

time and distance, exacerbating the low temperature effect (unless heated transit vehicles are used). Provision of the phlebotomy service and appropriate sample transport may become an additional responsibility for those GPs who presently have these services provided by the hospital. Figure 1 shows the effect of outdoor ambient temperature and improving phlebotomy technique on the percentage of samples giving significant hyperkalaemia (5.8 mmol/L or higher).

Changes to pathology services may be introduced insidiously and GPs need to be aware of proposals that will affect their practice. Automated sample analysis can be performed in bulk on large analysers, but phlebotomy and pre-analytical handling require skill and knowledge. If this is overlooked in planned changes, news of pathology modernisation may be heralded by an epidemic of pseudohyperkalaemia. Periodic assessments of the incidence of hyperkalaemia in GPs' own practices can yield powerful information. If the incidence of moderate hyperkalaemia (5.8 mmol/L or higher) rises above 0.7% or >9% are above reference range, transport and phlebotomy arrangements should be reviewed.

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## Connecting for Health

In an editorial in your March issue,<sup>1</sup> senior officials from the Department of Health claimed of the Summary Care Record (SCR) that 'It is a health record and there will be no access for police, immigration authorities, or others.'

This credulous view was undermined when *Computer Weekly* noted that the health minister Ben Bradshaw had already told parliament last year that the police have access given a court order, or where there is statutory authority, or where there is an overriding public interest.<sup>2</sup> As I had pointed out in my February editorial to which the Department was responding,<sup>3</sup> the police have always been able to get a court order to seize material that is actual evidence of a crime. For the Department to affect ignorance of this was perplexing.

In practice, medical confidentiality depends on who controls access as much as on the letter of the law. For example, one of the family planning charities was asked by the police to supply the names of all their under-16 patients; they refused, and the police sensibly did not press the matter.<sup>4</sup> Had they gone to court, there could have been an interesting test of whether UK law on medical privacy complies with the European Convention on Human Rights (a 2006 study for the Information Commissioner concluded that it doesn't).<sup>5</sup> However, in future the police will have a less troublesome option: they will be able to ask BT, the custodian of the secondary uses service (SUS). A BT manager may well be less combative than a practising gynaecologist who sees her patient relationships, professional integrity, self-esteem, and business viability all directly under threat from a police fishing trip.

Michael Thick and his colleagues also had a letter in your March issue that made an intemperate personal attack on me for encouraging patients to opt out of the SCR,<sup>6</sup> while their editorial boasted of

the fact that patients can opt out of the SCR. This bluster — that we can opt out of the SCR if we want to, though it's irresponsible to suggest that anyone actually do so — was echoed in parliament. When Mr Bradshaw was asked whether patients would be able to opt out of the care records service, he answered it by referring solely to the SCR.<sup>7</sup> Ministers and officials have been careful to focus on the safeguards for SCR, and avoid discussing SUS. Yet the new centralised system has at least three components holding large amounts of identifiable health information — SUS, the SCR, and the Detailed Care Record (DCR). The first two are already beyond clinical control, and the third is heading that way as more and more records from both primary and secondary care migrate from local to hosted systems. As I noted in February, many government departments have declared intentions to use identifiable health data, such as the Home Office's ONSET database that tries to predict which children will offend. And, despite the Department's comments, GP data have already been used to hunt illegal migrants.

I repeat my call for GPs to make leaflets from The Big Opt Out<sup>8</sup> available in waiting rooms. This will reassure patients that they will not suffer discrimination (in the practice at least) if they exercise their advertised right to opt out. Finally, I would like to invite all GP partners to think very carefully about whether it's wise to accept the Department's kind offer to move your practice records to a hosted system. Once you lose control, you will have a hard time getting it back.

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## Limitations of the Summary Care Record

I am glad the clinical leaders of Connecting for Health<sup>1,2</sup> have had a chance to reply to the concerns about data security and confidentiality laid out by Professor Anderson<sup>3</sup> and Gordon Baird<sup>4</sup> in February *BJGP*. In doing so they showed the weakness of their case and the strength of their opponents. In particular they protested about, 'a number of factual errors and wrongly conflated aspects of the National Programme for IT'. Sadly they failed to show what Professor Anderson's errors actually were.

I have no trust in the seemingly limited Summary Care Record. I suspect in future it will become more extensive, and more available, and for purposes beyond direct patient care. It is a part of the expensive and increasingly discredited and distrusted National Programme for IT. It is a thin end of a wedge.

The key phrase in Mark Davies *et al*'s editorial is 'Information governance'. The current evidence we have is that the government has no understanding of this, and only limited systems in place to fully secure data against loss. The recent loss of 15 million child benefit records showed this. Equally worrying was the apparent lack of concern among ministers, and the willingness of senior managers to blame the debacle on a junior staff member.

My own medical notes have 93c3 'refuses consent to have health records

transferred to central database' added to them. I will encourage my patients to do likewise. I think that this will give them more control over their medical records than any centralised system.

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## CAM

The work of Professor Ernst and his team at Exeter in the study of complementary medicine (CAM) is disappointing. Their obsessive search for 'compellingly positive evidence' of positive outcomes in specific disorders in response to specific treatments scratches the surface of a profoundly interesting and challenging phenomenon. It represents a kind of scientific tunnel vision.

For example, their 'table of treatments which demonstrably generate more good than harm' does not include homeopathy. And yet, the study of clinical outcomes at Bristol Homeopathic Hospital (United Bristol Healthcare Trust), in patients with a wide range of longstanding disorders responding poorly to conventional treatment and referred by their GPs or other specialists, shows an overall level of benefit of around 75%, often resulting in reduction or withdrawal of conventional medication.<sup>2</sup>

The familiarly dismissive argument that an uncontrolled study such as this yields no data of statistical significance deserving of serious attention, represents a severe case of what has been called 'paradigm paralysis'.<sup>3</sup> These are real results in really sick people. That they

may be achieved by a package of care that includes a decent dose of non-specific effects, alongside whatever specific effects the homeopathic prescription may have, does not make them invalid, it makes them particularly interesting, and very important. In his James Mackenzie lecture,<sup>4</sup> 'Who Cares?' David Haslam eloquently expounds the limitations of the prevailing medical paradigm of which the Ernst approach is a prime example.

Having met Professor Ernst a number of times I have no doubt of the earnestness and good intentions with which he and his team pursue their cause, but it is sad that the leader of such a potentially pioneering academic department is not prepared to be more of a 'paradigm pioneer'.

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## Back to the dark ages

It is my experience over the last 15 years that enthusiasts of ineffective alternative treatments tend to resort to two strategies when faced with convincingly negative data. The first is to slight the bearer of bad news, and the second is to call for a paradigm shift. Dr Swayne seems to do both. He affronts me by stating that I suffer from 'tunnel vision' and am 'obsessive'. And he goes to some length explaining that, in order to