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.

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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

out how consumers are reacting to changes in provision[16] and they have proposed that all general practitioners who provide contraceptive services should undergo recognized training first.

General practices are well able to provide training opportunities in family planning[1,17] but the position changed little during the 1980s. Only 11% of instructing doctors currently teach in general practice premises (report from the secretary of the Joint Committee on Contraception, October 1990) and such instructing doctors do not necessarily accept family planning trainees; some train only the practice's general practitioner trainee. The Joint Committee on Contraception has recently recognized a small number of pilot studies where new flexible ways of training in general practice can be examined. In the forseeable future, however, the lion's share of family planning training will take place in community clinics. Hamilton has recently drawn attention to the danger that the next generation of general practitioners will be relatively poorly educated in this field.[18]

The quality of family planning services depends on external factors[19] as well as the internal factors which are under the direct control of family planning staff. The fact that contraceptive devices need Drug Tariff approval[20] limits the availability of up-to-date technology to patients using the general practice service. Sterilization within the NHS is in sharp decline because of the negative attitude of managers of hospital acute units to expenditure on payments to consultants and the consultants' refusal to perform such operations without payment.

General practitioners providing contraceptive services (98% of all principals) are required to be conversant with up-to-date texts such as the *Handbook of contraceptive practice.*[21] But entry to the contraceptive services list (unlike obstetric, child surveillance and minor surgery lists) does not require any specified clinical experience. Courses run by the Joint Committee on Contraception are purely voluntary, although still immensely popular.

Little data that can be used for performance review are collected in surgeries or community clinics. Data from general practice are urgently needed as 70% of consultations for contraception now take place in this setting (Kenmir B, personal communication, 1990). The time is ripe to initiate audit of clinical work[22,23] as current practice must be determined before evaluation and planning for future improvements can be carried out. A joint audit by the general practitioners and clinic doctors in one locality would seem logical. Measurements of process should include analysis of the content of family planning consultations, accessibility to the service (in particular for patients requiring repeat depot injections and requesting emergency contraception), competence of staff and expertise in communication. Intermediate outcome can be assessed by simply checking that monitoring and screening has been carried out, and by measuring patient satisfaction either by structured interviews or by self-administered questionnaires.[24] Final outcome measures indicating contraceptive failure can include unplanned pregnancies[25] or fertility and abortion rates.[26] Case histories of contraceptive failure can be used to highlight deficiencies in service provision. These more readily measureable performance indicators, however, must not be the only ones used.[27]

The Netherlands sets a standard which the UK can strive for. Both fertility and abortion rates are considerably lower in the Netherlands[28] even in the under 25 years age group. The Dutch teenage pregnancy rate is one quarter of that in the UK. Although a much more enlightened approach to sex education is a large factor here, the Dutch family planning service, largely provided by general practitioners, is excellent.

We need to plan policies for the 1990s, based on adequate audit of current practice, which will raise standards of contraceptive care and reduce unplanned pregnancies. Cooperation between professionals working in the different settings from which family planning services are delivered will make success more likely.

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