*Psychiatric Bulletin* (1990), **14**, 97–109

# The College

## Position Statement on Confidentiality

### *Remit and membership of the Special Committee*

**Remit**

(i) A Special Committee was convened by Council to review the problems associated with confidentiality in psychiatry (Confidentiality Committee) whose remit was to consider:

patient access to their medical records, both computerised and manual, in the light of the Data Protection Act and the Access to Personal Files Act

the use of shared confidential information with particular reference to the difficulties encountered by child and adolescent psychiatrists working in multidisciplinary teams concerned with child mental health and child protection

confidentiality and research

conflicting advice on confidentiality from Mental Health Act Commission, General Medical Council, and other Authorities.

(ii) The Special Committee was to report to Council and if necessary was to propose its own draft guidelines on confidentiality.

**Membership**

*Chairman:* Dr T. H. Bewley

*Members from Council:*

Professor R. G. Priest
Dr A. R. M. Freeman
Dr C. Davies

*Representatives of Sections:*

Dr J. Hendriks (Child and Adolescent Psychiatry)
Dr A. Bolton (Child and Adolescent Psychiatry)
Dr P. Taylor (Forensic Psychiatry)
Dr Y. Wiley (Mental Handicap)
Professor B. Pitt (Old Age Psychiatry)
Dr J. S. Madden (Substance Misuse)
Dr R. Whiteley (Psychotherapy)
Dr K. A. Day (representing the Joint British Psychological and Royal College of Psychiatrists Standing Committee)

### *Brief overview*

**Confidentiality**

One of the fundamental principles of medical practice is that all which passes between a patient and a doctor in the course of a professional relationship is confidential. The General Medical Council has stated that it is a doctor's duty (except in certain special situations) strictly to observe the rule of professional secrecy by refraining from disclosing voluntarily to any third party information about a patient which he has learned directly or indirectly in his professional capacity. The exceptions are listed by the GMC in the pamphlet *Professional Conduct and Discipline: Fitness to Practice* (pp. 19–22). The exceptions listed by the GMC are given in full in Appendix A.

**Psychiatric case notes**

(i) Psychiatric case notes are not produced by a single individual and generally contain much more than the information contributed by doctors. They can include information provided directly by nurses, social workers, and others in the form of notes, reports and letters. As well as this, they contain information from similar sources which is second hand (for example copies of summaries and case notes from other hospitals or reports from Probation Officers). They also may contain much information, the origin of which may be uncertain. *It cannot be emphasised too strongly that a psychiatric case record differs markedly from other medical records.*

(ii) When a report is written, giving information about the past history and upbringing of a patient, this is generally an amalgam of information from a number of different sources. Present hospital practice differs markedly from private practice where any recorded notes will be seen solely by the practitioner.

**Sharing information with other professionals**

(i) Changes in the way that medicine in general, and psychiatry in particular, are practised have led to a much more widespread sharing of general information obtained from a patient by a doctor, for example within multidisciplinary teams.

(ii) Personal information is also very much more widely disseminated. Notes may be photocopied and sent to other professionals, who may include them in their notes which may be available to further professionals. In practice, it is increasingly difficult to preserve strict confidentiality.

(iii) The consent of patients to the disclosure of information about themselves may sometimes be implied – if, for example, they have referred a third party, such as a housing authority or an employer, to

the doctor for information. However, even in these cases, it is good practice to receive in writing the consent of the patients to disclose such information, and to specify what should or should not be included.

(iv) Two further problems arise with psychiatric case notes. They contain much information given by third parties and they contain many opinions – they are not solely factual records. *There are moves towards allowing patients access to their own records* and there is no likelihood of any reversal of these trends, nor a return to a previous pattern of practice where a patient saw, and was treated, by a single doctor without consultation with other doctors or other professionals. It is therefore necessary to reconsider the degree of confidentiality that can be offered to a patient.

(v) One possible solution is that patients should have the situation concerning confidentiality more clearly explained to them. This would enable the patient to decide for himself how much information he would be prepared to give. However, some psychiatric patients are incapable of understanding the position and therefore their consent to any particular course of action cannot be obtained. Another possibility is to guarantee the patient complete confidentiality and for the doctor to keep separate notes not divulged to anybody. This makes normal treatment impossible (i.e. treatment by a multidisciplinary team, with whom the information is shared).

#### Access to own notes

(i) Until recently, patients did not see their own case notes. Much greater openness and accountability has been demanded and the amount of information about a person that he may have the right to see has increased and is continuing to increase. Medical records have not been exempted from this movement and patients are now entitled (with some safeguards) to see any computer held records which refer to them. It is illogical to disallow a patient from seeing his notes solely because they have been produced manually as there should be no difference in the accuracy or otherwise of the information stored.

(ii) It may be necessary to reconsider the way that medical case notes are currently compiled to take into account that, *in the future, patients will have access to them*. It may also be necessary to ensure that certain information from other people will be recorded separately in such a way that it is clear that this information is not to be given to the patient if he seeks it (in order that the informants' confidentiality can be protected).

#### Confidentiality and non-volitional patients

(i) There are special problems in relation to the severely mentally handicapped, the elderly mentally infirm, and some acutely psychiatrically disturbed patients who are unable to give consent themselves. Mildly mentally handicapped individuals can, after an explanation, usually give valid consent (for example, permission to dress a wound).

(ii) Following a recent court case, the legal problem which existed with a non-volitional patient (who did not understand what treatment was proposed well enough to give consent and nobody else could act on his behalf) was explored. The Supreme Court in England is establishing rules which will allow the Court to rule when controversial treatment is proposed. The Court will normally be approached by those caring for the patient, or whoever is intending to carry out the treatment. Psychiatrists who are treating patients in this position should seek legal advice. It remains to be seen whether these new rules will resolve the problems of non-volitional patients requiring routine medical care.

