PRACTICE OBSERVED

Practice Research

Are general practitioners prepared to share information about their patients and their work?

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Abstract

A questionnaire survey of the 44 general practices in Central Nottinghamshire Health District elicited 43 responses. Ten scenarios on sharing information were graded on a five point scale by each practice according to its willingness to share the information. Responses varied from 41 practices that would at least "probably" give the number of their young chronic sick patients to the local district health authority to 17 practices that were positive towards sharing with a local charity the names of elderly patients living alone. This second example raises profound issues of confidentiality. The extent to which practices were prepared theoretically to share practice generated information with outside bodies was generally high and showed a willingness to do so if the reasons were sound and the requesting body was acceptable.

Introduction

Following a discussion paper,¹ the Department of Health and Social Security has published a white paper which proposes an increase in the performance sensitivity of the general practice contract.² It is now the policy of the Royal College of General Practitioners to establish fellowship by assessment. The standards applied in these two initiatives are largely based on information about primary care gathered externally—for example, from family practitioner committees and district health authorities—and the published findings from research practices.

Increasing refinement in setting standards, as well as planning services and resources, will require increasingly detailed information, some of which may be supplied by the new "no cost" computer schemes.³ For the first time this will mean having a wide variety of practices routinely collecting data concerning their patients and their workloads and making them available to other general practitioners, the National Health Service, social services, and the voluntary sector. The research described here was designed to assess attitudes in practices in the Central Nottinghamshire Health District to such requests for sharing information.

Method

A single questionnaire was sent to all 44 practices in the Central Nottinghamshire Health District. Those that did not respond were sent a reminder and later were telephoned; 43 responses were received, representing 128 out of 129 principals in the area. The questionnaire asked the partners in each practice to discuss the scenarios assuming that they had ready access to the information concerned. Each scenario was rated on a five point scale from "Perfectly happy to pass on this information" (which scored 1) to "Definitely would not pass on this information" (which scored 5).

Results

The responses to the 10 scenarios (table) showed a positive bias towards sharing information. Over these 10 disparate scenarios 235 responses (54.7%) were "perfectly happy to" and 91 (21.2%) "probably would" pass on the information, giving an overall positive response of 75.9%. Only 57 (13.2%) responses were in the two negative categories.

Of those examples that required the sharing of numbers of patients (not identities), the range was between 41 (95%) practices that would share numbers of chronic sick with the district health authority to 28 (65%) practices that would share availability details with the Royal College of General Practitioners. Scenarios that entailed identifying patients to agencies outside the practice varied from 37 practices (86%) that were

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Number (percentage) of practices (n=43) rating each scenario for each level of willingness to share information and average score per practice and per partner (n=128) when weighted for practice size

Scenario	Perfectly happy to pass on this information (score=1)	Probably would pass on this information (score=2)	Not sure (score=3)	Probably would not pass on this information (score=4)	Definitely would not pass on this information (score=5)	Average score per practice	Average score weighted for practice size
(1) The district health authority asks you for the number of young chronic sick patients in your practice in order to assess the need for a "young chronic sick unit" covering your area	35 (81.4)	6 (14.0)	2 (4.7)	0	0	1.23	1.17
(2) Your attached district nurse asks for the number of diabetics in your practice so that her nursing officer can plan services	35 (81.4)	5 (11.6)	1 (2.3)	1 (2.3)	1 (2.3)	1.33	1.25
(3) Your health visitor asks for the names of all the housebound patients in the practice so that she can plan a visiting programme	29 (67.4)	8 (18.6)	2 (4.7)	3 (7.0)	1 (2.3)	1.58	1.54
(4) The BMA asks for the practice uptake rates for immunisations and cervical cytology for use in making its case to the Salaries Review Body	26 (60.5)	11 (25.6)	3 (7.0)	1 (2.3)	2 (4.7)	1.65	1.63
(5) Your patient participation group (given that you have one) asks for the numbers of patients without transport in each part of the practice to plan a transport system to the surgery*	24 (55.8)	12 (27.9)	2 (4.7)	1 (2.3)	2 (4.7)	1.66	1.60
(6) The local rural community council requests the number of patients over 75, number of single parent families, number with no transport, and number of carers in the community so that it can identify gaps in the services in your area	16 (37.2)	14 (32.6)	9 (20.9)	2 (4.7)	2 (4.7)	2.07	2.00
(7) The local university department of general practice asks permission to gather statistics on the practice prescribing from the Prescription Pricing Authority with the intention of providing interpractice comparisons	18 (41.9)	12 (27.9)	8 (18.6)	1 (2.3)	4 (9.3)	2.09	2.12
(8) The local Royal College of General Practitioners' faculty asks for details of appointment availability of individual partners at various times of the week in order to compile a local availability profile which would not identify individual practices†	20 (46.5)	8 (18.6)	6 (14.0)	3 (7.0)	5 (11.6)	2.16	2.22
(9) The family practitioner committee requests the names of all women who have had a hysterectomy so that it can avoid including their names on a cervical cytology call system	22 (51.2)	8 (18.6)	2 (4.7)	4 (9.3)	7 (16.3)	2.21	2.14
(10) A charity for the elderly asks for the names of all elderly patients living on their own in order to set up a "visiting of the elderly by lay people" service	10 (23.3)	7 (16.3)	9 (20.9)	10 (23.3)	7 (16.3)	2.93	3.20

