PostScript

LETTER

Mobile communication regulations updated: how safely are doctors' telephones used?

Mobile telephone use in British hospitals was previously restricted, based on the 1997 Medical Devices Agency guidelines.¹ These guidelines reflected concerns that mobile phones generate electromagnetic interference which can interfere adversely with electronic medical devices. Sensible precautionary measures have led to calls to decrease the restrictions on mobile telephone usage within hospitals.^{2,3} Updated guidelines have recently been published which aim to clarify inconsistent policies among healthcare organisations.⁴

Many doctors find that mobile telephones are a convenient method of communicating within the hospital environment. We conducted a questionnaire based survey of doctors from all specialties in a city teaching hospital (unpublished data). Of the 381 doctors questioned, 178 (47%) replied, 174 of whom (98%) owned a mobile telephone, and 114 (66%) admitted to using it in hospital. The most common reason given for use in hospital was for emergency clinical matters ($n = 83$, 73%), although over half used their telephones for personal calls. 112 doctors (64%) admitted to leaving their telephones on in "high risk" areas such as operating theatres and high dependency units which contain vital electronic medical devices. However, only five doctors (3%) reported ever seeing an adverse effect on medical equipment.

With the use of mobile telephones being so widespread and the emergence of new mobile equipment for electronic health records and prescribing, it is clear that the recent revision of national policy was needed. Mobile telephones are an established method of communication in hospital and are commonly used with many benefits to patient care. The Medicines and Healthcare Products Regulatory Agency (MHRA) recommends that "a balanced approach is necessary to ensure that all the benefits of mobile wireless technology can be made to all organisations".⁴ The MHRA recommendations also include careful consideration of areas where restrictions should still apply.

We have established that mobile telephone usage is widespread by doctors, particularly in emergencies, within both the general hospital environment and in high risk areas. Our findings show that mobile telephones have rarely been observed to cause adverse effects to medical equipment. Policies to prevent the unmanaged use of mobile communication equipment are still necessary to reduce the risk to patients. However, if mobile phones are used sensibly, the benefits to patient care may outweigh the limited risk of interfering with equipment, particularly in emergency situations. Mobile telephones are soon to be joined in hospital by a variety of other electronic mobile communication devices. It is therefore essential that the

emphasis is now placed on assessing the risk to and protecting sensitive equipment.

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- 3 Aziz O, Sheikh A, Paraskeva P, et al. Use of mobile phones in hospital: time to lift the ban? *Lancet* 2003;36:788.
- 4 Medicines and Healthcare Products Regulatory Agency. *Supplementary document to DB9702*, <http://www.medical-devices.gov.uk/mda/mdawebsitev2.nsf> (accessed 10 August 2004).

BOOK REVIEWS

Getting to Grips with Clinical Governance

S C W Harrison, C T S Pollock, S J Symons. UK: Shrewsbury, 2003, £25.00. ISBN 1 903378 16 8

Clinical governance is the local component of the quality improvement system in the UK NHS. Each healthcare organisation—whether hospital, general practice, or community service—is required to have a clinical governance system in place. *Getting to Grips with Clinical Governance* has been written for the practising clinician in order to explain the justification for clinical governance and what it involves.

It is five years since clinical governance was introduced into the NHS so it is an appropriate time to reflect on what has been achieved. The book is evidence that clinicians, particularly doctors, have yet to be fully engaged. They still need to be convinced that clinical governance is a good idea. In the preface the authors say: "it is our belief that there is a serious risk that clinical governance may fall into disrepute as being a bureaucratic nuisance inflicted on overstretched workers in a top-down manner".

The authors spend some time trying to make the case for clinical governance. The first five chapters outline the long process in the evolution of the health service and changing public expectations that led to the flurry of reforms of the late 1990s. Next, they address the difficult problem of defining clinical governance. The formal definition is familiar, but the difficulty lies in describing a coherent concept that fits together the

various quality improvement activities and places them in a consistent and effective structure. At the same time, a culture must be created that fosters learning and improvement. In the following chapters the authors detail many of the constituent activities such as risk management, professional development, clinical audit, and patient involvement.

