
FROM THE GMSC

Support for confidentiality for AIDS patients

The General Medical Services Committee has endorsed the BMA's advice that the traditional confidentiality of the doctor-patient relationship should be upheld in the case of people suffering from the acquired immune deficiency syndrome (AIDS) or who are positive for human immunodeficiency virus (HIV).

After a long debate on 16 April the committee agreed that the interests of the patient should come first. Unless the patient had given consent personal health data should not be disclosed to anyone for any purpose other than the health care of that patient.

The debate arose from the following letter from Leicestershire Local Medical Committee:

"We as a body represent some 400 general practitioners and are concerned at the present guidelines on confidentiality re HIV antibody positive patients. It appears that these patients are to be treated differently from any other patient we may encounter—for example, epilepsy, syphilis, and cancer—in that we are prevented from being informed of a patient on our NHS list who is positive for HIV antibodies. We feel this is very wrong. A general practitioner should be informed in confidence, by another professional person dealing with the case. If this is not to be so a patient may present repeatedly to a general practitioner with minor ailments which fail to respond to treatment in the normal course of time; inappropriate or dangerous investigations may be undertaken because the patient has chosen not to allow his general practitioner to know, or be under the mistaken belief that he does in fact know. Just as with an epileptic patient a general practitioner has certain duties to protect the public, so he has a duty towards himself and his staff with regard to an HIV positive patient, and this is being denied him by the current guidelines."

The chairman, Dr Michael Wilson, suggested that specific problems that committee members raised on the subject should be referred to the BMA's working party on AIDS.

The request from Leicestershire implied that general practitioners should be given the information without the patient's consent. As HIV was not spread through casual non-sexual contact the risk to general practitioners was small and Dr David Easthan did not think that they should automatically be told. There was no parallel with an illness such as epilepsy, where patients should not be allowed to drive public service vehicles.

Some speakers did not want a firm decision taken as motions on the subject would inevitably come up at the conference of representatives of

local medical committees and the annual representative meeting. Dr Michael Illingworth had some sympathy for Leicestershire as there was a "need to know" in some cases by colleagues and laboratory workers.

According to Dr Eddie Josse the NHS (Venereal Diseases) Regulations 1974 were not helpful. These stated that people who attended sexually transmitted disease clinics should be treated in confidence but the regulations did not define sexually transmitted diseases. Until they did the committee should keep an open mind. The general practitioners on his local medical committee would like to know if their patients were HIV positive but the patients would have to agree.

Dr Simon Jenkins quoted from the 1974 regulations, which he believed did cover the confidentiality of information on these patients. They state that every health authority should take all necessary steps to secure that any information capable of identifying an individual examined or treated for *any sexually transmitted disease* should not be disclosed except "(a) for the purpose of communicating that information to a medical practitioner... in connection with the treatment

BMA's advice on confidentiality

"With counselling, the majority of infected individuals can be persuaded voluntarily to inform their general practitioner, dentist, and sexual partner(s) of their infected status."

"It is the duty of the general practitioner to ensure that information is kept strictly confidential, unless the patient consents to disclosure. Patients should be strongly encouraged to permit disclosure when there are firm medical reasons for this, such as when undergoing surgery."

"General practitioners should complete insurance company forms truthfully to the best of their knowledge, but should make it clear to the patient what information is being disclosed, and what the possible implications may be."

"General practitioners should not make statements about their patients' lifestyles unless they are absolutely certain of the facts. For example, a patient should never be described as a homosexual or possibly homosexual unless he has himself told his doctor of this."

of persons suffering from such disease or the prevention of the spread thereof, and (b) for the purpose of such treatment or prevention."

Dr Patricia Price was adamant that confidentiality should be preserved. Otherwise, those at risk would be deterred from coming forward for testing or treatment. She thought that if a general practitioner referred a patient to a clinic after counselling him or her that inferred that the patient wanted the general practitioner to be kept informed; if it was a self referral the patient probably did not want the general practitioner to know.

It was sad if patients did not think that they could go to their general practitioner, Dr Gordon

Taylor said. How could general practitioners treat their patients properly if they did not know all the facts. He thought that Leicestershire would get a lot of support at the annual conference.

