

Guidance for Occupational Physicians

on compliance with the

Access to Medical Reports Act

Produced by a group of consultant occupational physicians, representative of major UK occupational medical organisations.

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and

Key Stakeholder Organisations consulted

Association of Local Authority Medical Advisers
Association of National Health Occupational Physicians
British Medical Association Occupational Health Committee
Commercial Occupational Health Providers Association.
Faculty of Occupational Medicine
Royal Society of Medicine Section of Occupational Medicine
Society of Occupational Medicine

Contents	
Background	page 3
Preface	page 4
Executive summary	page 5
Introduction	page 6
Expert Group Discussion and Clarification of Key Issues	page 8
'Responsible for Clinical Care'	page 10
Potentially Difficult Areas of Interpretation	
Enhanced First Aid and Health Risk Management Services	page 12
Functional Assessments	page 13
Health Surveillance at Work	page 14
Referrals for Assessment or Treatment	page 14
Referral through Private Healthcare Services for Treatment	page 16
Health Promotion and Health Screening	page 16
Potential Consequences to Occupational Medical practice if the AtMRA Applies	page 17
GP's in Occupational Health Practice	page 18
Appendix 1: Terms and Definitions	page 20
Appendix 2: Use of consent form	page 21
Appendix 3: Summary of Research Study Findings (Presented ASM 2007)	page 22
Appendix 4: Brief Summary of Methodology and Results of Expert Group Discussion	page 24

Background

Inappropriate application of this Act would have potential consequences to the objectivity and speed of response of occupational medical advice. Some occupational physicians are apparently already being sent AtMRA consent forms with routine HR referrals, although most seem to believe this is unnecessary in law and normal practice. The group felt that it was important to state an occupational medical view rather than risk confusion with mainstream practice.

The idea for this document arose from a number of difficult clinical situations, where no clear and much conflicting advice was given by defence bodies, different Information Commissioner Advisers and various experts. Researchers at Kings College Hospital NHS Foundation Trust subsequently conducted an audit of the Society of Occupational Medicine (SOM) members' practice that has been presented at recent SOM and Royal Society of Medicine (RSM) meetings and submitted to the journal *Occupational Medicine*. This audit confirmed the significant lack of consensus within the SOM membership over case-based scenarios. Over 70% of the total respondents (400+) asked for further guidance. The AtMRA group met in May 2007. Several versions of the document have been produced in response to a lengthy consultation exercise with occupational medicine organizations in the UK.

The primary objective of this document is to explain the legal basis of our practice and how this differs from mainstream medicine in relation to this Act. The second aim is to provide a level of guidance on the Act based upon the consensus of the working group and the further consultation with stakeholders, with a third aim to promote further discussion towards consensus in the more contentious areas.

We are grateful to the Faculty of Occupational Medicine for making this document available via its website.

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May 2008

Preface

- 1) There are significant differences between general and occupational medicine practice. Difficulties can arise on a day-to-day basis when law, such as the Access to Medical Reports Act 1988 (the Act), aimed at general medical practice, is applied to specialist areas such as occupational medicine.
- 2) The Faculty of Occupational Medicine publications, "Guidance on Ethics (sixth edition May 2006)" and "Good Medical Practice for Occupational Physicians" specifically guide occupational physicians on ethics in occupational health practice, above and beyond GMC requirements. They do contain advice about matters relating to this Act, but there are currently no detailed evidence based guidelines to help practitioners with day to day interpretation of some difficult areas of practice.
- 3) That these difficulties do exist has been highlighted by some difficult cases that resulted in differing opinions from different medical defence, other medical bodies and legal experts. A study into occupational health physicians' practice in this area, presented at the Society of Occupational Medicine Annual Scientific Meeting in July 2007, also highlighted differing practices between occupational physicians and gave rise to unequivocal requests for guidance from Society of Occupational Medicine members.
- 4) As a result, a group of consultant occupational physicians representative of major UK occupational medical organisations, met to take a lead on exploring practice in this area, with a view to providing a level of evidence based guidance to occupational health physicians. This booklet is the result of the outputs of that group and subsequent consultation with key stakeholder organisations. It must be read in conjunction with the Faculty of Occupational Medicine Guidance on Ethics for Occupational Physicians, 6th edition May 2006.
- 5) In the absence of clear case law this document hopes to inform occupational physicians and any legal or professional Tribunal about good practice in this area. This document is created in good faith and whilst it does seek to provide a view of acceptable practice, it does not presume to usurp the role of any authoritative body in any way. It is hoped that publication of this work will help to inform on the context of occupational health practice and reduce the risk of misunderstanding.

