reflect reversible or irreversible myocardial injury and how necrosis could be distinguished from reversible myocardial damage. Further experimental studies are required to clarify this point, which has in recent years been considered in numerous clinical studies that showed that raised troponins are predictors for mortality or worse clinical outcome independently of acute coronary syndromes and myocardial infarction. However, raised cardiac troponins alone will never allow us to make a clinical diagnosis, but they are an important contribution to a complex clinical picture, be it in the context of acute coronary syndromes or other conditions. Above all they contain prognostic information for most of these conditions that may be relevant for the management of patients.

Peter Ammann  
Senior physician  
Kantonsspital St Gallen, CH-9000 St Gallen, Switzerland  
(peter.ammann@kssg.ch)

Matthias Pfisterer  
Professor  
Division of Cardiology, Department of Internal Medicine, University Hospital Basel, CH-4031 Basel, Switzerland

Thomas Fehr  
Research fellow  
Transplantation Biology Research Center Massachusetts General Hospital, Boston, Boston, MA 02129, USA (thomas.fehr@verizon.net)

Hans Rickli  
Senior physician  
Division of Cardiology, Department of Internal Medicine, Kantonsspital St Gallen, CH-9000 St Gallen, Switzerland (hans.rickli@kssg.ch)

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Data protection, informed consent, and research  
Medical research suffers because of pointless obstacles

Cancer Research UK and other medical research charities have warned the government that the human tissue bill will cause damaging confusion among doctors and hamper medical research unless crucial sections are clarified. The Data Protection Act, another well intentioned but loosely drafted law, has also been in the news. The Bichard inquiry has been investigating the decision by Humber Foundation Hospitals not to give medical students access to data because of the need to strike a balance between individual confidentiality and public health interest. So Professor Julian Peto is simply wrong when he states that the Data Protection Act is preventing data from being passed to medical researchers. That those who enact and interpret radical social legislation should be so ignorant of its actual effects is another important recommendation of the new Wanless report on improving health and raising standards in health care. Lord Falconer says: “Data can be used for any medical research purpose under the Data Protection Act, without the need for the consent of individuals. So Professor Julian Peto is simply wrong when he states that the Data Protection Act is preventing data from being passed to medical researchers.” That those who enact and interpret radical social legislation should be so ignorant of its actual effects is
alarming. Custodians of medical records are fearful of litigation if they allow any access for research or even audit without each patient’s informed consent. The effects on British epidemiology are illustrated by two of our current studies.

The NHS cancer screening programme commissioned us to abstract the screening records of women who had died of cervical cancer and an anonymised 1% random sample of all British women. We had to correspond with the director of public health or the Caldicott guardian in almost 100 former health authorities for permission to obtain these data. These negotiations occupied much of a senior researcher’s time for two years, and the data have still not been released in a few areas.

The Health and Safety Executive commissioned us to conduct a national case-control study of patients with mesothelioma. We asked the Department of Health to provide the names of clinicians with newly diagnosed eligible patients (not the patients’ names) from the hospital inquiry system, but this was refused for over two years. The information commissioner’s office finally advised the hospitals that it is not illegal to put medical researchers in touch with doctors. To obtain random population controls from general practitioners’ lists again entailed protracted correspondence with NHS data custodians in each region before the project could begin, and several areas, including the whole of Scotland, still refuse to participate.

At a public meeting in November 2002, organised by the Parliamentary Group on Cancer and opened by Alan Milburn, then secretary of state for health, the audience were provided with an electronic voting facility. After a discussion of the restrictions on access to medical records that British epidemiologists now face and their effects on our work, the audience were invited to vote for or against the following proposed law: “Consent is not required for access to medical records for non-commercial medical research that has no effect on the individuals being studied and has been approved by an accredited research ethics committee.”

The vote in favour was 93%. The audience included members of the general public, patients’ support groups and cancer charities, doctors, nurses, and public health workers. The widespread belief among politicians and senior civil servants that the public would no longer tolerate access to their records by bona fide medical researchers is assiduously promulgated by many medical ethicists and lawyers, but it is not true. Even the tiny minority of patients and controls who express any concern that we have identified and contacted them through their medical records are almost always satisfied when we explain our work to them.

The only substantive difference between the proposed exemption for medical research that this audience supported so overwhelmingly and the relevant parts of the 1998 Data Protection Act and the 2001 Health and Social Care Act is the requirement that permission for medical researchers to access individual records without informed consent must be granted by the Patient Information Advisory Group. Multicentre research ethics committees typically include general practitioners, hospital specialists, nurses, ethicists, lay members, and patients or their representatives. The government has not explained why the Health and Social Care Act usurped the authority of this effective national network of highly professional committees by creating the Patient Information Advisory Group.

None of the hundreds of data custodians in hospitals, cancer registries, and primary health care trusts with whom we have corresponded has ever indicated that our access to their records might raise ethical concerns. These are resolved in discussion with the multicentre research ethics committee before a research protocol is approved. Their concern relates solely to their legal liability, and it can be allayed only by clarifying the law. The Data Protection Act was intended to accommodate medical research, as Lord Falconer claims it does. In practice, however, data custodians are increasingly cautious, and the current government seems unlikely to grant the explicit exemption for non-commercial medical research that would resolve their fears.

Lord Falconer further asserts that it is the common law, not the Data Protection Act, that demands informed consent for medical researchers to access named patients’ records “unless there is an overriding public interest.” This suggests a practical solution. Medical researchers have been allowed confidential access to medical records throughout the ages, and until recently such access without informed consent was explicitly allowed under the Medical Research Council’s guidelines on research. To reverse this ancient tradition in the name of the common law seems absurd, and a high court judge could presumably restore the status quo by simply stating in a test case that the novel demand for informed consent to access records for non-commercial medical research has no basis either in law or in established common practice. He or she would become a minor icon of 21st century medical research, for many lives and a great deal of public money would be saved.

But no such remedy can rescue British medical research from the ambiguities of the Human Tissue Bill. Doctors who store any human tissue that may be used for future research without obtaining informed consent could face punitive criminal sanctions, and many will simply discard it.

Julian Peto Cancer Research UK chair of epidemiology (julian.peto@lshtm.ac.uk)
Olivia Fletcher lecturer London School of Hygiene and Tropical Medicine, London WC1E 7HT
Clare Gilham medical statistician Institute of Cancer Research, Sutton, Surrey SM2 5NG

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