

When confidences should be kept and what constitutes an exception

In the final article of a series on the 2007 code of ethics, Joy Wingfield discusses the issues around confidentiality and privacy, and how they affect professional boundaries

In some ways, confidentiality and privacy are matters of taste. Most of us would recoil from the idea of a closed-circuit television surveillance camera, monitored by the authorities, in our living room, as envisaged in George Orwell's novel '1984', yet the participants in television's "Big Brother" do not seem to mind. Similarly, some patients are prepared to whip off clothing on the shop floor to show you their rash, whereas others will not voice their concerns unless assured of absolute secrecy.

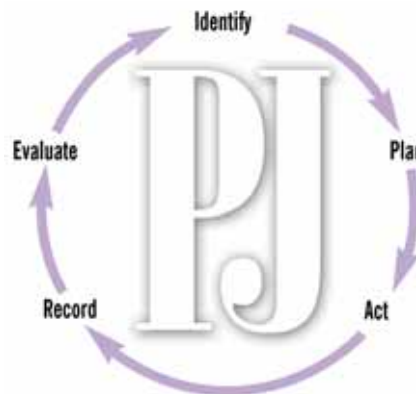
The presumption, however, is that health care related information should be regarded as confidential unless other overriding considerations apply. If this was not the case, patients would not confide in us and would not have confidence in our discretion. Taken to its extreme, if confidentiality of health care information were not the norm, the effectiveness of health care would be undermined — the general public could be at risk if patients could not trust that their confidences would be respected and they, therefore, went untreated.

As with consent (see *PJ*, 13 October, pp411–4), keeping confidences is a part of showing respect for patients and under principle 3 of the 2007 code, two statements are made:

- "Respect and protect the dignity and privacy of others. Take all reasonable steps to prevent accidental disclosure or unauthorised access to confidential information and ensure that you do not disclose con-



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Identify knowledge gaps

1. Panel 1 (below) contains examples of situations that pharmacists have encountered. Can you identify which aspects of confidentiality and privacy might be at issue?
2. How does the guidance on confidentiality in the 2007 code of ethics differ from previous guidance and why?
3. What are the standards you must observe when considering disclosure of confidential information without the consent of the patient?

Before reading on, think about how this article may help you to do your job better. The Royal Pharmaceutical Society's areas of competence for pharmacists are listed in "Plan and record", (available at: www.rpsgb.org/education). This article relates to "being a pharmacist" (see appendix 4 of "Plan and record").

Panel 1: Applying ethics to real-life situations*

- You are taking in prescriptions at the prescription reception. Just after the patient you are dealing with leaves, the one behind her says: "Poor lady, those Herceptin tablets on the computer are for breast cancer, aren't they?"
- You are reviewing the medication charts on a hospital ward and a woman visiting her daughter asks you to tell her, in confidence, what medicines her daughter is taking because she is worried about side effects.
- You are part of the contract monitoring team for your local primary care trust (England). On a visit, the pharmacy manager says: "Hang on, before I show you the records for our medication use reviews, how are you going to keep them confidential?"
- You provide a medicines service for the local prison. On a visit to review the medicines storage, a medical orderly says: "We've had a couple of prisoners beaten up for their pain killers recently. Of course, they all queue up and share cells. What could we do to improve things?"
- The dispensing assistant in the separate dispensary for assembling monitored dosage systems asks you: "We've got all these old phone messages for 'urgents' for the local homes — can I put them in the bin now?"
- A fellow lecturer says: "I think we can arrange some student practice visits to community pharmacies this year. Can you draw up a confidentiality policy for us?"
- A young man calls to collect a prescription for his grandmother and asks: "Can you tell me which one is for what, because she gets rather confused these days."
- You are carrying out a three-month assessment for your preregistration trainee pharmacist when she tells you: "I got a conviction in my second year for selling cannabis but I'm over that now. It won't affect my registration, will it?"

