Patient confidentiality and disciplinary or quality assurance inquiries

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Under what circumstances is it legally justifiable for patients' confidential information to be revealed? Can a patient's records be used without his or her consent in investigations by registration bodies of a doctor's practice?

An investigation currently being undertaken by the General Medical Council (GMC) in the UK raises an issue that has not to my knowledge been considered in Australia. What rights does a patient have if his or her medical records are disclosed to a registration body investigating the practices of one of its members? Similarly, what are a patient's rights if his or her records are disclosed to a body undertaking a routine audit of a doctor's practice – for example, to monitor the doctor's skills or for 'credentialling' as a specialist practitioner?

UK investigation of Ms Briony Ackroyd

Some of these issues apparently arose during an investigation into the practices of suspended UK surgeon, Ms Briony Ackroyd. According to a newspaper report, medical records from at least 10 of Ms Ackroyd's patients were forwarded to the GMC without their permission.[1] Nineteen patients had apparently complained to the Walsgrave Hospital, Coventry, about the treatments provided by Ms Ackroyd, and their records were referred to the GMC (presumably with the patients' consent, either express or implied). Later, however, a clinical audit was undertaken of about 1000 operations that Ms Ackroyd conducted at Walsgrave Hospital over five years, and records of 11 patients were then sent to the GMC without the consent, or knowledge, of those concerned.[1] Some of these patients apparently later objected to having their records used in this way, especially when they had no complaint against Ms Ackroyd.

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What if this happened in Australia?

Disciplinary inquiries by registration bodies

If there was a disciplinary inquiry into a doctor's practice in Australia, patients' files could, as in the UK, be examined without their consent. The registration bodies in Australia (the various Medical Practitioners Boards and Tribunals), like the General Medical Council, do not act solely in response to patients' complaints. (The *Medical Practice Act 1992* (NSW) and the *Medical Practice Act 1994* (Vic) allow any person to make a complaint to a registration body about the professional conduct of a registered medical practitioner.[2,3] In NSW, a complaint can be made by the Board or the Director-General; in Victoria, complaints can be referred by the Health Services Commissioner. The NSW Act also allows registered assessors to undertake assessments of the 'professional performance' of medical practitioners.[4])

The primary role of a registration body is to maintain standards within the profession. This is evident from the legislation that establishes them. In NSW and Victoria, for example, the first purpose of the relevant statutes, the *Medical Practice Act 1992* (NSW) and the *Medical Practice Act 1994* (Vic), is to protect the public.[5,6] A registration body can use a patient's records in the investigation of a doctor's practices in response to a complaint from someone else, even if that particular patient has not complained about the doctor to the body.

When a registration body is conducting an investigation, it has extensive statutory powers under each State's Medical Practice Act to search premises and take documents away for the investigation.[7,8] The lawful authority for removing the documents is either the doctor's consent or a search warrant. In Victoria, the registration body is required by the legislation to investigate all complaints unless it decides the complaint is frivolous or vexatious, or the complaint is to be dealt with by the Health Services Commissioner.[9] In NSW, there is no equivalent provision, and there is presumably a discretion concerning which complaints should be investigated. However, this is a decision for the registration body, not the individual patient concerned. In Australia, as in the UK, patients are not entitled to dictate the matters that disciplinary bodies investigate.

If the files of a doctor are accessed or removed for the purposes of an investigation by a registration body, the patient has no redress against the doctor or the registration body. The doctor has an obligation under the common law to maintain confidentiality, but it is not an absolute obligation. It can be over-ridden by a statutory duty or authority (such as the duty to report suspected child abuse or a notifiable disease), or by a court order (the search warrant). In complying with the search warrant, the doctor is acting lawfully and the breach of confidentiality is legally justifiable. The patient has no redress against any member of the registration authority because the members have statutory immunity from legal action in relation to their acts or their omissions in carrying out their duties, provided they act in good faith and without negligence.[10,11]

Quality assurance in hospitals and health services

If patients' records are examined for quality assurance (QA) or audit purposes in hospitals (in NSW, a public hospital or other body prescribed by regulations;[12] in Victoria, these, private hospitals and health services[13]), there is also statutory protection for the members of the QA committees undertaking those inquiries. In NSW, the *Health Administration Act 1982* (NSW) protects QA committee members from personal liability for anything done in good faith in exercise of the Committee's functions.[14] Section 139 of the *Health Services Act 1988* (Vic) prevents any communication in a QA committee from being used in court proceedings.[15] Strict procedures are prescribed for QA investigations under the legislation and these need to be invoked in order to be covered by the statutory immunity.

