

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 We conducted a questionnaire based survey of doctors from all specialties in a city teaching hospital (unpublished data).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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References

- 1 **Medical Devices Agency.** *Electromagnetic compatibility of medical devices with mobile communications*, Devices Bulletin DB9702. London: Department of Health, 1997.
- 2 **Myerson SG, Mitchell AR.** Mobile phones in hospitals. *BMJ* 2003;**326**:460-1.
- 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