*Suggested answers can be found at: www.pjonline.com/CPD

fidential information without consent, apart from where permitted to do so by the law or in exceptional circumstances.” (statement 3.5)

- “Use information obtained in the course of professional practice only for the purposes given or where otherwise lawful.” (statement 3.7)

However, in principle 4 of the code, there appears the statement: “Subject to paragraph 3.5, ensure that information is shared appropriately with other health and social care professionals involved in the care of the patient.” So the duty to keep patient matters confidential is relative. There may be circumstances in which a pharmacist must disclose such material or when he or she may disclose, subject to his or her judgement and discretion.

What is confidential information?

All information obtained about a patient during the course of professional practice by pharmacists and other members of the pharmacy team should be regarded as confidential. This would include details such as name, address and date of birth, and information about a patient’s medication, medical history, treatment or care. Such information will appear on prescriptions, owing receipts and labels. It is stored on computer records, entered in private prescription books, Controlled Drugs registers and ward charts, and it will be in the memories of the staff involved.

Intrinsic to the maintenance of confidentiality is preservation of privacy. This involves careful planning of prescription reception points and consultation areas, use of bed screening, modulation of the voice to avoid being overheard, and provision of secure storage for records (out of sight of patients) — all these measures will help to avoid accidental disclosure of information or breach of privacy.

Positive measures, such as shredding confidential documents, strict security protocols for computer access, the inclusion of specific requirements concerning confidentiality in job descriptions and employment contracts with regular and frequent training of staff, all reinforce proper awareness of the need to keep information confidential.

Information governance Although the ethical imperative of respecting patient confidences goes back at least to the Hippocratic oath, it was only after the advent of electronic methods of recording information that it was deemed necessary to have legislation to protect the public interest in confidentiality of personal data. Although data protection law covers all information (manually or electronically maintained) that can identify a living individual, and not just that related to health care, its requirements have supported considerable strengthening and clarification of practice by health care professionals. For example, within the NHS, the requirements of the Data Protection Act 1998 have prompted a radical appraisal of custom and practice and

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the adoption of a detailed code of practice on confidentiality.

The control of the Data Protection Act does not extend to those who have died but clinical confidentiality extends beyond death (or at least it should — if you are a monarch or a celebrity, the interest and curiosity of the public may result in disclosure after a while).

As early as 1984, the original Data Protection Act prompted a review, chaired by Dame Fiona Caldicott, of the ways in which electronic data about patients was created and transferred around the health care environment. Subsequently, the managed NHS service was required to appoint “Caldicott guardians” to oversee the security and privacy of “data flow” and, later still, the concept of “information governance” — the management and maintenance of the confidentiality of patients’ personal information — has been incorporated into the much broader concept of clinical governance. All providers of health care, both private and public, are now expected to demonstrate clinical governance, often by the development of standard operating procedures to define:

- Who has access to confidential information and in what circumstances
- How confidential information will be processed, used and stored
- The circumstances in which disclosure of information can be made
- Maintenance of appropriate records of requests for disclosure and details of the information disclosed

It should also be noted that, save in limited circumstances, patients have the right to see their records and challenge the contents, so the records should be factual, accurate, legible and comprehensible. All this is outlined by the first two professional standards for patient confidentiality which support the code of ethics (standard 1 covers the duty of confidentiality and standard 2 covers aspects of keeping information confidential). Standards 3 and 4 describe disclosure of confidential information with, or without, patient consent.

Disclosure of confidential information

Although lawyers frequently argue about who owns the records containing confidential patient information, it is clear who owns the actual information: it is the patient. And as discussed in my previous article, it is the patient — not the doctor, not the relatives and not the carer — who should decide whether or not to consent to disclosure of his or her records or other confidential information. Once again, the gold standard for a decision to disclose confidential information is to have the valid consent of the patient. To achieve valid consent, the same criteria as consent to treatment should be met. The patient should be told and given the opportunity to understand:

- What information will be released
- The circumstances in which the information will be released and to whom

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- The likely consequences of releasing the information (or possibly not releasing it)

There is a general expectation (and an exemption in the 1998 Data Protection Act) that confidential information about patients may be shared where it is necessary for their care and the recipient is another health professional or similar individual with their own recognised duty of confidentiality. (For example, the NHS code suggests that social workers might be included if their involvement is an essential part of health care.) However, it is important to recognise, particularly with the advent of centralised and computerised NHS records, that such expectation and acceptance may not be universal.