Executive Summary

- 1) Occupational medicine practice is not normally arranged to treat the patient and occupational physicians are almost never responsible for clinical care in the way a general practitioner or hospital specialist would be and they do not normally hold the full patient medical records.
- 2) The consensus view was that the Act should not apply to occupational health reports in normal circumstances of occupational health practice but difficult scenarios may arise and further guidance is given in the body of the document.
- 3) All occupational physicians should be providing a degree of 'care' as defined by Good Medical Practice and Good Medical Practice for Occupational Physicians when they interact with their clients.
- 4) **"Care"** is also defined in the Act (includes examination, investigation or diagnosis for the purposes of, or in connection with, any form of medical treatment).
- 5) The definition of the physician providing a report to an employer, who would have a duty placed upon them by the Act to obtain appropriate written consent before a report is produced, would be the physician **"responsible for clinical care"**.
- 6) **"Responsible for clinical care"** in the Act is not specifically defined.
- 7) A doctor "responsible for clinical care" would normally diagnose, treat and hold the appropriate medical records of their patient, upon which a qualifying report would be produced, based upon this definition. This would exclude occupational physicians in most normal circumstances but where more 'clinical' than advisory services are provided the distinction becomes more blurred and needs a careful ethical evaluation.
- 8) GP's in occupational health practice who include their own patients in the group of employees they serve need to take particular care as they may come under the duty laid down in the Act.

Introduction to the Access To Medical Reports Act 1988

"An Act to establish a right of access by individuals to reports relating to themselves provided by medical practitioners for employment or insurance purposes and to make provision for related matters".

- 1) Most employers in the UK still do not have access to comprehensive occupational health services and their human resource departments would frequently write directly to the patient's general practitioner or specialist for information when medical problems, such as long-term sickness absence, impact upon the organisation.
- 2) Given that the information held by the general practitioner or hospital specialist could include highly sensitive and possibly third-party information, and that severe economic hardship could result from the communication of factual errors, the Access to Medical Reports Act 1988 (the Act) was introduced to provide a degree of patient protection over the information that could be passed from a patient's doctor to an employer or insurance company.
- 3) Prior to the Act, there had been a number of cases where incorrect information had been provided. The Act gives the patient the right to check the report before it goes and amend it where there are factual inaccuracies. There is also the opportunity to discuss the tone of the report and possibly negotiate a change, although the doctor's opinion if given, does not need to be changed.
- 4) The Act has been in place for almost 20 years with little or no legal controversy in general medical circles and therefore seems to be good law, although its scope and application to occupational health practice remains untested.
- 5) This lack of medico-legal controversy has paradoxically left questions for occupational physicians about their day-to-day practice that do not yet have definitive answers in case law.
- 6) A series of such issues arose in a large London Teaching Hospital occupational health department between 2004 and 2005. Not only was no clear consensus advice obtained from colleagues, union, defence bodies and experts, but also the advice that was given was contradictory.
- 7) This generated a national audit of occupational physicians' practice in the UK using test cases based on real examples to see if other practitioners were clear on the impact of the Act in practical situations.
- 8) The findings of the research were that there was no general consensus on good practice. Guidance was requested by 76% (>400) of participants in the study. The study was presented at the Society ASM in July 2007 and the RSM in February 2008. It has been submitted for publication, the results are briefly summarised at Appendix 3.
- 9) We would hope that in a technical legal context of statutory interpretation, a 'purposeful' rather than 'literal' interpretation of the legislation is made, that recognises the relatively unique contextual issues in occupational medicine.

- 10) A nationally based ethics committee, without specific reference to occupational health professionals, has published a literal interpretation in their guidance and so there is real concern amongst occupational physicians that the contextual nature of their work may be misunderstood.
- 11) This document, through many drafts and after wider consultation with the major occupational health organisations in the United Kingdom, sets out the findings reached. In the absence of clear evidence from other sources, this work sets out to provide some expert evidence at a practical level.
- 12) The reader is also referred to Chapter 3 of the Faculty of Occupational Medicine Guidance on Ethics for Occupational Physicians, sixth edition May 2006 and Good Medical Practice for Occupational Physicians, which should be read in conjunction with this document.

Expert Group Discussion and Clarification of Key Issues

Section 1 - Right of Access

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.

- 1) On the face of it this Act is unambiguous and clear, '**any report supplied by a medical practitioner for employment purposes**', would mean that all occupational physician reports would be covered by the Act. However, the Act goes on to discuss the interpretation of various terms that serve to limit this potentially broad application.

