

This is the background for clause 67 of the Health and Social Care Bill, currently going through parliament.⁶ The bill itself enacts various measures necessary to implement the NHS plan, but clause 67 has been inserted into the bill without any consultation with patient or professional groups. It grants the secretary of state for health two sweeping new powers: (a) to collect all personal health information in identifiable form—not just from the NHS, but from the private sector too; and (b) to regulate (or even ban) the use of personal health information by third parties such as Source Informatics. The arguments initially offered to justify these sweeping new powers were surprising. Health minister John Denham claimed that the purpose of the bill was to protect patient information.⁷ But in reality the clause 67 powers will remove the remaining effective legal restraints that protect patients and doctors from detailed surveillance by central government.

A bias against industry also appears in government statements. Denham says he wants to overturn the Source Informatics judgment by legislation because it “allowed a company to sell patient information to the pharmaceutical industry for marketing purposes. The aim of such marketing was to drive up the costs of the drugs prescribed on the NHS, and if successful would lead to a waste of resources.”⁸ But this is clearly a matter for the pharmaceutical price regulation scheme. Press comment has suggested that the real motive for tightening the regulation of healthcare data is not to hinder drug marketing so much as to suppress “awkward” reports by third parties on NHS performance.⁹ Comment on a public mailing list devoted to the bill has a similar tone.¹⁰

In any case, it is unclear how the health and well-being of the nation could be improved by this measure. It will certainly have a chilling effect on the doctor-patient relationship: non-consensual data sharing is contrary to medical ethics and appears to violate the European Convention on Human Rights.

It is also at odds with the welcome declaration of the Secretary of State, in the wake of the Alder Hey scandal, that the days of the old paternalistic NHS are over and that patient consent must be paramount in future. Healthcare data management is a complex and emotive subject, which requires proper investigation and debate. In the United States there was public consultation on the regulations passed on this topic under the Health Insurance Portability and Accountability Act, with the result that the regulations have at least the grudging agreement of most of the affected parties.¹¹ Britain's patients, doctors, and healthcare companies deserve nothing less.

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RA was paid by the BMA to evaluate the security of the Source Informatics system referred to in this article.

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Physical health of people with severe mental illness

Can be improved if primary care and mental health professionals pay attention to it

Over 60 years ago the *BMJ* reported an association between mental illness and poor physical health.¹ Subsequent research, in many countries, has consistently confirmed that psychiatric patients have high rates of physical illness, much of which goes undetected.^{2,3} Such investigations have led to calls for health professionals to be more aware of these findings and for better medical screening and treatment of psychiatric patients. So far there is no evidence that this is happening, and the excess illness and mortality continue unabated, with people being managed as psychiatric outpatients being nearly twice as likely to die as the general population.⁴

People with schizophrenia are subjected to the long term effects of antipsychotic medication and have high rates of substance misuse. Yet much of their excess mortality is due to natural causes. They eat less well, smoke more, and take less exercise than the general

population.⁵ Smoking related fatal disease is commoner than in the general population, as are deaths which could have been avoided by medical treatment.⁶ Comparative studies have, however, failed to compare patients with people from similar social backgrounds, so it is not clear to what extent poverty, poor housing, and unemployment are causal factors, rather than the direct effects of mental illness.

Several factors prevent people with mental illness from receiving good physical health care. People with schizophrenia are less likely than healthy controls to report physical symptoms spontaneously.⁷ Some symptoms of the consequences of schizophrenia—cognitive impairment, social isolation, and suspicion—may contribute to patients not seeking care, or adhering to treatment. When they do present themselves their lack of social skills and the stigma of mental illness may also make it less likely that they

receive good care. In the United States a fragmented healthcare system, and difficulties in accessing care, have exacerbated the problems.⁸

In most industrialised countries reform in mental health care has led to the closure of long stay mental hospitals and the development of community mental health teams. Such teams are expected to meet the whole range of health and social needs. Hospital admissions are often short and infrequent, and physical health care is not necessarily given priority. In Britain the national service framework for mental health states that people with a severe mental illness should have their physical needs assessed. However, many mental health practitioners have little training in physical care. Physical assessments of psychiatric inpatients by junior psychiatrists are poor,⁹ and the monitoring of physical health and health education by community mental health staff is generally unsatisfactory.¹⁰

Most patients with severe mental illness are in frequent contact with primary care services, and for many this is their only contact with health services. However, such contact does not necessarily ensure that they receive good physical health care. The orientation of primary care is reactive, and this does not fit well with patients who may be reluctant, or unable, to seek help. Short consultation times make it difficult for doctors to assess mental state and conduct a physical assessment, especially in vague or suspicious patients. When patients are accompanied by mental health staff more emphasis may be given to psychological and social issues. Doctors who are inexperienced in, or uncomfortable with, mental health work may resist intensifying their engagement with a patient by actively asking about symptoms and performing a physical examination.

A study in the US has highlighted that structured physical assessments of patients with schizophrenia are effective in revealing physical illness.⁷ In the UK the NHS Executive has suggested that general practitioners should be paid for showing that they have assessed the general physical health of patients with severe mental illness and made any necessary interventions.¹¹ For such schemes to be successful practices would need to identify their patients with a severe mental illness and to have an effective and acceptable screening mechanism. This should highlight physical symptoms

and unmet physical healthcare needs, such as cervical screening and dental care.

The lifestyle of patients with severe mental illness suggests a need for health promotion—which can be effective. For instance, group therapy is effective in helping patients with schizophrenia stop smoking.¹² But progress in this is hampered by negative staff attitudes. Initiatives in this area should be accompanied by research, so that the most effective approaches can be identified and widely adopted.

The evidence suggests that it is possible to improve the physical health of this vulnerable section of the population. Progress will, however, depend on both mental health and primary care staff being aware of the problem and being willing to find imaginative solutions which are acceptable and useful to patients.

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Towards a global definition of patient centred care

The patient should be the judge of patient centred care

Key messages about patient centred care can be drawn from the paper by Little et al in this issue of the *BMJ* (p 468).¹ Firstly, strong agreement exists between the definition of patient centredness that arises empirically from this observational study of patients in the United Kingdom and another definition arising from reflections on practice in South Africa and Canada,² suggesting an international definition of patient centred medicine. Secondly, the premise of the observational study is

correct—that the best way of measuring patient centredness is an assessment made by the patients themselves.

Patient centredness is becoming a widely used, but poorly understood, concept in medical practice. It may be most commonly understood for what it is not—technology centred, doctor centred, hospital centred, disease centred. Definitions of patient centred care seek to make the implicit in patient care explicit. Such definitions are, we recognise, oversimplifications

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An additional table appears on the *BMJ's* website