The doctor-patient relationship, confidentiality and consent in occupational medicine:

_Ethics and ethical guidance_

A thesis submitted to The University of Manchester for the degree of

**PhD in Bioethics and Medical Jurisprudence**

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School of Law
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ABSTRACT

The University of Manchester
Doctoral Programme in Bioethics and Medical Jurisprudence

Jacques Tamin
15 November 2015

The doctor-patient relationship, confidentiality and consent in occupational medicine: Ethics and ethical guidance

This thesis seeks to examine the ethical basis for occupational medicine, as it is practised in the United Kingdom (UK). There is empirical evidence of occupational physicians being confused with regard to confidentiality and consent, and variations in their practice. It is argued that the ethical guidance from the General Medical Council and the Faculty of Occupational Medicine on these matters, contributes significantly to such confusion. The doctor-patient relationship, consent for disclosure of a medical report, and medical confidentiality, all in the context of occupational medicine practice, are explored. These issues are addressed in the core part of this thesis in the form of the three published papers. In the first paper, the doctor-patient relationship in occupational medical practice is reviewed, and it becomes apparent that in the UK, the occupational physician carries out different roles and functions, ranging from duties that mirror those of a therapeutic encounter, to those that require the occupational physician to be completely independent for the purposes of a particular type of assessment (for ill-health retirement). The former is compatible with the assumption of a fiduciary relationship between doctor and patient, whereas in the latter situation, it would be incongruous to expect the doctor to be independent and owe the patient a “duty of undivided loyalty” simultaneously. In the second paper, consent for disclosure of information, in particular a medical report, is distinguished from the “informed consent” for treatment or interventional research, and the phrase “permission to disclose” is proposed for the disclosure situations. Although this distinction may not have much significance in therapeutic practice, the output of virtually all occupational physician activities results in the writing of a report, so this difference between the two “consents” has greater relevance. The third paper reviews the ethical, and in particular, legal basis for medical confidentiality with reference to an independently commissioned report. In such a situation, UK courts have been consistent in stating that disclosure of such a report to the commissioning party does not breach confidentiality, and no further consent for such disclosure is required. This conflicts with ethical guidance to occupational physicians on this matter. Such conflict between the law and ethical guidance are a further, and important, source of ethical confusion for occupational physicians. Indeed, a common theme through the three papers is that ethical guidance to occupational physicians is in parts either incongruent, incoherent, or conceptually flawed. This may not be surprising, as current ethical guidance is predicated on a doctor-patient relationship that exists in the usual setting for most doctor-patient encounters, that is, the therapeutic setting. It seems unreasonable to expect that simply transposing such an ethical paradigm into a different setting, with dissimilar roles and obligations, could work in a seamless manner. The occupational physicians’ ethical confusion thus reflects the confusion in their ethical guidance.
DECLARATION

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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_________________________________________ 15 November 2015

Jacques Tamin
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My two supervisors, Sarah Devaney and Søren Holm have been truly inspirational. They have supported me in many ways, and helped me to challenge and clarify my ideas. I am very appreciative of their mentorship and teaching. I am also especially grateful to Margot Brazier, my annual reviewer, for her continued encouragement and her kind and wise words. Many others, too many to mention, have helped me in so many ways when I have come to an impasse many, many times during this journey.
I am very grateful to my wife Susan for her unfailing support and cheerful optimism, and to my mother Helene for reading the published papers with pride.
I dedicate this thesis to the memory of my father, Soon Foh, who shared his passion for knowledge with me.
THE AUTHOR

My background training is in medicine, initially in general practice and then in occupational medicine, which I have practised for over 25 years. Throughout my career I have been interested in the ethico-legal problems that arise in the course of medical practice, especially in occupational medicine. I feel very privileged to have had the chance to explore some of these issues further in the last six years. I retired from clinical practice in December 2014, but continue to do some teaching, in my capacity as an honorary senior lecturer in occupational medicine, University of Manchester.

Presentations

Some parts of this thesis were presented at academic meetings:

1. Should “informed consent” apply to information disclosure based on biological samples and data?, ESPMH (European Society for Philosophy in Medicine and Health Care) Conference, Basel, 14-17 August 2013.
2. “Permission to disclose” rather than informed consent: A practical example, SOM (Society of Occupational Medicine) Annual Scientific Meeting, Nottingham, 1-3 July 2014.
5. Who can access my medical information?: A new privacy paradigm for health data, ESPMH Conference, Ghent, 19-22 August 2015.

Papers

The core of this thesis is made up of three articles, which have been published as follows:

1. Tamin J, Models of occupational medicine practice: an approach to understanding moral conflict in "dual obligation" doctors, Medicine, Health Care and Philosophy, 2013, 16, 3, 499-506. (Chapter 6)
2. Tamin J, Can informed consent apply to information disclosure?: Moral and practical implications, Clinical Ethics, 2014, 9 (1), 1-9. (Chapter 7)
### GLOSSARY OF ABBREVIATIONS USED

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<tr>
<td>AIDS</td>
<td>Acquired Immuno-deficiency Syndrome</td>
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<td>BMA</td>
<td>British Medical Association</td>
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<td>COHPA</td>
<td>Commercial Occupational Health Providers Association</td>
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<td>DPR</td>
<td>Doctor-patient relationship</td>
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<td>ECHR</td>
<td>European Convention on Human Rights</td>
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<td>GMC</td>
<td>General Medical Council</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>HIV</td>
<td>Human Immuno-deficiency Virus</td>
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<td>IC</td>
<td>Informed consent</td>
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<tr>
<td>IIGOP</td>
<td>Independent Information Governance Oversight Panel</td>
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<tr>
<td>IRMP</td>
<td>Independent Registered Medical Practitioner</td>
</tr>
<tr>
<td>MMR</td>
<td>Measles, Mumps and Rubella (vaccine)</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>OH</td>
<td>Occupational Health</td>
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<td>OM</td>
<td>Occupational Medicine</td>
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<td>OP</td>
<td>Occupational Physician</td>
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<td>OPW</td>
<td>Occupational Physician-Worker</td>
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<td>PEP</td>
<td>Post-Exposure Prophylaxis</td>
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<td>PTD</td>
<td>Permission to Disclose</td>
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<td>TEP</td>
<td>Therapeutic Ethical Paradigm</td>
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<td>UK</td>
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Saltman Engineering Company Ltd v Campbell Engineering Company Ltd (1948) 65 R.P.C. 203

Sidaway v Governors of the Bethlem Royal Hospital and Maudsley Hospital [1985] UKHL 1

Stokes v GKN (Nuts and Bolts) Ltd [1968] 1 WLR 1776

Vidal-Hall & Ors v Google Inc [2014] EWHC 13 (QB)

Von Hannover v Germany 2004 European Court (Application no. 59320/00), 2004

W v Egdell [1990] 1 All ER 835

Wainwright v Home Office [2003] UKHL 53

West London Mental Health NHS Trust v Chhabra [2013] UKSC 80

W, X, Y and Z v The Secretary of State for Health [2015] EWCA Civ 1034
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PART I

INTRODUCTION
Chapter 1

1.1 The Problem

Occupational physicians (OPs)\(^1\) are reported to have “significant variation”\(^2\) in their understanding and application of General Medical Council (GMC) guidance on disclosure of their reports. Where does this confusion arise?

In 2009, the GMC updated its guidance to doctors on confidentiality\(^3\). In addition, it produced supplementary guidance\(^4\), which included a section entitled “Disclosing information for insurance, employment and similar purposes”\(^5\), and this clearly applied to doctors with “dual obligations”, including occupational physicians\(^6\). The doctor was now required to “obtain or have seen written consent to the disclosure from the patient” and also to “offer to show (the) patient, or give them a copy of, any report you write about them for employment or insurance purposes before\(^7\) it is sent”\(^8\). This provoked great consternation amongst OPs, who had previously been used to offering the worker a copy of their report at the same time as the employer or other commissioner. Now having to offer the report to the worker before the

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\(^1\) For initial general background information on occupational medicine (OM) and occupational physicians (OPs), see British Medical Association (BMA), *The occupational physician*, 2015, available at [http://bma.org.uk/support-at-work/occupational-health/the-occupational-physician](http://bma.org.uk/support-at-work/occupational-health/the-occupational-physician). I will also give a brief description of OM as practised in the UK at chapter 2, section 2.2.


\(^5\) As above, p22-26.

\(^6\) As above, at p24.

\(^7\) Emphasis added.

\(^8\) As above, at p23.
commissioning party could have far reaching implications to the way OPs practised. The UK Faculty (FOM) and the Society (SOM) of Occupational Medicine issued a joint statement which reflected this unease: “Publication of this (GMC) guidance has caused widespread concern among occupational physicians about the practical difficulties associated with compliance and unintended consequences relating to the impact that it may have on the perceived impartiality of reports”\(^9\). An example of the “practical difficulties and unintended consequences” is the fact that if an individual applied for an early pension release on ill-health grounds (IHR) and then was found not to be eligible for this, he could now simply refuse to give his consent for this report to be released, in order to seek a more favourable opinion at a later date from a different physician\(^{10}\). The GMC met with the FOM, SOM, and separately with representatives from a large occupational health provider, as well as from COHPA (Commercial Occupational Health Providers Association), and issued some clarification in an open letter\(^{11}\) to the President of the FOM (which is the standard setting body for OM in the UK). Both the letters from the FOM/SOM and the GMC stress the practical difficulties arising from this guidance, and seek to address these to some extent. In practice, OPs and occupational health (OH) providers have since changed their processes and consent forms to address this\(^{12}\).

However, there is still widespread confusion\(^{13}\) about confidentiality and consent in the occupational medicine (OM) community.

On the other hand, I aim not to focus just on the practical consequences of a seemingly trivial change in the GMC guidance, but intend instead to explore the wider underlying issues that

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\(^{10}\) The implications of this example will later be discussed, especially in paper 3 (chapter 8).

\(^{11}\) Keegan M. (GMC Standards and Ethics), Confidentiality (in an open communication to the President of the FOM), 12 October 2010.

\(^{12}\) For example, most consent forms for disclosure of a report now offer the opportunity for the worker to read it 2 to 5 days prior to sending to the employer or other commissioning party, and is only sent to the latter with the worker’s permission.

\(^{13}\) Stern and Sperber (2012), p561. They suggest that “the background ethical reasoning should be stated so that the parameters of the guidance are delineated” (at p562).
this change and the consequential “widespread concern” and “confusion” experienced by OPs may have unearthed. I believe there may be a more fundamental reason why the basic cornerstones of medical ethics, namely the doctor-patient relationship and medical confidentiality, do not sit comfortably in OM practice. Maybe the very nature of that relationship, and the information exchange which it entails, are sufficiently different in OM encounters compared with the therapeutic ones, for the same ethical rules derived from therapeutic medicine not to be coherent in the OM context. The purpose of my thesis therefore, is not to focus only on the GMC guidance and its effects on OPs, but to use this as a starting point and a stimulus to exploring the underlying ethical and legal issues.

The main problem that this thesis will seek to address is the lack of clarity in the nature of the doctor-patient relationship in the context of OM. It will also seek to clarify what confidentiality and consent mean, or should mean, in OM practice. OPs generate as their usual output a report to the employer or other commissioning party, so confidentiality relating to disclosure of that report is key to their practice. Ultimately, I critically review the current UK OM ethical paradigm, and suggest improvements where possible\textsuperscript{14}.

\textbf{1.2. Research Questions}

There are problems\textsuperscript{15} caused by the most recent GMC guidance, in requiring that the worker or applicant be shown the report of their OM assessment first, thereby effectively imposing a need for further specific consent before this report can be released to the commissioning party. It could be argued that these problems and the reported variations in OP practice\textsuperscript{16} arise from the fact that OM practice is significantly different from therapeutic medicine, and/or disclosing

\textsuperscript{14} This will be done in my conclusions, at chapter 9.

\textsuperscript{15} I will later explain the problems, especially in the context of the disclosure of an independent report, initially in section 2.2.2(b), but more fully in chapter 8.

\textsuperscript{16} Stern and Sperber (2012), p562.
an OM report is in some way different in to a usual report written by the treating doctor. For this reason, I will analyse the following issues: (i) whether the nature of the DPR in OM practice is different to the usual therapeutic one, and if so, how an OP’s ethical obligations might differ; (ii) whether applying the concept of consent in its usual form (that is, consent to treatment or interventional research) to disclosure of information is erroneous, such that the concept of “consenting” to the release of the report is inherently flawed; and (iii) how the rules of medical confidentiality apply, or should apply, in the context of disclosing an OM report.

Therefore the research questions I will seek to answer in my papers are:

**Question 1:** Is the doctor-patient relationship different in the normal therapeutic context compared with the OM one, from an ethical perspective? If so, what are the implications for OPs?

**Question 2:** Is “consent” for the disclosure of health information different to “consent” for treatment or interventional research?

**Question 3:** What does “medical confidentiality” mean in OM practice, especially in the context of the disclosure of a commissioned report?
Chapter 2

BACKGROUND

This thesis aims to explore the ethical, and where relevant, the legal issues in the DPR, confidentiality, and consent in OM practice. However, before I am able to do this, I will review these areas of interest in “normal” therapeutic practice, in order to later identify any differences with OM practice. Such differences will be the subject of much of my discussion throughout this thesis. This chapter provides some background to the themes that will be developed further (for example, the DPR in chapter 3 and confidentiality in chapter 4), and to the analyses that will be done in later chapters. In this chapter, I will first briefly review my three main areas of interest (that is, the DPR, confidentiality and consent) in the first part, and then provide a description of OM as it is practised in the UK in the second part.

2.1. Ethical and Legal background

2.1.3. Doctor-patient relationships

In order to be able to later1 examine the difference(s) between the “normal”2 DPR, and that which occurs in OM practice, the normal DPR will first be described from an ethical viewpoint. A literature review of the normal DPR highlights the fact that there are not one, but many possible relationships. Several authors have sought to group these into “models” of relationships. Szasz and Hollender3 for example proposed 3 models, ranging from “activity-

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1 In section 2.2.2., then chapters 3 and 6.
2 That is, that which occurs in a therapeutic relationship.
passivity” (which was a paternalistic model, and the predominant one at that time) to a “mutual participation” one, where some “partnership” could be countenanced, though they did comment that this was “essentially foreign to medicine”\(^4\). There have been further models suggested since then\(^5\), and of those, the set of models developed by Emanuel and Emanuel\(^6\) is one of the most widely discussed\(^7\). They proposed four models, which will be described in the next chapter. They also analysed the ethical obligations of the doctor in each model, especially in relation to patient autonomy\(^8\). Veatch\(^9\) offered a structurally different model, proposing a more contractual basis for the relationship, while other authors have criticised various aspects of all the different models\(^10\). Nevertheless, the predominant types of models do suggest a paternalistic one on the one hand, to one which stresses patient autonomy on the other. De Zueleta\(^11\) described the models at the autonomy end the “mutuality” models. She suggested that “trust looms large”\(^12\) in these mutuality models, and is “intrinsic to them”. She also maintained that the mutuality model was the “most conducive to trust”\(^13\), but O’Neill pointed out that DPRs

\(^4\) At p588.
\(^6\) Emanuel EJ and Emanuel LL, Four models of the Physician-Patient Relationship, JAMA, 1992, 267, p2221-6.
\(^7\) Clarke et al (2004), at p16.
\(^8\) Their analysis of these models will be described in the next chapter, at 3.1.
\(^10\) For example: Brody H, The Physician-Patient Relationship: Models and criticisms, Theoretical Medicine 8, p205-220, D. Reidel Publishing Company, 1987; Clarke G, Hall RT, Rosencrance G, Physician-Patient Relationships: No More Models, The American Journal of Bioethics, 2004, 4, 2, w16-w19. These papers criticise various aspects of the models offered by different authors. Clarke and Hall point out that the models ignore the social context of the DPR, and that many patients would wish their families to be involved with their decision making, at w16. Brody on the other hand, points out strengths as well as weaknesses in various models, including Veatch’s contractual one, initially suggesting a shift to a “contractarian” one, then to a more virtue-based approach. He suggests that “a creative amalgam between a contractarian model and elements of a virtue-based approach, combined with appropriate empirical investigation, may yield richer models in the future”, at p205.
\(^12\) At p14.
\(^13\) At p20.
“were viewed as relationships of trust only because a paternalistic view of medicine was assumed”\textsuperscript{14}.

The importance of trust in the DPR will be discussed further in chapter 3, where I will also elaborate further on the models themselves. At this stage, it may suffice to note that as there is not just one, but several types of DPR in therapeutic encounters, there could be similarly several types of relationships between OPs and workers. Indeed, later in this chapter (at 2.2.2.), I will propose and describe a set of models for OP-worker relationships.

2.1.2. Fiduciary relationships

In their analysis of informed consent in the context of psychiatric patients, Dyer and Bloch suggested that “the fiduciary principle offers a resolution to the conflict between the principles of autonomy and paternalistic beneficence”\textsuperscript{15}. The authors do not explain what they mean by fiduciary principle in their paper, beyond a requirement for “mutual trust” between doctor and patient. Although this will be discussed later, especially in chapter 3, for the purposes of clarification at this stage, I would describe it as a principle that is based on trust, but also recognises a power imbalance between the two parties, such that certain constraints are placed on the fiduciary. On the other hand, Tauber stressed a deep tension between trust and autonomy, which was “not easily overcome”\textsuperscript{16}. However, trust is still of central importance in the DPR, and this proposition is strongly supported by O’Neill\textsuperscript{17} and Brazier and Lobjoit\textsuperscript{18}. The DPR is

\textsuperscript{16} Tauber AI, \textit{Patient autonomy and the ethics of responsibility}, MIT Press, 2005, p120.
\textsuperscript{17} As above, at p17.
also stated to be based on this trust by the regulatory or professional bodies in the UK\textsuperscript{19} and US\textsuperscript{20}.

However, although trust is a requirement for a fiduciary relationship to exist, it is not in itself sufficient grounds to claim that a relationship is fiduciary in nature. The duties imposed on the fiduciary to the beneficiary or vulnerable party are largely due to the power imbalance between the two parties. Such a power imbalance\textsuperscript{21} is said to be evident in the DPR by Kennedy\textsuperscript{22} and Grubb\textsuperscript{23}, whereas Brody has drawn attention to the power of the doctor in the relationship\textsuperscript{24}. If the DPR is a fiduciary relationship, then the Law Commission has summarised the duties that arise\textsuperscript{25}, which Bartlett\textsuperscript{26} amended for the doctor-patient context. Kennedy\textsuperscript{27} objects to the notion of doctor as fiduciary mainly on the basis that it “entrenches the paternalism and power of the doctor”. English courts have also so far rejected a fiduciary basis for the DPR. The leading case is \textit{Sidaway}\textsuperscript{28}, where Lord Scarman dismissed the view that the DPR could be fiduciary\textsuperscript{29}. This however contrasts with North American common law cases, where the leading judgment is that of MacLachlin J. in \textit{Norberg}\textsuperscript{30}, which “has come to be regarded as the seminal judgment on the doctor as fiduciary”\textsuperscript{31}. Although my approach in this thesis will be mainly from an ethical, rather than legal, perspective, the debate as to whether the DPR is fiduciary in nature will be

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\textsuperscript{21} This power imbalance is described further in the next chapter, especially at 3.3. It is said to arise, for example, from the vulnerability of the patient, and the greater knowledge of the doctor.


\textsuperscript{25} Law Commission, \textit{Fiduciary Duties and Regulatory Rules}, Consultation Document 124, HMSO 1992, para 2.4.9. I list these duties in chapter 3, at 3.3.


\textsuperscript{27} Kennedy (1996), at p131-132.

\textsuperscript{28} \textit{Sidaway v. Governors of the Bethlem Royal Hospital and Maudsley Hospital} [1985] UKHL 1

\textsuperscript{29} Lord Scarman’s reasons for this will later be discussed in chapter 4.


\textsuperscript{31} Kennedy (1996), at p132.
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reviewed in greater depth in chapters 3 and 4, where I describe both my philosophical and legal approaches. This is because it is important for me to establish that the “normal” DPR is fiduciary, as I will later aim (in chapter 6) to show that assuming the same fiduciary relationship in OP-worker interactions can be problematic in certain situations.

2.1.3. Confidentiality

It will later be mentioned that one of the duties required of a fiduciary is the duty of confidentiality. However, regardless of whether the DPR is fiduciary or not, “the principle of medical confidentiality- that doctors must keep their patients’ secrets- is one of the most venerable moral obligations of medical ethics” Beauchamp and Childress justify the moral requirement for medical confidentiality on the basis of three types of arguments: (1) consequence-based ones: if the patient did not trust the doctor to keep the information confidential, then he would not disclose all relevant information, and this may be detrimental to his treatment and medical management; (2) respect for autonomy and privacy; and (3) fidelity-based arguments, as confidentiality would be one way of a doctor demonstrating fidelity to the patient in their relationship.

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32 In chapter 3, section 3.3. This is derived from the Law Commission Consultation Document 124 (see above), at para 2.4.9.
Some authors support a requirement for **absolute confidentiality**, such as Kottow and Parkes, whereas others maintain that this is not possible, such as Siegler and Emson. There is evidence that at least a section of the public is uncertain about what medical confidentiality means. There are also the situations where the GMC allows a breach, for example in the “public interest”, and even requires a breach of confidence in some circumstances. On that basis, Warwick argues that doctors should not even accept information in confidence, given the allowed or required breaches of confidence. She maintains that such breaches could lead to patients mistrusting, rather than trusting doctors. So, if absolute confidentiality does not exist in medicine generally, can it be expected in OM? The literature on confidentiality in OM is sparse, although some authors have discussed aspects of this issue. A detailed legal and ethical analysis of what medical confidentiality means, or should mean, in OM practice, would be a new contribution to the literature in this area.

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35. A detailed account of the opposing arguments will be given in my third paper (chapter 8), so this is just a brief summary at this stage.


42. GMC, *Confidentiality: Supplementary guidance*, London 2009, p8-13, on “Reporting gunshot and knife wounds”.


44. Although I believe that authors on both sides of the debate make valid points, I favour the arguments put forward by Kottow and Warwick, especially that the current medical confidentiality paradigm could well lead to mistrust rather than trust. I describe this more fully in my third paper (chapter 8).

45. Although the GMC does not specify that absolute confidentiality is required, the only instances where “patient” information can be disclosed without consent are identical to those in therapeutic relationships, see for example: GMC, *Confidentiality: Supplementary guidance*, London 2009, p23.


47. This is the basis of my third paper (chapter 8).
In therapeutic practice, if it is important for doctors to respect patient confidence, then the current NHS drive to share patient data would seem rather incongruous. It seems ironic that, while doctors have to be so careful about disclosing any patient information, when this information is in the form of “electronic data,” it could then be shared with a number of third parties with apparent ease. A similar situation was said to arise out of the Health and Social Care Act 2001, where “patients apprised of the possibility of disclosure of their records to ‘government departments’ may be less frank with their doctors.”

So, while the GMC places exacting controls on the fitness for work advice by an OP to an employer, UK patients may have their much more sensitive health data (contained in their GP records) shared with a number of bodies, and it is unclear how much control they will have over this process. Although it is claimed that this would lead to better care, the project has been criticised.

More recently, the Independent Information Governance Oversight Panel (IIGOP), chaired by Dame Fiona Caldicott, produced a report which sought various assurances, including that patients would be appropriately informed and given opt out choices, and as long as those conditions are satisfied, the pilot stage will take place in 6 “pathfinder” GP practices.

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49 See for example Mason JK and Laurie GT, Mason and McCall Smith’s Law and Medical Ethics [9th Edition], Oxford University Press, 2013, p186. They argue that computerisation has heightened the risk of disclosure.
50 Case P, Confidence Matters: The Rise And Fall Of Informational Autonomy In Medical Law, Med Law Rev 11, 2003, 208-236, at 235. Although the Health and Social Care Act 2001 has now been repealed by the Care Act 2014, the argument remains valid. For example, under section 251 of the National Service Act 2006, “the common law duty of confidentiality (can) be temporarily lifted so that confidential patient information can be transferred to an applicant without the discloser being in breach of the common law duty of confidentiality.” See for example, http://www.hra.nhs.uk/documents/2014/02/cag-frequently-asked-questions-1.pdf
51 GMC, Confidentiality: Supplementary guidance, London 2009, 23. Health data is held in a number of settings, of which some have no or little therapeutic purpose, such as insurers, benefits agencies and employers.
52 See for example, http://www.dailymail.co.uk/news/article-2567980/Sharing-medical-files-harms-trust-says-BMA-Senior-doctors-warn-using-data-cause-irreversible-damage.html. On the other hand, this has been defended on the grounds that research could improve effectiveness of treatments, for example in O’Dowd A, Medical Data: Does patient privacy trump access for research?, BMJ, 2013, 347, p20-21. However, it is beyond the scope of this thesis to explore in depth the issue of NHS data sharing.
55 IIGOP, Information to share or not to share, 2014 Annual Report, December 2014.
reported evidence of broad public support for their health data to be used for secondary purposes, including health service improvement or research, but “this support is said to fall away to a significant extent where they are not asked, or where the research involves private companies operating for profit.”

I mention the issues raised by data sharing to highlight a possible inconsistency in approach to protecting the privacy of patient information. Computerisation *per se* has made protecting patient privacy more difficult, but in addition the care.data programme demonstrates the UK government’s desire to make wider use of such data, which in the form of GP records, can be very sensitive. Given that health data is intended to be used in this way, I would argue that the disclosure of an OM report, which will contain much less sensitive information in any case, has in comparison been made subject to disproportionate constraints by the GMC (in requiring further consent for release of this report to the commissioner).

### 2.1.4. Consent

The issue of consent for disclosure of an occupational medical report will also be explored. Should the same underlying moral arguments for patient consent to treatment and research participation apply to disclosure of a report? In the context of clinical research, for example, it

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57 I am simply pointing out the inconsistencies in policy approaches to patient data. The fact that this is government policy does not in itself provide an ethical justification for the wider use of patient data. For a comprehensive analysis of the ethical implications of data sharing, see: Nuffield Council on Bioethics, *The collection, linking and use of data in biomedical research and health care: ethical issues*, 2015.

58 In contrast, GP records usually do contain more sensitive information. For example, recently the BMA has warned GPs that disclosing the whole record for insurance purposes without the patient realising the implications of such practice, is likely to be in breach of the DPA: BMA, *Focus on Subject Access for insurance purposes*, August 2015 (updating July 2015), downloadable from http://bma.org.uk/practical-support-at-work/gp-practices/service-provision/subject-access-requests-for-insurance-purposes.

has been argued that there are different degrees of harm\textsuperscript{60}, and a less mechanistic approach would be better\textsuperscript{61}.

But I aim to show that the difference between consent to treatment and consent to disclosure goes further than this. Rather than it being simply a matter of degree of harm that could be corrected by improvements in the process of obtaining consent, I will argue in my second paper (chapter 7) that the underlying justifications for the requirement to consent to treatment and consent to information disclosure should in fact be significantly different. Such a difference may not matter greatly for treating doctors and interventional researchers\textsuperscript{62}. On the other hand, virtually all OM consultations result in a written report, so even a subtle difference between the two types of consent could have a major effect on OM practice. I will later argue that this is indeed the case\textsuperscript{63}.

But first, in order to clarify the differences between therapeutic medicine and OM, I will briefly describe the practice of OM in the UK in the next section.

\section{2.2. Occupational medicine in the UK}

\subsection{2.2.1. A brief description}

OM is described as being that branch of medicine that deals with the effects of work on health, and of health on work\textsuperscript{64}.  

\textsuperscript{60} Assiter A, Informed consent: is it sacrosanct?, \textit{Research Ethics Review}, 2005, 1, 3, p77-83, at p81

\textsuperscript{61} Ibid. The author argues for example, that in research where there is negligible risk of harm to the subject, individual consent may not be necessary. She is critical of the “blind and unthinking” application of the principle of informed consent.

\textsuperscript{62} However, I will argue that consent for research based on subject data, such as bio-bank research, shares features in common with consent for disclosing an OM report.

\textsuperscript{63} In my conclusions, at chapter 9, section 9.2.2.

\textsuperscript{64} See for example, Smedley J, Dick F, Sadhra S (Eds), \textit{Oxford Handbook of Occupational Health}, Oxford University Press, 2007, p384-385. It is also part of the wider discipline of occupational health (OH), which
In the past, an OP65 would have been mainly concerned with workplace toxic hazards and their effects on the health of workers, but as work environments in the UK, as in other developed countries, have become increasingly better controlled and safer66, the emphasis has been shifting increasingly to whether workers meet the appropriate medical standards for their occupation, that is, medical assessments of their fitness for work67. The FOM describe a very wide range of duties that an OP would be expected to undertake, including monitoring the health of workers who are potentially exposed to hazards at work, analysing data from health surveillance programmes, visiting the workplace regularly and advising on the provision of safe and healthy working conditions, promoting compliance with relevant health and safety legislation, and giving policy advice68, but a survey reveals that 75% of OP working time is spent on attendance and absence assessments69. Thus the majority of an OP’s time is spent in consultations, where the worker would have been referred by his manager for advice on fitness for work, and in a substantial number of these cases, whether the worker would meet a pension scheme’s criteria for early retirement on the grounds of ill-health70(IHR).

So, although the primary aim of OM is the protection of the health of workers at work, a large proportion of UK OPs find that their time is spent in helping employers deal with sickness

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65 An OP is a registered medical practitioner who has undertaken specialist training and qualifications in OM. See also BMA, *The occupational physician*, 2015.
66 For example, in Centre for Workforce Intelligence, *Medical Specialty Workforce Factsheet: Occupational Medicine*, August 2010, accessed at http://www.cfwi.org.uk/intelligence/cfwi-medical-factsheets/recommendation-for-occupational-medicine-training-2011. It is said “Industry has changed from manufacturing to a service majority over the last 20 years and this trend may continue. The main hazards have changed from dust, heat, noise and vibration to workplace pressure”.
70 For example a survey reported in Ballard J, OH professional practice, Part 1: jobs, priorities, concerns, threats and opportunities, *Occupational Health [at Work]*, 2011, 8(1), p21-27, at p22, found that 17% of OPs list “dealing with IHRs” amongst their top three priorities.
absence\textsuperscript{71}. There are understandable reasons for this, in that an OP will have a good working knowledge of both the health conditions and their functional implications, and also of the workplace and the job requirements. So, where plans for rehabilitating a worker into work are successful, the OP may be seen as helpful, by both the employer and the worker. On the other hand, when there is conflict between the two parties, an OP may find himself in a “no-win” situation.

It has been said that the practice of OM involves “trying to satisfy the worker and the employer at the same time”, and OM ethics has been described as “two-master ethics”\textsuperscript{72}. The ethical issues of consent and confidentiality, which exist in all areas of medical practice, then have an added dimension. On the one hand, the employer may have expectations that the OP feels unable to meet\textsuperscript{73}, and on the other, the worker may view the OP with suspicion (as being “the employer’s lackey”). For example, a manager may ask the OP for the specific diagnosis, and other clinical details that an OP would not feel able to divulge, as the FOM ethical guidance is that “the employer rarely needs clinical information about a worker…and the occupational physician can give all the necessary information…without disclosing clinical information.”\textsuperscript{74} However, the worker may still be suspicious and uncooperative, especially where his relationship with his employer is strained, and he may view the consultation with the OP as a means for the employer to get rid of him. For example, a small survey of workers found that about a third of workers responded that as a result of an OH consultation, OH would “favour the manager”, a third “didn’t know”, and a third disagreed with the

\textsuperscript{71} This is in complete contrast to the situation in Belgium, for example, where OPs do not get involved with sickness absence at all, unless the worker contacts them. See Tamin J, \textit{A comparison of occupational medicine practice in Belgium and the United Kingdom as a basis for clarifying ethical guidance (Golden Jubilee Travelling Fellowship 2014 report)}, available at https://www.som.org.uk/members/reading-room/golden-jubilee-travelling-fellowship-reports/report-dr-jacques-tamin/.


\textsuperscript{73} For example, the OP may consider disclosure of clinical information to be unethical.

On the other hand, some reporting of worker distrust of OPs or OH is not confined to the UK, nor is it recent. One might postulate that some worker mistrust inevitably arises from the “two master ethics” that operates in OM.

In the UK, there has also been a growing trend for OH services to be outsourced from in-house services to external commercial providers. Arguably, this distances the workers from the OP further, and therefore they may be even less trusting of the OP’s motives in this type of service provision. On the other hand, this “distancing” could provide a perception of greater independence of the OP from the employing organisation. However, this would be too simplistic a view, and there are many factors that could influence workers’ views of their OH service, whether in-house or outsourced. There are several other features of OM in the UK which are worth mentioning, as they may also have a bearing on the OPW interaction. Firstly, in the UK, OH departments do not provide treatment services, except for first aid. Otherwise, it would arguably be a duplication of effort, given the extensive treatment provision available from the National Health Service (NHS). Secondly, although the NHS provides this treatment service, it specifically does not provide a National Occupational Health Service, and this was

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75 Stilz R and Madan I, Worker expectations of occupational health consultations, Occup Med, 2014, 64, p177-180, in Table 1, at p178. The authors point out that this was a survey of health care workers with an in-house service, so their results may not be applicable to other workers.

76 See for example, Plomp HN and Ballast N, Trust and vulnerability in doctor-patient relations in occupational health, Occup Med, 2010, 60, p261-269. This was a study carried out in the Netherlands. The authors suggest that “Where physician’s independence, agency or expertise is questioned, distrust is harder to overcome.” They also found that workers who were more “vulnerable” (for example, more seriously ill) or had work-related concerns were more likely to trust OPs, but the responses were not uniform.

77 Plomp HN, Workers’ attitude toward the occupational physician, Journal of Occup Med, 1992, 34, 9, 893-901. In this study, again carried out in the Netherlands over 20 years ago, the author found that “A negative evaluation of the OHS is mainly because of unclarity and uncertainty as to how the occupational physician combines his/her responsibility toward individual workers with his/her responsibility toward the company.”, at 893.

78 I believe that this is likely to a relevant factor in workers being suspicious of OH services to some extent, and suggest that some evidence for this is found in the Plomp (1992) paper, given the “unclarity and uncertainty” mentioned above.


80 For example, the previous experience of workers referred to the service or the outcomes of such referrals.
done quite deliberately when the NHS was formed in 1948\textsuperscript{81}, so OH is largely \textit{not} state funded\textsuperscript{82}. Thirdly, although OH is mainly employer funded, there is no legal obligation\textsuperscript{83} on employers to fund this, which is a different situation to that in some other European countries\textsuperscript{84}. These background factors in OH provision in the UK may in part contribute to some of the particular tensions that can arise between employers, OH services, and workers.

2.2.2. OM models

Given the different demands on an OP in practising OM as it has now evolved in the UK, it is likely that the types of relationships or interactions with workers will vary according to the different settings. So, just as it has been argued that there is not just one type of DPR in the practice of therapeutic medicine, I would suggest that the relationship or interaction between OP and worker will vary according to the type and purpose of the OM consultation. I propose three models of the OPW situation, accepting that this may not be exhaustive.

(a) Model 1: The “quasi\textsuperscript{85}-therapeutic” model

\textsuperscript{81} See for example: Bruton DM, \textit{The Faculty of Occupational Medicine, The first twenty five years}, Faculty of Occupational Medicine, London, 2004, p2-3.


\textsuperscript{83} However, there is a statutory requirement for health surveillance of workers working with certain chemicals, or exposed to certain physical or biological hazards, for example, The Control of Substances Hazardous to Health Regulations 2002 SI 2002/267, and The Control of Vibration at Work Regulations 2005 SI 2005/1093.

\textsuperscript{84} See for example, WHO Regional Office for Europe, \textit{Good practice in Occupational Health Services: A contribution to Workplace Health}, 2002, \url{http://www.euro.who.int/__data/assets/pdf_file/0007/115486/E77650.pdf} at p 3: “There is, however, great variation between European countries in the provision of occupational health services, ranging from: (i) no legal requirement, through (ii) requirements for enterprises to manage and control occupational health risks implying appropriate use of external consulting services, to (iii) a requirement for every enterprise to provide occupational health services.” In addition, FOM, \textit{Position Statement, Provision of Occupational Health Services to Small and Medium-sized Enterprises (SMEs)}, 2006, list Belgium, France, Germany, the Netherlands and Finland as countries where the provision of OH services is mandatory, accessed at \url{http://www.fom.ac.uk/wp-content/uploads/pp_smes.pdf}

\textsuperscript{85} As in “seeming to be something but not really so”, Oxford Essential English Dictionary, Oxford University Press, 2011.
As mentioned above, in the UK OH services do not provide treatment, except for first aid. It could be argued that the fact that vaccinations are provided (such as against hepatitis B in health care workers, or for business travel) or the fact that some OH departments include or can refer workers for physiotherapy or counselling, constitutes an element of “treatment”, or at least clinical care. However, although the GMC appears insistent on calling anyone who comes into contact with a doctor, a “patient”, and the FOM had previously followed suit, the term “patient” comes from the Latin “pater” which means “to suffer”. It is unlikely that a worker will feel that he is a “patient” during his interactions with an OP. After all, he may feel perfectly well, and having been referred by his manager for “fitness to work” advice, he may not want any personal advice himself.

On the other hand, although I would maintain that truly “therapeutic” encounters are not part of OM as it is practised in the UK, there are instances where OPW interactions may come close to being indistinguishable from the traditional doctor-patient ones. An apposite example quoted by the FOM is where a worker self-refers to the OH service or to the OP for advice. Although the OP cannot prescribe or treat in this scenario, the encounter is often similar to a therapeutic one, in terms of the doctor giving advice, and presumably the worker trusting this advice, having sought it in the first place, hence a “quasi-therapeutic” encounter.

88 This is my preferred term, and agree with the FOM current edition (2012) note which indicates the use of the term “worker” throughout their guidance, at p10, para 1.9.
90 However, it differs in an important respect to a truly therapeutic encounter in that the OP does not offer treatment, although he may refer the worker to a physiotherapist or to psychological services. If any other medical condition were identified, the OP would need to refer the worker, usually to his GP or more rarely (unless in an emergency) to a specialist, for treatment. Hence the concept of a “quasi-therapeutic” relationship seems apposite.
Such self-referrals would not have been uncommon when most OH provision was “in-house”. However, as mentioned previously, the trend has been for OH to be outsourced, and in-house services are fast disappearing, probably most of the survivors being NHS OH services. Even where they have survived, OH departmental budgets are under constant pressure, and often under direct control of another department, such as the Human Resources or Health and Safety departments. Where this has occurred, many OH professionals have found that they have little control over their clinic appointments (sometimes directly booked by Human Resources), and “self-referrals” are no longer possible. Therefore, although it is possible that at least in this model, the OPW interaction may not be far from a traditional DPR, in practice this occurs infrequently, and the current trend suggests that this will continue to become more and more infrequent.

(b) Model 2: The “independent\textsuperscript{91} expert” model

In this model, the interaction between OP and worker is remote (both in terms of the type of work, as well as in a geographic sense), and it would be difficult to say that there was anything like a “relationship” between the two parties. Such work would include advice on early ill-health retirement (IHR) applications\textsuperscript{92}, where the OP assesses the evidence presented in support of the application (which would usually include specialist reports and evidence of attempts at workplace adjustments) against the medical criteria of the pension scheme. It could be viewed to some extent as being similar to expert witness work that doctors of any speciality can do for the courts. It is reasonable to assume, I believe, that the same advice given by the GMC to

\textsuperscript{91} The term “independent” is used, for example, in the title “Independent Registered Medical Practitioner” (IRMP) in the Local Government Pension Scheme (Benefits, Membership and Contributions) Regulations 2014. The IRMP signs the certificate including the following statement: “I have not previously advised, or given an opinion on, or otherwise been involved in this case, nor am I acting or have ever acted as the representative of the member, the scheme employer or any other party in relation to it”. Similar terminology is used in some other public sector pension schemes, such as “IQMP” (Independent Qualified Medical Practitioner) for the Firefighters’ Pension Scheme Order 1992.

\textsuperscript{92} Other work that would fall in this category would be OPs sitting on Medical Appeal Boards for these pension schemes.
expert witnesses should apply\textsuperscript{93}, for example in terms of the requirement to be “honest, trustworthy, objective and impartial”\textsuperscript{94}. However, I would not wish to overstate the court analogy, as expert witnesses have “an overriding duty to the court”\textsuperscript{95}, whereas OPs do not have a similar duty to the commissioner of their report\textsuperscript{96}. Therefore, if I claimed that work that OPs undertake is much the same as that undertaken by medical expert witnesses, I think that any conclusions that I would reach as a result of exploiting the similarities between expert witnesses and OPs, could be susceptible to the criticism that the lack of a similar duty to the third party in the OP situation would invalidate these conclusions. For example, it could be argued that the expert witness’s overriding duty to the court \textit{de facto} reduces his duty to the claimant\textsuperscript{97}, whereas the OP’s balancing of his duties to the worker and the pension fund trustees still has to be more equipoised\textsuperscript{98}. The reason I have made reference to expert witnesses is really to point out that OPs in the independent expert role should similarly be “honest, trustworthy, objective and impartial”\textsuperscript{99}.

An OP undertaking an IHR assessment is, in my view, in a more distant relationship with the worker or pension fund applicant (when compared with that described as “model 1” above), and this type of interaction needs to be acknowledged. As mentioned previously, this type of

\textsuperscript{93} GMC, \textit{Acting as an expert witness: Supplementary guidance}, London 2008.
\textsuperscript{94} At para 14.
\textsuperscript{95} Ministry of Justice, \textit{Civil Procedure Rules, Part 35- Experts and assessors}, Rule 35.3, accessed at http://www.justice.gov.uk/courts/procedure-rules/civil/rules/part35. In addition, a further difference until recently would have been that the expert witness would have been immune from civil prosecution for negligence, but this has now changed since the Supreme Court ruling in Jones v Kaney [2011] UKSC 13. See Devaney S, Balancing duties to the court and client: The removal of immunity from suit of expert witnesses, \textit{Med Law Rev}, 2012, 20, p450-459.
\textsuperscript{96} In the court situation, there are three actors involved (the court and the two parties to the case). The overriding duty to the court is a duty which comes before the duty to the party that pays the expert. In the OP case there is usually only two parties, so no third party to whom one could have an overriding duty. For these reasons, the analogy between OP work and that of expert witnesses is weak, hence why I do not wish to overstate this.
\textsuperscript{97} However, as Devaney (2012) reminds us, the expert witness still has a “duty to exercise reasonable skill and care” to those instructing them, in contract and tort law (at p453). She further points out that this dual duty is also highlighted in paragraph 4.1 of the Protocol for the Instruction of Experts to give Evidence in Civil Claims (2005).
\textsuperscript{98} This is considered further in my first paper (chapter 6).
\textsuperscript{99} This could be regarded the \textit{minimum standard} of OPs’ moral obligations towards workers and IHR applicants. The standard is higher in the quasi-therapeutic relationship, as the latter is similar to the usual DPR, where the doctor would have fiduciary obligations.
work forms a significant proportion of the workload of many OPs, and even more so in terms of case complexity, and challenges and appeals by applicants who fail to be awarded IHR. Compared with a DPR in a therapeutic setting, I believe this model describes an interaction that is quite different from the DPR. Indeed, for most IHR assessments, it could be said that no relationship exists at all.

(c) Model 3: The “impartial” doctor model

This model will be used to describe the majority of OP work, which usually arises from referrals by managers, asking for advice on workers’ fitness for work, or health aspects of attendance or performance problems. In relationship terms, this model would be somewhere between models 1 and 2. It would probably not be quite as distant as in model 2 (as independent implies no relationship at all), but nor would it be quite as close as in model 1.

Although the FOM does recognise the need for OPs to be impartial, it does also stress that OPs, like other registered medical practitioners, have an ethical responsibility to put the

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100 There is a wider use of the term, as for example in Oxford Essential English Dictionary, Oxford University Press, 2011, the definition includes “the way in which two or more people or groups think of and behave towards each other”, which does not imply any closeness. However, in chapter 3, the DPR will be described in terms such as “mutuality” and even “friendship”. It is this implied closeness that I suggest does not exist in the independent expert model.

101 Although the OP still has a duty to exercise reasonable skill and care, for example, to assess the evidence competently. In Kapfunde v Abbey National [1998] EWCA Civ 535, the Court of Appeal described the duty of care as being “no more than a duty to exercise the skill and care to be expected of a reasonably competent occupational health physician carrying out a medical assessment of a job applicant such as this appellant”, per Kennedy LJ para5. This was a case of a pre-employment assessment, which would not be too dissimilar to an IHR assessment. Kapfunde will be described and discussed further in chapter 9, section 9.2.1.

102 “Impartial” being defined as “not favouring one person or side more than another”, Oxford Essential English Dictionary, Oxford University Press, 2011.

103 75% of their workload, as previously mentioned, from the survey reported in: Suff P, Welcome to the working week (OH work survey), Occupational Health [at Work], 2007, 4(3): 22-28.

104 For example, one of the definitions of “independent” in the Oxford online dictionary is “not connected with another or with each other; separate”.

105 “Occupational physicians also need to build good relationships with managers. Integrity, respect, good communication, and a focus on impartial (emphasis added) evidence-based medical advice are important elements in building a relationship of trust in which patients’ health problems and health and safety issues can be discussed constructively”, Faculty of Occupational Medicine, Good Occupational Medical Practice, Royal College of Physicians, London, 2010, available at http://www.fom.ac.uk/wp-content/uploads/p_gomp2010.pdf, p12.

106 There is also a legal duty to warn of the health risks to the worker from workplace hazards (see Stokes below).
interests of individual patients first (emphasis added). Thus a physician, learning of a health risk to a worker, has “a responsibility to protect the health of the employee, even if this is to the detriment of the employer”\(^\text{107}\). In the context of a health risk from work, this is entirely understandable. An example would be the case of Stokes\(^\text{108}\), where the OP failed to adequately warn management or the workforce of the risk of scrotal cancer from mineral oils, when the workers stayed in oil-drenched overalls for long periods. Stokes died from scrotal cancer, and the OP was found to be negligent for not warning and screening the workers (and the employer found to be vicariously liable). This failure to warn of such a recognised risk was clearly unacceptable, both legally\(^\text{109}\) and morally\(^\text{110}\). However, the duty to warn the workers did not arise out of any close relationship with any individual worker, but arguably arose more from one of the primary functions of an OP\(^\text{111}\)\(^\text{112}\).

Such cases are fortunately rare, and likely to become even more so in the UK with its diminishing manufacturing base. Service industries are much more prevalent, and workplace stress and musculoskeletal problems have become the predominant occupational illnesses. These are often more multifactorial, although a significant proportion will be caused or aggravated by work, and it remains an OP’s responsibility to advise on such matters. But what

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\(^{107}\) Faculty of Occupational Medicine, *Guidance on ethics for occupational physicians*, 6\(^{th}\) edition, Royal College of Physicians, London, 2006, p4. The current 7\(^{th}\) edition (2012) does not make this statement. Instead it states: “Where a worker is in employment the occupational health professional owes a duty to take reasonable care to take reasonable care to protect him against risks to his physical or mental health. This may involve advising the worker about hazards or advising the employer about necessary health and safety precautions”, at p55. In terms of health risks arising out of work, I prefer the statement in the 6\(^{th}\) edition.

\(^{108}\) *Stokes v GKN (Nuts and Bolts) Ltd* [1968] 1 WLR 1776.

\(^{109}\) For example, the trial judge found that the factory doctor should have given “appropriate warnings” (see below).

