Consultation Response

GMC Confidentiality guidance

January 2015

MPS's response to the GMC consultation on 'Confidentiality guidance'

General Comments

MPS welcomes this review by the GMC into how it gives guidance to doctors on dealing with confidentiality issues. MPS believes confidentiality is the cornerstone of a successful doctor-patient relationship.

The issue of confidentiality is a complex one for medical professionals. With an increasing focus by patients on the security of their personal data, GMC guidance should be clear, comprehensive and up to date so medical professionals can have confidence that they are fulfilling their obligations and legal duties. We are concerned that a number of sections of the guidance are out of date, and that others are difficult to apply in practice. We outline our concerns in our responses to the questions below, and would be happy to meet with and assist the GMC as it looks to improve the guidance.

Questions

Given the purpose and scope of our guidance, do you think there is anything missing from it? If so, what?

Yes. We think a particular area where the guidance is lacking is on the question of the material that should be held in training logs, particularly in surgical specialties. Training logs are an essential tool in a medical professional's training, and in supporting members to comply with the guidance, MPS has identified this as a source of some confusion for a number of professionals.

Clearer guidance in respect of the information captured in training logs and how it applies with the general guidance would be welcome, and we believe aid a more consistent approach to compliance.

Is anything in the guidance inconsistent with the law? If so, what?

Yes. Certain areas of the guidance require updating. For instance, paragraph 45 makes reference to the National Information Governance Board, which no longer exists. Connected to that, the guidance needs to make reference to the office of the National Data Guardian with the National Information Board.[1]

To provide a clear position, the guidance should also make reference to the National Information Governance Review, 2013, and the revised Caldicott principles[2]:

- One: Justify the purpose(s)
- Two: Don't use personal confidential data unless it is absolutely necessary
- Three: Use the minimum necessary personal confidential data
- Four: Access to personal confidential data should be on a strict need-to-know basis.
- Five: Everyone with access to personal confidential data should be aware of their responsibilities
- Six: Comply with the law
- Seven: The duty to share information can be as important as the duty to protect patient confidentiality.

Is anything in our guidance inaccurate or wrong? If so, what?

No. We do not believe anything contained within the guidance amounts to actual inaccuracies. However, as noted in our response to the previous question, there are areas of the guidance that require considerable updating. For instance, the Health and Social Care Act 2012 has created a number of additional legal requirements for doctors to follow, requirements which are pertinent to this guidance. We deal with this issue further on in our response.

Is anything in the guidance confusing or misleading? If so, what and how could it be improved?

Yes. We believe some areas of the guidance are difficult to apply in practice.

For instance, with regards to paragraph 66, when in conversation with someone close to a patient, it is not always possible for the treating doctor to be aware that concerns about the patient are about to be imparted. By which time it is too late for the doctor to warn the third party that their identity may not be

[1] GMC Confidentiality guidance, pg. 19, para 45
[2] Information to share or not share: The Information Governance Review, 2013, pg 20-21

able to be kept confidential. Equally, the scenario gives the doctor the problem of deciding whether or not listening to the third party would amount to a breach of trust.

To take another scenario, a doctor may open a letter from a third party regarding their patient – again, it would then not be possible to inform the person writing the letter that its contents would possibly have to be shared with the patient. The guidance should reflect these realities.

There is also the issue of information relating to vulnerable third parties. Certain information might be highly relevant to protecting vulnerable third parties, and if warnings are given beforehand, or the doctor believes it might be a breach of trust to listen to the individual's concerns about a patient, this may result in safeguarding issues not coming to light.

Any revised guidance should bring clarity to these issues.

Do we strike the right balance between protecting confidential patient information and sharing information appropriately? If not, what do you think should change?

The revised Caldicott guidelines are not dealt with adequately in the guidance and so should be clearly referred to in any revised guidance. The Health and Social Care Act 2012 made it a legal requirement for healthcare providers to share patient data with the Health and Social Care Information Centre. The *care.data* scheme, implemented to facilitate this requirement, has of course been the subject of wide ranging concerns, and considerable revision. While *care.data* is still in its pilot stage, the legal requirement contained in the 2012 Act is an area that must feature in the revised guidance.

care.data, and the legal duty behind it, is an issue of great concern to our GP members. The extraction of patient information from clinical records for data sharing purposes causes considerable anxiety for both patients and healthcare professionals. Guidance should reflect the revised Caldicott guidelines; the reality of an increasing concern amongst patients about the disclosure of their data, and the healthcare professional's responsibility to explain to their patient the right to object.

Are there confidentiality issues that are challenging in practice where you think the guidance or other materials (such as case studies) could be more helpful? If so, please tell us what they are and how you think we should address them.

Yes. In our experience there can be a lack of detailed knowledge about issues of confidentiality on the part of NHS organisations, medical managers and investigating officers when dealing with potential

concerns about medical practitioners. The lack of understanding amongst these groups of paragraph 30 of the guidance, currently leads to Medical Defence Organisations (MDOs) and their members facing false criticism from Local Area Teams (LATs). Such criticism can take the form of an alleged failure to cooperate, when the reality is that doctors are simply being reminded of their obligations under GMC guidance.

This type of criticism is unjustified and unhelpful. Doctors should be supported from all quarters of the profession to follow their GMC obligations. Any revised guidance should deal with this issue more clearly.

Is the guidance structured in a helpful way? If not, how would you prefer it to be structured?

From our experience in supporting members, we regularly see the challenges healthcare professionals face in searching through multiple strands of interrelated GMC guidance. We believe that the splitting of guidance, so a full picture can only be obtained after reading a core document, alongside further explanatory guidance, and case studies, is unhelpful. Consolidated guidance would be much better in this regard.

Are there any ways that we could make the guidance easier to access and use?

Yes. Guidance should not be split so a complete understanding is only possible after studying a core document, alongside additional explanatory notes and case studies. Guidance should be consolidated as much as possible.

Can you give us any examples of guidance formats that you find easy to use, or are innovative, that we could learn from?

We have no examples to provide for this question.

About MPS

MPS is the world's leading protection organisation for doctors, dentists and healthcare professionals. We protect and support the professional interests of more than 290,000 members around the world. Our benefits include access to indemnity, expert advice and peace of mind. Highly qualified advisers are on hand to talk through a question or concern at any time.

Our in-house experts assist with the wide range of legal and ethical problems that arise from professional practice. This includes clinical negligence claims, complaints, medical and dental council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries.

Our philosophy is to support safe practice in medicine and dentistry by helping to avert problems in the first place. We do this by promoting risk management through our workshops, E-learning, clinical risk assessments, publications, conferences, lectures and presentations.

MPS is not an insurance company. All the benefits of membership of MPS are discretionary as set out in the Memorandum and Articles of Association.

CONTACT

Should you require further information about any aspects of our response to this consultation, please do not hesitate to contact me.

Thomas Reynolds
Policy and Public Affairs Officer

Email: thomas.reynolds@mps.org.uk

The Medical Protection Society Limited
33 Cavendish Square
London W1G 0PS
United Kingdom

Tel: +44 (0)20 7399 1300
Fax: +44 (0)20 7399 1301

info@mps.org.uk

www.mps.org.uk
www.medicalprotection.org

The Medical Protection Society
A company limited by guarantee
Registered in England no. 36142
at 33 Cavendish Square, London
W1G 0PS