A recent large study suggests that all events relating to life stress and social isolation must be taken into account and that the lack of a job or the frustrations of work are of paramount importance. In 2320 survivors of acute myocardial infarction who entered the beta blocker heart attack trial, a psychosocial assessment carried out two to three months after the index event was found to correlate with three year mortality.¹¹ Two variables (social isolation, in terms of lack of membership of any club or religious group or lack of contact with family and friends; life stress, which included lack of job, lowly status of job, job dissatisfaction, and family and financial difficulties) were of major prognostic importance. Men with high levels of life stress and social isolation had four times the risk of death of the men with low levels of stress and isolation. The inverse relation observed in many other studies between education and mortality was found in this study to parallel the psychosocial variables in that the least educated men had the highest levels of stress and isolation and the best educated had the lowest levels of these predictive variables. The association between death and the results of the psychosocial interview applied to total deaths as well as to sudden deaths and seemed independent of the extrasystolic activity noted during the index admission with acute infarction.

This important study is transmitting three messages to us. Firstly, association does not mean causation, so it does not follow that reducing life stress and isolation by social engineering or individual counselling will alter the fourfold risk gradient. Secondly, the mechanisms which lie behind the association must be explored to determine whether the problem lies in who people are (their nature, for in Britain social class is strongly associated with some genetic markers such as blood group¹²) or what they do (their nurture). Finally, Britain is currently witnessing two uncontrolled mass experiments in social isolation and life stress in the shape of our 3 million unemployed and the conflicts between working and non-working miners, which will produce lasting bitterness for them and their families within previously tightly knit communities. Can we ensure that the medical consequences of the resulting life stress and social isolation will be properly documented?

The history of the stress concept, the woolly thinking, and the poor studies which have often been cited to support it have allowed many of us to remain "don't knows." The beta blocker heart attack trial shows that we must now include life stress and social isolation among our prognostic markers and try to find out how "pain, pleasure, hope, or fear is the cause of an agitation whose influence extends to the heart."¹³

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1 Pasternak B. *Doctor Zhivago*. London: Collins, 1958.

2 Dunbar F. *Psychosomatic diagnosis*. New York: Hoeber, 1943.

3 Russek HI, Zohman BL. Relative significance of heredity, diet and occupational stress in coronary heart disease in young adults. *Am J Med Sci* 1958;235:266-9.

4 Friedman M, Rosenman RH. Association of specific overt behavior pattern with blood and cardiovascular findings. *JAMA* 1959;169:1286-96.

5 Arnott EM. The changing aetiology of heart disease. *Br Med J* 1954;ii:887-91.

6 Mickle WJ. *General paralysis of the insane*. London: Lewis, 1880.

7 Anonymous. Are we killing ourselves or not? [Editorial]. *Lancet* 1981;ii:669-70.

8 Hinkle LE, Whitney LH, Lehman EW. Occupation, education and coronary heart disease. *Science* 1968;161:238-46.

9 Brand RJ, Rosenman RH, Shultz RI, Friedman M. Multivariate prediction of coronary heart disease in the Western Collaborative Group Study compared to the findings of the Framingham study. *Circulation* 1976;53:348-55.

10 Gallacher JEJ, Yarnell JWG, Elwood PC, Phillips KM. Type A behaviour and heart disease prevalent in men in the Caerphilly study. *Br Med J* 1984;289:732-3.

11 Ruberman W, Weinblatt E, Goldberg JD, Chaudhary BS. Psychosocial influences on mortality after myocardial infarction. *N Engl J Med* 1984;311:552-9.

12 Beardmore JA, Karimi-Booshehri F. ABO genes are differentially distributed in socio-economic groups in England. *Nature* 1983;303:522-4.

13 Harvey W. Exercitatio de motu cordis et sanguinis, 1628. Cited by Hackett TP, Rosenbaum JF. Emotion, psychiatric disorders, and the heart. In: Braunwald E, ed. *Heart disease*. Philadelphia: Saunders, 1984:1826-946.

NHS thik hai?

