Disclosure and anonymity in patient confidentiality

Sir,

The article by Keegan and Levenson on patient confidentiality (vol 71(7), 2010, p. M105) is well written, but does not deal with two matters in the General Medical Council (2009) guidance. The first is that the guidance (paragraphs 36 and 42) advises that public interest can justify disclosure of patient information without consent for medical research. The common law duty of confidentiality underlies the presumption that all information given by a patient to his/her doctor will be treated in confidence and that disclosing it without consent or other legal basis will be a breach of that duty. This is fundamental to maintaining the trust of patients in the custodians of their records, so that they may consult freely.

In England and Wales, there is statutory provision that gives protection from liability of breach of the common law, which is granted by the Secretary of State, on the advice of the Ethics and Confidentiality Committee. This is not available in Scotland and Northern Ireland. Thus in England and Wales reliance by disclosing trusts on the uncertainty of the common law is inadvisable, particularly since the case law suggests a high threshold of public interest, such as to prevent a crime or prevent harm, may be required by the courts. The uncertainty is removed by applying to the Ethics and Confidentiality Committee, which applies the requirements set out in section 251 of the NHS Act 2006.

The second matter is that paragraph 49b of the guidance says that the task of anonymising the information or seeking patients' consent to disclosure (for research) can be delegated to someone incorporated into the health-care team on a temporary basis.

The common law duty of confidentiality expects that confidential patient information is only used for purposes which the patient expects. While implied consent can be used as a basis for adding members to a primary health-care team to provide clinical care, this cannot extend to secondary uses without some reasonable basis for this expectation.

If there is debate and development of evidence of public expectations, through consultations and research, we could reach a definition of a limited scope of what circumstances access to records for research can have implied consent, as has been done with local audit.

The fact that the classes that may be registered under section 251 include the purposes in paragraph 49b is evidence that the statutory intent was that section 251 protection should be sought for consent and anonymisation processes that were not required for clinical care. It also clearly demonstrates that disclosing patient data for that purpose without consent is liable to breach the common law duty of confidentiality.

It seems that both these sections of General Medical Council guidance are liable to mislead and misrepresent the law, which may result in legally insecure handling of confidential patient information. Given the large gap in perceptions between the public and researchers about what is and should be disclosed without consent, these aspects of General Medical Council guidance may be favoured by the research community, but create even greater dissonance with the general public and themselves potentially damage the patients' trust in the custodianship of their records by their doctors.

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General Medical Council (2009) *Confidentiality*. General Medical Council, London

Sir,

Dr Harris suggests that the statutory intent of section 251 of the NHS Act 2006 is that approval should be sought for disclosures of identifiable patient information without consent for purposes covered by the Health Service (Control of Patient Information) Regulations 2002 in England and Wales. It is our view that section 251 does not require approval to be sought. Rather the intention of the legislation is to provide a means whereby doctors, trusts and others can be assured that disclosures that might otherwise be unlawful can be lawfully undertaken. The Act describes this as follows:

'for securing that, where prescribed patient information is processed by a person in accordance with the regulations, anything done by him in so processing the information must be taken to be lawfully done despite any obligation of confidence owed by him in respect of it'.

The obligation of confidence is not, and has never been, an absolute obligation. It is well established that disclosures may be made 'in the public interest'. The public interest test must now take account not just of case law, such as *Egdell* and *AG* v *Guardian Newspapers*, but also Article 8 of the European Convention on Human Rights. The test is one of proportionality, where the benefits to an individual or society of a disclosure outweigh both the public and the patient's interest in keeping the information confidential. It is the only basis for relevant disclosures of identifiable information without consent in Scotland and Northern Ireland, where doctors should seek advice from Caldicott guardians and the Privacy Advisory Committee respectively. If public interest disclosure for secondary purposes in those countries is not unlawful, it seems unlikely that the existence of section 251 makes it unlawful in England or Wales.

Nonetheless, the General Medical Council supports the use of section 251 approval for secondary uses of confidential patient information. This benefits both patients and doctors by providing careful, independent scrutiny of certain uses of information without consent, and enabling doctors to use identifiable data without any fear (however unlikely) of later censure from the courts if a patient were to bring a civil action against them.