Section 2 - Interpretation

"care" includes examination, investigation or diagnosis for the purposes of, or in connection with, any form of medical treatment

"medical report", in the case of an individual, means a 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**

- 2) The Act clearly intended to cover an employer writing to the patient's treating GP or consultant. This is important as the entire context is different where the employer seeks advice or opinion from an occupational physician as:
 - a) The occupational health physician (OHP) is not usually the 'treating physician'.
 - b) Occupational physicians do not normally hold the entire patient record.
 - c) The quantity and quality of medical information in occupational health records does not usually compare to those held by the general practitioner.
 - d) The occupational physician would more often write a report after seeing the employee rather than report from the occupational health record.
 - e) Occupational physicians are usually retained to give objective opinion on questions such as health and safety at work, fitness to work, rehabilitation, health risk management and prevention of disability discrimination and personal injury and are not frequently requested to provide a report from the notes.
 - f) The roles of the OHP and GP are significantly different.

- 3) The Act does not apply to any professional who is not a 'registered medical practitioner'. Occupational health nurses work in and manage many departments. Asking the nurse to write the report would circumvent the Act.
- 4) It could be argued that sufficient 'patient control' over sensitive personal information exists under the Data Protection Act 1998 and the specific codes of professional ethics that occupational health physicians practice under.

For the Act to apply to the corresponding physician, the report must be provided to the employer by '**a doctor who is or has been responsible for the clinical care of the individual**'.

"Care" is defined in the Act as above, but **"responsible"** and **"clinical"** are not.

- 5) The expert group noted that exploring this area provoked significant debate within the group, later replicated when the early drafts of the document went out for wider consultation.
- 6) It was identified by the expert group and later in consultation that this area was the most confusing in interpretation even amongst occupational physicians and seems to require the greatest attention.
- 7) Clarification of the occupational health practice issues seems to centre around what is meant by '**clinical care**' in occupational health practice, and whether occupational health physicians are **"responsible"** for that clinical care **within the meaning of the Access to Medical Reports Act 1988** – and therefore whether a duty is placed upon them under the Act or not.
- 8) Given that occupational medical practice can be potentially as diverse as work itself this causes difficulty, but some key themes were identified.

Discussion of the Definition of 'Responsible for Clinical Care' in Occupational Health Practice Relating to the Access to Medical Reports Act 1988.

- 1) This issue was vigorously debated for a prolonged period in the expert group. Initially there appeared to be significant disparity of views until the group began to realise that each other's perception of the **question** being asked was different. The questions posed and results of this discussion can be found in further detail in Appendix 3.
- 2) In the UK, clinical 'care' (defined in this Act as, "examination, investigation or diagnosis for the purposes of, or in connection with, any form of medical treatment") is almost universally delivered through the NHS or agreed private practice, as the NHS is currently practically a monopoly.
- 3) The NHS is legally created and governed by the NHS Act 1948 as amended, which does not cover occupational health services.
- 4) A private patient is defined in the NHS Acts as, "a patient who gives (or for whom is given) an undertaking to pay charges for accommodation and services".
- 5) Private occupational health practice carried out by a Consultant Occupational Physician in the NHS does not amount to 'private practice' under the NHS terms and conditions applicable when the Access to Medical Reports Act 1988 was created (Page 43 Consultant Handbook NHS Consultant Contract - BMA Pre-2003).
- 6) 'Private practice' in the BMA handbook is defined as "the diagnosis or treatment of patients by private arrangement". Further guidance is given on Page 44 where it states that fees for category 2 work, for example, medico-legal work, insurance reports and third party work are not counted as income derived from private practice.
- 7) Occupational health practice is not normally funded by the patient, the NHS via normal health care commissioning arrangements, a private healthcare insurer or any other easily recognised mechanism for obtaining normal healthcare in the United Kingdom.
- 8) It is almost invariably the employer - or other third-party with a legitimate interest, for example a pension fund - that funds normal occupational health practice in the UK, not the NHS, the employee or their health insurer.
- 9) The occupational health service will be defined under a contract of or for service but this contract is not normally defined in such a way as to create a direct duty to provide primary or secondary health care services to employees.
- 10) If it does create a direct duty to provide normal treatment based general medical services for employees and such are provided, the expert consensus was that the Act should probably apply to that occupational physician.