(iii) Except in the case of minors, next of kin do not have a legal right of access to personal information about their relatives.

(iv) Rules may be introduced to allow access to data by an applicant when the patient is of unsound mind and unable to manage his affairs. However, not every individual with mental disorder or impairment would be incapable. An applicant might be a relative who would be dismayed to learn certain information that might be in the notes. Information, for example, might have been given by the patient at a time when able to give an adequate history, regarding sexual indiscretions unknown to the applicant. The applicant could therefore be distressed to learn of such matters. The general need to withhold or modify data regarding sources of information may be less important. But it should be remembered that an applicant might later divulge the contents of case notes to a patient who had regained some capacity to understand them. It is unlikely that many applications of this nature would be made.

## *Recording case histories*

(i) It is an essential and basic part of the work of any doctor, including a psychiatrist, to take a full case history. This may include the patient's account to the doctor not only of his illness, but of the characteristics of his family and their health and other most private matters including sexual and marital history and possibly criminal record and history of substance abuse. Further information will be provided by others including family, friends or professionals depending on the circumstances of the case.

(ii) The purpose of this gathering of information is to make a provisional diagnosis or diagnostic formulation or a list of diagnostic possibilities. At this stage of the enquiry, preliminary opinions and conjectures will be recorded. Following further history taking,

observation and investigations, it is customary for the whole record to be condensed into a case summary which will form the basis of a report to a general practitioner.

(iii) At the present time, the case history and case summary are prepared with a view to the sharing of both factual details and provisional opinions for the purposes of consultation between doctors, the training needs of doctors and the needs of the multidisciplinary team, the whole process being directed to optimum patient care. It is at present compiled in the belief that it is a document restricted to the professionals concerned. Subject access to enable the patient to detect and correct errors of fact or emphasis may also reveal contents which may be emotionally loaded and it seems probable that many patients – whether or not recovered from their illness – will have strong views about what has been recorded. It seems likely that many patients may be distressed about what they read even if this does not amount to actual detriment to their health.

(iv) It follows that either the present type of case history may have to be abandoned or else the patient may have to have access to the record during its compilation so that its contents can be explained or discussed.

*Recommendations:*

(i) Patients and informants should be helped to understand the complexities of confidentiality during the initial interview. It must be recognised that this may inhibit the gathering of information.

(ii) Medical case notes are essential for the planning of treatment of a patient and may be shared for this purpose. Psychiatric case notes nowadays may only have limited confidentiality, particularly with multidisciplinary team work. Patients have a right to know that confidential information may be shared with other professionals. Drug misusers are particularly sensitive about confidentiality and should be reassured that information concerning individuals is not divulged to the police.

## *Interprofessional transfer of information*

(i) This may occur along a spectrum from the informal to the legally defined. Doctors should identify the framework within which information has been shared and, where appropriate, the consent given for such transfer.

(ii) Information may be shared within networks of professionals in the health service or community settings, and where some members of the group are employed other than by the NHS, for example by Departments of Social Services and Departments of Education. Examples are special schools, children's homes, teams for the mentally handicapped and physically handicapped, teams working with substance misusers and teams working with the elderly. These may range from small close-knit groups of people with clear rules and guidelines about the sharing of information to groups occasionally convened where the majority may not be known one to another. Records may be kept in settings other than those managed by the NHS; for example, schools, children's homes, probation offices, Departments of Social Services, etc. Doctors may wish to contribute medical information for the benefit of individual patients yet are not responsible for the recording or storage of such information. Information may be shared within National Health or private health facilities where teams of 'health professionals' work together for the benefit of patients.

(iii) Information sharing may be empowered or required by regulations or codes of conduct supported by law, such as the codes of conduct regarding the exchange of personal health and social services information and circulars relating to the Education Act 1981 (England and Wales). Information may be shared within guidelines outlined by the Department of Health; for example, those relating to child protection.

(iv) Information may be requested or subpoened in the form of evidence to civil or criminal courts or other tribunals. It may also be requested by officers of such courts, such as the Official Solicitor, guardians *ad litem*, divorce court welfare officers or probation officers.

(v) Information may be required via legislation. Examples are the law concerning public health, mental health legislation, vehicle licensing law and criminal justice legislation. (Appendix B discusses the law concerning disclosure of information.)

## *Shared information*

In order to provide the best service for patients, sharing of information between professionals is inevitable and indeed essential. This is a two way process and doctors cannot expect other disciplines to share information if doctors are not prepared to share with them. Information should be shared only if it is essential for the welfare of the patient or the safety of others and if its confidential nature is made clear. (The principles to be observed are outlined in the Department of Health draft Code on Confidentiality Appendix C.)

*Recommendation*

Patients should be made aware that appropriate sharing of information with other professionals is

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necessary in order to provide the best possible care, support and treatment.

## *Multidisciplinary teams*

(i) Confidentiality within multidisciplinary teams working in NHS premises should present no problems where information is shared with health professionals, particularly now that 'health professional' has been defined by the DHSS (HC (87) 14 Article 2).

(ii) Difficulties arise when information has to be shared with team members who are employed by another authority, particularly social workers, but also, sometimes teachers and educational psychologists. Most local authority Social Services Departments insist that their employees keep separate notes. These notes are the property of the local authority but they will, if good clinical work is to be done, inevitably contain some confidential information from medical sources. Some Social Services Departments also computerise information which thus can become more widely available.

(iii) The suggestion that all patients on first contact might be told that any information given by them is at risk of being widely disseminated is unrealistic and could damage any positive doctor–patient relationship.