\(^{110}\) For example, based on the principle of beneficence, which requires agents to “take positive steps to help others”: Beauchamp TL and Childress JF, *Principles of Biomedical Ethics* [5\(^{th}\) Edition], Oxford University Press, New York, 2001, p165.


\(^{112}\) The trial judge, Swanwick J, found that Dr Lloyd, the factory doctor, should have given appropriate warnings and instituted periodic medical examinations, which would be standard OP functions.
does “putting the interests of individual patients first” actually mean in such cases? The employer may argue with some justification that it is the role of the GP to put the interests of his patient first, and not the OP. This is because in the UK, the employer pays for the advice from the OP, and if it were to be no different to that received from the worker’s GP, the employer may then question the value of paying for an OP’s advice at all. An example would be where a worker suffers from work-related stress, which he alleges is caused by his manager bullying him. A report from his GP, if one were obtained in these circumstances, could possibly be biased towards his patient, and could even be critical of the employer. This is not surprising, as the GP is expected to put his patient first, and would also usually have only one side of the story. However, there may be other factors that are relevant, such as feedback on poor performance or competence by the manager to the worker prior to the alleged bullying. The OP should not be judge or jury, but at least would have a more balanced account of the situation, and be able to recommend more objective approaches, such as the use of stress risk assessments or workplace mediation. If the OP were also simply to “put the patient first” in such circumstances, which occur much more often than those in Stokes, there is a risk that UK employers would largely cease to fund OH services, given that only a small proportion of OH work is legally required.

From a relationship perspective, a worker may be somewhat disappointed that the OP is not “taking his side”, and may also mistrust the OP. The latter should explain the impartial nature

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113 That is, cases such as work-related stress, where the causative factor(s) may not be as clear as the link between mineral oils and scrotal cancer.

114 On the other hand, the OP should remain unbiased, so there will be cases where the employer will not welcome the OP advice. However, the OP should be able to show that he has taken available evidence into account, and try to be as objective as possible. Hopefully more enlightened employers will realise this, but some employers may decide to change OH providers if they feel that they do not receive the advice they want from the OP.


116 One of the consequences would be that less OH would then be available to UK workers, arguably to their detriment, as they would have even less access to expert advice and diagnosis for work-related conditions.
of his role at the outset of the consultation (and even before this, as it is good practice to send
an explanation of the role of the OH service with the appointment letter).

Whether the normal DPR is in fact a fiduciary relationship or not, the importance of trust, and
the power imbalance, in that relationship is very evident. It is not suggested that in this third
model, which describes the majority of OPW interactions, trust or power imbalance play no
part. Rather, it is likely that the nature and extent of any trust and power imbalance are different.
As O’Neill points out, we can trust individuals in some matters but not others\textsuperscript{117}, or to different
extents. For example, in the DPR, patients should be able to “trust doctors with their lives and
health”\textsuperscript{118}. This level of trust is not required from workers in their OP, for the normal OH
consultation. Indeed, it would be rather incongruous if that were the case. On the other hand,
one would hope for some level of trust in the OP, for example of his competence at evaluating
health and work issues (although some workers challenge this when the assessment results are
not to their liking), and of his honesty and integrity (although this trust becomes less evident
when increasing emphasis is placed on written consent(s), and a worker reading the report
before its issue). Similarly, in the normal DPR it is argued that the power imbalance\textsuperscript{119} arises
partly from the patient being ill and more vulnerable than he would otherwise be, and partly
from the doctor’s power. In the OPW situation, the worker is most often not ill, but may still
be more vulnerable through lack of expert knowledge\textsuperscript{120}, which the OP will have. However,
there are also situations where the power imbalance shifts in the opposite direction, for
example, where some workers attend with their union representatives who can be very
knowledgeable on the relevant issues, or be coercive (such as threatening to refer the OP to the
GMC) if the favourable outcome were not obtained for their member. Although such situations

\textsuperscript{117} O’Neill O, \textit{A Question of Trust, The BBC Reith Lectures 2002}, Cambridge University Press, 2002, where at
p9 she gives the following examples: “I might trust a schoolteacher to teach my child arithmetic but not
citizenship… I might trust my bank with my current account, but not my life savings.”

\textsuperscript{118} GMC, \textit{Good Medical Practice}, London, 2013 (before p1, on the inside of the front cover).

\textsuperscript{119} See references above in section 2.1.2, including Kennedy (1996), Grubb (1994) and Brody (1992).

\textsuperscript{120} In addition, the worker may have concerns regarding his employment and financial security.
are rare, these are mentioned here to illustrate why the power imbalance might not always be as one imagined it to be\textsuperscript{121}.

If in the DPR, trust and power imbalance are of central importance in the analysis of that relationship, then it is suggested that in this third model, the emphasis should be on the *impartiality* of the OP. This need for the OP to be impartial can create tensions with both the worker and the employer (and other stakeholders, such as “the public”\textsuperscript{122}).

This section is intended to be a brief outline of the current practice of OM in the UK, and further analysis and discussion of the issues raised will be carried out in later chapters\textsuperscript{123}. The chapter as a whole is intended to serve as a starting point for analysing the major themes of this thesis, namely the DPR, confidentiality and consent in OM practice. However, before each of these themes is reviewed in the OM settings, they are first explored in the therapeutic ones. By using this approach, I aim to identify the underlying ethico-legal justifications that are made when these issues are considered in therapeutic settings, and later assess whether the same justifications remain coherent in the context of OM practice\textsuperscript{124}.

\textsuperscript{121} It is accepted that even in the DPR, a GP may occasionally feel threatened by his patient, and prescribe some medication or write a certificate, against his better judgment.

\textsuperscript{122} For example, in public safety scenarios, such as passengers and other members of the public, when a train driver suffers from seizures or loss of awareness, and does not want this to be disclosed by the OP.

\textsuperscript{123} In particular, the DPR and whether it is a fiduciary one will be explored further in chapters 3 and 4 (at 3.1, 3.3 and 4.1); the basis for medical confidentiality is analysed in section 4.2 and my third paper at chapter8; and consent for information disclosure is the subject of my second paper, at chapter 7, and I discuss the relevance of having a different concept for consent for the disclosure of an OM report in my conclusions at 9.2.2.

\textsuperscript{124} Chapters 3 and 4 will first describe my philosophical and legal approaches respectively to these issues, and chapters 6, 7 and 8 are my published articles, where I carry out the in-depth analyses.
Chapter 3

PHILOSOPHICAL APPROACH

Gillon describes philosophical medical ethics as “the analytic activity in which the concepts, assumptions, beliefs, attitudes, emotions, reasons and arguments underlying medicomoral decision making are examined critically”\(^1\). My aim in this chapter is to critically examine the assumptions and arguments used in justifying the importance of the DPR in medical practice, in particular the role of trust in that relationship. I will then consider the question whether the DPR is a fiduciary one, from an ethical perspective in this chapter, and from a legal perspective in the next.

3.1. The doctor-patient relationship

“The physician-patient relationship is the cornerstone of medical practice and therefore of medical ethics.”\(^2\) There is as yet no ethical analysis of the nature of the DPR or, more accurately, the OP-worker (OPW) relationship, in OM practice. I will first describe the “normal” DPR in this chapter, which will later help in the analysis of the relationship in the OPW context\(^3\).

The important contribution of the “normal” DPR to medical ethics is highlighted by Brody\(^4\), who suggests that “the usefulness for the physician-patient relationship as an entry point into

\(^3\) This forms the basis of my first paper, at chapter 6.
the domain of medical ethics is supported by the now-voluminous literature on the subject”5. However, it is only sixty years ago that Szasz and Hollender6 commented that “the concept of a relationship is a novel one7 in medicine”8. They described the situation hitherto9 as being one where doctors had been more concerned with things, such as anatomical structures, lesions or bacteria, rather than relationships. The doctor patient encounter was viewed as an opportunity for doctors to do the right thing for the patient, and the latter was assumed to be entirely passive. This paternalistic approach was reflected in the first of the three possible models of the DPR that they proposed, namely the “activity-passivity” (or parent-infant) one. Their other two models were described as “guidance-cooperation” (parent-adolescent), and “mutual participation” (adult-adult) models. The authors stressed that they did not consider any of the models to be inherently better than the other, offering instead a contextual approach. They viewed “each of the three types of therapeutic relationship (to be) entirely appropriate under certain circumstances and each (being) inappropriate under others”10. On the other hand, although they had put these models forward, they did consider the model of mutual participation to be “essentially foreign to medicine”11 (at that time at least), this relationship requiring as it did, “elements often associated with the notions of friendship and partnership”12. I think there is much merit in the approach they suggested, and in my view, adopting a contextual approach in determining which model is appropriate at a given time would apply even today. Some of their comments are clearly a reflection of the prevalent approach to doctor-patient interactions some sixty years ago. For example, the approach of doctors working “in
partnership with patients”\textsuperscript{13} is now considered essential to practising good medicine, whereas it was a notion “foreign to medicine”\textsuperscript{14} when Szasz and Hollender proposed their models. More recently, Emanuel and Emanuel\textsuperscript{15} outlined four different models\textsuperscript{16} of the DPR, namely: *paternalistic, informative, interpretive, and deliberative*, but did not consider this list to be exhaustive. Their analysis focused on the doctor’s role and obligations, the patient’s values, and the conception of patient autonomy, in each of these models. In the paternalistic model, the doctor is described as being the patient’s “guardian”, and as such has an obligation to place the patient’s interest above his own. In the informative model, the patient’s values are assumed to be known, and may be fixed, and the doctor is the “technical expert” providing the necessary information to the patient. The main obligation on the doctor here is to provide truthful information. In the interpretive model, the main aim of the DPR is to elucidate the patient’s values, and the doctor is described as a “counsellor or adviser”\textsuperscript{17}. The doctor’s role here is to help the patient develop self-understanding relevant to healthcare. In the deliberative model, the doctor is said to act as a “teacher or friend”, with obligations to “articulate and persuade the patient of the most admirable values, as well as inform the patient and implement the patient’s selected intervention”\textsuperscript{18}. The deliberative model was their preferred choice, as it “more nearly embodied their ideal of autonomy”\textsuperscript{19}. However, there is a conception of patient autonomy in each of the models, albeit only rudimentary in the paternalistic model, being limited to the patient “assenting to objective values”. It is also interesting to note that whereas Szasz and Hollender seemed to distance themselves from the notion of the doctor being a *friend*.  

\textsuperscript{13} GMC, *Good Medical Practice*, 2013, para 2.  
\textsuperscript{14} Ibid, p588.  
\textsuperscript{15} Emanuel EJ and Emanuel LL, Four models of the Physician-Patient Relationship, *JAMA*, 1992, 267, 2221-6.  
\textsuperscript{16} Emanuel and Emanuel (1992), a table comparing the four models is at p 2222.  
\textsuperscript{17} At p2222.  
\textsuperscript{18} At p2222.  
\textsuperscript{19} At p2226.
to the patient, Emanuel and Emanuel were comfortable with such a friendship being a key feature of their preferred model. Downie and Calman also list “friend” as one of the roles a health care professional might adopt, in a list that also included healer, technician, counsellor and educator. Veatch, who supports a “contractual model”, has also analysed whether the “friend/physician” model of the DPR is the one that should be normative for medical practice. He suggested that “both the Hippocratic and the contract theories of medical ethics are compatible with the friend/physician model of health care.”

The notion of friendship as the basis for such a relationship may be somewhat unexpected, given the closeness and intimacy it suggests, although admittedly it is not included in all the models proposed by various authors. However, the fact that it is even considered suggests that in the therapeutic DPR, some closeness between the two parties probably does exist. I highlight this close relationship to contrast it with the situation in the independent expert OM model, where I have pointed out that the two parties are quite distant from each other.

3.2. Trust

Whereas friendship might only be present in some of the relationships, trust, on the other hand, has been said to be intrinsic to the DPR, and one may expect some degree of trust to operate in the OM context as well. In the therapeutic arena, the central importance of trust is especially

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21 See for example Veatch RM, Models for Ethical Medicine in a Revolutionary Age, Hastings Center Report, 2, 1972, p5-7.
23 At p195. However, he concluded that the “stranger/physician” model in reality occurred more often, at least in the American system of health care delivery.
24 However, even in the therapeutic contexts, not all DPRs are equally “close”. For example, one would expect a patient to feel closer to a GP with whom he has a long term relationship, as opposed to an emergency department doctor he sees on only one occasion.
25 See previously at section 2.2.1. (b). I described this as a “remote” interaction, both in terms of the context and often, geographically.
26 Although it will later be argued in chapter 6 that the same level of trust is not required in the independent expert OM model.
evident in the “mutuality models”\textsuperscript{27}: “in all these models, trust looms large- indeed, is intrinsic to them. They reflect the essence of those more intimate relationships and friendships we have in other parts of our lives”\textsuperscript{28}. Moreover, O’Neill has described the DPR as a “paradigm of a relationship of trust…It is a professional relationship that is supposed to be disinterested, long-lasting, intimate and trusting”\textsuperscript{29}.

Similarly, Brazier and Lobjoit have commented: “It is trite to describe the health professional’s relationship with his or her patient as a relationship of trust yet the description encapsulates the very heart of the relationship. Patients trust doctors, nurses and other health professionals with intimate details of their lives which they may even conceal from their families”\textsuperscript{30}. I agree with their comments, and it is important to note that trust is \textit{at the very heart} of a therapeutic DPR, as I will later argue that this is not necessarily the case in the OPW relationship\textsuperscript{31}.

Rogers and Braunack-Mayer have claimed that “no other speciality has embraced the doctor-patient relationship as a defining feature in the way of general practice”\textsuperscript{32}. This appears to be a reasonable claim, given that a general practitioner (GP) will usually develop this relationship with his patient over time, in different encounters and in many varying situations. They “belief(d) that trust is a central and crucial ethical value in the GP-patient relationship as, without trust, we cannot seek or provide healthcare”\textsuperscript{33}. They further elaborated that in the GP-patient context, “trust in one area need not extend to trust in other areas. A patient may trust the goodwill of their GP in terms of confidentiality, affability, honesty and the like, but may

\textsuperscript{27} Which include Szasz and Hollender’s (1956) mutual participatory model and Emanuel and Emanuel’s (1992) deliberative model.


\textsuperscript{31} In my first paper, chapter 6.


\textsuperscript{33} As above, at p29.
not trust their competence in some clinical areas.”\(^{34}\) Likewise, O’Neill felt that she “might trust (her) GP to diagnose and prescribe for a sore throat, but not for a heart attack.” On the other hand, she later said that “nurses and GPs are more trusted than hospital consultants”\(^{35}\).

However, in light of her earlier, and Rogers and Braunack-Mayer’s comments, the levels of trust are likely to be different dependent on what the trust was required for, such as whether it was for a competent and complex diagnosis from a hospital consultant, or for a sympathetic ear from a GP or nurse. O’Neill pointed out that polls (which she seems to be wary of\(^ {36}\)) show that doctors and judges are far more trusted than politicians and ministers, and the least trusted being journalists\(^ {37}\). A recent poll commissioned by the BMA also confirms that the public trusts doctors far more than politicians\(^ {38}\).

De Zulueta, as mentioned previously, commented that trust is intrinsic to all the mutuality models, and concluded that the DPR “that is most conducive to trust is one of mutual engagement and respect. The relationship most inimical to trust is the one whereby individuals are treated instrumentally”\(^ {39}\). This may be rather counter-intuitive, as at first sight at least, one might think that more trust would be required in a paternalistic model, as a less dependent patient might be less reliant on needing to trust his doctor. As O’Neill put it, DPRs “were viewed as relationships of trust only because a paternalistic view of medicine was assumed, in which dependence of patients on professionals was generally accepted”\(^ {40}\). However, although

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\(^{34}\) As above, at p31.


\(^{36}\) She comments for example that “The pollsters ask carefully controlled cross-sections of the public whether they trust certain professions or office-holders. The questions aren’t easy.”, at p9, and later notes that “We depend on journalists for our knowledge of the results of these polls and the levels of reported public trust. There is some irony in this, since these polls repeatedly show that no profession is less trusted in the UK than journalism”, at p10.

\(^{37}\) As above, at p10.

\(^{38}\) Munn F, *Public declares doctors the most trusted professionals*, BMA News Review, 2 July 2011, p2. In this MORI poll, 88% believed doctors would tell the truth, compared with only 15% trusting politicians.


she stressed the tension between trust and autonomy in this way, she also made reference to those who believe that trust and patient autonomy can be properly combined in the right conditions, such as in a scenario where “the patient too is a professional, dressed in a suit and sitting like an equal at the desk” (metaphorically speaking, I would think); that is, a “relationship between equals”. This appears to be similar to de Zulueta’s view. On the other hand, although autonomy is defined and described in many ways, it has as its focus, the individual. In his analysis of autonomy, Tauber admitted that “a deep tension between “autonomy” and “relationship” is not easily overcome”. The solution he offered was to define autonomy in a relational construct, and suggested that “relational autonomy then becomes a more complete, and honest, depiction of the doctor-patient relationship, because it more accurately describes the agency of each party”.

Patient trust also appears to be the salient feature of the DPR on which the regulatory authorities, in the UK at least, base their ethical guidance to doctors: “Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and you must… make the care of your patient your first concern…” (followed by the remaining list of duties). In the same vein, the American Medical Association (AMA) Code of ethics states: “the relationship between patient and physician is based on trust and gives rise to physicians’ ethical obligations to place patients’ welfare above their own self-interest and above obligations to other groups, and to advocate for their patients’ welfare.”

Although there may be different degrees of trust involved in different contexts, and trust may be situation- or condition-specific (such as the diagnosis of a sore throat rather than of a heart

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41 The tension between trust and autonomy is only briefly mentioned here, but it is discussed more fully in my first paper (chapter 6).
42 Tauber AI, Patient autonomy and the ethics of responsibility, MIT Press, 2005, p120.
43 As above, at p122.
attack), I agree with many commentators and the regulators that trust is an essential component of the normal DPR. In the context of my thesis, it is important that trust is central to the DPR for two reasons. Firstly, I will later contrast this level of trust with that in the OP-worker interaction\(^ {46}\). Secondly, trust is an essential requirement\(^ {47}\) of a fiduciary relationship, and the relevance of fiduciary relationships to my arguments will be highlighted later\(^ {48}\).

3.3. Is the DPR a fiduciary relationship?

A fiduciary relationship imposes certain duties on the fiduciary or trustee, because of the vulnerability of the beneficiary to the fiduciary, and the power imbalance between the two parties. Fiduciary comes from the Latin *fidere* meaning, "to trust", and refers to “a person or company that is in a position of trust, especially when it involves controlling money or property belonging to others”\(^ {49}\).

As I have mentioned in the previous section, a relationship of trust “encapsulates the very heart of the (DPR)”\(^ {50}\). Brazier and Lobjoit further propose that a “therapeutic alliance” between doctors and patients would be “best represented by developing the concept of the fiduciary relationship between patient and professional”\(^ {51}\). They suggest that recognizing the fiduciary nature of that relationship would have several benefits for healthcare\(^ {52}\):

(i) Partnership will be placed at the centre of the agenda between the parties to the relationship.

\(^{46}\) For example at chapter 6, footnote 53.
\(^{47}\) But not the only one, as will be described in the next section.
\(^{48}\) Later in this chapter, at section 3.4.
\(^{49}\) From the Oxford Advanced Learner’s Dictionary Online.
\(^{50}\) Brazier and Lobjoit (1999), p187.
\(^{51}\) Ibid, p180.
\(^{52}\) Generally, as well as in the context of HIV screening, which was the topic of their paper.
Within a partnership the focus shifts from patients in general to that particular patient with whom partnership is forged.

Recognition can be given to the fact that both partners have responsibilities as well as rights. Reciprocity of obligations can be given real meaning.

Establishing the parameters of the partnership between individual patients and professionals allows society to make a better-informed and more reflective judgment on when, if at all, obligations derived from that partnership may be overridden by obligations owed to society.\(^\text{53}\)

I believe that Brazier and Lobjoit present quite well thought out arguments in support of their proposal of a fiduciary relationship between doctors and patients\(^\text{54}\). This approach also provides a good conceptual framework for “doctors working with patients”\(^\text{55}\), as it encourages partnership, reciprocal obligations and openness. I find their arguments to be quite persuasive, and I agree with their reasons for this conceptual approach. Indeed, I will henceforth assume the therapeutic DPR is indeed a fiduciary one in this thesis.

Furthermore, Beauchamp and Childress assert that “the patient-physician relationship is founded on trust and confidence; and the physician is therefore necessarily a trustee\(^\text{56}\) for the patient’s medical welfare.”\(^\text{57}\) However, although a fiduciary relationship requires trust as a necessary condition of that relationship, a power imbalance is also required. This power imbalance is arguably present in the DPR, and Kennedy\(^\text{58}\) has even described this as a “principal feature” of this relationship:

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\(^{53}\) Ibid, p180.

\(^{54}\) It is to be noted that the aim of my thesis is to explore the OP-worker relationship in OM practice, rather than the therapeutic DPR. Nonetheless, there are good reasons for me to fully explore the DPR first, and I will explain why it is important for my arguments that I establish the fiduciary nature of the therapeutic DPR in section 3.4.

\(^{55}\) See for example, GMC, Good Medical Practice (2013), para 49.

\(^{56}\) Emphasis added.


“The doctor-patient relationship has special, perhaps unique, features. Principal among these is the very significant disequilibrium of power between the two parties. The patient is uniquely vulnerable, being not only ignorant of the expertise constituted by the practice of medicine but also, in most cases, ill and anxious or anxious about possibly being ill. By contrast, the doctor has expert knowledge.”59

Similarly, Grubb60 describes this power imbalance thus:

“The patient is in a position of vulnerability: he is both trusting and in need of help. An asymmetry in the relationship exists which stems from the imbalance in knowledge and power vested in the doctor through his training and his position as the patient’s doctor”61.

Brody62 has drawn particular attention to the importance of the doctor’s power in the therapeutic relationship, and suggested that this power could be broken down63 to Aesculapian power (deriving from the medical knowledge and skills), social power (doctors generally coming from socially and educationally privileged backgrounds), and charismatic power (he postulated that many drawn to medicine would have this).

Brody also summarised the doctor’s obligations to the patient using the following formulation: lucidity, autonomy, fidelity and humanity64. In terms of fidelity, he viewed the doctor’s obligation as a requirement “to act in a trustworthy fiduciary manner and to view himself as the patient’s agent in healthcare matters.” He suggested that the doctor would not be able to share social or charismatic power with the patient, but could share Aesculapian power by better informing the patient about disease and treatment, and adhering to the obligations of lucidity and autonomy.

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59 As above, at p111.
61 As above, at p314.
63 Ibid, p62.
64 Ibid, p45.
On the other hand, it is possible that at times this power imbalance could be overstated: “it is too easy a step to define all clients as vulnerable and all therapists as powerful and then conclude that any relationship between the two is necessarily dysfunctional.” Although this was said in the context of doctors or therapists abusing their power, it is possible that the emphasis on patient autonomy and patient choice, and the greater availability of medical information on the internet, have all reduced this power imbalance to a degree.

Nevertheless, as Kennedy has argued, illness or anxiety about possibly being ill, is in itself disempowering, as it leaves the patient in a vulnerable position, especially compared with the doctor’s Aesculapian (and possibly social and charismatic) sources of power, as described by Brody.

Given this power imbalance, one would expect a fiduciary relationship to impose certain obligations on the fiduciary. The Law Commission maintains that the nature of the duties arising from these obligations is reasonably clear, and the duties can be summarised as follows:

1. The “no conflict” rule: A fiduciary must not place himself in a position where his own interest conflicts with that of his customer, the beneficiary;
2. The “no profit” rule: A fiduciary must not profit from his position at the expense of his customer, the beneficiary;
3. The “undivided loyalty” rule: A fiduciary owes undivided loyalty to his customer, the beneficiary;

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4. The “duty of confidentiality”: A fiduciary must use information obtained in confidence from his customer, the beneficiary, for the benefit of the customer and must not use it for his own advantage or for the benefit of any other person.\(^{68}\)

A patient may not usually consider himself to be a doctor’s customer, except maybe where there is a contractual relationship, either as suggested by Veatch\(^{69}\) or as a private patient, but he is in a sense the beneficiary of the doctor’s expertise, or as Bartlett\(^{70}\) suggested, the “vulnerable party”. Bartlett does point out that there is a risk that fiduciary duties would be viewed through the paradigm of trusts of property and that paradigm should not be overstated. He suggested that in terms of the scope of fiduciary duties, there were “four central principles”\(^{71}\) which he considered to be core values, and he based these on the Law Commission formulation above:

1. Fiduciaries must avoid conflicts of interest, or indeed even possible conflicts of interest, with the vulnerable party;
2. Fiduciaries must not profit from their position without prior disclosure to and authorisation from the vulnerable party;
3. The fiduciary owes a duty of undivided loyalty to the vulnerable party;
4. The fiduciary owes a duty of confidentiality to the vulnerable party

Given that doctors must “make the care of their patient their first concern”\(^{72}\), and “place patients’ welfare above their own self-interest”\(^{73}\), then we might expect there to be no conflicts of interest to arise in the DPR. This is probably what doctors, and maybe patients, would like

\(^{68}\) Para 2.4.9.

\(^{69}\) Veatch RM, Models for Ethical Medicine in a Revolutionary Age, Hastings Center Report, 2, 1972.


\(^{71}\) As above, at p198.


to believe. However, Bartlett himself described situations where conflicts of interest might arise\textsuperscript{74}, in a more financially driven UK National Health Service. For example, a GP who is financially incentivised to reach vaccination targets\textsuperscript{75}, could find himself in having to choose between what is good for himself (payment) and what is good for the patient (informed consent, autonomy, “best” or most appropriate treatment). Similar concerns have been voiced in the US where a conflict may arise because doctors may be paid more if they perform certain investigations or procedures, which may not be entirely necessary, and therefore not in the patient’s best interest.\textsuperscript{76}

Although there are instances where the other “central principles” might also be breached in the DPR context\textsuperscript{77}, in my view these rules or principles do apply to therapeutic doctor-patient encounters. For example, I believe that a GP would find no problems complying with the four obligations, namely not to have a conflict of interest, not to profit from his position, to maintain his patient’s confidence and to give his patient his undivided loyalty\textsuperscript{78}.

### 3.4. Conclusions

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\textsuperscript{74} Bartlett (1997), p193-224, at 219-223.

\textsuperscript{75} See for example, BMA, \textit{Focus on vaccines and immunisations, Guidance for GPs}, June 2014: “Should a practice for whatever reason feel unable to provide these additional services a percentage of the global sum will be extracted from the practice’s global sum. For vaccines and immunisations this will be a 2% reduction and for childhood immunisations and pre-school boosters there will be a 1% reduction”. The “additional services” included “catch up MMR immunisations”. Rogers WA and Braunack-Mayer AJ, \textit{Practical Ethics for General Practice}, 2\textsuperscript{nd} edition, Oxford University Press, 2009, mention other examples of financial incentives that could give rise to possible conflicts of interest, such as GP practices who “receive benefits from their contact with a pharmaceutical company” or “receive fees for enrolling patients in a clinical trial”, at p190. Another example would be the recent claim that GPs “are being paid to cut referrals to hospitals”, see \url{http://www.bbc.co.uk/news/health-34421115}. Although the Clinical Commissioning Group involved said they had evaluated the implications carefully, and that there was no conflict of interest, I believe that there is still a possibility that patient confidence in their GPs could be undermined by such incentivisations.

\textsuperscript{76} See for example: Rodwin MA, \textit{Medicine, money and morals, Physicians’ conflicts of interest}, Oxford University Press, 1993.

\textsuperscript{77} For example, breaches of confidentiality “in the public interest”.

\textsuperscript{78} As mentioned above, there could be breaches of these obligations, for example if a third party might be harmed from the GP complying with these duties. However, these instances would be rare, and for the most part, adherence to the fiduciary duties does not present a problem for the GP.
My philosophical approach has been, as Gillon put it, to critically examine concepts, assumptions and arguments in medicomoral thinking\textsuperscript{79}. In particular, I have examined the DPR, and trust which is at the core of the DPR. Both these concepts are important to my thesis, because although my interest is in the relationship(s) in OM, it is useful to understand the basis of the DPR in “normal” operation first, in order to highlight any differences between the relationships in OM and therapeutic practice later\textsuperscript{80}. It is also important for me to establish that the therapeutic relationship is fiduciary, as I will later argue that the obligations that arise from a fiduciary relationship are not compatible with certain OP-worker situations\textsuperscript{81}. However, there are some objections to the view that the DPR is a fiduciary one, and as they arise from the English courts and an academic lawyer, these will be reviewed in the next chapter.

\textsuperscript{79} Gillon (1985), p2, although Gillon said “decision making” rather than “thinking”.
\textsuperscript{80} In chapter 6 in particular.
\textsuperscript{81} The “independent expert” situation, see chapter 6.
Chapter 4

LEGAL APPROACH

Although the main aim of this thesis is to clarify the moral obligations of OPs, “medicine must operate within broadly stated legal rules”\(^1\). Jackson goes further than this, and reminds us that when the law and ethics are in conflict, compliance (with the law) is “not optional”\(^2\). A recent publication “aims to shed light on the question of who should define what constitutes ethical, and thus lawful\(^3\), medical practice- judges, the legislature, doctors, scientists or someone else?”\(^4\) The aim of this chapter is much more modest. It aims to make use of legal sources to clarify the ethical questions around the DPR and confidentiality where possible.

This chapter explores the following questions from a legal perspective:

(i) Is the therapeutic DPR a fiduciary one? In the previous chapter, it was seen that there are good ethical arguments why it should be. In the first part of this chapter, the legal arguments both for and against the doctor being a fiduciary will be examined in order to answer this question.

(ii) What does an obligation of confidence mean in OM practice? The moral justifications for medical confidentiality have previously been mentioned\(^5\). In the second part of this chapter, the legal justifications for maintaining medical confidence will be reviewed. In particular, the approach I will take in this analysis

\(^3\) However, it could be argued that what is ethical is not always lawful, and *vice versa*, given that there are some examples of conflict between ethics and the law. See for example Jackson (2015) at p96.
will be to compare the legal and moral arguments used to justify this obligation in the therapeutic context, in order to detect any discrepancies between the two sets of arguments, if there are any. This is because I will later argue that ethical guidance and the law give conflicting accounts of what an OP should do in disclosing an OM report. One possible explanation for these conflicting requirements could be that they arise from some intrinsic difference in the moral and legal reasoning that underpins medical confidentiality. This possibility will therefore be explored in the second section.

4.1. A fiduciary relationship?

In the UK, the main objections to a fiduciary basis to the DPR have come from a legal perspective. It is therefore useful to see how the courts have approached this issue, and to assess whether such objections could inform our view of the DPR when looked at from a moral perspective. However, when describing the DPR, Mason and Laurie bemoan the intrusion of the law, and believe it has subtly influenced the relationship. They point out that “trust and respect are more likely to flourish in (a relationship) which is governed by morality rather than by legal rules…”

Nevertheless, taking account of the law is important, both for individuals and for professional bodies. In England, the legal position is currently that the DPR is not a fiduciary one. This

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6 In chapter 8.
was “set in stone”\(^8\) in 1985 by the House of Lords in \textit{Sidaway}\(^9\). Lord Scarman was the only one to address the fiduciary argument, and he stated:

“…in an attempt to persuade your Lordships that the relationship between a doctor and patient is of a fiduciary character entitling a patient to equitable relief in the event of a breach of fiduciary duty. The attempt fails: there is no comparison to be made between the relationship of doctor and patient with that of solicitor and client, trustee and cestui qui trust or the other relationships treated in equity as of a fiduciary character.

Nevertheless the relationship of doctor and patient is a very special one, the patient putting his health and his life in the doctor’s hands.”\(^10\)

This is in direct contrast to the situation in North America. In the 1992 Canadian Supreme Court case of \textit{Norberg}\(^11\), where McLachlin J delivered the “seminal judgment on the doctor as a fiduciary”\(^12\), and said the following:

“The doctor-patient relationship can be conceptualized as a creature of contract or tort but its most fundamental characteristic, rooted in the trust inherent in the relationship, is its fiduciary nature”\(^13\).

She then went on to explain her reasons for affirming the fiduciary nature of this relationship:

“A fiduciary relationship is marked by the following characteristics:

(1) the fiduciary has scope for the exercise of some discretion or power; (2) the fiduciary can unilaterally exercise that power or discretion so as to affect the beneficiary's legal or practical interests; and (3) the beneficiary is peculiarly vulnerable or at the mercy of the

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\(^9\) \textit{Sidaway v. Governors of the Bethlem Royal Hospital and Maudsley Hospital} [1985] UKHL 1, p8. Bartlett (1997) asserts that “the plaintiff patient’s argument was reduced to a summary dismissal by Lord Scarman” (p193) with this comment.

\(^10\) At 8.


\(^13\) At p6.
fiduciary holding the discretion or power. A physician owes his or her patient the classic duties associated with a fiduciary relationship -- "loyalty, good faith, and avoidance of conflict of duty and self-interest".\textsuperscript{14}

I think it is readily apparent that the doctor-patient relationship shares the peculiar hallmark of the fiduciary relationship - trust, the trust of a person with inferior power that another person who has assumed superior power and responsibility will exercise that power for his or her good and only for his or her good and in his or her best interests. Recognizing the fiduciary nature of the doctor-patient relationship provides the law with an analytic model by which physicians can be held to the high standards of dealing with their patients which the trust accorded them requires."\textsuperscript{15}

McLachlin J therefore stressed the inherent trust in the DPR, as well as vulnerability of the beneficiary (patient) and the power imbalance, and has explained in detail her reasons for stressing the fiduciary nature of that relationship. On the other hand, Lord Scarman did not expand on his reasons for finding that the DPR, “although a very special one”, could not be fiduciary in nature. One might speculate that he viewed fiduciary obligations in terms of narrow equitable considerations (he used the phrase “other relationships treated in equity”). Similarly when \textit{Sidaway} was considered in the Court of Appeal\textsuperscript{16}, Browne-Wilkinson LJ restricted the notion of the doctor as a fiduciary to situations where the doctor would abuse his position of trust to make a personal profit from it\textsuperscript{17}. However, neither argument helps our understanding of why the DPR should not be a fiduciary one\textsuperscript{18} in a wider sense, from an ethical perspective if not a legal one.

\textsuperscript{14} At p7.
\textsuperscript{15} At p153.
\textsuperscript{16} [1984] 1 All ER (CA).
\textsuperscript{17} At 1031-1032.
\textsuperscript{18} It is important for me to establish that a treating doctor \textit{is} a fiduciary. This is because I will later show that one of the fiduciary obligations that arise from that position is incompatible with the “independent expert” OP situation (in chapter 6), and this will be an important argument in one of the key areas of my thesis (that is, the DPR in OM practice).
In this regard, Kennedy is more helpful in that he does clearly articulate his objections to this proposition\textsuperscript{19}. His main objections\textsuperscript{20} include the following: firstly, he considers that the focus should be on patients’ rights rather than on doctor duties; and secondly, if the DPR were to be considered fiduciary one, it would entrench paternalism\textsuperscript{21} in English law. For example, he suggests that “the whole tenor of the doctor as fiduciary approach is to perpetuate the notion of the patient as victim…What the adoption of the fiduciary approach does, in fact, is to entrench the power imbalance, to make it part of the law”\textsuperscript{22}. His proposal for addressing the power imbalance would be for the courts (if it were left to them to do so) to develop the legal framework of the DPR within the mainstream of human rights law\textsuperscript{23}, but he concedes that more work would be needed for this to happen.

Although Kennedy considers MacLachlin J’s judgment in Norberg in detail, he presents no arguments why the DPR is not fiduciary in nature. His objections are based on the possible consequences\textsuperscript{24} of the adoption of the fiduciary principle for the DPR in English law, rather than presenting reasons why the DPR intrinsically could not be a fiduciary one. This contrasts markedly from MacLachlin J’s clear enunciation of the characteristics of a fiduciary relationship\textsuperscript{25}, which she then closely matched with the characteristics of the DPR\textsuperscript{26}. I found her line of argument to be very persuasive.

\textsuperscript{20} At p137-140.
\textsuperscript{21} Brazier and Lobjoit take a contrary view, as they believe that recognizing the fiduciary nature of this relationship would foster a partnership between doctor and patient, where “reciprocity of obligations can be given real meaning”, in Brazier M and Lobjoit M, Fiduciary Relationship: An Ethical Approach and a Legal Concept?, in Bennett R and Erin CA (Eds), HIV and AIDS testing: Screening and Confidentiality; Oxford University Press, 1999, p179-199, at p180.
\textsuperscript{22} At p139.
\textsuperscript{23} At p140; On the other hand Bartlett argues that “a paternalistic model would foster an image of the doctor at odds with patient rights, but it is less obvious that this creates problems of legal substance”, in Bartlett P, Doctors as fiduciaries: Equitable regulation of the doctor-patient relationship, Med Law Rev, 5, Summer 1997, p193-224, at p195.
\textsuperscript{24} For example, in addition to the objections listed above, he also argues that it would lead to doctors deciding the “best interests” of the patient, which he describes as “one of medical law’s most glaring weaknesses” (at p140).
\textsuperscript{26} Ibid, p153.
In summary, there are objections to the notion of the doctor as a fiduciary from a legal perspective. These arose out of Lord Scarman’s judgment in Sidaway\(^{27}\), and then were more clearly articulated by Kennedy\(^{28}\). However, a closer inspection of both sets of objections reveals no persuasive reasons for the DPR not to be considered fiduciary in nature. Lord Scarman did not expand on his statement why there should be “no comparison to be made between the relationship of doctor and patient with that of solicitor and client”\(^{29}\). This is the reason a doctor is not a fiduciary in English law, whereas he is in US and Canadian law\(^{30}\). In contrast, MacLachlin J’s analysis in the Canadian case of Norberg\(^{31}\) to support the fiduciary nature of the DPR from a legal perspective is well articulated and reasoned. Brazier and Lobjoit endorse the Canadian Supreme Court model of a doctor-patient fiduciary relationship\(^{32}\), and see as a way forward that the role of the courts would be “to create a mechanism through which the law can give full force to this relationship of trust”\(^{33}\).

Nonetheless, this “ideal” is not yet “clothed with legal reality”\(^{34}\) in England. However, in terms of legal and ethical arguments for or against, I believe that the balance comes strongly in favour of the notion of the doctor as a fiduciary, which is the position I will support throughout this thesis.

4.2. A duty of confidence?

\(^{27}\) Sidaway v. Governors of the Bethlem Royal Hospital and Maudsley Hospital [1985] UKHL 1 at p8.
\(^{28}\) Kennedy I, The fiduciary relationship and its application to doctors and patients, in Wrongs and Remedies in the twenty-first century, (Ed. Birks P), Oxford University Press, 1996, p111-140. However, as mentioned above, his objections seem to me to hinge more on his preference for a rights based approach to medical law, rather than offering any reasons why the DPR could or should not be a fiduciary one.
\(^{29}\) At 884.
\(^{30}\) As well as Australian law, to some extent.
\(^{32}\) Brazier and Lobjoit (1999), p199.
\(^{33}\) Ibid, p199.
\(^{34}\) Ibid, p191.
If the DPR is central to medical ethics\(^\text{35}\), and trust is central to the DPR\(^\text{36}\), then “confidentiality is central to trust between doctors and patients”\(^\text{37}\). So, what does confidentiality mean in the context of disclosing a medical report?

This thesis takes as its starting point, the ethical guidance by the GMC in relation to an OP disclosing his report to the commissioning party\(^\text{38}\). OPs also have to comply with the law of the land. I will later argue\(^\text{39}\) that the ethical and legal requirements in terms of disclosing an independently commissioned report are in fact in conflict. As I mentioned above\(^\text{40}\), where the two are in conflict, “compliance with the law is not optional”\(^\text{41}\). In a later chapter\(^\text{42}\) I review common law cases that specifically involve disclosure of OM reports, so there will be the opportunity to assess why and where the discordance arises in the OM context.

In this section, my approach will be first look at the moral justifications that underpin medical confidentiality in general. I will then review how the courts have justified the need for medical confidentiality, where such reasoning is evident. This is because it could be postulated that the aforementioned conflict (in the context of an independently commissioned report) is due to some inherent difference in the approaches that moral and legal argumentation take, leading to conflicting conclusions. In other words, I will review the arguments used by the courts to justify a requirement for medical confidentiality and compare these with the moral arguments used for the same purpose. In so doing, I hope to see whether the way the courts have justified medical confidentiality, especially in the context of disclosure of a report, can confirm or refute the hypothesis that there may be some *intrinsic* reason for the law and ethical guidance in this area to be in conflict.

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\(^{39}\) In chapter 8.

\(^{40}\) In the introduction to section 4.

\(^{41}\) Jackson (2015), p97.

\(^{42}\) In chapter 8.
I have previously referred to Beauchamp and Childress listing the moral justifications for medical confidentiality, namely consequence based arguments, the need to respect autonomy and privacy, and fidelity-based arguments. The consequentialist line of argument hinges on the assumption that patients would not disclose all their information if they did not trust their doctor to keep secrets, and this could affect the effectiveness of therapeutic endeavours. However, they maintain that “consequentialist arguments also support exceptions to the rule of confidentiality”, for example, to prevent third party harm. Their second line of arguments is based on respect for autonomy and privacy. They suggest that breaches of confidence “have often been viewed primarily as violations of privacy and autonomy”. The third line of reasoning stresses the doctor’s obligation of fidelity to the patient that they claim arises from the DPR. On that basis, they argue that “part of the binding force of confidentiality derives from the health care professional’s implicit or explicit promise to the person seeking help.”

Jackson gives a similar account of the moral justifications for medical confidentiality, describing these as duty-based arguments “which would emphasize the patient’s right to privacy, and her interest in controlling access to what will often be sensitive and personal information”; and the consequentialist argument that “high quality medical care depends upon patients being honest with their doctors.” She does not invoke fidelity based

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46 I agree with this premise, as it mirrors the duty of confidentiality that arises from conceptualising the doctor as fiduciary, as discussed in section 3.3. The duties of a fiduciary (including that of confidentiality) as derived from the Law Commission consultative document (1992) and amended for the DPR by Bartlett (1997) are listed there.
49 Ibid, p358.
arguments. However, there is general concordance from both sets of justifications why doctors should respect patient confidence. How well do legal justifications match these? Brazier and Cave remind us that “English law on breach of confidence developed haphazardly. The core obligation requiring doctors to respect patient confidence derives from the common law”\textsuperscript{50}. But nowadays, “any attempt to understand the law governing medical confidentiality must take into account a bewildering array of sources”.\textsuperscript{51} Nonetheless, I will confine my comparison of legal and moral argumentation to the common law.

In \textit{X v Y}\textsuperscript{52}, two doctors who were AIDS sufferers and continued to work as GPs, sought an injunction to prevent a newspaper from revealing their identities. These were obtained from their hospital records, and disclosed to the newspaper by an employee of the hospital. Although this was information from medical records, rather than a medical report, the justification for confidentiality as stated by Rose J, the trial judge, is instructive:

“In the long run, \textbf{preservation of confidentiality is the only way of securing public health}\textsuperscript{53}; otherwise doctors will be discredited as a source of education, for future individual patients 'will not come forward if doctors are going to squeal on them'.

Consequently, confidentiality is vital to secure public as well as private health, for unless those infected come forward they cannot be counselled and self-treatment does not provide the best care …”\textsuperscript{54}

I suggest that the justification for preserving confidentiality, namely “securing public health” because otherwise future patients will not go to doctors, reflects a consequentialist approach. This approach was cited with approval\textsuperscript{55} by the Court of Appeal in the leading case of \textit{W v}

\textsuperscript{50} Brazier M and Cave E, \textit{Medicine, patients and the law}, 5\textsuperscript{th} edition London, Penguin Books, 2011, p84.
\textsuperscript{51} Brazier and Cave (2011), p85. They point out that “in addition to case law, it is necessary to take into account of Articles 8 (right to privacy) and 10 (freedom of expression) of the European Convention on Human Rights, the Data Protection Act 1998, and voluminous guidance from the GMC and NHS.”
\textsuperscript{52} [1988] 2 All ER 648.
\textsuperscript{53} Emphasis added.
\textsuperscript{54} Ibid, at 653.
\textsuperscript{55} At 843.
Egdell\textsuperscript{56}. W was a psychiatric patient held in a secure unit for violent crimes, including several killings. He applied to a Mental Health Tribunal to be considered for transfer to a less secure unit, which would be a first step to his eventual release. To that end, W’s solicitors instructed Dr Egdell, an independent forensic psychiatrist, to assess his mental health and produce a report. However, Dr Egdell was concerned that W was more of a danger to the public than his treating doctors realised, and his report indicated this. When W’s solicitors received this report, they withdrew their appeal to the tribunal and did not disclose Dr Egdell’s report. When the latter learnt of this, he contacted the hospital authorities and sent them a copy of his report, as well as asking them to send a copy to the Secretary of State. W’s action for breach of confidence was dismissed, as Dr Egdell was held to have had an overriding duty to the public. However, the Court of Appeal did affirm that Dr Egdell owed W a duty of confidence. Their justification for a need to preserve medical confidence, which is the point of interest here, was again based on a consequentialist argument\textsuperscript{57}. However, a balance needed to be “struck between the public interest in maintaining professional confidences and the public interest in protecting the public against possible violence.”\textsuperscript{58}

In the case of Campbell\textsuperscript{59}, the issue was disclosure of her information about her health, rather than her medical records or a medical report\textsuperscript{60}. Campbell was a well-known fashion model, and a newspaper disclosed information about her drug addiction and attendance at Narcotics Anonymous. Lady Hale noted that

\textsuperscript{56} [1990] 1 All ER 835.

\textsuperscript{57} As stated above, by approving the justification for confidentiality in X v Y, “preservation of confidentiality is the only way to preserve public health”, in Egdell at 843.

\textsuperscript{58} Ibid, at 851.

\textsuperscript{59} Campbell v MGN [2004] UKHL 22.

\textsuperscript{60} Although Lady Hale points out that “But the information was of exactly the same kind as that which would be recorded by a doctor on those notes: the presenting problem was addiction to illegal drugs, the diagnosis was no doubt the same”, at 146.
“information about a person's health and treatment for ill-health is both private and confidential. This stems not only from the confidentiality of the doctor-patient relationship but from the nature of the information itself.”

Her justification for this was to be found in the following passage from the European Court of Human Rights case, *Z v Finland*:

"Respecting the confidentiality of health data is a vital principle in the legal systems of all the Contracting Parties to the Convention. It is crucial not only to respect the sense of privacy of a patient but also to preserve his or her confidence in the medical profession and in the health services in general. Without such protection, those in need of medical assistance may be deterred from revealing such information of a personal and intimate nature as may be necessary in order to receive appropriate treatment and, even, from seeking such assistance, thereby endangering their own health and, in the case of transmissible diseases, that of the community."

Thus once again, the justification for a need to protect confidence in health matters is a consequentialist one. In addition, in *Campbell*, Lord Hoffman asserted that an action for breach of confidence now has as its focus “the protection of human autonomy and dignity - the right to control the dissemination of information about one's private life and the right to the esteem and respect of other people”.

Therefore, there seems to be some good concordance between the reasons given for the courts to protect confidentiality with two of the moral justifications previously detailed.

