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.

TYRRELL EVANS
GERALDINE BLACHE

South London Education and Development Unit for Primary Care
Department of General Practice and Primary Care
King's College School of Medicine
Bessemer Road
London SE5 9PJ

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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.

WOODY CAAN

Lifespan Health Care
Douglas House
18b Trumpington Road
Cambridge CB2 2AH

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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

health information generally where issues of autonomy, harm and quality of care are at stake. Cases from Australia[4] and the United States of America[5] and British legislation (for example, the access to health records act 1990, section 5;1a) show that there must be a likelihood of harm and that the harm must be serious.[6]

Doctors have the opportunity, however, to interpret the decision in *Martin* generously, in a way that seeks to enhance patients' autonomy, affirm their interests in personal health information, and respect their capacity to work through information which might, from a paternalistic view, seem too detrimental to disclose.

DERMOT FEENAN

25 Rathkeltair Road
Downpatrick
County Down BT30 6NL

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Audit in summative assessment

Sir,

I read with interest the paper by Benett and Hayden discussing audit as part of summative assessment.[1] The establishment of vocational training for general practice was an important step in the reform process of the health system in Hungary almost three years ago. Nowadays the introduction of audit into general practice is another important task.

Developing a relevant final assessment at the end of vocational training is of fundamental importance because it can influence the work of future general practitioners. Despite continuous evaluation during vocational training in Hungary, trainees' basic knowledge of family medicine, their clinical competence and their consulting skills are tested at the end of the programme. The opinions of general practitioner trainers and clinical tutors are also considered. However, having read Benett and Hayden's paper, I think that using audit as part of summative assessment is an interesting idea. It could extend the use of audit in general practice in Hungary, with future general practitioners using audit in their everyday work.

Implementation of such a system has several preliminary requirements, the most important of which are the establishment of specific training sessions on audit for trainers and trainees, finding relevant areas of clinical activity for auditing, and gaining agreement from those university medical schools responsible for general practice vocational training in Hungary. I thank Benett and Hayden for the idea of audit as part of summative assessment of vocational training.

ISTVÁN ILYÉS

Training Centre of Family Medicine
University Medical School
POB 53 Debrecen
Hungary H-4012

Reference

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Preventing skin cancer

Sir,

In his paper discussing the prevention and team management of skin cancer in general practice, Jackson demonstrates the role of the enthusiast in providing a service akin to secondary care in a primary care setting (February *Journal*, p.97).

New initiatives are needed as skin cancer is reaching epidemic proportions,[1] albeit causing few deaths (1.6% of cancer deaths in the south west of England[2]). This trend is likely to continue as we are now seeing the cumulative effect of sun exposure throughout life. Longevity, foreign holidays and ozone depletion add to the problem and many mothers ignore advice to protect their children.[3] The much vaunted *Health of the nation* target of halting the year on year rise in skin cancer[4] now seems a far cry.

What should the primary health care team be doing about this problem? It is clearly not feasible for every practice to run such clinics described by Jackson as there is a dearth of suitably trained physicians. Those who are interested are not encouraged to start them as funding through the former health promotion clinic system has been stopped. This negative move caused the demise of a 'mole-check' clinic in my surgery.[5]

Clinics provide focused advice to patients, but must be supported by the written work. Some educational materials have been produced for use in general practice including the 'play safe in the sun campaign' supported by Boots the chemists and the Cancer Research Campaign. There are, however, no British leaflets that explain how to recognize non-melanoma skin cancer. This is surprising as non-melanoma skin cancer conveniently appears on exposed skin sites, and patients in my practice had no difficulty in identifying their own basal cell carcinomas from leaflets produced by the American Skin Cancer Foundation. This foundation produces a whole range of support materials for those involved in skin cancer awareness campaigns.

There is no United Kingdom equivalent to the American Skin Cancer Foundation, but a working party has been established under Professor Rona MacKie to advise the government on *Health of the nation* targets. There are no general practitioners in this group. Primary health care teams are ideally placed to give advice focused on those at risk, without causing anxiety among the general public or diminishing the natural enjoyment of sunshine. Much can be achieved at low cost, but not without help including training, educational materials and financial encouragement to run initiatives such as skin cancer clinics.

RUPERT JONES

Roborough Surgery
1 Eastcote Close
Plymouth PL6 6PH

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Videotaped consultations

Sir,

Campbell and colleagues' discussion of the acceptability of videorecording general practice consultations demonstrates a recognition, if not an acceptance, of the considerable disquiet generated both within and outwith the profession by the use of