As with all forms of consent, a competent adult may refuse disclosure and, other than in exceptional circumstances, that refusal must be respected. In such a situation it would be necessary for the pharmacist to explain to the patient any possible implications of refusing disclosure and to advise him or her that this decision must be recorded. Finally, even with patient consent, only the minimum information necessary for the purpose should be disclosed and the recipient should be advised to maintain continuing confidentiality of the information.

Release of information without consent

Confidentiality is a classic example where the rights of an individual may conflict with "the public interest". This term does not mean — contrary to some impressions given by the media — where something is merely of interest to the public. An excellent definition in the NHS code of practice is: "exceptional circumstances that justify overruling the right of an individual to confidentiality in order to serve a broader societal interest. Decisions about the public interest are complex and must take account of both the potential harm that disclosure may cause and the interest of society in the continued provision of confidential health services."

The NHS code also provides detailed guidance, decision frameworks and case studies to help in making decisions about disclosures to support or audit health care, disclosures for medical purposes and disclosures for non-medical purposes. Although some of the case studies may be outside the realms of traditional pharmacy practice (unless your role includes accountability for clinical governance), they are instructive exercises in balancing individual versus wider rights in confidentiality.

Professional standard 4 lists six circumstances where disclosure without patient consent may be permissible or even mandatory.

Lack of capacity The legal concept of capacity (discussed in the second article of this series; *PJ*, 13 October, pp411–4) is equally applicable to consent to disclosure of information. A patient's parent, guardian or carer may give consent to a disclosure if the patient is deemed by law to lack capacity to consent (as



The Society has published standards and guidance for patient confidentiality

in the case of an infant or someone detained compulsorily under the Mental Health Act) or appears to be incapable of consenting (as in the case of unconsciousness). However, just as with consent to treatment, pharmacists should satisfy themselves that the criteria for assessing competence in adults are being properly applied before accepting consent by someone other than the patient.

Disclosure required by statute There is a quantity of legislation that formalises the superiority of the public interest over an individual's right to confidential health care. Much of this is in the field of public health, such as the prevention of the spread of infectious disease, and public audit and accountability, such as the monitoring of births, deaths, abortions and road traffic accidents. The legislation empowers a person or a body (eg, the General Medical Council or the Royal Pharmaceutical Society) to require disclosure for the performance of their statutory duties.

Although disclosure of information in these circumstances is not optional it is still important to establish, in writing preferably, that the person or body who is requiring the information is properly authorised. Even when such disclosure is mandatory it is good practice to tell the patient that information will be released, why it is being released and to whom it is being released.

Disclosure to the courts A court can order the release of patient information even without the patient's consent. Moreover, when a court case is pending, the Crown Prosecution Service and its Welsh and Scottish equivalents may require disclosure. Refusal may bring the holder of the information in contempt of court and this can carry serious penalties. Again, care is needed in releasing only the information requested by the court and it may be wise to seek further legal or specialist advice, from a legal defence organisation for example, before complying with the order.

This does not include disclosure to solicitors and such requests should be supported by the written consent of the patient involved.

Disclosure to the police General legislation on criminal justice and the data protection laws recognise that disclosure of confidential information may sometimes be necessary to assist in the prevention, detection and prosecution of serious crime. The extent to which this is necessary, the amount and nature of the necessary information and the definition of what crime is serious are all debated from time to time.

It is advisable to apply the customary safeguards of releasing the minimum information necessary, and requiring that such requests are made in writing and that they state clearly under what authority and for what purpose the information is required. It is also advisable to discuss the investigation with the officer involved to ensure there are no better sources

of the information being requested and to be satisfied that, without disclosure, the investigation would truly be delayed or prejudiced.

To prevent serious injury or damage

The subject in this exemption might be close relatives (identification of a genetic predisposition to disease) or sexual partners (a diagnosis of AIDS or hepatitis C) or the wider general public (continuing to drive when suffering frequent epileptic fits). Decisions to disclose confidential information in such circumstances can be difficult and contentious. Pharmacists should discuss with the patient the implications of continuing to undertake the activity that may cause serious injury or damage to others and seek consent to the disclosure, wherever possible.