- 11) The contractual arrangements for occupational health services usually address the employer's duties under health and safety law, trust law (for example pensions), insurance law (for example income protection policies), employment law, discrimination law or other legal obligation, none of which are related to the normal provision of healthcare through any usual arrangement in the UK.
- 12) Given that occupational health physicians almost invariably practice in such an economic, legal and social structure, it is difficult to suggest that they are taking 'responsibility for clinical care' as defined in the Act in any normal circumstances, as all patients in the UK will continue to have their general practitioner as the doctor with primary responsibility.
- 13) It might be argued that occupational health consultants are specialists in their own right and are providing health care on that basis. The fundamental problem with such an argument however, is that there is no referral letter to hand care over from any other doctor, for example the GP, who maintains primary responsibility.
- 14) There is currently no mechanism through the NHS or usual health insurance for GP's to refer to consultants in occupational medicine, even if the GP suspects occupational illness.
- 15) Without such a referral from the GP or other consultant, the expert group were of the opinion that it would normally be inappropriate for an occupational health consultant to assume clinical responsibility for care, except temporarily and where the best interests of the patient are served.
- 16) If they do so they should consult the Faculty of Occupational Medicine Guidance on Ethics for Occupational Physicians, sixth edition May 2006 and consider their position against appropriate professional boundaries, referring back to the GP or other specialist as soon as appropriate and practicable.

Potentially Difficult Areas of Interpretation

- 17) The expert group recognised that there are some areas of occupational medical practice that might strongly appear to be 'clinical care' and so give rise to particular uncertainty about whether the Act applies to the doctor's report, in the absence of a clear ruling. Examples include:

Enhanced First Aid and Health Risk Management Services

18) This would include for example:

- a) The provision of extended first aid and emergency treatment services where potentially serious injury might be more likely – for example in a factory, construction site, mine or other work environment following health and safety risk assessment. Such a service would be provided to manage a foreseeable workplace risk to health, not to provide normal primary care services.
- b) Travel medicine services for overseas workers required following health and safety risk assessment to manage a foreseeable workplace risk to health through travelling as part of the job role.
- c) Post-exposure prophylaxis and follow up following a needle-stick injury in the healthcare sector – The service would be provided following health and safety risk assessment to manage a foreseeable workplace risk to health from blood borne virus transmission.
- d) The delivery of a psychological care package following a traumatic event may be required following health and safety risk assessment, to manage a foreseeable workplace risk to health after psychological trauma, for example in emergency services.
- e) Vaccinations in a wide variety of workplace settings, e.g. the NHS as an employer, required following health and safety risk assessment to manage a foreseeable biological workplace risk to health under the Control of Substances Hazardous to Health Regulations 2002.

This list is indicative rather than exclusive.

- 19) These appear to be clear examples of occupational physicians providing **"care"** (includes examination, investigation or diagnosis for the purposes of, or in connection with, any form of medical treatment).

20) This is not the full definition under the Act however. The definition in the Act defines a medical practitioner covered by the Act as the physician **'responsible for clinical care'**.

21) The occupational physician does take responsibility for these workplace health programmes and could therefore be understood to fall within the definition if a 'literal' interpretation is made.

- 22) However, these activities are all driven by the employer's duty of care under the Health and Safety at Work etc Act 1974 and business risk. They are not specifically designed to provide healthcare per se for a patient, but rather to improve safety and health at work as required of the employer by law. This is where a 'purposeful' interpretation would be hoped for.
- 23) The management of such a programme regarding any work-induced condition often centres on non-medical intervention, primarily control of exposure to harm, achieved via changes in the work or work environment rather than the prescription of medical or surgical treatments.
- 24) These programmes are therefore often best placed in the work environment, due to the need for integration with employer risk management systems. For example, the 'golden hour' in treatment with anti-viral agents after sharps injury carrying a blood borne viral risk, is arguably best managed at the workplace with trained staff familiar with the necessary complexities involved in risk assessment.
- 25) Occupational physicians would advise both the employer about the work or work environment and the employee in such programmes. Clinical problems, apart from immediate necessary treatment, would normally be sent to the GP or referred on as soon as reasonably practicable. The GP normally retains responsibility for their patient's care.
- 26) The group was of the opinion therefore, that provision of services by an occupational health physician, driven by a risk assessment under health and safety legislation, should not normally be considered as qualifying under the Act. The occupational physician is primarily managing business risk rather than seeking to treat patients. Where they do act clinically, it should be in the patient's best interest with a view to handing over care as to the GP soon as practicable and appropriate.
- 27) If, however, the occupational physician actually does assume the responsible treatment role of the patient, then the view was that they would come under the duty in the Act.
- 28) Any such treatment should be carried out with reference to a doctor's general duty of care under Good Medical Practice, Faculty Guidance on Ethics 2006 and the current version of Good Medical Practice Occupational Physicians. Ethical professional boundaries would need particular consideration at all times in order to act in the patient's best interest.