Dr John Oldroyd is a member of the AIDS working party and sits on the medical advisory committee of one of the medical defence societies. The latter had had to deal increasingly with questions on confidentiality, he said. Because the government believed that it was faced with a major public health risk it had told those at risk that if they came forward for tests their confidentiality would be preserved. Some general practitioners, Dr Oldroyd told the GMSC, had felt excluded because of this. An exception had been made for morticians to be told if someone had had AIDS or had been HIV positive. There were, he said, different scenarios. If a patient was counselled by a clinician but did not want his general practitioner to know that he was HIV positive that would be honoured. On the other hand, a general practitioner might refer a patient and believe that he and his colleagues should know the outcome.

Dr Oldroyd referred to the position in London, where some general practitioners had rejected patients who had to be looked after in the community because the hospitals could not cope. Some of the patients were homosexuals who had looked after their partners who had now died so they had no one to care for them. Nursing officers were organising the care in the community and had reported the hostile reaction of some general practitioners' receptionists and the fact that confidentiality was being breached. Nevertheless, the Department of Health and the Chief Medical Officer were aware, Dr Oldroyd said, that their advice on confidentiality was creating problems for doctors.

Dr David Williams did not see any difference between AIDS and other diseases. Confidentiality had to be absolute and exceptions always justified—breaching confidence in the case of epilepsy could be justified. Leicestershire's request should be thrown out. In his view the primary health care team was like a small village; there was no one in his village who did not pass on information "in complete confidence."

Disagreeing, Dr Tony Keable-Elliott said that confidentiality was important but was not totally paramount. He sympathised with Leicestershire because he thought that general practitioners had a duty to protect their staff. A general practitioner should be told if a patient was suffering from a disease that could kill other people. Dr Alan Rowe reminded the committee that whenever doctors or their staff were handling body fluids the standards should be so high that risks were minimal. Unlike other speakers Dr Rowe maintained that AIDS was different because it had such appalling social effects.

Reality of community care

Sir Roy Griffiths, deputy chairman of the NHS Management Board, is reviewing community care (3 January, p 72) and last month he met a team from the BMA. This included a representative from the GMSC but the committee decided that it

should also seek a separate meeting with Sir Roy. The GMSC has submitted evidence to the review based on a working party's analysis of the Audit Commission's review *Making a reality of community care*.

The commission had pointed out that although the policy of successive governments had been to promote and foster community care there had been slow progress. Progress had been slowest for mentally ill people, for whom the reduction of NHS hospital provision had been faster than the build up of community resources. The response across the country had been uneven, and future prospects were unattractive. The reduction in NHS facilities had been partly offset by the growth in residential homes funded in part through supplementary benefit payments to residents rather than by growth in more flexible forms of community care.

Among the options put forward for examination the commission suggested that local authorities could be made responsible for the long term care except for the most severely disabled who required medical supervision. For the care of the elderly in the community a single budget could be established by contributions from the NHS and local authorities—the budget under the control of a manager. The NHS would remain the prime authority for the care of mentally ill people but there could be an arrangement similar to that proposed for services for the elderly. The commission suggested that care funded by supplementary benefits in the private and voluntary sector could be better coordinated.

The GMSC's working party welcomed the analysis and made several recommendations:

- Family practitioner committees and local medical committees must be involved in the planning of all types of residential care facilities.
- Professional assessment should always be carried out to establish the best way of meeting the needs of people who, because of disability or infirmity, can no longer live independently. This is particularly important before any permanent move is made from home into institutional care.
- The general practitioner, who has particular knowledge of the person and his or her environment and family, should be involved in this assessment.
- Residential care should be planned as part of the community services.
- National guidelines are necessary to ensure consistency in the standards of provision.
- Centrally made restrictions on the use of existing resources and the recruitment of staff should be removed in order to encourage local flexibility and innovation.
- The primary health care teams should have the responsibility for providing services to residents of community based institutions.
- The NHS regulations should be reviewed so that the special needs of those people who are resident in nursing homes, hospices, hostels, and residential homes can be properly met.
- Community hospitals can play an important role in the provision of respite care.

The commission had taken up nearly everything that the committee had been saying, Dr Arnold Elliott said, but he did not think that combined funding would be practical for services to the elderly, and he suggested a trial in one area. He hoped that the aim of the Griffiths review was not to save money and cut down on supplementary benefits; if so it should be opposed.