This is the best introduction to clinical governance for clinicians that I have read. The short chapters are easily digested. The description of the RAID model is excellent, and all the principal issues are addressed. Each chapter includes suggestions for further reading and there are plenty of summary lists from practical suggestions. A few aspects could be improved. For example, a short chapter outlining the methods of clinical audit is probably not needed. Audit has been a formal feature of the health service for 15 years and there are plenty of other more detailed introductory textbooks. The chapter on consultation and public involvement is rather narrowly focused. It describes the new systems being introduced (such as Patient Forums), makes the case for involvement, and briefly reviews methods of feedback from patient diaries or questionnaires, focus groups, and so forth. However, the more radical idea of designing services around patients' preferences is not really addressed. The book's emphasis relies on clinical governance in hospitals, and the occasional references to primary care trusts are insufficient for meeting the needs of clinicians in primary care. But, despite these qualifications, the book can be recommended.

It is interesting to see some ambivalence expressed by the authors. They admit on the final page that it is difficult not to be apprehensive about the future, and they urge those in power to temper their reforming zeal. Earlier in the book, when discussing underperforming colleagues, they state that the recommendations of the Bristol inquiry lack in places an anchor of reality. In their view there is somewhere that can be described as "the real clinical world" which is different from the "idealised professional world". Perhaps many clinicians feel this way, but surely one of the aims of clinical governance is to bring the real clinical world in line with the expectations of patients and policymakers. It sounds as though the next phase of clinical governance must be to fully engage clinicians.

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Medical Records, Use and Abuse

H Tranberg, J Rashbass. Oxon: Abingdon. ISBN 1 85775 604 5

This is a clearly written, well structured book that explores the challenges involved in maintaining the confidentiality of medical records. It is written by Heida Tranberg, a lawyer who specialises in intellectual property, information technology and privacy issues, and Dr Rashbass, previously a consultant in histopathology and now director of

the Clinical and Biochemical Computing Unit in the University of Cambridge.

Five of the 10 chapters address questions and the answers provided are far from clearcut. For example, the authors start by asking: "Is there a medical privacy crisis?" They write that it is difficult to assess whether or not privacy is really under more threat today than ever before, but that many people perceive this to be the case. As evidence they cite the results of surveys undertaken mostly in the USA and Australia. However, it then transpires that, in these surveys, data protection did not promote strong spontaneous feelings—it emerged as a concern when people were prompted.

With paper health records handled millions of times a day (the authors quote data from the USA showing that in a single hospital admission the case records are handled by 150 people), it is interesting to read that there are relatively high numbers of medical negligence claims yet very few cases dealing with breaches of medical privacy. Numbers are not provided and the reference is to a contribution to a debate by Community Health Councils to the British Medical Informatics Society 4 years ago.

It is interesting to speculate whether confidentiality was raised as an issue when the surgeon, Ernest Codman, devised a medical records system for the Massachusetts General Hospital 100 years ago. For the first time there were moderately accurate and transparent records of the outcome of surgical interventions. I suspect that it was the doctors rather than the patients who were alarmed at this accumulation of information. Be that as it may, Dr Codman lost his job as a result of his efforts to gather and store information.

Other chapters that pose questions relate to consent, technology, how medical information should be treated, and the disclosure of records for legal proceedings. The issues raised are explored comprehensively and the arguments tightly addressed. This reader was grateful for the summaries at the end of each chapter. The potential benefits of an effective electronic record system are enormous—ask any hospital doctor struggling through a clinic with incomplete case records (and sometimes without any case record at all) or a GP coping with a patient recently discharged from hospital without accompanying information. One can understand the well meaning statement that "the benefits are only considered to outweigh the risks if appropriate privacy safeguards are in place". But the authors do not attempt to define "appropriate". Clearly, there are risks that people inside the system might misuse information that they are able to access quickly and easily, but one has to ask to whom would that information be of value—

potentially insurance companies, the police, private investigators and possibly employers—but would they really use an internal mole? On the other hand, the information technologists will wish to make their systems as secure as possible against external interference because it is almost certain that hackers would be more likely to damage the system than to gain much valuable information.