*Two practices did not answer scenario 5.
†One practice did not answer scenario 8.

prepared to consider sharing names of patients with their health visitor to 17 (40%) giving a similar reaction to a request from a local charity.

When the number of partners represented by each practice reply was taken into account there was no difference in scenario ratings except in the response to scenario 10, where the non-significant difference in mean scores between practice (2.93) and practices weighted for number of partners (3.20) reflected the reduced inclination of larger practices to share information.

Discussion

In general practice sharing information is subject to two main influences: the requirement to maintain confidentiality for the doctors and patients and the desire to improve services to patients. The 10 scenarios were chosen to offer a range of choices in both requesting organisation (from attached staff to a charity) and types of information (just numbers of patients or their identities). Though scenarios including patients' identities were viewed less favourably, the overlap with those including only numbers of patients suggests that the decision on sharing information was not primarily based on the need to protect patients' identities. Two thirds of practices were "perfectly happy" to give the names of patients to a health visitor, and over half to a patient participation group or the family practitioner committee. The decision appeared to be based primarily on the standing of the requesting organisation and the intended purpose to which the information would be put. This reflects a pragmatic as against principled approach.

Scenario 10, which entailed giving the names of elderly patients

living alone to a local charity, was deliberately included as an extreme case. It did not mention informed consent and at face value contravened accepted standards for the confidentiality of information derived from patients. It might lead to more practical outcomes: what if the list of patients became available to a local burglar? Only 17 (40%) practices would theoretically be unlikely to or definitely would not release the names of patients to a charity, but possibly if really faced with such a request the response of the other practices would be less positive.

For those people both within general practice and in the health services administration who see the gathering of statistics on primary care as important these findings are cautiously reassuring. It seems that requests from respected medical bodies for information which superficially cannot be used judgmentally are regarded by most practices as acceptable.

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References

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2 Department of Health and Social Security. *Promoting better health*. London: HMSO, 1987.
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ONE HUNDRED YEARS AGO

In December some paragraphs appeared in the Journal on cases of poisoning by unwholesome mackerel. The two patients, who had severe peritonitis, faecal vomiting, and violent delirium, are both convalescent, yet remain very weak. In both these cases peritonitis and delirium, almost maniacal, were the most marked symptoms. This fact is noteworthy, for in the great majority of instances of poisoning by unwholesome food, the patient is seized with symptoms of enteritis, cholera, or collapse, or at least one to two of these three symptoms predominate. It will be remembered that, in the case of the young gentleman at Bayswater, the two other members of his family who partook of the same mackerel had severe choleraic diarrhoea within a few hours, and felt perfectly well next day. Dr George Johnson, F.R.S., has collected some interesting cases of collapse from poisonous food, which are published in his *Medical Lectures and Essays*. A woman had collapse and other choleraic symptoms twice in three months—first, after eating pungent

decayed cheese; and on the second occasion, after eating tinned lobster. A case of the poisoning of a mother and three children by decayed American cheese is recorded; there were symptoms of gastro-enteritis, and the mother had several fits, to which she had never previously been subject; she and one child died. Some Irish peasants, in 1826, made a stew of the flesh of a dead calf which they found on the sea-shore; choleraic symptoms, followed by coma, as in opium-poisoning, occurred and proved fatal. Still, the occurrence of collapse, choleraic symptoms, and even coma, after poisonous food, is well known even to the non-medical public. The recent cases of mackerel poisoning show what is not known to all medical men, and is certainly not taught in the schools—namely, that poisonous fish may cause acute peritonitis, with symptoms suggesting strangulated hernia or rupture of intestine, and acute delirium after the peritonitis has abated.

(*British Medical Journal* 1888;i:91)