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61 At 145.
63 *Z v Finland*, para 95, quoted by Lady Hale in *Campbell* at 145.
64 Emphasis added.
65 At 51.
66 Namely consequence-based arguments, and claims for a right to respect for privacy and autonomy, from Beauchamp and Childress (2001) and Jackson (2010) above.
On the other hand, as English courts have not adopted a fiduciary view of the DPR\textsuperscript{67}, it is not likely that they will have produced fidelity-based arguments\textsuperscript{68} to justify the need for medical confidentiality. Were English law to embrace the fiduciary approach to the DPR, then “consent and confidentiality cease to be separate concepts but are seen as inextricably linked within that fiduciary relationship”\textsuperscript{69}. In such a scenario, maintaining medical confidence would be justifiable in terms of the fidelity owed by the doctor to the patient\textsuperscript{70}.

In summary, a review of the arguments used by the courts to justify a requirement for medical confidentiality reveals no conflict with the moral arguments used for the same purpose. Indeed, they show good concordance with each other. The relevance of this finding in the context of my thesis, is that there appears to be no intrinsic reason for conflict between ethical and legal guidance on medical confidentiality. Therefore the conflict I will later highlight between ethical guidance and the law\textsuperscript{71} when applied to the disclosure of an independent OM report must be due to some other reason\textsuperscript{72}.

4.3. Conclusions

The primary focus of my thesis is “ethics and ethical guidance” for OPs. However, a review of the relevant law and legal arguments is important for at least two reasons. Firstly, OPs need to comply with the law\textsuperscript{73}. Secondly, I suggest that a review of legal arguments can help in clarifying what the ethical position should be. For example, in the first part of this chapter,

\textsuperscript{67} See previous section. However, some commentators argue that they should. For example, see Brazier and Lobjoit (1999): “We would argue that the time has come for the fiduciary principle to extend to the whole doctor-patient relationship…”, p199.
\textsuperscript{68} As per Beauchamp and Childress’s third category of justifications, as listed above.
\textsuperscript{69} Brazier and Lobjoit (1999), p187-188.
\textsuperscript{70} Indeed, such a duty of confidentiality is listed as one of the “four principles” in the Law Commission Consultation Document (1992) (section 3.3).
\textsuperscript{71} In chapter 8.
\textsuperscript{72} Which I will later discuss in chapter 8, and my conclusions (chapter 9).
\textsuperscript{73} This statement is not as trite as it may first seem, as I will later show in chapter 8 that ethical guidance to OPs on medical confidentiality conflicts with the law.
I reviewed the objections to the notion of the doctor as a fiduciary, which come from legal sources. I concluded that the arguments in favour of the doctor as a fiduciary outweighed those against\textsuperscript{74}. The approach I took in the second part of this chapter was to compare the legal and moral justifications for medical confidentiality, and found good agreement between these. Therefore the conflict between the law and ethical guidance with regards disclosing an independent report\textsuperscript{75} does not arise from some inherent difference in the legal and moral arguments that underpin the need to keep medical confidence\textsuperscript{76}.

\textsuperscript{74} This is relevant to the arguments in my first paper, in chapter 6.
\textsuperscript{75} See later, chapter 8.
\textsuperscript{76} I will argue in chapter 8 that the conflict arises from inconsistent ethical guidance in this area.
Chapter 5

OUTLINE OF SUBMITTED PAPERS

5.1. Is the doctor-patient relationship different in the normal therapeutic context compared with the OM one, from an ethical perspective? If so, what are the implications for OPs?

In order to address this question, in my first paper *Models of occupational medicine practice: an approach to understanding moral conflict in “dual obligation” doctors*, I start by considering the normal therapeutic DPR, as in chapter 3. Although different models of the DPR have been described, whatever the model, trust is of central importance in that relationship. A power imbalance between the two parties is also very evident in the DPR, and many authors have suggested that the DPR is a fiduciary one. The main objections to this proposition have come from the English Courts¹ and a law professor². These objections have been described in chapter 4, where I also explain that I find the arguments in favour of the doctor as a fiduciary more persuasive. So, as I view the normal DPR as a fiduciary one, I further suggest that it would be subject to the four principles listed by the Law Commission³, and amended by Bartlett⁴ for the DPR context. The practice of OM in the UK is briefly described, based on chapter 2, and the different types of OPW relationships are characterised in my proposed OM

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¹ Lord Scarman in *Sidaway v. Governors of the Bethlem Royal Hospital and Maudsley Hospital* [1985] UKLR 1.
models. These OM models are then used to explore to what extent trust, power imbalance and the fiduciary principles could be said to apply to each of the models, compared with the normal DPR. This highlights specific OM functions where the fiduciary principle of “undivided loyalty” to the patient would be in direct conflict with the need for “independence” in order for the OP to perform their function. This first paper therefore identifies this as a source of conflicting demands on OPs in the “independent expert” role\(^5\).

5.2. Is “consent” for the disclosure of health information different to “consent” for treatment or interventional research?

“Consent” in is the term currently used to describe the worker’s agreement for the OP report to be sent to the commissioning party. However, most of the moral argumentation that underpins consent\(^6\) relates to consent to treatment\(^7\). In my second paper, *Can informed consent apply to information disclosure? : Moral and practical implications*, I argue that using the term *consent*\(^8\) in both situations is misleading, in that the moral reasons for justifying the need for consent to treatment may not apply in the same way in the context of releasing a report\(^9\). This is especially important in the context of OM practice, as the OP’s report is the tangible output of most OM consultations. I therefore propose the phrase “permission to disclose” (PTD) in the information disclosure

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\(^5\) The independent expert role is required for IHR assessments.

\(^6\) For example, Gillon argues that it arises out of the principle of autonomy, in Gillon R, *Philosophical medical ethics*, John Wiley & sons, Chichester, 1985, at p113.

\(^7\) Failure to obtain consent to treatment could be actionable in law under the tort of battery (see for example Brazier M and Cave E, *Medicine, patients and the law*, 5th edition London, Penguin Books, 2011, p122, 5.3), whereas a failure to obtain consent to release a report would not.


\(^9\) For example, Professor Margot Brazier has suggested that the term *authorisation* may be more appropriate for the disclosure of a report (personal communication).
situations instead of “informed consent” (IC). I argue that PTD and IC aim to protect different interests (privacy rather than autonomy respectively), as well as having some common ground in what they protect (such as voluntariness). I also show that there are differences in the process of obtaining PTD and IC. I conclude that the difference between PTD and IC matters, and support this conclusion with an example drawn from OM practice, a case of a healthcare worker who sustains a needle-stick injury from an HIV positive patient.

5.3. What does “medical confidentiality” mean in OM practice?

My third paper, What are “patient secrets” in occupational medicine practice?: Privacy and confidentiality in “dual obligation doctor” situations, explores the ethico-legal justifications for medical confidentiality, and what this requirement means in OM practice. In particular, the example of an independently commissioned OM report is used to explore what “medical confidentiality” means or should mean in that context.

I point out that confidentiality is concerned as much with the protection of a relationship as the nature of the information itself, and their relative importance has been clarified in English case law. Moreover, the exchange of information has usually been considered in a doctor-patient setting. However, nowadays patient data is often not only shared with other members of the healthcare team, but also beyond that immediate therapeutic setting. With the advent of electronic patient records and data, medical confidentiality alone can no longer do the job of protecting patient secrets\(^\text{10}\) on its own, so the concept of privacy has become increasingly important in this regard. A

free standing right to privacy is not recognised in English courts, so “in developing a right to protect private information, including the implementation in the English courts of articles 8 and 10 of the European Convention on Human Rights, the English courts have to proceed through the tort of breach of confidence, into which the jurisprudence of articles 8 and 10 has to be ‘shoehorned’”\textsuperscript{11}, and this is mentioned in the paper. I also describe how the courts have developed an approach to protect private information based on one’s right to \textit{control} that information. However, I do point out the weaknesses of that conceptual approach, based on Tavani’s arguments, and so suggest a different privacy paradigm, using the context of an independently commissioned OM report to illustrate this.

On the other hand, even within the current privacy and confidentiality paradigms, case law, including \textit{Egdell}, makes it clear that medical confidentiality is \textit{not} breached when a doctor discloses information in a report to a commissioning party. I conclude this paper by suggesting the GMC guidance on confidentiality is clearly in conflict with the law.

\textsuperscript{11} \textit{Ash v McKennitt} [2006] EWCA Civ 1714, \textit{per} Buxton LJ at 8(ii)
PART II

THE SUBMITTED PAPERS
“First they ignore you, then they say you’re mad, then dangerous, then there’s a pause and then you can’t find anyone who disagrees with you.” (Tony Benn)
Chapter 6

Paper 1

Models of occupational medicine practice: an approach to understanding moral conflict in “dual obligation” doctors

Abstract
In the United Kingdom (UK), ethical guidance for doctors assumes a therapeutic setting and a normal doctor-patient relationship. However, doctors with dual obligations may not always operate on the basis of these assumptions in all aspects of their role. In this paper, the situation of UK occupational physicians is described, and a set of models to characterise their different practices is proposed. The interaction between doctor and worker in each of these models is compared with the normal doctor-patient relationship, focusing on the different levels of trust required, the possible power imbalance and the fiduciary obligations that apply. This approach highlights discrepancies between what the UK General Medical Council guidance requires and what is required of a doctor in certain roles or functions. It is suggested that using this modelling approach could also help in clarifying the sources of moral conflict for other doctors with “dual obligations” in their various roles.

Key words
6.1. Introduction

In 2009, the United Kingdom (UK) General Medical Council (GMC) updated its guidance to doctors on confidentiality¹, with supplementary guidance², including a section entitled “Disclosing information for insurance, employment and similar purposes”³, which clearly applied to doctors with “dual obligations”⁴, including occupational physicians (OPs). One of the requirements was for the doctor to “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”⁵. This provoked great consternation amongst OPs. Most had been used to offering a copy of their report to the worker at the same time as to the employer or pension fund manager. Having to offer the report to the worker before the commissioning party however, could have significant implications to the way they practised. The UK Faculty (FOM) and the Society (SOM) of Occupational Medicine issued a joint statement which reflected this unease⁶: “Publication of this (GMC) guidance has caused widespread concern among OPs about the practical difficulties associated with compliance and unintended consequences relating to the impact that it may have on the perceived impartiality of reports”⁷. In practice, OPs and occupational health (OH) providers have since changed their processes and consent forms to address this⁸. However, I suggest that there is a more fundamental reason why such ethical guidance does

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² GMC (2009)b.
³ p22-26.
⁴ The GMC (2009)b p24 state that “dual obligations arise when a doctor works for or is contracted (such as) by a patient’s employer, an insurance company, an agency assessing a claimant’s entitlement to benefits, the armed forces”. The British Medical Association (BMA) 2012 p649 describes these as “situations where doctors have clear obligations to a third party that can be in tension to the obligation to the patient”.
⁵ p23.
⁶ For example, an applicant who had been found not to meet the medical criteria for an early pension release due to ill-health, could simply refuse consent for this report to be released, and seek a more favourable opinion at a later date from a different physician.
⁷ FOM, SOM (2010).
⁸ For example, most consent forms for disclosure of a report now offer the opportunity for the worker to read it 2 to 5 days prior to sending to the employer.
not sit comfortably with OM practice. I aim to show that the very nature of the doctor-patient relationship (DPR) is sufficiently different in OM practice compared with the therapeutic setting, for the same ethical rules to be at times incongruent in the former context.

To achieve this aim, I will describe OM as it is practised in the UK, and propose a set of models distinguishing the different OP roles and facilitating clearer comparisons between the OP situation and the normal therapeutic DPR.

6.2. OM in the UK

OM is that branch of medicine that deals with the effects of work on health, and of health on work. In the past, an OP would have been mainly concerned with the effects of toxic hazards in the workplace on the health of workers, but as work environments in the UK and other developed countries have become increasingly better controlled and safer, the emphasis has shifted to assessing whether workers meet the appropriate medical standards for their occupation, that is, their fitness for work. A UK survey reveals that 75% of OP working time is spent on attendance and absence assessments (Suff 2007). Thus the majority of an OP’s time is spent in consultations to which the worker would have been referred by his manager for advice on fitness for work, and in a number of these cases, whether the worker would meet a pension scheme’s criteria for early retirement on the grounds of ill-health (IHR).

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9 It is also part of the wider discipline of OH, which also includes nurses and physiotherapists, as well as ergonomists and occupational hygienists.
10 An OP is a registered medical practitioner who has undertaken specialist training and qualifications in OM.
11 For example, in Centre for Workforce Intelligence (2010): “Industry has changed from a manufacturing to a service majority over the last 20 years and this trend may continue. The main hazards have changed from dust, heat, noise and vibration to workplace pressure”.
12 For example a survey reported in Ballard J (2011) found that 17% of OPs list “dealing with IHRs” amongst their top three priorities (p 22).
There are several other features of OM in the UK which may have a bearing on the OPW interaction. Firstly, in the UK, OH departments do not provide treatment services, except for first aid. Secondly, although the National Health Service (NHS) provides this treatment service, it specifically does not provide a National *Occupational* Health Service, so OH is largely *not* state funded\(^\text{13}\). Thirdly, although OH is mainly employer funded, there is no legal obligation on employers to fund this\(^\text{14}\), which is a different situation to that in some other European countries\(^\text{15}\). Lastly, there has also been a growing trend for OH services to be outsourced from in-house services to external commercial providers\(^\text{16}\). These background factors in UK OH provision may also contribute to some of the particular tensions that can arise between employers, OH professionals, and workers. However, before I describe the OP-worker (OPW) interaction in this context, the normal doctor-patient relationship will first be discussed, as this may clarify any differences between the two types of interaction.

### 6.3. The normal doctor-patient relationship (DPR)

Trust is said to be “intrinsic”\(^\text{17}\) to the DPR\(^\text{18}\). O’Neill (2002) has described the DPR as a “paradigm of a relationship of trust…It is a professional relationship that is supposed to be disinterested, long-lasting, intimate and trusting”\(^\text{19}\). Similarly, Brazier and Lobjoit (1999) have

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\(^{13}\) FOM (2010)a p7.

\(^{14}\) However, there is a statutory requirement for health surveillance of workers working with certain chemicals, or exposed to certain physical or biological hazards, for example, The Control of Substances Hazardous to Health Regulations 2002 SI 2002/267, and The Control of Vibration at Work Regulations 2005 SI 2005/1093.

\(^{15}\) See for example: WHO Regional Office for Europe (2002) at p 3.


\(^{17}\) For example, De Zulueta P (2007) p 14.

\(^{18}\) However, many authors point out that there is not a “single” DPR, and have proposed various models to describe the different types of DPR . See for example Szasz and Hollender (1956) and Emanuel and Emanuel (1992).

\(^{19}\) p17.
commented: “Patients trust doctors, nurses and other health professionals with intimate details of their lives which they may even conceal from their families”\textsuperscript{20}.

Although this paper aims to highlight the differences between OM and all therapeutic medicine, rather than specifically between OM and general practice\textsuperscript{21}, the importance of the DPR in the GP context has been described as its “central distinguishing feature” by Rogers and Braunack-Mayer (2009)\textsuperscript{22}, so the differences in the nature of the relationships may be more obvious between OM and GP. They also suggest that “trust in one area need not extend to trust in other areas. A patient may trust the goodwill of their GP in terms of confidentiality, affability, honesty and the like, but may not trust their competence in some clinical areas.”\textsuperscript{23} Likewise, O’Neill (2002) felt that she “might trust (her) GP to diagnose and prescribe for a sore throat, but not for a heart attack.”\textsuperscript{24} She also pointed out that polls show that doctors and judges are far more trusted than politicians and journalists\textsuperscript{25}. Patient trust also appears to be the salient feature of the DPR on which the regulatory authorities, in the UK at least, base their ethical guidance to doctors: “Patients must be able to trust doctors with their lives and health.”\textsuperscript{26}

Although there may be different degrees of trust involved in different contexts, and trust may be situation- or condition-specific (such as the diagnosis of a sore throat rather than of a heart attack) there seems to be little doubt that trust is an essential component of the normal DPR.

The central role of trust in the DPR has led some authors to advocate that this relationship is subject to a fiduciary principle\textsuperscript{27}. However, although trust is a requirement for a fiduciary

\textsuperscript{20} p187.
\textsuperscript{21} Also known as Family Medicine (FM), but “General Practice” is more commonly used in the UK. A definition of GP/FM by WONCA (2011), the World Organisation of Family Medicine, describes GPs as “personal doctors” (at p8). In the UK, the GP is usually the first point of medical contact for most patients, other than for accidents and some emergencies, refers to specialist or other health services where appropriate, and maintains a long term relationship with his patients.
\textsuperscript{22} p2.
\textsuperscript{23} p31.
\textsuperscript{24} p9.
\textsuperscript{25} p10. A recent poll commissioned by the BMA, Munn F (2011), also confirms that the public trusts doctors far more than politicians.
\textsuperscript{26} GMC (2006).
relationship, it is not in itself sufficient grounds to claim that a relationship is fiduciary in nature. The duties imposed on the fiduciary to the beneficiary or vulnerable party are largely due to the power imbalance between the two parties. Such a power imbalance is said by Kennedy (1996)\textsuperscript{28} to be evident in the DPR:

“The doctor-patient relationship has special, perhaps unique, features. Principal among these is the very significant disequilibrium of power between the two parties. The patient is uniquely vulnerable, being not only ignorant of the expertise constituted by the practice of medicine but also, in most cases, ill and anxious or anxious about possibly being ill. By contrast, the doctor has expert knowledge.”

Brody (1992) has drawn attention to the importance of the doctor’s power in the therapeutic relationship, breaking this power down\textsuperscript{29} to Aesculapian power (deriving from the medical knowledge and skills), social power (doctors generally coming from socially and educationally privileged backgrounds), and charismatic power (he postulated that many drawn to medicine would have this). The Law Commission (1992) has summarised the duties that arise in fiduciary relationships\textsuperscript{30}, and Bartlett (1997)\textsuperscript{31} amended these for the doctor-patient context:

1. Fiduciaries must avoid conflicts of interest, or indeed even possible conflicts of interest, with the vulnerable party. (The “no conflict” rule).
2. Fiduciaries must not profit from their position without prior disclosure to and authorisation from the vulnerable party. (The “no profit” rule).
3. The fiduciary owes a duty of undivided loyalty to the vulnerable party. (The “undivided loyalty” rule).

\textsuperscript{28} p111.
\textsuperscript{29} p62.
\textsuperscript{30} para 2.4.9.
\textsuperscript{31} p198.
4. The fiduciary owes a duty of confidentiality to the vulnerable party. (The “duty of confidentiality”).

Bartlett, Grubb (1994) and Brazier and Lobjoit (1999) have all presented strong arguments in support of the fiduciary nature of the DPR, although Kennedy (1996) objects to this mainly on the basis that it “entrenches the paternalism and power of the doctor”.

6.4. OM models

I propose three models to describe the current UK OP-worker (OPW) interactions, accepting that this may not be exhaustive.

6.4.1. Model 1: The “quasi-therapeutic” model

As mentioned previously, OH services do not provide treatment in the UK, except for first aid. Some argue that because some OH departments administer vaccinations (such as against hepatitis B in health care workers, or for business travel) or can refer workers for physiotherapy or counselling, these constitute some element of “treatment”, or at least of clinical care. On the other hand, although truly “therapeutic” encounters may be not part of OM in the UK, there are instances where OPW interactions may come close to being indistinguishable from the traditional doctor-patient ones, especially where a worker self-refers to the OH service or to the OP for advice. Although the OP cannot prescribe or treat in this scenario, the encounter is often similar to a therapeutic one, in terms of the doctor giving advice, and presumably the worker trusting this advice, having sought it in the first place, hence a “quasi-therapeutic” encounter.

32 p131-132.
33 As in “seeming to be something but not really so”, Oxford Essential English Dictionary, Oxford University Press, 2011.
6.4.2. Model 2: The “independent expert” model

This model describes work such as IHR applications, where the OP assesses the evidence presented (including specialist reports and evidence of attempts at workplace adjustments) against the medical criteria of the pension scheme. It would have similarities with expert witness work that doctors of any speciality can carry for the courts. However, for IHR medical assessments, it is the submitted evidence rather than the individual that is being assessed, so the applicant does not even have to be present in person at a “consultation”. One would expect the same advice by the GMC given to UK expert witnesses to apply, for example in terms of the requirement to be “honest, trustworthy, objective and impartial”. This makes it clear that the expert’s position is to be unbiased. In contrast, in an adversarial legal system, a lawyer must “present his client’s best case and draw the court’s attention to the weaknesses of the opposing party”. Both set of ethical obligations, for the expert to be unbiased on the one hand, and for the lawyer to be biased on the other, are clear and unequivocal (albeit with some qualification for the lawyer). One would like to believe that other doctors (in a non-expert role) are also bound to be objective, unbiased and impartial in their judgments and their advice, but clearly this could be in conflict with their “duty of undivided loyalty” to their patient. This leaves them

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34 For example, the term “independent” is used in the title “Independent Registered Medical Practitioner” (IRMP) in the Local Government Pension Scheme (Benefits, Membership and Contributions) Regulations 2007. The IRMP signs the certificate including the following statement: “I have not previously advised, or given an opinion on, or otherwise been involved in this case, nor am I acting or have ever acted as the representative of the member, the scheme employer or any other party in relation to it”. Similar terminology is used in some other public sector pension schemes, such as “IQMP” (Independent Qualified Medical Practitioner) for the Firefighters’ Pension Scheme Order 1992.
35 Other work that would fall in this category includes OPs sitting on Medical Appeal Boards for these pension schemes.
36 For the NHS Pension Scheme, which is the largest in the UK, virtually all are done remotely.
37 GMC (2008).
38 para 14.
40 However, he must not knowingly mislead the Court (Bar Council 2004, paragraph 302).
in the uneasy position where their duties from the two sets of obligations can be in direct opposition to each other.

6.4.3. Model 3: The “impartial doctor” model

This model will be used to describe the majority of OP work, which usually arises from referrals by managers, asking for advice on workers’ fitness for work, or health aspects of attendance or performance problems. Although the FOM recognises the need for OPs to be impartial, it does also stress that OPs, like other registered medical practitioners, have an ethical responsibility to put the interests of individual patients first. Thus a physician, learning of a health risk to a worker, has “a responsibility to protect the health of the employee, even if this is to the detriment of the employer”. In the context of a health risk from work, this is understandable. However, in the UK workplace stress and musculoskeletal problems have become the predominant occupational illnesses. These are often more multifactorial in causation, and it remains an OP’s responsibility to advise on such matters. But what does “putting the interests of individual patients first” actually mean in such cases? The employer may argue with some justification that it is the role of the GP to put the interests of his patient first. So in the UK, where the employer pays for the OP’s advice, if this were to be no different to that received from a worker’s GP, then the employer might question the value of paying for an OP’s advice at all. An example would be where a worker suffers from work-related stress.

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41 It is beyond the scope of this paper to offer a solution to this situation, except to note this intrinsic tension in the therapeutic role. It is the aim of this paper however to show that the differences between a treating doctor and an OP are such that in some aspects of the OP role (as expert, or model 2), this ethical conflict should not exist.
42 “Impartial” being defined as “not favouring one person or side more than another”, Oxford Essential English Dictionary, Oxford University Press, 2011.
43 75% of their workload, as previously mentioned, from the survey reported in: Suff P (2007).
44 “Occupational physicians also need to build good relationships with managers. Integrity, respect, good communication, and a focus on impartial (emphasis added) evidence-based medical advice are important elements in building a relationship of trust in which patients’ health problems and health and safety issues can be discussed constructively”, FOM (2010)b p12.
which he alleges is caused by his manager bullying him. A report from his GP, if one were obtained, would be heavily biased towards his patient. However, in many cases, there are other factors that may be relevant, such as feedback on poor performance by the manager to the worker prior to the alleged bullying. The OP should have a more balanced account of the situation, and be able to recommend more objective approaches, such as the use of stress risk assessments or workplace mediation. If the OP were also simply to “put the patient first” in such circumstances, there is a risk that UK employers would largely cease to fund OH services, especially as only a small proportion of OH work is legally required.

6.5. OM models and moral implications

In model 1 (“quasi-therapeutic”), the OPW interaction is the closest to that between a doctor and patient in a normal DPR. Although a worker may not need to trust the OP with his “health and life”, given that the OP will not carry out life-saving or other major interventions, he still needs to trust the OP to the extent that he is taking advice from the latter. Similarly, the power imbalance may be similar to that in the DPR, as the worker is generally in a position of knowing less than the OP about the health matter of concern. The main difference compared with the normal DPR is that fewer workers are likely to be as vulnerable as patients through pain and suffering, although some workers will seek help when they are distressed, especially if they have the facility to self-refer to the OH service. Given the similar levels of trust required and power imbalance in this model to the normal DPR, it is likely that the fiduciary obligations that arise in the normal DPR may also apply in model 1. Indeed, three of

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46 This is not intended to be a criticism of the GP, as the latter is clearly expected to put his patient first, and in addition he would have only one side of the story.
47 See for example http://www.hse.gov.uk/stress/standards/downloads.htm
48 One of the consequences would be that less OH would then be available to UK workers, arguably to their detriment, as they would have even less access to expert advice and diagnosis for work-related conditions.
the four “central principles”\(^{49}\) of a fiduciary relationship, namely the no conflict rule, the no profit rule, and the duty of confidentiality, seem appropriate in this context as well. On the other hand, the fiduciary’s duty of “undivided loyalty” to the vulnerable party is less easy to support, given the OP’s duty to the employer, and also to third parties if they could be harmed, for example. Although it could be argued that even in a therapeutic relationship, doctors also have obligations to third parties\(^{50}\), there is likely to be a difference of emphasis: the treating doctor usually puts his patient’s interests first\(^{51}\). This is illustrated in figure 1 below:

![Figure 1: Obligations to patients v. society in model 2 and treating doctors](image)

This figure illustrates the continuum between the two sets of obligations and the two extremes of the doctor role. However, for the purposes of this paper I will consider the treating doctor’s obligations to be mainly towards the patient, and the model 2 doctor to be mainly towards the third party, although this is clearly an oversimplification. In OM practice

\(^{49}\) As described by Bartlett (1997).
\(^{50}\) For example Gillon (1985), p158: “despite this acceptance (of obligations to society) doctors often talk and think as if they believe that they invariably give absolute moral priority to their patients over the moral demands of society”. The GMC appear to reinforce this message: “you must make the care of your patient your first concern” (GMC 2006).
\(^{51}\) In their role, one would find this partiality towards their patient acceptable, similar to Holm’s (2011) arguments in support of such partiality in the context of public health care systems.
this different emphasis can be reflected in disagreements between the patient’s treating
doctor, such as the cardiologist of a train driver with a heart problem, and the OP who has to
advise the employer on the risk assessment. The cardiologist may feel that the residual risk
posed by his patient in terms of a sudden incapacitating event to be acceptable, but an
employer or the public may take a different view.

In model 2 ("independent expert"), the OP acts as an expert assessor of evidence, for example
for pension funds. There may be no direct contact with the worker (or applicant) in the UK,
as the major public sector pension funds52 use systems which involve the OP usually only
reviewing the submitted evidence, and then presenting their advice or decision to the
employer or pension fund managers. If there is any relationship at all between the OP and
applicant, it would be, at best, an “arm’s length” one, and therefore the level of trust required
by the applicant would differ markedly from that expected of a doctor to whom he entrusts
his life and health, or even accepts advice from. It would be limited to trusting that the OP
has the appropriate training and qualifications to carry out this assessment, and will perform
it competently and objectively. Such a level of trust bears little or no resemblance to that in
the normal DPR, and would be more akin to that type of trust that we would have on a day to
day basis in many individuals would provide us with a particular service, such as a surveyor
assessing a building for electrical safety, and providing the required certificate53. Similarly, a
power imbalance is less evident, or at least arguably less relevant. However, the OP is still in
a some position of power54, as his advice or decision will determine whether the early release
of the pension on ill-health grounds will proceed or not, and the applicant is in a position of
vulnerability for the same reason. On the other hand, if there is no real relationship between

52 This is the case for the largest fund, the NHS Pension Scheme. The other schemes may involve either a
similar paper review, or a face-to-face assessment of the applicant.
53 For example, if the property is to be let.
54 On the other hand, the power imbalance can be reversed, for example when the applicant or his union
representative threatens the OP with referral to the GMC and the courts if early ill-health retirement is not
recommended.
the two parties, then the power imbalance seems to be an artificial consideration here. For example, although there is a clear power imbalance between a judge and a defendant when in court, this is not relevant in that context, and does not affect the validity of the process. The main reason for highlighting the power imbalance in the normal DPR (and other fiduciary relationships) is to provide the vulnerable party with some protection, by placing obligations on the fiduciary. In this model, the application of Bartlett’s fiduciary principles to this context sits the least comfortably. One would not deny the need to avoid a conflict of interest or the OP profiting from his position, although it is difficult to see how the latter could do this, given the remoteness between the two parties. There could also be a need for some degree of confidentiality, although in practice most if not all the information will have been gathered by other parties beforehand. For example, the OP could find reference to distressing details in a psychiatric report about child abuse, and should be careful not to include such details in his report to the pension fund manager or trustees. However, such instances are rare, and a report for pension purposes will mainly concentrate on the applicant’s ability to work, to perform certain tasks, and the likely permanence or otherwise of any health conditions and impairments. The fiduciary principle that would be completely incompatible with the OP’s role would be the “duty of undivided loyalty”, otherwise he could not give independent advice as required by the pension schemes.

Model 3 (“impartial doctor”) represents the majority of OPW interactions in the UK, and reflects the need for OPs to be impartial in a “dual obligation” system. The types of interactions and obligations are more difficult to characterise, given the wide range of activities that are included here. However, that range can be illustrated by two examples of

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55 Although these examples serve to illustrate the different levels of obligations in model 3, the main aim of this paper is to demonstrate that at the extremes (i.e. models 1 & 2), the underpinning ethical reasons for doctors’ obligations are different, so that the anomalies and conflicts arising in the ethical guidance are due to its being based on wrong assumptions.
activities in this model: on the one hand, for “health surveillance”\textsuperscript{56} activities, the OP may be towards the right of the figure 1 “model2/treating doctor axis”. That is, there is significant obligation towards the worker, as this activity concerns protecting workers’ health from workplace agents\textsuperscript{57}. On the other hand, for sickness absence referrals (the majority of OP work) the OP would be more to the left of that axis, as usually this is more for the employer’s benefit. From a relationship perspective, model 3 is in the “middle ground”\textsuperscript{58} between models 1 and 2, and the worker may be somewhat disappointed that the OP is not “taking his side”. In the normal DPR, the importance of trust and the power imbalance in that relationship is very evident. It is not suggested that in this third model, trust or power imbalance play no part. Rather, it is likely that the nature and extent of any trust and power imbalance are different. As O’Neill points out, we can trust individuals in some matters but not others\textsuperscript{59}, or to different extents. For example, in the DPR, patients should be able to “trust doctors with their lives and health”\textsuperscript{60}. This level of trust is not required from workers in the normal OH consultation. Indeed, it would be rather surprising if anyone expected such a level of trust. On the other hand, one would hope for some trust in the OP, for example of his competence at evaluating health and work issues (although some workers challenge this when the assessment results are not to their liking), and of his honesty and integrity (although this trust becomes less evident when increasing emphasis is placed on signed consent(s), and a worker reading the report before its issue). Similarly, in the normal DPR it is argued that the power imbalance arises partly from the patient being ill and more vulnerable than he would otherwise be, and partly from the doctor’s power. In the OPW situation, the worker is often

\textsuperscript{56} That is, monitoring workers’ health from workplace exposures to chemical, physical or biological agents, under legislation such as mentioned at ref (14).

\textsuperscript{57} However, this is also to a lesser extent for the benefit of employers, for example, in discharging their duties under health and safety legislation.

\textsuperscript{58} But as seen from the examples, the middle ground is not a fixed point on the figure 1 “model2/treating doctor axis”, but will vary according to the type of activity, and maybe the context.

\textsuperscript{59} O’Neill O (2002), where at p9 she gives the following examples: “I might trust a schoolteacher to teach my child arithmetic but not citizenship… I might trust my bank with my current account, but not my life savings.”

\textsuperscript{60} GMC (2006).
not ill, but may still be more vulnerable through lack of expert knowledge, which the OP will have. However, there are also situations where the power imbalance shifts in the opposite direction, for example, when workers attend with their union representatives who can be very knowledgeable on the relevant issues, or be coercive (such as threatening to refer the OP to the GMC) if the favourable outcome were not obtained for their member. Although such situations are relatively rare, they serve to illustrate that the power imbalance may not always be as one imagines it to be.

OPs aim to be impartial whichever model they are operating in, as it is a requirement of their function. Nonetheless, it is a difficult balance to achieve in everyday practice. In model 1, where the relationship may be close to the DPR, there is probably a greater risk that the OP could develop a closer affinity with the worker’s views, although he may not recognise this himself. However, even in this model, if the outcome of that consultation were unwelcome by the worker, the OP is still not bound by a “duty of undivided loyalty”. Indeed, the duty of undivided loyalty cannot be expected of the OP in any of the three models, although the incongruity of expecting such a duty in OPW interactions is most evident in model 2, where the independence of the OP is essential. If in the DPR, trust and power imbalance are of central importance in the analysis of that relationship, then it is suggested that in this third model, the emphasis should be on the impartiality of the OP. This need for impartiality can create tensions with the worker and the employer (and other stakeholders, such as “the public”).

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61 It is accepted that even in the DPR, a GP may occasionally feel threatened by his patient, and prescribe some medication or write a certificate, against his better judgment.

62 These models are intended to be a description of current UK OM practice, rather than what it ought to be. It is accepted, for example, that if OH provision became state rather than employer funded, this would change the pressures arising from the employer-OP relationship. Alternatively, OPs could adopt a definite servant-master approach with employers, which arguably would make it clearer for all parties to understand the OP role(s). However, whether one of these, or other approaches were to be pursued, it would still take some time to come into effect. In the meantime, it is hoped that a clearer understanding of the different tensions, and why they arise, will help OPs in their practice, and regulators producing ethical guidance.

63 For example, passengers and other members of the public, when a train driver suffers from epilepsy and does not want this to be disclosed by the OP.
Other doctors with dual obligations, such as in sports, insurance\textsuperscript{64} or military medicine, may also be in situations where some of their roles fit the normal DPR paradigm, but at other times be in roles where that paradigm does not apply\textsuperscript{65}. In the latter cases, as with the OM situation, different ethical guidance for the situations that are similar to models 2 and 3 that recognises these differences may help to reduce or resolve moral conflicts.

This table summarises the main differences described above:

<table>
<thead>
<tr>
<th></th>
<th>Normal DPR</th>
<th>Model 1 “QUASI-THERAPEUTIC”</th>
<th>Model 2 “INDEPENDENT EXPERT”</th>
<th>Model 3 “IMPARTIAL DOCTOR”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust</td>
<td>Very important</td>
<td>May be similar to normal DPR</td>
<td>Very limited</td>
<td>Limited. For example, that even in a non-therapeutic context, certain professional standards will apply</td>
</tr>
<tr>
<td>Power imbalance</td>
<td>Usually significant</td>
<td>May be similar to normal DPR</td>
<td>May not be relevant</td>
<td>Variable</td>
</tr>
<tr>
<td>Fiduciary obligations</td>
<td>Consistent with all four fiduciary central principles</td>
<td>May be similar to normal DPR, except for duty of “undivided loyalty”</td>
<td>Fiduciary obligation of “undivided loyalty” is totally incompatible as independence is essential</td>
<td>Limited fiduciary obligations</td>
</tr>
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\textsuperscript{64} For example, Grubb (1994) p334, opines that the insurance medical context would not give rise to a fiduciary relationship: “One of the most important conditions for the (fiduciary) duty to arise is absent: an entrusting of power by the beneficiary which is to be exercised \textit{only for his benefit}.” This condition is also absent in OM models 2 and 3, and presumably in some sports medicine and military medicine situations.

\textsuperscript{65} It is envisaged that the equivalent of models 1 and 2 could be reasonably clearly established for other dual obligation disciplines, though they would be different to the OM models. For example, in sports medicine, model 1 would actually be therapeutic, and the arm’s length model 2 arises for example during a pre-transfer medical assessment of a prospective team player. The middle ground, model 3, could arise for example when the team coach wanted a player recovering from injury to play possibly too early in an important match, and the club doctor had to advise.
Table 1: Trust, power imbalance and fiduciary obligations in the three OM models compared with normal DPR

6.6. Conclusion

Ethical guidance for doctors is usually based on the assumption that a normal DPR exists. By using the modelling approach in OM, it becomes evident that not all OPW interactions fit this assumption. On the one hand, in model 1 the OPW interaction is close to the normal DPR, and therefore not surprisingly most of the ethical constraints in a normal DPR make sense in model 1. At the other extreme, when the interaction is very “arm’s length” (model 2), most of the underlying assumptions used in the normal DPR are incorrect in that situation. The fiduciary obligation of undivided loyalty, for example, is incongruous if applied in a context where independence is essential. In model 2, the ethical requirement (by the GMC) for the OP to offer to show his report (of an independent assessment) to the applicant before submitting it to the employer or pension fund manager would be akin to a judge offering a defendant first sight of his judgment, and requiring the defendant’s consent before delivering it. It would be helpful if regulators such as the GMC could make a distinction between these different situations, and adjust the guidance to reflect the reality of the different OM roles.

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References


Can informed consent apply to information disclosure? : Moral and practical implications

Abstract

This paper aims to show that the ethical justifications and the processes for requiring consent for interventional research or treatment are different to requiring consent for the disclosure of patient or subject information. I will argue that these process and theoretical differences are sufficient to view “consent” in the two situations as different concepts, and suggest that the phrase “permission to disclose” would be more appropriate in the information disclosure situations.

Key words
Informed consent- information disclosure- informational privacy- information flow – consent process- permission to disclose

Introduction

“Consent” is a term that is used in all treatment and research situations, and it does not matter at present whether this consent is required for invasive research or treatment, or for non-invasive research and situations where patient information is disclosed, such as the production
of a medical report. In the context of biobank research Otlowski¹ has sought to explore “the essence of the concept of consent itself” to justify the modified approach to consent that she proposes in this type of research. However, I would suggest that the difficulties with biobank research and other instances where “consent” is for the disclosure or use of data, arise partly as a consequence of trying to apply the same term and approach in both situations, when the underpinning of the concepts is actually different.

Therefore, it may help to use different terms in the two situations. For example, the Scottish Independent Review Group on the Retention of Organs at Post-Mortem, felt that the term “authorisation”, or “the granting of permission” was more appropriate than consent in their context³. O’Brien and Chantler support this approach in a wider sense, stating:

“by moving to a term such as “authorise”, we can more freely seek agreement to use of data which is based on the appropriate principles of protecting privacy and autonomy—rather than by trying to use the model of consent to treatment, which at root serves to protect doctors against charges of assault or maim⁴.

Beauchamp suggests that “in biomedical ethics the language of “consent” has been framed almost entirely as “informed consent”.”⁵ For the purposes of this paper, the phrase “informed consent” will be used when consent is sought for treatment purposes or in carrying out invasive research (although there are some differences between consent for treatment and research⁶), to

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². p204.
³. Independent Review Group on retention of organs at Post-Mortem, Report on Phase 3, Appendix 2 Draft Standards for the Management of Post-Mortem Examinations instructed by the Procurator Fiscal, p13 accessed at http://www.sehd.scot.nhs.uk/publications/romp3/romp3-07.htm. Their context was the permission to use organs and tissues at post-mortem. The move away from the term “consent” in that situation helps to illustrate the fact that the use of this term carries with it the expectations of a process that is not always applicable. This paper will argue that there are other contexts and situations where it would be better to use a different term and process.
⁶. For a comprehensive analysis of the difficulties with consent in research, see Foster C, The ethics of medical research on humans, Cambridge University Press, 2001: 113-129. She lists for example the evidence that subjects often misinterpret the information they are given, such as a lack of understanding of randomised case
distinguish it from consent required for the disclosure of patient/subject data. In the latter
circumstances, such consent will be described in this paper as “permission to disclose” (PTD). There are similarities between the two types of consent. For example, “disclosure, comprehension, voluntariness, competence and consent (or decision)” are listed as components of informed consent. It seems reasonable to suggest that these conditions need to be met in both types of consent. In this paper it is the differences between the two that will be highlighted and discussed, as the aim is to establish whether there is, or should be, sufficient distinction between seeking informed consent and seeking PTD to warrant using a different process of obtaining each.

Informed consent

Following the horrors of the Nazi experiments, the need to protect human subjects from such research saw the publication of the Nuremberg Code in 1947, which was “the first authoritative statement of consent requirements in biomedical ethics”. Beauchamp and Childress suggest that following this initial concern about minimising harm, from the 1970s “the primary

7. This is to be distinguished from disclosure of information to patients in order to obtain their informed consent. See for example Beauchamp TL, Informed consent: Its history, meaning and present challenges, Cambridge Quarterly of Healthcare Ethics, 2011, 20, p515-523:518 “in the United States… informed consent has often been treated as synonymous with this legal doctrine, which is centered almost entirely on disclosure and on liability for injury”(emphasis added). However, it is not claimed that PTD is necessarily the best term, but it distinguishes consent for disclosure from “informed consent” for the purposes of this paper. For example, “permission to disclose” is more applicable when used in the context of a report, as opposed to research based on data, as the permission may not always be for disclosure of data, but may also be for further uses of that data.
See also Faden RR and Beauchamp TL, A history and theory of informed consent, Oxford University Press, 1986; 153-6.
justification for consent has been to protect autonomous choice”¹⁰. However, Manson and O’Neill guard against over-reliance on autonomy in this way¹¹. The problems they list¹² include the fact that the various conceptions of individual autonomy¹³ make it less clear what form of autonomy one might be seeking to protect (for example, can it be “mere choice” as opposed to “reasoned or reflective choice”¹⁴)?; and the relative merits of protecting autonomy¹⁵ over other ethical considerations. Other reasons for requiring informed consent are advanced by Otlowski: in addition to autonomy, she lists “respect and protection as the primary ethical principles underpinning consent”¹⁶. She does not elaborate on what she means by respect, but the Belmont Report describes respect for persons as “incorporat(ing) at least two basic ethical convictions: first, that individuals should be treated as autonomous agents, and second, that persons with diminished autonomy are entitled to protection”¹⁷. Similarly, Harris suggests that respect for persons “has two distinct dimensions: respect for autonomy and concern for welfare”¹⁸. From both these accounts, it would seem that there is overlap between the concept of respect used in this way, and the concepts of autonomy and protection, which so far form the moral basis for requiring informed consent.

Although it has been claimed that “the heart of issues about informed consent is moral, not legal”¹⁹, nonetheless a review of what legal commentators have said about informed consent

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¹¹. As above, 70.
¹². At 70-71.
¹⁴. Manson and O’Neill (2007); 70.
¹⁵. See for example Downie RS and Calman KC, Healthy respect, Ethics in health care, 2nd edition, Oxford University Press, Oxford, 1994; 63, where they view respect for the autonomous individual as being the underlying moral principle from which other moral principles derive their authority.
¹⁶. At ref (1), 200.
may help in our exploration of its basis and its application. However, this approach needs to be tinged with some caution, as from an English legal perspective, Brazier also questions “whether the process of adversarial litigation alone can ever provide satisfactory answers to the difficult questions of ethics and law raised in the debate on ‘informed consent’”20.

Lord Steyn21 has underlined the reasons why, from a legal perspective, informed consent matters:

“in the context of attributing legal responsibility, it is necessary to identify precisely the protected legal interests at stake. A rule requiring a doctor to abstain from performing an operation without the informed consent of a patient serves two purposes. It tends to avoid the occurrence of the particular physical injury the risk of which a patient is not prepared to accept. It also ensures that due respect is given to the autonomy and dignity of each patient”22.

Brazier and Cave further comment: “Should he fail to obtain a patient’s agreement at all, should a doctor force himself on a patient, he commits the tort of battery, and the crime of assault. Not only does he infringe on his patient’s autonomy, he also violates her bodily integrity”23.

Therefore, from both accounts, the law requires informed consent in order to protect bodily integrity and to respect patient autonomy. Indeed, Miola cites Lord Diplock24 to claim that “the purpose of the law (is) to protect the autonomy of the patient”25, but it has been commented that “it seems hard to believe that a court would allow damages for the harm done to the patient’s autonomy. Nevertheless, we do see judges increasing autonomy’s importance.”26 On

22. At 18.
the other hand, Sheila McLean sees “a poor fit between the ethical concept of autonomy and the legal rules of consent”\textsuperscript{27}, and in terms of what form of autonomy the courts may be aiming to protect, Alasdair MacLean suggests that in \textit{Chester}, “the majority adopted a liberal vision of autonomy”\textsuperscript{28}. He also opines that a review of the law in this area could “reflect a more sophisticated view of autonomy, going beyond the simple individualistic right to self-determination”\textsuperscript{29}. However, for the purposes of this discussion, it may be sufficient to note that the English courts do protect autonomy\textsuperscript{30}, and informed consent is a crucial part of that process. Trust has also been listed as one of the reasons for requiring informed consent\textsuperscript{31}, although it could be argued that it was a \textit{lack} of trust in doctors and researchers that led to the requirement for consent as a means of protecting patients and subjects in the first place. In terms of justifications for claiming trust to be a reason for requiring informed consent, these are both, forward-looking, such as “the importance of ongoing societal trust in caretakers and medical institutions, for example, so the public will continue to comply with medical advice, participate in medical research and fill in organ donor cards”\textsuperscript{32}, and backward-looking, where “this version defends informed consent as an intrinsically valuable way to honor the trust that the patient has placed in the physician”\textsuperscript{33}. There is some merit in these arguments, but I would still suggest that one should not forget that consent originally arose from mistrust (sometimes justifiably so, when one recalls the Nazi experiments). O’Neill makes a lesser claim in terms of trust, that

\textsuperscript{27} McLean SAM, \textit{Autonomy, consent and the law}, Routledge, 2010; 87. She argues for example that for policy reasons, the patient’s individual choice makes way to an “objective” or “reasonable patient” test.

\textsuperscript{28} MacLean A, From Sidaway to Pearce and Beyond: is the legal regulation of consent any better following a quarter of century of judicial scrutiny?, \textit{Med Law Rev}, 2012, \textbf{20(1)}; 108-129, at 119.

\textsuperscript{29} At 121. He appears to use “self-determination” as a concept similar to Dworkin’s (1988) “second order” autonomy, where those who exercise this “define their nature, give meaning and coherence to their lives, and take responsibility for the kind of person they are” (at 20).


\textsuperscript{31} Eyal N, \textit{Informed consent}, The Stanford Encyclopaedia of Philosophy (Fall 2011 Edition), Zalta EN (Ed.), forthcoming URL = \url{http://plato.stanford.edu/archives/fall2012/entries/informed-consent/}, 2.4. The other reasons listed are: protection, autonomy, preventing abusive conduct, self-ownership, non-domination and personal integrity.

\textsuperscript{32} 2.4.

\textsuperscript{33} 2.4.
“informed consent requirements play…a role that can have distinctive importance in maintaining trust”\textsuperscript{34}. Although I agree that having informed consent procedures in place can help in maintaining trust (which is a two-way process, as informed consent also serves to protect the researcher and doctor), I suggest that if there were complete trust between the two parties, then there would not be a requirement for informed consent. It could be argued that this requirement may arise from a third party (such as an organisation or a regulator) even if the two parties completely trusted each other. In my view, the third party requirement (whether it is to protect either party or itself) still reflects mistrust of the doctor/researcher or patient/subject, or both. Therefore although there may be individual trust in specific instances, the requirement for informed consent still reflects systematic mistrust.

