Review of police inquiries to an accident and emergency department

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Abstract

Objective—To assess the workload generated by police inquiries to an accident and emergency (A&E) department and the adherence of medical staff to departmental guidelines relating to these inquiries.

Design—Prospective analysis of the number, nature, and timing of police inquiries and the information released by medical staff.

Setting—A&E department of an inner city teaching hospital.

Outcome measures—Number of personal and telephone requests for information from police; completion of a form of inquiry; record of patient consent for release of information.

Results—A daily average of 8.7 police inquiries were made, but in only 10% of cases was a form of inquiry completed. The patient's consent for release of information to the police was recorded in 4% of cases.

Conclusions—Police inquiries generate a significant workload for an A&E department, often at clinically busy times. Medical staff need further education to ensure that patient confidentiality is respected while assisting the police with their investigations.

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Key terms: confidentiality; legislation; police; emergency medicine

By the very nature of the specialty, accident and emergency (A&E) departments are regularly required to deal with crime related injuries. The doctor repeatedly faces a conflict of duty—an obligation to respect patient confidentiality¹ and a common law requirement to assist police investigations.^{2,3} This ethical dilemma is exacerbated because medical confidentiality has not been incorporated into British criminal legislation. Increasing awareness of this issue is evidenced by its topicality in recent reports¹⁻⁴ and the compilation of guidelines for dealing with police requests for information.⁵ These documents commend the Police & Criminal Evidence (PACE) act (1984) as guidance for disclosure, but this has no equivalent statute under Scottish law, compounding the problem for those practitioners working in Scotland. Two distinctly separate categories of information are frequently sought: clinical and non-clinical information. Misunderstanding may exist between both police and medical staff as to which category of

information, if not both, should be disclosed in different cases, without patient consent or court writ. In Scotland, following involvement in an incident where a person requires medical attention, the police are obliged to file a report as to the nature of the injuries and treatment received by that person. This does not constitute a formal "statement to the police" as it does in England and Wales. Formal medical statements are taken by an agent of the Procurator Fiscal upon precognition of the doctor.

To our knowledge no one has studied the volume of work generated by police inquiries to an A&E department. We aimed to assess this workload more accurately, although we were unable to measure the precise amount of time spent on each inquiry. We were interested to discover whether the relevant departmental guidelines were being followed. Our prospective one month study attempted to address these issues.

Methods

For the period 1 March to 28 March 1993 inclusive, the reception staff of Glasgow Royal Infirmary A&E department recorded all verbal police inquiries to the department for information about patients' injuries, treatment, and outcome. It was noted whether these requests were made by telephone or in person, and a form of inquiry (Appendix) was completed in each case. This form had been in use in the department before the start of our study and was therefore a piece of familiar documentation. The receptionist completed the patient, incident, and police officer details in part A of the form of inquiry, and then escorted the officer to the doctor "in charge" (of middle grade or consultant status), handing the form of inquiry and clinical notes to the doctor. The form of inquiry part B was intended to be completed by the doctor, serving as a record of the information disclosed. Any telephone requests for information were to be offered discussion of the relevant matter with a doctor if the officer attended the department in person. No details were to be released by any member of staff by telephone. At the conclusion of the study period the relevant cases notes were reviewed to determine the accuracy of the information given and the frequency with which patient consent was documented.

Results

WORKLOAD

Total inquiries numbered 245. There were 152 inquiries by telephone (62%) and 93 were made in person (38%). On average, 8.7 inquiries were made each day. The daily distribution of these is illustrated in fig 1.

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Figure 1 Total number of each type of inquiry by day and 6 h time period.

FORM OF INQUIRY

Only 25 forms were completed for the total 245 inquiries made to the department. This accounted for only 10% of the total and 26% of the personal inquiries. Six sets of clinical notes were untraceable and therefore could not be matched with the corresponding form of inquiry.

Clinical data released matched the clinical record in three cases (12%), did not match in one case (4%), and the match was unknown in 21 cases (84%), in which details of the clinical data disclosed were not recorded.

Patient consent was documented in one case (4%), not documented in 18 cases (72%), and this information was unknown in six cases (24%), in which the casenotes were not available for review.

POLICE DATA

The ranks of the police officers making the inquiry were as follows: detective constable 7 (28%); detective superintendent 1 (4%); constable 14 (56%); unknown 3 (12%); inspector 0.

In Scotland, constable and detective constable are the same rank but occupy different departments of the force.

REASON FOR REQUEST FOR INFORMATION

Information was required for the following reasons: police report 21 (84%); Procurator Fiscal report 3 (12%); unknown 1 (4%).

The temporal distribution of inquiries for the study period is shown in fig 1. The mean daily number of inquiries for each individual day of the week is shown in fig 2. Five police inquiries related to patients who attended before the study period. One inquiry form stated "No information given as no consent in the notes". In one case the form had been completed by the requesting police officer—"full details obtained, thank you".

Discussion

The doctors' responsibility to maintain patient confidentiality is clearly stated in such documents as the *International code of medical ethics* (1958) and the General Medical Council "blue book" (1991).⁷ The legal position is somewhat less clear. Medical information is not legally privileged because medical confidentiality has not been incorporated into British criminal legislation. In the case *Hunter-v-Mann* (1974) the court ruled "...the doctor is under a duty not to voluntarily disclose, without the consent of the patient, information he has gained in his professional capacity". Yet in the same case the Road Traffic Act (1972) was invoked to allow a doctor to give information which may have enabled the identification of the driver of a vehicle.

