fom
Faculty of Occupational Medicine

3rd Floor, New Derwent House
69-73 Theobald's Road
London
WC1X 8TA

t: 020 7242 8698
f: 020 3116 6900
e: fom@fom.ac.uk
www.fom@fom.ac.uk

Registered Charity No 1139516
Scottish Charity No SC040060
Registered in England No 07461063
VAT Registration No 798 6604 62

CONSULTATION RESPONSE

Name of organisation:

General Medical Council (GMC)

Name of consultation/policy document:

Confidentiality

Date:

January 2015

The Faculty of Occupational Medicine welcomes the opportunity to comment on the General Medical Council's review of its guidance on Confidentiality. The dual responsibilities of Occupational Health in providing advice to both the patient / employee, and the organisation, mean that challenges relating to confidentiality arise on a daily basis. The Faculty is committed to supporting sound principles of confidentiality. It sees opportunities for improving the way in which that guidance is presented, and would welcome the opportunity to provide ongoing support to the GMC in developing any additional / modified guidance.

1. Given the purpose and scope of our guidance, do you think there is anything missing from it? If so, what?

YES

a) The Faculty recommends that specific reference be made to, and guidance given on handling the issues of confidentiality when there are responsibilities to both the patient (employee) and a third party who has a right to expect sound medical guidance from medical advisers. The rights of the patient to withhold consent provides protection for them when they are not content with proposed disclosure, but it is critical that it is recognised that the Occupational Physician cannot be partial, or the advocate of the patient in situations where advice is being provided to several parties.

Practically, these situations can generally be managed by careful communication with the patient, so that impasses are seldom encountered. However, the Faculty is of the view that it would be appropriate for the GMC to address this issue of dual responsibilities more directly. There are accepted examples such as in relation to driving, where the patient may feel that their best interests were not being met when their personal sensitive information is given to the DVLA. It is widely understood that it would not acceptable for the patient to withhold consent to disclosure where that disclosure would be relevant in protecting the safety of others. Similar principles apply throughout Occupational Medicine, particularly when safety critical roles are being considered. The statement "make the care of the patient your first concern" is one to which all doctors should subscribe as an enduring principle, but it does need to be qualified, as it can inconsistent with the wider needs that society expects from its medical professionals.

b) The Faculty believes that specific reference to confidentiality as it relates to the treatment of doctors and other health professionals would be appropriate. The boundaries of confidentiality are often blurred when physicians treat other doctors and inappropriately share personal medical information about them with other clinical colleagues / managers, perhaps in the belief that these 'third party' clinicians are within the 'circle of confidentiality'. There is reason to believe that concerns about this practice may be a factor inhibiting clinicians with personal problems from seeking help, with, in some cases, unfortunate consequences which have been elsewhere documented.

When health professionals seek advice, treatment and support from other doctors and clinical colleagues, it is important that the treating doctors do NOT disclose to clinical 'third parties' / managers any more than they would regarding their non-clinician patients. The role of Occupational Medicine should be recognised as the means by which these interfaces can be managed. The expected level of confidentiality can be afforded to the patient, and sound advice, devoid of personal clinical details, provided (with consent) to the organisations managing them. This is not only consistent with the sound principles of confidentiality, but may help ensure that the troubled clinician would feel more confident about seeking help and support.

2. Is anything in the guidance inconsistent with the law? If so, what?

The Faculty has received representations from some of its members suggesting that the requirement for doctors to offer to show their patient any report before it is sent to a third party may be contrary to legal precedent – citing the cases of Egdell and Kapadia. They submit that there should be no requirement for further consent at the point of disclosure if consent to be assessed and for a report to be issued to a third party has been given at the outset.

The legal and / or ethical advice that both the Faculty and BMA Ethics Department have obtained is that these judgements were associated with very specific circumstances. They contend that the GMC's current position on offering sight of any report before dispatch is not affected by them, and is not contradicted by these judgements. The Faculty's position, therefore, is that it does not see any of the GMC's guidance as inconsistent with the law, but recognises that that GMC may wish to test this legal position independently.

3. Is anything in our guidance inaccurate or wrong? If so, what?

The Faculty has not identified any inaccurate or incorrect statements in the GMC guidance.

4. Is anything in the guidance confusing of misleading? If so, what and how could it be improved?

See point 5, below.