(iv) The Körner Report (Confidentiality Working Group) makes some statements about disclosure of personal health data. (Appendix D).

(v) Many of these provisions require the health professional concerned with the patient to be satisfied that disclosure is necessary. "Mutual trust between the social services department and those using its services, where involved in their cases, is central to the successful provision of services both with the supply of information in confidence by the user of the service and on exchange of information between social services departments and other organisations or individuals. Donors of information must be satisfied that their confidence will be respected and that the information supplied by them for social work purposes will not normally be disclosed without their permission except to those who can demonstrate a need. . . . *All* staff have a general duty to respect the confidentiality of donors and subjects.

(vi) The Department of Health regards consent as *unnecessary* where the disclosure is justified for social work purposes. Other people as well as the members of the staff directly involved in the case may have access to this personal information; for example, an authority's finance department (to provide residential care), its legal staff (if there are court proceedings), other agencies (child abuse cases) and general management.

(vii) Apart from the circumstances listed above, the consent of the donor should be obtained before information is disclosed.

*Recommendations:*

(i) All staff concerned with patient care should have a contractual obligation to maintain confidentiality and should be trained accordingly and reminded of this responsibility in staff handbooks.

(ii) Medical members of multidisciplinary teams should accept only professional members *known to have undertaken to maintain confidentiality*.

## *Case conferences*

(i) Case conferences which may involve a large number of people from a variety of disciplines, including lay persons, pose particular problems. A balance has to be struck between the proper exchange of sometimes sensitive information necessary for the proper care and management of the individual, and the requirements of confidentiality. The confidential nature of the proceedings should be made clear to all attending at the onset. Circulation of reports of case conferences should be restricted to key personnel. Psychiatrists should indicate quite clearly any information given verbally which they do not want recorded in the case conference report. The practice by some Social Services Departments of circulating the draft report with requests for comments before wider circulation is to be commended.

(ii) Psychiatrists should use their judgement as to what information to divulge or withhold in relation to the nature and composition of the case conference.

## *Teaching and conferences*

Good clinical practice can only be taught by reference to previous clinical experience. Education of non-medical professionals who work with patients and with the general public is also partly dependent on recorded case material. In all these circumstances, steps must be taken to preserve confidentiality.

*Recommendations:*

(i) Where case material, or the patient in person, is presented to a closed audience in which all participating in the conference can be identified by the presenter, it is usually sufficient to ask the audience to undertake to maintain confidentiality. The oral consent of the patient should be sought at the time of the presentation even if he has previously consented or given an undertaking on admission to hospital that his case may be used for teaching purposes.

(ii) Where case material which refers to relatives, friends or other significant people is presented, their right to confidentiality must also be preserved.

(iii) Where the audience is not known to the patient, the patient's responsible doctor or the presenter, the standards of confidentiality or consent

must be much higher. Special care is necessary in open meetings, international conferences, presentations in professional journals and media broadcasting. It is preferable, wherever possible, to present only anonymous case material in these circumstances.

(iv) Appearance on film, videotape, audiotape or photograph must also be treated with great care. The conditions which operate at the time the material is made may not apply at the time of any future use, and there is also the potential risk that the material could be copied. Useful guidelines are that the patient and the responsible doctor should together consent to any such material being made, and the patient's consent in general terms for any future use taken at the time of the recording.

## *Patient and child access to personal files*

When patient access to personal files is being considered, it must be remembered that much of the information in the file may have been provided by, or be about other people who may not wish the patients to have access to that part of the file. The situation with children is more complex again since whatever the age and legal status of a child, there may be information that he should know, but his parents should not, and vice versa. There may also be sensitive information from the past, e.g. illegitimacy, parental sexual activity and delinquency which it could be inappropriate for the child to discover, even many years later. Careful consideration must be given to the position of children with regard to access with adequate legal safeguards (see Appendix E).

*Recommendation:*

Patients or their parents should not have automatic access to the entire clinical and social record as it may cause distress, particularly if it contains information, as it generally will, from a relative, or information about a relative. This third party is also entitled to be assured that what is said is confidential. On occasion, it might be dangerous, if, for example, a third party has given information about the violence of a pathologically paranoid individual.

## *Responsibility when information is withheld*

(i) There are differing aspects to withholding information. One is the responsibility of a doctor who is considering whether to divulge or to withhold information regarding a patient whose conduct might endanger the public. The second is the problem of professionals who have duties towards a patient or patients when another professional partially withholds information from them.

(ii) The General Medical Council has provided guidance regarding instances when a doctor might voluntarily disclose information about a patient. Its document entitled *Professional Conduct and Discipline: Fitness to Practice* (April 1987) discusses the possible exceptions in Sections 80–85. A psychiatrist might consider in such instances that, although not always responsible in law for the consequences if information is concealed, his responsibility in a moral sense to the public or to the patient could justify a breach of confidentiality. A doctor might find it helpful to discuss the circumstances with his medical defence society or other professional organisation. The Medical Adviser at the Driver and Vehicle Licensing Centre (Swansea 0792 72151) could also be approached, at least initially as a general issue, when a patient persists in driving against medical advice. The DHSS issued in 1989 a draft *Code of Confidentiality of Personal Health Information* together with a draft handbook of guidance. The two publications outline principles of confidentiality of personal information and exceptional circumstances where, in the view of the Department, disclosure is appropriate. The circumstances include disclosure to a person having a close personal relationship with a patient who is unable to give consent to disclosure, information to a social worker employed by a local authority or some other person whom the health authority recognises as having undertaken to look after the well-being of the patient, the prevention of serious illness or damage to the health of any person (most commonly for suspected child abuse), the prevention, detection or prosecution of serious crimes. The Code states that any person to whom disclosure is made in this manner must have accepted the legally binding nature of the confidentiality obligation imposed by his or her authority.

