SAFEGUARDING CONFIDENTIALITY: A REPLY*

By Professor J. K. Wing

Most psychiatrists have been willing, for some 30 years, to supply information to a central register held in a Government department. This confidence has not been abused. It may not be generally known that even medical research workers do not have access to names or other identifying information. They must submit lists of names which they have already acquired, with appropriate permission, in some other way. If their *bona fides,* which is strictly examined, is considered by the medical officer responsible for confidentiality to be beyond reproach, they are issued with the name of the hospital where the patient was admitted. They must then apply to that hospital for any further information they require. The decision as to whether to release the information lies in the hands of the local medical committee or individual consultant, according to local practice. The DHSS has frequently reaffirmed that this procedure has always been followed and that it will always be adhered to.

In spite of reassurance that this excellent tradition will continue, it is clear that there is considerable unease about the names and addresses of psychiatric patients being held on computer files which also contain sensitive information. Most small research psychiatric registers are under local medical control, and in any case do not place the patient's name on the computer file; identification is by a number and coded address. It is very difficult for large regional and national registers to adopt this procedure, and, even if they could, a number-name index would still have to be kept.

Dr Hall puts forward two grounds for not making identifying information about any patient available to the Mental Health Enquiry on form HMR1; the first is patient-doctor confidentiality, the second is the possibility of misuse. I am not sure whether she regards the first of these grounds as sufficient in itself. The implicit trust between patient and doctor allows a great deal of use of medical records for clinical, teaching and research purposes that could not be covered, in every detail, by any form of 'informed consent'. For example, if a doctor wishes to examine a series of records collected within his own hospital over a period of years, it is not usually regarded as necessary to obtain the consent of patients first, and to refrain from examining records of patients who cannot be traced or who do not reply. It is considered reasonable to assume that the patient's consultants, or appointed representatives, can give permission. Furthermore, the large majority of psychiatrists see no risk to their patients arising from completing the MHE form at the moment.

Dr Hall's second point is that doctors are wrong to see no risk. 'It is not improbable', she says, in spite of all explicit statements to the contrary, that information about identified patients will be transferred and then misused, because Government attitudes 'could subtly alter over the years'.

When Dr John Baldwin, Dr Julian Leff and I considered these matters we thought there was no such risk in the immediate future. We did not believe that the medical officer charged with preserving the confidentiality of MHE records would flout medical ethics so blatantly or that politicians and non-medical officials, several of whom would have to be corrupted, would conspire to do so without his knowledge. It certainly did not occur to us that any such breach of trust could possibly be regarded as well-intentioned. We did, however, understand the fears that had been expressed that future Governments might conceivably be so corrupt that a deliberate attempt could be made to exploit computer files for purposes we would regard as criminal. We therefore suggested that the Mental Health Enquiry be administered by a body independent of Government, a majority of whose members would not be drawn from Government departments, and whose chairman and medical director would be acceptable to the medical profession. An organization of this kind has already been working satisfactorily for several years in Scotland. We thought there was time for negotiations to take place with the DHSS and that, meanwhile, MHE forms could continue to be completed.

We also put forward proposals governing the use of confidential information, whatever the size or setting of the data system, including control and licensing by ethical committees and the adoption of security precautions and a strict code of practice. I am very sorry that Dr Hall found herself unable to mention any of these proposals. She agrees that the current likelihood of harm is low, judging from the very good record of the Mental Health Enquiry so far, but nevertheless urges us to act as though we were already in the grip of a dictatorial and oppressive regime. Her suggestions would effectively prevent a national register being of any value for research purposes, thus bringing to an end a long, honourable and useful tradition which has never harmed a single individual.

* A special Committee of the College has submitted a report which has been approved by Council and will be published shortly. The Chairman of the Committee is Sir Martin Roth. The Secretary is Professor J. K. Wing, but this note is written in his personal capacity.

I should like to suggest that there is no need for precipitate action, that the College has time to negotiate with the DHSS and the Regions, taking into account the recommendations of its Special Committee and the report of the Data Protection Committee (1978), and that no harm will come to patients if MHE forms continue to be completed while negotiations are taking place.

CORRESPONDENCE

PSYCHIATRIC EXAMINATIONS IN THE UNITED STATES AND CANADA

DEAR SIR,

I think that Dr Joseph Berger's article comparing psychiatric examinations in the United States and Canada (*Bulletin,* October 1978) is outdated and misleading. The Canadian written examination changed completely to the 'objective' type (multiple choice questions) in 1976. Dr Berger has relied heavily on his impressions rather than on factual information, and although it may have *seemed* to him that the Canadian multiple choice examination was 'too heavily basic science oriented' the proportion of questions related to basic science is limited; for example, in 1978 basic science questions constituted about 15 per cent of all the questions, with the same percentage devoted to questions about psychodynamics and psychotherapy.* Dr Berger believes that 'a clinical examination is no longer the place to test text-book knowledge'. Since text-books these days are so comprehensive, it would be difficult to conduct a clinical examination that did not require of the candidate some knowledge of what is recorded in text-books. However, if Dr Berger is implying that basic science information or abstruse academic information is sought in the clinical examination, he is mistaken: examiners are specifically instructed not to ask questions that do not refer directly to the problems posed by the examined patient, or to the practical problems of treatment posed by patients described in clinical vignettes.

The impressionistic nature of Dr Berger's article is strongly apparent in many of his statements. It 'seems' to him that the pool of Canadian examiners is small. In fact, it is potentially large, since new examiners are recruited and others retired every year. As for their 'highly variable' quality, I think Dr Berger would agree that without supporting evidence this is a gratuitous judgement. In fact, the examiners themselves are regularly assessed for their thoroughness and fairness. When Dr Berger states that in Canada the candidate is seen as a student, he is definitely wrong. Before the candidate is permitted to sit the examinations he must have a report from the Director of his residency training program stating that he is fit to function as a specialist psychiatrist. The problem for the examiners is that the *candidates* so often see themselves only as students in spite of the communications they get to the contrary from their colleague-teachers and from the Canadian Royal College. Clinical examiners are specifically instructed to try and put candidates at ease. A candidate's interview technique is judged not only as it pertains to the inquiry and conduct of the mental status examination but also as it affects his ability to be therapeutic with the patient he is assessing. For example, a candidate who pushes ahead with the inquiry completely disregarding indications that the patient is distressed or needs reassurance is marked down. It is common for examiners to ask such questions as 'Doctor ———, if this (the patient examined) had been a patient you had seen in your office, what parts of your assessment would you have liked to follow further?'; or 'Dr ———, if your preferred plan of management did not produce the improvement you hoped for, what else would you have considered?'.

Half my psychiatric training was done in Canada and half in the United States. I have taught residents in both the US and Canada. Although it may be true that American trainees are more adept at speculating about psychodynamic formulations, I believe that the Canadian residents I have seen are more comprehensively trained clinicians than their American counterparts, and potentially just as good as psychotherapists. I hope that those British trainees who plan to sit the Canadian examinations will see Dr Berger's article for what it is—one psychiatrist's impression—and not regard it as a source of accurate information.

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