Functional Assessments

- 29) It is common in occupational medical practice to be asked by the employer to see the employee and assess the functional capacity or well-being of the employee as problems have arisen at work.
- 30) Performance, attendance or conduct issues at work would be common reasons behind such a request and the manager is seeking advice on how to support and manage the employee. Disability related advice might also

be required to comply with the Disability Discrimination Act 1995 and other employment or discrimination legislation.

- 31) In cases such as this, no report from medical records is being sought from the occupational physician and an objective opinion is asked for. There seems no reason for the Act to apply in such circumstances.

Health Surveillance at Work

- 32) The primary purpose of such programmes is to ensure that control measures at work are satisfactory and to refer employees into an appropriate healthcare system early, should any health related problems arise.
- 33) The conduct of health surveillance is often a statutory requirement (under health and safety law) to manage a foreseeable workplace risk to health and for the identification and prevention of certain conditions e.g. noise-induced hearing loss, hand-arm vibration syndrome or occupational asthma. For example, where a real risk of contracting occupational asthma exists, Health and Safety Executive medical guidance requires a health surveillance programme to check the effectiveness of the controls at work and to refer an individual early for specialist assessment in treatment.
- 34) The group recognised the elements of diagnosis and treatment inherent in such a programme but emphasised their view that the occupational physician does not take responsibility for the clinical care of the patient and that this would always sit with the patient's GP or specialist.
- 35) In keeping with Good Medical Practice, the occupational physician needs to act in the best interests of the patient and this would involve some clinical management which would fall within the categories of care as defined in the Act, but the occupational physician should operate to ensure that their role is secondary to and supportive of the patient's general practitioner or consultant when it comes to treatment and diagnosis.
- 36) The contributors recognised the fine distinction in examples such as this, but held the consensus view that such distinctions were valid and should not necessarily place the occupational physician within the qualifying terms of the Access to Medical Reports Act 1988.

Referrals for Assessment or Treatment

- 37) The NHS currently provides no priority for the working population to have access to its services and these are driven primarily by clinical need. As a result, delays can occur in diagnosis, investigation and treatment for less clinically severe conditions, which nevertheless may impact on work performance. These delays may in turn impact upon the efficiency of the employing organisation.
- 38) Larger organisations will often contract an occupational health physician to assist in managing absenteeism and there is a growing industry, especially

in the private sector, to expedite diagnosis or treatment with a view to returning people back to work as soon as safe and practicable.

- 39) This area of occupational health practice is usually funded by the employer, directly or through a third-party, is usually separate from mainstream NHS provision and may possibly increase in future. Examples could range from providing private physiotherapy or other rehabilitation based therapy service to more direct clinical intervention by paying for investigations with a waiting list (for example an expensive scan). This may extend to a private consultation with a specialist, surgery or other treatment (see later). This whole area of practice would clearly fall within the definition of "care", as defined in the Act.
- 40) If an occupational physician refers an individual for assessment or treatment as above, do they become 'responsible for clinical care' under the Act?
- 41) This was fully debated by the expert group and subsequent contributors. Consensus was reached that the occupational physician usually facilitates access to appropriate treatment or further diagnostic activity, and in normal occupational medicine practice is unlikely to assume responsibility for clinical care in the way a GP or hospital specialist does or as defined in the Act.
- 42) The group felt that if the physician advises the individual that a particular line of treatment is likely to be beneficial, but does not personally make arrangements for that treatment to be delivered, he or she has not assumed responsibility for care.
- 43) The group considered when the occupational physician makes arrangements to ensure speedy access to diagnostic or rehabilitative services, funded by the employer as part of a package to facilitate safe, early and appropriate return to work following sickness absence.
- 44) This was considered not to be taking responsibility for clinical care by the expert panel, but facilitation of access, through appropriate third party channels, to such care more swiftly. The GP would normally receive the results or a copy of the results and would continue the overall management of their patient's investigations and treatment.
- 45) The occupational physician may commonly refer directly for an assessment by another specialist, for example a psychiatrist or orthopaedic consultant. It is usually explicit in such referrals that the specialist is not providing clinical care, merely professional opinion to the occupational physician. Such assessments are designed to inform the occupational physician and help them advise with regard to the employee and their work.
- 46) It was also agreed that the GP may or may not be copied in to the occupational physician report from such a specialist assessment. Whether the GP was sent a report or not would be a matter of consent between the assessing specialist and the 'patient' and was a matter for discussion and normal measures of consent between doctor and patient, but it should not be covered by the Act as the report was not to the employer.
- 47) The group did not consider that the subsequent report to the employer, prepared by the occupational physician, was covered by the Act. This was

but part of a wider, more detailed, objective occupational health assessment so it should not be covered by the Act.

