Confidentiality and the police

Guidelines in Scotland

During the past two years the BMA and the Association of Chief Police Officers (Scotland) have been discussing problems of confidentiality, and guidelines have now been agreed. These are summarised here. Copies of the guidelines may be obtained from the BMA Scottish Office (7 Drumsheugh Gardens, Edinburgh EH3 7QP).

Although doctors in general wish to co-operate with the police, they must be sure that any information divulged *in confidence* to the police will not be used in court, unless they are aware at the time of interview that information might be so used. The profession is aware, however, of the difficulty that, when information is requested, a decision on legal action may not have been taken and the police officer may not be able to give an unequivocal answer as to whether or not confidential material might be used in court.

It is suggested that the following arrangements might apply.

Hospital

It is thought appropriate that exchange of information should be between clinicians and police officers, but that within normal working hours the first point of contact for the police should be the appropriate community medicine specialist of the health board. The community medicine specialist would then direct the police to the correct clinician and would also ensure that access was arranged in a manner convenient to both parties. The role of the police surgeon would be to evaluate, in an unbiased manner, the information received by the police officer from the clinician.

General practice

A medical liaison officer might be appointed by each BMA division. This officer would be a man of professional standing, nominated by the local BMA division; he should normally be a police surgeon. The police force would approach this officer in sensitive cases; he would then contact the general practitioner where appropriate, and would himself report back to the police.

Effective liaison should be sought at three levels:

(*i*) The police officer at operational level and the doctor to whom a request for information is made would liaise at hospital or GP level. It is noted that in England and Wales it has been agreed between the BMA and ACPO that the officers who regularly liaise with doctors in cases of non-accidental injury to children might carry out primary liaison work.

(*ii*) At area level the BMA division secretary and/or chairman would liaise with the chief constable or his nominee. This level would be used where progress could not be made at the lower level.

(*iii*) The Scottish Secretary of the BMA and the Secretary of the ACPO (Scotland) would liaise at national level.

It is not possible to draw clear lines for requests by police officers to look at records in hospital accident and emergency departments. The police should ensure that a proper explanation of the reasons for a request for information is given in all cases so that lack of co-operation will not be caused by lack of communication, and that no police officer should give the impression that he has a legally enforceable right to compel disclosure. Doctors in hospital accident and emergency departments should also be aware of their legal rights and obligations.

Inquiries concerning clinical details of women suspected of infanticide, of concealment of stillbirth, or of child stealing are primarily a question of communication, and if doctors were made aware of the reasons for the police investigation much of their concern might be dispelled.

No general rules should be laid down about the circumstances in which doctors should disclose information concerning the medical history of girls under 16 relating to possible criminal offences by a male partner. The decision to disclose would have to be a matter for the doctor's discretion in individual cases.

It is essential that the police officer at case conferences involving non-accidental injury to children is a person of experience and trust, and that he must not be bound by the need to raise prosecutions in cases where there is doubt whether non-accidental injury has taken place. It is important, however, that doctors realise that where it becomes clear to a police officer attending a case conference that there are reasonable grounds to suspect that a child is suffering from a non-accidental injury, he has a statutory duty to report the facts to the Procurator Fiscal.

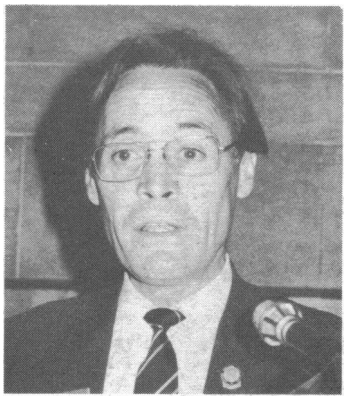
Buying added years

The BMA has written to associate members to explain the advantages of buying added years in the NHS superannuation scheme. Most NHS employees begin to pay superannuation contributions at the age of 20. This means that they can retire at 60 with 40 years' service. This entitles them to a pension at half the rate of their final salary. A single lump sum is made at a rate of three times the pension. Most doctors do not enter the scheme until their mid-20s so that it is not possible for them to qualify for a half-rate pension at 60. They can obtain this only if they purchase extra years of service—added years.

The new arrangements for buying added years, which were expected to be introduced in September, have been further delayed. The DHSS Superannuation Branch hopes that the scheme will become operable before the end of the year, and because of the delay the regulations will be applied retrospectively to 1 May 1982. As soon as the scheme is launched explanatory leaflets will be distributed to all NHS employees.

The new scheme, though more flexible, will certainly be more expensive than the existing arrangements. It is, therefore, to the long-term advantage of those doctors in their first 12 months in the NHS, to buy added years now rather than delaying until later in their career. The existing scheme for buying added years will end when the new arrangements come into operation.

New CEC chairman



The Central Ethical Committee has a new chairman. Dr A W Macara, a senior lecturer in community medicine at the University of Bristol, was unanimously elected at the Central Ethical Committee's first meeting of the session on 11 August. Dr Macara said that he hoped that the commmittee would continue to carry out the wishes of the Representative Body and to engage in debates of matters that were of wide importance to the profession. He also hoped that BMA divisions could be encouraged to play a more active role in the discussion of ethical matters.

There are three members of the CEC on the BMA's In-vitro Fertilisation Working Group (15 May, p 1500). They did not think that the full report would be ready by the end of the year and an extension of the deadline will be sought. The group, which is chaired by Professor J P Quilliam, has met twice. The committee was told that the Government's inquiry into in-vitro fertilisation (31 July, p 386) would take two years to report.

The CEC will scrutinise closely any proposed legislation on data protection. The BMA's comments on the White Paper on data protection (26 July, p 1966) have been sent to a large number of MPs and it was agreed that UK members of the European Parliament should also be contacted.

The 1982 ARM resolved "that further consideration of the ethics of the treatment of handicapped infants should be given priority for attention by the Central Ethical Committee." The committee decided to ask the motion's proposer and members of the committee interested in the subject to produce background papers, which, in the first instance, will be considered by the CEC's Standing Subcommittee.

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