Letters to the Editor

Independent ethical review of studies involving personal medical records

Editor—When the report of a working group of the Royal College of Physicians Committee on Ethical Issues in Medicine was published in the *Journal* (September/October 1994, pages 439–43), the President invited comments on its recommendation that it was not obligatory to seek consent from individuals for their records to be used in epidemiological research, provided strict rules of confidentiality were obeyed. We discussed this report at a meeting of the Barnet Research Ethics Committee, on 14 June 1995.

We felt that research involving access to medical records and health related registers without direct patient involvement did not require explicit individual patient consent. However, we were unhappy about not submitting this research to independent ethical review as it would appear to open the floodgates to any researcher who wishes to gain access to any form of patient medical record.

Although explicit consent for access to a person's records should be obtained from the official custodian of the records, it may well be that these custodians, ie GPs, will not have the competence to satisfy themselves as to the bona fides of the investigator. We are also not convinced that the official custodian of the records will necessarily insist on adequate confidentiality or anonymity.

We felt that the paragraphs a) to d) in the summary represented good guidelines for our research ethics committee but would not like it to be thought that independent ethical review of the research project was not needed.

Although human tissues would not appear to be regarded as property, we felt that where existing biological samples were to be used it would be courteous to inform the donors.

LINDA M STANTON
Chairperson, Barnet Research Ethics Committee

Editor—In drawing up its recommendations the working group of the Royal College of Physicians was concerned that no unnecessary obstacle should limit research while at the same time ensuring that no individual would be harmed (September/October 94, pages 439–43). Much good, with a notable absence of any harm, has come from using medical records in large scale studies into disease causation as well as in smaller studies and reviews into patient management. Use of records among doctors is part of a long tradition in medicine.

It may not be appreciated how serious an obstacle it would be for each record review to require ethical committee approval. A strict application of the view expressed by Mrs Stanton (see above) would mean that any doctor wishing to share medical records with another doctor outside the care of an individual patient would be prohibited from doing so unless an ethics committee first gave approval

Mrs Stanton and her committee have raised the possibility of a custodian of records being uncertain over the *bone fides* of a particular investigator. In such a (surely rare) instance, it would be entirely appropriate to refer the request to an ethical committee for guidance. With regard to courtesy over using stored blood and urine samples, the practice is not fundamentally different from using medical records. In many cases it would be impractical to seek explicit consent from donors, some of whom may have changed their address or died.

It would be desirable if patients, in general, were made more aware of the fact that their records and blood samples may be used for research and the benefits that can arise, together with the strict safeguards that apply. The agreement of the patient's doctor or the professional custodian of the records is required and the recipient of the information must be a professional person who is subject to professional disciplinary proceedings in the event of a breech of confidence.

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Appropriateness of acute geriatric admissions

Editor—I read with interest the paper by Tsang and Severs (July/August 1995, pages 311–4). I have to say that I have the gravest anxiety about their concept of appropriateness of admission illustrated by their Table 2.

Elderly people, like the physically and mentally handicapped can be sidelined by acute medical specialists if their illness is not readily amenable to technical treatment. Our ethic as physicians should surely be the relief of suffering and the treatment with dignity of those who require skill and care in their management. This must include all the categories in the right hand column of Table 2 who either require reassessment, pain management or professional advice and have not received it, otherwise they would not have been in hospital.

I accept we have a professional responsibility to utilise acute facilities efficiently but for many departments of geriatric medicine,