5. **Do we strike the right balance between protecting confidential patient information and sharing information appropriately? If not, what do you think should change?**

The Faculty would like to see greater clarity on this balance. While doctors' primary responsibility and professional duty of care is to the patient, there may ALSO be a legal duty of care to others including those they advise. While this is recognised to some extent in the current document, the emphasis is heavily weighted in support of the patient with the practical outcome that disclosure is frequently driven by the patient's beliefs and personal wishes rather than impartiality by the doctor. This may limit the doctor's ability to provide information that they consider to be in the best interest of the patient / and or other members of the public. Consequently, the advice received by third parties may be misleading or difficult to interpret. The Faculty's view is that medical advice / disclosure about a patient must be accurate, sound, objective, relevant and justifiable, with no significant information excluded, to enable the issue at hand to be effectively addressed. A patient taking exception to advice should a) be permitted to withhold consent for release and b) be aware that in doing so the third party who had in good faith attempted to obtain medical advice will have to make decisions without that advice. As a consequence of the decision to withhold consent, the ultimate outcome for the patient may not be in their best interests.

The Faculty strongly recommends that there should be greater clarity that a patient may withdraw consent in total, but not on a selective basis when medical opinion has been sought and given.

6. **Are there confidentiality issues that are challenging in practice where you think the guidance or other materials (such as case studies) could be more helpful? If so, please tell us what they are and how you think we should address them?**

Maintaining sound practices on confidentiality can be difficult when they are not uniformly applied. When detailed clinical information is inappropriately released by some practitioners, it makes it more challenging for other practitioners who adhere to the principles of limiting disclosure to sustain their position. The GMC guidance is clear on keeping disclosure to the minimum necessary, and this is supported by the Faculty of Occupational Medicine's Ethics Guidance for Occupational Health Practice, which states:

"This is an area of practice where difficulties can arise. The GMC requirement to '*keep disclosures to the minimum necessary when considering disclosure to a third party'* is crucial to occupational health practice. The employer rarely needs clinical information about an employee or applicant for employment and the occupational health professional can give all the necessary information, including recommending adjustments for compliance with the disability provisions of the Equality At 2010, without disclosing clinical information."

The Faculty's view it that this guidance on 'minimal disclosure' should be strengthened so that all physicians are fully aware of the importance of this aspect of practice; making it clear that clinical details should only be disclosed to the extent necessary to provide context to recommendations; and the rights of patients to confidentiality as it relates to **unnecessary and inappropriate** disclosure are protected.

To achieve this, the inclusion of a case study could be considered appropriate. The Faculty would be pleased to assist in its production.

7. Is the guidance structured in a helpful way? If not, how would you prefer it to be structured?

The current structure appears to be effective, with general principles and explanatory guidance notes on specific areas. The section on "disclosing information for insurance, employment and similar purposes" lends itself to addressing the issues outlined in this response. As disclosure to employers is the most common, it may be appropriate to amend the name of the section to "disclosing information for employment, insurance and similar purposes"

The Faculty's view is that the GMC document would be more meaningful to all physicians if this section was significantly strengthened to address the critical issues. Cross referencing with the Faculty's "Ethics Guidance for Occupational Health Practice", and the Guidance on Access to Medical Reports, produced by the BMA Medical Ethics Department would be beneficial.

8. Are there any ways that we could make the guidance easier to access and use?

The Faculty has no comment on this.

9. Can you give us any examples of guidance format that your find easy to use, or are innovative, that we could learn from?

Consistency of message and practicality of implementation are important characteristics, although the latter cannot override fundamental ethical principles. The specialty of Occupational Medicine is a key stakeholder on the issue of medical confidentiality by virtue of the fact that the majority of its clinical work involves providing advice to both the patient <u>and</u> a third party – generally the employer. The Faculty takes its responsibilities seriously, and both supports and supplements the GMC guidance in its regularly updated publication "Ethics Guidance for Occupational Health Practice" which is now a reference document for all health professionals working in the field of Occupational Health. The needs are special, but the principles the same, and consistency of message is essential.

A consultation process is designed to solicit the views of a wide church. The views of all are important. To ensure that the final product can be both meaningful and practical in operation in our field, it would be appreciated if the Faculty could be consulted once again when at the stage of final drafting of the section on employment and third party disclosure.

[JGB/19 January 2015]