The British Association for Accident and Emergency Medicine (BAEM), in conjunction with the British Medical Association Central Consultants and Specialists Committee (CCSC), has issued guidelines "regarding the release of information about patients attending accident and emergency departments in the United Kingdom". These guidelines refer to non-clinical information which, they advise, may be disclosed, without an instruction from the court, if the crime was sufficiently serious to endanger the lives of the general public". The degree of severity is a subjective assessment and the "serious arrestable offence" as defined in section 116, schedule 5, parts I and II, PACE (1984) is offered as guidance.

Figure 2 Average number of inquiries per day.

The BAEM/CCSC paper recommends that information be disclosed if (1) the crime committed is a "serious arrestable offence" as defined by PACE (1984) or is covered by the Road Traffic Act (1972); (2) a request is made by an officer of the rank of inspector or above; (3) a form of inquiry is completed and signed.

There is unanimous agreement in published reports that written informed patient consent must be given if disclosure of clinical information is to be made to a third party.

At Glasgow Royal Infirmary accident and emergency department, requests for non-clinical information are relatively uncommon and our study therefore dealt only with the requests for clinical information. Anecdotal evidence from discussion with staff suggests that non-clinical information is usually withheld on the grounds of medical confidentiality, and any requests would be referred to the consultant in charge. The police are prohibited from the reception area where the patient attendance register is kept, and reception staff refer all requests for information to the medical staff.

Our study shows that in all cases where a form of inquiry was completed the police officer's rank was never that of inspector. In fact in 56% of cases the request for information was made by a police constable. Clearly there is a discrepancy here between the police and medical perceptions of the importance of the information being dealt with. To the police officer it is often merely the details needed to complete an incident report but for the doctor such a disclosure may be a breach of patient confidentiality.

We audited the release of clinical information to the police by medical staff. Despite clear departmental guidelines that informed patient consent was required, we found that in 96% of cases this information was disclosed in the absence of documented consent. Only 25 forms of inquiry were completed for the 93 occasions on which a police officer personally sought information. One possible explanation for this discrepancy is that victims of violent assault or crime presenting to the department are closely followed by the police. In these situations their inquiry is noted but the officer collects the required details directly from the patient, thus circumventing the form of inquiry. A different situation exists following road traffic accidents where no consent is required before the release of information. We were unable to match clinical data released with the clinical record in six cases as the case record was unavailable. In 15 forms of inquiry part B had not been completed.

In our department, police requests should be dealt with by the duty registrar or consultant. From the eight forms which record clinical details in part B, we found that three were dealt with by the registrar, the remaining five by a senior house officer. One additional form was completed by the requesting police officer himself. We had no record of the advice given in response to telephone inquiries but administrative staff are precluded from giving information to any party, in keeping with the

BAEM/CCSC document. This practice is further endorsed by the code of practice relating to confidentiality of health information issued by the Scottish Office.⁸ Clearly there is a need for a more consistent and realistic approach to dealing with the regular personal police inquiries. Perhaps the provision of a dedicated telephone extension and trained member of staff to deal with all inquiries would satisfactorily address the problem.⁹

An acceptable daily average number of police inquiries has not been defined. On average our reception staff deal with eight inquiries per day. Our results further illustrate that this work tends to be concentrated around the most busy times of the week (figs 1 and 2). We did not define the length of time spent on each inquiry, but it is clear from the above description that for each personal police inquiry the receptionist must complete a form and find a doctor to deal with the request. She is therefore not available to deal with the next patient in the queue. If these inquiries were prioritised and presented at clinically quieter times the medical and reception staff would be able to cooperate more easily with the police. A&E staff often feel the need to maintain good relations with the local police, particularly in inner city areas where the potential for violence and disturbance is a very real problem. In such situations police assistance is essential and many feel this is jeopardised by the "new reluctance" to help police with their inquiries. Clearly, release of information cannot become a bargaining tool for ensuring A&E staff safety but there is a very real anxiety that previous goodwill may have been affected.

The BAEM/CCSC guidelines issued for "accident and emergency departments in the United Kingdom" promotes PACE (1984) as guidance for medical disclosure to the police. However, this act applies only to England and Wales, having no jurisdiction in Scotland. When the treaty creating the Parliament of Great Britain was signed in 1707 it was laid down that Scots Law and the courts administering it should continue for "all time coming". Scots law has evolved separately from, but in parallel to, English law. No equivalent or comparable provision to PACE exists under current Scottish law, leaving doctors in Scotland's A&E departments in further confusion, under pressure from a police force not guided by English law.

CONCLUSION

Our study has shown that police inquiries generate a significant workload for reception and medical staff in an A&E department, frequently at clinically busy times. The working relationship between HM Constabulary and accident and emergency services may be improved by further discussions to clarify the doctor's dilemma: an obligation to maintain patient confidentiality and a responsibility to respond to police requests. Appreciation of this would be evidenced by inquiries from more senior police officers. We have shown the need for regular re-education of staff on departmen-

tal policies relating to release of information to the police so that patient consent and a record of details disclosed is routinely obtained. Practising in Scotland is especially difficult as the law has not addressed the particular dilemmas noted above, adding further tension to a confused and unclear ethical/legal situation.

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Appendix

Departmental proforma to be completed in all cases of police inquiry.

POLICE FORM			
RECEPTION STAFF			
Tick as appropriate	Personal Enquiry.....		
	Telephone Enquiry.....		
PART A			
POLICE OFFICER			
Date:			
Patient's Name:			
DOB/Age:			
Date of Incident:			
Police Name/No:			
Police Office/Telephone No:			
Information Requested:			
Reason for Request:			
			Signed:
			Designation:
PART B			
MEDICAL STAFF			
Patient consent given ?	yes []	no []	unknown []
Information disclosed (Please record)			
			Signed:
Date:			Designation:
THIS FORM SHOULD BE RETURNED TO THE RECEPTIONIST SUPERVISOR WHEN THE ENQUIRY HAS BEEN PROCESSED AND DEALT WITH.			