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 services[3] and social services[4] 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