-392.
5. Harris J. *The value of life.* London: Routledge, 1985.

Suicide rates

Sir,

David Aldridge's review of suicidal behaviour (November *Journal,* p.482) was timely following the government's white paper *Health of the nation.*[1] Targets for mental health include a reduction in overall suicide rates by at least 15% by the year 2000. It is to be hoped that the development of local and national policies to achieve the targets will lead to an overall improvement in the quality of life of those suffering mental ill health and a reduction in suicide rates. Aldridge addresses the importance of treating individuals who attempt suicide within their social context, however, from the British perspective certain statistics need clarification.

The author highlights the current concern with increasing suicide rates in young people (this is mainly seen in adult males aged less than 45 years[2]). He goes on to state that there is an increase in the number of suicides among older people. However, in England and Wales the rate of suicide among those aged 65 years and over has declined since 1946–50. Charlton and colleagues report that the rate of suicide among adult men aged 65–74 years has fallen from just over 40 per 100 000 (1946–50) to approximately 15 per 100 000 (1986–90).[2] Similar reductions have been seen in those aged 75 years and over. The rate of suicide among women aged 65 years and over has also decreased substantially although the overall rate is considerably lower than that for men. Despite these reductions the rate of suicide in older age groups remains higher than among those aged less than 45 years.[2]

Dr Aldridge goes on to predict a widespread social tragedy resulting from the social upheaval and dislocation currently occurring in continental Europe. Whereas these changes are clearly a cause for concern, the effect on suicide rates is less certain. It is of note that during both the first and second world wars there were marked reductions in suicide rates in England and Wales.[2] The disruption occurring in England and Wales at that time, however, may have been of a different nature to that seen currently in Europe.

The rate of suicide in England and Wales compares favourably with that in many of our European neighbours. The rate of death by suicide and self inflicted injury when standardized by age against the world standard population was 6.0 per 100 000 population for England and Wales in 1989. Comparable rates per 100 000 were: 11.8 in West Germany (1989), 15.9 in France (1989), 14.9 in Sweden (1988), 8.3 in the Netherlands (1989), 10.2 in Poland (1989), 17.6 in Switzerland (1989), 18.9 in Austria (1989), 5.5 in Italy (1988) and 5.7 in Spain (1987).[3] Sainsbury and Jenkins suggest such international comparisons are valid despite differences in reporting procedures.[4] These figures suggest that suicide is less of a problem in this country than elsewhere in Europe. However, this is not to belittle the problem; most deaths from suicide are tragic and the government's focus on this group is to be welcomed. The ability of the health service to reduce rates of suicide must be considered in the wider context of the many factors outside health service control which may also influence these rates.

D J GUNNELL

Somerset Health Authority
Wellsprings Road
Taunton
Somerset TA2 7PQ

References

1. Secretary of State for Health. *The health of the nation: a strategy for health in England (Cm 1986).* London: HMSO, 1992.
2. Charlton J, Kelly S, Dunnell K, *et al.* Trends in suicide deaths in England and Wales. *Population Trends* 1992; **69:** 10-16.
3. World Health Organization. *World health statistics annual.* Geneva, Switzerland: WHO, 1990, 1991.
4. Sainsbury P, Jenkins J. The accuracy of officially reported suicide statistics for purposes of epidemiological research. *J Epidemiol Community Health* 1982; **36:** 43-48.

Request for information about gout

Sir,

Little is known in detail about the epidemiology of gout, and the information required can come only from general practice. May I ask any general practitioners who keep a register of sufferers from gout if they would be willing to let me know. No details are required in the first instance, but I will send anyone who replies the questions to which I hope to get answers — mainly the number, age, sex and treatment of the patients concerned.

One aspect of the study will be to see the extent to which prescribing data about allopurinol may serve as a guide to the prevalence of the condition in a practice population.

I will be grateful for all replies to the address below (or tel 0532-336770) and subsequent information.

C M HARRIS

Prescribing Research Unit
Academic Unit of General Practice
University of Leeds
26 Clarendon Road
Leeds LS2 9NZ