variations, and the other is that no idea is given of the outcome in the various groups.

The paper is useful in classifying antibiotic prescribing, but there must surely be well-conducted clinical trials (which on the evidence Dr Howie presents could ethically be double-blind) before we can tell whether the agreement on clinical care is justified. Are the younger doctors being over influenced by the advertisers?

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REFERENCE

Howie, J. G. R. (1973). *Journal of the Royal College of General Practitioners*, **23**, 895-904.

DELAY PATTERN ANALYSIS IN CLINICAL AUDIT

Sir,

Hodgkin may be right in the November *Journal* in suggesting that the main impetus for evaluation must come from the doctor himself. However, in proposing delay pattern analysis (DPA) as a method of evaluating clinical performance, he has ignored some basic issues.

(1) "*Delay is capable of measurement*"

This is literally, of course, true; but what of the accuracy and reliability of measurement?

Delay in reporting. Measurement here is based on the assumption that delay is to be measured from the onset of particular symptoms or symptom-clusters: e.g. cough—carcinoma of bronchus; altered bowel habit, blood mucus—carcinoma of rectum.

This assumption is plainly untenable—as is well illustrated by his own comment that " . . . in almost every case, the long delays arose because the the carcinoma (of lung) arose in someone with already established chest disease". Equally difficult to accept are his periods of patient reporting delay in myxoedema—for the same reason.

Delay by the doctor. This too, has major difficulties in measurement. Delay of what? The answer in his Fig. 1 is "before action is taken": in table 5 it is "diagnosis". Yet vigorous early action may paradoxically delay diagnosis (e.g. his statement "a high index of suspicion may be counter-productive by leading to early, falsely negative, results") and accurate diagnosis may even delay effective action (e.g. his patient whose carcinoma of breast lay untreated for 26 weeks because of four previous negative biopsies).

The importance of what is here being measured may thus be obscure. So, in many situations, is its end point.

Before concluding that "the widespread circulation of similar delay pattern analyses by interested doctors . . . has considerable potential". Hodgkin must demonstrate that the measurements of delay for a given situation have high reliability in the hands of multiple observers. However much self-motivated criticism reduces distortion or manipulation of "key facts", the matter of observer variation must be considered.

(2) *Delay is capable of analysis*

True again, but the analysis of such uncertain measurement serves only to compound confusion.

(3) *Consensus criteria*

"If DPA is performed . . . by different doctors, it is possible to produce a consensus picture *that will allow doctors to evaluate their own performance*".

This is true but only in consensus terms. And this may be counter productive. Thus, for example, by deciding to x-ray the chest of every cigarette-smoking male patient complaining of cough, the stomach of every patient complaining of ulcer type dyspepsia, the doctor could doubtless improve his DPA ratings in competition with his peers.

But whether this would represent an improvement of care is perhaps questionable.

Before we rush into delay pattern analysis perhaps we should pause and think about observer variation, reliability, validity and consensus criteria. Clinical audit is far too important a subject to do otherwise.

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IMPORTANCE OF GENERAL-PRACTITIONER LISTS

Sir,

Dr Donald Crombie (December *Journal*) emphasises the significance of the general-practitioner lists as the one basic unit of population in the health service—the one exclusive sub set—in relation to records and research. I should like to re-iterate its importance to the planning of services and buildings. Trying to plan for primary care in relation to arbitrary geographical areas, when real units—the general-practitioner lists—already exist, is both laborious and unsatisfactory.

Not only do these real units exist, but machinery for their maintenance and checking is in continuous operation and its margins of error are known: the size and content of every unit is always currently available, without the need for extrapolation from intermittent surveys. By using the general-practitioner lists planners can take account of the patient's freedom to choose his own doctor, whereas when services are provided in relation to a geographical area economic considerations require that all residents of that area be persuaded to use the appropriate centre. This element of direction runs counter to a basic principle of primary care, and it also weakens the motivation, which competition supplies, towards maintaining and raising standards of care.

Crombie asserts that " at the main level of regions and areas no problems of incongruity of populations will arise. " This will only be true in so far as the districts can solve their boundary problems, and at present the complicated administrative arrangements necessary to allow attached

nurses to cross county boundaries are typical of the problems that are to be perpetuated.