Other statutory audit or credentialling checks

The Health Insurance Commission (HIC) has statutory powers under the *Health Insurance Act 1973* (Cwlth) for supervision of medical practice. Part VAA of the Act deals with the Professional Services Review Scheme 'under which a person's conduct can be examined to ascertain whether inappropriate practice is involved' and 'action…taken'.[16] The HIC has powers under the Health Insurance Commission Regulations to investigate 'if there are reasonable grounds to suspect that a practitioner…has engaged in inappropriate practice'.[17]

In addition, the *Health Insurance Act 1973* (Cwlth) has broad quality assurance provisions similar to those of the States (Part VC) and the confidentiality of inquiries under this Part is protected by the Act.[18] Its members are immune from suit as in NSW,[19] although the immunity seems to relate to potential actions by health service providers, rather than other people.

Conclusion

In summary, the need to protect the public and ensure that medical practitioners are practising to an appropriate standard justifies the law enabling patients' confidential information to be revealed to a range of supervisory bodies. The members of those bodies have statutory and common law obligations to keep confidential any information they acquire, and to use it only for the purpose of the investigation. Provided that they adhere to that obligation and act in good faith, they have statutory protection from liability. Patients have no right to prevent their information being used in such investigations or to claim compensation for it being used without their consent.

Series Editor's comment

There is no such thing as an absolute 'right' to confidentiality. Doctors have both ethical and common law duties to preserve their patient's confidences. However, the community, through its elected representatives in Parliament, can impose statutory obligations on doctors to reveal their patients' secrets, such as in mandatory reporting of certain infectious diseases, child abuse and medical incapacity to safely drive motor vehicles. In the same way, statutory powers can be granted to some instrumentalities to seize documents which, without those powers, would be privileged.

For example, the Victorian *Accident Compensation Act 1985* gives, in sections 239 to 241, the Victorian WorkCover Authority sweeping powers to authorise

a person 'to enter, inspect and examine at any reasonable time *any* premises' (my emphasis) and to 'inspect, examine and make extracts from, or copies of *any* books in or on those premises' (again, my emphasis). Put as baldly as that, these provisions would enable a Victorian WorkCover Authority inspector to enter a doctor's surgery and examine and copy any of the documents held at that surgery, including clinical notes, irrespective of whether the doctor or the patients give their consent.

Further, in the ACT and shortly in Victoria, patients will have a right of access to health records made by others about them. Thus there is, or soon will be, a legislated right to access by both patients and some third parties to medical records. This highlights the need for doctors to ensure that the records they create are accurate, complete and non-pejorative. The doctor who wrote 'I've met the patient, her family and their pet rabbit – of the lot of them, the rabbit is the most intelligent', the one who had to explain that the acronym 'WPB' stood for 'whingeing Pommy bitch', and the one who had to explain that 'TTFO' meant something like 'told to go away' each had a lot of explaining to do in court!

Then there was the furore recently when a company marketing a medical records software program suggested that some clinical information from databases of subscribers – denominated of course – might be sold. The safest position for a doctor to take is that no information about his or her patients, even just the information that they are his or her patients, will be given to any third party unless that third party can demonstrate a legal right to that information. And a prudent doctor will not accept without question a third party's assertion that they have that legal right: they will seek a second opinion from their medical defence organisation.

You may pine for the halcyon days of yore when your records were your personal aide mémoire, but they are gone. Yes, you should guard your records jealously, but it is your patient's secrets, not yours, that you have a duty to protect, and even that duty can be over-ridden by legal compulsion – for very proper reasons. MT

References

1. Wright O. Surgeon's allies fear notes were misused. The Times 2001 26 January, p 12.
2. *Medical Practice Act 1992* (NSW), s 41.
3. *Medical Practice Act 1994* (Vic), s 22.
4. *Medical Practice Act 1992* (NSW), Part VA.
5. *Medical Practice Act 1992* (NSW), s 2A(1).
6. *Medical Practice Act 1994* (Vic), s 1(a) and s 66(1)(ab).
7. *Medical Practice Act 1992* (NSW), s 118. (documents can be removed with consent of owner or occupier; or in response to a search warrant); s 120(1) (investigative powers may be exercised to see if Act or Regulations complied with or to investigate complaints); s 120 (3)(c), (d), (4)(a), (b) (require production of records, copy records); see also s 125 (search warrants).
8. *Medical Practice Act 1994* (Vic), s 93A (search warrants).
9. *Medical Practice Act 1994* (Vic), s 23(1).
10. *Medical Practice Act 1992* (NSW), s 189.
11. *Medical Practice Act 1994* (Vic), s 76.
12. *Health Administration Act 1982* (NSW), s 20D.
13. *Health Services Act 1988* (Vic), s 139(1).
14. *Health Administration Act 1982* (NSW), s 20J(1).
15. *Health Services Act 1988* (Vic), s 139(5).
16. *Health Insurance Act 1973* (Cwlth), s 80(1).
17. Health Insurance Commission Regulations, Reg 3 3.(1)(b).
18. *Health Insurance Act 1973* (Cwlth), s 124V(2)(a)(i),(ii).
19. *Health Insurance Act 1973* (Cwlth), s 124ZB(1)(b).