Moreover, if justification for informed consent were to be mainly grounded in autonomy, then the suggestion that it could also be based on trust could arguably be even more problematic. Although there are many different conceptions of autonomy\textsuperscript{35}, it always has as its focus the individual, whereas trust necessarily involves at least two parties, with some sort of relationship between them. In his analysis of autonomy Tauber\textsuperscript{36} comments that “a deep tension between “autonomy” and “relationship” is not easily overcome”. The solution he offers is to define autonomy in a relational construct, where “autonomy must be placed in a social context where supporting relationships enable individuals to achieve various degrees of autonomy”\textsuperscript{37}. O’Neill points out that doctor-patient relationships “were viewed as relationships of trust only because a paternalistic view of medicine was assumed, in which dependence of patients on professionals was generally accepted”\textsuperscript{38}. However, although she also recognises the tension between trust and autonomy in this way, she refers to this older form of trust as “blind trust”,

\textsuperscript{36} Tauber AI, Patient autonomy and the ethics of responsibility, MIT Press, 2005; 120.
\textsuperscript{37} At 121.
which has given place nowadays to a more sophisticated “genuine trust”, of which autonomy is seen as a precondition: informed consent then is a “ritual of trust that embeds it in a properly institutionalised respect for patient autonomy”\textsuperscript{39}. The central role of trust in the doctor-patient relationship is the basis for asserting that it is a fiduciary one\textsuperscript{40}, although it has also been argued that some doctor-patient situations may not have such a fiduciary basis\textsuperscript{41}. In an analysis of the effect of a fiduciary doctor-patient relationship\textsuperscript{42} on informed consent, the doctor-fiduciary has been described as either “agent”, where there would be no need to seek consent for each action\textsuperscript{43} (as the doctor would use his discretion to achieve the patient’s broad objectives), or “adviser” (the authors’ preferred model) where there is a “more robust requirement for informed consent”\textsuperscript{44}. This description reminds us that informed consent in the healthcare setting is given by patients within the context of a relationship, and the situations and relationships can differ greatly. Having given informed consent, patients may either be happy to leave the doctor to decide some of the aspects of their treatment (the agent scenario) or want to retain more control of each step of decision making (the adviser situation). In my view, neither appears inherently the morally better approach, but rather depends on the context and the relationship between the parties, including the level of trust that exists.

It has also been said that “a suspicion of trust is central to contemporary autonomy-based bioethics, and typically reflects fears that trust can be misplaced, and that the cost of trusting

\textsuperscript{39} At 19.
\textsuperscript{42} Joffe S and Truog RD, Consent to medical care: The importance of Fiduciary Context, in Miller FG and Wertheimer A (Eds), \textit{The ethics of consent}, Oxford University Press, 2010; 347-373.
\textsuperscript{43} At 353.
\textsuperscript{44} At 354.
the untrustworthy can be high”. This fear may explain the “belt and braces” approach to regulating doctors in the UK: on the one hand doctors are told patients must be able to trust them, but on the other hand, the emphasis on patient autonomy and informed consent effectively may mean that patients need not be as reliant on trusting doctors. Indeed, if there is to be any relationship between autonomy and trust, it may be more logical to view it as an inverse one, that is, the greater the level of patient/subject autonomy in the consenting decision, the less crucial the degree of trust needed in the doctor/researcher. Or put in a different way, trust is based on greater interdependence, whereas autonomy is based on independence, as illustrated in figure 1:

46. General Medical Council, Consent: patients and doctors making decisions together, London, 2008; listed under “The duties of a doctor registered with the General Medical Council”: “Patients must be able to trust doctors with their lives and health.”
47. For example, Rogers WA and Braunack-Mayer AJ, Practical Ethics for General Practice, 2nd edition, Oxford University Press, 2009;115: “the principle of respect for patient autonomy has become one of the central planks of contemporary medical ethics, with the practice of informed consent serving as a legal reminder of its importance”.
48. For a fuller description, see Baier A, Moral prejudices: Essays on ethics, Harvard University Press, 1994, 20-23, where she contrasts “personal autonomy and independence” with “the more satisfactory interdependence”.

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Figure 1 Varying levels of dependence in autonomy and trust

However, this does not mean that trust and autonomy are incompatible. For example, when autonomy is considered in relational terms\textsuperscript{49}, then there would be a higher level of dependence and trust. In addition, trust requirements will be different in various contexts\textsuperscript{50} (research as opposed to treatment, short term contact with a casualty doctor as opposed to a long term relationship with one’s general practitioner). Furthermore, trust is not necessarily all or none, and could be limited for example, to trusting that the correct information had been given, or

\textsuperscript{49} For example, Tauber (2005):120.
\textsuperscript{50} For example, O’Neill O, A Question of Trust, The BBC Reith Lectures 2002, Cambridge University Press, 2002 suggested that she “might trust (her) GP to diagnose and prescribe for a sore throat, but not for a heart attack.”
that the doctor/researcher would honour the patient/subject’s choices, and carry these out to an acceptable standard.

**Permission to disclose (PTD)**

Permission to disclose (PTD) information from patient records to produce a medical report for employment or insurance purposes can be distinguished from PTD information from data and samples (already held) of research subjects in certain regards. For example, in the research context, the eventual use of the data may not be known at the time when the data or samples are being stored, such as in research based on “population biobanks”\(^{51}\). In contrast, a medical report is available for inspection by the patient soon after it is produced\(^ {52}\), so the patient is able to know definitely what information is to be disclosed. However, PTD in both these situations share a similarity that distinguishes them from informed consent. This lies in the direction of “information flow”\(^ {53}\): in informed consent, the crucial information is to the patient or subject in order for him to make his decision, whereas in PTD (whether for research or a report) the issue is control of his own information. The direction of information flow has process implications for both PTD and informed consent, as will be shown later. In addition, although Manson and O’Neill initially appear to treat PTD as an extension of the informed consent requirements\(^ {54}\), they later clarify that in controlling one’s own information, there are other interests that need to be protected in addition to respect for autonomy and protection from harm\(^ {55}\), namely confidentiality\(^ {56}\) and informational privacy\(^ {57}\). If we are to suggest that

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51. See for example Otlowski (2012); 192-3.
52. For example, in England and Wales, the patient has up to 21 days to view the report before it is sent under the Access to Medical Reports Act 1988, chapter 28, HMSO at 4(2)(b).
53. Dworkin (1988); 104.
54. Manson and O’Neill (2007); 22.
55. For example, Laurie G, *Genetic privacy: A challenge to medico-legal norms*, Cambridge University Press, 2002; 213: “discrimination and stigmatisation can result from disclosure of sensitive personal information”.
56. At p99.
57. At p100-101.
confidentiality and privacy are relevant interests to be protected by PTD, then we should consider why they ought to be safeguarded in the first place.

In the medical context, the principle of medical confidentiality, “that doctors must keep their patients’ secrets”, has been described as “one of the most venerable moral obligations of medical ethics”\(^{58}\). The moral basis for medical confidentiality has been based on three types of arguments, (1) consequence-based ones: if the patient did not trust the doctor to keep the information confidential, then he would not disclose all relevant information, and this may be detrimental to his treatment and medical management; (2) respect for autonomy and privacy; and also, (3) fidelity\(^{59}\)-based arguments\(^{60}\). In England the importance of medical confidentiality has been stressed by the professional regulator\(^{61}\) and recognised by the courts\(^{62}\). However, confidentiality is not absolute, and may be breached for example in the public interest\(^{63}\).

Confidentiality aims to protect a relationship as well as information, whereas privacy requires no relationship\(^{64}\), so informational privacy is a more appropriate concept when considering personal data (especially health data, which the courts consider private *per se*)\(^{65}\) disclosed for research purposes. Laurie further points out that “an action for breach of confidence is possible only so long as the confidential information remains confidential. Once it becomes part of the public domain it is no longer protected. In contrast privacy is “concerned with interests in

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59. They claim that doctors owe an obligation of fidelity to patients, and assert that “the physician’s obligation to live up to the patient’s reasonable expectations of privacy and confidentiality is one way to specify the general obligation of fidelity”.
63. GMC (2009) para 8. *W v Egdell* [1990] per Lord Bingham at 848. However “public interest” is different to “what the public may find interesting”: see *Lion Laboratories Ltd v Evans* [1984] 2 All ER 417 at 422–423.
64. Laurie (2002):211-212. However, in addition to the doctor-patient relationship, the nature of the information itself (such as health information) is important in determining whether information is private and confidential: *Campbell v MGN* [2004] UKHL 22 per Baroness Hale at 145: “It has always been accepted that information about a person's health and treatment for ill-health is both private and confidential. This stems not only from the confidentiality of the doctor-patient relationship but from the nature of the information itself”.
65. *Ash v McKennitt* [2006] EWCA Civ 1714, per Buxton LJ at 23: “A person's health is in any event a private matter, as the *Campbell* case demonstrated. It is doubly private when information about it is imparted in the context of a relationship of confidence”.

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personal information…and those interests do not necessarily change with circumstances, nor do matters become any less personal simply because more people know about them”66. In England, the Data Protection Act (DPA) 1998 protects privacy interests in respect of the personal data67, but does “not apply when data are anonymised, for the law is concerned solely with personal data, that is, from which an individual can be identified”68. Moreover, the Human Rights Act (HRA) 1998 also protects the right to privacy69, through the common law, which has had to take account of the ECHR Articles since the HRA was enacted70. However, the courts have been reluctant to establish a tort of invasion of privacy71, and “in developing a right to protect private information, including the implementation in the English courts of articles 8 and 10 of the European Convention on Human Rights, the English courts have to proceed through the tort of breach of confidence, into which the jurisprudence of articles 8 and 10 has to be ‘shoehorned’”72. Sedley J has suggested that the law could “recognise privacy itself as a legal principle drawn from the fundamental value of personal autonomy”73. In similar vein, Lord Hoffman has said: “What human rights law has done is to identify private information as something worth protecting as an aspect of human autonomy and dignity”74. However, Dworkin warns that autonomy and privacy are different: “One reason for the confusion of the

66. Laurie G, Genetic privacy: A challenge to medico-legal norms, Cambridge University Press, 2002; 250. In addition, if one is in control of one’s information, the House of Lords has maintained that one can impose a duty of confidence (Douglas v Hello! [2007] UKHL 21, at 118).
67. Health information is classed as “sensitive personal data” (s 2), which requires explicit consent for processing, save for exemptions listed in Schedule 3.
68. Laurie (2002); 253.
69. Article 8 of the European Convention on Human Rights (ECHR), in HRA Schedule 1: “Everyone has the right to respect for his private and family life….”
70. Ash v McKennitt [2006] EWCA Civ 1714, per Buxton LJ at 8(ii).
71. See Wainwright v Home Office [2003] UKHL 53 per Lord Hoffman at 14-35; and Campbell v MGN [2004] UKHL 22 per Baroness Hale at 133: “our law cannot, even if it wanted to, develop a general tort of invasion of privacy”. This contrasts with the earlier case of Douglas v Hello! [2001] QB 967 which suggested that English law would recognise and protect a right of privacy, a position not endorsed by subsequent cases, such as Wainwright. Whether in fact there ought to be a discrete privacy tort rather than “shoehorning” article 8 into the tort of breach of confidence is beyond the scope of this article.
72. see ref(58).
73. Douglas v Hello! [2001] QB 967 at 126. However, as mentioned above, subsequent judgments have not supported a freestanding “right to privacy” in English common law.
74. Campbell v MGN [2004] UKHL 22 at 50.
concepts is that violations of autonomy and privacy exhibit a common failure to respect another person as an independent moral agent. But they do so in different ways and ought not be assimilated." On the other hand, it has been said that the concepts of privacy and autonomy are “interdependent, each relying on the other to fulfil its true function in the most effective way possible,” and it has also been argued that privacy is “autonomy-related.” Although I agree with Dworkin that autonomy and privacy are distinct concepts that ought not be confused, this is no way diminishes the importance of privacy, for “the privacy of personal information (is) something worthy of protection in its own right”, and this protection is provided by requiring that the extent to which such information can be disclosed, if at all, would be for the individual to decide, and to give or refuse permission to that disclosure (that is, PTD).

Autonomy and protection from harm were the main factors noted in justifying the need for informed consent. These justifications also play a part in requiring PTD, although there may be some qualitative differences. However, the main difference that arises in the analysis of the justifications for both is that PTD protects privacy and informed consent does not. In the next section other differences will be explored.

75. Dworkin (1988): 104. He gives the following examples to support this view: “One way of interfering with your autonomy is to deceive you. This kind of interference with information is, however, just the opposite kind from that involved in interference with privacy. What is controlled is the information coming to you, not the information coming from you. I do not know something about you that you might wish to conceal. I conceal something from you that you might wish to know. Thus, autonomy but not privacy is diminished. Similarly, privacy may be interfered with but not autonomy. If someone taps your phone conversations without your knowledge he interferes with your privacy. But your decisions, your actions, your values, are in no way changed or altered from what they might be otherwise. You are as self-determining as ever.” He also cites the Supreme Court decision in Griswold v Connecticut 381 US 479 (1965) when it ruled “that prohibition of the use of contraceptives was a violation of the constitutional right of privacy” as an example of “the intellectual disorder from confusing these two notions”.

76. Laurie (2002); 83.

77. Feldman D, Privacy as a civil liberty, in Current Legal Problems (Ed. Freeman MDA), University College London,47( II), (1994): 41-51 at 58.

78. Per Lord Hoffman in Campbell, at 46.

79. Lord Hoffman in Campbell, at 53: “the extent to which information about one’s state of health, including drug dependency, should be communicated to other people was plainly something which an individual was entitled to decide for herself”.

80. For example, “informational autonomy” is described in Case P, Confidence Matters: The Rise And Fall Of Informational Autonomy In Medical Law, Med Law Rev 2003,11, 208-236.
Process differences between informed consent and PTD

Voluntariness, competence and understanding of the patient/subject are important to both informed consent and PTD, and so will not be discussed in this paper, for it is the differences between the two that I wish to highlight here. So far, I have suggested that these include the opposite direction of informational flow in the two situations, and also that PTD primarily protects privacy, whereas informed consent primarily protects autonomy. In this section, I will explore the differences in the processes used in informed consent and PTD situations. For this analysis, I will assume that the “event” (requiring consent or permission) is a single one in the treatment (a surgical intervention) and the invasive research situations, in order to simplify the description of the processes. For the PTD situations, writing a report would be a finite event in any case, whereas bio-bank research is necessarily on-going. If we consider what is required prior to the event, then in both informed consent situations, great emphasis is placed on the information given to the patient or subject. This is highlighted by the English courts: a “material risk” has to be disclosed to the patient\(^\text{81}\), and a doctor who fails to do so could be found to be negligent if the risk materialises and the patient is harmed\(^\text{82}\). The doctor would be aware of such material risks, often in great detail, for example of a percentage risk of a specific complication. In interventional research the risk information may not be as accurate, but safety data will still be available, and relevant risks need to be communicated. On the other hand the information available to be communicated to the patient/subject in the PTD situations is quite scant in comparison. In writing a report, the doctor will be aware of who this is addressed to, and the stated purpose of the request, which he can communicate to his patient. However,


\(^{82}\) See for example Devaney S, Autonomy rules ok, Med Law Rev, 2005, 13(1); 102-7.
beyond this, he will usually not know the consequence of sending his report. Therefore although he should communicate the relevant information to his patient, the information available to him will be more limited, when compared with the informed consent situations. In the case of bio-bank research, the available information to the subject is again limited, but for a different reason. The very nature of such research means that it is not possible to predict exactly what further use the data or samples may be put to, except in general terms. For this reason, approaches advocated in bio-bank research include the use of “broad”\(^{83}\), “unspecified”\(^{84}\) or “hybrid”\(^{85}\) consent.

After the event consent cannot be withdrawn retrospectively as the event has already taken place\(^{86}\) in the informed consent situations, whereas in both PTD situations permission can be withdrawn. In the case of a report, this could be after the patient has read it and no longer agrees for the information to be disclosed, or in the case of bio-bank research, this could be at any point during the course of the research project if the subject changes his mind\(^{87}\).

The main differences in the processes are summarised in the following table:

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85. Otlowski (2012): 203. This is her preferred approach, and she defines hybrid consent as “specific consent for collection and storage together with broad consent for future unspecified use”.
86. However, it is still possible for the patient or subject to claim post-event that information given prior to the event was not sufficient for valid informed consent, as was argued in *Chester*.
Pre-event | Event | Post-event
---|---|---
Informed consent to surgery | Information to patient +++ | Surgical intervention | Cannot withdraw consent
Informed consent to invasive research | Information to subject +++ | Research intervention | Cannot withdraw consent
PTD a report | Only limited information to patient possible | Report written | Can withdraw permission
PTD data in bio-bank research | Only limited information to subject possible | On-going, not a finite event | Can withdraw permission

Table1. Process differences between informed consent and PTD

A practical example

To further illustrate the differences between informed consent and PTD in practice in other situations, consider the case of a needle-stick injury sustained by Health Care Worker X, the source patient Y being HIV positive. In the first scenario Y’s HIV status is not known, whereas it is known to Y and his doctors in the second scenario. The relevance of X obtaining information of Y’s HIV status is that it would help her in deciding whether to start post-exposure prophylaxis(PEP, which should be as soon as possible and certainly within 48-72 hours of exposure). X is also at risk of stress and anxiety from acquiring HIV, and if she does start PEP, there are a number of unpleasant, sometimes debilitating, side effects from taking such medication.

In the first scenario, if Y refuses to have a blood test, then venepuncture clearly could not proceed without informed consent. It would constitute battery and assault in English law, as

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well as being morally reprehensible. The fact that X may suffer anxiety, or side effects from PEP would arguably not provide sufficient justification to override Y’s autonomy.

In the second scenario, X would need to obtain Y’s PTD a result already known to himself and his treating team. The same tensions between Y’s rights and the harm to X do exist, but Y’s predominant interest to be protected here is his privacy rather than his autonomy. I would not wish to suggest that privacy is less deserving of protection than autonomy, but rather that the analysis of the competing interests needs to be done on a case by case basis. In this scenario, I suggest that the harm to X may be sufficient justification to obtain the HIV result without Y’s PTD. Y would still need to be assured of the limits of disclosure, such as limiting knowledge of the result to X and her occupational health advisers, who would all be bound by a duty of confidentiality. However, if the distinction between informed consent and PTD were not made in this way, it may be too easy for clinicians working under pressure to assume that a refusal of “consent” (in the generic sense) precludes any further analysis, especially with the threat of an action in battery and the crime of assault. I suggest that making this distinction explicit helps in seeing the real issues which need to be considered.

<table>
<thead>
<tr>
<th>Requirement from patient</th>
<th>If not given…</th>
<th>Consequences to Y of proceeding without consent or permission</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV status unknown</td>
<td>Informed consent</td>
<td>Cannot proceed</td>
</tr>
<tr>
<td>HIV status known</td>
<td>PTD</td>
<td>May be able to proceed</td>
</tr>
</tbody>
</table>

Table 2. An example to illustrate differences between informed consent and PTD in practice
Conclusion

Consent has been described as “a process whereby an individual having been provided with full information and understanding the consequences, agrees to a proposed action”\(^{89}\). This describes the “informed consent” situations well. However, in the context of information disclosure situations such as writing a medical report or biobank research, full information is not possible, and therefore the consequences cannot be fully understood by the patient or subject. Yet, although in these situations the available information to communicate to the patient or subject is more limited, I have argued that the primary interest to be protected is the privacy of patient’s/subject’s information already held, so the lack of “full information” to the patient/subject may be less of an issue.

Although Otlowski has analysed “the essence of the concept of consent itself”\(^{90}\) in biobank research, I would go one step further, and suggest that PTD is sufficiently different in its theoretical basis and its process to be considered a concept distinct from informed consent.

If this approach became widely used, then the requirements for PTD could be developed just as they have developed over time for informed consent. A starting point would be the acceptance that although in report writing and biobank research the information given to the patient or subject is necessarily limited, the PTD process is nonetheless valid.

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\(^{90}\) Otlowski (2012): 204.
Conflicts of interest. None

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Whatever, in connection with my professional practice or not, in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret. (Hippocrates)
WHAT ARE “PATIENT SECRETS” IN OCCUPATIONAL MEDICINE PRACTICE? : PRIVACY AND CONFIDENTIALITY IN “DUAL OBLIGATION DOCTOR” SITUATIONS

Keywords
Dual obligation doctor, English law, medical confidentiality, medical ethics, occupational medicine

Abstract
In order to understand what might constitute a “patient secret” in occupational medicine (OM), this article first reviews why information is confidential in doctor-patient relationships in therapeutic settings. The GMC does not treat medical confidentiality any differently whether the setting is therapeutic or not. However, it will be argued that the legal and ethical justifications for medical confidentiality in therapeutic situations cannot simply be transposed into the OM setting, especially in the context of independently commissioned reports. Moreover, the recent GMC guidance on confidentiality which requires doctors to seek further consent for a report commissioned by third parties will be shown to be in conflict with English Court of Appeal judgments.

8.1.INTRODUCTION
Doctors must keep patient secrets. But is everyone who confides in a doctor (in his professional capacity) a patient? And everything he says a secret?

In England, medical confidentiality is recognised and upheld in common law and statute, as well as by the regulator, the General Medical Council (GMC), it is “enshrined in all codes of medical ethics”, and it is said to be central to the therapeutic relationship.

However, is it also central to a non-therapeutic relationship? Not all doctor-patient encounters occur within a therapeutic setting. “Dual obligation” doctor situations arise “where doctors have clear obligations to a third party that can be in tension to the obligation to the patient”, for example when a doctor works for or is contracted by third parties such as a patient’s employer, an insurance company, an agency assessing a claimant’s entitlement to benefits, or the armed forces. It has been argued that these relationships are significantly different from the

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1 This article focuses on doctors, but it is recognised that other healthcare professional will also have obligations of confidentiality. Where ‘he’, ‘his’ etc. are used, this is intended to represent both genders throughout this article.

2 M. Brazier and E. Cave, Medicine, patients and the law, 5th edition, London: Penguin Books, 2011, 83: “Doctors, like lawyers and priests, must be able to keep secrets.” However, they also point out that this obligation of confidence is not necessarily absolute. I use the term “secrets” in a relatively neutral way here, not intending to presume the level of secrecy that is required at this stage, as this is explored later.

3 W v Egdell [1990] 1 All ER 835; Campbell v MGN [2004] UKHL 22.

4 Data Protection Act 1998 (DPA), where health information is classed as “sensitive personal data” (s 2), and explicit consent must be obtained from the data subject for the processingle of this data (s 3). Jackson makes the point that “Some statutes, most notably the Data Protection Act 1998, clearly have an impact upon medical records, and yet because this was never their principal focus, their application to the doctor-patient relationship can be ambiguous and confusing”, in E. Jackson, Medical Law: Text, cases and materials, 3rd edition, Oxford University Press, 2013, 360. Nonetheless, the DPA has some direct relevance to OM records, so this will be discussed later in section 8.3.2.

5 GMC, Confidentiality, London, 2009, p. 4; and GMC, Good Medical Practice, Manchester, 2013, p. 17.


8 “Therapeutic” is used here in a wide sense, to include diagnosis as well as treatment.

9 British Medical Association, Medical Ethics Today: The BMA’s Handbook of Ethics and Law, 3rd edition, London, 2012, p. 649. Although it could be argued that to some extent, all doctors have obligations to parties other than their patients, in practice doctors in therapeutic relationships “talk and think as if they believe that they invariably give absolute moral priority to their patients over the moral demands of society” (R. Gillon, Philosophical medical ethics, John Wiley & sons, Chichester, 1985, p. 158). In this paper, it will be assumed that treating doctors do indeed give “absolute moral priority” to their patients.

“normal” therapeutic doctor-patient relationship\(^\text{11}\). Some dual obligation doctors will provide treatment, as in military or sports medicine, whereas doctors practising occupational or insurance medicine do not. This paper explores the nature of medical confidentiality in these dual obligation non-therapeutic roles. In particular, one of the occupational medicine (OM) roles requires the doctor to be independent\(^\text{12}\). In the context of such independent reports, could the doctor’s obligation of confidentiality be different? Or is any communication to a doctor\(^\text{13}\) in any professional capacity a “patient secret”, which the type of information\(^\text{14}\), or the context in which it is shared, cannot undermine?

In order to understand what might constitute a “patient secret” in OM, this article will first review why information is confidential within doctor-patient relationships in therapeutic settings. The GMC does not treat medical confidentiality any differently whether the setting is therapeutic or not\(^\text{15}\). So, if it can be shown that the legal and ethical justifications for medical confidentiality in therapeutic situations cannot simply be transposed into the OM setting, then the GMC approach could be flawed. If patient information is confidential, then the consent of

\(^{11}\) J. Tamin, Models of occupational medicine practice: an approach to understanding moral conflict in “dual obligation” doctors, *Medicine, Healthcare and Philosophy*, 2013, 16(3), pp. 499-506. In addition, it has been pointed out that there is no single doctor-patient relationship, and different models have been proposed. See for example E.J. Emanuel and L.L. Emanuel, *Four models of the Physician-Patient Relationship*, JAMA, 1992, 267, pp. 2221-6. However, for the purposes of this paper, it will be assumed that all doctor-patient relationships in the therapeutic context are based on trust, and that the doctors in these relationships “make the care of their patients their main concern”, GMC (2013) at p. 4. It will later be argued that the same level of trust may not be required in the non-therapeutic relationships described here.

\(^{12}\) J. Tamin (2013) at p. 502. For example, in ill-health retirement (IHR) assessments for the Local Government Pension Scheme Regulations 2014 require the OP doing this assessment of not having advised, or given an opinion on, or otherwise been involved with the case previously.

\(^{13}\) See for example, Editorial, Medical confidentiality, *J Med Ethics*, 1984, 10, pp. 3-4, at 3: “in the context of medical ethics the patient may well consider all information concerning his or her interaction with the doctor as secret, including the fact that the consultation has occurred at all”.

\(^{14}\) Lord Phillips in *HRH Prince of Wales v Associated Newspapers Ltd* [2006] EWCA Civ 1776, at para. 36, puts it thus:

“It is not easy in this case, as in many others, when concluding that information is private to identify the extent to which this is because of the nature of the information, the form in which it is conveyed and the fact that the person disclosing it was in a confidential relationship with the person to whom it relates.”

The tension between the relative importance of the nature of the information and that of the relationship will be explored further in section 8.2.2.

\(^{15}\) GMC, *Confidentiality: Supplementary guidance*, London, 2009:

“The first duty of a doctor registered with the GMC is to make the care of their patient their first concern. The term ‘patient’ in this guidance also refers to employees, clients, athletes and anyone else whose personal information you hold or have access to, whether or not you care for them in a traditional therapeutic relationship.” (para. 2)
the patient is required before it can be disclosed. On the other hand, if there are circumstances where confidentiality does not preclude disclosure to a party, then it becomes less evident why consent would be needed. Indeed, in the case of a report commissioned from a doctor following an assessment, it will be shown that the courts have clearly indicated that consent for disclosure of this report is not required. Unfortunately GMC guidance states the opposite, which puts OPs writing such independent reports in a difficult position.

“Secrecy” may conjure up the imagery of “cloak and dagger” scenarios, which could be more than just metaphorical in this context, if one considers the potential for deception with the GMC confidentiality rules. In any case, it will be later argued that the current confidentiality paradigm may no longer suffice to protect patient data, and it is necessary to look to privacy instead. So another development that is particularly apposite to a discussion of privacy of information is the recent contribution of English courts to this area of the law, which will be described in the next section.

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16 See Farnsworth at 8.3.2(b).
17 In particular in Kapadia v London Borough of Lambeth [2000] IRLR 699. This will be discussed in section 8.3.2(b).
18 GMC (2009), pp. 22-26. This will also be described in section 8.3.2(b).
20 Insofar as disclosures in “the public interest” are allowed, arguably the courts also support this deceit.
21 See later in section 8.3.2(b).
22 The courts have used the language of privacy for some time. For example, “Information about an individual’s private life would not, in ordinary usage, be called ‘confidential’. The more natural description today is that such information is private”, Campbell v MGN [2004] UKHL 22, per Lord Nicholls at 14. However, in section 8.2.2(a), I will later describe the need in common law to “shoehorn” the right to privacy into an action of breach of confidence, so it can hardly be argued that the courts have already adopted a privacy paradigm. Moreover, I will later also point out the limitations with the current conception of privacy that the courts have used so far, and propose a model which I suggest will better protect privacy, as it provides a more transparent process for disclosures.
23 I am not the first to suggest this. See for example G. Laurie, Genetic privacy: A challenge to medico-legal norms, Cambridge University Press, 2002, p. 3. He argues this in the context of protecting genetic privacy, but his arguments remain valid beyond the genetic context.
24 See for example HRH Prince of Wales v Associated Newspapers Ltd [2006] EWCA Civ 1776, Ash v McKennitt [2006] EWCA Civ 1714, and Campbell v MGN [2004] UKHL 22. Although I will primarily focus on English court judgments, I will also make reference to European court decisions where appropriate.
8.2 PRIVACY AND CONFIDENTIALITY IN THERAPEUTIC SETTINGS

Medical ethics and law\(^{25}\) concentrate mainly on the exchange of information in a doctor-patient setting when considering medical confidentiality and its breach\(^{26}\). However, even in therapeutic settings patient data is shared far beyond just that individual doctor for legitimate reasons, such as within multidisciplinary teams\(^{27}\), or with those who process patient data, or for research purposes. In an age of electronic patient records and data, it has been argued that traditional medical confidentiality alone can no longer do the job of protecting patient secrets\(^{28}\). So, although confidentiality will continue to have a role to play\(^{29}\), privacy\(^{30}\) may become the more important player.

8.2.1 Privacy

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\(^{25}\) M. Brazier and E. Cave (2011), p. 84, point out that “English law on breach of confidence developed haphazardly. The core obligation requiring doctors to respect patient confidences derives from the common law”.

\(^{26}\) J.K. Mason and G.T. Laurie, Mason and McCall Smith's Law and Medical Ethics [7th Edition], Oxford University Press, 2006, p. 253, list the three elements needed for an obligation of confidentiality to be breached. These are: (1) The information must have the necessary quality of confidence, (2) The circumstances must import an obligation of confidence, and (3) There must be unauthorised use of the information. This paragraph is not found in the more recent 9th edition (2013), so I have referred to this earlier edition.

\(^{27}\) See for example, M. Seigler, Confidentiality in medicine - a decrepit concept, New England Journal of Medicine, 1982, 307, pp. 1518-1521, and G.L. Anesi, The “Decrepit Concept” of Confidentiality, 30 Years Later, American Medical Association Journal of Ethics, 2012, 14, 9, pp. 708-711. Siegler described over 30 years ago how a patient admitted to hospital for a simple operation would have his medical record legitimately accessed by between 15 and 100 hospital staff and students. Anesi suggests that “anyone recently in an American academic teaching hospital would say these numbers are far higher today”, at p. 708. I would suggest that the situation in the UK would be comparable.

\(^{28}\) G. Laurie (2002), p. 3.

\(^{29}\) See later in 8.2.2.

\(^{30}\) G. Laurie (2002) points out that while confidentiality and privacy “overlap in many ways, they are by no means identical”. “In particular, while confidentiality cannot protect the interest in not knowing...a properly designed right to privacy may do so”; at pp. 211-212. See also R v BSC, ex p BBC [2000] 3 All ER 989, 1002 per Lord Mustill: “Privacy and confidentiality are not the same”, but he was distinguishing these in the context of corporate secrets: “A company can have secrets, can have things which should be kept confidential, but I see this as different from the essentially human and personal concept of privacy”.

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Privacy has been defined as “a state of separateness from others”\(^{31}\) and the right to privacy has traditionally been described as “the right to be alone”\(^{32}\). For the purposes of this paper, a more useful conception of privacy is to see it as “the condition of not having undocumented personal information about oneself known by others”\(^{33}\). A development of the right to privacy then “involves treating the control\(^{34}\) of information as inherent in privacy”\(^{35}\). The academic debate on the meaning of privacy has been mirrored in Court judgments in the last ten years.

For example, the European Court of Human Rights has declared\(^{36}\):

> The right to privacy, guaranteed by Article 8 of the European Convention on Human Rights\(^{37}\), has already been defined by the Assembly …, as “the right to live one's own life with a minimum of interference”.

In view of the new communication technologies which make it possible to store and use personal data, the **right to control one's own data**\(^{38}\) should be added to this definition.

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\(^{32}\) However, Laurie (2002) at p. 71, warns us that, by equating privacy as freedom from intrusion or interference, writers such as L. Blom-Cooper in “The right to be let alone”, *Journal of Media Law and Practice*, 1989, 10, p. 53, have confused privacy with liberty. Laurie (at p. 81) describes the example of an individual’s privacy being invaded by genetic information gathered about her “through the testing of her relatives when the individual in question is unaware, thereby having no effect on her liberty”. Although I have referred to Blom-Cooper’s article, the notion of privacy as a *right to be let alone* has been articulated for over a century. See for example S.D. Warren and L.D. Brandeis, *The Right to Privacy*, Harvard Law Review, 1890, 4, 5, pp. 193-220, at 195.

\(^{33}\) W. Parent, A New Definition of Privacy for the Law, *Law and Philosophy*, 1983, 2, 3, pp. 305-338, at 306. By “undocumented”, Parent refers to information not already in the public arena. Laurie (2002) calls this “informational privacy”, as distinct from the right to be left alone, which he calls “spatial privacy” (at p. 6). I agree with Laurie that both types of privacy remain distinct from liberty, although there is overlap in the interests that privacy and liberty aim to protect.

\(^{34}\) Emphasis added.


\(^{36}\) However, in the UK there is no common law freestanding “right to privacy”. See *Wainwright v Home Office* [2003] UKHL 53 *per* Lord Hoffman at paras 14-35; and *Campbell v MGN* [2004] UKHL 22 *per* Baroness Hale at para. 133: “our law cannot, even if it wanted to, develop a general tort of invasion of privacy”. This reverses the earlier proposition in *Douglas v Hello!* [2001] QB 967, where it was suggested that English law would recognise and protect a right of privacy, a position not endorsed by subsequent cases, such as *Wainwright*. Also, see *Ash v McKennitt* [2006] EWCA Civ 1714, *per* Buxton LJ at 8(ii):

> “in developing a right to protect private information, including the implementation in the English courts of articles 8 and 10 of the European Convention on Human Rights, the English courts have to proceed through the tort of breach of confidence, into which the jurisprudence of articles 8 and 10 has to be ‘shoe horned’”. This will discussed further subsequently in section 8.2.2.

\(^{38}\) Emphasis added.
Lord Hoffman\textsuperscript{39} described a “shift in the centre of gravity of the action for breach of confidence”\textsuperscript{40}. He indicated that it was the right to control one’s information which had now become central to what the law aims to protect in privacy cases:

Instead of the cause of action being based upon the duty of good faith applicable to confidential personal information and trade secrets alike, it focuses upon the protection of human autonomy and dignity - the right to control the dissemination of information about one's private life\textsuperscript{41} and the right to the esteem and respect of other people\textsuperscript{42}.

However, Tavani has criticised this “control theory” conception of privacy as being counter-intuitive in the following circumstances:

The prospect of someone disclosing all of his or her personal information and still somehow retaining privacy, merely because he or she had control over whether to reveal that information, would seem to be counter to our intuitions about what is required for privacy, as well as to the way we use that concept in ordinary discourse. Although one could exercise one’s individual autonomy in choosing to disclose every piece of one’s personal information to others, it would be difficult to understand how one could still retain one’s privacy\textsuperscript{43} in that case. It would seem that the control theory confuses privacy with autonomy.\textsuperscript{44}

He also points out that although the control theory rightly highlights the role of choice in privacy, it is unclear with respect to “which kinds of personal information one can expect to

\textsuperscript{39} Campbell v MGN [2004] UKHL 22.
\textsuperscript{40} Campbell v MGN [2004], at para. 51.
\textsuperscript{41} Emphasis added.
\textsuperscript{42} Campbell v MGN [2004], at para. 51.
\textsuperscript{43} Tavani’s use of the term “privacy” here is likely to refer to “informational privacy” as described by Laurie (2002), as having all one’s information in the public domain would not entail loss of one’s “spatial privacy”.
\textsuperscript{44} H.T. Tavani, Philosophical Theories of Privacy: Implications for an Adequate On-line Privacy Policy,\textit{ Metaphilosophy}, 2007, 38, 1, pp. 1-22, at 8. Arguably to choose to have no privacy at all could be an expression of one’s autonomy. On the other hand, in more usual circumstances, see G. Dworkin,\textit{ The Theory and Practice of Autonomy}, Cambridge University Press, 1988, p. 104, for a cogent discourse on the differences between privacy and autonomy.
have control over, and how much control one can expect to have over one’s personal information.”

He suggests that another theory of informational privacy, namely the limitation theory, has the advantage of not confusing privacy with autonomy in the way that the control theory does. The limitation theory sets up “zones” or contexts of privacy where others would be restricted from accessing one’s personal information. However, this theory underestimates “the role of control or choice that is also required in one’s having privacy.”

His solution, which I support, is to combine elements of both theories into a “restricted access/limited control” (RALC) model. In this model, “the concept of privacy is defined in terms of protection from intrusion and information access by others in the context of a situation.” He uses the example of medical information to illustrate this:

That information is private because a normative zone has been established to restrict people from accessing the information, not because an individual has complete control over who has access to that information within a medical setting. Doctors, nurses, financial administrators, and insurance providers may have legitimate access to various pieces of it.

Nevertheless, he does not dismiss the importance of control in privacy:

Control is (also) important for the management of privacy. In managing one’s privacy, however, one need not have absolute control over information about oneself (as implied

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45 Tavani (2007), at p. 7. I will not elaborate on the types of, and degrees of control over, information at this stage, as these will be discussed at 8.3.3., in the context of the proposed solution. However, I agree with Tavani that the control theory on its own does not do this.

46 See for example R. Gavison, Privacy and the Limits of the Law, Yale Law Journal, 1980, pp. 421-471. She describes this type of privacy as “limitation of others’ access” to one’s personal information, at 428.


48 Originally proposed by J.H. Moor in “The Ethics of Privacy Protection”, Library Trends, 1990, 39, (1-2), pp. 69-82. In theory, it would still be possible for an individual to waive his privacy rights in each of the zones that are established. However, I would suggest that the “default” settings of each zone, and the RALC process itself (as described later at 8.3.3.), would make it inherently more difficult, although not impossible.

49 As above, at p. 12.

50 As above, at p. 11.
in many versions of the control theory of privacy). Instead, an individual needs to have some degree of control with respect to three elements: choice, consent, and correction.\textsuperscript{51}

It is not clear whether the courts would favour an RALC approach when considering a patient’s control of his information. In \textit{Ash v McKennitt}\textsuperscript{52} a different concept of “zones” was suggested by counsel for Ash, in that the zones referred to internal\textsuperscript{53} areas of McKennitt’s private life, rather than external “zones”\textsuperscript{54} as proposed by Tavani. It was argued that having revealed a part of her life in order to support a charity, McKennitt had thereby placed that whole zone of her life in the public domain:

Information that is already known cannot claim the protection of private life. Mr Price however advanced a striking extension of that principle, that once a person had revealed or discussed some information falling within a particular “zone” of their lives they had a greatly reduced expectation of privacy in relation to any other information that fell within that zone. This argument was used in particular in respect of Ms Ash’s revelations about Ms McKennitt’s health and her distress at the death of her fiancé. The material said to contain revelations by Ms McKennitt falling within the same zone were remarkably sparse, which is in itself an indication of how protective Ms McKennitt has been of her privacy.\textsuperscript{55}

Buxton LJ was very dismissive of this approach:

\textsuperscript{51} As above, at p. 12. In terms of choice, Tavani suggests that “a person needs some control in choosing situations that offer others the level of access that the person desires”. He also maintains that the consent process helps in managing privacy: “for example, one can waive one’s right to restrict others from access to certain kinds of information about oneself”. Finally, “individuals need to be able to access their information and amend it if necessary”. These appear to be a reasonable account of how “limited control” would work in protecting privacy (given that “restricted access” should also be in place). I agree that choice, correction and consent are important elements of this model, and will illustrate their role in the example at 8.3.3.

\textsuperscript{52} [2006] EWCA Civ 1714.

\textsuperscript{53} In this case, the death of her fiancé.

\textsuperscript{54} That is, an external “zone” where an individual would allow some of his information to be held.

\textsuperscript{55} At para. 53.
It was cruelly insensitive to use Ms McKennitt’s promotion of the Cook-Rees fund, and her explanation of her reasons for setting up the fund, to suggest that she had thereby opened up whole areas of her private life to intrusive scrutiny\textsuperscript{56}…. If information is my private property, it is for me to decide how much of it should be published. The "zone" argument completely undermines that reasonable expectation of privacy\textsuperscript{57}.

Although the “zone argument” advanced in \textit{Ash} is completely different to that in Tavani’s RALC model, there is some danger that the two could be confused. For that reason, I would suggest that when applying the RALC approach, it may be preferable to use the term \textit{domain} rather than \textit{zone}\textsuperscript{58}. The “medical domain” would in turn have sub-divisions, such as a “GP domain” and (where applicable) a “psychiatric domain”, where information would be more tightly controlled compared with an “orthopaedic specialist domain”.

Health data is held in a number of settings, both therapeutic and non-therapeutic. For example, insurers, benefits agencies, research bodies and employers will also hold some health data. Ironically, while the GMC places exacting controls on the fitness for work advice by an occupational physician (OP) to an employer\textsuperscript{59}, UK patients face the prospect of having their much more sensitive health data (held by their GP) shared with a number of bodies with little

\textsuperscript{56} At para. 54. This is in contrast to the situation in \textit{Campbell}, where her “public lies” precluded her from claiming protection…When talking to the media Miss Campbell went out of her way to say that, unlike many fashion models, she did not take drugs. By repeatedly making these assertions in public Miss Campbell could no longer have a reasonable expectation that this aspect of her life should be private…where a public figure chooses to present a false image and make untrue pronouncements about his or her life, the press will normally be entitled to put the record straight.” (para. 24).

\textsuperscript{57} At para. 55.

\textsuperscript{58} That is, “domain” would be the same as “external” zone.

\textsuperscript{59} GMC, \textit{Confidentiality: Supplementary guidance}, London 2009, p. 23. This will be discussed later in 8.3.2.
control over this process, or so it would seem.\textsuperscript{60} A more open and explicit approach to the handling of \textit{all} health information, with appropriate safeguards in place, may promote greater public trust in health data management.

I will later describe how privacy domains might operate, using the OM domain as an example\textsuperscript{61}. Before we consider this proposed approach to protecting the privacy of health information, let us first review the role of confidentiality in the current paradigm.

\textbf{8.2.2. Confidentiality: Information or relationship?}

It has been said that confidentiality “is concerned as much with protection of a relationship as with personal information”\textsuperscript{62}. However, is this still currently the case?

In 1981, the Law Commission advised:

\begin{quote}
Once information has been entrusted in circumstances giving rise to an obligation of confidence, that information is in effect impressed with a duty of confidence owed to the person who has entrusted it.\textsuperscript{63}
\end{quote}

\textsuperscript{60} See for example http://www.telegraph.co.uk/health/nhs/10647031/NHS-medical-records-database-halted-amid-concerns.html (accessed 9 November 2014). On the other hand, this has been defended on the grounds that research could improve effectiveness of treatments, for example in A. O’Dowd, Medical Data: Does patient privacy trump access for research?, \textit{British Medical Journal}, 2013, 347, pp. 20-21. However, it is beyond the scope of this article to explore the issue of NHS data sharing.

\textsuperscript{61} At 8.3.3.

\textsuperscript{62} G. Laurie, \textit{Genetic privacy: A challenge to medico-legal norms}, Cambridge University Press, 2002, p. 211. However, information has now a greater role, see later in this section.

The “circumstances giving rise to an obligation of confidence” at that time included some relationship of trust. It seemed that both the information to be entrusted and the relationship itself were equally important in creating this duty of confidence. However, since then, Lord Goff has re-formulated the underlying principle:

…where an obviously confidential document is wafted by an electric fan out of a window into a crowded street, or when an obviously confidential document, such as a private diary, is dropped in a public place, and is then picked up by a passer-by…

…a duty of confidence arises when confidential information comes to the knowledge of a person (the confidant) in circumstances where he has notice, or is held to have agreed, that the information is confidential, with the effect that it would be just in all the circumstances that he should be precluded from disclosing the information to others.

Lord Hoffman described this “statement of principle, which omits the requirement of a prior confidential relationship” as being “now firmly established”. Therefore the nature of the information itself has primacy in establishing a duty of confidence.

Information that is already in the public domain is not generally considered to be private. However, in the medical context, one should be careful about assuming that information al-

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65 At para. 28.
66 At para. 27.
68 However, what constitutes the “public domain” has been a matter requiring clarification in many cases. See for example the discussion in the Law Commission Report 110, Breach of confidence, 1981, paras 4.17-4.24. Information would not be considered to be in the public domain merely because there were “other people in the world who knew the facts in question”, or part of the information was already in the public domain, and had “also to be distinguished from information which is only obtainable in the public domain (such as a product available in the open market) by the expenditure of a significant element of labour, skill or money”.
69 That is, “not be something which is public property and public knowledge”, Saltman Engineering Company Ltd v Campbell Engineering Company Ltd (1948) 65 R.P.C. 203, 215; [1963] 3 All E.R. 413, 415 per Lord Greene M.R. He also said that for the information to be capable of protection for breach of confidence, the information needed to have “the necessary quality of confidence about it”. This was interpreted by the Law Commission as reflecting “the secret character of the information”, as above, para. 4.15. In R v Department of
ready known to third parties is necessarily no longer private. To illustrate this with an example from the non-therapeutic setting, consider the guidance from the UK Faculty of Occupational Medicine (FOM):

Where information provided by a third party (medical certificates, referral letters) gives clinical information, even if the worker may have been the source of that information (e.g. the worker has told their manager about their illness), the occupational physician should not confirm such details without the worker’s consent.  

Although this advice may seem strange at first sight given that this information appears to be already in the public domain (or at least known by the employer’s representatives), it is possible that managers or even the worker himself could misinterpret the clinical information they were given, so their understanding of the diagnosis and other details may be inaccurate. Then, even if the OP merely confirms or refutes any clinical information given to him in a referral, the resultant effect is in fact disclosure of clinical information which had not really previously been in the public domain, and by so doing, he would inadvertently breach confidence.

Although health information is per se private information, it has been claimed that “not all medical information meets the criteria of confidentiality”. For example, one might agree

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Health, ex p Source Informatics [1999] 2 BMLR 65, CA, [1999] EWCA Civic 3011, at para. 35, Brown LJ again held that in personal privacy cases, a breach of privacy could not occur if the information was anonymised: “the confidence is not breached where the confider’s identity is protected”.

Faculty of Occupational Medicine, Guidance on ethics for occupational health practice, 7th edition, Royal College of Physicians, London, December 2012, 29, para. 3.61. OM information will be considered in greater detail in section 8.3.2.

This would also be consistent with the Law Commission Report comment above that if only part of the information were in the public domain, then the information is not considered to be in the public domain.

See for example Campbell v MGN [2004] UKHL 22 per Baroness Hale at 145, where she maintains that health information is private and confidential “not only from the confidentiality of the doctor-patient relationship but from the nature of the information itself” (emphasis added). Health information is also classed as “sensitive personal data” in England, under the Data Protection Act 1998 (s 2).