*Recommendations:*

(i) The informant should be asked to give consent when access to a case record is requested by a patient. If the informant does not consent, the right of confidentiality must be respected and patient access restricted.

(ii) When information is deliberately withheld by another professional, doctors should consider seeking advice from their medical defence organisations.

## *Sharing information with relatives*

It is commonly desirable to involve relatives in treatment arrangements. The need arises because of the importance of family interactions and because relatives may require factual knowledge to assist in the management of patients' needs. Moreover, a doctor who declines to see relatives at their request could be regarded as unhelpful and unsympathetic.

*Recommendations:*

(i) It is neither customary nor desirable to obtain written consent from patients when a relative is seen. Verbal or implied consent is sufficient. If verbal consent is sought then emphasis could be given to the positive aspects of the interview; it can be explained that promotion of family knowledge and understanding of the patient's difficulties will benefit the latter. Whether relatives are seen in the presence or absence of the patient depends on the particular circumstances.

(ii) Caution is necessary if it is thought a spouse may be looking for information to support a legal action for separation, divorce or custody. In these circumstances, it is essential then to obtain the patient's written consent before divulging information. At all times, the doctor must remember that the identified patient is his primary concern and responsibility.

## *Medical records*

### Ownership of written records

(i) Ownership of information held in medical records is not in law distinct from ownership of the document containing it. This is usually the property of the employer of the professional (although in private practice, it may be the professional him/herself). It is frequently the case that the interests of the doctor and the employer are broadly the same – namely the promotion of the health of the individual and the protection of privacy. There are circumstances, however, where the employer has other interests in the patient apart from his health, for example the Home Office (the employer of prison medical officers), in occupational health services, or with employees of the NHS.

(ii) The legal ownership of the medical record, whether written or computerised, is only partly relevant to the chief concerns – the right of the patient to privacy and confidentiality. In many parts of the United States, a privilege statute confers legal protection on medical confidences, but in the United Kingdom, there is no such legal right – although there is a generally acknowledged moral one.

(iii) In the United Kingdom, the crucial protection comes from the standards set by the professional bodies and is likely to continue to do so. Doctors all subscribe to standards laid down by the General Medical Council (GMC). Not all other disciplines working with patients have a comparable body, or subscribe to one where such a body exists. Apart from the GMC's guidelines on professional conduct, the Association of Healthcare Information and Medical Records Officers provides the most pertinent guidelines in relation to records. If a patient believes that medical confidence has been breached, he may take his case to the GMC, lodge a civil suit, or take his case to the European Court under the European Convention of Human Rights.

(iv) In most discussion of confidentiality issues, the primary concern is for the patient's rights, but rarely, if ever, is the information in records only about the patient. This is of as much importance when the issue is not of privacy but of a patient's access to his own records. Birmingham City Council has issued guidelines in relation to Social Service Records which may be of use in relation to medical records if patient access becomes more widely available.

### Security of medical records

(i) In the hospital service, there is usually a central medical records department controlled by the administrative medical records staff, who hold within their departments all records of previous patients, which may date back many years. Usually, these records are kept in filing systems under lock and key and indexed. Current case notes for in-patients are usually kept in the Ward Offices. The weaknesses of these systems in terms of security are many. At the level of the records department, much will depend on the Records Officer and the discipline of his staff; whether the drawers of the filing cabinets are left open; who has access and the siting of keys; what response the Records Officer makes to requests for case records from multiple outside sources and agencies; the degree of medical oversight and control of records being sent elsewhere. The latter two situations are critical. It is possible, though rare, that unauthorised persons will break into or abuse the records filing system. However, requests for case notes to be sent to outside agencies are common and come from a variety of sources. These sources include medical (other hospitals, doctors in private practice), solicitors, police, government departments, etc. Frequently the reason for requiring the notes is not given and is merely a brief formal request. In some hospitals, it is customary to send notes, in others they are usually refused; there is often no clearly defined hospital policy and much is left to the Records Officer's discretion. Records Officers usually adopt policy governed by the general hospital pattern and often these records are sent with a brief note requesting their return. All available notes may be sent, often including details of treatment in several departments over the years. Frequently no directions are given to the agency receiving the case notes as to their confidentiality or who may be allowed access. The records department will not know exactly what may happen to the case notes. It is not unusual, for example, for these case notes to be placed within the case notes of the general hospital at the end of the bed where the patient and even others may read them. In some

hospitals, the consultants have little knowledge of the whole procedure and may not know when their records are leaving the hospital. The procedure has frequently become a matter of routine by junior staff and little attention is given to what information is actually being sent out.

(ii) Many Medical Records Officers now belong to the Association of Health Care Information and Medical Records Officers, a professional organisation which conducts examinations. It is expected that in due course all administrative officers in charge of medical records departments will have obtained the professional qualification of the Association or the Institute of Health Service Administrators. Both bodies normally include questions on confidentiality in training and assessment.

(iii) The College's Interdisciplinary Working Party on Confidentiality which reported in 1985 invited the Association of Health Care Information and Medical Records Officers to submit evidence, and the following extract from the paper submitted is relevant:

> "A medical record is a confidential document and the primary objective of all members of staff connected with a medical records department is to maintain the confidential relationship between doctor and patient. The Medical Records Officer is responsible for the safe custody and confidential custody of the documents within the department and to ensure a policy exists that clearly outlines to staff the importance of this aspect of their work."

