of the outcome for the patient and of the existence and strength of supporting scientific evidence. They must also take account of the views of patients and be applied correctly. There is a danger that, in adopting an approach to policies based on outcomes, unrealistic expectations of scientific methodology may replace uncritical acceptance of conclusions reached by consensus. However, the introduction of critical appraisal skills[15] into vocational training for general practice will lead to a more thoughtful evaluation of policy statements. It is also important to remember that written policies are only part of a range of interventions that can be used to improve the quality of care, although their statement of objectives and plan of care underlie other efforts to bring about change.

ANDREW FARMER

General practitioner, Thame, and Stuart research fellow, Department of Public Health, Oxford

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Address for correspondence

Dr A Farmer, The Health Centre, East Street, Thame OX9 3JZ.

Medical confidentiality and records in general practice

TAKING a personal history from the patient is fundamental to the practice of medicine, especially in general practice, involving as it does, consideration of the physical, psychological and social aspects of a patient's problem. Much sensitive information will pass from patient to doctor, and this may involve information about third parties who do not know that they are being talked about. Patients are likely to provide details of personal and interpersonal history on the understanding that confidence will be preserved, and that the information will only be used in connection with their own medical care.

The principal of medical confidentiality is one of the oldest obligations upon doctors, and one to which much lip service is paid. Many patients are under the impression that it is absolute. Yet in 1982 an influential Chicago physician, Siegler, wrote an article entitled 'Confidentiality in medicine: a decrepit concept'.[1] Since then, anxiety has been expressed by patients, both individually and through various organizations, about the subject of confidentiality, particularly in relation to access to records, the use made of the results of investigations and the prescription of drugs to people who may not be able to give full, informed consent. In addition, patients are increasingly asking for information already in their records to be removed, on the grounds that it may prejudice future doctors or other health care workers. So how does the principle of confidentiality stand at the moment?

Havard,[2] in his Green College lecture stated that 'It would be difficult to name a democracy in the Western world that pays less respect to confidential medical information than the United Kingdom'. In England, only the Roman Catholic confessional is subject to the rule of absolute confidentiality whereas in France the absolute confidentiality of medical records is enshrined in law, even if the patient were to gain advantage from it being broken. The General Medical Council's 'blue book'[3] lists situations when medical information may be revealed:

1. When the patient or his or her legal adviser give written and valid consent.
2. When other doctors or other health care professionals are participating in the patient's care.
3. When the doctor believes that a close relative or friend should know about the patient's health but it is medically undesirable to seek the patient's consent.
4. When the doctor believes that disclosure to a third party other than a relative would be 'in the best interests of the patient' and when the patient had rejected 'every reasonable effort to persuade'.
5. When there are statutory requirements to disclose information.
6. When a judge or equivalent legal authority directs a doctor to disclose confidential information.
7. When the public interest overrides the duty of confidentiality, such as, investigation by the police of a very serious crime.
8. When medical research approved by a 'recognized ethical committee' is being carried out.

Given these exceptions it is no wonder that patients are anxious about divulging sensitive information.

Difficulties relating to the issue of confidentiality may arise in many areas, for instance where the doctor's duty to society or to another patient conflicts with the duty to the individual, but the area I would like to consider in particular is medical records.

It seems almost axiomatic that to treat patients as whole persons within the context of their families and society, we need adequate information about them. In addition, with the

increasing emphasis on prevention, we often ask questions about lifestyle. These may cover not only areas such as exercise and diet, but smoking and alcohol consumption, occupation, and sexual activity. Information of a very private nature may also arise in the general management of illness.

When patients leave a practice they may ask for certain information in their records to be removed. The implications of such requests are manifold. They involve the autonomy of the individual patient and the question of whether the patient loses 'rights of ownership' over personal details once they have been divulged to a doctor. In addition, the ability of subsequent doctors to treat patients adequately may be impaired if information in the records is not complete. In the case of a patient who is positive for the human immunodeficiency virus it also raises the question of risk to the health of doctors who may treat that patient. But are we, as doctors, ever justified in assuming that records are complete? Surely patients frequently withhold information.

