system are already well known (Bradshaw-Smith, 1976), and this study gives food for further thought.

It also brings into the open the smouldering problem of the confidentiality of the patient's record. Here for the first time practitioners are actually sending total records instead of or with letters of referral to hospitals.

This issue has never before been faced, because in the past relative privacy was provided for patients through their general practitioners being highly selective in using information in their referral letters. Now a system is available which could eliminate general-practitioner selection altogether and open the patient's record not only to the consultant but, if it is sent with the referral letter, to the records clerk, the outpatients sister and her staff, and if the patient is subsequently admitted, to ward staff as well. The print-out really will display sexual histories after referral for a bunion.

The efficiency from the point of view of hospital staff of greater access to information may prove desirable; demands for such access may increase. But what say are patients to have? How far do they know that what they say in privacy to their own doctor for one condition may be printed out in outpatients years later for another? Even when patients give written consent for disclosure they may not remember its significance. A growing number of patients are becoming surprised and angry to find that information given to doctors about, for example, depressive illnesses, may be used by other doctors to load or refuse life assurance years after the event.

General principles

The first general principle which needs to be clarified is the legal basis of the ownership of the record and who has right of access. As Jones and Richards argue today, the legal position is unclear and they make a plea to the responsible professional bodies to take an ethical stand and take it quickly. Crombie (1973) has emphasized the crucial distinction between primary files, like the general practitioner's, which refer to individually identifiable people, and secondary files, which contain information in a form in which individual patients cannot be personally identified.

The new computer techniques provide ways of making primary files available in secondary centres and general practitioners will increasingly become involved with computerized records.

The second task must be to examine the tradition of the general practitioner selecting information for the appropriate specialist at referral. Is this simply an old-fashioned, out-of-date tradition or does it provide a precious safeguard against widespread dissemination of personal and intimate information?

Now is therefore the time to clarify the ethical rights of patients while the technology is still flexible enough to include safeguards—if patients and doctors still wish to do so. But time is running out.

As a general principle we believe that patients should be entitled to know and understand the degree of confidentiality of information given to any clinician.

References

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What kind of College?

A WIND of change is blowing through the corridors of the College. As if to celebrate its Silver Jubilee, the Council is conducting an unprecedented review of the role of the College and re-examining both its structure and function.

We publish today four discussion papers, all written by members of the Council. These documents were considered at a special meeting of the Council in December 1977, at which virtually all the members of the Council spoke in what was a thoughtful and reflective session. Analysis of these papers reveals some common themes.

Watershed

The first is the remarkable agreement from almost all sides that the College has reached a watershed in its development and that there is now a great need for change. Twenty-five years has a symbolic significance, for the College has changed greatly since the far-off days of 1952.

The restlessness in some faculties, the discussion documents, and the complaints from some members of Council all add up to a call for reform.

Decentralization

The second general principle which runs through the documents and the debate is the call for more decentralization within the College. It has become generally recognized that the growing number of new members—especially younger members—and their interest in clinical medicine means new ways must be found to meet these needs. Local involvement becomes essential. Some members, like Marinker, call for decision-taking to move from the Officers to strength-

ened committees of Council. Others, like Donald, comment on the somewhat overpowering procedure of the Council, while Irvine urges greater devolution of decision-making to the faculties.

Authority itself is being questioned both in the roles and responsibilities of the Officers and in the use of symbols such as the gown and the mace. Certainly one interpretation of these phenomena is a feeling that during the last two decades the balance of activity has become too concentrated at the apex of the College.

Twenty-mile radius

At a recent meeting of the provosts of the faculties the view was expressed that a 20-mile radius around any centre was about as much as the average general practitioner was able to travel to attend meetings. This view was widely endorsed in the later Council debate.

Small groups

Simultaneously, a remarkable consensus emerged about the value of small groups for furthering the development of British general practice. The College, it was said, had discovered the power of the small group and has analysed and formalized its potential.

With trainer groups springing up all round the country, audit groups developing in some centres, and a growing number of faculty groups appearing, a general trend is emerging. Vocational trainees, after all, have for several years become accustomed to learning in groups.

Two of the Council's leading members, however, pinpointed some side-effects of group work. Carne noted that without leadership they could degenerate into "the blind leading the blind" and McCormick emphasized that they could fail merely by becoming a mechanism for producing the lowest common denominator.

Nevertheless, the majority view, expressed most clearly by Hasler, was that groups could and usually did produce more than the sum of their component parts and that working through the ideas and applications in peer groups remained the best mechanism yet known for raising clinical standards.

If this is so, much of the current work of faculties, such as answering queries from Princes Gate, may be seen to be increasingly irrelevant as local members of the College up and down the country buckle down to the practical problem of improving the quality of care in their own practices and begin to hammer out a consensus on clinical care.

If they do, the need for local college leadership becomes critical. Perhaps the role of the college tutor working in and around local postgraduate centres may lead to a much more spirited *local* presence by the College in the future?

Views of the members

In the end, however, it will not matter what the Council thinks—do members of the College want to meet with their colleagues in and around their home towns? Will doctors travel up to 20 miles? Will the plans work in practice? What should the functions of the faculties be?

Through the democratic constitution of the College every member has a voice at local faculty and at general meetings. Every faculty has a voice in Council. It is a sign of the flexibility, resilience, and optimism of the College that it can now conduct such a far reaching review of itself.

Nations, it is said, get the governments they deserve—the same may be true of Colleges. The future of the College is now in the hands of all its members and associates who are now invited to express their opinions through their faculties, the College's committees, and Council, or to write letters for publication in this *Journal*.

Reduction in referral rates

In my own practice (Fry, J. 1971, *Lancet,* ii, 148) the referral rate has been halved during 25 years. In 1951 I was referring 105 per 1,000 of my patients to hospital. In 1970 the rate was 51 per 1,000 and in 1975 it was 37 per 1,000. There was a general overall reduction in referrals among all clinical groups but the greatest reductions were in rheumatic disorders, cardiovascular conditions, neurological disorders, and psychiatric disturbances. In my own case the chief reasons for this reduction in referrals have been that I have become more experienced and more knowledgeable in the nature and natural history of these common diseases and more aware of the limitations of my consultant colleagues.

There is a need at this period of national economic crisis to use less of our expensive resources, the hospitals. To achieve this may involve changes at the interface between general practice and the hospital service and yet we have very few reliable data on what goes on at this interface.

Reference

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