J.V. McHale, Medical Confidentiality and Legal Privilege, Routledge, London, 1993, 133. She goes on to say that “what does (meet the criteria of confidentiality) ought to be protected. Separating the wheat from the chaff, the crucially confidential from the superficially confidential, is no easy task.” She also suggests that “information imparted in the psychiatric consultation is generally regarded as crucially confidential”. Although McHale was making these points to support the development of “medical privilege” akin to “legal privilege”, and these predated Campbell, I agree with McHale’s comments and believe they remain valid post-Campbell.
that a doctor’s appointment for a blood pressure check is a less private matter than one for an HIV test. However, McHale warns us that some medical conditions may be more or less sensitive according to the circumstances and moreover, that “the level of sensitivity between different ailments may also vary between those of different cultural and ethnic groups.”

This raises doubts as to how any external party could possibly guess whether a patient would consider any given piece of information to be private or not, taking into account the circumstances, the ethnic and cultural differences, and any other personal beliefs and values. Therefore whether any information ought to be considered to be private seems to be a matter for the individual concerned to determine.

Although it may not always be clear what information an individual would consider to be private, in an action for breach of confidence, the nature of that information is now of prime importance, and the “limiting constraint of the need for an initial confidential relationship” has been “shaken off”.

Lord Nicholls goes on to say:

The continuing use of the phrase ‘duty of confidence’ and the description of the information as 'confidential' is not altogether comfortable. Information about an individual's

Indeed, comparable comments have been made more recently, albeit in the context of doctors weighing up situations where they might breach confidence in the public interest:

“Individual doctors are bound to weigh the scales differently in any particular instance while, in general, all relative weighting must change from case to case—there is, for example, a great deal of difference in respect of confidentiality between being stung by a bee and suffering from venereal disease.


74 As above, McHale (1993), at p. 76 where she suggests that “a gynaecological problem may be something which a young girl has great difficulty in discussing with her general practitioner, and she may be adamant that no one else should know about it. An older woman may feel no such inhibition”.

75 As above, McHale (1993), at p. 76.

76 On the other hand, it is not only the patient who has a legitimate interest in the confidentiality of his information, the hospital may also have one. See for example Ashworth Hospital Authority v Mirror Group Newspaper (MGN) Ltd [2002] UKHL 29, at para. 32, per Lord Woolf:

“while Ian Brady's conduct in putting similar information into the public domain could well mean that he would not be in a position to complain about the publication, this did not destroy the authority's independent interest in retaining the confidentiality of the medical records contained in Ashworth's files”.

77 Campbell v MGN [2004] UKHL 22, per Lord Nicholls at 14.
private life would not, in ordinary usage, be called 'confidential'. The more natural description today is that such information is private. The essence of the tort is better encapsulated now as misuse of private information.78

Given the primacy of information in determining confidentiality, do we need to consider the relationship at all? I advance two reasons for us to at least consider the role of a relationship in this context. Firstly, the fact that in England there is no common law “right to privacy”79, article 880 of the European Court of Human Rights has to be “shoehorned” (see below) into an action for breach of confidence; and secondly, medical confidentiality is said to be central to trust in the doctor-patient relationship81, so the interaction between that relationship and confidentiality also merits further discussion.

8.2.2(a) The “shoehorning” of article 8

Lord Phillips82 stated the conclusions of the Court of Appeal to be the following:

We conclude that, in so far as private information is concerned, we are required to adopt, as the vehicle for performing such duty as falls on the courts in relation to Convention rights, the cause of action formerly described as breach of confidence... The court should,

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78 As above, at 14. Subsequent cases have cited this to claim that a distinct tort of misuse of private information now exists. See for example Imerman v Tchenguiz [2010] EWCA Civ 908 per Lord Neuberger MR at para 65; Vidal-Hall & Ors v Google Inc [2014] EWHC 13 (QB) at 69. However, it is beyond the scope of this article to explore further the development of such a privacy tort.
79 See for example Ash v McKennitt [2006] EWCA Civ 1714, 8(ii).
80 Article 8 of the European Convention on Human Rights (ECHR), in Human Rights Act (HRA) 1998 Schedule 1: “Everyone has the right to respect (emphasis added) for his private and family life...”. This is a qualified right, and subject to consideration of conditions listed in Schedule 2, which includes “interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals”.
81 See for example West London Mental Health NHS Trust v Chhabra [2013] UKSC 80, per Lord Hodge at 33: “There is no doubt that patient confidentiality is an overriding principle and is central to trust between patients and doctors (General Medical Council, Good Medical Practice (2006) page 5 and paras 21 and 37, Guidance on Confidentiality (2009), para 6).”
82 Douglas v Hello (No. 3) [2005] EWCA Civ 595, at para. 53.
insofar as it can, develop the action for breach of confidence in such a manner as will give effect to both Article 8 and Article 10\(^83\) rights.

Buxton LJ\(^84\) commented that:

That feeling of discomfort arises from the action for breach of confidence being employed where there was no pre-existing relationship of confidence between the parties, but the "confidence" arose from the defendant having acquired by unlawful or surreptitious means information that he should have known he was not free to use.

Lord Phillips also expressed this “discomfort” in Douglas:

We cannot pretend that we find it satisfactory to be required to shoe-horn within the cause of action of breach of confidence claims for publication of unauthorised photographs of a private occasion.\(^85\)

In spite of this discomfort, in English courts the right to privacy is given effect by this shoe-horning, so at first sight, a relationship of confidence remains relevant. However, in “identifying the basis for claiming privacy or confidence in respect of unauthorised or purloined information…the primary focus has to be on the nature of the information, because it is the recipient’s perception of its confidential nature that imposes the obligation on him”\(^86\). Thus a relationship is imputed in such circumstances from the nature of the information, rather than

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\(^83\) “Everyone has the right to freedom of expression”, article 10 of ECHR, in Schedule 1 of HRA 1998. This “balancing test” between articles 8 and 10 was also done for health information in Campbell. This balancing exercise replaced that between private and public interests that one would have in the disclosure or not of one’s information, and Lord Hope felt that the new balancing exercise was “essentially the same” as the one it replaced, “although it is plainly now more carefully focused and more penetrating” (para. 86).

\(^84\) Ash v McKennitt [2006] EWCA Civ 1714, at 8(iii).

\(^85\) Douglas v Hello (No. 3) [2005], at para. 53.

\(^86\) Ash v McKennitt [2006] EWCA Civ 1714, at para. 15.
from the existence of any real relationship prior to receiving the information. It could therefore be argued that a tort of “misuse of private information” already exists but in name. On the other hand, Phillipson suggests that “case law discloses a certain amount of ambiguity” because if an obligation of confidence “could be imposed simply on the basis of the private nature of the material itself”, then at conceptual level, the notion that “in some sense, trust must be abused, would simply disappear”.

If it is indeed a notion of abuse of trust that the courts aim to retain in a breach of confidence action, then this may not be very evident, given the primacy that has been given to the information over the relationship. However, the Court of Appeal still holds that the “nature of the relationship that gives rise to the duty of confidentiality may be important”. This is because:

There is an important public interest in the observance of duties of confidence. Those who engage employees, or who enter into other relationships that carry with them a duty of confidence, ought to be able to be confident that they can disclose, without risk of wider publication, information that it is legitimate for them to wish to keep confidential.

One such relationship is undoubtedly the doctor-patient relationship.

\(8.2.2(b)\) The doctor-patient relationship

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87 As mentioned previously, it is beyond the scope of this article to explore whether the development of a privacy tort would be preferable to the current shoehorning as described.
89 On the other hand, I will later argue that the “privacy domain” approach (which will be described at 8.3.3.) will be more likely to engender trust, as it is a more transparent process than the way medical confidentiality currently operates (see later at 8.3.2(b)).
90 HRH Prince of Wales v Associated Newspapers Ltd [2006] EWCA Civ 1776, per Lord Phillips, at para. 69. This was in the context of balancing the right to privacy against the right to freedom of expression, in situations where the information could be deemed to be in the public interest.
91 HRH Prince of Wales v Associated Newspapers Ltd [2006], at para. 67.
“Confidentiality is central to trust between doctors and patients. Without assurances about confidentiality, patients may be reluctant to seek medical attention or to give doctors the information they need in order to provide good care.”92 The level of trust required is of the highest order: “Patients must be able to trust doctors with their lives and health.”93 So there can be no doubt how much importance the UK medical regulator, the GMC, attaches to confidentiality and trust between doctor and patient. It has also been said that “the principle of medical confidentiality— that doctors must keep their patients’ secrets— is one of the most venerable moral obligations of medical ethics.”94 Similarly, medical confidentiality95 is recognised in English law. In the leading case of W v Egdell96, Bingham LJ described the medical duty of confidence:

(Dr Egdell) could not lawfully sell the contents of his report to a newspaper, as the judge held. Nor could he, without a breach of the law as well as professional etiquette, discuss the case in a learned article or in his memoirs or in gossiping with friends…97

93 GMC, Good Medical Practice, London, 2013. This is the opening statement of “Duties of a doctor registered with the General Medical Council”, which are listed on the inside of the front cover page.
95 For a description of the development of the action for breach of confidence (not just of medical confidence), see Law Commission Report 110, Breach of confidence, 1981. For example, it notes that “in later cases, decided in the early years of the nineteenth century, the Court of Chancery recognised an equitable right in confidentiality of information” (at para. 3.2). Thus, “the remedies available in an action for breach of confidence have been greatly influenced in their development by the equitable origins of the action” (at para. 4.73).
96 [1990] 1 All ER 835. W was a psychiatric patient in a secure hospital, having killed five people. W’s solicitors commissioned a report from Dr Egdell, a consultant forensic psychiatrist, to support his application to a mental health tribunal for discharge or move to a lower risk unit prior to discharge. Dr Egdell deemed W to be still a danger to the public, so his report was not favourable and was suppressed by W’s solicitors. When he discovered this, Dr Egdell sent a copy of his report to the hospital authorities without W’s consent. Although the judge held that Dr Egdell did owe W a duty of confidence, the possible serious consequences of not disclosing his report overrode his duty of confidence. This is a case where a balancing exercise was needed between the private interest of W having his information kept confidential, against the public interest of safeguarding the safety of other individuals. On the facts of this case, the public interest “trumped” medical confidentiality, and it could be argued that the particularly serious consequences of non-disclosure were important in the judge’s determination.
97 At para. 849. Another example of a doctor breaching medical confidentiality (although without a public interest defence) is Chhabra v West London Mental Health Trust [2013] EWCA Civ 11, where it was held that Dr Chhabra, a consultant forensic psychiatrist, breached her duty of confidence when she read patient records in
In *Egdell*, there was a contractual, as well as a doctor-patient, relationship between Dr Egdell and W. Nowadays, any doctor-patient relationship would suffice for the information imparted to be confidential. As Pattenden commented:

Recent developments in the law have removed the need for impartation of the information within a relationship of trust…A professional (like anyone else) who somehow acquires confidential personal information may be saddled with an obligation of confidentiality to X, the subject of the information, whether there was direct, indirect or no contact with X. All that is necessary is that the professional was aware, or a reasonable person in her position would have been aware, that the information was private to X.

Even therapeutic relationships occur in different clinical settings, such as “short-term contact with a casualty doctor as opposed to a long term relationship with one’s general practitioner”, and so may give rise to varying levels of trust required or experienced, both qualitatively and quantitatively. Notwithstanding the actual closeness of the relationship or the level of trust in a particular doctor-patient situation, it would then seem that the existence of a professional relationship would be sufficient in common law to establish a duty of confidentiality.

way that details were visible to others, and discussed a patient’s case with a colleague on a train, overheard by other parties.

98 The contractual relationship with W was a further reason for Dr Egdell to keep W’s confidence. Had Dr Egdell been instructed by the hospital authorities instead, no breach of confidence would have occurred, given Bingham LJ’s comments at para. 849 (see below).

99 See for example *Ash*, at para. 15.

100 *R. Pattenden, The Law of Professional-Client Confidentiality: Regulating the Disclosure of Confidential Personal Information*, Oxford University Press, 2003, p. 13. Some ambiguity in interpreting this statement could arise if one imagined someone displaying a disability, say with his right hand, obvious even to a lay person. However, further information that a doctor could elicit would be a diagnosis, and the full level of disability and function. So although the fact that a disability existed would not necessarily be confidential, the diagnosis and full degree of disability would.


103 See Pattenden (2003) above, who suggests that this would apply to any professional in that position.
What does this common law duty of confidence require of doctors? In *Egdell*, having confirmed the existence of a duty of confidence by Dr Egdell to W, Bingham LJ went on to say:

The breadth of such a duty in any case is, however, dependent on circumstances. Where a prison doctor examines a remand prisoner to determine his fitness to plead or a proposer for life insurance is examined by a doctor nominated by the insurance company or a personal injury plaintiff attends the defendant’s medical adviser …, the professional man’s duty of confidence towards the subject of his examination plainly does not bar disclosure104 of his findings to the party at whose instance he was appointed to make his examination.105

Thus although the Court of Appeal held that a duty of confidence existed, they took this to mean Dr Egdell could not “lawfully sell the contents of his report to a newspaper... Nor could he, without a breach of the law as well as professional etiquette, discuss the case in a learned article or in his memoirs or in gossiping with friends”106. This did not mean that a doctor could not disclose his report to a commissioning party, such as an insurance company. Medical confidentiality is therefore not breached when the report is disclosed107 to the commissioning party108.

In addition, when patient information is disclosed, there should be a consideration of the possible justifications and interests in the disclosure of such information. It is not sufficient to say that this information is confidential and therefore no disclosure is possible.109 In *Mersey*...

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104 Emphasis added.
105 As above, at para. 849. It is important to note that although *Egdell* itself is rightly remembered as a case where the public interest overrode medical confidentiality because the public could have been severely at risk had the information not been disclosed, in making this statement at para. 849, Bingham LJ was referring to other scenarios such as insurance reports, where public safety is not an issue.
106 As above, at para. 849.
107 Without further consent. See *Farnsworth* and *Kapadia* later in 8.3.2(b).
108 An analogous situation to such an insurance doctor report would be an occupational physician’s report, especially as they are both “dual obligation doctor” situations.
109 I accept that this is already the case in public interest situations or if required by law. However, I am arguing here that the interests that could justify disclosure should be broader in scope.
Care NHS Trust v Ackroyd, the Court of Appeal had to consider new facts since the case had been heard in Ashworth Hospital Authority v Mirror News Group Newspapers (MGN) Ltd, and had to repeat the balancing exercise between the public interest in maintaining medical confidentiality and that of disclosing information in the public interest. Jackson comments: “The case demonstrates that the confidentiality of medical records has to be put in the balance with other important interests, such as press freedom”. I suggest that medical confidentiality would need also to be balanced against other interests, such as the proper administration of pension fund awards. In order to discuss this and other issues with “confidentiality” in non-therapeutic (OM) doctor-patient interactions further, I will first briefly describe the practice of OM in the UK.

8.3. OCCUPATIONAL MEDICINE (OM) PRACTICE IN THE UNITED KINGDOM

8.3.1. A brief description

OM is predominantly a preventative rather than curative speciality, so generally OPs do not provide treatment, except for some immunisations, but instead assess and advise on workers’

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10 (No. 2) [2007] EWCA Civ 101. Mr Ackroyd, a freelance journalist, had refused to name his source at Ashworth Hospital who had disclosed Ian Brady’s medical notes to him. The new facts included the motives of the source, which were likely not financial, and could have been “misguidedly” in the public interest. The passage of time (6 years) was also reassuring in that there had been no new leaks, possibly as a result of the hospital adopting better systems to protect patient confidentiality.

11 E. Jackson, Medical Law: Text, cases and materials, 3rd edition, Oxford University Press, 2013, p. 363. As previously mentioned, Campbell and subsequent cases have required a balancing exercise between articles 8 and 10. I draw here on Jackson’s comment that the balancing exercise might also be required against “other interests” (although she herself quotes “press freedom”).

113 See discussion later in section 8.3.
fitness for work. Moreover, “industry has changed from a manufacturing to a service majority over the last 20 years and this trend may continue. The main hazards have changed from dust, heat, noise and vibration to workplace pressure.” The practice of OM, which had previously been mainly concerned with the effects of workplace hazards on workers’ health, has changed to one that provides “a reduced emphasis on health protection, with more attention now being paid to assessment of fitness for employment and the management of incapacity for work.” There has also been a growing trend for OH services to be outsourced from in-house provision to external commercial providers. These developments have led to an increase in the type of OP work that would result in a written report to the commissioning party, usually the employer for a sickness absence assessment or a pension fund manager for an ill-health retirement (IHR) application. Thus whether OM information and reports are or are not, or should or should not be, confidential is an important consideration in this setting.

8.3.2. Is OM information confidential?

8.3.2(a) Why should it be?

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116 See for example in: Faculty of Occupational Medicine, Future directions for the occupational health care in the UK, A strategic overview, 2010, p. 3 para. 4.

117 For a description of OP work in the UK, see J. Tamin, Models of occupational medicine practice (2013). In particular, one of the roles of an OP requires “independence” in order to conduct ill-health retirement (IHR) assessments.

118 This forms a significant amount of the OP’s workload in the UK. For example a survey reported in J. Ballard, OH professional practice, Part 1: jobs, priorities, concerns, threats and opportunities, Occupational Health at Work, 2011, 8(1), pp. 21-27, at 22 found that 17% of OPs list “dealing with Ill Health Retirements” amongst their top three priorities. The majority of these assessments are made on evidence provided only, and no face-to-face consultation takes place, as with for example the largest pension scheme, the NHS Pension Scheme. Even when a face-to-face consultation takes place, it would be rare for new information to become available, as the applicant’s treating doctors will normally have provided beforehand the results of investigations that have been undertaken.
Health information is private information\textsuperscript{119}, so OM information is *de facto* private. It can be argued that there is statutory support for this position. The Data Protection Act requires the information pertaining to the “physical or mental health or condition” of an individual to be classed as “sensitive personal data”\textsuperscript{120}. The Information Commissioner has issued specific guidance on information about workers’ health\textsuperscript{121}:

Managers should not have access to more information about a worker’s health than is necessary for them to carry out their management responsibilities. As far as possible the information should be confined to that necessary to establish fitness to work, rather than consist of more general medical details.\textsuperscript{122}

There is also a directive to:

Act in a way that is consistent with the Guidance on Ethics for Occupational Physicians published by the Faculty of Occupational Medicine. Although this is guidance for occupational physicians rather than employers, it should give you a clear understanding of the legal and ethical constraints that apply to the exchange of information when working with occupational health professionals.\textsuperscript{123}

The FOM guidance in this regard is as follows:

Paper occupational health records must be held confidentially and be accessed only by members of the occupational health team on a need-to-know basis. The same principles apply equally to electronic records.\textsuperscript{124}

\textsuperscript{119} *Campbell v MGN* [2004] UKHL 22, para. 145.
\textsuperscript{120} Section 2(e). Such data are subject to the more stringent processing requirements in Schedule 3.
\textsuperscript{122} At para. 4.1.4.
\textsuperscript{123} At para. 4.2.3.
The Court of Appeal has also confirmed that OM information is confidential. In *Hartman v South Essex Mental Health and Community Care Trust*[^125^], Scott Baker LJ commented:

..it was not right to attribute to the Trust in their capacity as employers, knowledge of confidential medical information disclosed by Mrs Hartman to the OHD…[^126^]

Kloss argues:

There is no legal authority for the proposition that confidential information in someone’s personnel file can be communicated to other members of the workforce without consent. It is a breach of the employer’s duty of trust and confidence.[^127^]

From the foregoing, there appears to be strong support, both in statute and in common law, for her assertion. However, in the next section, I will aim to demonstrate that there are circumstances where OM information can legally be disclosed without consent[^128^].

8.3.2(b) When can OM information be disclosed?

In the case of an OM report following a pre-employment assessment, an Employment Appeal Tribunal (EAT)[^129^] stated:

[^125^] [2005] EWCA Civ 06. Mrs Hartman was a nursing auxiliary at a respite centre for children with learning difficulties. She claimed that her employer ought to have known that she was at higher risk of mental breakdown, as she had declared to the occupational health department (OHD) her past history of a breakdown.

[^126^] At para. 33.


[^128^] And without requiring the public interest justification.

[^129^] *Farnsworth v London Borough of Hammersmith & Fulham* [2000] IRLR 691. Ms Farnsworth had been offered the post of residential social worker subject to a medical assessment. Dr Cooper received information from her GP and hospital doctor that she had a past history of depression for which she had been hospitalised, but had been well for the last year, and wrote a report to the employer to the effect that Ms Farnsworth had had past health problems which could recur and affect her future performance and attendance, following which the offer of employment was withdrawn. Ms Farnsworth claimed that, because she had not further consented to this report being sent to the employer, Dr Cooper had breached her confidence.
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.

Dr Cooper, the OP in the above case, was held to owe a duty of confidence to Farnsworth, in that she could not disclose the medical information to parties other than the employer’s decision makers or for other purposes. However, this duty of confidence did not prevent her from disclosing information to the employer for the purposes of making their employment decision. This position is entirely consistent with Bingham LJ’s dictum in Egdell. On the other hand, Kloss, a former employment tribunal judge, views this ruling as reflecting “the general lack of knowledge of occupational health issues among the tribunals”. She bases her criticism of this finding on the fact that “Miss Farnsworth was unlikely to have given informed consent to the disclosure of all her medical information to any manager in the London borough”. However, this criticism seems to me to be unfair. The EAT did not suggest that disclosure could be made to “any manager”, but would be made specifically to the “decision makers”, and the information was to be confined to that which would allow them to make their employment decision.

130 Emphasis added.
131 At para. 21.
132 At para. 22.
133 As above, at para. 849. The fact that Egdell relates to a report which had to be balanced against the public interest is immaterial here. At para. 849, Bingham LJ was clearly referring to doctors commissioned to produce an independent report, such as insurance doctors. Doctors commissioned to produce an independent report following an IHR assessment would be in an analogous situation to those instances that Bingham LJ had in mind. In addition, Egdell differs from OM reports in a further important aspect, in that the contractual relationship was between W and Dr. Egdell, whereas for OM reports the contract will be between the OP and employer or pension fund manager. In Egdell, this adds a further reason why consent would have been required for disclosure of the report, although public safety was held to justify confidentiality being breached in that case. For OM reports, confidentiality is not breached if the disclosure is only to the commissioning party, and there is no issue of contractual obligations between the OP and worker.
134 As above, see Kloss (2010) at p. 323.
135 It has been argued that the concept of “informed consent” is incorrectly applied when used for disclosure of a report, as opposed to treatment. See J. Tamin, Can informed consent apply to information disclosure? (2014). This is because of the informational flow being in opposite directions, the inability to predict the consequential outcomes as accurately as with treatment interventions (so making “informed” questionable), and differences between the two “consenting” processes, so that “permission to disclose” is proposed as an alternative to “informed consent” in the context of releasing a report.
136 As above, at p. 323.
137 This is consistent with Egdell, at para. 849, in that such disclosure of information would not be a breach of confidence, as it is disclosure “to the party at whose instance he (the professional man) was appointed to make his examination”.

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In *Kapadia v London Borough of Lambeth*\(^{138}\), a case where an OP was asked to assess a worker for an independent opinion, but then did not provide the employers with a report because the worker subsequently did not give consent for this report to be released, the Court of Appeal ruled that:

On the facts the Court knows, the report should, in my judgment, 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. A practice under which a person who has agreed to be examined in circumstances such as these, but then claims a veto upon disclosure of the report to those who obtained it is not, in my view, a good practice. Indeed it is an impediment to the fair and expeditious conduct of litigation.\(^{139}\)

Kloss points out that:

In fact, it may be that the information given to the Court of Appeal about the OH doctor’s report was inaccurate. The doctor in question states that he did not write a report because Kapadia had not given informed consent.\(^{140}\)

However, in my view, whether he did not write the report or did not produce it to the employer is largely immaterial to the Court’s ruling. Once again, the legal position is that once the worker has consented to the assessment process, further consent is *not* required before disclosing the report to the commissioning party. This is also consistent with *Egdell*\(^{141}\).

Although it may appear at first sight that the judgment in *Hartman* is at odds with those in *Farnsworth* and *Kapadia*, I would suggest that it is not. OM information is confidential, so information should not simply be extracted from a worker’s OH file and passed to his employer without his

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\(^{138}\) [2000] IRLR 699. Mr Kapadia was pursuing a disability discrimination claim against his employer.

\(^{139}\) At para. 34.

\(^{140}\) As above, p. 82.

\(^{141}\) “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”, at para. 849. As previously mentioned, the public interest defence in *Egdell* does not affect my use of Bingham LJ’s *dictum*, as he was referring to other instances, that is, doctors commissioned to produce a report, such as insurance doctors. In addition, there is no public interest defence in *Kapadia*. 
knowledge and consent. On the other hand, once a worker has agreed to be assessed for the purposes of a report being produced, no further consent is required prior to information disclosure to the commissioning party, and when this is disclosed, confidence is not breached. If English law gives us a pragmatic and coherent answer to the issue of confidentiality of OM information and reports, unfortunately UK ethical guidance does not.

GMC guidance requires doctors to “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”. However, I would argue that such a requirement to obtain further consent before sending a report exceeds what the law requires. Firstly, disclosure of medical information in a report to the commissioner does not breach confidentiality, so why would consent for such a disclosure be necessary? Moreover, case law involving OPs reinforce the fact that consent for disclosure of such a report to the employer’s decision makers or the courts is not required. There is no legal authority to support the opposite view, namely the GMC and FOM guidance that consent is required for disclosure of such a report to the commissioner.

The practical consequence is that a worker (or ex-employee applying to the pension fund) who has been found not to meet the medical criteria for an ill-health retirement (IHR) by one OP, can see this report first, then simply refuse consent for the report to be released to the pension fund managers.

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142 This is different to a report written by “a medical practitioner who is or has been responsible for the clinical care of the individual”, which would be subject to the Access to Medical Reports Act 1988, and would require patient consent and up to 21 days for the patient to view the report prior to its release.

144 GMC, Confidentiality: Supplementary guidance, London 2009, at p. 23. This includes a section entitled “Disclosing information for insurance, employment and similar purposes” (pp. 22-26), which applies to those doctors with no therapeutic relationship with the patient, such as OPs (p. 24). The fact the applicant can read the report before the commissioner, and withdraw “consent” if he chooses to suppress this report, is evidence that this guidance requires specific consent for the disclosure of this report.

145 Namely Egdoll and Kapadia.

146 Egdoll, at para. 849.

147 Farnsworth, at para. 22.

148 Kapadia, at para. 34.

149 However, it might be argued that the GMC is seeking to affirm the importance of confidentiality and consent in all circumstances, and for doctors to reflect on the need for this. Nonetheless, in the specific situation of an independently commissioned report to be disclosed to the commissioner, the courts have been very clear that subject consent is not required. GMC and FOM guidance ought to reflect this legal position, and currently they do not.

150 Current consent forms used in OM offer the worker or pension fund applicant the choice to see the report before the commissioning party (and giving them the option of withdrawing consent when they have read the
allowing him to seek a more favourable opinion from a different OP at a later date. This right of veto clearly indicates that specific consent for the report to be released is required by the GMC and FOM. This is in direct conflict with *Egdell*. The FOM acknowledges that “ethical responsibilities in this area (of IHR assessments) are more complex than in much of occupational health because stakeholders include the pension scheme administrators and trustees as well as the workers and the employers”.

Nonetheless, in terms of guidance, it merely repeats the GMC approach and justifies this on the basis of the “ethical principle of ‘no surprises’”. Those who defend this FOM position emphasise the importance of trust in the doctor-patient relationship. They claim this trust is maintained by the “patients’ confidence that sensitive personal information will not normally be divulged outside the clinical team without prior consent”, and that OPs need this “high level of trust on the part of the worker, who often enters the occupational health (OH) process with a level of mistrust or apprehension in the integrity of the healthcare professional”.

However, in its guidance to all doctors, the GMC allows a breach of confidence without consent, for example, “if it is required by law” or “if it is justified in the public interest”, and even requires a breach of confidence in some circumstances. The GMC states doctors “must inform patients about disclosures for purposes they would not reasonably expect, or check that they have already received information about such disclosures”. However, either some doctors do not explain this clearly enough, or some patients do not understand it fully, but the net result is the same: the doctor ends up having knowledge of a patient secret that he must then disclose. I assume that if patients fully understood the implications of sharing secrets that could have adverse consequences for them, they would

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152 At p. 26.
156 GMC, *Confidentiality: Supplementary guidance*, London 2009, pp. 8-13, on “Reporting gunshot and knife wounds”.
choose not to reveal these. So, patients are being *misled* with a promise of confidentiality, only later to discover the “get out clauses” that they had failed to appreciate fully. Therefore, this version of “confidentiality”, which is meant to foster doctor-patient *trust*, could actually involve inadvertent *deception*\textsuperscript{158}. For this reason, Kottow\textsuperscript{159} argues that there should be no allowed breaches at all, even in the public interest:

This postulated exemption to confidentiality is self-defeating. Firstly, if physicians become known as confidence-violators, problem-ridden patients will try to lie, accommodate facts to their advantage or, if this does not work, avoid physicians altogether. Physicians would then be unable to give optimal advice or treatment to the detriment of both the reluctant patients and their threatened environment…

If public interest demands a catalogue of situations where the physician would be under obligation to inform, medicine becomes subaltern to political design and starts down a treacherous path.

Should one prefer to leave the management of confidentiality to the physician's conscience and moral judgement, public interest would not be relying on a consistent and trustworthy source of information. Fear of either political misuse\textsuperscript{160} or personal arbitrariness should make us wary of opening the doors of confidentiality for the sake of public interest.\textsuperscript{161}

I believe that Kottow makes a valid point. If the GMC and FOM aim to engender trust in doctors through the current confidentiality rules, the fact that breaches are allowed or even required, makes it possible that patients would end up *mistrusting* them instead\textsuperscript{162}.

\textsuperscript{158} O. O’Neill suggests that “If we want to restore trust we need to reduce deception and lies rather than secrecy”, in *A Question of Trust, The BBC Reith Lectures 2002*, Cambridge University Press, 2002, p. 70.


\textsuperscript{160} Kottow was possibly more acutely aware of political pressures in the Chile of the 1980’s, but even outwith this context, I believe that his point remains valid.

\textsuperscript{161} At p. 120.

\textsuperscript{162} S.J. Warwick, in *A vote for no confidence, J Med Ethics*, 1989, 15, pp. 183-5, argues on that basis that all doctors should not accept information in confidence.
The second weakness in the FOM’s current position, I would suggest, is that it ignores the context of the report that is being written. In producing a report to pension fund trustees, there is an explicit requirement on the OP to be independent. It has been argued that in such a role, the OP is not in a fiduciary relationship with the applicant, so the level of trust required need not be as high as in a therapeutic relationship. Furthermore, a consideration of confidentiality needs to be balanced against other competing interests. In this context, it would need to be balanced against the benefit of having a process that allowed the production of an independent and unbiased medical report, which could not be suppressed by the applicant, so that public funds are not misused.

Interestingly, Pattenden misunderstands the OM process as advocated by the FOM. She includes reference to previous GMC guidance and the previous edition of the FOM ethical guidance to state:

At the outset of the examination, the professional should (as a matter of ethics and of law) tell the examinee (if he is capable of understanding the information) that:

The usual seal of confidentiality in a professional relationship does not apply and (if the examinee has any choice in the matter) that he must consent to being seen on that basis.

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163 For example, the term “independent” is used in the title “Independent Registered Medical Practitioner” (IRMP) in the Local Government Pension Scheme (Benefits, Membership and Contributions) Regulations 2014. The IRMP will sign a certificate including a statement such as:

“I have not previously advised, or given an opinion on, or otherwise been involved in this case, nor am I acting or have ever acted as the representative of the member, the scheme employer or any other party in relation to it”.

164 J. Tamin, Models of occupational medicine practice (2013), at p. 503. It is argued that a fiduciary relationship entails a “duty of undivided loyalty” to the patient, which is de facto incompatible with the requirement for independence in this role.

165 Possibly limited to trusting that the OP in the IRMP role has the necessary qualifications and training, and will perform the assessment competently.

166 Ackroyd (No. 2) [2007].

167 By withdrawing consent.

168 From an ethical point of view, this would be supported by the principle of distributive or social justice. There is also legal support for this position. In the ECHR case of MS v Sweden (1997) 45 BMLR 133, case 74/1996/693/885, the court held that disclosure of private medical information was necessary in a democratic society for the proper administration of public funds:

“the Court considers that there were relevant and sufficient reasons for the communication of the applicant’s medical records by the clinic to the Office and that the measure was not disproportionate to the legitimate aim pursued.” (at para. 44).


171 Emphasis added.

172 At p. 17.
In fact, although both the GMC and the FOM required the OP to explain the purpose of the consultation at the earliest opportunity (and this remains current advice), they did not intend to suggest that the “usual seal of confidentiality” did not to apply. It could be argued that if OPs did not accept information in confidence, this would help reduce confusion and improve transparency, which in turn would improve the trust of workers in the OH process. However, although it might be more honest not to accept information in confidence, it could be equally confusing to the worker or patient. What can he tell this doctor, if anything? Should he withhold all information? For this reason, I suggest another approach, based on “privacy domains”\footnote{Which in turn is an approach based on Tavani’s RALC (restricted access/limited control) model.}, which I will next describe.

\textit{8.3.3. A proposed privacy paradigm: The example of an OM Domain}

The scenario of an independent assessment for a pension fund application for early ill-health retirement will be used to illustrate how a privacy domain, in this case an OM domain, would function\footnote{The same process is likely to be adaptable to the therapeutic, or more generally, health information scenarios, but these settings are beyond the scope of this article.}, and this will be called domain OM2\footnote{For a discussion of various OM roles in the UK, see J. Tamin, Models of occupational medicine practice (2013). In terms of OP-worker relationships, model 1 is described as “quasi-therapeutic” and model 2 as “independent doctor”, and these would translate to domains OM1 and OM2 respectively for this article.}. The worker (or applicant to the pension fund) has a choice of what information is given to the independent doctor (OP), that is, what information is contained in domain OM2. For example, any information that is sensitive to the applicant, but not likely to be relevant to the application could be excluded, such as abortions or miscarriages for a female applicant\footnote{On the other hand, in \textit{MS v Sweden} [1997] 45 BMLR 133, it was held that her abortion was in fact relevant as it was deemed to be connected with her back pain, which was the basis of her claim.}. Arguably, the applicant could also ask to see the written records in possession of the OP\footnote{He would have a right to this under the Data Protection Act.}, and if there were factual errors, correct these.
In practice, it may be less likely to be relevant in this scenario as the OP would only have limited information, but correction could be a useful aspect of control where more sensitive or significant information is held, such as in a GP domain. The recipients of any disclosures from this domain will be clearly specified to all parties. The pension fund managers would definitely be allowed to receive the report, whereas a newspaper definitely would not. Where parties are specified in this way, and it is clear whether they are entitled or not to receive information, then applicant consent is not required. On the other hand, if other situations occurred, such as the OP wishing to submit a report of the case to a learned journal, or share details with other medical colleagues, then applicant consent is required. In this way, by having specified and restricted access to the information contained within that domain, the applicant retains some control over the disclosures, but does not require complete control to protect his privacy. In this way, a privacy domain works because it restricts (and specifies who has) access to the information contained within that domain, and a reduced level of control is sufficient to ensure that the disclosures are in line with what has been agreed between the parties beforehand.

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178 I suggest this would be a more transparent process, and remove (or at least reduce) confusion about what secrets are meant to be kept, and what is to be disclosed, and to whom. For example, see S. Warwick (1989), p. 183, where she describes this uncertainty around patients’ expectations of what is to be kept secret, and for what reason, in the current “confidentiality” paradigm. P. Singleton, N. Lea, A. Tapuria and D. Kalra (Cambridge Health Informatics), General Medical Council: Public and Professional attitudes to privacy of healthcare data, A Survey of the Literature, GMC, London, 2007, p. 27, also provide empirical evidence of this public uncertainty about medical confidentiality.

179 Which would be consistent with both Egdell, at para. 849, and Kapadia, at para. 34.

180 As per Bingham LJ in Egdell, at para. 849.

181 In practice, disclosure of information from a privacy domain merely mirrors the current legal position, as expressed in Egdell and Kapadia. However, I would hope that having such a process described more explicitly in this way would make it more likely that the GMC and FOM guidance will reflect this process in future, rather than give advice that conflicts with the legal position.

182 The difference between control and consent is that consent in this paradigm is only required if the report is intended to be disclosed to a party not previously specified, such as to a journal for publication.

183 However, in some ways an OM privacy domain is easier to operate than other health domains. This is partly because the OM2 domain describes a one-off situation where the OP is assessing an application for ill-health retirement. Other health situations will be more complex, as health conditions may change over time, and patients may change their minds as to what information is contained in a specific domain, and who might access the domain. Although it is beyond the scope of this article to address these more complex scenarios, I would suggest that the privacy domain approach at least brings these difficult issues to the foreground, and this process should be a more transparent way of dealing with privacy of health information.
What then are “patient secrets” in OM practice?

Given that health information is private, it follows that information held in a worker’s OM record should be private. The OP also owes a duty of confidence to the worker. It matters little that the relationship between OP and worker differs from the usual doctor-patient relationship\textsuperscript{184} in a therapeutic setting. Such a duty is imparted to any professional\textsuperscript{185} or other recipient of the information by its very nature\textsuperscript{186}. However, I have argued that the present system of medical confidentiality lacks transparency and has the potential for deception\textsuperscript{187}, rather than engendering trust as it is intended to. In a “privacy domain” paradigm, it would be clear to all what information would be contained in each domain, and to whom information could or could not be communicated. Nonetheless, even in the current paradigm, disclosing an independently commissioned report to the commissioning party does not breach the common law duty of confidence\textsuperscript{188}, and disclosing such a report to the commissioner without further consent is entirely legitimate\textsuperscript{189}. I believe that current GMC and FOM guidance on this matter is unnecessarily inconsistent with the law’s requirements. Even those who may not agree with me on this point would concede that it is confusing for OPs to be in the situation where disclosure of their report to the commissioner without further consent is lawful but, according to the GMC and FOM, unethical.

Acknowledgments

\textsuperscript{184} See J. Tamin, Models of occupational medicine practice (2013).
\textsuperscript{185} R. Pattenden (2003), at p. 13.
\textsuperscript{186} Campbell, at para. 145.
\textsuperscript{187} For example, breaches of confidence in the public interest.
\textsuperscript{188} Egdoll, at para. 849.
\textsuperscript{189} Farnsworth, at para. 22; Kapadia, at para. 34.
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PART III

A policeman’s lot is not a happy one
(Gilbert & Sullivan)
Chapter 9

CONCLUSIONS

9.1. Confusion

In his preface to the previous edition of the FOM’s guidance on ethics\(^1\), David Snashall, the then President of the FOM, stated:

“Practising occupational physicians probably think about ethics every day. At least they think about the subject more often than most doctors...”

Why should practising OPs think about ethics every day, or at least more often than most doctors? After all, they are not involved in life or death decisions, or complex moral issues around the beginning and end of life, for example. Furthermore, it seems that thinking about ethics more often than most doctors apparently does not make OPs any more proficient at clarifying their ethical problems, as a survey revealed significant variations in their interpretation and practices around confidentiality and consent\(^2\).

The ethical difficulties that arise from OM practice may partly be explained by the intrinsic nature of the discipline of OM itself. The very fact that it places “dual obligations” on doctors produces a tension between their obligations to the two (or more) parties, especially when these parties are in conflict. For example, a worker may believe himself to be too ill to work,


\(^{2}\) Stern AF and Sperber S. Occupational physicians’ perceptions and impact of 2009 GMC consent guidelines. *Occupational Medicine*, 2012, 62, p560-562. However, another possible interpretation of the findings is that OPs, having thought through and reflected on the ethical issues, come up with different interpretations of the guidance on confidentiality and consent, and this leads to different practices. This is more likely to be the case if the guidance itself is inconsistent and confusing, as I will later argue it is, especially in section 9.3.
whereas the employer does not believe this to be the case. Conversely, another worker may want to continue to work when his employer does not believe it to be safe for him to do so. So one can understand that on a day-to-day basis, OPs would need to give advice that one or other party might not like.

On the other hand, one might expect that with clear and consistent ethical guidance, OPs would be able to navigate these difficulties and perform their role in the impartial and unbiased way that is expected of them. However, if the ethical guidance instead expected OPs to be simultaneously a *fiduciary* and *independent* from the “patient”, applied the usual concept of consent for disclosure of their report, and even conflicted with the law on confidentiality, then it may not be too surprising if OPs were confused. One might expect such confusion to hamper OPs in the performance of their roles and duties, especially in the “independent expert”\(^3\) role.

In the next section, I will review the main arguments in my submitted articles, in order to demonstrate that the current state of ethical guidance to OPs is confusing and conflicting, and elucidate the reasons why this is the case.

### 9.2. The submitted articles

#### 9.2.1. The relationship

In a therapeutic setting, “patients must be able to trust doctors with their lives and health”\(^4\) or with “intimate details of their lives which they may even conceal from their families”\(^5\), and in

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\(^3\) Which is required when they carry out IHR assessments (see chapter 6).

\(^4\) GMC, *Good Medical Practice*, (2013), introductory remarks on the inside of the front cover.

return, “good doctors make the care of their patients their first concern”\(^6\). It is therefore not surprising that the relationship between patients and their doctors has been described as a “paradigm of a relationship of trust”\(^7\), and there is strong support for the view that the DPR is a fiduciary one\(^8\). In such a relationship, the doctor would need to adhere to the principles of no conflict of interest, not profiting from his position, a duty of undivided loyalty to the patient and a duty of confidentiality\(^9\).

In my first paper, I contrast this relationship with that between OPs and workers, given the roles and functions that UK OPs undertake. I argue that in particular, the role that I label the “independent expert” (or model 2) specifically requires the OP to be completely independent from the worker. This is the clearest situation where an OP could not possibly be expected to owe a “duty of undivided loyalty” to the “patient”, and be “independent” from the “patient” at the same time! These are diametrically opposed obligations that cannot possibly be actioned concurrently. So, it is not surprising that such an expectation for both sets of obligations to be satisfied puts the “independent expert” in an impossible situation.

Those who object to my proposition that the two sets of obligations are imposed on a doctor in this “independent expert” role might argue that these obligations are not in fact expected to co-exist. I suggest that the requirement for independence could be in little doubt in this function\(^10\). On the other hand, it could be argued that the need for fiduciary obligations to apply here is less explicit. However, I would refute this argument by referring to the language used by the GMC to describe the duties owed by doctors. Phrases such as “make the patient

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\(^8\) See for example Brazier and Lobjoit (1999). The requirement for a power imbalance between the two parties is also satisfied. Although there are some objections to the view that the DPR is fiduciary in nature, as described in chapter 6, I find the arguments in favour more persuasive.


\(^10\) Indeed, I have pointed out previously that some large public sector schemes, such as the Local Government Pension Fund, have a statutory requirement for this independence (Local Government Pension Scheme (Benefits, Membership and Contributions) Regulations 2014).
your first concern” and patients needing to be able to “trust doctors with their life and health”, in my opinion indicate that the GMC also characterise the relationship between doctors and their patients as a fiduciary one. Thus I maintain that the independent expert is expected to be a fiduciary and independent at the same time, when the two sets of obligations are mutually incompatible.

A further objection to my proposition could be that my portrayal of OP-worker interactions is not sufficiently nuanced, that situations are rarely all or none, black or white. To some extent, I agree with this objection. Although OPs should, at the beginning of a consultation, explain its purpose and their role\textsuperscript{11}, it can be by no means certain that the resulting relationship will be the intended one. On the one hand, some workers will have been referred to see the OP and feel defensive regardless of the OP’s assurances of impartiality. On the other, workers who have formed a long term relationship with an OP, especially in an in-house service setting, can be overly trusting of the OP, and so may be disappointed later at the outcome when this is not what they had hoped for. There is therefore a range of possible relationships dependant on many factors, including the type of OH provision and the type of or reason for the consultation. This is why I have proposed three models of OP-worker interactions to reflect this range.

Although this approach in itself does not necessarily reduce the confusion that arises out of all OP-worker relationships, I would suggest that this is a first step. The most confusing, or most conceptually absurd, situation is to expect an OP to be a fiduciary and independent at the same time, which I have argued is the current position of the independent expert\textsuperscript{12} (model

\textsuperscript{11} FOM Ethical guidance for Occupational Health Practice (2012), p26, para 3.44.

\textsuperscript{12} It could be argued that English case law provides some further support for the concept of the “independent expert” situation and a distant DPR. In Kapfunde v Abbey National [1998] EWCA Civ 535, where Kapfunde had declared a condition of sickle cell anaemia on her pre-employment medical questionnaire and Dr Daniel, the OP, found her to be medically unfit for the post on that basis, Kennedy LJ pointed out “the lack of any doctor/patient relationship” (at 4(A)(1)) as Dr Daniel never saw Kapfunde, who in turn “probably never knew of the existence of Dr Daniel” when she submitted her questionnaire. This pre-employment situation mirrors very much the IHR process, where the applicant and OP lack the “proximity” to give rise to a duty of care to the applicant (per Kennedy LJ at 4(B)). Even when there is a face-to-face pre-employment assessment, such as in
2). At the other end of the spectrum (of possible relationships), I have suggested in my first paper that the quasi-therapeutic OP-worker relationship (model 1) does mirror the therapeutic relationship closely, so I believe it could be considered to be a fiduciary one.

The most important finding in my first paper, I believe, is the fact that in the “independent expert” role (for IHR assessments), the OP would be expected to be a fiduciary and independent at the same time. These expectations cannot be fulfilled concurrently, so at least some of the difficulties in performing the independent expert role¹³ might arise from this conceptual impossibility.

9.2.2. Consent

In my second paper, I argue that “consent” for disclosure of medical information is different to the “informed consent” required before proceeding to medical treatments or interventional research, and so propose the phrase “permission to disclose” (PTD) to be used instead, for the former purpose. I demonstrate that making the distinction between PTD and “informed consent” can be helpful in reminding us that the primary interests to be protected are different (privacy rather than autonomy). I show that this differentiation can be helpful in the ethical analysis of a needle-stick injury sustained by a health care worker where the source patient is HIV positive, in two different scenarios where in one case, autonomy is the main interest to be protected, and in the other, it is privacy.

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¹³ For example, in sending the independent report to the commissioning party.
However, although my example is drawn from OM practice, in reality such an example of an HIV positive needle-stick injury occurs only fairly infrequently\(^{14}\). So it could be argued that even if PTD and “informed consent” are different, it is little more than of academic interest.

On the other hand, the output of virtually all OM consultations is a report to the referring or commissioning party. I would argue that whereas the majority of medical practice may not be affected by a subtle difference between the two “consents”, in OM practice, this difference could cause further confusion for OPs. Indeed, I believe that FOM guidance on “consent” to disclose the report already contributes to such confusion:

> “The key element in practising ethically and in satisfying the requirements of the new guidance will be to ensure that patients’ **informed consent**\(^{15}\) to the disclosure of information is obtained.”\(^{16}\)

What are the implications of this “informed consent”? The current FOM guidance says the following:

> “It is the duty of the occupational health professional to ensure that the subject of the health assessment has been properly informed at the outset about its purpose, its nature and its outputs, including **likely consequences**.”\(^{17}\)\(^{18}\)

I believe the concept of “informed consent” to be especially problematic when used in the context of disclosure of information in an OM report. Firstly, as I have argued in my second paper, there will be much less information that can be communicated to the worker about the report. Clearly, there needs to be an explanation of the process, including who will and will

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\(^{15}\) Emphasis added.


