Editorials

CONFIDENTIALITY IN GENERAL PRACTICE

IS modern medical practice threatening confidentiality?

Doctors can only do their work properly if they know all the relevant facts—but patients often want to keep some of these facts secret. Confidential information is what the patient does not want the neighbour to know. In recent years it has become more difficult to keep things quiet: in the future it is going to be harder still.

Records

Team work in general practice means that many more people now have access to patients' records. If two doctors work with a nurse, a health visitor, and four secretaries, eight people can see the notes. If four such teams work together in a group practice, eight doctors, four nurses, four health visitors and 16 secretaries number 32. The chance of any individual patient being a neighbour, friend or enemy of one member of the staff, who might be interested in the notes has risen considerably. How often is confidentiality considered in relation to optimum group size?

General practice has changed. In the last 40 years there have been great advances in the understanding of human development and behaviour. Emotional factors are significant in at least a third of all consultations, so generalists are constantly dealing with patients' fears and feelings. The kind of information handled has become more sensitive and this will continue.

Records are becoming fuller and more detailed, and are now documenting behaviour. In the past single-handed practitioners could afford not to record many intimate details: nowadays it all goes down in the notes. Diagnosing alcoholism, for example, may involve detailing aberrations of behaviour or conflicts with the police or other authorities.

Furthermore, in the National Health Service these notes are all marked government property, and have to be passed through at least two health service offices every time a patient moves from one executive-council area to another.

In 1974 the new regional and area health authorities will bring together for the first time the three branches of the British National Health Service and more exchanges of medical information will follow. Similarly, the Seebohm social service departments, although somewhat unsteady at present, will find their feet eventually. Many social workers regard the medical tradition of confidentiality as unreasonably restrictive—if not anachronistic. They will seek more access to medical records in the future.

As society becomes inevitably more complex, so the rules requiring statutory notification will be expanded. Yesterday the problem was the epileptic train driver, today there is concern about mentally-ill doctors, and tomorrow there will be more demands from the community for information about individuals.

Computers

Finally, computers are coming and this *Journal* has already published several papers from practitioners already using them. The British Medical Association Planning Unit (1969) wrote, " We do not consider that computer-based medical record systems give

an inherently lower degree of confidentiality than manual systems, rather the reverse ". We disagree.

Reassuring statements like this arise because computer experts stress that they can build security locks into the system and can limit access to graded information to authorised users. This may be true, but the problems in practice will be not only of access but of guarding output.

Computers produce information either through television-like visual display units, which are expensive, or on printouts of various kinds. Will the houseman read and destroy the printout every time? Or will it be kept to be read by the consultant, the registrar and the nursing staff? Will these highly-detailed records be any more secure than the present ward notes? If parity is basic obstetric information, how will a woman going into hospital to have a baby conceal a previously adopted child or an abortion?

Computers, regardless of safety keys or restrictions on access, will disseminate personal information much more widely. If general-practice records are computerised, as is already happening in several centres, a major step is taken towards a medical data bank. The next step is record linkage, and if this becomes widespread the information known to the personal doctor may be provided for hospital and perhaps clinic doctors.

Patients at present are protected by their general practitioners whose referral letter now only gives information relevant to the current complaint. Are psychiatric and sexual histories to be printed out every time a patient goes to hospital for a bunion? Is it likely that general surgeons and orthopaedic consultants are going to accept exclusion from these areas of the records? If they are allowed access, how far will they delegate this right?

What can be done?

Many developments now threaten confidentiality. So what can be done? First it is necessary to recognise that new ways of working, like teams, and new machines, like computers, bring new problems. A continual dialogue is needed if the tradition of centuries is to be maintained. The College has done well to form a working party and to debate this subject in the Council. The Medical Recording Service of the College (1973) has also just issued a new tape on this subject. Crombie today emphasises the central importance of the general practitioner and his records, and his distinction between primary and secondary files is most helpful.

Special attention must be given to the quantity and quality of information transmitted between doctors especially in referrals for routine simple procedures. The patient's consent for disclosure now needs continual thought. Surely patients should participate much more in deciding how far their secrets should go?

Many practitioners feel strongly about confidentiality, and many of their staff are meticulous in observing the rules, but how many general-practice staff have a confidentiality clause in their contracts of employment? Would not such clauses both underline the importance of confidentiality and simultaneously protect both patient and doctor?

Architects have to be briefed. How many new group-practice buildings and health centres allow voices to be heard from consulting or examination rooms? How many waiting rooms can overhear the practice office? How many telephone calls are answered within earshot of other patients? Do doctors, when planning buildings, often enough *demand* an adequate standard of soundproofing?

All the responsibility does not lie with doctors. If the public wants greater medical confidentiality it is open to Parliament to provide for the general practitioners of medicine the legal privilege it has already provided for the general practitioners of the

law. What people tell their solicitors is privileged: the doctor has no such protection in court.

The future

Much of primary care will always depend on patients talking frankly and freely to their doctors about their families and themselves. Patients will soon get a poorer service and doctors much less professional satisfaction if people become afraid to talk. Already some patients are beginning to say, " Please don't write it down, doctor ". What is this but a plea for more confidentiality?

General practice now faces the challenge of ensuring that the administration of the team, the soundproofing of the rooms, the arrangement of the records, the control of the computers, and the whole practice organisation, as far as possible, combine to keep the concept of confidentiality.

REFERENCES

British Medical Association Planning Unit (1969). London: B.M.A.
Medical Recording Service Foundation of the Royal College of General Practitioners (1973). *Quests in general practice: the quest for confidentiality.* Tape 73/67. Chelmsford: M.R.S.F.

DR E. V. KUENSSBERG

DR E. V. Kuenssberg's three-year term as Chairman of the College Council ended in November. His prime-ministerial qualities had been known long before his election as chief executive, but in office he developed still further. Not only was he able to keep himself fully aware of all the scattered activities in the College but he was constantly in the thick of all the action.

Dr Kuenssberg's remarkable mind and endless energy created much of the activity. The College has never been so busy and has rarely been guided so effectively.

Looking back, three characteristics stand out. First, he had a rare readiness to consider new ideas, secondly he never became remote and he remained approachable, and thirdly he had a great interest in younger doctors with whom he spent much time and many of whom he greatly encouraged. It is good news that he has just been awarded a Woolfson travelling professorship which will spread his ideas and optimism even further afield.

Not only the College, but general practice as a whole has reason to be grateful for Dr Kuenssberg's leadership during these last three hectic years.

LEICESTER IN THE LEAD

IT is becoming difficult to keep track of academic developments in general practice as the pace is accelerating so fast. In our editorial *The first English chair* (February 1972 *Journal*) we welcomed Professor Byrne to the first chair of general practice in England, yet now, only 22 months later, Dr Marinker becomes the ninth general practitioner to become a university professor in the British Isles.

The Leicester appointing committee has shown vision and imagination. It is notable that for a chair of community health they have selected, from an outstanding field, a general practitioner in active practice, without an M.D., an M.R.C.P., or any