(iv) Some hospitals mark all documents to be sent on to another institution with a message in red "This report is confidential and for your information only, it is not for redistribution in any form, and MUST NOT BE DUPLICATED".

(v) Within the Health Service, there are numerous records kept by a variety of disciplines and these records are filed in various situations. However, the most comprehensive records are contained in the medical case files and they often contain a considerable amount of confidential and private information. The central area of information, particularly in some specialties, e.g. psychiatry, is that compiled by the medical staff. The medical contributions to these case files are compiled on an individual professional basis and are compiled principally as an *aide-memoire* to the doctor who makes the entries and can only be interpreted accurately by that doctor. Often the medical case files contain records produced by several professions and from a variety of sources. The storage of these records, particularly at ward level, gives rise to anxiety. These records have never been produced to be seen by the patient or relatives and are not in a form that would in any way be suitable to be seen. Much of the treatment of a patient takes place at the verbal and not the written level and in the end is negotiated between patient and therapist in the course of their direct relationship. This is the best safeguard of confidentiality. There should be a record, however brief, of all treatment. (Further information on the control of medical records is given in Appendix F.)

*Recommendations:*

(i) Safekeeping of notes is the responsibility of Medical Records Departments. Such Departments should have a clear written policy.

(ii) Access to the notes should be restricted to those concerned with the clinical care of the patient with special provision for limited access to students of all disciplines for training purposes.

### Confidentiality and staff contracts

(i) District Health Authorities now expect their staff to accept the Code of Practice for the Security and Confidentiality of Medical Casenotes. Employees of the District Health Authorities in the Wessex Regional Health Authority now have to sign a Code of Practice of Confidentiality which if broken will result in disciplinary proceedings against that member of staff. In one Health Authority twenty-six categories of staff have been identified who need access to casenotes when dealing with patients. Staff in these categories may only call for casenotes when it is essential for the proper provision of treatment of the patient (presumably appropriate staff may decide for themselves when it is essential for them to see the notes).

(ii) The Steering Group on Health Services Information (Körner) produced a report from its Confidentiality Working Group and recommended that Health Authorities negotiate formal written Confidentiality Policies with corresponding Local Authorities. These agreements were intended to ensure that Social Workers who may have access to Patient Data are bound with the same standards of Confidentiality as Health Service staff.

(iii) The Public Policy Committee Working Party recommended that there should be national standards of Confidentiality Policies between Health and Local Authorities.

## *Confidentiality and disclosure in relation to forensic work*

### Legal considerations

(i) The Medical Protection Society document on Disclosure of Medical Records states:

> "There is not – and has not been – any automatic right for a patient or his legal adviser to have access to any medical notes of the patient before the commencement of legal proceedings. However, a patient or his legal adviser

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may apply to see relevant medical records (but this is no absolute right)".

*This situation is likely to change.*

(ii) Case notes may be required to be disclosed in the course of legal proceedings before the trial in which case it is customary for both parties to produce for each other all relevant documents in their possession.

According to the Administration of Justice Act, 1970, a new provision was introduced whereby in actions for personal injuries or in respect of a person's death, the court can order the production/disclosure of relevant documents before the issue of a writ. This aspect of the law has been codified in the Supreme Court Act, 1981. Documents are likely to be required by the court:

(a) When a doctor or health authority is likely to be party in proceedings.
(b) Where the records are relevant to issues in an action between a patient and another party, e.g. industrial accident.

**Legal minors: civil law, juvenile justice, child protection**

Doctors working within the framework of Civil Law concerning legal minors are governed by its provision that the welfare of the child throughout his childhood is of the first importance (or, in the case of wardship proceedings, paramount). The Children Bill will lay down the general principle that the child's welfare is paramount. Psychiatrists must obtain the leave of the Court concerned when interviewing or preparing reports on children who are wards of court or subject to Court Orders in matrimonial proceedings. Reports may be written, with the Court's permission, at the request of an officer of the Court. Help may also be sought by solicitors acting on behalf of children. Psychiatrists also may be asked for reports in juvenile justice proceedings, on behalf of young people who have reached their majority. Doctors may be asked to provide information and opinions to case conferences convened on behalf of children involved in child protection or juvenile justice proceedings.

*Recommendations:*

(i) Where psychiatric opinion is sought by any other party to a Civil Hearing concerning children, care should be taken regarding the release of information concerning other parties, or related family members, foster parents, co-habitees, step-parents, etc. . . . who may have been involved in assessment of the child. Appropriate consents should be sought in writing; it may be appropriate to consult a Defence Union and the Court. Consideration should be given to evidence being presented directly to an officer of the Court on behalf of the child or, failing this, to the necessity for witness summons of the doctor concerned. When a report is requested on a parent or other adult who is a psychiatric patient, the written consent of the patient must be obtained.

(ii) When psychiatric reports are requested on behalf of legal minors involved in Juvenile Justice proceedings, consideration also must be given to the rights of parents, guardians and others involved in the care and control of the minor. It should be borne in mind that such reports may be read aloud in court at the disposal stage of proceedings in a Juvenile Court.

(iii) When young people in England and Wales over 16 years of age ask for access to psychiatric reports, or release of information to concerned professionals such as Probation Officers, advice should be sought from Defence Unions if such reports contain information about parents, guardians or other relatives who may have taken part in interviews concerning the child when he was under 16 years of age. Consent should be obtained as appropriate. (The position in Scotland is different.)

(iv) Similar considerations apply to oral or written information offered by doctors to Case Conferences concerning civil or criminal issues relating to children (see under section headed Case Conferences).

