

1994 on the involvement of clinicians in commissioning and purchasing care (organized jointly by the Institute of Health Services Management and the Conference of Medical Colleges and their Faculties in the UK) to 'base contracts on consensus' involving clinicians and patients as well as managers. He was referring to the conclusions of an NHS Executive task force set up in response to professional concerns that purchasers were not seeking clinical advice. It seems that while successive NHS Executive letters were advocating clinical involvement in purchasing decisions,¹ the dominant market ethos in many localities kept clinicians out of the process. Provider as well as purchaser managers often perceive clinicians as having conflicts of interest which may affect clinicians' negotiating stance over contracting. Current health service guidance (which is still being discussed) makes clear the requirement of health authorities to ensure that the professions are involved in the full range of health authority work and discusses ways of achieving it.²

The secretary of state's announcement of the expansion of fundholding together with the publication of a document on primary care led purchasing³ means, however, that the commissioning agenda has already moved on. The focus is now on the purchasing decisions of fundholding general practitioners. The debate is not how 'non-professional' commissioners can make valid decisions but is around the legitimacy of general practitioners' responsibility for purchasing as well as providing care. How will general practitioners resolve the ethical dilemma this raises in the balance between personal and public health priorities? How will they make their decisions on purchasing services and from where will they get their information?⁴

Identifying and overcoming the difficulties of obtaining sound, unbiased, local professional advice is necessary to ensure uniform quality of care across the NHS. Research undertaken in South Thames (West) Region has confirmed that both managers and clinicians are happy to rely on local advisory mechanisms for day-to-day contracting problems but that external guidance is considered necessary for major investment and strategy decisions.⁵ The two groups differed on the relative importance of local advice versus published national effectiveness data: commissioners considered local professionals as only one of the sources of professional advice to be used in coming to a decision, while clinicians thought their own views should take priority. General practitioner fundholders preferred to rely on their own

experiences and contacts with local clinicians rather than try to assimilate all the national effectiveness literature. In practice this may be a legitimate stance but puts the onus back onto providers to offer only effective care.⁶

Public health physicians were considered by managers and clinicians to have a central role in these negotiations on service changes, having an appreciation of clinical as well as managerial issues, understanding the process of critical appraisal and being able to take a non-partisan population perspective. Despite this, many new commissioning agencies are now being established on the basis of a primary care led service with the public health role being questioned.⁷ A primary care led health service is a new health policy that still has to prove itself. New health commissions should bear this in mind.

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Facilitation projects

Sir,
We are pleased to see a report from the Royal College of General Practitioners

focusing on the special and challenging needs of inner-city primary care.¹ We welcome its emphasis on seeking solutions rather than on identifying problems. The information is a valuable review of the literature and confirms the key issues in and obstacles to delivering primary care. We are concerned, however, at the lack of references to the role and contribution of facilitation projects in recent years in enabling solutions to long-standing problems in primary care.²⁻⁴

In the original work of the Camberwell primary care development project, a number of key principles emerged which underpinned our activities: support would be offered to all practices; areas of work would start from issues of importance for local practices; regular contact with practices (both in person and in writing) would be critical to reduce isolation and increase involvement; support would empower the primary health care teams to serve the needs of their local populations, as well as local people themselves; and that one of the most important enablers of change was education.

Meetings between members of the Camberwell project and the Liverpool primary health care facilitation project⁴ highlighted shared common principles and experiences and we believe these shared principles and experiences to be important in our achievements. We wanted to see if other long-term facilitation projects elsewhere in the country had similar experiences and were delighted when the King's Fund centre for health service development offered to organize and run a workshop. The aim was to share experiences and knowledge, and to identify common processes and methods of working which were key factors in achieving sustained change in primary care. Representatives of projects from London, Sheffield, Norwich, Cardiff and the Welsh valleys, Birmingham, Leeds, and Newcastle attended the workshop. We are surprised that only three of these appear to be mentioned in the inner city task force report.¹ The day produced considerable consensus, and a report of the workshop and a summary of the projects' activities are to be published.⁵

The inner city task force report makes little mention of the role of education as a key enabler of change, and gives little specific advice and few references to projects that have improved teamwork. We note the comments in advice given to the Culyer report⁶ that there is a lack of peer review journals covering development work, and that education was highlighted in the evidence given to the task force as an excellent way of disseminating research-based changes in practice.