The health service may be "the jewel in the crown" of the welfare state, but for some of the ethnic minorities in Britain it does not sparkle. The rates for stillbirths and perinatal and infant deaths in the various groups from the Indian subcontinent continue, in most areas of Britain, to be higher than those of the indigenous population.¹

Much early research on this subject was vitiated by a failure to realise that each ethnic group has its own distinctive problems. Recent work from Dudley Road Hospital, Birmingham, has shown that both the Indian (in the Dudley Road area, mainly Sikhs from Punjab) and the Pakistani communities have a high perinatal mortality rate: however, the Indian mothers have a high stillbirth rate, which the Pakistani mothers do not.² For age and parity the Indians were in a low risk group, and their high stillbirth rate is surprising. Among the Pakistanis there was a high proportion of grand multiparas and of women over the age of 35. Fifty five per cent of the Pakistani marriages were between first cousins compared with 2% in the Indians. The types of congenital malformations were different in the two groups; the Indians had an excess of malformations of the gastrointestinal tract, while the Pakistanis had a relatively high incidence of multiple malformations, possibly genetically determined, and of chromosomal disorders, presumably related to high maternal age.³

Watson has recently analysed the attitudes to and the usage of the health services by the various ethnic groups in the London borough of Tower Hamlets, where there is a large, socially homogeneous Bengali (Bangladeshi) community.⁴ Social classes IV and V were considerably overrepresented in the Bengalis, and their housing was inferior to that of the other groups. The Bengali mothers consulted their doctors about pregnancy much later than did the English speaking immigrants (mainly West Indians) and the indigenous population. Recollected waiting times in the antenatal clinics were much longer for the Bengali mothers, though it was not clear whether this was due to lost case records, linguistic difficulties, shyness, or an altered perception of time due to anxiety and confusion.

Clearly much must be done to make the health services more accessible and acceptable to our Asian communities. One welcome initiative is the "Asian mother and baby campaign" launched in September by the Department of Health and the Save the Children Fund. This will pay for link workers from local Asian communities who will help health professionals and mothers communicate. In the Mothers' Hospital, not far from Tower Hamlets, women from the local communities have already been appointed to "speak for" the mothers and to discuss their problems with the medical and nursing staff.⁵ This has proved very successful. The NHS could and should do much more to help. Notices and instruction leaflets should be printed in the appropriate languages, and record clerks and receptionists should be instructed how to pronounce and record Asian names. For Moslem families in particular, hospitals should provide clinics where women and older girls may be sure of being examined by a woman doctor. There should be more evening clinics in hospitals to enable women and mothers with children to attend with their husbands after finishing work. Halal meat should be available for Moslem patients in hospital. Nurses should be taught not to attempt to

remove jewellery of possible religious importance from children and from patients too ill to object. The new campaign should help to educate and persuade Asian women to attend early for antenatal care; unless they do so early detection of obstetric abnormalities and screening for congenital malformations, genetically determined disorders, and chromosomal abnormalities is not possible. The Birmingham work has shown the need for further investigation into the cause of stillbirths in Indian women.²

It is not only the communities from the Indian sub-continent who need help, however: isolated Chinese families in small towns may have great difficulty in making effective use of the medical and social services. The Vietnamese are still trying to create their own communities and to repair the damage caused by the disastrous policy of dispersal which the government adopted for the "Boat People."⁶

Our medical and nursing schools still give little formal instruction in the religious beliefs and cultural patterns and in the medical and emotional problems of our Asian and other ethnic minorities. The conference at the Royal College of Obstetricians and Gynaecologists in 1981 on "Obstetric Problems of the Asian Communities in Britain,"⁷ and the conference on "Diseases in Ethnic Minorities" in May of this year at the Royal College of Physicians in London indicate an awakening of interest. Even so, this important subject still does not receive the attention which our patients deserve.

