Editorial

CONFIDENTIALITY AND THE MORBIDITY SURVEY

THE question of confidentiality of medical records is one which has vexed practitioners for some time now. That records of patients' attendances and clinical details of their illnesses are essential is nowadays universally accepted. It is no longer acceptable that the family doctor stores these things in his head and relies on his memory to recall the essentials. Patients now are passed from consulting room to hospital and from one hospital department to another, followed by an ever increasing volume of notes and reports. The number of ancillaries and secretaries to whom private information about them is accessible is quite large. The confidentiality of clinical notes and letters is understood by those who handle them. Suspicion is likely to be aroused when the impersonal computer is called into service. For this reason doctors and planners have expended much time and thought in finding ways to make these records completely secure. Nevertheless it is surely right that a close watch be kept on all research activities in which patients' records may be used.

If the confidentiality appears, on sound evidence, to have been breached, the press and the politician have a duty to the public to draw attention to what is happening. They should first enquire closely into the situation to establish that it is in truth as they suspect before taking the matter further.

The statement which follows has been drawn up by those responsible for the planning of the second National Morbidity Survey:

The undoubted success of the first National Morbidity Survey (England and Wales 1957) published in three volumes, still the only study of its kind, imposed a duty on the College to conduct further surveys of a similar type. It is not usual to anticipate the conclusions of a scientific study by describing the method used in detail. However, the exceptional circumstances precipitated by statements in the press and by parliamentary exchanges call for some explanation.

The second National Morbidity Survey initiated by the College and supported by the Office of Population Census and Surveys will be based on information regarding the illnesses about which approximately 25,000 patients consult their general practitioners throughout a year.

The first phase of this study, the establishment of the main file in the computer of the OPC and S at Tichfield, began in May 1970 and is now completed. The main file consists only of the code for each individual in the defined population, the patients on the practice lists of the 55 participating practitioners. The code—the 'Hogben number'—consists of the first three letters of the patient's surname, the first letter of the patient's first forename and the full date of birth. This information was abstracted and coded from the practices' age–sex registers prepared by the respective executive councils. After the main computer file was checked for accuracy, these age–sex registers were returned to the general practitioners. Thus no individual patient once in the computer file can be identified except by matching his code with records in the consulting room of his own practitioner.

The second phase of the study, the recording of diagnoses, began on 15 November,

when general practitioners and their staffs began entering on standard disease index ledger sheets the following information:

Code number of practice

Patient's gender

Patient's identification and date of birth

Code of the diagnosis made at the doctor–patient contact

Date of onset of the illness

Coded information about referrals, subsequent consultations and any changes in diagnosis (again coded).

No intimate personal details or full medical histories are recorded on the disease index ledger sheets. Only the data precoded by the practitioner or coded by the punch operator will be admitted to the computer file.

By February 1971, this data will begin to be received at Tichfield where punch operators will punch the coded information and the code for the individual patient for entry into the main computer file. Immediately after this procedure has been completed, the disease index ledger sheets will be returned to the general practitioners. Any other data required subsequently from the practitioners whether related to the patient's illness or to other characteristics will be requested by using the patient's code only. The computer will essentially produce similar tabulations to those published in the first morbidity survey in 1957.

This short description will help to correct the incomplete statements which have been made about this study and will emphasize the great care taken to conserve confidentiality.

A full description of the methodology for this study will be published as soon as is practicable after the completion of the survey.

MICHAEL BALINT

WE learn with deep regret of the passing of Dr Michael Balint on 31 December 1970. In his lifetime his name became a byword in general practice; it is likely to remain so for a very long time. His seminars at the Tavistock Clinic were attended by numbers of general practitioners who will carry on his teaching. After the publication of his classic *The Doctor, His Patient and the Illness*, in which he detailed and illustrated the techniques that he used, these seminars became internationally known. His frequent addresses at conferences and congresses were always lucid and attracted large, appreciative audiences. He showed how it was necessary for the family doctor to learn about himself, to recognize his own reactions to the patient, as well as how to listen, not only with his ears but also with his eyes and his intuition. He taught how to bring comfort and health into many unhappy households. Patients and doctors are the better for the wisdom of Michael Balint.