More seriously—in view of the capital outlay represented by the current building programme—it will remain impossible to define with any precision the population to be served by any given health centre. The main component—the aggregate lists of the participant general practitioners—is easily assessed, but there is always a group of nearby residents for whom the centre is the appropriate local source of certain services. The overlap between the two components can seldom be estimated with any accuracy, so provision of staff and buildings must always err on the safe side, and any advantage in the dual system must, surely, be outweighed by the costs of this manoeuvre.

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REFERENCE

Crombie, D. L. (1973). *Journal of the Royal College of General Practitioners*, **23**, 863–79.

CONFIDENTIALITY IN GENERAL PRACTICE

Sir,

The Editorial *Confidentiality in General Practice* (December *Journal*) asks whether modern medical practice is threatening confidentiality. In the same issue Dr Crombie refers to the need to preserve the important ethical principle that a confidence given to a doctor by a patient must never be divulged without the clearly expressed permission of the patient (to which one might add also the patient's legal guardian). The report from the Awards and Ethical Committee makes the same point. No doctor would wish to deny the importance of this principle and Dr Crombie and the Awards and Ethical Committee are to be congratulated on drawing to the attention of the profession its fundamental importance in the preservation of the mutual trust that permeates the relationship between doctor and patient.

As you, Sir, rightly imply, in your Editorial, the behavioural component of a patient's clinical problem is now recognised as being a major factor in making an adequate clinical assessment, and that it may involve information of a sensitive nature. Although there are few hard data to indicate that present methods of handling clinical data in general practice are leading to widespread breaches of confidentiality, it is right that we should be giving serious consideration to this question. It is certainly a potential problem of significance. The crux of the problem is how we should handle the sensitive, largely behavioural, information.

Documentation

General practitioners accept the need for information about past clinical events. To trust to the doctor's memory is unreliable and inefficient, to trust to the patient's memory may be equally so. Therefore, information should be documented. Most of the information that is contained in a patient's clinical notes is derived from the patient. The only exception being when information is obtained from a third party or when the doctor adds his own thoughts. If all information contained in the record was known to the patient (much of it will be anyhow), there would be no objection in principle to the patient being the custodian of his own clinical notes and charged with the responsibility of producing them when he had need to consult a doctor. Such a possibility might strengthen the doctor-patient relationship.

In practice this very situation occurs more often than we realise. Take, for example, the patient who has newly joined a practice; his notes may not be received for months and in the meantime we rely (generally successfully) on what the patient tells us. Take also the situation that so frequently arises when we do eventually receive the notes; they are so scanty or illegible as to be largely meaningless; again we are forced to rely on the patient. The same situation occurs when we see a temporary resident.

If the patient were to be the custodian of his own clinical record the problem of confidentiality would become less. He would have absolute control regarding who should have access to them. Is this therefore a possibility to which we should give serious consideration?

There are other questions to which answers are required. Is it appropriate that NHS records should be government property? What are the implications of the suggestion that doctors should examine the content of records before forwarding them to a colleague (via the executive council)? Because the law allows a patient, under certain circumstances, to see and examine his clinical notes, should information that would be desirable to withhold from a patient's knowledge ever be recorded? Should general practitioners have two sets of clinical records—one in the possession of the patient and the other private to the doctor concerned?

Dr Crombie's separation into primary and secondary records does not help the general problem of confidentiality, though it is extremely appropriate to the particular problem of collecting research data. Perhaps there should be an additional category of record, neither primary nor secondary as defined by Dr Crombie, but a confidential *aide memoire* retained by the practitioner and not forwarded to executive councils.

The Awards and Ethical Committee gives some prominence to the content of a medical certificate, especially where it is shown to a party other than the staff of the Department of Health and Social Security. This is not a problem that need concern the medical profession unduly. The certificate is given into the care of the patient personally and it is his decision to whom he shows it. It is perhaps not sufficiently known that if a patient is given form Med.3 he may obtain a document, free of charge, from his local Department of Health and