To protect children or vulnerable adults

The past decade has seen an increase in legislation designed specifically to protect children and vulnerable adults from physical and sexual abuse, exploitation and neglect. The support and protection of children is now a requirement implicit in child protection law (*PJ*, 6 August 2005, p169) and most recently, the Mental Capacity Act 2005 specifically creates a new offence of abusing, exploiting or neglecting those who lack capacity.

If a pharmacist suspects that a person is being neglected or abused, wherever possible that person should be encouraged to consent to disclose their confidential information to the appropriate professional authority but it may sometimes be necessary to proceed without consent. Pharmacists now have a duty to protect those who are vulnerable. The Royal Pharmaceutical Society has produced further guidance for these difficult areas (see Resources).

In all of the above circumstances accurate records must be kept, stating who made the request and why, what attempts were made to secure patient consent (or why no attempt was made), why patient consent was refused and what information was released.

Professional boundaries

For the first time, the code of ethics includes, under principle 3, the following statement: "Maintain proper professional boundaries in the relationships you have with patients and other individuals that you come into contact with during the course of your professional practice, taking special care when dealing with vulnerable individuals."

No standard has been set for compliance with this principle but there are likely to be developments soon. In April 2007, the Council for Healthcare Regulatory Excellence (CHRE), which oversees the regulation of all health care professions, announced proposals for guidelines to regulate sexual behaviour between every health professional and his or her patients. The CHRE is also pressing for a new mandatory responsibility on universities, regulatory bodies and



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employers to make sure all health professionals receive this training. The desirability of a chaperone policy has also been highlighted in connection with the 2005 community pharmacy contract and the use of consultation areas.

The Pharmaceutical Services Negotiating Committee has published guidance on the use of chaperones in primary care. This covers why a chaperone might be necessary in a pharmacy, who should act as a chaperone and how they should be trained as well as examples of a chaperone policy and how that policy should be explained to a patient (see Resources).

This series on the 2007 code of ethics has only considered aspects that deal with respect for patients and the associated concepts of consent and confidentiality. But there is more. Revised and enhanced standards for the sale and supply of medicines, advertising medicines, professional services and internet services will be fairly familiar; those for pharmacist prescribers and pharmacists and pharmacy technicians in positions of authority will be less so.

If it is years or only months since you really studied the code of ethics now would be a good time to get acquainted with the new principles, standards and guidance. They will now be the statutory benchmark for the performance of the pharmacy profession in the foreseeable future.

Resources

- The document "Professional standards and guidance for patient confidentiality" was sent to every registered pharmacist and pharmacy technician with the 21 July issue of *The Journal*. It is also available at www.rpsgb.org.
- Guidance from the Royal Pharmaceutical Society on child protection and the protection of vulnerable adults is available at www.rpsgb.org.uk
- The NHS code of practice on confidentiality can be viewed at www.dh.gov.uk for England and Wales and at www.confidentiality.scot.nhs.uk for Scotland
- The Pharmaceutical Services Negotiating Committee chaperone framework is available at www.psn.org.uk (accessed 15 October 2007).

Action: practice points

Reading is only one way to undertake CPD and the Society will expect to see various approaches in a pharmacist's CPD portfolio.

1. Go to the customer side of your prescription reception point and dispensary. What can you see? Are the computer screens visible to casual observers? Can you read details of patients' names and addresses from the prescriptions waiting for collection?
2. Read thoroughly the professional standards and guidance for confidentiality supporting the 2007 code of ethics. Explain the content to a fellow member of staff and invite questions to check your understanding.
3. Visit the Department of Health website: www.dh.gov.uk and search on "confidentiality". Study the NHS code of practice on confidentiality and write down three examples of how you will now change practice to comply with this.

Evaluate

For your work to be presented as CPD, you need to evaluate your reading and any other activities. Answer the following questions:

What have you learnt? How has it added value to your practice? (Have you applied this learning or had any feedback?) What will you do now and how will this be achieved?