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

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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

Social Security office to the effect that he has been certified as being unfit to work. This document rather than form Med.3. could be sent to employers.

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THE COLLEGE AND ETHICS

Sir,

How refreshing to read of the remarks by Prince Philip regarding the responsibility of the College to pass on the traditional outlook and ethics of our profession.

Many years ago when we were deeply concerned about criteria for membership, it was suggested that each new entrant should be enrolled at a simple ceremony, where he would promise, as far as it was in his power, to uphold the ethics of the profession based on the Hippocratic oath and that this with regular postgraduate study, similar to that practised by our College in Canada, would be sufficient for election.

I feel that many older practitioners who supported the College in its early days and even before its inception, would welcome some initiative from Council as a follow up on our patron's speech.

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RADIO-PAGING SERVICE

Sir,

The Post Office recently introduced a new automatic, radio-operated, 'bleep' service. This covers an irregularly shaped area extending up to 30 miles south and rather less north of the Thames, between Staines and Goring.

The doctor on call in the practice carries a small instrument in his breast pocket and this gives a 'bleep', similar to that given by systems operated in most hospitals. The signal is actuated by dialling a number specific to the instrument from any Post Office telephone. The doctor responds to the bleep by ringing back to base for the message.

This instrument has been in use, in this four-man practice, for the past year and has proved to be a useful additional item of equipment. It is very reassuring to the ancillary staff to know that they are able to contact a doctor within minutes. In spite of efforts to avoid the problem, there is inevitably some time, during working hours, when no doctor is immediately available at the surgery premises. It had occasionally happened, especially at lunch-time, that all the doctors were out visiting when an urgent call came in. Moreover, when on duty alone at weekends, it is possible to do a series of visits, without reporting back to the base telephone, secure in the knowledge that no messages requiring urgent action have arrived. It enables the doctor on call to be available without being next to a telephone, thus allowing him to attend meetings, entertainments and other activities without making telephone arrangements.

A two-way radio link would give more direct communication, but involves bulkier equipment and is considerably more expensive to install and maintain.

The Post Office charges £5 deposit and £5 monthly rental for the instrument and there is of course, only a need for one instrument for each doctor on call, at any one time. In this group practice of four doctors, one instrument is adequate.

At present, this system is only available in the area mentioned above, and no decision has yet been made about extending the service.

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MEDICAL VISIT TO THE U.S.S.R.

Sir,

Under the auspices of the Society for Cultural Relations with the Soviet Union and with the cooperation of the Health Workers Union in the U.S.S.R. I am trying to gather a group of doctors and other health workers to visit the U.S.S.R from the 9–23 September, 1974. The cost at present prices is estimated at £163 all in. We hope that both the organisation and the composition of this group will ensure that the visit is neither a pilgrimage to the Holy Land, nor a search for ammunition for Kremlinologists. We hope to visit various units within a single regional sector, ranging from primary care to a teaching hospital all within the same catchment area.

I would be most grateful if anyone interested would write to me, when I can send further details.

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