The transfer of information to insurance companies is another problem area. When applying for insurance cover, applicants are asked to allow their doctor to pass on medical information held in their records. Yet it is unlikely that when patients give information to the doctor they envisage it later being passed to an insurance company. Patients now have access to their doctor's report to the insurance company, but if the report is amended the doctor has to indicate this. The annotation of patients' general records to show that information has been removed is unlikely to satisfy those seeking a high degree of confidentiality.

When patients consult we should make clear the arbitrary nature of confidentiality and ask whether there are any pieces of information which they wish to be kept absolutely private. This has to be negotiated, like so much else in the doctor–patient relationship. Ideally, patients should have an opportunity to review their medical records and agree on what these should contain for wider circulation or onward transmission. In addition, when we refer a patient it is important to agree the boundaries of confidentiality. However, it needs to be made clear to patients that for their treatment to be effective, a large number of people may need to receive sensitive information.

The consequence of patients controlling what is contained in their records would be that doctors would have to accept the possibility of incomplete notes. The implications of this suggestion have not been thought through by the profession or by the General Medical Council. Yet it is not as startling a possibility as it might seem at first sight. We all operate an implicit, if not explicit, filter by omitting information which we think is unimportant or irrelevant.

None of these problems has a clear cut solution, but they all need to be examined closely. If we, as a profession, do not do so, patients will increasingly come to agree with Siegler that confidentiality is a decrepit concept. They will cease to trust us with their secrets, and without trust, we will not be able to practise our profession of healing.

A C MARKUS

Tutor in general practice, Department of Public Health and Primary Care, Oxford and general practitioner, Thame, Oxfordshire

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Address for correspondence

Dr A C Markus, The Health Centre, East Street, Thame, Oxon OX9 3JZ.

Raising standards in family planning services

FAMILY planning is not just a social need but an important element of preventive medicine.[1,2] The medical, social and psychological consequences of unplanned pregnancy have long been a concern;[3-6] as have the sequelae of induced abortion.[7]

Family planning is in a state of turmoil. Not only is the government's review of the health service causing problems but there have been delays in the negotiations for the proposed Faculty of Family Planning and in the implementation of new certification for training in intrauterine device insertion. A review of family planning services is perhaps timely, especially when the political and medicopolitical problems are combined with downward trends in the number of consultations at family planning clinics[8] and upward trends in the numbers of conceptions,[9] unplanned pregnancies[10] and abortions.[11]

In the 15 years since general practitioners started providing contraception on the National Health Service the provision of contraceptive care has shifted from clinics to general practice: the ratio of general practice to clinic attendances has increased from 0.9:1 to 2.3:1 (Kenmir B, Family Planning Association, London, personal communication, 1990). It is difficult to say how much this is due to cuts in the family planning clinic services, to changing consumer views or to general practitioners improving and promoting the service they offer.

Despite this shift, family planning services will continue to be offered by all district health authorities; the Department of Health recently restated its backing for consumer choice of site for family planning. In addition, a recent document on contracts for health services states that regional health authorities will be expected to ensure that clinics where self-referral is the norm (accident and emergency, genitourinary medicine and family planning) must be adequately funded.[12] Some regions have already agreed to organize funding for family planning in such a way that patients from outside a district can be seen without documentation.

There are a number of issues to be considered in any review of family planning: consumer opinion, training and quality of care.

Much is known about consumer views of family planning,[13] but service providers do not always take heed of them. Patients and doctors have given varied reasons for preferring general practice or clinic services,[14] and there will always be some women who prefer not to see their general practitioner for sexual and contraceptive problems. A recent survey of clinic attenders from Newcastle[15] reports that patients changing from general practice to the clinic service gave dissatisfaction with the general practitioner and wanting a more specialist service as the two commonest reasons for the change. There was a clear demand for evening sessions and, in areas of high social need, for walk-in clinics. Pregnancy testing and male contraception, not widely available in general practice, were 'special' services requested by a large majority of clinic attenders. The Consumers' Association has stated that health authorities should fund surveys to find