Doctors in England and Wales are advised to 'seek and abide by the independent advice of the Ethics and Confidentiality Committee of the National Information Governance Board'. However, we believe it would be inappropriate to impose an absolute duty on doctors in England and Wales that does not exist in law.

Paragraph 49b of the General Medical Council guidance advises that a person incorporated into the health-care team on a temporary basis may undertake the task of anonymising data before it is disclosed for a secondary purpose, provided he/she is bound by legal and contractual obligations

of confidentiality. This is a pragmatic response to a problem which has caused concern and confusion in the profession.

There is no doubt that the tasks of anonymising or coding patients' information for secondary purposes can be delegated to non-clinical health-care team members. Nor is it in dispute that temporary staff can be incorporated into a health-care team, e.g. to cover staff absences or to manage an increased workload, so long as they are bound by contractual confidential obligations. Dr Harris suggests that it is a clear breach of the common law duty of confidentiality for doctors to delegate to temporary staff (but retain overall responsibility for) the task of anonymising or coding information or seeking patients' consent; but only if they do not also support the provision of those patients' care, e.g. by filing their notes.

Doctors in England and Wales who are in any doubt about the lawfulness of their actions should seek the advice of the Ethics and Confidentiality Committee of National Information Governance Board for Health and Social Care. We would be concerned if disclosures made on a public interest basis or with section 251 support were shown to be undermining trust in the confidentiality of medical records, which we regard as an essential part of the wider trust and confidence in the profession.

The guidance is clear that doctors should use anonymised or coded information for research and other secondary uses whenever that is practicable and will serve the purpose, otherwise patients' express consent should be sought. Only if neither is practicable should doctors go on to rely on a public interest justification or support under section 251 where it is available.

The General Medical Council's role is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. Confidentiality has always been at the heart of good medical practice. Our new guidance ensures it remains there.

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Can we justify the cost of information technology in the NHS?

Sir,

We read with interest the article by Trivedi et al (vol 71(9), 2010, p. M130) on information governance. While the duty to respect confidentiality is paramount, the challenge is to safeguard information while ensuring appropriate access to make clinical decisions and communicate with other professionals involved in patient care. It follows that NHS employers and health-care systems have a corresponding duty to provide appropriate facilities to permit these activities without jeopardising patient privacy.

While the authors cite the billions of pounds which have been spent on improving capacity and performance, they do not comment on the vast degree of waste and failure to deliver which have been exposed over the past few years, and that the 'basics' are often ignored. For example, hospital doctors are frequently required to make referrals or share information to other hospital teams via telephone. Such conversations may be overheard. A secure telephone, access to patient notes and charts, and results (usually computerized) are necessary.

We have both previously worked in hospitals where only the minority of adult inpatient wards had an office in which doctors may work. The consequence was that most telephone conversations occurred in the open ward, potentially audible to other patients and visitors. Even though the majority were innocuous, we are aware of instances in which discussions about patient resuscitation status, blood-borne virus infection and recreational drug use inadvertently led to disclosure of this information to third parties.

It is easy to argue that due caution was not observed in these situations. Nonetheless it was ultimately environmental factors, and specifically failure to provide a space that was 'secure' and 'inaccessible to the public' yet within reach of the required information, that predisposed to these mishaps. In the era of nationalized projects, we urge NHS trusts to consider how small-scale local provision of facilities for health-care providers can so greatly impact on protecting patient confidentiality.

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Sir,

With the rapid advances in information technology happening every day, even the NHS has to keep up with the technology advances happening in the United States and Europe. Billions of pounds were spent on information technology in the era of modernising the NHS, which is crucial for better patient record and information management. Every piece of information in whatever form, either in the form of notes or electronically, requires one to follow the basic principles of data protection and confidentiality. In our view, development in information technology was essential within the NHS. Our aim in this article was to highlight the importance of information governance relating to this.

The authors have also raised the issue about 'waste' – in our view, it is all about developing the basic understanding of using the resources and, more importantly, awakening everyone's consciences to stop wasting, which was not the aim of our article.

As regards the issues about conversations regarding patient resuscitation status, blood-borne virus infection and recreational drug use inadvertently leading to disclosure of this information to third parties, due care should have been taken to follow the basic principles of patient confidentiality and data protection. However, many trivial incidents are very difficult to avoid no matter how hard one tries.

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