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Interim guidelines on confidentiality and medical audit

Guidance from the Conference of Medical Royal Colleges and their Faculties in the United Kingdom

Medical audit is primarily an educational activity and will be professionally led (Health Circular (91)2. Para 3). It is designed to improve the standards of patient care. As part of the arrangements to implement the National Health Service and Community Care Act (1990), all doctors working in the National Health Service are required to undertake medical audit and, while recognising the need for confidentiality, it is required that managers and health authorities are provided with regular reports (HC(91)2. Para 4). Potential conflicts of interest, therefore, arise in relation to the data required for medical audit and the needs of patients and clinicians for confidentiality and of management for information.

The Data Protection Act (1984) already allows patients access to data held on computers and word processors. The Access to Health Records Act (1990) will allow such access to manual records by the end of 1991. It is possible that medical audit data will be considered part of the medical record. Such records are likely to be discoverable at law in relation to litigation conducted on behalf of patients' interests and also may be used by employing authorities for disciplinary purposes. The Colleges have been advised that the only exception to discovery in relation to litigation would be that the disclosure of records was not in the public interest. Such protection appears to have been implied for large regional or national audits (for example, the Confidential Enquiries into Maternal and Perioperative Deaths), but has never been tested in the courts. The audit records of individual clinicians and units are almost certainly discoverable. No record of an audit meeting should contain any information that could allow identification of patient, clinicians or other hospital staff.

There are particular problems relating to issues of medical audit and confidentiality for patients, clinicians and management which need separate consideration.

1. Patients

The confidentiality of all personal health information has been recently emphasised (NHS/90 (GEN)22). Usually patient consent is implicit, or explicit consent is obtained before passing on such information to other professionals. This will not generally apply to medical audit. The necessity to anonymise patient data related to audit meetings is, therefore, emphasised. Only aggregated data or general conclusions should be passed on to management or to health authorities to ensure that individual patients cannot be identified (HC(91)2. para 6e).

However, it should be noted that the Audit Commission have rights of access to such information as appears to it to be necessary for the purposes of audit without consent of patients or clinicians.

2. Clinicians

In order to achieve the goals of improved patient care and professional education, open and frank discussion during peer review of medical audit meetings is essential. The likelihood of discoverability of the records of such meetings poses a difficult problem for clinicians. All records of audit meetings written or computerised, must be anonymised. There is no need to retain working protocols or proformas used for recording data from patient records, as they duplicate information already available in the primary medical record. Serious problems relating to patient care identified by medical audit should be dealt with within the established professional procedures.

3. Management

The primary educational aims of medical audit in improving the overall standard of patient care rather than attempting to identify 'bad apples' should be emphasised. Management needs to ensure that adequate medical audit procedures are in place involving all doctors and that the activity is both efficient and effective. It is the responsibility of local managers to ensure that adequate resources are available to support the agreed audit programme, together with the associated education and training programmes. Support staff and appropriate information systems will be necessary in all units. (HC(91)2. para 14).

The requirements of confidentiality for both patients and clinicians mean that the regular reports of audit activities to management must be

anonymised. The reports should cover the general areas of activity audited, the overall conclusions and recommendations made, and plans for action or procedural changes, the necessity for which has been revealed by the audit (HC(91)2 para 8). There should also be a record of when a review of the results of the changes should be made and the proposed methods of review. These reports will normally be submitted to management through the medical Audit Committee.

These interim guidelines have been endorsed by the Chief Medical Officer of the Department of Health.

The conference is grateful to Dr Peter Beck and to Dr Anthony Hopkins for their help in preparing this guidance.

Winter Quarterly Meeting, 1992

The Winter Quarterly Meeting was held at the Royal Institute of British Architects, London on 21 and 22 January 1992 under the Presidency of Professor A. C. P. Sims.

Business Meeting

The business meeting was held on 22 January, attended by 24 Members of the College.

Minutes

The minutes of the Autumn Quarterly Meeting held at Kensington Town Hall, London on 23 October 1991 were approved and signed.

Registrar's report

The Confidential Enquiry into 'Homicide and Suicide in Mentally Ill Persons' has now found premises at No.16 Belgrave Square and a Director, Dr Bill Boyd, currently Treasurer of the College. The Department of Health is providing the financial backing.

The College has responded to the initial reports of the three advisory groups to the Reed Committee on Mentally Abnormal Offenders. There will be further deliberations of this Committee with a strong input of general as well as forensic psychiatrists.

The division of purchasers and providers has now pervaded many of the reports coming from the Sections and Working Groups of the College. A working partly jointly established with the Faculty of Public Health is endeavouring to provide members of the College with some guidelines to assist them to maintain high standards of clinical practice under these new arrangements.

Two new special interest groups will be formally established at our Spring Meeting in Dundee. They are the special interest group for transcultural psychiatry and the special interest group for management issues.

There is now some discussion about the frequency of meetings. It is suggested that overall attendance would be highest if there were only two meetings – the Annual Meeting and a second early in the year. The meetings could be longer and have more parallel sessions and we welcome comments from all the members about this.

PROFESSOR ANN GATH

Discussion paper on frequency of College meetings

It has been suggested that the format of the College's Quarterly Scientific Meetings should change. This paper puts forward the proposal that there should be two large scientific meetings per year, one of which might be held in London and the other might rotate and be held where suitable conference facilities are available.

Members and speakers are experiencing greater problems in claiming travelling expenses and study leave in order to attend College meetings. While attendance at Section meetings is growing, the attendance at some Divisional meetings is decreasing. The number of delegates at the Autumn and Annual meetings continues to grow each year while attendance at the Winter and Spring meetings is variable. It is anticipated, as at the recent Annual Meeting, that if the College meetings are limited to two per year then attendance overall will increase.

The suggestion to restrict the College meetings has come, not only from many Chairmen of Sections and Divisions, but also from members of the Programmes and Meetings Committees. A paper