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- 1 Social Services Committee. *Perinatal and neonatal mortality. Second report from the Social Services Committee, 1979-80*. London: HMSO, 1980:107. (Short report.)
- 2 Terry PB, Condie RG, Sattatree RS. Analysis of ethnic differences in perinatal statistics. *Br Med J* 1980;281:1307-9.
- 3 Terry PB, Condie RG, Mathew PM, Bissenden JG. Ethnic differences in the distribution of congenital malformations. *Postgrad Med J* 1983;59:657-8.
- 4 Watson E. Health of infants and use of health services by mothers of different ethnic groups in east London. *Community Med* 1984;6:127-35.
- 5 Winkler F, Yung J. Advising Asian mothers. *Health and Social Services Journal* 1981;91:1244-5.
- 6 Owen L. Boat family sails into British storm. *Observer* 1984 June 24:3 (cols 7-8).
- 7 McFadyen JR, MacVicar J. *Obstetric problems of the Asian community in Britain*. London: Royal College of Obstetricians and Gynaecologists, 1982.

Confidentiality of personal health information

The Data Protection Act of 1984 (which regulated the use of automatically processed personal information) was seen to be inadequate for the problem of medical information. Hence an interprofessional working group was set up under the chairmanship of Sir Douglas Black to draft appropriate amendments.

A draft code has now been circulated for comment by the medical, dental, and nursing professions and by health service administrators. Health authorities have been asked to consider whether the code should apply only to automatically processed data or to manual records as well. The Department of Health and Social Security also wants to know whether the inclusion of manual records under the code would add unacceptably to the cost of implementation. Last month the Steering Group on Health Services Information (p 1559) published a further report, *The Protection and Maintenance of Confidentiality of Patient and Employee Data*, which sets out the practical implications of the draft code.¹

The code opens with five pages of principles densely worded in legal phraseology. These are followed by a set of

supplementary notes designed to amplify the principles. These are based on two fundamental concepts: the need to know and the patient's right to confidentiality.

The basic principle is that a health authority holds information about a patient only for the purpose of health care; the patient has a right to have that information kept confidential and not disclosed to third parties without his consent. The health authorities have a duty to respect that right. Professionally qualified staff employed by the health authority have obligations to keep personal health data confidential and to ensure that these are disclosed only to those who need them for the health care of the patient. Health professionals entrust personal data to health authorities only on the understanding that those authorities will respect the patient's confidentiality and recognise the obligation that professional staff owe to their patients.

The patient has a right to expect that personal data entrusted to health authorities will not be disclosed to members and employees of the authority for reasons other than his health care. He also has the right that any information concerning another person connected with him—for example, a sick wife—should be protected by the same confidentiality as his own personal information.

These principles should give extensive protection of the patient's personal data, but the draft code recognises exceptional circumstances in which information might reasonably be disclosed to third parties. Disclosure may be required (not merely permitted) under statute—for example, in the notification of infectious diseases under the Public Health Acts. Agencies such as the Health Service Commissioner can require the provision of personal health data. In these circumstances health authorities are not required to obtain consent—but they would normally notify the patient and the health care professional when practicable.

Disclosure may also be ordered by a court of law or by a person empowered by statute to require its disclosure—for example, the coroner's court. Here again the patient's consent is not required, but he should be informed so that should the information not be required it can be set aside by the court. Disclosure may also be necessary for investigation of complaints and for essential management functions—for example, maintaining the local authority register of disabled persons. Here again the patient's consent is not essential.

Disclosure may be authorised by the appropriate ethical committee (which must include lay members) for health research. The provisos are that no damage or distress will be caused to the patient and that the patient's anonymity is preserved in published work. Furthermore, the ethical committee must ensure that consent is obtained from the professionally qualified person who collected the health data in the first place. No approach should be made to the patient without the consent of the professionally qualified person responsible for that aspect of his health care (or perhaps his general practitioner). If personal health data are disclosed to a research team then these must not be disclosed to anybody outside the research team and must be adequately secured against unauthorised access. They must also be destroyed when no longer needed.

Exceptionally, the disclosure of personal health data may be justified if it can help prevent or detect serious crime or bring the perpetrator to justice. For this to be appropriate the crime must be sufficiently serious and it must be established that without the personal health data the task of preventing or detecting the crime would be prejudiced, delayed, or impossible. Again, such disclosure requires the consent of the health care professional responsible for that aspect of the