\(^{17}\) Emphasis added.

not be sent a copy of the report. However, this information will necessarily be much less comprehensive and detailed when compared with the usual level of information given in the context of, for example, a surgical operation. For the latter, there will usually be objective and quantifiable facts about failure, mortality and complication rates, which should be shared with a patient if these are “material”\textsuperscript{19}. This leads us to the second problem, a consideration of the “likely consequences” of an OM report. The consequences of the OP sending his report to the worker’s manager are much less certain than surgical failure, mortality and complication rates. For example, if the OP advised in his report that the worker would need certain adjustments to his work in order for him to be able to continue in this job, what might the “likely consequences” be? As a result of such a report, the employer may well follow the OP’s advice and implement the adjustments, or choose to partially follow the advice, or try other adjustments, or ignore the advice altogether. Alternatively, the employer may deem the adjustments to be impractical or too costly, and dismiss the worker instead. The OP cannot possibly know what the “likely consequence” might be, especially when most OM provision is now carried out by outsourced providers, so the OP may have very little, if any, knowledge of the employer’s culture or values in such “arm’s length” relationships. He has even less chance of knowing the likelihood of any of these possibilities occurring. Is the likelihood of dismissal 5% or 50%? In “informed consent” parlance, both levels\textsuperscript{20} of risk would very likely be considered to be “material”, and therefore ought to be disclosed, if such risk did really exist. I think this puts the OP in an impossible situation. If he chose not to discuss the risk of dismissal, and the worker was subsequently dismissed, the OP could be judged to have fallen

\textsuperscript{19} In consenting for treatment, “The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient’s position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.” Montgomery v Lanarkshire Health Board [2015] UKHL 11, at 87. See also Fovargue S and Miola J, How much information is ‘enough’?, Clin Ethics, 2010, 5, p13–15.

\textsuperscript{20} However, it is to be noted that “the assessment of whether a risk is material cannot be reduced to percentages.” Montgomery [2015] at 89. In addition to the magnitude of the risk, other factors such as the nature of the risk and its effect on the life of the patient need to be considered. Arguably, dismissal would have a significant effect on the “patient” if the same informed consent paradigm is used for disclosure of a report!
below the standards required by the FOM guidance. But if he did discuss this risk at the outset, he might find himself discussing nothing else for the rest of the consultation!

I suggest it is the inappropriate use of the concept of “informed consent” for the disclosure of a report that leads to this confused and confusing situation. The OP would almost never be in possession of sufficient information about the “likely consequences”, and so would almost never be able to “inform” the worker adequately\(^{21}\) for this consent to be “informed”. If the concept of PTD as I propose in my second paper is used instead, then this situation would not arise. It would be made clear that what the OP needs to inform the worker of would be an explanation of the process of an OM assessment and report, including who would receive the report, but not of the “likely consequences”.

### 9.2.3. Confidentiality

In my third paper, a key finding is that confidentiality is not breached from a legal viewpoint when a report is disclosed to the commissioning party. Therefore I have argued that specific consent by the worker prior to the OP disclosing his report to the commissioner is not required, as disclosure to the commissioner does not breach confidentiality. This then begs the question whether there is any value at all in my pointing out that “permission to disclose” (PTD) is the preferable concept to “informed consent” when a report is to be disclosed.

However, there are circumstances where the report might be disclosed to parties other than the commissioner. For example, the OP might wish to publish this information in a “learned article”, in which case this would need to be done with PTD, as to publish it without this

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\(^{21}\)Even in the “independent expert” role (for IHR assessments), where the OP makes a definite recommendation of whether the applicant does or does not meet the medical criteria for IHR, as it is the employer (in conjunction with the pension fund) who makes the final decision, the OP cannot be certain of the outcome. See, for example, the Pensions Ombudsman’s decision in Mrs Bell, PO 773: “they (the employer) are not bound by the opinion(s) offered by the IRMP and should come to a properly considered decision themselves having duly weighed up the evidence before them.” Accessed at [www.pensions-ombudsman.org.uk/wp-content/uploads/po-773.doc](http://www.pensions-ombudsman.org.uk/wp-content/uploads/po-773.doc)
permission would be a breach of confidence\textsuperscript{22}. Another example would be when the OP wishes to send a copy of this report to the worker’s GP. FOM guidance states:

“it should not be assumed that the worker would wish information to be shared in this way and consent should be sought on each occasion unless there are exceptional reasons for making a disclosure without it”\textsuperscript{23}.

I have pointed out elsewhere\textsuperscript{24} that this specific aspect of the guidance merits further thought and debate. However, for the purposes of this present discussion, I will assume that worker permission is indeed required for an OP to disclose health information to the worker’s GP.

Insofar as a report is disclosed to parties other than the commissioner, I maintain that PTD would be the appropriate concept to be applied, rather than “informed consent”. As I have argued in the previous section, the “likely consequences” of such information would be difficult to predict, and the level of information that could be given to the worker in this regard would fall short of that expected if the concept of “informed consent” were applied, but this would not be a problem if “PTD” were used instead.

On the other hand, in terms of disclosure of the report to the commissioner, neither PTD nor informed consent is required by the courts, as such disclosure does not breach confidentiality. The fact that the GMC and FOM position on this is the exact opposite can only be a further source of confusion for OPs.

As a post-script to my third published paper (chapter 8), I would now change the comments about not all medical information meeting the criteria of confidentiality\textsuperscript{25} in light of the

\textsuperscript{22} Per Bingham LJ, \textit{W v Egdell} [1990] 1 All ER 835, at 849.

\textsuperscript{23} Faculty of Occupational Medicine, \textit{Guidance on ethics for occupational health practice}, 7\textsuperscript{th} edition, Royal College of Physicians, London, 2012, p15, para 2.13.

\textsuperscript{24} Tamin J, Ethics guidance for occupational health practice: a commentary, \textit{Clin Ethics}, June 2014, 9 (2-3), p61-62. For example, in the UK, a worker’s GP retains clinical responsibility for his patient 24 hours a day, and it is conceivable that a missing piece of clinical information in the GP records, which an OP had not shared with the GP, could lead to an “adverse health outcome” subsequently. This is why I think there ought to be more discussion between OPs and GPs on this point, rather than to assume that the only possible ethical position is to only disclose to GPs with workers’ consent.

\textsuperscript{25} On p12, ref (73).
recently\(^{26}\) reported judgment in *W, X, Y and Z*\(^{27}\), where the Court of Appeal do not agree that “information at the least intrusive end of the spectrum” is not private\(^{28}\). However, this does not alter the main finding of my paper, which is that GMC guidance on confidentiality is inconsistent with the law.

In the next section, I will address some areas that I believe are relevant to the ethical conflicts and confusion in OM, but that I have not been able to cover in my published articles. My thesis focusses on the disclosure of an independent OM report to the commissioner. In order to more fully understand the context within which this takes place, I propose to explore the role of the regulator, the coherence of the guidance, and the defence of the regulator’s approach (namely, the principle of “no surprises”). I conclude the next section with the suggestion that an ethical paradigm based on therapeutic practice may not be appropriate for the independent OP situation.

### 9.3. Incoherent regulation

#### 9.3.1. The regulator

“The primary stated purpose of the GMC is to protect patients. Yet…the ‘complaints pyramid’ of the GMC produces a climate of fear in which the changes to practice are almost certain to damage more patients than the small number of doctors sanctioned by the regulator could ever do.”\(^{29}\) It has also been said that “every doctor fears the GMC more than anything. Getting a letter sends a chill through your spine.”\(^{30}\) A recent study reports that amongst

\(^{26}\) On 14 October 2015.

\(^{27}\) *W, X, Y and Z v The Secretary of State for Health* [2015] EWCA Civ 1034.

\(^{28}\) At para. 34.


\(^{30}\) Vize R, Why doctors don’t dare go into management, *Br Med J*, 2015, 350, p16-18. This statement was made by an NHS Trust chief executive, referring to a period when she had been medical director.
doctors who received complaints, distress (including depression, anxiety and suicidal ideation) was highest after GMC referral. It could be said that this is a very one-sided representation of the effect of the GMC on doctors. Indeed, Niall Dickson, Chief Executive and Registrar of the GMC, has reflected on a study they commissioned and commented that 75% of doctors were confident of GMC regulation, and acknowledged more work needed to be done by the GMC. On the other hand, my aim here is not to be critical of the GMC, but rather provide some background on the perceptions of doctors of their regulator. Although there has not been a separate study of GMC referrals of OPs, there is no reason to believe that their experience would be different. Thus the threat of a referral to the GMC by an applicant who does not receive his early retirement on ill-health grounds could have an anxiety provoking effect on the OP in the independent assessor role. The GMC also make it clear that they do not treat OPs any differently to other doctors. For example, they specify that “The term ‘patient’ in this guidance also refers to employees, clients, athletes and anyone else whose personal information you hold or have access to, whether or not you care for them in a traditional therapeutic relationship.” Although this wide ranging definition of “patient” also affects other dual obligation doctors, by referring to “employees” as patients, the same expectations are placed on OPs as on other doctors (albeit this reference is concerned with confidentiality of patient information). More important, I believe, is the fact that when an OP is investigated by the GMC following a complaint by a worker or pension fund applicant, the “standards”

33 GMC Tracking Survey 2014 at http://www.gmc-uk.org/about/research/26472.asp
34 GMC, Supplementary guidance, Confidentiality: Disclosing information for insurance, employment and other similar purposes, 2009, para 2.
against which an OP is assessed are no different to those of other doctors. Thus, if an applicant claimed a breach of confidence, or that the OP had not looked after his “health and welfare” by denying him the opportunity of his early pension with an adverse report, the GMC investigates these complaints against standards which assume the OP is a fiduciary, whereas in fact he is statutorily required to be independent by the pension fund regulations. As I indicated in my first paper, these are mutually incompatible positions for an OP to assume, so it cannot be right for the GMC and FOM to put OPs in such a situation.

9.3.2. Coherent guidance?

If OPs are placed in an ambiguous position when trying to disclose their report to a commissioner, and face a fearsome regulator if they “get it wrong”, can they at least rely on clear and coherent guidance to navigate such difficulties? Unfortunately, I believe they do not have such clarity and coherence in the guidance available to them. I have already argued that GMC and FOM guidance on confidentiality and disclosure of a report lacks external consistency with the law. I believe that it also lacks internal consistency. I will illustrate this with the following:

“The GMC position is that there is no need for separate or repeat consent for the disclosure of the report following an examination, assuming that informed consent

35 The standards are set out in “Good medical practice” (2013), which applies equally to treating doctors and those in the independent role (for IHR) I am describing. See for example http://www.gmc-uk.org/DC4483_Guidance_to_the_FTP_Rules_28626691.pdf where a warning (para 22) is issued when the doctor’s standard of behaviour reflects “a significant departure from the principles set out in the GMC’s guidance Good medical practice”, in cases that are not serious enough to warrant referral to a fitness to practice panel. There is no indication in this document, or in “Good Medical Practice” that there are any different standards for non-treating doctors.

36 Although the GMC and FOM may point out that they do not explicitly require doctors to act as fiduciaries, I will later point out (in sub-section 9.3.4.) that their ethical paradigm is built on patients trusting doctors “with their lives and health”. One cannot imagine a higher level of trust and power imbalance than this! I believe that it inevitably follows that they expect doctors to act as fiduciaries, even though they do not make this explicit.

37 For example, the Local Government Pension Scheme (Benefits, Membership and Contributions) Regulations 2014.

38 This is the main conclusion of my third paper.

39 Emphasis added.
(including consent specifically for the disclosure – see paragraph 34(b) of Confidentiality) was obtained at the outset.\footnote{GMC, personal communication (2014).}

This contradicts an earlier statement by the GMC:

“Except where there are legal requirements or overriding public interests involved, the disclosure of medical reports containing personal information about patients for employment and insurance purposes is a consensual process, and patients have always been able to withhold or withdraw their consent\footnote{Emphasis added.}.”\footnote{Keegan M. (GMC Standards and Ethics), Confidentiality (in an open communication to the President of the FOM), 12 October 2010. A copy of this letter is included in Appendix 1.}

The phrase “before it is sent” that has been added in the GMC’s supplementary guidance\footnote{GMC, Confidentiality: Supplementary guidance, London 2009, p.23.} gives the applicant an automatic right of veto over the report. Thus the comment that “doctors (are not required) to get separate or repeat consent for the disclosure at this stage, or even to remind patients that they can withdraw consent“\footnote{Keegan (2010).} becomes redundant. Applicants need not be reminded that they could withdraw consent because the process now provides applicants with a de facto facility to withdraw consent. This means that applicants who do not obtain the result they wanted (such as ill health retirement) now have the ability to withdraw their consent, thereby suppressing that report. The phrase “before it is sent” therefore has the same effect as requiring separate consent for the disclosure of the report, which apparently was not the intention of the GMC. I suggest that the contradiction between the GMC’s intention in this regard, and the actual effect of their guidance, is evidence of internal inconsistency.

However, the confusion and inconsistencies that have arisen may need to be accepted if there are strong reasons for the changes in the GMC guidance. What then are the justifications for these changes in its most recent guidance on confidentiality?
9.3.3. The principle of “no surprises”

‘An Ambush,’ said Owl, ‘is a sort of Surprise.’
‘So is a gorse-bush sometimes,’ said Pooh. (A.A. Milne)45

The GMC justify their requirement to offer to show the report to the “patient” before it is sent on the basis of “no surprises”:

“The purpose of the change (at paragraph 34(d)) is to make sure that patients are so informed and that there are ‘no surprises’ when reports are sent.”46

In its latest ethical guidance, the FOM uses the same language:

“The overriding principle which occupational health professionals should apply in producing reports is one of ‘no surprises’.”47

It later goes on to call this “the ethical principle of ‘no surprises’”48. However, neither the GMC nor the FOM describe this “principle” in any detail. They do not explain, for example, the basis for such a “principle”, nor its limits, nor how it might relate to other competing ethical interests. Should there be no pleasant as well as unpleasant surprises? I would maintain that without further clarification and elaboration, this GMC/FOM version of “no surprises” is a nebulous concept.

On the other hand, the Department of Health (DH), in its guidance on confidentiality, also refers to a concept of “no surprises”:

“Patients must be made aware that the information they give may be recorded, may be shared in order to provide them with care, and may be used to support clinical audit and other work to monitor the quality of care provided. Consider whether patients would be

45 Milne AA, Winnie the Pooh, Chapter 8, at http://www.winnie-pooh.org/expotition-north-pole.htm. I am grateful to Hugh Davies, Ethics Adviser, Health Research Authority, for reminding me of this quote.
46 Keegan (2010).
48 At para 3.47.
surprised to learn that their information was being used in a particular way – if so, then they are not being effectively informed.”

Similarly, the Internet Society (IS), in its position paper on trust and identity, lists the no surprises principle and explains it thus:

“One practical “rule of thumb” for privacy is that the use of data should not come as a surprise to the data subject. This is reflected in the basic principle that the use of personal data should conform to a stated purpose.”

Both the DH and IS stress the importance of the data subjects being aware of the way their data will be used, and of the purpose of any data sharing. So if my health information or bank details ended up with commercial companies without my being informed beforehand, this would come as an unpleasant surprise. On the other hand, if my information were being used in a clinical or Financial Services Authority audit, I would not be surprised. Nor would I expect to know the outcome of that audit.

This example highlights the difference in the way the GMC and FOM are using a “principle of no surprises”. In writing an OM report, the purpose and recipients of the report would always be clarified with the worker or a pension fund applicant at the beginning of the assessment. So these aspects of data sharing would never come as a surprise in any case.

Therefore, the applicant seeing the pension fund report before the commissioner does not dispel any surprise about the purpose or recipients of this report. It only serves for the applicant to see the content of the report prior to its release, in other words, the outcome of that process. It could be argued that there is nothing inherently ethically wrong with this.

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51 At p3. This approach concords with the second principle of the Data Protection Act 1998: “Personal data shall be obtained only for one or more specified and lawful purposes, and shall not be further processed in any manner incompatible with that purpose or those purposes.”
However, if this practice allows an applicant to withdraw their consent for the report to be released, then the report is effectively suppressed. If this occurred, public funds could be misused\(^52\), which would be an undesirable consequence of this version of a “no surprises” principle.

In my view if the GMC and FOM wish to use a principle of “no surprises” to justify the requirement to show the worker or applicant the report before the commissioner, they need to elaborate what they believe this principle to mean. I agree with the DH and IS version of a principle of no surprises, but I have argued that their versions try to prevent data from being used in ways and for purposes unknown to the individuals whose data it is. This is not the case in the GMC/FOM scenario, as the worker/applicant is told the purpose and the recipients of the report anyway. I would suggest that the extension of “no surprises” principle to cover the actual content of the report is a step too far, and for an IHR report, any perceived benefit from this ought to be weighed against the possibility of public funds being misused as a direct consequence of allowing the applicant, but not the fund managers, sight of this report (that is, when the report is suppressed). Indeed, I believe that the practice prior to the 2009 guidance, which was of OPs sharing a copy of their report with the assessed individual \textit{at the same time} as the commissioner, fulfilled the DH/IS version of “a principle of no surprises” very well.

This is because the worker or pension fund applicant seeing the report may help them in gaining an understanding of how the commissioner reached their decision\(^53\). That is, the outcome is less likely to come as a surprise when it is communicated to them, even though they did not see the report \textit{before} the commissioner.

I do not mean to be critical of GMC guidance as a whole, as its primary purpose is the protection of patients, and arguably it achieves this. However, I have a particular focus on

\(^{52}\) See ref 168 of my third paper, chapter 8.

\(^{53}\) Although they might also need to read their Pension Fund rules as well. These would normally be available to them, but are not always easy to understand.
that part of its guidance which impacts on OM communications. In that area, it seems to me that its guidance is conflicting, confusing and inconsistent. In the next sub-section, I will further consider why that might be the case.

9.3.4. Wrong paradigm?

GMC guidance applies to all doctors\textsuperscript{54}. Applying a standard approach to all doctors in all circumstances has the advantage of simplicity, at least for the regulator. However, the GMC does recognise that there is a “wide variety of doctors’ practice”\textsuperscript{55} and sees Faculties and Royal Colleges as “hav(ing) an important role in producing speciality-specific guidance, while reflecting and being consistent with the principles of good practice laid (out) in the GMC’s guidance.”\textsuperscript{56} It could be argued that the GMC also allows the individual doctor to judge how to apply its guidance:

“You must use your judgement in applying the principles to the various situations you will face as a doctor, whether or not you hold a licence to practise, whatever field of medicine you work in, and whether or not you routinely see patients. You must be prepared to explain and justify your decisions and actions.”\textsuperscript{57}

The GMC may think that the distinction between “must” and “should” in its guidance would allow doctors to apply such judgment:

“In Good medical practice, we use the terms ‘you must’ and ‘you should’ in the following ways.

\textsuperscript{54} See Keegan (2010), at appendix 2: “The new guidance is for all doctors registered with the GMC; it is not (generally or in the sections about which you have raised concerns) addressed to occupational health doctors in particular, although it does of course apply to them.”

\textsuperscript{55} Keegan (2010).

\textsuperscript{56} Keegan (2010). However, the FOM merely repeats this GMC guidance on this verbatim: Faculty of Occupational Medicine, \textit{Ethics Guidance for Occupational Health Practice}, 7\textsuperscript{th} edition, December 2012, Royal College of Physicians, London, p 26, para 3.46.

\textsuperscript{57} GMC, \textit{Good Medical Practice}, 2013, para 4.
‘You must’ is used for an overriding duty or principle.

‘You should’ is used when we are providing an explanation of how you will meet the overriding duty.

‘You should’ is also used where the duty or principle will not apply in all situations or circumstances, or where there are factors outside your control that affect whether or how you can follow the guidance.”58

Indeed the stem of the GMC supplementary guidance does state:

“If you are asked to provide information to third parties, such as a patient’s insurer or employer or a government department or an agency assessing a claimant’s entitlement to benefits, either following an examination or from existing records, you should59,60:

This then appears to give OPs some discretion as to whether to actually offer to show the worker or applicant the report before the commissioner. After all, is should rather than must not used here?

However, I believe this apparent discretion for the OP to use his judgment is actually an illusion. The first condition of the GMC using “you should” is when they give an explanation in how the OP will “meet the overriding duty”, but the explanation is the “no surprises” principle, and the way to meet this duty is to offer to show the worker the report first.

Secondly, “‘You should’ is used where the duty or principle will not apply in all situations or circumstances, or where there are factors outside your control that affect whether or how you can follow the guidance.” However, the GMC’s exceptions to this duty or principle are those where the public interest may override this, or if disclosure is required by law61. Disclosure to the commissioning party is not one such exception, so it would be difficult, if not impossible,

58 Para 5.
59 Emphasis added.
60 GMC, Confidentiality: Supplementary guidance, 2009, para 34.
61 GMC, Confidentiality, 2009, para 8.
for an OP to successfully argue that he had used his professional judgment in not following GMC guidance! Therefore, I find the distinction between “must” and “should” in this aspect of GMC guidance to be purely cosmetic, and of no real practical benefit at all in giving OPs some discretion in using their judgment, if this were truly the intention.

On the other hand, I do agree that there should be a common set of values and attributes that all doctors share. I think this could be summarised by part of the GMC statement:

“Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law.”

I believe that if the stem “good doctors make the care of their patients their first concern” were removed, then the rest of this statement applies to all doctors, in any role (albeit it would be preferable to use the term “workers” to “patients” in the case of OPs). This also has some resonance with the Royal College of Physicians’ (RCP) definition of medical professionalism:

“Medical professionalism signifies a set of values, behaviours, and relationships that underpins the trust the public has in doctors.”

However, there is a danger is that if there is no qualification regarding the different roles and functions that doctors undertake, the level of “trust the public has in doctors” is still set at

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62 Emphasis added.
63 GMC, Good Medical Practice, 2013, para 1. There may be some irony that the GMC requires doctors to “act within the law”, when I have argued in the previous chapter that its own guidance on confidentiality could lead to OPs feeling, because of the conflict between their professional guidance and the law, that they were doing the opposite! However, I would not wish to suggest that current GMC guidance would require OPs to act outside the law. Indeed, it could be argued that what the GMC seeks to achieve is to go beyond the law. If this were the case, I would urge the GMC to consider the consequences of such an approach in this situation, namely the applicant’s ability to veto an independent IHR report, which could lead to misuse of public funds (see for example, chapter 8, footnote 168).
65 Albeit in a silent manner, which is more problematic as the unspoken assumption is probably not recognised.
“trusting (doctors with) their life and health”\textsuperscript{66}. This expected level of trust, which is entirely appropriate in the context of a therapeutic relationship, is not so when an applicant is being assessed for an IHR report. Of course, an IHR applicant needs to be able to trust that the OP will be professional, that is, competent, act with honesty and integrity, and within the law. The IHR applicant should not trust that OP with his life and health. If he did, then he has misunderstood the IHR assessment process\textsuperscript{67}.

In other words, the “therapeutic ethical paradigm” (TEP) which is built on patients trusting doctors “with their life and health” will unsurprisingly produce inconsistent guidance when this is applied without qualification in the context of an independent assessment for IHR\textsuperscript{68}. In the next section, I will consider to what extent, if any, these inconsistencies in ethical guidance might also be present in other forms of “dual obligation doctor” situations.

9.4. Applicability to other “dual obligation doctor” situations

In the previous section, I have argued that the usual TEP ought not to be applied to all areas of OM practice. It might be assumed that this would also be the case for other types of dual obligation doctor situations. However, such situations are actually somewhat diverse in nature, and “dual obligation doctors” are far from a homogeneous group. For example, military doctors have an obvious therapeutic role, whereas OPs do not. I will return to this point shortly. Before I do so, I would like to consider the issue that to some extent, all doctors have “dual obligations” (or more).

\textsuperscript{66} GMC (2013), inside of front cover.

\textsuperscript{67} The OP should explain the assessment process at the outset of the consultation, and make sure that the applicant understands this. See for example FOM Ethical Guidance for Occupational Health Practice (2012), p26, para 3.44: “It is the duty of occupational health professional to ensure that the subject of the health assessment has been properly informed at the outset about its purpose, its nature and its outputs…”. This should include the fact that his role is different to a treating doctor’s.

\textsuperscript{68} For example, I have previously argued that an OP in this role cannot be both independent and have “a duty of undivided loyalty” to the applicant (chapter 6), and disclosing his report to the commissioner does not require further “consent” (or permission to disclose) as such a disclosure does not breach medical confidentiality (chapter 8).
I have previously described the differences in obligations to patients versus other parties, between treating doctors and independent doctors (such as OPs doing IHR assessments)\textsuperscript{69}. In the description, I suggest a sliding scale, with a treating doctor having the highest obligations towards his patients and least to “others”, whereas an independent doctor would have the highest level of obligations to the third party (pension fund) and the least to the assessed individual. However, the level would never be set at “no obligation”, either for the patient or for other parties. I envisage that in between these extreme positions, other doctors depending on their role and the circumstances, would have different levels of obligations in the two directions. Thus “dual obligation doctors” would describe those situations where the obligations to other parties were more explicit and apparent. Although treating doctors do have obligations to third parties, it is claimed that “doctors often talk and think as if they believe that they invariably give absolute moral priority to their patients over the moral demands of society”\textsuperscript{70}. However, our interest here is not in treating doctors, but in “dual obligation doctors”, especially in how ethical guidance affects them, or ought to affect them. In the OM situation, I have shown that the diverse roles that OPs undertake in the UK can be categorised into “models”\textsuperscript{71}. Thus the in-house OP could have a “quasi-therapeutic” relationship with workers, and the TEP approach fits reasonably well in this type of practice. At the other extreme, the OP doing an IHR assessment would be taking on an “independent expert” role, and I have argued that it is wrong to apply the TEP in this context. An independent expert cannot be “independent” and owe the IHR applicant a “duty of undivided loyalty” simultaneously\textsuperscript{72}. I would not wish to speculate to what extent comparable situations

\textsuperscript{69} In chapter 6, particularly illustrated in figure 1.

\textsuperscript{70} Gillon (1985), p158. Although doctors cannot objectively \textit{invariably} give absolute moral priority to their patients over the moral demands of society, for example, in the reporting of gun crime, I agree with Gillon that doctors do indeed \textit{talk (as if) and think} that “the patient’s interests always come first” (also at p158).

\textsuperscript{71} Chapter 6.

\textsuperscript{72} I have argued in 9.3.2. that the TEP assumes a fiduciary relationship although the GMC does not explicitly state this.
arise out of other forms of dual obligation doctor practices. I believe that it would be best for those who practice in this field to carry out such an analysis. However, they may wish to use a template similar to mine\textsuperscript{73} in order to ascertain to what degree a specific role or function might entail fiduciary obligations, or require independence. I have mentioned above that military doctors may retain a therapeutic aspect to their various roles, so my approach may not help their situation. On the other hand, one might expect sports medicine to be closer to OM. Some roles might entail a therapeutic relationship, whereas other roles might require the sports physician to act on behalf of the club rather than the sportsperson. In the UK, the regulatory body for sports doctors is the Faculty of Sport and Exercise Medicine (FSEM). In 2010 they published a Code of Practice\textsuperscript{74}, which is intended to supplement the GMC’s “Good Medical Practice”\textsuperscript{75} with additional guidance for practitioners in this field. It re-iterates much of the GMC’s guidance, for example, that the practitioner must “make the care of the patient the primary concern”\textsuperscript{76}. It further states that “The primary contract remains that between the patient and the Practitioner taking into account any contractual obligations entered into by the patient with any sporting body”\textsuperscript{77}. Therefore, it seems that the TEP is the basis for the FSEM guidance, which at first sight is laudable. I have no experience of this field, so it is possible that this paradigm works well here. In the section “conflicts of interest”\textsuperscript{78}, the patient is again given primacy. It is the conflict that could arise if the sports doctor happened to also be the patient’s GP that is highlighted\textsuperscript{79}. It may be that sports clubs and other sports organisations are less demanding than employers or pension fund managers in their requirement for patient information and medical advice based on this. That is, sporting organisations or clubs are

\textsuperscript{73} Chapter 6, table 1.
\textsuperscript{74} Faculty of Sports and Exercise Medicine, Code of Practice, 2010, accessed at http://www.fsem.ac.uk/media/35841/professional-code-1july-2010-1-.pdf
\textsuperscript{75} The current edition was published in 2013.
\textsuperscript{76} At p9.
\textsuperscript{77} At p10.
\textsuperscript{78} At p15, section 4.2.
\textsuperscript{79} At p15, section 4.3.
prepared to give the patient veto over what information can be communicated to them.

However, if this were not always the case, then sports doctors could find it useful to separate out their roles in the way I have done for OM\textsuperscript{80}. If they find that some of their roles require them to be “independent” in the way an OP carrying out an IHR assessment should be, then they may find the approaches I have described in chapter 6 useful\textsuperscript{81}.

In summary, I believe that it is possible that applying a “one size fits all” approach may also be problematic in other forms of dual obligation doctor situations. However, the applicability of my line of analysis to these other situations\textsuperscript{82}, would need to be carried out by, or in conjunction with, those with more intimate knowledge of those different specialities.

9.5. The future

In relation to guidance on confidentiality, the GMC is at present carrying out a consultation exercise\textsuperscript{83} prior to a revision of its 2009 guidance. If, as one would hope, the revised guidance ceases to require doctors to show their report to the assessed individual before the commissioning party, then a source of confusion and of conflict\textsuperscript{84} would be removed. I would expect that the FOM would follow suit, so it might appear at first sight that a major ethical problem for OPs would be resolved.

\textsuperscript{80} In chapter 6.
\textsuperscript{81} That is, if there are different roles, to characterise these, and then determine whether the roles require the doctor to be a fiduciary or be independent.
\textsuperscript{82} That is, separating various roles into “models”, and then assessing the nature of those relationships, especially whether they are fiduciary or not.
\textsuperscript{83} https://gmc-e-consultation.net/econsult/default.aspx?dm_i=CUG%2e2ZXTW%2e5091VE%2eASIIK%2c1. There was an initial opportunity for feedback to the GMC until January 2015. A number of colleagues and I have highlighted in our feedback to the GMC, the inconsistencies caused by the 2009 guidance, including the conflict with the law. The GMC indicate that they will consult further when they have drafted revised guidance later in 2015.
\textsuperscript{84} For example with the law, in disclosing an independent medical report.
However, if this were the only action taken by the FOM in this area, I would consider this to be a missed opportunity. The FOM itself states that “Ethical responsibilities in this area are more complex than in much of occupational health because stakeholders include the pension scheme administrators and trustees as well as the employers and the employers”, but does not then go on to provide any solutions to the “more complex” responsibilities. It seems to attribute the greater complexity to the larger number of stakeholders, whereas I believe that the cause to be much more fundamental than this. As I have indicated above, the GMC and FOM ethical paradigm pre-supposes a fiduciary relationship, whereas in the “independent expert” role, the doctor is required to be completely independent from the IHR applicant being assessed. This role best illustrates the impossibility of having to be simultaneously independent and owe the assessed individual a duty of undivided loyalty. I think as a way forward, the FOM should make this impossibility explicit, and advise that in the independent role, the doctor should make it clear to all parties that as he must be independent, the assessed individual cannot expect bias in his favour. He should continue to be professional, that is he will act with competence, honesty and integrity. However, he will not make the assessed individual “his first concern”, and the GMC will not expect this of a doctor in this role.

Although my preference is for the GMC and FOM to produce role specific ethical guidance for OPs, there is a possible alternative. I have indicated in chapter 6 that UK OPs perform a wide range of roles, and it could be argued that UK OPs “wearing too many hats” may be contributing to the confusion. Belgian OPs for example, do not get involved at all with sickness absence and ill-health retirement assessments. Instead, “insurance doctors” do

85 Of IHR assessments.
86 FOM (2012), p42.
87 In sub-section 9.3.4.
88 See chapter 6.
these assessments in Belgium, and OPs confine themselves to workplace health, for example, concentrating on the workplace environment and health surveillance\(^90\). However, I believe this would be an unlikely development here, because it would probably affect UK OPs’ incomes and job prospects, at least in the short term. It would also still require in my view, role specific ethical guidance, albeit it would now be for OPs and “insurance doctors” (or equivalent term), so the distinctions may be clearer in any case.

Although I have supported the arguments in favour of recognising the therapeutic DPR as fiduciary in nature, I recognise that English law has not gone this far. The major stumbling block has been *Sidaway*, which has “set (the law) in stone”\(^91\) on this issue. One could speculate however, that two recent occurrences may influence the future development of English law in this area. Firstly, “the decision of the UK Supreme Court in *Montgomery v Lanarkshire*\(^92\) has at long last overruled the decision of the House of Lords in *Sidaway v The Royal Bethlem Hospital*”\(^93\). It is possible that the demise of *Sidaway* may open the door to the notion of doctor as fiduciary to be reconsidered by English courts\(^94\). Although *Montgomery* itself did not explicitly describe the DPR as being a fiduciary one, it does cite with approval the GMC approach in its more recent guidance that doctors should work in *partnership* with patients\(^95\). One may recall that Brazier and Lobjoit viewed the benefits of a fiduciary formulation of the DPR as being the promotion of partnership, reciprocity of obligations and openness between doctors and patients\(^96\), so there is some resonance between their approach and the direction *Montgomery* seems to favour. A second development which may advance

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\(^90\) Health surveillance is regular monitoring to detect early signs of occupational ill-health and disease. I have included such activities and functions in “models 1 and 3” in chapter 6.


\(^92\) [2015] UKSC 11.


\(^94\) However, it could be argued that Lord Scarman’s *dictum* on the doctor as a fiduciary was *per obiter*. A fuller analysis is required, but is beyond the scope of this thesis.

\(^95\) At para 77 and 78.

\(^96\) At chapter 3, section 3.3.
the notion of doctor as fiduciary is that of the recent statutory duty of candour\textsuperscript{97}. Although this is directed at service providers rather than individual doctors, its aim is to “promote a culture that encourages candour, openness and honesty”\textsuperscript{98}. I would suggest that the recent emphasis on openness (duty of candour) and partnership (Montgomery) could make this an opportune time for the concept of the doctor-fiduciary to be re-visited, and hopefully this time, formally adopted, by the English courts.

I have also previously argued that the current GMC confidentiality paradigm lacks transparency\textsuperscript{99}. For example, the fact that disclosures are allowed in some circumstances\textsuperscript{100} could lead to mistrust\textsuperscript{101} rather than engendering trust in the medical profession. Instead of the current approach to confidentiality, the privacy paradigm\textsuperscript{102} I described in chapter 8 would have the benefit of being more transparent\textsuperscript{103}. However, I think it unlikely that the GMC will adopt a different approach to medical confidentiality in the near future, especially in view of the fact that the courts have endorsed this approach\textsuperscript{104}. It is possible that, if there is to be any impetus for change by the GMC, this may eventually arise out of future legislation following commentaries\textsuperscript{105} and reviews of how to balance usage of health data with privacy.

One such in-depth review undertaken by the Nuffield Council on Bioethics has recently been published\textsuperscript{106}. It points out that the increasing use of health data has become a “strategic

\textsuperscript{97} Health and Social Care Act 2008 (Regulated Activities) 2014, Regulation 20.
\textsuperscript{98} Care Quality Commission, Regulation 20: Duty of Candour, Information for all providers, March 2015, p8.
\textsuperscript{99} Chapter 8.
\textsuperscript{100} Such as in the “public interest”.
\textsuperscript{102} Based on Tavani’s restricted access/limited control (RALC) approach.
\textsuperscript{103} For example, it would be specified at the outset who would and who would not (without further permission) have access to the information contained in a specific health domain.
\textsuperscript{104} For example, Egdell, where a breach of medical confidentiality to protect members of the public from violent harm, was held to be lawful.
\textsuperscript{105} See for example, Sterckx S, Rakic V, Cockbain J and Borry P, “You hoped we would sleep walk into accepting the collection of our data”: controversies surrounding the UK care.data scheme and their wider relevance for biomedical research, Med Health Care and Philos, 2015, DOI 10.1007/s11019-015-9661-6.
focus” at p22. Although the Nuffield Council report proposes no easy solutions, it stresses the importance of “participation of those with morally relevant interests”108, with a complementary “principle of accounting for decisions”109, and recognises the fluidity of the social, scientific and political settings within which this balanced110 oversight of privacy protection would operate. Crucially, such an approach is underpinned by complete transparency at each step of the development of privacy norms for any data initiatives111. I believe that if such an approach became the norm, then the current GMC approach to medical confidentiality could come under some scrutiny, and in my view, this would be for the better.

9.6. Concluding remarks

I have used the GMC’s 2009 guidance on confidentiality, which created significant variations in OPs’ interpretations and practices around confidentiality, as a vehicle for exploring the ethical basis of OM. If the GMC do remove the stipulation to offer the worker first sight of an independently commissioned report in their revised guidance on confidentiality, having realised that this actually conflicts with the law, then one could be tempted to think that this source of confusion (in the recent past at least) would have been removed. Although this would be correct, I believe it would be a missed opportunity if one did not also address the more fundamental reasons for the malaise in OM ethics. The GMC’s approach to ethics guidance is to assume that all doctors have to be trusted with patients’ lives and health.

107 At p22.
108 At p155, para 8.10.
109 At p155, para 8.10.
110 That is, balancing private and public interests.
111 See, for example, p156-157. Some practical precepts for data initiatives are listed, and these include the continued involvement of stakeholders to reflect on and determine the morally important issues, values and interests, as well as the continuing review and governance of these initiatives.
This is simply not the case. Those doctors who perform an independent function, as an IHR assessment, should not be subject to the same TEP without further qualification. A “one size fits all” approach may be convenient and simple to regulate, but there is also a danger of rigidity of thinking and intellectual inertia. I believe that if the GMC had been more responsive to the actual circumstances of OM practice, then it would not have made the mistake of issuing guidance that was so out of touch with the context where it was to be used. Therefore I would recommend a more fundamental structural change to future ethical guidance aimed at OPs. It should reflect the realities of their actual practice, the different relationships they have with workers in different functions, and their wider responsibilities for health in the workplace. I suggest that this would be best achieved with role specific ethical guidance in the areas where doctors perform non-therapeutic roles and functions, and this guidance would not assume that such doctors were also entrusted with the lives and health of the “patients”.
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Appendices:

Appendix 1: FOM/SOM and GMC letters

Appendix 2: Published papers
Dear Colleague

JOINT STATEMENT TO FOM & SOM MEMBERS
New GMC Guidance on Confidentiality

Background


The guidance is wide ranging, but there is specific mention about the provision of information to a patient’s employer, and supplementary guidance relating to the disclosure of information for insurance, employment and similar purposes has been produced. The guidance makes it clear that the term “patient” refers to employees, clients, athletes and anyone else whose personal information a doctor has access to, whether or not the doctor cares for the individual in a traditional therapeutic relationship.

The new guidance largely restates the previous position that information gathered as part of a professional encounter between a doctor and a patient must be treated confidentially and that any disclosure of such information must only be made with the informed consent of that patient, except in defined, exceptional circumstances. However, the guidance is more specific than the previous document in the manner by which patients should be advised of the content of any report. Whereas it has been the practice of many occupational physicians to describe verbally the content of a report, or dictate it in front of the patient, this is no longer deemed sufficient. The new guidance is explicit in stating that a doctor should:
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:

- They have already indicated that they do not wish to see it
- Disclosure would be likely to cause serious harm to the patient or anyone else
- Disclosure would be likely to reveal information about another person who does not consent

The draft guidance was the subject of consultation, and the Faculty and the Society made a joint response earlier this year. The guidance as published does not reflect all the reservations made in the joint response.

Publication of the guidance has caused widespread concern among occupational physicians about the practical difficulties associated with compliance and unintended consequences relating to the impact that it may have on the perceived impartiality of reports. A meeting was therefore arranged for 09 October 2009 between the GMC and representatives of the specialty; the Presidents of the Faculty and the Society together with the Chair of the Faculty’s Ethics Committee attended.

Clarification of Intent

The new requirement has been inserted to try and ensure that the patient understands fully what will be said in a report about them to an employer or to the other third parties covered by the guidance. The principle is that there should be “no surprises” when a patient subsequently has dealings with their employer on the basis of the report. The previous guidance was intended to achieve the same aim but, in the view of the GMC on the basis of concerns articulated by the public, has not proved adequate. Occupational physicians have not been singled out as a group particularly failing in this duty and the new guidance is directed towards all doctors who undertake reports in respect of employment, insurance and related matters. The GMC’s intention is that this specific requirement will encourage doctors to inform patients more effectively about what information relating to them is going to be disclosed.

Clarification of Scope

The guidance applies to all situations in which a doctor interacts in a professional capacity with patients. No types of occupational medicine practice are inherently exempt and it is the nature of the information which the occupational physician is processing and how it was obtained, which will determine whether the guidance applies. In context of this guidance, an opinion based on confidential personal information is considered a disclosure and, as with any form of medical practice, consent may be withdrawn at any stage. Consequently reports to a pension scheme where the doctor is acting as an independent adviser would fall within scope if the opinion is based on information obtained directly from a patient or directly from other health professionals. However, if an opinion is given based solely on information provided by the commissioning authority (e.g. pension scheme) then the guidance would not be held to apply. Doctors delegating tasks to other health professionals should ensure that the same standards of conduct are applied.
Practical Issues

The key element in practising ethically and in satisfying the requirements of the new guidance will be to ensure that patients’ informed consent to the disclosure of information is obtained. As with many other medical situations, consent obtained at the beginning of a process is held to be valid for the duration unless the patient withdraws it, or there is good reason to believe that they would wish to do so. It is not necessary to constantly confirm consent at every stage in a process provided the initial consent has been suitable and sufficient for purpose.

Where a patient indicates that they wish to see a report before it is sent, the new guidance does not specify any time period that must be allowed before disclosure to the commissioning body (employer, pension scheme, etc). Clearly the concept of “reasonableness” must be applied but the detail of good practice will be dependent upon a range of factors including the mechanism for showing the patient the report (e.g. in person, electronically, by post, etc).

Patients may highlight errors of fact in reports, which should be corrected. However, it is no more acceptable to alter an impartial opinion on the basis of pressure from the patient than it is to do so on the basis of pressure from an employer.

If a patient withdraws consent for a report at any stage, then employers or other commissioning bodies can only act on the information available to them. The absence of occupational health information rarely benefits the patient and it is appropriate to highlight this when initially obtaining consent. The withdrawal of consent for an impartial report based on knowledge of its content may well prejudice the patient’s case in the eyes of the person commissioning the report.

The GMC recognises that implementing the changes detailed in the new guidance will be complex for some occupational health providers and that it would be unreasonable to expect full compliance from 12 October 2009. Any complaints against doctors for failing to comply fully in the short term will be considered with these difficulties in mind. Occupational physicians should, however, take immediate steps to initiate action which will allow compliance as soon as is reasonably practicable.

The GMC also recognises the multi-disciplinary nature of occupational health provision and has agreed to initiate discussions with other relevant regulatory authorities to try and ensure consistency in this area of practice.

Next Steps

The GMC has confirmed its thinking and position in a supplementary letter which is promulgated with this statement.

The Faculty and the Society will continue to give consideration to the impact of these changes on members’ practice and advise accordingly.

A list of “Frequently Asked Questions & Answers” will be formulated and posted on the two websites.
The Faculty’s advice on this subject in the 6th edition of *Guidance on Ethics for Occupational Physicians* will be reviewed urgently and amendments promulgated.

Yours sincerely

[Signatures]

President FOM

President SOM

Chair, FOM Ethics Committee
12 October 2009

Dr David Coggon  
President  
Faculty of Occupational Medicine

By email

Dear Dr Coggon

Confidentiality

I write further to our meeting on Friday last, where you were joined by Tony Stevens (President of the Society of Occupational Medicine) and Paul Litchfield (Chair of the Faculty Ethics Committee) to discuss our new guidance.

As you know, we also met with Drs David Wright and Mike Goldsmith, representing the Commercial Occupational Health Providers Association and Atos Healthcare, later in the day to discuss the same issues.

The purpose of this letter is to recap the salient points of discussion, with particular focus on the intention and implementation of the guidance.

We recognise that where doctors, or the organisations they work with or for, need to amend their procedures to comply with our guidance, a reasonable time may be needed to amend established those procedures. We agreed that it would be unhelpful to specify a time limit for this, given the variety of contractual, procedural and practical elements that may be involved.

The new guidance is for all doctors registered with the GMC; it is not (generally or in the sections about which you have raised concerns) addressed to occupational health doctors in particular, although it does of course apply to them. Paragraph 3 states: ‘You must use your judgement to apply the principles in this guidance to the situations you face in your own practice. The purpose of this guidance is to help you identify the relevant legal and ethical considerations, and to help you make decisions that respect patients’ privacy, autonomy and choices, and that also benefit the wider community of patients.’ This reflects what the introduction to Good Medical Practice so clearly explains: it is not a statutory code, so doctors must use their judgement to apply the principles to the various situations they will face, whether or not they routinely see patients.
Much of our discussion inevitably focused on paragraph 34, the primary purpose of which is to ensure that patients are informed about, understand and consent to the disclosure of reports for employment and insurance purposes.

Except where there are legal requirements or overriding public interests involved, the disclosure of medical reports containing personal information about patients for employment and insurance purposes is a consensual process, and patients have always been able to withhold or withdraw their consent. This might be when they are asked to see an occupational health doctor, or to agree to disclosure of their personal information to an occupational health doctor or to an employer or insurer. It might also be when they have had communicated to them (during an examination or when they see a report) the scope, purpose and likely consequences of a disclosure, either from existing records held in confidence or following an examination. The guidance does not change this; nor does it require doctors to get separate or repeat consent for the disclosure at this stage, or even to remind patients that they can withdraw consent.

For the avoidance of doubt, I should state that the disclosure of a report expressing an opinion (on a patient’s fitness to work, for example) based on confidential information is a disclosure. I think that was common ground.

It was also agreed that it is already established good practice, as explained in our old guidance, for doctors to explain to patients the scope, purpose and likely consequences of any examination and disclosure to a third party. The purpose of the change (at paragraph 34(d)) is to make sure that patients are so informed and that there are ‘no surprises’ when reports are sent. In the various scenarios discussed, e.g. when patients are assessed and the report is prepared in their presence, there will be no difficulty in communicating its contents to the patient. In those cases, the purpose of the guidance and the underlying legal and ethical duties will have been satisfied.

Reports based on information to which patients’ employers or insurers already have access are not disclosures for the purposes of this guidance, although the involvement and role of doctors should be explained as part of the information about the process.

The purpose of the guidance is not to introduce unnecessary delay, or to give patients an opportunity to lobby for doctors to change their opinions. The guidance is clear that doctors should explain at the outset that relevant information cannot be concealed or withheld. It is obviously important to ensure that the information on which doctors base their opinions is correct and complete if erroneous conclusions are to be avoided. Doctors may also consider
explaining that they will not alter any opinion offered in the report, unless this is based on a factual error.

It may be worth reiterating that the stem of paragraph 34 ends with ‘should’ and not ‘must’. The introduction to Good Medical Practice explains those words in the following ways:

- ‘You must’ is used for an overriding duty or principle.
- ‘You should’ is used when we are providing an explanation of how you will meet the overriding duty.
- ‘You should’ is also used where the duty or principle will not apply in all situations or circumstance, or where there are factors outside your control that affect whether or how you can comply with the guidance.

We recognise the wide variety of doctors’ practice. The GMC gives guidance for all doctors. The Faculty of Occupational Health, like the Royal Colleges and specialist societies, have an important role in producing speciality-specific guidance, while reflecting and being consistent with the principles of good practice laid out in the GMC’s guidance.