Referral through Private Healthcare Services for Treatment

- 48) A number of scenarios emerged.
- a) The occupational physician refers directly to a specialist, for example when the employee has private health insurance as part of an employment benefit package and presents to the occupational physician, perhaps merely as a matter of convenience.
 - b) Alternatively, the employee may be seeing the occupational physician for an occupational matter when the physician incidentally notes a condition requiring further attention and refers directly in the patient's best interest.
- 49) If the occupational physician adopts a traditional treatment role, investigating, diagnosing, prescribing and taking responsibility for the 'patient', then this is likely to be considered taking responsibility for clinical care under the Access to Medical Reports Act 1988.
- 50) If the occupational physician does undertake such a duty to provide general medical services, they should also consider carefully the ethical position in relation to the patient and the patient's GP. This role conflict was considered unlikely in normal occupational medicine practice.
- 51) The usual role is to facilitate access to a treating physician with a copy of any referral to the GP. This was not considered normally to be taking responsibility for clinical care by the group, but facilitation of access, through appropriate channels, to such care. The GP would be copied in on any such referral to ensure continuity of care by the responsible GP.
- 52) This facilitation role is widespread, particularly in the private sector where such benefit packages are more common and does not normally give rise to complaint by the patient, specialist or the GP. If carried out correctly the GP always remains at the centre of the patient's care.
- 53) Given the rise of 'consumerism' and 'choice' in health care, this whole area may need to be revisited in due course as patients currently are on the list of one NHS GP, but they may potentially expect to use a number of doctors in future. Demand may also potentially increase for primary care services at work.

Health Promotion and Health Screening

- 54) Health education and health screening often include some diagnostic tests, for example, blood sugar or cholesterol levels, as part of an employee wellness program.

- 55) Many companies, particularly large multinationals, see benefit in developing programs, to promote and maintain the health of the workforce, as part of their duties of corporate and social responsibility as well as to maximise productivity and business efficiency.
- 56) The expert group considered that these are all forms of "care" as defined in the Act.
- 57) However, provided the doctor did not attempt to take responsibility for general medical services and referred any problems discovered to the GP, then this was adopting a broad public health and health risk management role in a workplace setting.
- 58) The contributors felt that this was normally unlikely to bring the occupational physician under the Act as taking responsibility for the clinical care of the patient.

Potential Consequences if the Act Applies

- 59) There was consensus in the group that the Act does not normally apply to occupational medical practice. It is therefore not usual or necessary at present to obtain written consent under the AtMRA to provide a report to management when an employee is referred to the OHP.
- 60) If the Act is subsequently found to apply however, the medical practitioner must ensure that the employee fully understands the provisions of the Act relating to the release of the report and this must be done with **written consent** under this Act.
- 61) If an occupational physician is "**responsible for the clinical care**" of employees, then his or her reports to management concerning any individual who has received such care are then, and apparently afterwards, subject to the provisions of the Act.
- a) The individual must consent to the release of the report in writing.
 - b) If the individual indicates a wish to see the report on the original consent form, then the person asking for the report (usually the employer) must notify the individual when the application for the report is made and give them 21 days to begin the process to see it.
 - c) In order to meet the requirements of the Act, it would be appropriate for the occupational physician to explain the right of access at the time of the consultation and to obtain written consent, including an expression of the individual's wish to see the report or not.
 - d) In that case, the date of the consultation would be the date of notification from which the period of 21 days is calculated.
 - e) It is essential to keep in mind that the period of 21 days concerns only the time within which the individual must exercise his right to

see the report. It does not have any bearing on the release of the report if that right has been exercised.

Where an individual has been given access to a report under section 4 above the report shall not be supplied in response to the application in question unless the individual has notified the medical practitioner that he consents to its being so supplied.

- 62) The Act sets no limit on the time the individual may take to consent to the release of the report and so it may potentially be delayed indefinitely.
- 63) The medical practitioner must keep a copy of the report for at least 6 months and must allow the individual access to that report during that period.
- 64) If the individual wishes to have a copy of the report *the practitioner may charge a reasonable fee to cover the costs of supplying it.*
- 65) The Act stipulates that any notification required or authorised to be given under the Act *shall be given in writing*. When an individual has elected to see the report before its release, the author of the report would be unwise to rely on a verbal confirmation for the report to be released to the employer.
- 66) If the Act does apply, it would have a significant impact upon the ability of occupational health doctors to practice effectively in many key risk areas.
- 67) The Act only applies to reports provided by registered medical practitioners and there is no requirement for written consent etc to reports about employment provided by other professional or lay practitioners. Occupational health nurses for example, are not covered by the Act.