Dr Idris Humphreys did not think that the working party's recommendations went far enough. All members of the primary health care

team should take part in the assessment because this was where things often went wrong. He also thought that families should be given more information about the availability of community care.

It was unrealistic for community care to be funded from three sources, Dr John Callander said, but though he agreed with the suggestion of a manager he did not think he should control the budget; that smacked of health maintenance organisations.

The recommendation for the need for consistency in the standard of provision should be spelt out, according to Dr Mervyn Goodman. For example, the only occupational therapy in one residential home he had visited was television.

Dr Lionel Kopelowitz pointed out that community care was not a cheap option; it needed more resources—that is, more money.

Dr John Ball thought that it made sense to have a manager but he wanted some kind of medical advisory machinery. His experience with working in a home for the mentally handicapped had been the plethora of people in charge. The committee should say that one person should be in charge of the management of the patient.

Dr Alison Hill pointed to the need to train general practitioners in caring for the mentally handicapped as more of them would be cared for in the community.

Information to patients on medicines

The GMSC has endorsed the following recommendations from the Association of the British Pharmaceutical Industry on information to patients on medicines:

(i) Written information, as a patient package leaflet, should be given to reinforce and amplify that given by the doctor and pharmacist.

(ii) The leaflet should be included in the original pack on the introduction of original pack dispensing.

(iii) The information should be as brief and succinct as the leaflet regulations allow and should be in a standardised layout, if appropriate, taking due account of the presentation requirement of the regulations—namely, that statutory particulars about the product are kept separate from the balance of the leaflet.

(iv) Further consideration should be given to the needs of the blind and of those who do not understand the English language.

(v) The leaflets and additional detailed information should be collated into a compendium (by the ABPI for publication by Datapharm) for provision to doctors and pharmacists and for reference by patients.

(vi) The leaflet should clearly state that the information it contains is limited and that further information can be obtained from other sources, including the doctor and the pharmacist.

(vii) Individual manufacturers should be responsible for preparing the information and should hold the copyright thereof.

(viii) The cost of providing the information should be borne by the manufacturer.

(ix) The leaflet should be approved by the DHSS at the time of issue of the product licence or at the five yearly renewal of the product licence.

(x) An interim leaflet should be issued for existing products.

(xi) The effect of the provision of patient information should be reviewed.

Dietary advice

The chairman reminded the committee that the terms of service prohibited general practitioners from accepting a fee from an NHS patient for treatment or for supplying any drug except under certain specified circumstances. Dr Wilson gave this advice because general practitioners often give advice on diet and may be asked to supply dietary products to patients.

Working group on audit

Last year's special conference on primary health care resolved that local medical committees should establish local guidelines for informal audit of general practitioner activities such as patterns of hospital referral and use of laboratory investigations. A working group has been set up to review the position and to produce a discussion document. Dr Ian Bogle will chair the group helped by Dr Gareth Emrhys-Jones, Dr David Godfrey, Dr John Lynch, and Dr Jane Richards.

Treating overseas visitors in the NHS

Charges to overseas visitors who are treated as inpatients in the National Health Service have been increased by 17.6% and outpatient charges have gone up by 6.1% with effect from 1 April. The increases are in line with the central list that the Department of Health and Social Security recommended last month for charges for private patients (28 March, p 852).

Visitors will continue to have emergency treatment free at accident and emergency departments, and treatment for people with communicable diseases and for patients compulsorily detained in psychiatric hospitals is also free. People from countries with which the United Kingdom has reciprocal health agreements and from the European Community are treated free of charge. Other people who are entitled to free treatment include overseas visitors (including students) who have been in the country for more than a year, people coming to this country to work, and dependants of people already settled here.

GPs reappointed to Scottish MPC

Dr John MacKay of Kilmacoll, Renfrewshire, and Dr John Burt of Dunfermline have been reappointed chairman and medical member of the Scottish Medical Practices Committee. The appointments are for three years. The committee consists of a chairman and five other members, three of whom must be general medical practitioners engaged in practice. All are appointed by the Secretary of State for Scotland after consultation with the Scottish General Medical Services Committee.