Finally, we explained that obtaining or seeing written consent is a matter of sensible good practice, not principle. The important issues are that patients are told about the purpose and nature of the information doctors propose to disclose, and are not put under pressure to agree. The way in which patient’s agreement or dissent is recorded is a secondary issue, and there may be a number of ways in which doctors can assure themselves of this when they are not in a position to obtain a patient’s written consent themselves.

I hope this accurately captures the relevant aspect of our discussions. Please feel free to circulate or reproduce this letter as you wish. I am copying it to Drs David Wright and Mike Goldsmith.

Yours sincerely

Michael Keegan Standards & Ethics
Appendix 2: Published papers
Models of occupational medicine practice: an approach to understanding moral conflict in “dual obligation” doctors

Jacques Tamin

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Models of occupational medicine practice: an approach to understanding moral conflict in “dual obligation” doctors

Jacques Tamin

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Abstract In the United Kingdom (UK), ethical guidance for doctors assumes a therapeutic setting and a normal doctor-patient relationship. However, doctors with dual obligations may not always operate on the basis of these assumptions in all aspects of their role. In this paper, the situation of UK occupational physicians is described, and a set of models to characterise their different practices is proposed. The interaction between doctor and worker in each of these models is compared with the normal doctor-patient relationship, focusing on the different levels of trust required, the possible power imbalance and the fiduciary obligations that apply. This approach highlights discrepancies between what the UK General Medical Council guidance requires and what is required of a doctor in certain roles or functions. It is suggested that using this modelling approach could also help in clarifying the sources of moral conflict for other doctors with “dual obligations” in their various roles.

Keywords Occupational medicine models · Occupational physician · Doctor-patient relationship · Dual obligation · Fiduciary obligations

Introduction

In 2009, the United Kingdom (UK) General Medical Council (GMC) updated its guidance to doctors on confidentiality, with supplementary guidance, including a section entitled “Disclosing information for insurance, employment and similar purposes”, which clearly applied to doctors with “dual obligations”, including occupational physicians (OPs). One of the requirements was for the doctor to “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”. This provoked great consternation amongst OPs. Most had been used to offering a copy of their report to the worker at the same time as to the employer or pension fund manager. Having to offer the report to the worker before the commissioning party however, could have significant implications to the way they practised. The UK Faculty (FOM) and the Society (SOM) of Occupational Medicine issued a joint statement which reflected this unease: “Publication of this (GMC) guidance has caused widespread concern among OPs about the practical difficulties associated with compliance and unintended consequences relating to the impact that it may have on the perceived impartiality of reports”. In practice,

1 GMC (2009a).
2 GMC (2009b).
3 p 22-26.
4 The GMC (2009a) p 24 states that “dual obligations arise where a doctor works for or is contracted (such as) an insurance company, an agency assessing a claimant’s entitlement to benefits, the armed forces”. The British Medical Association (BMA) (British Medical Association 2012) p 694 describes these as “situations where doctors have clear obligations to a third party that can be in tension to the obligation to the patient”.
5 p 23.
6 For example, an applicant who had been found not to meet the medical criteria for an early pension release due to ill-health, could simply refuse permission for this report to be released, and seek a more favourable opinion at a later date from a different physician.
7 FOM, SOM (2010).

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OPs and occupational health (OH) providers have since changed their processes and consent forms to address this. However, I suggest that there is a more fundamental reason why such ethical guidance does not sit comfortably with OM practice. I aim to show that the very nature of the doctor-patient relationship (DPR) is sufficiently different in OH practice compared with the therapeutic setting, for the same ethical rules to be at times incongruent in the former context.

To achieve this aim, I will describe OM as it is practised in the UK, and propose a set of models distinguishing the different OP roles and facilitating clearer comparisons between the OP situation and the normal therapeutic DPR.

OM in the UK

OM is that branch of medicine that deals with the effects of work on health, and of health on work. In the past, an OP would have been mainly concerned with the effects of toxic hazards in the workplace on the health of workers, but as work environments in the UK and other developed countries have become increasingly better controlled and safer, the emphasis has shifted to assessing whether workers meet the appropriate medical standards for their occupation, that is, their fitness for work. A UK survey reveals that 25% of OP working time is spent on attendance and absence assessments (Staff 2007). Thus the majority of an OP’s time is spent in consultations to which the worker would have been referred by his manager for advice on fitness for work, and in a number of these cases, the worker would meet a pension scheme’s criteria for early retirement on the grounds of ill-health (BIR).

There are several other features of OM in the UK which may have a bearing on the OPW interaction. Firstly, in the UK, OH departments do not provide treatment services, except for first aid. Secondly, although the National Health Service (NHS) provides this treatment service, it specifically does not provide a National Occupational Health Service, so OH is largely not state funded. Thirdly, although OH is mainly employer funded, there is no legal obligation on employers to fund this, which is a different situation to that in some other European countries. Lastly, there has also been a growing trend for OH services to be outsourced from in-house services to external commercial providers. These background factors in UK OH provision may also contribute to some of the particular tensions that can arise between employers, OH professionals, and workers. However, before I describe the OP—worker (OPW) interaction in this context, the normal doctor-patient relationship will first be discussed, as this may clarify any differences between the two types of interaction.

The normal doctor—patient relationship (DPR)

Trust is said to be “intrinsic” to the DPR. O’Neill (2002) has described the DPR as a “paradigm of a relationship of trust.” It is a professional relationship that is supposed to be disinterested, long-lasting, intimate and trusting. Similarly, Brazier and Lobhy (1999) have commented: “Patients trust doctors, nurses and other health professionals with intimate details of their lives which they may even conceal from their families.”

Although this paper aims to highlight the differences between OM and all therapeutic medicine, rather than specifically between OM and general practice, the importance of the DPR in the OP context has been described as its “central distinguishing feature” by Rogers.
and Brannack-Mayer (2009), so the differences in the nature of the relationships may be more obvious between OM and GP. They also suggest that trust in one area need not extend to trust in other areas. A patient may trust the goodwill of their GP in terms of confidentiality, affability, honesty and the like, but may not trust their competence in some clinical areas. Likewise, O’Neill (2002) felt that she might trust her GP to diagnose and prescribe for a sore throat, but not for a heart attack. She also pointed out that polls show that doctors and judges are far more trusted than politicians and journalists. Patient trust also appears to be the salient feature of the DPR on which the regulatory authorities, in the UK at least, base their ethical guidance to doctors: “Patients must be able to trust doctors with their lives and health.”

Although there may be different degrees of trust involved in different contexts, and trust may be situation- or condition-specific (such as the diagnosis of a sore throat rather than a heart attack) there seems to be little doubt that trust is an essential component of the normal DPR.

The central role of trust in the DPR has led some authors to advocate that this relationship is subject to a fiduciary principle. However, although trust is a requirement for a fiduciary relationship, it is not in itself sufficient grounds to claim that a relationship is fiduciary in nature. The duties imposed on the fiduciary to the beneficiary or vulnerable party are largely due to the power imbalance between the two parties. Such a power imbalance is said by Kennedy (1996) to be evident in the DPR:

“The doctor-patient relationship has special, perhaps unique, features. Principal among these is the very significant difference in power between the two parties. The patient is uniquely vulnerable, being not only ignorant of the expertise constituted by the practice of medicine but also, in most cases, ill and anxious or anxious about possibly being ill. By contrast, the doctor has expert knowledge.”

Boody (1992) has drawn attention to the importance of the doctor’s power in the therapeutic relationship, breaking this power down to Aschulpin power (derived from the medical knowledge and skills), social power (doctors generally coming from socially and educationally privileged backgrounds), and charismatic power (postulated that many drawn to medicine would have this). The Law Commission (1992) has summarised the duties that arise in the fiduciary relationship, and Bartlett (1997) amended these for the doctor-patient context:

1. Trustees must avoid conflicts of interest, or indeed even possible conflicts of interest, with the vulnerable party. (The “no conflict” rule).
2. Trustees must not profit from their position without prior disclosure to and authorisation from the vulnerable party. (The “no profit” rule).
3. The fiduciary owes a duty of undivided loyalty to the vulnerable party. (The “undivided loyalty” rule).
4. The fiduciary owes a duty of confidentiality to the vulnerable party. (The “duty of confidentiality”).

Bartlett, Gribb (1994) and Brazier and Lohoff (1999) have all presented strong arguments in support of the fiduciary nature of the DPR, although Kennedy (1996) objects to this mainly on the basis that it “entrenches the paternalism and power of the doctor”.

OM models

I propose three models to describe the current UK OPW (OPW) interactions, accepting that this may not be exhaustive. Model 1: The “quasi-therapeutic” model

As mentioned previously, OPW services do not provide treatment in the UK, except for first aid. Some argue that because some OPW departments administer vaccinations (such as against hepatitis B in health care workers, or for business travel) or can refer workers for physiotherapy or counselling, these constitute some element of “treatment”, or at least of clinical care. On the other hand, although truly “therapeutic” encounters may not part of OM in the UK, there are instances where OPW interactions may come close to being indistinguishable from the traditional doctor-patient ones, especially where a worker self-references to the OP or OPW for advice. Although the OP cannot prescribe or treat in this scenario, the encounter is often similar to a therapeutic one, in terms of the doctor giving advice, and presumably the worker trusting this advice, having sought it in the first place, hence a “quasi-therapeutic” encounter.

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22 p 2.
23 p 111.
24 p 3.
25 p 9. A recent poll commissioned by the BMA, Mear (2011), also confirms that the public trusts doctors far more than politicians.
28 p 111.
29 p 62.
Model 2: The “independent” expert model

This model describes work such as IHR applications, where the OP assesses the evidence presented (including specialist reports and evidence of attempts at workplace adjustments) against the medical criteria of the pension scheme. It would have similarities with expert witness work that doctors of any specialty can carry out for the courts. However, for IHR medical assessments, it is the submitted evidence rather than the individual that is being assessed, so the applicant does not even have to be present in person at a “consultation”. One would expect the same advice by the GMC given to UK expert witnesses to apply, for example in terms of the requirement to be “honest, trustworthy, objective and impartial.” This makes it clear that the expert’s position is to be unbiased. In contrast, in an adversarial legal system, a lawyer must “present his client’s best case and draw the court’s attention to the weaknesses of the opposing party.” Both sets of ethical obligations, for the expert to be unbiased on the one hand, and for the lawyer to be biased on the other, are clear and unequivocal (albeit with some qualification for the lawyer). One would like to believe that other doctors (in a non-expert role) are also bound to be objective, unbiased and impartial in their judgments and their advice, but clearly this could be in conflict with their “duty of individual loyalty” to their patient. This leaves them in the uneasy position where their duties from the two sets of obligations can be in direct opposition to each other.

Model 3: The “impartial” doctor model

This model will be used to describe the majority of OP work, which usually arises from referrals by managers, asking for advice on workers’ fitness for work, or health aspects of attendance or performance problems. Although the FOM recognises the need for OPs to be impartial, it does also stress that OPs, like other registered medical practitioners, have an ethical responsibility to put the interests of individual patients first. Thus a physician, learning of a health risk to a worker, has “a responsibility to protect the health of the employee, even if this is to the detriment of the employer.” In the context of a health risk from work, this is understandable. However, in the UK workplace stress and musculoskeletal problems have become the predominant occupational illnesses. These are often more multifactorial in causation, and it remains an OP’s responsibility to advise on such matters. But what does “putting the interests of individual patients first” actually mean in such cases? The employer may argue with some justification that it is the role of the OP to put the interests of his patient first. So in the UK, where the employer pays for the OP’s advice, if this were to be no different to that received from a worker’s GP, then the employer might question the value of paying for an OP’s advice at all. An example would be where a worker suffers from work-related stress, which he alleges is caused by his manager bullying him. A report from his GP, if one were obtained, would be heavily biased towards his patient. However, in many cases, there are other factors that may be relevant, such as feedback on poor performance by the manager to the worker prior to the alleged bullying. The OP should have a more balanced account of the situation, and be able to recommend more objective approaches, such as the use of stress risk assessments or workplace mediation. If the OP were also simply to “put the patient first” in such circumstances, there is a risk that UK employers

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20 For example, the term “independent” is used in the title “Independent Regional Medical Practitioners” (IRMP) in the Local Government Pension Scheme (Benefits, Membership and Contributions) Regulations 2007. The IRMP signs the certificate including the following statement: “I have not previously advised, or given an opinion on, or otherwise been involved in this case, nor am I acting or have I acted as the representative of the member, the scheme employer or any other party in relation to it”. Similar terminology is used in some other public sector pension schemes, such as “IRMP” (Independent Qualified Medical Practitioner) for the Firefighters’ Pension Scheme Order 1997.

21 Other work that would fall in this category includes OPs sitting on Medical Appeal panels for these pension schemes.

22 For the NHS Pension Scheme, which is the largest in the UK, virtually all are done remotely.


24 Gower (2012).


However, he must not knowingly mislead the Court (Bar Council 2012: paragraph 300).

41 It is beyond the scope of this paper to offer a solution to this situation, except to note this intrinsic tension in the therapeutic role. It is the aim of this paper however to show that the differences between a treating doctor and an OP are such that in some aspects of the OP role as expert, or model 3, this ethical conflict should not arise.

42 “Impartial” being defined as “not favouring one person or side more than another”, Oxford Essential English Dictionary, Oxford University Press, 2011.

43 75% of their workload, as previously mentioned, from the survey reported in Saff (2007).

44 “Occupational physicians also need to build good relationships with managers, integrity, respect, good communication, and a focus on impartiality (emphasis added). Evidence-based medical advice is important elements in building a relationship of trust in which patients’ health problems and health and safety issues can be discussed constructively,” FOM (2010) p. 12.


46 This is not intended to be a criticism of the OP, as the latter is clearly expected to put the patient first, and in addition he would have only one side of the story.

Model 2: The “independent” expert model

This model describes work such as HIA applications, where the OP assesses the evidence presented (including specialist reports and evidence of attempts at workplace adjustments) against the medical criteria of the pension scheme. It would have similarities with expert witness work that doctors of any specialty can carry for the courts. However, for HIA medical assessments, it is the submitted evidence rather than the individual that is being assessed, so the applicant does not even have to be present in person at a “consultation”. One would expect the same advice by the GMC given to UK expert witnesses to apply, for example in terms of the requirement to be “honest, trustworthy, objective and impartial”. This makes it clear that the expert’s position is to be unbiased. In contrast, in an adversarial legal system, a lawyer must “present his client’s best case and draw the court’s attention to the weaknesses of the opposing party”. Both sets of ethical obligations, for the expert to be unbiased on the one hand, and for the lawyer to be biased on the other, are clear and unequivocal (albeit with some qualification for the lawyer). One would like to believe that other doctors (in a non-expert role) are also bound to be objective, unbiased and impartial in their judgments and their advice, but clearly this could be in conflict with their “duty of individual loyalty” to their patient. This leaves them in the uneasy position where their duties from the two sets of obligations can be in direct opposition to each other.

Model 3: The “impartial” doctor model

This model will be used to describe the majority of OP work, which usually arises from referrals by managers, asking for advice on workers’ fitness for work, or health aspects of attendance or performance problems. Although the FOM recognises the need for OPs to be impartial, it does also stress that OPs, like other registered medical practitioners, have an ethical responsibility to put the interests of individual patients first. Thus a physician, learning of a health risk to a worker, has “a responsibility to protect the health of the employee, even if this is to the detriment of the employer”. In the context of a health risk from work, this is understandable. However, in the UK workplace stress and musculoskeletal problems have become the predominant occupational illnesses. These are often more multifactorial in causation, and it remains an OP’s responsibility to advise on such matters. But what does “putting the interests of individual patients first” actually mean in such cases? The employer may argue with some justification that it is the role of the OP to put the interests of his patient first. So in the UK, where the employer pays for the OP’s advice, if this were to be no different to that received from a worker’s GP, then the employer might question the value of paying for an OP’s advice at all. An example would be where a worker suffers from work-related stress, which he alleges is caused by his manager bullying him. A report from his GP, if one were obtained, would be heavily biased towards his patient. However, in many cases, there are other factors that may be relevant, such as feedback on poor performance by the manager to the worker prior to the alleged bullying. The OP should have a more balanced account of the situation, and be able to recommend more objective approaches, such as the use of stress risk assessments or workplace mediation. If the OP were also simply to “put the patient first” in such circumstances, there is a risk that UK employers

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35. Other work that would fall in this category includes OPs sitting on Medical Appeal panels for these pension schemes.

36. For the NHS Pension Scheme, which is the largest in the UK, virtually all are done remotely.

37. GMC (2003).


40. However, he must not knowingly mislead the Court (Bar Council 2012, paragraph 30).

41. It is beyond the scope of this paper to offer a solution to this situation, except to note this intrinsic tension in the therapeutic role. It is the aim of this paper however to show that the differences between a treating doctor and an OP are such that in some aspects of the OP role as expert, or model 2, this ethical conflict should not arise.

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45. This is not intended to be a criticism of the OP, as the latter is clearly expected to put his patient first, and in addition he would have only one side of the story.

OM models and moral implications

In model 1 ("quasi-therapeutic"), the OP/SP interaction is the closest to that between a doctor and patient in a normal DPR. Although a worker may not need to trust the OP with his "health and life," given that the OP will not carry out life-saving or other major interventions, he still needs to trust the OP to the extent that he is taking advice from the latter. Similarly, the power imbalance may be similar to that in the DPR, as the worker is generally in a position of knowing less than the OP about the health matter of concern. The main difference compared with the normal DPR is that fewer workers are likely to be as vulnerable as patients through pain and suffering, although some workers will seek help when they are distressed, especially if they have the facility to self-refer to the OH service. Given the similar levels of trust required and power imbalance in this model to the normal DPR, it is likely that the fiduciary obligations that arise in the normal DPR may also apply in model 1. Indeed, three of the four "central principles" of a fiduciary relationship, namely the no conflict rule, the no profit rule, and the duty of confidentiality, seem appropriate in this context as well. On the other hand, the fiduciary's duty of "undivided loyalty" to the vulnerable party is less easy to support, given the OP's duty to the employer, and also to third parties if they could be harmed, for example. Although it could be argued that even in a therapeutic relationship, doctors also have obligations to third parties. There is likely to be a difference of emphasis: the treating doctor usually puts his patient's interests first. This is illustrated in Fig. 1.

This figure illustrates the continuum between the two sets of obligations and the two extremes of the doctor role. However, for the purposes of this paper I will consider the treating doctor's obligations to be mainly towards the patient, and the model 2 doctor to be mainly towards the third party, although this is clearly an oversimplification. In OM practice this different emphasis can be reflected in disagreements between the patient's treating doctor, such as the cardiology of a train driver with a heart problem, and the OP who has to advise the employer on the risk assessment. The cardiologist may feel that the residual risk posed by his patient in terms of a sudden incapacitating event to be acceptable, but an employer or the public may take a different view.

In model 2 ("independent expert"), the OP acts as an expert assessor of evidence, for example for pension funds. There may be no direct contact between the worker (or applicant) in the UK, as the major public sector pension funds use systems which involve the OP usually only reviewing the submitted evidence, and then presenting their advice or decision to the employer or pension fund managers. If there is any relationship at all between the OP and applicant, it would be, at best, an "arm's length" one, and therefore the level of trust required by the applicant would differ markedly from that expected of a doctor to whom he entrusts his life and health, or even accepts advice from. It would be limited to trusting that the OP has the appropriate training and qualifications to carry out this assessment, and will perform it competently and objectively. Such a level of trust bears little or no resemblance to that in the normal DPR, and would be more akin to that type of trust that we would have on a day to day basis in many individuals would provide us with a particular service, such as a surveyor assessing a building for electrical safety, and providing the required certificate. Similarly, a power imbalance is less evident, or at least arguably less relevant.

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21. One of the consequences would be that less OH would then be available to UK workers, arguably to their detriment, as they would have even less access to expert advice and diagnosis for work-related conditions.

22. As described by Bartlett (1997).

23. For example Gilber (1977), p 138: "despite this acceptance (of obligations to society) doctors often talk and think, as if they believe that they never give absolute moral priority to their patients over the moral demands of society". The GMC are keen to reinforce this message: "you must make the care of your patient your first concern" (GMC 2005).

24. In their role, one would find this partiality towards their patient acceptable, similar to that of the OH doctor in the context of public health care systems.

25. This is the case for the largest fund, the NHS Pension Scheme. The other schemes may involve either a similar paper review, or a face-to-face assessment of the applicant.

26. For example, if the property is to be let.
However, the OP is still in a somewhat position of power, as his advice or decision will determine whether the early release of the pension on ill-health grounds will proceed or not, and the applicant is in a position of vulnerability for the same reason. On the other hand, if there is no real relationship between the two parties, then the power imbalance seems to be an artificial consideration here. For example, although there is a clear power imbalance between a judge and a defendant when in court, this is not relevant in that context, and does not affect the validity of the process. The main reason for highlighting the power imbalance in the normal DPR (and other fiduciary relationships) is to provide the vulnerable party with some protection, by placing obligations on the fiduciary. In this model, the application of Bartlett's fiduciary principles to this context sits the least comfortably. One would deny the need to avoid a conflict of interest or the OP profiling from his position, although it is difficult to see how the latter could do this, given the remoteness between the two parties. There could also be a need for some degree of confidentiality, although in practice it is not always the information will have been gathered by other parties beforehand. For example, the OP could find reference to distressing details in a psychiatric report about child abuse, and should be careful not to include such details in his report to the pension fund manager or trustees. However, such instances are rare, and a report for pension purposes will mainly concentrate on the applicant's ability to work, to perform certain tasks, and the likely permanence or otherwise of any health conditions and impairments. The fiduciary principle that would be completely incompatible with the OP's role would be the "duty of undivided loyalty", otherwise he could not give independent advice as required by the pension scheme.

Model 3 ("impartial doctor") represents the majority of OPW interactions in the UK, and reflects the need for OPs to be impartial in a "dual obligation" system. The types of interactions and obligations are more difficult to characterise, given the wide range of activities that are included here. However, that range can be illustrated by two examples of activities in this model: on the one hand, for "health surveillance" activities, the OP may be towards the right of the Fig. 1 "model 2treating doctor axis". That is, there is significant obligation towards the worker, as this activity concerns protecting workers' health from workplace agents. On the other hand, for sickness absence referrals (the majority of OP work) the OP would be more to the left of that axis, as usually this is more for the employer's benefit. From a relationship perspective, model 3 is in the "middle ground" between models 1 and 2, and the worker may be somewhat disappointed that the OP is not "taking his side". In the normal DPR, the importance of trust and the power imbalance in that relationship is very evident. It is not suggested that in this third model, trust or power imbalance play no part. Rather, it is likely that the nature and extent of any trust and power imbalance are different. As O'Neill points out, we can trust individuals in some matters but not others, or to different extents. For example, in the DPR, patients should be able to "trust doctors with their lives and health". This level of trust is not required from workers in the normal OP consultation. Indeed, it would be rather surprising if anyone expected such a level of trust. On the other hand, one would hope for some trust in the OP, for example of his competence at evaluating health and work issues (although some workers challenge this when the assessment results are not to their liking), and of his honesty and integrity (although this trust becomes less evident when increasing emphasis is placed on signed consent(s), and a worker reading the report before its issue). Similarly, in the normal DPR it is argued that the power imbalance arises partly from the patient being ill and more vulnerable than he would otherwise be, and partly from the doctor's power. In the OPW situation, the worker is often not ill, but may still be more vulnerable through lack of expert knowledge, which the OP will have. However, there are also situations where the power imbalance shifts in the opposite direction, for example, when workers attend with their union representatives who can be very knowledgeable on the relevant issues, or be coercive (such as threatening to refer the OP to the GMC) if the favourable outcome were not obtained for their member. Although such situations are relatively rare, they

54 That is, monitoring workers' health from workplace exposures to chemical, physical or biological agents, under legislation such as mentioned in ref. 14.
55 However, this is also to a lesser extent for the benefit of employers, for example, in discharging their duties under health and safety legislation.
56 But as seen from the examples, the middle ground is not a fixed point on the Fig. 1 "model 2treating doctor axis", but will vary according to the type of activity, and maybe the context.
57 O'Neill (2002), who at p. 91 gives the following examples: "I might trust a schoolteacher to teach my child arithmetic, but not to cut her hair...I might trust my bank with my current account, but not my life savings."
Table 1: Trust, power imbalance and fiduciary obligations in the three OP models compared with normal DPR

<table>
<thead>
<tr>
<th></th>
<th>Normal DPR</th>
<th>Model 1 “QUASI THERAPEUTIC”</th>
<th>Model 2 “INDEPENDENT EXPERT”</th>
<th>Model 3 “IMPARTIAL DOCTOR”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust</td>
<td>Very important</td>
<td>May be similar to normal DPR</td>
<td>Very limited</td>
<td>Limited. For example, even in a non-therapeutic context, certain professional standards will apply</td>
</tr>
<tr>
<td>Power imbalance</td>
<td>Usually significant</td>
<td>May be similar to normal DPR</td>
<td>May not be relevant</td>
<td>Variable</td>
</tr>
<tr>
<td>Fiduciary obligations</td>
<td>Consistent with all four fiduciary core principles</td>
<td>May be similar to normal DPR, except for duty of “undivided loyalty”</td>
<td>Fiduciary obligation of “undivided loyalty” is wholly incompatible as independence is essential</td>
<td></td>
</tr>
<tr>
<td>1. No conflict of interest (not a conflict of interest)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. No profit motive</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>3. Duty of undivided loyalty</td>
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<tr>
<td>4. Duty of confidentiality</td>
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</tbody>
</table>

serve to illustrate that the power imbalance may not always be as one imagines it to be.65

OPs are to be impartial whichever model they are operating in, as it is a requirement of their function. Nonetheless, it is a difficult balance to achieve in everyday practice.66 In model 1, where the relationship may be close to the DPR, there is probably a greater risk that the OP could develop a closer affinity with the worker’s views, although he may not recognise this himself. However, even in this model, where the outcome of that consultation was uncounseled by the worker, the OP is still bound by a “duty of undivided loyalty”. Indeed, the duty of undivided loyalty cannot be expected of the OP in any of the three models, although the inconsistency of expecting such a duty in OPI interactions is most evident in model 2, where the independence of the OP is essential. If in the DPR, trust and power imbalance are of central importance in the analysis of that relationship, then it is suggested that in this third model, the emphasis should be on the impartiality of the OP. This need for impartiality can create tensions with the worker and the employer (and other stakeholders, such as “the public”).67

Other doctors with dual obligations, such as in sports, insurance or military medicine, may also be in situations where some of their roles fit the normal DPR paradigm, but at other times be in roles where that paradigm does not apply.68 In the latter cases, as with the GM situation, different ethical guidance for the situations that are similar to models 2 and 3 that recognises these differences may help to reduce or resolve moral conflicts. Table 1 summarises the main differences described above.

65 It is accepted that even in the DPR, a GP may occasionally feel threatened by his patient, and prescribe some medication or write a certificate, against his better judgment.

66 These models are intended to be a description of current UK OP practice, rather than what it ought to be. It is accepted, for example, that if OP provision became state rather than employer funded, this would change the pressures arising from the employer-OP relationship. Alternatively, OPs could adopt a different service-user approach with employers, which arguably would make it clearer for all parties to understand the GP’s role. However, whether one of these or other approaches were to be pursued, it would still take some time to come into effect. In the meantime, it is hoped that a clearer understanding of the different tensions, and why they arise, will help OPs in their practice, and regulations producing ethical guidance.

67 For example, passengers and other members of the public, when a train driver suffers from epilepsy and does not wish this to be disclosed by the OP.

68 For example, Grubb (1998) p 334, states that the insurance medical context would not give rise to a fiduciary relationship: “One of the most important conditions for the (fiduciary) duty to arise is absent: an enacting of power by the beneficiary which is to be exercised only for his benefit.” This condition is also absent in OP models 1 and 3, and precarious in sports medicine and military medicine situations.

69 It is envisaged that the equivalent of models 1 and 2 could be reasonably, clearly established for other dual obligation disciplines, though they would be different to the OP models. For example, in sports medicine, model 1 would actually be therapeutic, and the arm’s length model 2 arises for example during a pre-selection medical assessment of a prospective team player. The middle ground, model 3, could arise for example when the team coach wanted a player recovering from injury to play possibly too early in an important match, and the club doctor had to advise.
Conclusion
Ethical guidance for doctors is usually based on the assumption that a normal DPR exists. By using the modelling approach in OM, it becomes evident that not all ODP interactions fit this assumption. On the one hand, in model 1 the ODP interaction is close to the normal DPR, and therefore not surprisingly most of the ethical constraints in a normal DPR make sense in model 1. At the same time, these interactions are very close to the extent of their length (model 2), most of the underlying assumptions used in the normal DPR are incorrect in that situation. The last obligation of unidemedicality, for example, is inconsistent if applied in a context where independence is essential.
In model 2, the ethical requirement for the GMP for the ODP in the case of independent endorsement to the patient before submitting it to the employer or human resource manager would be akin to a judge offering a defendant first sight of his judgment, and requiring the defendant's consent before delivering it. It would be helpful if guidelines such as the GMC could make a distinction between these different situations, and adjust the guidance to reflect the reality of the different ORM roles.

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Conflict of Interest
None.

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Can informed consent apply to information disclosure? Moral and practical implications

Jacques Tamin

Abstract
This paper aims to show that the ethical justifications and the processes for requiring consent for interventional research or treatment are different to requiring consent for the disclosure of patient or subject information. I will argue that these process and theoretical differences are sufficient to view “consent” in the two situations as different concepts and suggest that the phrase “permission to disclose” would be more appropriate in the information disclosure situations.

Keywords
Informed consent, information disclosure, informational privacy, information flow, consent process, permission to disclose

Introduction
“Consent” is a term that is used in all treatment and research situations, and it does not matter at present whether this consent is required for invasive research or treatment or for nonintervening research and situations where patient information is disclosed, such as the production of a medical report. In the context of tissue bank research, Olszewski has sought to explore “the essence of the concept of consent itself” to justify the modified approach to consent that she proposes in this type of research. However, I would suggest that the difficulties with tissue bank research and other instances where “consent” is for the disclosure of information as a consequence of this paper and not necessarily the same term and approach in both situations, when the underpinning of the concepts is actually different.

Therefore, it may help to use different terms in the two situations. For example, the Scottish independent Review Group on the Retention of Organs at Post-mortem felt that the term “authorization,” or “the granting of permission,” was more appropriate than consent in their context. O’Brien and Chantril support this approach in a wider sense, stating:

“by moving to a term such as “authorization”, we can more freely seek agreement to use of data which is based on the appropriate principles of protecting privacy and autonomy—rather than by trying to use the model of consent to treatment, which at root serves to protect doctors against charges of assault or malpractice.”

Beauchamp suggests that “in biomedical ethics the language of “consent” has been framed almost entirely as “informed consent.” For the purposes of this paper, the phrase “informed consent” will be used when consent is sought for treatment purposes of or in carrying out invasive research (although there are some differences between consent for treatment and research) to distinguish it from consent required for the disclosure of patient/subject data. In the latter circumstances, such consent will be described in this paper as “permission to disclose” (PTD).

There are similarities between the two types of consent. For example, “disclosure, comprehension, voluntariness, competence, and consent (or decision)” are listed as components of informed consent. It seems reasonable to suggest that these conditions need to be met in both types of consent. In this paper, it is the differences between the two that will be highlighted and discussed, as the aim is to establish whether there

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is, or should be, sufficient distinction between seeking informed consent and seeking PTD to warrant using a different process of obtaining each.

Informed consent

Following the horrors of the Nazi experiments, the need to protect human subjects from such research saw the publication of the Nuremberg Code in 1947, which was “the first authoritative statement of consent requirements in biomedical ethics.”

Beauchamp and Childress suggest that following this initial concern about minimizing harm, from the 1970s, “the primary justification for consent has been to protect autonomous choice.” However, Manson and O’Neill guard against over-reliance on autonomy in this way. The problems they list include the fact that the various conceptions of individual autonomy make it less clear what form of autonomy one might be seeking to protect (for example, can it be “mere choice” as opposed to “reasoned or reflective choice?”); and the relative merits of protecting autonomy over other ethical considerations. Other reasons for requiring informed consent are advanced by Ciolkowski: in addition to autonomy, she lists “respect and protection as the primary ethical principles underpinning consent.” She does not elaborate on what these means by respect, but the Belmont Report describes respect for persons as “incorporating (at least two basic ethical convictions): first, that individuals should be treated as autonomous agents, and second, that persons with diminished autonomy are entitled to protection.”

Similarly, Harris suggests that respect for persons “has two distinct dimensions: respect for autonomy and concern for welfare.” From both these accounts, it would seem that there is overlap between the concept of respect used in this way and the concepts of autonomy and protection, which so far form the moral basis for requiring informed consent.

Although it has been claimed that “the heart of issues about informed consent is moral, not legal,” nonetheless, a review of what legal commentators have said about informed consent may help in our exploration of its basis and its application. However, this approach needs to be tinged with some caution; as from an English legal perspective, Brazier also questions “whether the process of adversarial litigation alone can ever provide satisfactory answers to the difficult questions of ethics and law raised in the debate on informed consent.”

Lord Steyn has underlined the reasons why, from a legal perspective, informed consent matters

“in the context of attributing legal responsibility, it is necessary to identify precisely the protected legal interests at stake. A role requiring a doctor to obtain from performing an operation without the informed consent of a patient serves two purposes. It tends to avoid the occurrence of the particular physical injury the risk of which a patient is not prepared to accept. It also ensures that due respect is given to the autonomy and dignity of each patient.”

Brazier and Cave further comment: “Should he fail to obtain a patient’s agreement at all, should a doctor force himself on a patient, he commits the tort of battery, and the crime of assault. Not only does he infringe on his patient’s autonomy, he also violates her bodily integrity.” Therefore, from both the accounts, the law requires informed consent in order to protect bodily integrity and to respect patient autonomy. Indeed, Mila cite Lord Diplock to claim that “the purpose of the law (is) to protect the autonomy of the patient,” but it has been commented that “it seems hard to believe that a court would allow damages for the harm done to the patient’s autonomy. Nevertheless, we do see judges increasing autonomy’s importance.”

On the other hand, Sheila McLean sees “a poor fit between the ethical concept of autonomy and the legal rules of consent,” and in terms of what form of autonomy the courts may be aiming to protect, Alasdair MacLean suggests that in Chester, “the majority adopted a liberal vision of autonomy.” He also opines that a review of the law in this area could “reflect a more sophisticated view of autonomy, going beyond the simple individualistic right to self-determination.” However, for the purposes of this discussion, it may be sufficient to note that the English courts do protect autonomy, and informed consent is a crucial part of that process.

Trust has also been listed as one of the reasons for requiring informed consent, although it could be argued that it was a lack of trust in doctors and researchers that led to the requirement for consent as a means of protecting patients and subjects in the first place. In terms of justifications for claiming trust to be a reason for requiring informed consent, these are both forward-looking, such as “the importance of ongoing societal trust in caregivers and medical institutions, for example, so the public will continue to comply with medical advice, participate in medical research and fill in organ donor cards” and backward-looking, where “this version defends informed consent as an intrinsically valuable way to honor the trust that the patient has placed in the physician.” There is some merit in these arguments, but I would still suggest that one should not forget that consent originally arose from mistrust (sometimes justifiably so, when one recalls the Nazi experiments). O’Neill makes a lesser claim in terms of trust that “informed consent requirements play…a role that can
have distinctive importance in maintaining trust.” Although I agree that having informed consent procedures in place can help in maintaining trust (which is a two-way process, as informed consent also serves to protect the researcher and doctor), I suggest that if there were complete trust between the two parties, then there would not be a requirement for informed consent. It could be argued that this requirement may arise from a third party (such as an organization or a regulator) even if the two parties completely trusted each other. In my view, the third party requirement (whether it is to protect either party or itself) still reflects mistrust of the doctor/researcher or patient/subject or both. Therefore, although there may be individual trust in specific instances, the requirement for informed consent still reflects systemic mistrust.

Moreover, if justification for informed consent were to be mainly grounded in autonomy, then the suggestion that it could also be based on trust could arguably be even more problematic. Although there are many different conceptions of autonomy, it always has as its focus the individual, whereas trust necessarily involves at least two parties, with some sort of relationship between them. In his analysis of autonomy, Tauber comments that “a deep tension between autonomy and ‘relationships’ is not easily overcome.” The solution he offers is to define autonomy in a relational construct, where “autonomy must be placed in a social context where supporting relationships enable individuals to achieve various degrees of autonomy.” O’Neill points out that doctor-patient relationships were viewed as relationships of trust only because a paternalistic view of medicine was assumed, in which dependence of patients on professionals was generally accepted.” However, although she also recognizes the tension between trust and autonomy in this way, she refers to this older form of trust as a “blind trust,” which has given place nowadays to a more sophisticated “genuine trust,” of which autonomy is seen as a pre-condition: informed consent then is a “ritual of trust that embeds it in a properly institutionalized respect for patient autonomy.” The central role of trust in the doctor-patient relationship is the basis for asserting that it is a fiduciary one. Although it has also been argued that some doctor-patient situations may not have such a fiduciary basis. In an analysis of the effect of a fiduciary doctor-patient relationship on informed consent, the doctor-fiduciary has been described as either “agent,” where there would be no need to seek consent for each action (as the doctor would use his discretion to achieve the patient’s broad objectives) or “adviser” (the authors’ preferred model) where there is a “more robust requirement for informed consent.” This description reminds us that informed consent in the healthcare setting is given by patients within the context of a relationship, and the situations and relationships can differ greatly. Having given informed consent, patients may either be happy to leave the doctor to decide some of the aspects of their treatment (the agent scenario) or want to retain more control of each step of decision-making (the adviser situation). In my view, neither appears inherently the morally better approach, but rather depends on the context and the relationship between the parties, including the level of trust that exists.

It has also been said that “a suspicion of trust is central to contemporary autonomy-based bioethics, and typically reflects fears that trust can be misplaced, and that the loss of trust the trustworthy can be high.” This fear may explain the “belt and braces” approach to regulating doctors in the UK: on one hand, doctors are told patients must be able to trust them, but on the other hand, the emphasis on patient autonomy and informed consent effectively may mean that patients need not be as reliant on trusting doctors. Indeed, if there is to be any relationship between autonomy and trust, it may be more logical to view it as an inverse one, that is, the greater the level of patient/subject autonomy in the consenting decision, the less crucial the degree of trust needed in the doctor/researcher. Or put it in a different way, trust is based on greater interdependence, whereas autonomy is based on independence, as illustrated in Figure 1.

However, this does not mean that trust and autonomy are incompatible. For example, when autonomy is considered in relational terms, then there would be a higher level of dependence and trust. In addition, trust requirements will be different in various contexts (research as opposed to treatment, short-term contact with a casually doctor as opposed to a long-term

![Figure 1: Varying levels of dependence in autonomy and trust.](image-url)
relationship with one's general practitioner). Furthermore, trust is not necessarily all or none and could be limited for example to trusting that the correct information had been given or that the doctor/researcher would honor the patient/subject's choices and carry these out to an acceptable standard.

Permission to disclose

Permission to disclose (PTD) information from patient records to produce a medical report for employment or insurance purposes can be distinguished from PTD information from data in samples (already held) of research subjects in certain regards. For example, in the research context, the eventual use of the data may not be known at the time when the data or samples are being stored, such as in research based on "population biobanks". In contrast, a medical report is available for inspection by the patient soon after it is produced, so the patient is able to know definitely what information is to be disclosed. However, PTD in both these situations share a similarity that distinguishes them from informed consent. This lies in the direction of "information flow" in informed consent, the crucial information is to the patient or subject in order for him to make his own decision, whereas in PTD (whether for research or a report), the issue is control of his own information. The direction of information flow has process implications for both PTD and informed consent, as will be shown later. In addition, although Munson and O'Neil initially appear to treat PTD as an extension of the informed consent requirements, they later clarify that in controlling one's own information, there are other interests that need to be protected in addition to respect for autonomy and protection from harm, namely confidentiality and informational privacy. If we are to suggest that confidentiality and privacy are relevant interests to be protected by PTD, then we should consider why they ought to be safeguarded in the first place.

In the medical context, the principle of medical confidentiality "that doctors must keep their patients' secrets" has been described as "one of the most venerable moral obligations of medical ethics." The moral basis for medical confidentiality has been based on three types of arguments: (a) consequences-based ones: if the patient did not trust the doctor to keep the information confidential, then he would not disclose all relevant information, and this may be detrimental to his treatment and medical management; (b) respect for autonomy and privacy; and also (c) fidelity-based arguments. In England, the importance of medical confidentiality has been stressed by the professional regulators and recognized by the courts. However, confidentiality is not absolute and may be breached for example in the public interest.
Autonomy and protection from harm were the main factors noted in justifying the need for informed consent. These justifications also play a part in requiring PTD, although there may be some qualitative differences.53 However, the main difference that arises in the analysis of the justifications for both is that PTD protects privacy and informed consent does not. In the next section, other differences will be explored.

Process differences between informed consent and PTD

Voluntariness, competence, and understanding of the patient/subject are important to both informed consent and PTD and so will not be discussed in this paper, for it is the differences between the two that I wish to highlight here. So far, I have suggested that these include the opposite direction of informational flow in the two situations and also that PTD primarily protects privacy, whereas informed consent primarily protects autonomy. In this section, I will explore the differences in the processes used in informed consent and PTD situations. For this analysis, I will assume that the "event" (requiring consent or permission) is a single one in the treatment (a surgical intervention) and the invasive research settings, in order to simplify the description of the processes. For the PTD situation, writing a report would be a finite event in any case, whereas bio-bank research is necessarily ongoing. If we consider what is required prior to the event, then in both informed consent situations, great emphasis is placed on the information given to the patient subject. This is highlighted by the English courts: a "material risk" has to be disclosed to the patient,54 and a doctor who fails to do so could be found to be negligent if the risk materializes and the patient is harmed.55 The doctor would be aware of such material risks, often in great detail, for example, a percentage risk of a specific complication. In interventional research, the risk information may not be as accurate, but safety data will still be available, and relevant risks need to be communicated. On the other hand, the information available to be communicated to the patient/subject in the PTD situations is quite scant in comparison. In writing a report, the doctor will be aware of what is addressed to, and the stated purpose of the request, which he can communicate to his patient. However, beyond this, he will usually not know the consequence of sending his report. Therefore, although he should communicate the relevant information to his patient, the information available to him will be more limited, when compared with the informed consent situations. In the case of bio-bank research, the available information to the subject is again limited, but for a different reason. The very nature of such research means that it is not possible to predict exactly what further use the data or samples may be put to, except in general terms. For this reason, approaches advocated in bio-bank research include the use of "bread,"56 "unspecified,"57 or "hybrid"58 consent.

After the event consent cannot be withdrawn retrospectively as the event has already taken place in the informed consent situations, whereas in both PTD situations, permission can be withdrawn. In the case of a report, this could be after the patient has read it and no longer agrees for the information to be disclosed, or in the case of bio-bank research, this could be at any point during the course of the research project if the subject changes his mind.59

The main differences in the processes are summarized in the following table (Table 1).

A practical example

To further illustrate the differences between informed consent and PTD in practice in other situations, consider the case of a needle-stick injury sustained by Health Care Worker X, the source patient Y being HIV positive. In the first scenario, Y's HIV status is not known, whereas it is known to X; and his doctors in the second scenario. The relevance of X obtaining information of Y's HIV status is that it would help her in deciding whether to start postexposure prophylaxis (PEP, which should be as soon as possible and certainly within 48-72 h of exposure). X is also at risk of stress and anxiety from acquiring HIV, and if she does start PEP, there are a number of unpleasant, sometimes debilitating, side effects from taking such medication.

In the first scenario, if Y refuses to have a blood test, then venepuncture clearly could not proceed without informed consent. It would constitute battery and assault in English law as well as being morally reprehensible. The fact that X may suffer anxiety, or side effects from PEP would arguably not provide sufficient justification to override Y's autonomy.

In the second scenario, X would need to obtain Y's PTD a result already known to himself and his treating team. The same tensions between Y's rights and the harm to X do exist, but Y's predominant interest to be protected here is his privacy rather than his autonomy. I would not wish to suggest that privacy is less deserving of protection than autonomy, but rather that the analysis of the competing interests needs to be done on a case by case basis. In this scenario, I suggest that the harm to X may be sufficient justification to obtain the HIV result without Y's PTD. Y would still need to be assured of the limits of disclosure, such as limiting knowledge of the result to X and her occupational health advisers, who would all be bound by a duty of confidentiality. However, if the distinction between
Table 1. Process differences between informed consent and PTD.

<table>
<thead>
<tr>
<th>Preference</th>
<th>Event</th>
<th>Permission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent</td>
<td>Information to patient</td>
<td>Surgical intervention</td>
</tr>
<tr>
<td>Consent</td>
<td>Information to subject</td>
<td>Research intervention</td>
</tr>
<tr>
<td>PTD</td>
<td>Only limited information to patient possible</td>
<td>Report written</td>
</tr>
<tr>
<td>PTD</td>
<td>Only limited information to subject possible</td>
<td>On-going, not a finite event</td>
</tr>
</tbody>
</table>

PTD: "permission to disclose."

Table 2. An example to illustrate differences between informed consent and PTD in practice.

<table>
<thead>
<tr>
<th>Requirement from patient</th>
<th>Consequences to Y of proceeding without consent or permission</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV status unknown Consent given</td>
<td>Cannot proceed Better/assess</td>
</tr>
<tr>
<td>HIV status known PTD</td>
<td>May be able to proceed Failure to respect Y's privacy</td>
</tr>
</tbody>
</table>

PTD: "permission to disclose."

informed consent and PTD were not made in this way, it may be too easy for clinicians working under pressure to assume that a refusal of "consent" (in the generic sense) precludes any further analysis, especially with the threat of an action in battery and the crime of assault. I suggest that making this distinction explicit helps in seeing the real issues, which need to be considered (Table 2).

Conclusion

Consent has been described as "a process whereby an individual having been provided with full information and understanding the consequences, agrees to a proposed action." This describes the "informed consent" situations well. However, in the context of information disclosure situations such as writing a medical report or biobank research, full information is not possible, and therefore the consequences cannot be fully understood by the patient or subject. Yet, although in these situations, the available information to communicate to the patient or subject is more limited, I have argued that the primary interest to be protected is the privacy of patient's/subject's information already held, and so the lack of "full information" to the patient/subject may be less of an issue.

Although Orlowoda has analyzed "the essence of the concept of consent itself" in biobank research, I would also step further and suggest that PTD is sufficiently different in its theoretical basis and its process to be considered a concept distinct from informed consent.

If this approach became widely used, then the requirements for PTD could be developed just as they have developed over time for informed consent. A starting point would be the acceptance that although in report writing and biobank research, the information given to the patient or subject is necessarily limited, and the PTD process is nonetheless valid.

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None

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References and notes

3. Independent Review Group on retention of organs at Post-Mortem. Report on Phase 3, Appendix 2 Draft Standards for the Management of Post-Mortem Examinations (instructed by the Presumptive Fatal, p.13 accessed at http://www.schd.nhs.uk/publications/tmp3tmp3p-07.htm). Their context was the permission to use organs and tissues at postmortem. The move away from the term "consent" in that situation helps to illustrate the fact that the use of this term carries with it the expectations of a process that is not always applicable. This paper will argue that there are other contexts and situations where it would be better to use a different term and process.
6. For a comprehensive analysis of the difficulties with consent in research see Foster C. *The Ethics of Medical Research on Humans*. Cambridge: Cambridge University Press, 2000, pp.113-129. She lists for example the evidence that subjects often misunderstand the information they are given, such as a lack of understanding of randomized control designs. The critical difference between consent for treatment and research is that in the therapeutic setting, the patient believes that the doctor knows what is best for her, whereas in research, the patient/subject does not. Also, clearly in nontherapeutically, the benefit is for others rather than the subject. However, this distinction does not affect the way “informed consent” is being used for this paper, especially as the requirements and the processes followed are the same.

