HEOPS November 2015 conference Salford

OH confidentiality, consent and confusion

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13 November 2015

overview

- Sources of confusion
- OP-worker relationships
- Consent for reports
- Confidentiality and the law

Confusion

- In the UK, there is “significant current *variation* between occupational physicians and *uncertainty* regarding best practice with regard to consent and confidentiality”.

- Stern AF and Sperber S. Occupational physicians’ perceptions and impact of 2009 GMC consent guidelines. *Occup Med (Lond)* 2012; **62**: 560-562.

Possible cause of “confusion”

- “two-master ethics”: “trying to satisfy the worker and the employer at the same time”
- Sieghart P, The Lucas Lecture 1981: Professional ethics- for whose benefit?, *J Soc Occ Med*, 1982, 32, 4-14.

- “dual obligation doctors”: BMA (2012) describes these as ‘‘situations where doctors have clear obligations to a third party that can be in tension to the obligation to the patient’’

The setting

- Independently commissioned OM report for IHR
- For some public sector pension funds, there is a statutory requirement for the OP to be **independent**

UK GMC guidance on confidentiality

- GMC guidance requires doctors to “obtain or have seen written consent to the disclosure from the patient” and “offer to show (their) patient, or give them a copy of, any report you write about them for employment or insurance purposes *before it is sent*”.
- GMC, *Confidentiality: Supplementary guidance*, London 2009.

The problems

- *Different* doctor-patient relationship
- *Different* consent for reports
- *Conflict* with UK law

	"Quasi-therapeutic" OM	"Independent expert" OM	Therapeutic Doctor-Patient Relationship
Trust	+	Minimal	+++
Power imbalance	+	+/-	++
Fiduciary obligations ➢ No conflict rule ➢ No profit rule ➢ Duty of undivided loyalty ➢ Duty of confidentiality	+/-	**Incompatible** with "duty of undivided loyalty"	++

Consent for treatment or interventional research

- Nuremberg code
- Protection from harm
- Voluntariness
- Autonomy
- “informed consent”

Information disclosure

- Some common features in disclosing a report etc (understanding, competence, decision)

- BUT note differences:
- “information flow”
- Privacy v autonomy

- “Permission to disclose” (PTD)

- Also differences in process:

	Pre-event	Event	Post-event
IC (surgery)	Information +++	Surgical intervention	Cannot withdraw consent
PTD (report)	Limited information	Report written	Able to withdraw permission

Practical example

- HCW with needlestick injury
- Source patient HIV +ve
- Scenario 1: testing of source patient required,
- therefore “informed consent”: if refused cannot proceed (battery and assault)
- Scenario 2: diagnosis is known, but not to HCW/OH
- therefore PTD: if refused, balance patient’s right to privacy vs. non-maleficence to HCW

Needle-stick scenarios

	Requirement from patient	If not given…	Consequences to patient
HIV status unknown	**Informed consent**	**Cannot proceed**	**Battery/assault**
HIV status known	**PTD**	**May be able to proceed**	**Failure to respect patient's privacy**

Medical confidentiality and reports : UK law (1)

- “the professional man's duty of confidence towards the subject of his examination plainly does not bar disclosure of his findings to the party at whose instance he was appointed to make his examination.”
- Bingham LJ in *W v Egdell* [1990] 1 All ER 835, at 849.

Medical confidentiality and reports : UK law (2)

- "the report should… have been disclosed by the doctor to the employers. No further consent was required from the claimant. By consenting to being examined on behalf of the employers the claimant was consenting to the disclosure to the employers of a report resulting from that examination"
- Walker LJ in *Kapadia v London Borough of Lambeth* [2000] IRLR 699

Medical confidentiality and reports : UK law (3)

- A report following pre-employment medical: “A duty of confidence is one which prevents the holder of confidential information from using it or disclosing the information for purposes other than those for which it has been provided without the consent of the person to whom the duty of confidence is owed”.
- *Farnsworth v London Borough of Hammersmith & Fulham* [2000] IRLR 691

Summary

Three main areas giving rise to conflicting ethical advice were identified:

- 1. The application of the therapeutic doctor-patient paradigm in the practice of OM was found to be problematic .
- 2. The concept of “consent” when disclosing an OH report was found to be different to “consent” to treatment.
- 3. There is conflict between UK law and ethical guidance with regard to confidentiality in the context of an independently commissioned report.

references

- Tamin J., *Models of occupational medicine practice: an approach to understanding moral conflict in "dual obligation" doctors*, **Medicine, Healthcare and Philosophy**, 2013, 16(3), 499-506.
- Tamin J., *Can informed consent apply to information disclosure?: Moral and practical implications*, **Clinical Ethics**, March 2014, 9, 1, 1-9.
- Tamin J., *Is the GMC guidance on confidentiality compatible with English law?*, **Occupational Medicine,** 2015, 65, 266-267.
- Tamin J., *What are "patient secrets" in occupational medicine?: Privacy and confidentiality in "dual doctor obligation" situations*, **Medical Law International**, 2015 (1), 19-48, DOI: 10.1177/096853215587051.

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Thank you