GP's in Occupational Health Practice

- 68) GPs who work in Occupational Health may be in a potentially vulnerable position regarding this Act if their patients form part of the employee population. This remains a theoretical risk as there is no reported case law on this point, but they should also consult the Faculty Guidance on Ethics in full.
- 69) If an occupational health practitioner also provides general medical services to the same population as is covered by his or her occupational health practice, then the Act would potentially apply to any qualifying report that the practitioner provides concerning employees from that GP practice population.
- 70) A fine point of distinction might be whether the records are held as a GP or as an occupational physician. The GP would probably be caught by the Act, the occupational physician might not be. This remains unclear.
- 71) This point is also particularly relevant to general practitioners or occupational physicians who provide general medical services at work to employees. This occurs e.g. in the City of London, where employees are dislocated from their normal GP and the employer provides such services.

The consensus view was that the occupational physician/GP is likely to be caught by the Act and would need appropriate written consent for a report from the notes.

- 72) The position is also confusing if the employee is employed in the UK but based overseas in an expatriate facility. If the occupational physician also provides primary care, this doctor may be excluded from the Act by virtue of jurisdiction whilst abroad, but whether the duty may apply to reports to the UK or upon the doctor's return to the UK remains unclear.

Appendix 1 - Terms and Definitions

The Act can be found in full at:

http://www.uk-legislation.hmso.gov.uk/acts/acts1988/ukpga_19880028_en_1

Use of the Term 'Consent'

The reader is referred to page ii of the Faculty of Occupational Medicine Guidance on Ethics for Occupational Physicians, sixth edition May 2006.

Use of the Term 'Patient or Client'

The reader is referred to page iii of the Faculty of Occupational Medicine Guidance on Ethics for Occupational Physicians, sixth edition May 2006.

"Medical Practitioner"

"Medical practitioner" means a person registered under the [1983 c. 54.] Medical Act 1983. Thus, the Act applies only to reports provided by medical practitioners. It does not apply to reports provided by other health professionals (such as occupational health advisers, physiotherapists and clinical psychologists) or lay workers.

"Medical Report"

"medical report", in the case of an individual, means a 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"

Is defined in the Act - "care" includes examination, investigation or diagnosis for the purposes of, or in connection with, any form of medical treatment;

Appendix 2

Use of a Consent Form to Request an Occupational Health Report

- a) The contributors agreed that there is no doubt that, whether or not the Act applies, no physician should engage with an employee without informed consent. The employee must be made aware of the purpose of the interview or examination and the consequence of it, i.e. a report to management.
- b) It is undesirable for management routinely to use a consent form in the Access to Medical Records Act 1988 format when the employee is referred to occupational health because this could engender false expectations in employees that they will be able to see a copy of the report and approve it before it is sent to the employer.
- c) The group were agreed that the employee should be consulted about what was being written or said to the employer and if necessary a negotiation should take place about the content.
- d) The employee has the right to withhold consent to the physician reporting clinical or personal information to management, though he or she can be advised that if a medical report is unreasonably withheld managers can act without it.
- e) In addition, where the employee may constitute a health or safety risk, both law and medical ethics entitle a doctor to breach confidence in order to warn the employer of the risk. This is the law whether or not the Access to Medical Records Act 1988 applies.
- f) The group agreed that the employee has the right to control the personal and clinical information in the report, but not the professional opinion given by the occupational physician, which is subject also to a duty of care to the employer.
- g) This is especially true in the case of pensions and similar fiduciary work where a duty is clearly owed to the Trustees. If the Access to Medical Records Act 1988 were to apply, the 'patient' would have the right to withhold the report, defeating the purpose of it, as objective advice on eligibility is required.

Appendix 3

Summary of Research Study findings (Presented ASM 2007)

This study demonstrated important variation in understanding and practice with respect to the exercise of duties created under the Data Protection Act and the Access to Medical Reports Act. This may reflect the fact that there is neither widely available, nor easily understood guidance or a relevant body of substantive case law to support practice in this common and important area. The study identified differences in opinion between Diploma doctors, (most of them working part time) and doctors with higher FOM qualifications. There were also differences in interpretation between occupational physicians who were qualified the longest in medicine and those more recently qualified.

Only a doctor, registered with a GMC in line with the Medical Act 1983 is subject to the Act and not other treating health professionals such as occupational health nurses.

