

analyse their prescribing habits, particularly in partnerships, trainer groups, College groups, and symposia, and reasons for taking prescribing decisions are increasingly discussed.

The Department of General Practice at the University of Aberdeen has an outstanding reputation for carrying out important studies on general-practitioner prescribing and it was Howie in 1972 who first showed that general practitioners' prescribing decisions are related more to the medical history and physical signs than to conventional, pathologically based diagnostic labels. Later (1976) he showed that prescribing decisions in the treatment of sore throat reflect information about personal and social factors regardless of the objective appearance of the throat. Now Taylor, in this issue today (p.531) has begun to develop an index of quality and to tease out a logical system for analysing prescriptions.

Another recent trend is the growing involvement of the patient, in terms of his knowledge and understanding, his choice, and his criticism. It is certain that topics of public concern today, such as the writing of prescriptions by receptionists, which is studied by Jones in this issue (p.543), or problems about patients driving whilst under sedation, will snowball during the years ahead.

It is likely that the scientific precision with which many drugs are prescribed in general practice will increase through biochemical monitoring of blood levels, just as anticoagulants may be titrated against serum prothrombin times and anticonvulsants adapted in the light of their blood levels, so that many more drugs are likely to become susceptible to more specific monitoring in general practice.

Two further principles stand out. First is the growing concern of Government, public, and profession with adverse reactions to drugs. Whether it be oral con-

traceptives on the one hand, or the most potent new chemical on the other, the public is becoming increasingly aware that a price has to be paid for all major chemical revolutions and that the absolutely safe drug never has, and probably never will, exist.

Secondly, an immediate challenge to general practice is to improve the quality of its records and in particular the quality of the recording system for drugs prescribed. Many practices are introducing drug record cards or systematizing the information about drugs prescribed. With medicine increasingly fragmenting and ever more complicated drugs affecting ever more systems of the body, the need for the generalist to co-ordinate and control all prescriptions becomes clearer. Here indeed lies one of the great and growing responsibilities of general medical practice and one which will require increasing study in the years ahead.

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Safeguarding personal information

BURIED among the mass of press releases supplied by various government departments in recent months is one from the Department of Health and Social Security (DHSS) of fundamental importance to the future of medicine in Britain. On 27 April 1978 the DHSS issued a press release from the Child Health Computing Committee enunciating a policy which has subsequently been confirmed by Mr Roland Moyle, Minister of State for Health, in the House of Commons (Moyle, 1978).

This one-page announcement summarizes the results of an important battle that has been raging behind closed doors in various professional associations and government departments in this country. It is interesting

and instructive to trace the origins, analyse the principles, and describe the resolution of these conflicts.

Fragmentation of the specialties

The first general trend was the growing tendency for medicine to fragment into numerous sub-specialties, each of which busily engaged in extending the frontiers of knowledge within its own field. Many of these separate specialties, and especially neonatology, were increasingly concerned with factors affecting their patients' health outside the immediate technical problems of the disease. Each of these specialties in turn has gradually come to appreciate the importance of the

generalists' traditional claim to deal with physical, psychological, and *social* factors. As a result, many specialists have begun to demand information about the personal, family, and social circumstances of his patients, or, in the case of neonatologists, about the parents.

Computerization

This general trend was limited in its development mainly by the problems of recording manually vast quantities of data about ever-increasing numbers of patients. It therefore required a second and separate development to bring the research interests of the different specialties into focus. This was, of course, the development of computers, which had the capacity to handle vast quantities of information, to correlate and co-ordinate them, and reveal the associations in a flash.

It was therefore entirely predictable that the new specialisms, armed with the new computers, would almost inevitably seek the right to computerize a vast amount of personal information about their patients.

Defence of personal privacy

It was equally inevitable that sooner or later this encroachment on personal privacy would be challenged. It has not been clear for some time whether this challenge would come from the patients themselves through patient associations, through community health councils, or through bodies like the Council for Civil Liberties, or whether on the other hand it would come from the generalists in medicine who have long claimed to speak as the patients' advocate. In fact, in the Spring months of 1978, the clash came from the generalists and the somewhat unexpected forum proved to be the Child Health Computing Committee of the DHSS.

Child Health Computing Committee

This Committee is widely representative of the NHS, the General Medical Services Committee, the British Paediatric Association, administrators, community physicians, the DHSS, as well as observers from both Scotland and Northern Ireland. It is to the credit of the General Medical Services Committee that it appointed two members with perception and resilience to represent it in this forum.

Irresistible force and immovable object

This was the setting where the irresistible force demanding ever more personal information about people met the immovable object of personal doctors committed against the unnecessary disclosure of highly personal and sensitive information.

The battle when it came turned inevitably and appropriately on the policy of the Central Ethical Committee of the British Medical Association, which sided decisively with the personal doctors. This important intervention tipped the balance in the Com-

puting Committee and although the personal doctors were heavily outnumbered, the final resolutions have safeguarded for the future the patients' confidences. It is hard to believe that proposals had seriously been made which would have allowed highly personal information such as previous therapeutic abortion, previous venereal disease, or previous illegitimacy, to be distributed wholesale through health authorities and hospitals with identifiable names on the documents.

Subsequently the Government through Mr Roland Moyle, Minister of Health, confirmed these principles as the policy of Her Majesty's Government (Moyle, 1978). The three ethical principles therefore are:

1. Identifiable information is to be regarded as held for the specific purpose of the continuing care of the patient and should not be used without appropriate authorization or the consent of the patient (parent or guardian in the case of a child) for any other purposes.
2. Access to identifiable information held in medical records is to be confined to the author and to the person clinically responsible for the patient during the episode from which the data has been collected (or their successors) unless specifically authorized by the clinician in the clinical interest of the patient.
3. An individual is not to be identifiable from data supplied for statistical or research purposes except when follow-up of the individual patient is a necessary part of the research (and either the patient has given informed prior consent or consent has been obtained from the chairman of an appropriate ethical committee).

There are undoubtedly those who do not regard even these principles as wholly secure and who may well press for a further tightening up of the procedures in the future. So be it. The debate on such topics is never finished and there is always room for further improvement. What, however, is clear is that the debate initiated in this *Journal* in 1973 and re-emphasized by Jones and Richards in the March issue this year with its accompanying editorial symbolizes the traditional determination of personal doctors to maintain the highest standards of medical trust and not to abuse the confidences of patients unnecessarily or inappropriately.

When the history of medical research in this country comes to be written and the ethical principles and standards are examined, full recognition will be given to the handful of personal doctors who throughout recent months and at times in difficult circumstances held the line on confidentiality.

The Department of Health can be congratulated on listening to informed opinion on ethical problems and on coming to an acceptable policy as partners with the medical profession, ensuring high ethical standards in the further development of medical research in Britain.

Reference

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