There are many statements on the need for more people and resources in primary care (which we strongly support), but the need for good teamwork becomes even more important with increasing numbers of people working together.

Permanent change in primary care is often slow and the stress of providing facilitation work can be hard, matching the stresses encountered by those we seek to support in the primary care setting.

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Research and development in primary care

Sir,
The Culyer task force urged the National Health Service Executive that 'it is time to place [research and development] in primary and community care settings on an equal footing with the acute sector.'¹ The potential problems in promoting research across the whole primary care team are formidable,² but both in health services³ and social services⁴ the last year has seen many fresh opportunities arise for introducing new research projects and service developments in primary care.⁵

Over the last year, an interprofessional group interested in promoting research and development in primary health care has begun to coalesce in East Anglia. Parallel developments in the neighbouring

Trent region were an early inspiration. Professional bodies including the Royal College of General Practitioners and Royal College of Nursing provided helpful advice and the former East Anglia Regional Health Authority stimulated much fresh thinking locally by funding some primary care initiatives at Cambridge University. Those working in general practice, community paediatrics, health visiting, occupational therapy, psychology, management, clinical audit, established hospital research units and various university departments offering postgraduate training, as well as patient advocates and scientists already researching primary care, all contributed to addressing such issues as the priorities for local research, gaps in training or support, and opportunities for collaboration (primary care research networks). Collectively and individually, we were able to provide a wealth of ideas in response to a recent postal consultation that originated from the new Anglia and Oxford Region.

This seems to be a good example of what the NHS Executive set as goals:³ to work with NHS staff to identify and prioritize the research and development requirements of the service; to work with others to ensure an adequate supply of skilled staff to undertake the research and development needed by the NHS; and to develop alliances between the NHS and the research community.

Primary care professionals in East Anglia from any background are welcome to join us as participants or corresponding members (our next meeting is here at Douglas House on Tuesday 26 September, 1995). From Northern Ireland to Wessex, infrastructure is growing for research and development, and we suspect that many enthusiasts around the United Kingdom are working along similar lines in mapping out the new frontiers of research. May I invite readers of the *Journal* who are at any stage of this learning curve to let your peers in East Anglia know what progress is being made.

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Records, law and paternalism

Sir,
The Court of Appeal's recent recognition of a person's common law entitlement to access to his or her medical record is a welcome clarification for doctors in the United Kingdom of the law regarding access to records not covered by legislation, but risks supporting a paternalistic and restrictive approach to access.

In R v Mid Glamorgan Family Health Services Authority, ex parte Martin^{1,2} the Court of Appeal decided that a health authority, in common with a doctor, is under a common law duty to allow access to the record except where this would not be in the person's best interests, for example where detrimental to the person.

Under the data protection act 1984, as modified,³ and the access to health records act 1990, individuals have statutory rights to see their medical records. However, the former applies only to records stored electronically, for example on computer; the latter applies only to records made on or after 1 November 1991. *Martin* now establishes the general circumstances in which persons whose manually held records were made before 1 November 1991 are entitled to access.

Mr Martin, aged 45 years at the time of trial, had as an adolescent received psychiatric treatment by the authority's doctor. He wanted to understand his past treatment and move on psychologically, believing that inspection of his record would help this process. It seems that the Court of Appeal, which ruled that Mr Martin should not see the records because it would be against his best interests, was influenced by the opinion of a consultant psychiatrist. Although never having seen Mr Martin but having read his records, the psychiatrist believed that access would be detrimental. Arguably, such opinion, without assessment of a person's current health or competency, is inappropriate paternalism.

Moreover, the Court of Appeal's reference to detriment alone seems insufficient. Although general rules may be helpful, they are too vague and inconsistent with law regarding disclosure of personal