

Confidentiality & Consent

An Occupational Physician's Perspective

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Why me??

PLAN

- Legislation/ guidance etc.
- Service provision – implications??
- Relevance of legislation/ guidance.
 - To the practise of Occupational Medicine.
 - Areas of debate.
- My practise.
- FOM guidance: Is this a problem?

RELEVANT LEGISLATION/ GUIDANCE ETC.

- Access to Medical Reports Act 1988.
- Data Protection Act 1998.
- The Human Rights Act 1998.
- Disability Discrimination Act 1995.
- Guidance on ethics for Occupational Physicians FOM 2006.
- The Occupational Physician.
 - Guidance for specialists and others practising Occupational Health. BMA 2009.
- Access to medical reports: Guidance from the BMA Medical Ethics Department. June 2009.

RELEVANT LEGISLATION/ GUIDANCE ETC.

- Confidentiality:- A draft consultation GMC – Sept-Nov 2008. **Guidance now published with effect from 12 October 2009.**
- Good Occupational Medical Practise FOM Draft. May 2008.
- Guidance for Occupational Physicians on compliance with the Access to Medical Reports Act. May 2008. (Prof. Holland Elliott and others).
- Occupational Health Law: 4th Edition Diane Kloss. 2005. Draft Chapter 3 for next edition.
- Common Law.
- ?? Many others.

WAYS IN WHICH SERVICES ARE PROVIDED

- In-House.
 - Private companies/ organisations.
 - NHS
 - Local Authorities? Emergency services.
 - ? Higher Education?
 - Armed forces. Government bodies e.g. HSE, transport.
- Large Private Providers.
 - Range of organisations, companies, Government departments etc.
- Single handed or small group providers.
 - Range of companies/ services/ organisations (sometimes subcontracted).
- GP's and others with a special interest working within Occupational Medicine via variety of routes.
- Advisers to pension funds/ insurance companies.

Providing a wide variety of Occupational Health Services

IMPLICATIONS

FOM Guidance on Ethics for Occupational Physicians (3.10:3.11)

- Difficulties arise if employers and employees have a poor understanding of what to expect; what information will be disclosed.
- Need to build up trust: Patients, Managers, Trade Unions.
- Useful to have regular meetings/ presentations etc., employees/ employee representatives management.

Purpose: To foster trust, confidence and mutual understanding.

Occupational Health Review: Survey/ Articles 2009

RELEVANCE OF LEGISLATION

- All relevant.
- Interpretation of Access to Medical Reports Act 1988 results in most controversy.

On the face of it the Act is unambiguous and clear and would mean that all Occupational Physician's reports would be covered by the Act.

The Act states:-

“It shall be the right of an individual to have access, in accordance with the provisions of this Act, to any medical report relating to the individual which is to be, or has been, supplied by a medical practitioner for employment purposes or insurance purposes.”

HOWEVER!

The Act goes on to discuss the interpretation of various terms:-

This limits the potential broad application.

MEDICAL REPORT: Report relating to the physical or mental health of the individual
prepared by a medical practitioner who is or has been responsible for the clinical care of the individual.

CARE: Includes examination, investigation or diagnosis for the purpose of/ in connection with any form of medical treatment.

GENERAL CONSENSUS

That the Act does not apply to the vast majority of Occupational Health Services in NORMAL circumstances.

It is argued that NORMALLY we are not:

“Responsible for clinical care” as defined by the Act.”

(Refer to KHE et al guidance).

ACKNOWLEDGE

Scenarios open to debate:-

- GP's in OH practise: who include their own patients in the group of employees they service. May also apply to armed forces Occupational Physician's.
- Enhanced First Aid: e.g. PE prophylaxis etc.
- Travel medicine advice/ prescribing.
- Management referrals: May be an issue?
 - Functional assessments under DDA.
 - Sickness absence advice.
 - Fitness to work.

ACKNOWLEDGE

Scenarios open to debate (continued):-

- Health surveillance.
 - COSHH etc., (right to autonomy?).
- Health promotion/ screening.
- Consultations resulting in on-going referrals to other specialists e.g. psychiatrists, Physiotherapy and other treatment services.
- A few Occupational Physicians taking formal referrals from primary care.
- Commissioned to provide a report:
 - Pension funds.
 - Solicitors requests.