## *Special situations in adult forensic psychiatry*

(i) The Forensic Psychiatry Section of the Royal College of Psychiatrists has agreed a document on confidentiality in this field, which is available from the College (Appendix G). The principles related to confidentiality are the same as in any other branch of medicine, but some of the special circumstances in which it cannot be fully protected are more likely to arise. One example is where the public interest duty to the community may override the confidence duty. In such circumstances, the doctor must be prepared to justify his disclosures in full and wherever possible, not only to tell the patient about the disclosure but to make every effort to persuade him to concur with it. The courts may require information from case notes to be disclosed. It would be unusual, but the doctor, or his employing authority, may be held in contempt if they fail to do so. When a medical report is being sought by the court, the patient should understand when asked to co-operate with the doctor in its preparation that this, in effect, becomes a public document.

(ii) People often have difficulty in understanding that a doctor could be acting in anything other than his traditional role; in these circumstances there is a particular need to explain the situation carefully. Further special consideration must be given where

relevant to the reporting of third party information. Evidence of a family history of psychiatric disorder, for example, may be relevant to diagnosis of the patient for whom the report is being prepared, but disclosure to a court, or in a public hearing that an identifiable relative has schizophrenia may be regarded as a breach of confidence. *Once the report leaves the possession of the psychiatrist, he has no control over its future use or distribution.* Almost invariably, such a report is given to the patient, but it may be disseminated widely among others, and occasionally read out in open court.

*Recommendations:*

(i) Psychiatrists should explain formally to all adult patients the likely legal requirements in relation to divulgence of information to the Courts or statutory bodies.

(ii) Where possible, the psychiatrist should allow the patient to read a copy of any major court report prepared and make time to discuss it with the patient.

(iii) If the patient is given a copy of any such report, he should be counselled about protecting its confidentiality.

(iv) As far as possible, reference to identifiable relatives or victims should be avoided in the reports for Courts, unless the material is already public knowledge, or the said party has given consent.

## *Confidentiality and disclosure in relation to research*

(i) There are several helpful documents available which provide guidelines into the ethical issues around research, including confidentiality, and these include those of the Medical Protection Society and the Medical Research Council (Appendix H). The College has now prepared guidelines for Research Ethics Committees, on Psychiatric Research involving Human Subjects.

(ii) The most fundamental advice is that all research must be referred to a bona fide ethical committee for guidance. The principle issue for this document is that of confidentiality. It should be possible to guarantee absolute confidentiality of data collected for a research project. Researchers must be scrupulous about the security of both their manual and computer records, the latter being subject also to the provision of the Data Protection Act.

## *Other matters*

### Code of confidentiality of personal health information

(i) In 1989 the DHSS issued draft codes of confidentiality on personal health information and personal social services information (Appendix C).

(ii) The DHSS has stated in 1987 that "The need for the code rose from the concern of the health professions that registration of health authorities as data users under the Data Protection Act should not be seen in any way as reducing the ethical responsibility of the health professionals for protecting the confidentiality of personal health information." When issued these codes will have the force of law and be subject to authoritative interpretation by courts of law.

(iii) In a previous draft, the DHSS had stated "the code covers information regardless of whether or not it is recorded and in what form. It therefore covers medical illustrations, videos, tape recordings, computer files and ordinary written records, as well as information which has not been recorded and is only in someone's mind". The code only *allows*, and never *requires*, personal health information to be disclosed, except when some other part of the law positively compels disclosure.

### Patients' right to know and correct factual material

(i) Under the Data Protection Act the subject is in general given the right to inspect and correct factual material held about him. The Interprofessional Working Group supported "the right of patients and clients to have access to all information which is held about them on their behalf". While it is recognised that "the imposition of an absolute requirement to afford unrestricted access could inhibit health professionals from recording sensitive information or opinions, to the inevitable detriment of patients care" (Körner Annex C Para 2) it is considered that the restrictions should be of a regulated sort, and a patient whose access is denied should have appropriate rights of appeal, for example to another professional.

(ii) The Interprofessional Working Group supported patient access as "Such access encourages openness and can improve the quality of the record by correcting factual errors and reducing misunderstandings" (Annex C, Para 1). There can be no objection to this for the purpose of correction of simple factual errors. Patients may wish to inspect their records fearing a situation similar to that in, for example, the records of Credit Reference Agencies where non-existent adverse Court judgements for debts have been discovered.

### Privacy

(i) The Körner Report defines Privacy (Para 1.8) as "the ability of individuals or bodies to determine for themselves when, how and to what extent information about them is communicated to others". The 1982 White Paper (Para 2.4.g) states: "The data subject ... shall have access to information held about him and be entitled to its correction or erasure when

the legal provisions safeguarding personal data have not been complied with." Thus the patient is entitled to see the record of information supplied by him and to correct it and there can be no objection to this. The Körner definition would appear to imply that the only entitlement is to see information which might be passed on from the medical records. The patient is also entitled to see information about himself put in the record by the doctor, for example a description of his abnormal mental state, but the information will be correct as long as it is a statement of the doctor's professional opinion at the time. Although the patient may disagree, it is not correctable by him – e.g. the description by a spouse of a marital dispute before a suicidal attempt may be disputed by the patient but not correctable by him, providing the professional who recorded it believes it to be an accurate report of what the spouse said.

(ii) The order on modified access to personal health information under the Data Protection Act allowed information to be withheld on the basis that it "would be likely to cause serious harm to the physical or mental health of the data subject." If one follows the spirit of the Act (and applies it to non-computerised records) and allows access unless there is a serious contraindication, it will not infrequently be the case that a patient will be dissatisfied with what is in his record without being entitled to correct it.