Questions raised

The interpretation of the original AtMRA appears to be difficult, or as one of the respondents put it *"confusing and controversial not only for the doctors but also employers, patients, unions and sometimes legal advisors"*. The results of the study raise important questions:

- At what point does OH assessment constitute "care" as defined by the AtMRA?
- What impact would its implementation into routine OH practice have on our impartiality and independence, if any?
- How might the potential delays incurred by the 21 day viewing rule hinder turn around times in case management?
- Even with fairly recent, more consistent advice from the BMA and FOM, should we rely on individual assessments of the Act in its application to OH reports?
- How will it affect the development of administrative procedures and a protocol?
- Will strict adherence to the definition of the Act really help with its interpretation and relevance to OH reports? It may be that a single OH fitness report falls outside the Act or alternatively, after referral to a specialist, that the report will fall within the scope of the Act.
- However should the Act be interpreted as applying to a 'one off' OH fitness for work assessment even when the OHP recommends the employee sees his GP for consideration of treatment?
- Why do more senior and junior colleagues answer so differently?

- What explains the difference between practice in Diploma (usually but not exclusively part time) and other more qualified doctors?
- What degree of risk does this variation in practice create for the doctor, the patient and management?

Appendix 4

Brief Summary of Methodology and Results of 'Expert Group' Discussion

The applicability of the AtMRA to OH practice and the release of employee's personal data under the DPA have implications in terms of clinical practice, policy, guidance development and research.

Method

An authoritative panel was drawn from a wide and comprehensive representation of the diversity of occupational health practice. Drawing upon the key questions identified in the research and adapted to the task in hand, the panel were asked specific and positive questions and were required to grade their responses from one (strongly disagree) to nine (strongly agree).

The initial questions focused on strategic and fundamental issues such as definitions, which produced robust debate and the subsequent development of more detailed questions. The marks given were divided by the number of participants, to obtain the score. The results are shown as follows.

Results

	Question	Score	Range	Consensus?
1	An individual has a right of access to the medical report produced by the occupational health practitioner.	8.75	8-9	Strongly Agree
2	The vast majority of occupational medicine consultations constitute 'care' under S2(1) of the Access to Medical Reports Act 1988	3.75	1-7	No Consensus
3	Medical treatment is given in the vast majority of occupational medicine consultations	2.38	1-7	Disagree
4	In the vast majority of cases where an occupational health physician facilitates referral via the GP to private services, the occupational health physician provides 'care' within the Access to Medical Reports Act 1998.	1.25	1-2	Strongly disagree
5	In the vast majority of cases where an occupational health physician refers directly to private healthcare, the occupational health physician provides 'care' within the Access to Medical Reports Act 1998.	4.75	1-7	No consensus

	Question	Score	Range	Consensus?
6	Where an occupational physician provides immediate assistance in the workplace for injury or ill-health, in the vast majority of cases, they provide 'care' within the Access to Medical Reports Act 1998.	1.88	1-5	Strongly disagree
7	Where an occupational physician provides primary care services in the workplace they provide 'care' within the Access to Medical Reports Act 1998.	9	9	Strongly agree
8	Where an occupational physician provides health surveillance services in the workplace they provide 'care' within the Access to Medical Reports Act 1998.	1	1	Strongly disagree
9	Where an occupational physician provides medical services with regard to overseas travel on business they provide 'care' within the Access to Medical Reports Act 1998.	1	1	Strongly disagree
10	Where the occupational health physician provides leaflets and other health information to clients they provide 'care' within the Access to Medical Reports Act 1998.	1	1	Strongly disagree
11	In the vast majority of cases the occupational health physician requires written consent to send a report to the manager.	1.25	1-2	Strongly disagree
12	The occupational health report from the occupational physician to the manager has to be agreed in the vast majority of cases.	2.5	1-7	Disagree
13	Pension reports should be agreed in the vast majority of cases.	1	1	Strongly disagree
14	Consent is essential at the beginning of the consultation.	9	9	Strongly agree
15	Consent is essential at the end of the consultation to agree the outline and content of most occupational health reports.	7.12	7-9	Agree
16	Consent to continue is needed throughout the occupational health	9	9	Strongly agree

	Question	Score	Range	Consensus?
	consultation.			
17	An occupational health physician needs consent to give an opinion based on occupational health records.	9	9	Strongly agree
18	An occupational health physician needs consent to give an opinion based entirely upon information supplied by the employing organisation.	1	1	Strongly disagree
19	Where there is a separate face-to-face review with the client, new consent is needed.	9	9	Strongly agree
20	When an occupational health physician writes a report based upon medical records supplied by the GP or hospital, the occupational health physician needs consent to send the report.	9	9	Strongly agree
21	Consent should be obtained in such cases from the consent form that allows release of the records in the first instance.	9	9	Strongly agree
22	If an occupational physician is asked to state whether a condition has been declared on a pre-employment form, in the absence of written consent to do so incorporated into the form when completed, specific consent must be obtained.	9	9	Strongly agree