MY PRACTICE

Having considered legislation/ guidance:-

- Service: Statement of Confidentiality.
- All staff sign Statement of Confidentiality.
- Security of records.
- All documents include statement/ heading:
“Confidential to the Occupational Health Service”
Reinforced at the end.
- Consent form: Details and explanation AMR Act.
- Information with appointment: What to expect.

CONSULTATION

Management referral: Report

Self referral: No report unless agreed.

- Management referral:-
 - Obtain and confirm informed consent to consultation. NB Liverpool.
 - Explanation of process and procedure.
 - Discussion at end – verbal details of report and copy of report offered.
- All this is documented in notes.
- (Regular case meetings: employee, HR, TU and Manager).

DISCLOSURE OF CLINICAL INFORMATION

- Generally unnecessary: If you ensure the report does not disclose any confidential information and is limited to the impact of the condition and the ability to do the work there should be no difficulty.
- With informed consent: “Strictly need to know basis” e.g. diabetes, epilepsy, certain psychiatric conditions. Reports ill-health retirement etc.
- Without consent: Health and safety grounds.
Legal: required by Judge etc.
Statutory requirement e.g. GMC

All cases DOCUMENT/ DATE/ SIGN.

GENERAL MEDICAL COUNCIL 2009

Supplementary guidance

Confidentiality: disclosing information for insurance, employment and similar purposes.

- d) Offer to show your patient, or give them a copy of, any report you write about them for employment or insurance purposes before it is sent, unless:

FACULTY: Draft 2009

Introduction: Good Occupational Medical Practice (2009)

*“The need for specific additional guidance for Occupational Physicians arises because their Practice differs significantly from that of Doctors in **most** other specialties. The Occupational Physicians usually has responsibilities to employers as well as to workers. More over, Occupational Physicians often work in privately organised Occupational health Services, and undertake a range of clinical and managerial activities that differ markedly from those of other doctors.”*

IS THERE A PROBLEM?

We have all been interpreting the various Acts/ guidance etc., with no prosecutions (under AMR Act) to date:

What is the problem?

FOM Good Occupational medical Practice 2009

Consent 36

When acting as an Occupational Physician you:

- a. must explain to the worker the purpose, context and potential outcomes of the consultation, including the scope of disclosure to employers or third parties;
- b. **must obtain a worker's consent before carrying out any assessment or before issuing advice as a result of that assignment.**
- c. should offer the worker a copy of any such report;
- d. must obtain a worker's consent before revealing any sensitive personal information to employers or third parties;
- e. must obtain informed consent from the worker when seeking information from another clinical specialist and observe their rights under the Access to Medical Reports Act;
- f. must, where appropriate, consult with workers or their representatives regarding the arrangements for any necessary health surveillance procedures.

THE PROBLEM (AS I SEE IT?)

Interpretation of second part sentence in b)

FOM Position/ Interpretation

If, at the conclusion of the consultation, you explain the nature of your advice/ report and the employee/ client withdraws consent: you are then unable to send the full report and can only indicate that consent has been withdrawn leaving it up to the employer or those commissioning the report to draw their own conclusions.

PROBLEMS WITH THE GUIDANCE

Discussed: NW Audit Group

BMA Occupational Medicine Committee

Considered: Serious risk that this would undermine our ability to provide independent advice in some limited cases (c.f. nurses).

(Many scenarios considered: Health & Safety/ legal implications).

However others:-

- Difficult cases: where individuals are inappropriately using a medical condition as an excuse/ reason e.g. failure to perform/ attend work/ meetings, disciplinary hearings, requiring adjustments etc.
- Professional opinion IHR: NB Presentation pension ombudsmen stated need to provide details/ reasons for decision.
- And others???

THE SOLUTION

- Restrict (b) to:-

Must obtain a worker's consent before carrying out an assessment.

or:-

Must obtain a worker's consent before carrying out an assessment with a view to providing advice/ report.

CONCLUSION

In the vast majority of cases there is no need to divulge clinical information.

We are not the patient's advocate: we provide objective, independent and impartial advice based on all the evidence available (including clinical examination).

Provided the patient is aware of the nature/ purpose of the consultation, provides informed consent at the outset and is offered a copy of the report.

I do not consider there is a problem for the Occupational Physician.