

from home—it is also likely to lead to an erosion of the confidentiality of the disseminated information. Given this trade off, the critical issue is whether the patient will be permitted to implement his or her preferences. This bill does not grant the patient that capability.

Lord Walton's bill has the virtue of criminalising certain categories of improper disclosure and of establishing penalties, albeit modest, for such infractions. But there are highly important practices that invade privacy which the bill does not address. It does not attempt to regulate the disclosure of personal health information once such information has left the circle of health care provision. Neither does it attack the ever growing commerce in personal medical information nor penalise those who obtain such information under false pretences (by impersonating a doctor, for example.)

Finally, it does not address the challenges to privacy posed by those who wish to use the computer to do all inclusive research—for example, research on “all the inhabitants of . . .” or “all the people who became ill with the . . . disease in 19 . . . .” With respect to research, the bill permits the

use of patient identified information without consent when obtaining consent would not be “practicable.” Of course, obtaining consent from all the members of a large population set is generally not practicable. But given the kinds of studies that statisticians can now undertake with the aid of computer technology, do we really wish to permit the extensive and intensive invasions of privacy that are possible under this rule? If we wish only “de-identified” information to be used for such studies, can we come to an agreement about what counts as de-identified? The time has come for public discussion of these important issues. It is to be hoped that Lord Walton's bill will help to provoke it.

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- 1 General Medical Council. *Good medical practice*. London: GMC, 1995.
- 2 Anderson R. *Security in clinical information systems*. London: BMA, 1996.

## Providing intensive care

### *High dependency units and bed registers will help, but not without more resources*

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The recent deaths of two severely ill patients being transferred from one hospital to another in search of specialised intensive care have caused public alarm in Britain and have raised questions about the resourcing and organisation of adult and paediatric intensive care.

The British Paediatric Association has repeatedly pointed to the apparent shortfall in paediatric intensive care beds,<sup>1,2</sup> but to seemingly little effect. The fact that major paediatric centres often have to refuse admission negates the association's recommendation that sick children be provided with specialist nursing and medical care. Shann points out that twice as many children per head of population are admitted to intensive care in Australia and the United States as in Britain.<sup>3</sup> Small units with low admission rates and often without a full time intensive care specialist lead to a fragmented service, with detrimental impacts on morbidity and mortality. Shann suggests that the solution would be to set up large paediatric intensive treatment units with a minimum of 12-14 beds and 1200 admissions a year.

The situation of adult intensive treatment is no more encouraging.<sup>4</sup> Provision varies widely across England, from 1.8 beds per 100 000 population in Oxford and East Anglia Region, 2.6 in Northern Region, and 3.0 in South East Thames, according to a survey due to be published by Metcalfe and McPherson. They found that nearly a third of health authorities had fewer than four staffed intensive treatment beds, a number that is neither clinically nor economically viable. Only 28% of units had a full time director. Britain has fewer intensive treatment beds than other countries in western Europe,<sup>5</sup> and resources are stretched. Patients are more severely ill when they are finally admitted and have a higher death rate. When outcomes are adjusted for severity of illness British units perform well, but patients are disadvantaged by such late intervention.

All major hospitals provide specialist facilities for burns, dialysis, and coronary care, but these units are so selective that most patients are not eligible for admission to them. High dependency units, which provide a standard of care between

that achieved on the ward and in the intensive treatment unit, may help.<sup>5,6</sup> In one study, within a year of setting up a high dependency unit, ward mortality fell by 13.3%.<sup>7</sup> It makes clinical and economic sense to anticipate problems early, to intervene quickly, and to concentrate ill patients in specialised areas rather than have them scattered throughout the hospital.<sup>8,9</sup> Currently only 15% of hospitals in Britain have high dependency units. Cases currently cared for in intensive treatment units would be suitable, as would cases planned for major elective surgical procedures, which are a part of every intensive treatment unit's admission load.<sup>10</sup> There is also the possibility of influencing the unit's discharge mortality, which in Britain currently ranges from 6% to 16%.<sup>4,6</sup>

However, high dependency units alone will not solve the problem. There is no doubt that the major hospitals have insufficient numbers of intensive treatment beds.<sup>10</sup> Moving critically ill patients between hospitals has become a far from ideal way of life. A central register of intensive treatment beds could remove some of the frustration that doctors and nurses now experience when searching for beds for their patients, but such an initiative should not be used to hide the reality of how desperate we are for more resources.

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- 1 British Paediatric Association. *Report of a working party on paediatric intensive care*. London: BPA, 1987.
- 2 British Paediatric Association. *Towards a combined child health service*. London: BPA, 1991.
- 3 Shann F. Paediatric intensive care. *Lancet* 1993;342:1240.
- 4 Working Group on Guidelines on Admission To and Discharge from Intensive Care and High Dependency Units. *Report*. London: Department of Health, 1996.
- 5 Bion J. Cost containment: Europe. The United Kingdom. *Crit Care Med* 1994;2:341-4.
- 6 Ryan DW. Rationing intensive care. High dependency units may be the answer. *BMJ* 1995;310:682-3.
- 7 Franklin CM, Rackow EC, Mamdani B, Nightingale S, Burke G, Weil, MH, et al. Decreases in mortality on a large urban service by facilitating access to critical care. *Arch Intern Med* 1988;148:1403-5.
- 8 Kilpatrick A, Ridley S, Plenderleith L. A changing role for intensive therapy: is there a case for high dependency care? *Anaesthesia* 1994;49:666-70.
- 9 Peacock JE, Edbrooke DL. Rationing intensive care. Data from one high-dependency unit supports their effectiveness. *BMJ* 1995;310:1413.
- 10 Smith GB, Taylor BL, McQuillan PJ, Nials E. Rationing intensive care. Intensive care provision varies widely across Britain. *BMJ* 1995;310:412-3.