**Third party information**

Case taking involves collecting information from third parties who have their own right to privacy. At present relatives providing information can be assured that the same standards of privacy and confidentiality will apply to what they say as to the interaction with the patient. The recent Draft order (HC(87)14 Annex A Para 2(b) and 3(b)) allow withholding of disclosure in the absence of consent of a non-health professional informant if the informant's identity would be disclosed or could be inferred. If there is subject access to all records the doctor will have to make complex decisions about what sources can be inferred and will need to warn third party informants before obtaining information from them, for example in situations where it will be obvious to the patient who has provided the information, and that it is being withheld because of the third parties refusal to agree. This seems likely to lead to third parties becoming less willing to help the doctor – by, for example, a spouse or even a neighbour alerting the doctor to a concealed history of high alcohol intake.

**Children**

(i) The draft codes contain the statement "The position of children and that of the rights of parents under the Data Protection Act 1984 are extremely complex. Legal advice is being urgently sought and further guidance will be issued as soon as possible." This is now available in DHSS circular HC(87)25 which states:

"Concerning the rights of children and parents under the Data Protection Act the Data Protection Registrar has said in Guideline 5:

> "All individuals, including children, have the right of subject access. However, a child will not always be able to make his or her own request. The way in which the subject access right will work in this situation depends on the general law relating to the legal capacity of children. The law of Scotland differs in this respect from that of the rest of the United Kingdom.

(ii) Under forthcoming legislation, "Requests may also be made by another person recognised by the health professional as acting on behalf of, and whenever possible with the consent of, the patient, and in the patient's interest." (Department of Health Draft Code of Practice *Communicating Information to Patients and their Access to Their Own Manual Health Records* (March 1989). The position for mentally ill or handicapped adults is more complex since they may not be able to give valid consent.

A Data User in England, Wales and Northern Ireland who receives a subject access request from or on behalf of a child will need to judge whether the child understands the nature of the request.

If the child does understand, he or she is entitled to exercise the right and the Data User should reply to the child. A reply should be given to a request made on the child's behalf by a parent or guardian only if the Data User is satisfied that the child has authorised the request.

If the child does not understand, the parent or guardian is entitled to make the request on behalf of the child and to receive the reply. Parents or guardians should only make such a request in the interests of the child, not in their own interests.

In Scotland individuals under the age or 18 are, for legal purposes, either 'pupils' or 'minors'. Until the age of minority is reached (12 years for a girl and 14 years for a boy) the child is a pupil. From that age until he or she reaches 18 the child is a minor.

For a pupil the subject access right will be exercised by the person entitled under Scottish law to act as the 'tutor' of the child – this will usually be the parent.

Minors will be entitled to exercise the right for themselves. The Data User is not required to obtain the consent of the parent or other 'curator' of the minor. A request by a minor's parent or curator should only be complied with if there is evidence that the minor has authorised the request.

(iii) Psychiatrists are advised to obtain and make reference to the completed Codes. The Codes are

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enforceable by law and since they lay clear cut responsibilities on employing authorities, provide a back up to individual practitioners faced with complicated ethical and legal decisions (Appendix E).

**Conclusions**

(i) Subject access to personal health records, even if modified by the right to withhold if *serious* harm is likely, seems likely to affect the therapeutic relationship with some patients adversely, and possibly make doctors less willing to treat them.

(ii) With access, the right of the patient to correct inaccuracies may cause difficulties, as parts of the case record may be unacceptable to the patient but uncorrectable by him. Information may become more difficult to obtain from third parties to the detriment of the patient. Doctors involved as qualified health professionals would have difficult decisions to make about what might be inferred by the patient about third parties' provision of information.

The law concerning disclosure of information is discussed more fully in Appendix B.

## *Summary of recommendations*

**Confidentiality and non-volitional patients**

Special arrangements are necessary for non-volitional patients. (See under section headed Confidentiality and non-volitional patients).

**Shared information**

Patients should be made aware that appropriate sharing of information with other professionals is necessary in order to provide the best possible care, support and treatment.

**Recording case histories**

Patients and informants should be helped to understand the complexities of confidentiality during the initial interview. It must be recognised that this may inhibit the gathering of information.

Medical case notes are essential for the planning of treatment of a patient and may be shared for this purpose. Psychiatric case notes nowadays may only have limited confidentiality particularly with multidisciplinary team work. Patients have a right to know that confidential information may be shared with other professionals. Drug misusers are particularly sensitive about confidentiality and should be reassured that information concerning individuals is not divulged to the police.

**Multidisciplinary teams**

All staff concerned with patient care should have a contractual obligation to maintain confidentiality and should be trained accordingly and reminded in staff handbooks of this responsibility.

Medical members of multidisciplinary teams should accept only professional members *known to have undertaken to maintain confidentiality*.

**Patient and child access to personal files**

Patients or their parents should not have automatic access to the entire clinical and social record since this may cause distress, particularly if it contains information, as it generally will, from a relative, or information about a relative. This third party is also entitled to be assured that what is said is confidential. On occasion, it might be dangerous, if, for example, a third party has given information about the violence of a pathologically paranoid individual.

**Teaching and conferences**

Where case material, or the patient in person, is presented to a closed audience in which all participating in the conference can be identified by the presenter, it is usually sufficient to ask the audience to undertake to maintain confidentiality. The oral consent of the patient should be sought at the time of the presentation even if he has previously consented or given an undertaking on admission to hospital that his case may be used for teaching purposes.

Where case material which refers to relatives, friends and other significant people is presented, their right to confidentiality must also be preserved.

Where the audience is not known to the patient, the patient's responsible doctor or the presenter, the standards of confidentiality or consent must be much higher. Special care is necessary in open meetings, international conferences, presentations in professional journals and media broadcasting. It is preferable, wherever possible, to present only anonymous case material in these circumstances.