The authors also explore the less controversial issues of personal access to records, public interest, research interests, anonymous information, and the Freedom of Information Act. They provide useful flowcharts that take the reader through the process of obtaining information from computerised health records while satisfying the requirements of the Data Protection Act and, from the other side of the fence, coping with requests for information balancing the requirements of Freedom of Information against Data Protection.

The final chapter suggests a way forward and explores three key principles: transparency, anonymous information, and consent. The authors are cautiously optimistic about the way in which the NHS is setting out its plans to develop and use patient information safely and effectively. Their closely argued contentions are likely to be of considerable help in taking these issues further. Meanwhile, we can only hope that the billion pound NHS data project will not suffer the fate of some other large information technology projects such as those inflicted on the Passport Office and Inland Revenue.

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Delivering Quality in the NHS

M Rawlins, P Littlejohns, Eds. Abingdon, Oxon: Radcliffe Medical Press, 2004, pp 198. ISBN 1 85775 618 5

After years of focusing on throughput and a narrow definition of efficiency, the National Health Service in England turned its attention to dealing with the poor and variable quality of care. A mechanism was established for delivering a coordinated effort to set standards (National Institute for Clinical Excellence; NICE) to monitor them, and an expectation that all staff would have a duty for quality (clinical governance). Although policy makers had not sufficiently thought through the new system before implementing it and several aspects (such as the performance assessment framework and "star ratings") have been a failure, these core activities have made a difference.

This book brings together a selection of short contributions from the 2003 NICE conference. Although individual sections are rarely of sufficient academic depth or practical detail to add to knowledge or provide guidance for action, it provides a historical record—a snapshot of the sort of activities stimulated by these quality initiatives in gaining evidence, informing clinical practice, implementing and monitoring implementation and the quality of services. It demonstrates the incredible energy and initiative both from the top down and the bottom up to improve quality of care. The true test will be whether the enthusiasm, so obvious from this wide range of contributions, can be sustained and become part of the fabric of the NHS, and to what extent it will be stifled by bureaucracy or taken over and muted by some of the professional bodies (surprisingly absent from the collection).

There is a strong emphasis on the evidence base of clinical services, perhaps most comprehensively applied so far in cancer with the development of national guidance since the mid 1990s (Haward, pp 176–180). In order to produce reliable guidance on a range of health technologies, it is important to summarise evidence in systematic reviews or, where evidence is insufficient, to carry out rigorous primary evaluations of health care. In the NHS the national R&D programme has, over the years, established a process for prioritising and commissioning such evaluations in order to feed directly into the policy needs. The Health Technology Assessment programme (Gabbay, pp 14–17) is perhaps unique internationally in linking the conduct of new evaluations closely to the strategic needs of the NHS. A similar link has been established in research on service organisation and delivery.

If research evidence is one of the key inputs to fuelling the engine of quality improvement in the UK, it is vital that we maintain a system for ensuring its production in a timely way through clinical and health service trials and national clinical databases. Early in the book Sir Iain Chalmers (pp 5–8) highlights some of the threats to high quality evaluative research in the NHS. A mixture of the incompetence of those responsible for developing and implementing arrangements for both ethics and research governance approval and European legislation has resulted in increased bureaucratisation (highlighted also in the 31 July 2004 issue of the *BMJ*) which makes it more difficult to carry out independent evaluative research in the NHS. Unless this is dealt with decisively, the optimism shared in this book is likely to turn sour.

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