Appearance on film, videotape, audiotape or photograph must also be treated with great care. The conditions which operate at the time the material is made may not apply at the time of any future use, and there is also the potential risk that the material could be copied. Useful guidelines are that the patient and the responsible doctor should together consent to any such material being made, and the patients consent in general terms for any future use taken at the time of the recording.

**Responsibility when information is withheld**

The informant should be asked to give consent when access to a case record is requested by a patient. If the informant does not consent, the right of confidentiality must be respected and patient access restricted.

When information is deliberately withheld by another professional, doctors should consider seeking advice from their medical defence organisations.

### Sharing information with relatives

It is neither customary nor desirable to obtain written consent from patients when a relative is seen. Verbal or implied consent is sufficient. If verbal consent is sought then emphasis could be given to the positive aspects of the interview; it can be explained that promotion of family knowledge and understanding of the patient's difficulties will benefit the latter. Whether relatives are seen in the presence or absence of the patient depends on the particular circumstances.

Caution is necessary if it is thought a spouse may be looking for information to support a legal action for separation, divorce or custody. In these circumstances, it is essential to obtain the patient's written consent before divulging information. At all times, the doctor must remember that the identified patient is his primary concern and responsibility.

### Medical records

Safekeeping of notes is the responsibility of medical records departments. Such departments should have a clear written policy.

Access to the notes should be restricted to those concerned with the clinical care of the patient with special provision for limited access to students of all disciplines for training purposes.

### Legal minors

Where psychiatric opinion is sought by any other party to a Civil Hearing concerning children, care should be taken regarding the release of information concerning other parties, or related family members, foster parents, co-habitees, step-parents, etc., who may have been involved in assessment of the child. Appropriate consents should be sought in writing; it may be appropriate to consult a Defence Union and the Court. Consideration should be given to evidence being presented directly to an officer of the Court on behalf of the child or, failing this, to the necessity for witness summons of the doctor concerned. When a report is requested on a parent or other adult who is a psychiatric patient, the written consent of the patient must be obtained.

When psychiatric reports are requested on behalf of legal minors involved in Juvenile Justice proceedings, consideration also must be given to the rights of parents, guardians and others involved in the care and control of the minor. It should be borne in mind that such reports may be read aloud in court at the disposal stage of proceedings in a Juvenile Court.

When young people in England and Wales over 16 years of age ask for access to psychiatric reports, or release of information to concerned professionals such as Probation Officers, advice should be sought from Defence Unions if such reports contain information about parents, guardians or other relatives who may have taken part in interviews concerning the child when he was under 16 years of age. Consent should be obtained as appropriate. (The position in Scotland is different.)

Similar considerations apply to oral or written information offered by doctors to Case Conferences concerning civil or criminal issues relating to children. (See under section headed Case Conferences.)

### Special situations in adult forensic psychiatry

Psychiatrists should explain formally to all adult patients the likely legal requirements in relation to divulgence of information to the Courts or statutory bodies.

Where possible, the psychiatrist should allow the patient to read a copy of any major court report prepared and make time to discuss it with the patient.

If the patient is given a copy of any such report, he should be counselled about protecting its confidentiality.

As far as possible, reference to identifiable relatives or victims should be avoided in the reports for Courts, unless the material is already public knowledge, or the said party has given consent.

*Approved by Council*
*October 1989*

## *Appendices*

A GMC Statement on Confidentiality (PP 19–22 of GMC pamphlet entitled 'Professional Conduct and Discipline: Fitness to Practice' (April 1987)

B Working Party on Confidentiality discussion paper – The Royal College of Psychiatrists (1989)

C Department of Health: Draft Code (Revised 28.2.89) of the Interprofessional Working Group 'Confidentiality of Personal Health Information'

D Summarised extract from NHS/DHSS Steering Group on Health Services Information: A Report from the Confidentiality Working Group (October 1984)

E Confidentiality: current concerns of child and adolescent psychiatric teams (1987) *Bulletin of the Royal College of Psychiatrists*, **11**, 170–171, May 1987

F Extract: The Royal College of Psychiatrists 'A Guide to Confidentiality in Relation to Mental

Health: Discussion Document from a Joint Working Party' (1985)

G Working paper from the Forensic Psychiatry Section 'Confidentiality and Forensic Psychiatry' (1985)

H Responsibility in the Use of Personal Medical Information for Research: Principles and Guide to Practice (1985). Medical Research Council Statement (1985)

*Members of the College may obtain copies of the Appendices on request from the Publications Department at The Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG.*

## Reports available

The following documents are available from the Publications Department at the College. The prices indicated include postage and packing.

The Royal College of Psychiatrists' Position Statement on Confidentiality (£2.50)

Guidelines for Good Medical Practice and Discharge and After-care Procedures for Patients Discharged from In-patient Psychiatric Treatment (£2.50). (A complimentary copy has been sent to all Members of the College)

Joint Working Group on the Consent of Non-Volitional Patients and *De Facto* Detention of Informal Patients (£2.50).

## Eating disorders

The Section of General Psychiatry of the Royal College of Psychiatrists have asked Professor Gerald Russell of the Institute of Psychiatry to form a Working Group to prepare a Report on Eating Disorders to improve our understanding on this subject and to enhance the quality of care given to patients suffering from these illnesses. If any Member or Fellow of the College has any particular contribution to make on this subject to draw to the attention of the Working Party, please write to Professor Gerald Russell, Institute of Psychiatry, De Crespigny Park, Denmark Hill, London SE5 8AF or to Dr M. S. Alexander, Consultant Psychiatrist, St James's University Hospital, Roundhay Wing, Leeds LS9 7TF.