7. This is to be distinguished from disclosure of information to patients in order to obtain their informed consent. See for example Beauchamp TL. *Informed consent: its history, meaning and present challenges*. *Cambridge Quarterly Healthcare Ethics* 2011; 20: 515-523: “in the United States, informed consent has often been treated as synonymous with this legal doctrine, which is centered almost entirely on disclosure and on liability for injury.” (emphasis added). However, it is not claimed that PTO is necessarily the best term, but it distinguishes consent for disclosure from “informed consent” for the purposes of this paper. For example, “permission to disclose” is more applicable when used in the context of a report, as opposed to research based on data, as the permission may not always be for disclosure of data, but also for further use of that data (p.519).


16. At Ref. 1, p.300.


22. At 18.


27. McLean SAM. Autonomy, Consent and the Law: Abingdon: Routledge, 2010, p.87. She argues for example that for policy reasons, the patient’s individual choice makes way to an “objective” or “reasonable patient” test.


29. MacLean, 2012: 121. He appears to use “self-determination” as a concept similar to Dworkin’s (1986) “second order” autonomy, where those who exercise this “define their nature, give meaning and coherence to their lives, and take responsibility for the kind of person they are.” (at 20).


37. At 121.


39. At 19.

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43. At 355.

44. At 356.

45. Munson and O'Neill 2007, p.158.


47. For example, Rogers WA and Braunack-Mayer AJ. Practical Ethics for General Practitioners. 2nd ed. Oxford: Oxford University Press, 2009, p.115: “the principle of respect for patient autonomy has become one of the central planks of contemporary medical ethics, with the practice of informed consent serving as a legal reminder of its importance.”

48. For a fuller description, see Brier A. Moral Prejudices: Essays on Ethics. Massachusetts: Harvard University Press, 1994, pp.20-21, where he contrasts "personal autonomy and independence" with "the more satisfactory interdependence.”

49. For example, Tauber (2005): 120.

50. For example, O'Neill O. A question of trust. The BRC Roth Lectures 2002. Cambridge: Cambridge University Press, 2002 suggested that she might trust (her) GP to diagnose and prescribe for a sore throat, but not for a heart attack.


52. For example, In England and Wales, the patient has up to 21 days to view the report before it is sent under the Access to Medical Reports Act 1988, chapter 28, HMSO at 4(2)(b).


56. At p 99.


59. They claim that doctors owe an obligation of fidelity to patients and assert that "the physician’s obligation to live up to the patient’s reasonable expectations of privacy and confidentiality is one way to specify the general obligation of fidelity."


63. GMC (2009) para 8; W x Eykel [1966] per Lord Bingham at 848. However, “public interest” is different to “what the public may find interesting”. See: Lion Laboratories Ltd v Evans [1964] 2 All ER 417 at 422-423.

64. Laurie (2002): 211-232. However, in addition to the doctor-patient relationship, the nature of the information itself (such as health information) is important in determining whether information is private and confidential: Campbell v MGN [2004] UKHL 22 per Baroness Hale at 145: “It has always been accepted that information about a person’s health and treatment for ill-health is both private and confidential. This stems not only from the confidentiality of the doctor-patient relationship but from the nature of the information itself."

65. Ash v McKeating [2006] EWCA Civ 1714, per Buxton LJ at 23: “A person’s health is in any event a private matter, as the Campbell case demonstrated. It is doubly private when information about it is imparted in the context of a relationship of confidence.”

66. Laurie G. Genetic Privacy: A Challenge to Medical-Legal Norms. Cambridge: Cambridge University Press, 2002: 250. In addition, if one is in control of one’s information, the House of Lords has maintained that one can impose a duty of confidence (Douglas v Hallet [2007] UKHL 21, at 118).

67. Health information is classed as “sensitive personal data” (as 2), which requires explicit consent for processing, save for exemptions listed in Schedule 3.


69. Article 8 of the European Convention on Human Rights (ECHR), in HRA Schedule 1: “Everyone has the right to respect for his private and family life...”.

70. Ash v McKeating [2006] EWCA Civ 1714, per Buxton LJ at 86(iii).

71. See: Warrington’s Home Office [2013] UKHL 53 per Lord Hoffmann at 14-35; and Campbell v MGN [2004] UKHL 22 per Baroness Hale at 113: “One has to develop a general tort of invasion of privacy.” This contrasts with the earlier case of Douglas v Hallet (2001) QB 967 which suggested that English law would recognise and protect a right of privacy, a position not endorsed by subsequent cases, such as Warrington. Whether in fact there ought to be a discrete privacy tort rather than “shrouding” article 8 into the tort of breach of confidence is beyond the scope of this article.

72. See, Ref. 58.

73. Douglas v Hallet [2001] QB 967 at 126. However, as mentioned above, subsequent judgments have not supported a discrete “right to privacy” in English common law.

74. Campbell v MGN [2004] UKHL 22 at 50.

75. Dworkin (1988): 104. He gives the following examples to support this view: “One way of interfering with your autonomy is to deceive you. This kind of interference
with information is, however, just the opposite kind from that involved in interference with privacy. What is controlled is the information coming to you, not the information coming from you. I do not know something about you that you might wish to conceal. I conceal something from you that you might wish to know. Thus, autonomy but not privacy is diminished. Similarly, privacy may be interfered with but not autonomy. If someone taps your phone conversations without your knowledge he interferes with your privacy. But your decisions, your actions, your values, are in no way changed or altered from what they might be otherwise. You are as self-determining as ever.” He also cites the Supreme Court decision in Griswold v Connecticut (381 US 479 (1965) when it ruled “that prohibitions of the use of contraceptives was a violation of the constitutional right of privacy” as an example of “the intellectual disorder from confusing these two notions.”

78. Per Lord Hoffman in Campbell, at 46.
79. Lord Hoffmann in Campbell, at 55: “the extent to which information about one’s state of health, including drug dependency, should be communicated to other people was plainly something which an individual was entitled to decide for himself.”
80. For example, “informational autonomy” is described in Case P. Confidentia: matters the rise and fall of informational autonomy in medical law. Med Law Rev 2003; 11: 206-236.
84. Australian Government, National Statement on Ethical Conduct in Human Research, 2007, accessed at http://www.nhmrc.gov.au/Files/nhmrc/publications/attatchments/07.pdf on 19 February 2013, at p21: “unspecified” given for the use of data or tissue in any future research. The necessarily limited information and understanding about research for which extended or unspecified consent is given can still be sufficient and adequate for the purpose of consent.”
85. Odlowski (2012a): 203. This is her preferred approach, and she defines hybrid consent as “specific consent for collection and storage together with broad consent for future unspecified use.”
86. However, it is still possible for the patient or subject to claim post-event that information given prior to the event was not sufficient for valid informed consent, as was argued in Chester.
What are ‘patient secrets’ in occupational medicine practice? Privacy and confidentiality in ‘dual obligation doctor’ situations

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Abstract
In order to understand what might constitute a ‘patient secret’ in occupational medicine (OM), this article first reviews why information is confidential in doctor–patient relationships in therapeutic settings. The General Medical Council (GMC) does not treat medical confidentiality any differently whether the setting is therapeutic or not. However, it will be argued that the legal and ethical justifications for medical confidentiality in therapeutic situations cannot simply be transposed into the OM setting, especially in the context of independently commissioned reports. Moreover, the recent GMC guidance on confidentiality, which requires doctors to seek further consent for a report commissioned by third parties, will be shown to be in conflict with English Court of Appeal judgements.

Keywords
‘Dual obligation’ doctors, English law, medical confidentiality, medical ethics, occupational medicine.

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Introduction

Doctors must keep patient secrets. But is everyone who confides in a doctor (in his professional capacity) a patient? And is everything he says a secret?

In England, medical confidentiality is recognized and upheld in common law and statute, as well as by the regulator, the General Medical Council (GMC), it is ’enshrined in all codes of medical ethics’ and is said to be central to the therapeutic relationship.

However, is it also central to a non-therapeutic relationship? Not all doctor–patient encounters occur within a therapeutic setting. ’Dual obligation’ doctor situations arise ’where doctors have clear obligations to a third party that can be in tension to the obligation to the patient’, for example, when a doctor works for or is contracted by third parties such as a patient’s employer, an insurance company, an agency assessing a claimant’s entitlement to benefits, or the armed forces. It has been argued that these

1. This article focuses on doctors, but it is recognized that other health-care professional will also have obligations of confidentiality. ’Where ’he’, ’his’ etc are used, this is intended to represent both genders throughout this article’.

2. M. Brazier and E. Cave. Medicine, Patients and the Law, 5th ed. (London: Penguin Books, 2011), p. 80: ’Doctors, like lawyers and priests, must be able to keep secrets’. However, they also point out that this obligation of confidence is not necessarily absolute. I use the term ’secrets’ in a relatively neutral way here, not intending to presume the level of secrecy that is required at this stage, as this is explored later.


4. Data Protection Act 1998 (DPA), where health information is classed as ’sensitive personal data’ (section 2), and explicit consent must be obtained from the data subject for the processing of this data (section 3). Jackson makes the point that ’Some statutes, most notably the Data Protection Act 1998, clearly have an impact upon medical records, and yet because this was never their principal focus, their application to the doctor–patient relationship can be ambiguous and confusing’, in E. Jackson, Medical Law: Text, Cases and Materials, 3rd ed. (Oxford: Oxford University Press, 2013), p. 360. Nonetheless, the DPA has some direct relevance to OMI records, as this will be discussed subsequently in ’Why should it be?’ section.


8. ’Therapeutic’ is used here in a wide sense to include diagnosis as well as treatment.

9. British Medical Association, Medical Ethics Today: The BMA’s Handbook of Ethics and Law, 3rd ed. (London: British Medical Association, 2012), p. 649. Although it could be argued that to some extent, all doctors have obligations to parties other than their patients, in practice doctors in therapeutic relationships talk and think as if they believe that they invariably give absolute moral priority to their patients over the moral demands of society’ (G. Gillon, Philos. Psychiat. Psych. Ethics (Chichester: John Wiley & Sons, 1985), p. 158). In this article, it will be assumed that treating doctors do indeed give absolute moral priority to their patients.

relationships are significantly different from the 'normal' therapeutic doctor–patient relationship. Some dual obligation doctors will provide treatment, as in military or sports medicine, whereas doctors practising occupational medicine (OM) or insurance medicine do not. This article explores the nature of medical confidentiality in these dual obligation non-therapeutic roles. In particular, one of the OM roles requires the doctor to be independent. In the context of such independent reports, could the doctor's obligation of confidentiality be different? Or is any communication to a doctor in any professional capacity a 'patient secret', which type of information or the context in which it is shared, cannot undermine?

In order to understand what might constitute a patient secret in OM, this article will first review why information is confidential within doctor–patient relationships in therapeutic settings. The GMC does not treat medical confidentiality any differently whether the setting is therapeutic or not. So, if it can be shown that the legal and ethical

11. I. Tamin, 'Models of Occupational Medicine Practice: An Approach to Understanding Moral Conflict in “Dual Obligation” Doctors', *Medicine, Healthcare and Philosophy* 16(3) (2013), pp. 499-506. In addition, it has been pointed out that there is no single doctor–patient relationship, and different models have been proposed. See for example E.J. Emanuel and L.L. Emanuel, 'Four Models of the Physician-Patient Relationship', *Journal of the American Medical Association* 267 (1992), pp. 2221–2226. However, for the purposes of this article, it will be assumed that all doctor–patient relationships in the therapeutic context are based on trust and that the doctor in these relationships “make the care of their patients their main concern”. GMC (2013) at p. 3. It will later be argued that the same level of trust may not be required in the non-therapeutic relationships described here.

12. Tamin ‘Models of Occupational Medicine’, p. 502. For example, in ill-health retirement assessments for the Local Government Pension Scheme Regulation 2013, an occupational physician doing this assessment of not having advised, or given an opinion on, or otherwise been involved with the case previously.

13. See for example, Editorial, ‘Medical Confidentiality’, *Journal of Medical Ethics* 10 (1984), pp. 345, at 345: “in the context of medical ethics the patient may well consider all information concerning his or her interaction with the doctor as secret, including the fact that the consultation has occurred at all”.


It is not easy in this case, as in many others, when concluding that information is private to identify the extent to which this is because of the nature of the information, the form in which it is conveyed and the fact that the person disclosing it was in a confidential relationship with the person to whom it relates.

The tension between the relative importance of the nature of the information and that of the relationship will be explored further in “Confidentiality: Information or relationship?” section.

15. GMC, ‘Confidentiality: Supplementary’.

The first duty of a doctor registered with the GMC is to make the care of their patient their first concern. The term ‘patient’ in this guidance also refers to employees, clients, athletes and anyone else whose personal information you hold or have access to, whether or not you care for them in a traditional therapeutic relationship (para. 2)
justifications for medical confidentiality in therapeutic situations cannot simply be transposed into the OM setting, then the GMC approach could be flawed. If patient information is confidential, then the consent of the patient is required before it can be disclosed. On the other hand, if there are circumstances where confidentiality does not preclude disclosure to a party, then it becomes less evident why consent would be needed. 17 Indeed, in the case of a report commissioned from a doctor following an assessment, it will be shown that the courts have clearly indicated that consent for disclosure of this report is not required. 18 Unfortunately, GMC guidance states the opposite, 19 which puts occupational physicians (OPs) writing such independent reports in a difficult position.

'Screwy' may conjure up the imagery of 'clash and dagger' scenarios, which could be more than just metaphorical in this context, if one considers the potential for deception 13 with the GMC confidentiality rules. 20 In any case, it will be later argued 21 that the current confidentiality paradigm may no longer suffice to protect patient data, and it is necessary to look to privacy instead. 22 So another development that is particularly apposite to a discussion of privacy of information is the recent contribution of English courts 23 to this area of the law, which will be described in the subsequent section.

16. *See Farnworth* in "When can OM information be disclosed?" section.
17. In particular in *Kapadia v. London Borough of Lambeth* [2000] IRLR 699. This will be discussed in "When can OM information be disclosed?" section.
18. GMC (2009), at pp. 22-26. This will also be described in "When can OM information be disclosed?" section.
20. Insofar as disclosures in "the public interest" are allowed, arguably the courts also support this deceit.
21. See later in "When can OM information be disclosed?" section.
22. The courts have used the language of privacy for some time. For example, "information about an individual's private life would not, in ordinary usage, be called "confidential". The more natural description today is that such information is private", *Campbell v. MGN* [2004] UKHL 22, per Lord Nicholls at 14. However, in "The "abhorrent" of Article 8" section, I will later describe the need in common law to "shoot" the right to privacy into an action of breach of confidence, so it can hardly be argued that the courts have already adopted a privacy paradigm. Moreover, I will later also point out the limitations with the current conception of privacy that the courts have used so far and propose a model which I suggest will better protect privacy, as it provides a more transparent process for disclosures.
Privacy and confidentiality in therapeutic settings

Medical ethics and law concentrate mainly on the exchange of information in a doctor-patient setting when considering medical confidentiality and its breach. However, even in therapeutic settings, patient data are shared far beyond just that individual doctor for legitimate reasons, such as within multidisciplinary teams, or with those who process patient data, or for research purposes. In an age of electronic patient records and data, it has been argued that traditional medical confidentiality alone can no longer do the job of protecting patient secrets. So, although confidentiality will continue to have a role to play, privacy may become the more important player.

25. M. Brazier and E. Cave (2011), p. 84, point out that ‘English law on breach of confidence developed haphazardly. The core obligation requiring doctors to respect patient confidences derives from the common law’.

26. J.K. Mason and G.T. Laurie, Mason and McCall Smith’s Law and Medical Ethics, 7th ed. (Oxford: Oxford University Press, 2006), p. 253, list the three elements needed for an obligation of confidentiality to be breached. These are: (1) the information must have the necessary quality of confidence, (2) the circumstances must import an obligation of confidence and (3) there must be unauthorized use of the information. This paragraph is not found in the more recent 9th edition (2013), so I have referred to this earlier edition.


29. See later in ‘Confidentiality: Information or relationship?’ section.

30. G. Laurie (2002) points out that while confidentiality and privacy ‘overlap in many ways, they are by no means identical’. ‘In particular, while confidentiality cannot protect the interest in not knowing … a properly designed right to privacy may do so’, at pp. 211–212. See also R v. BBC, ex p BBC [2000] 3 All ER 889, 3012 per Lord Mustill: ‘Privacy and confidentiality are not the same’, but he was distinguishing those in the context of corporate secrecy. ‘A company can have secrets, can have things which should be kept confidential, but I see this as different from the essentially human and personal concept of privacy’.
Privacy

Privacy has been defined as "a state of separateness from others," and the right to privacy has traditionally been described as "the right to be left alone." For the purposes of this article, a more useful conception of privacy is to regard it as "the condition of not having undocumentated personal information about oneself known by others." A development of the right to privacy then involves treating the control of information as inherent in privacy. The academic debate on the meaning of privacy has been mirrored in Court judgements in the last ten years. For example, the European Court of Human Rights has declared the right to privacy, guaranteed by Article 8 of the European Convention on Human Rights, has already been defined by the Assembly as "the right to live one's own life with a minimum of interference."

32. However, Laurie (2002) at p. 71 warns us that, by equating privacy as freedom from intrusion or interference, writers such as L. Blom-Cooper "The Right to be Let Alone", Journal of Media Law and Practice 10 (1989), p. 53, have confused privacy with liberty. Laurie (at p. 81) describes the example of an individual's privacy being invaded by genetic information gathered about her "through the testing of her relatives when the individual in question is unaware, thereby having no effect on her liberty". Although I have referred to Blom-Cooper's article, the notion of privacy as a right to be let alone has been articulated for over a century. See for example S.D. Warren and L.D. Brandes, 'The Right to Privacy', Harvard Law Review 45(1) (1932), pp. 193–220, at 195.
33. W. Parent, 'A New Definition of Privacy for the Law, Law and Philosophy 2(3) (1983), pp. 305–338, at 306. By "undocumented", Parent refers to information not already in the public arena. Laurie (2002) calls this "informational privacy", as distinct from the right to be left alone, which he calls "spatial privacy" (at p. 6). I agree with Laurie that both types of privacy remain distinct from liberty, although there is overlap in the interests that privacy and liberty aim to protect.
34. Emphasis added.
37. However, in the United Kingdom, there is no common law free-standing 'right to privacy', see Wainwright v. Home Office (2003) UKHL 53 per Lord Hoffmann at paras 14: 35; and Campbell v. MGN [2004] UKHL 22 per Baroness Hale at paras 133: "our law cannot, even if it wanted to, develop a general tort of invasion of privacy"). This reverse the earlier proposition in Dougan v. Hedges [2004] QB 567, where it was suggested that English law would recognize and protect a right of privacy, a position not endorsed by subsequent cases, such as Wainwright. Also, see Asb v. McKean (2008) EWA Civ 1714, per Buxton LJ at 86f: "in developing a right to protect private information, including the implementation in the English courts of articles 8 and 10 of the European Convention on Human Rights, the English courts have to proceed through the tort of breach of confidence, into which the jurisprudence of articles 8 and 10 has to be 'shored up'. This will be discussed further subsequently in "Confidentiality: Information or relationship?"
In view of the new communication technologies which make it possible to store and use personal data, the right to control one’s own data should be added to this definition.

Lord Hoffmann described a ‘shift in the centre of gravity of the action for breach of confidence’. He indicated that it was the right to control one’s information which had now become central to what the law aims to protect in privacy cases:

Instead of the cause of action being based upon the duty of good faith applicable to confidential personal information and trade secrets alike, it focuses upon the protection of human autonomy and dignity, the right to control the dissemination of information about one’s private life and the right to the esteem and respect of other people.

However, Tavani has criticized this ‘control theory’ conception of privacy as being counterintuitive in the following circumstances:

The prospect of someone disclosing all of his or her personal information and still somehow retaining privacy, merely because he or she had control over whether to reveal that information, would seem to be counter to our intuitions about what is required for privacy, as well as to the way we use that concept in ordinary discourse. Although one could exercise one’s individual autonomy in choosing to disclose every piece of one’s personal information to others, it would be difficult to understand how one could still retain one’s privacy in that case. It would seem that the control theory confuses privacy with autonomy.

He also points out that although the control theory rightly highlights the role of choice in privacy, it is unclear with respect to ‘which kinds of personal information can be expected to have control over, and how much control one can expect to have over one’s personal information’. He suggests that another theory of informational privacy,

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38. Emphasis added.
40. *Campbell v. MGY* [2004], at para. 51.
41. Emphasis added.
42. *Campbell v. MGY* [2004], at para. 51.
43. Tavani’s use of the term ‘privacy’ here is likely to refer to ‘informational privacy’ as described by Laurie (2002), as having all one’s information in the public domain would not entail loss of one’s ‘spatial privacy’.
44. H.T. Tavani, ‘Philosophical Theories of Privacy: Implications for an Adequate Online Privacy Policy’, *Metaethics* 38(1) (2007), pp. 1–22, at 8. Arguably, this is to choose to have no privacy at all could be an expression of one’s autonomy. On the other hand, in more usual circumstances, see G. Dawkins, *The Theory and Practice of Autonomy* (Cambridge: Cambridge University Press, 1988), p. 104, for a cogent discussion on the differences between privacy and autonomy.
45. Tavani, ‘Philosophical Theories of Privacy’, at p. 7. I will not elaborate on the types of, and degrees of control over, information at this stage, as these will be discussed in ‘A proposed privacy paradigm: The example of an OM Domain’ section, in the context of the proposed solution. However, I agree with Tavani that the control theory on its own does not do this.
namely, the limitation theory, has the advantage of not confusing privacy with autonomy in the way that the control theory does. The limitation theory sets up "zones" of contexts of privacy where others would be restricted from accessing one's personal information. However, this theory underestimates "the role of control or choice that is also required in one's having privacy." His solution, which I support, is to combine elements of both theories into a "restricted access/limited control" (RALC) model. In this model, "the concept of privacy is defined in terms of protection from intrusion and information access by others in the context of a situation." He uses the example of medical information to illustrate this:

That information is private because a normative zone has been established to restrict people from accessing the information, not because an individual has complete control over who has access to this information within a medical setting. Doctors, nurses, financial administrators, and insurance providers may have legitimate access to various pieces of it.

Nevertheless, he does not dismiss the importance of control in privacy:

Control is also important for the management of privacy. In managing one's privacy, however, one need not have absolute control over information about oneself (as implied in many versions of the control theory of privacy). Instead, an individual needs to have some degree of control with respect to three elements: choice, consent, and correction.

46. See for example, R. Geison, "Privacy and the Limits of the Law", Yale Law Journal 89 (5) (1980), pp. 421-471. She describes this type of privacy as "limitation of others' access" to one's personal information, at 428.
47. Tavani, "Philosophical Theories of Privacy", at p. 9.
48. Originally proposed by J.H. Moor, "The Ethics of Privacy Protection", Library Trends 39 (1-2) (1990), pp. 69-82. In theory, it would still be possible for an individual to waive his privacy rights in each of the zones that are established. However, I would suggest that the "default" settings of each zone, and the RALC process itself (as described later, at "A proposed privacy paradigm: The example of an OM Domain" section) would make it inherently more difficult, although not impossible.
49. Tavani, "Philosophical Theories of Privacy", at p. 12.
50. Tavani, "Philosophical Theories of Privacy", at p. 11.
51. Tavani, "Philosophical Theories of Privacy", at p. 12. In terms of choice, Tavani suggests that "a person needs some control in choosing situations that offer others the level of access that the person desires." He also maintains that the consent process helps in managing privacy. "For example, one can waive one's right to restrict others from access to certain kinds of information about oneself." Finally, "individuals need to be able to access their information and amend it if necessary." These appear to be a reasonable account of how "limited control" would work in protecting privacy (given that "restricted access" should also be in place). I agree that "choice, control, and consent" are important elements of this model and will illustrate their role in the example at "A proposed privacy paradigm: The example of an OM Domain" section.
It is not clear whether the courts would favour an RALC approach when considering a patient’s control of his information. In Ash v. McKennitt, a different concept of zones was suggested by counsel for Ash in that the zones referred to internal areas of McKennitt’s private life, rather than external zones as proposed by Tavani. It was argued that having revealed a part of her life in order to support a charity, McKennitt had thereby placed that whole zone of her life in the public domain:

Information that is already known cannot claim the protection of private life. Mr Price however advanced a striking extension of that principle, that once a person had revealed or discussed some information falling within a particular “zone” of their lives they had a greatly reduced expectation of privacy in relation to any other information that fell within that zone. This argument was used in particular in respect of Ms Ash’s revelations about Ms McKennitt’s health and her distress at the death of her fiancé. The material said to contain revelations by Ms McKennitt falling within the same zone were remarkably sparse, which in itself is an indication of how protective Ms McKennitt has been of her privacy.

Buxton LJ was very dismissive of this approach:

It was extremely insensitive to use Ms McKennitt’s promotion of the Cook-Rees fund, and her explanation of her reasons for setting up the fund, to suggest that she had thereby opened up whole areas of her private life to intrusive scrutiny . . . . If information is my private property, it is for me to decide how much of it should be published. The “zone” argument completely undermines that reasonable expectation of privacy.

53. In this case, the death of her fiancé.
54. That is, an external “zone”, where an individual would allow some of his information to be held.
56. Ash v. McKennitt, at para. 54. This is in contrast to the situation in Campbell, where her “public life” precluded her from claiming protection . . . . When talking to the media, Miss Campbell went out of her way to say that, unlike many fashion models, she did not take drugs. By repeatedly making these assertions in public Miss Campbell could no longer have a reasonable expectation that this aspect of her life should be private . . . . where a public figure chooses to present a false image and make in-trust pronouncements about his or her life, the press will normally be entitled to put the record straight. (para. 34)

It does then beg the question, whether the “zone” approach would have been received more favourably by the courts had it been argued in Campbell rather than in Ash. However, in practice I believe this would not materially affect the way the courts would protect privacy of one’s medical information. I suggest that this would be a refinement of the approach they have taken so far, rather than being a sea change. The courts currently view privacy as “right to control one’s information” (Campbell, at para. 51). By adopting the RALC approach, privacy would be protected not just by control but also by the fact that there would be restricted access to certain areas of our information. It is beyond the scope of this article to fully develop an RALC model that the courts could apply.

57. Campbell, at para. 55.
Although the ‘zone argument’ advanced in Ash is completely different to that in Tavani’s RALC model, there is some danger that the two could be confused. For that reason, I would suggest that when applying the RALC approach, it may be preferable to use the term ‘domain’ rather than ‘zone’.28 The ‘medical domain’ would in turn have subdivisions, such as a ‘general practitioner (GP) domain’ and (where applicable) a ‘psychiatric domain’, where information would be more tightly controlled compared with an ‘orthopaedic specialist domain’.

Health data are held in a number of settings, both therapeutic and non-therapeutic. For example, insurers, benefits agencies, research bodies and employers will also hold some health data. Ironically, whilst the GMC places exacting controls on the fitness for work advice by an OP to an employer,29 UK patients face the prospect of having their much more sensitive health data (held by their GP) shared with a number of bodies with little control over this process, or so it would seem.30 A more open and explicit approach to the handling of all health information, with appropriate safeguards in place, may promote greater public trust in health data management.

I will later describe how privacy domains might operate, using the OM domain as an example.31 Before we consider this proposed approach to protecting the privacy of health information, let us first review the role of confidentiality in the current paradigm.

Confidentiality: Information or relationship?

It has been said that confidentiality ‘is concerned as much with protection of a relationship as with personal information’.32 However, is this still currently the case?

In 1981, the Law Commission advised:

> Once information has been entrusted in circumstances giving rise to an obligation of confidence, that information is in effect impressed with a duty of confidence owed to the person who has entrusted it.33

The ‘circumstances giving rise to an obligation of confidence’ at that time included some relationship of trust. It seemed that both the information to be entrusted and the

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28. That is, ‘domain’ would be the same as ‘external’ zone.
30. That is, ‘domain’ would be the same as ‘external’ zone.
31. That is, ‘domain’ would be the same as ‘external’ zone.
32. See for example, Available at: http://www.telegraph.co.uk/health/Jul1/0647031/NHS-medical-records-database-halted-amid-concerns.html (accessed 9 November 2014). On the other hand, this has been defended on the grounds that research could improve effectiveness of treatments, for example, in A. O’Dowd, ‘Medical Data: Does Patient Privacy trump Access for Research?’, British Medical Journal 347 (2013), pp. 20–21.
33. However, it is beyond the scope of this article to explore the issue of National Health Service data sharing.
34. Discussed in ‘A proposed privacy paradigm: The example of an OM Domain’ section.
35. G. Laurie, ‘Confidentiality: Information or relationship?’ section.
relationship itself were equally important in creating this duty of confidence. However, since then, Lord Gotts has reformulated the underlying principle:

... where an obviously confidential document is washed out of a window into a crowded street, or when an obviously confidential document, such as a private diary, is dropped in a public place, and is then picked up by a passer-by... 63

... a duty of confidence arises when confidential information comes to the knowledge of a person (the confidant) in circumstances where he has notice, or is held to have agreed, that the information is confidential, with the effect that it would be just in all the circumstances that he should be precluded from disclosing the information to others. 64

Lord Hoffman described this ‘statement of principle, which omits the requirement of a prior confidential relationship’ as being “now firmly established”. 65 Therefore, the nature of the information itself has primacy in establishing a duty of confidence.

Information that is already in the public domain is not generally considered to be private. 66 However, in the medical context, one should be careful about assuming that information already known to third parties is necessarily no longer private. To illustrate this with an example from the non-therapeutic context, consider the guidance from the UK Faculty of Occupational Medicine (FOM):

Where information provided by a third party (medical certificates, referral letters) gives clinical information, even if the worker may have been the source of that information

68. However, what constitutes the “public domain” has been a matter requiring clarification in many cases. See for example the discussion in the Law Commission Report 110, Breach of confidence, 1981, para. 4.17-4.24. Information would not be considered to be in the public domain merely because there were ‘other people in the world who knew the facts in question’, or part of the information was already in the public domain, and had also to be distinguished from information which is only obtainable in the public domain (such as a product available in the open market) by the expenditure of a significant element of labour, skill or money.
69. That is, ‘not be something which is in public property and public knowledge’, Salitman Engineering Company Ltd v. Campbell Engineering Company Ltd [1948] 65 R.P.C. 203, 213; [1961] 3 All E.R. 413, 415 per Lord Greene M.J. He also said that for the information to be capable of protection for breach of confidence, the information needed to have ‘the necessary quality of confidence about it’. This was interpreted by the Law Commission as reflecting ‘the secret character of the information’, as above, para 4.15. In R v. Department of Health, ex p. Sources Information [1999] 2 BMLR 65, CA, [1999] EWCA Civ 301, at para. 35, Brown LJ again held that in personal privacy cases, a breach of privacy could not occur if the information was anonymised: ‘the confidence is not breached where the confider’s identity is protected’. 235
Although this advice may seem strange at first sight, given that this information appears to be already in the public domain (or at least known by the employer’s representatives), it is possible that managers or even the worker himself could misinterpret the clinical information they were given, so their understanding of the diagnosis and other details may be inaccurate. Then, even if the OP merely confirms or refutes any clinical information given to him in a referral, the resultant effect is in fact disclosure of clinical information which had not really previously been in the public domain, and by so doing, he would inadvertently breach confidence.

Although health information is per se private information, it has been claimed that ‘not all medical information meets the criteria of confidentiality’. For example, one might agree that a doctor’s appointment for a blood pressure check is a less private matter than one for an HIV test. However, McHale warns us that some medical conditions

70. Faculty of Occupational Medicine, Guidance on Ethics for Occupational Health Practice, 7th ed. (London: Royal College of Physicians, December 2012), 29, para. 3.61. OM information will be considered in greater detail in the ‘Old Practice in the United Kingdom’ section.

71. This would also be consistent with the Law Commission Report comment above that ‘only part of the information were in the public domain, then the information is not considered to be in the public domain.’

72. See for example, Campbell v. McIntyre [2004] UKHL 22 per Baroness Hale at para. 145, where she maintains that health information is private and confidential ‘not only from the confidentiality of the doctor patient relationship but from the nature of the information itself’ (emphasis added). Health information is also classed as ‘sensitive personal data’ in England, under the Data Protection Act 1998 (section 2).

73. McHale, (1993), p. 133. She goes on to say that ‘what does meet the criteria of confidentiality ought to be protected. Separating the wheat from the chaff, the crucially confidential from the superficially confidential, is an easy task’. She also suggests that ‘information imparted in the psychiatric consultation is generally regarded as crucially confidential’. Although McHale was making these points to support the development of ‘medical privilege’ akin to ‘legal privilege’, and these predates Campbell, I agree with McHale’s comments and believe they remain valid post-Campbell. Indeed, comparable comments have been made more recently, albeit in the context of doctors weighing up situations where they might breach confidence in the public interest:

Indiscernible doctors are bound to weigh the scales differently in any particular instance while in general, all relative weighing must change from case to case—there is, for example, a great deal of difference in respect of confidentiality between being smut by a low and suffering from venereal disease.

may be more or less sensitive according to the circumstances and, moreover, that 'the level of sensitivity between different ailments may also vary between these of different cultural and ethnic groups.' This raises doubts as to how any external party could possibly guess whether a patient would consider any given piece of information to be private or not, taking into account the circumstances, the ethnic and cultural differences, and any other personal beliefs and values. Therefore, whether any information ought to be considered to be private seems to be a matter for the individual concerned to determine.

Although it may not always be clear what information an individual would consider to be private, in an action for breach of confidence, the nature of that information is now of prime importance and the 'limiting constraint of the need for an initial confidential relationship' has been 'shaken off.'

Lord Nicholls goes on to say:

The continuing use of the phrase 'duty of confidence' and the description of the information as 'confidential' is not altogether comfortable. Information about an individual's private life would not, in ordinary usage, be called 'confidential.' The more natural description today is that such information is private. The essence of the tort is better encapsulated now as matter of private information.

Given the primacy of information in determining confidentiality, do we need to consider the relationship at all? I advance two reasons for us to at least consider the role of a relationship in this context. Firstly, the fact that in England there is no common law 'right

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74. As above, McHale, (1993), at p. 76, where she suggests that 'a gynaecological problem may be something which a young girl has great difficulty in discussing with her general practitioner, and she may be adamant that no one else should know about it. An older woman may feel no such inhibition.'

75. As above, McHale, (1993), at p. 76.

76. On the other hand, it is not only the patient who has a legitimate interest in the confidentiality of his information, the hospital may also have one. See for example, Ashworth Hospital Authority v. Mirror Group Newspapers (MGN) Ltd [2002] UKHL 59, at para. 32, per Lord Woolf:

while it is likely's conduct in putting similar information into the public domain would well mean that he would not be in a position to complain about the publication, this did not destroy the authority's independent interest in retaining the confidentiality of the medical records contained in Ashworth's files.


78. As above, Campbell v. MGN [2004], at para. 14. Subsequent cases have cited this to claim that a distinct tort of misuse of private information now exists. See for example, Inswain v. Telematique [2010] EWHC Civ 908 per Lord Neuberger MR at para. 65; Vidal-Hall & Ors v. Google Inc [2014] EWHC 13 (QB) at para. 69. However, it is beyond the scope of this article to explore further the development of such a privacy tort.
to privacy. Article 8 of the European Court of Human Rights has to be “shoe-horned” (see below) into an action for breach of confidence; and secondly, medical confidentiality is said to be central to trust in the doctor-patient relationship, so the interaction between that relationship and confidentiality also merits further discussion.

The ‘shoe-horning’ of Article 8

Lord Phillips stated the conclusions of the Court of Appeal to be the following:

We conclude that, in so far as private information is concerned, we are required to adopt, as the vehicle for performing such duty as falls on the courts in relation to Convention rights, the cause of action formerly described as breach of confidence. . . . The court should, in so far as it can, develop the action for breach of confidence in such a manner as will give effect to both Article 8 and Article 10 rights.

Buxton LJ commented that:

That feeling of discomfort arises from the action for breach of confidence being employed where there was no pre-existing relationship of confidence between the parties, but the “confidence” arise from the defendant having acquired by unlawful or surreptitious means information that he should have known he was not free to use.

Lord Phillips also expressed this “discomfort” in Douglas:

We cannot pretend that we find it satisfactory to be required to shoe-horn within the cause of action of breach of confidence claims for publication of unauthorised photographs of a private occasion.

79. See for example, Ash v. McKean [2006] EWCA Civ 1714, Article 8(iii).
80. Article 8 of the European Convention on Human Rights (ECHR), in Human Rights Act (HRA) 1998 schedule 1: “Everyone has the right to respect for his private and family life...”. This is a qualified right, and subject to consideration of conditions listed in schedule 2, which includes “interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals”.
81. See for example, West London Mental Health NHS Trust v. Chhabra [2013] UKSC 90, per Lord Hope at para. 33: “There is no doubt that patient confidentiality is an overriding principle and is central to trust between patient and doctors (General Medical Council, Good Medical Practice (2006) page 5 and para 21 and 37, Guidance on Confidentiality (2009), para 6)’.
83. “Everyone has the right to freedom of expression”, Article 10 of ECHR, in schedule 1 of HRA 1998. This “balancing test” between Articles 8 and 10 was also due for health information in Campbell. This balancing test replaced that between private and public interests that one would have in the disclosure or not of one’s information, and Lord Hope felt that the new balancing exercise was “essentially the same” as the one it replaced, “although it is plainly now more carefully focused and more penetrating” (para. 86).
85. Ash v. McKean [2006], at para. 53.
In spite of this discomfort, in English courts the right to privacy is given effect by this shielding, so at first sight, a relationship of confidence remains relevant. However, in identifying the basis for claiming privacy or confidence in respect of unauthorised or purloined information … the primary focus has to be on the nature of the information, because it is the recipient’s perception of its confidential nature that imposes the obligation on him.88. Thus, a relationship is imputed in such circumstances from the nature of the information, rather than from the existence of any real relationship prior to receiving the information. It could therefore be argued that a sort of ‘misuse of private information’ already exists but in name.89 On the other hand, Phillipson88 suggests that ‘case law discloses a certain amount of ambiguity’ because if an obligation of confidence ‘could be imposed simply on the basis of the private nature of the material itself’ (Emphasis in original), then at conceptual level, the notion that ‘in some sense, trust must be abused, would simply disappear’. If it is indeed a notion of abuse of trust that the courts aim to retain in a breach of confidence action,89 then this may not be very evident, given the primary that has been given to the information over the relationship. However, the Court of Appeal still holds that the ‘nature of the relationship that gives rise to the duty of confidentiality may be important’.89 This is because:

There is an important public interest in the observance of duties of confidence. Those who engage employees, or who enter into other relationships that carry with them a duty of confidence, ought to be able to be confident that they can disclose, without risk of wider publication, information that it is legitimate for them to wish to keep confidential.90

One such relationship is undoubtedly the doctor-patient relationship.

The doctor-patient relationship
‘Confidentiality is central to trust between doctors and patients. Without assurances about confidentiality, patients may be reluctant to seek medical attention or to give doctors the information they need in order to provide good care’.91 The level of trust required is of the highest order: ‘Patients must be able to trust doctors with their lives

87. As mentioned previously, it is beyond the scope of this article to explore whether the development of a privacy tort would be preferable to the current shielding as described.
89. On the other hand, I will later argue that the ‘privacy domain’ approach (which will be described as ‘A proposed privacy paradigm: The example of an OM Domain’ section) will be more likely to engender trust, as it is a more transparent process than the way medical confidentiality currently operates (see subsequently in ‘When can OM information be disclosed?’ section).
90. HRH Prince of Wales v Associated Newspapers Ltd [2006] EWCA Civ 1776, per Lord Phillips, at para. 69. This was in the context of balancing the right to privacy against the right to freedom of expression, in situations where the information could be deemed to be in the public interest.
91. HRH Prince of Wales v Associated Newspapers Ltd [2006], at para. 67.
and health.\(^{93}\) So there can be no doubt how much importance the UK medical regulator, the GMC, attaches to confidentiality and trust between a doctor and a patient. It has also been said that ‘the principle of medical confidentiality – that doctors must keep their patients’ secrets – is one of the most venerable moral obligations of medical ethics.’\(^{14}\) Similarly, medical confidentiality\(^{30}\) is recognised in English law. In the leading case of *W v. Egdell*,\(^{42}\) Bingham LJ described the medical duty of confidence:

(De Egdell) could not lawfully sell the contents of his report to a newspaper, as the judge held. Nor could he, without a breach of the law as well as professional etiquette, discuss the case in a learned article or in his memoirs or in gossiping with friends . . .\(^{97}\)

In *Egdell*, there was a contractual, as well as a doctor-patient, relationship between Dr Egdell and W.\(^{70}\) Nowadays, any doctor-patient relationship would suffice for the information imparted to be confidential. As Pattenden commented:

\(^{93}\) GMC, *Good Medical Practice* (London: GMC, 2013). This is the opening statement of ‘Duties of a doctor registered with the General Medical Council’, which are listed on the inside of the front cover page.

\(^{94}\) Gillon, ‘Philosophical Medical’, p. 106.

\(^{95}\) For a description of the development of the action for breach of confidence (not just of medical confidence), see Law Commission Report 116, *Breaches of confidence*, 1981. For example, it notes that ‘in later cases, decided in the early years of the nineteenth century, the Court of Chancery recognised an equitable right in confidentiality of information’ (at para. 3.2). Thus, ‘the remedies available in an action for breach of confidence have been greatly influenced in their development by the equitable origins of the action’ (para. 4.73).

\(^{96}\) *W v. Egdell* [1990] P.EL.R.483. W was a psychiatric patient in a secure hospital, having killed five people. W’s solicitors commissioned a report from Dr Egdell, a consultant forensic psychiatrist, to support his application to a mental health tribunal for discharge or move to a lower risk unit prior to discharge. Dr Egdell deemed W to be still a danger to the public, so his report was not favourable and was suppressed by W’s solicitors. When he discovered this, Dr Egdell sent a copy of his report to the hospital authorities without W’s consent. Although the judge held that Dr Egdell did owe W a duty of confidence, the possible serious consequences of not disclosing his report overrode his duty of confidence. This is a case where a balancing exercise was needed between the public interest of safeguarding the safety of other individuals. On the facts of this case, the public interest ‘trumped’ medical confidentiality, and it could be argued that the particularly serious consequences of non-disclosure were important in the judge’s determination.

\(^{97}\) *W v. Egdell* [1990], at para. 849. Another example of a doctor breaching medical confidentiality (although without a public interest defence) is *Chhabra v. West London Mental Health Trust* [2013] EWHC Civ 11, where it was held that Dr Chhabra, a consultant forensic psychiatrist, breached her duty of confidence when she read patient records in a way that details were visible to others and discussed a patient’s case with a colleague on a train, overheard by other parties.

\(^{98}\) The contractual relationship with W was a further reason for Dr Egdell to keep W’s confidence. Had Dr Egdell been instructed by the hospital authorities instead, no breach of confidence would have occurred, given Bingham LJ’s comments at para. 849 (see subsequently).
Recent developments in the law have removed the need for impartation of the information within a relationship of trust. A professional (like anyone else) who somehow acquires confidential personal information may be saddled with an obligation of confidentiality to X, the subject of the information, whether there was direct, indirect or no contact with X. All that is necessary is that the professional was aware, or a reasonable person in his position would have been aware, that the information was private to X.\textsuperscript{99}

Even therapeutic relationships occur in different clinical settings, such as ‘short-term contact with a casualty doctor as opposed to a long term relationship with one’s general practitioner’,\textsuperscript{100} and so may give rise to varying levels of trust required or experienced, both qualitatively and quantitatively.\textsuperscript{101} Notwithstanding the actual closeness of the relationship or the level of trust in a particular doctor–patient situation, it would then seem that the existence of a professional relationship would be sufficient in common law to establish a duty of confidentiality.\textsuperscript{102}

What does this common law duty of confidence require of doctors? In \textit{Egdell v. Bingham}, having confirmed the existence of a duty of confidence by Dr. Egdell to W, Bingham LJ went on to say:

The breadth of such a duty in any case is, however, dependent on circumstances. Where a prison doctor examines a remand prisoner to determine his fitness to plead or a prisoner for life insurance is examined by a doctor nominated by the insurance company or a personal injury plaintiff attends the defendant’s medical adviser… 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.\textsuperscript{103}

\textsuperscript{99} See for example \textit{Ash v. Ash}, at para. 15.

\textsuperscript{100} K. Pattenden, \textit{The Law of Professional Client Confidentiality: Regulating the Disclosure of Confidential Personal Information} (Oxford: Oxford University Press, 2003), p. 13. Some ambiguity in interpreting this statement could arise if one imagined someone displaying a disability, say with his right hand, obvious even to a lay person. However, further information that a doctor could elicit would be a diagnosis, and the full level of disability and function. So although the fact that a disability existed would not necessarily be confidential, the diagnosis and full degree of disability would.


\textsuperscript{102} See for example, O’Neill, (2002), where she suggests that she ‘might trust her GP to diagnose and prescribe for a sore throat, but not for a heart attack’.

\textsuperscript{103} See Pattenden (2003) above, who suggests that this would apply to any professional in that position.

\textsuperscript{104} Emphasis added.

\textsuperscript{105} See \textit{W v. Egdell} [1990], at para. 849. It is important to note that although \textit{Egdell} itself is rightly remembered as a case where the public interest overrode medical confidentiality because the public could have been severely at risk had the information not been disclosed, in making this statement at para. 849, Bingham LJ was referring to other scenarios such as insurance reports, where public safety is not an issue.
Thus, although the Court of Appeal held that a duty of confidence existed, they took this to mean Dr Edgehill could not lawfully sell the contents of his report to a newspaper. Nor could he, without a breach of the law as well as professional etiquette, discuss the case in a learned article or in his memoirs or in gossiping with friends.106

This did not mean that a doctor could not disclose his report to a commissioning party, such as an insurance company. Medical confidentiality is therefore not breached when the report is disclosed107 to the commissioning party.108

In addition, when patient information is disclosed, there should be a consideration of the possible justifications and interests in the disclosure of such information. It is not sufficient to say that this information is confidential and therefore no disclosure is possible.109 In *Mersey Care NHS Trust v. Ackroyd*,110 the Court of Appeal had to consider new facts since the case had been heard in *Ashworth Hospital Authority v. Mirror Newspapers (MGN) Ltd*.111 and had to repeat the balancing exercise between the public interest in maintaining medical confidentiality and that of disclosing information in the public interest. Jackson112 comments, ‘The case demonstrates that the confidentiality of medical records has to be put in the balance with other important interests, such as press freedom’. I suggest that medical confidentiality would need also to be balanced against other interests, such as the proper administration of pension fund awards.113 In order to discuss this and other issues with ‘confidentiality’ in non-therapeutic (OM) doctor–patient interactions further, I will first briefly describe the practice of OM in the United Kingdom.

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107. Without further consent. See *Farrenworth and Kapadia* discussed subsequently in “When can OM information be disclosed?” section.
108. An analogous situation to such an insurance doctor report would be an occupational physician’s report, especially as they are both ‘dual obligation doctor’ situations.
109. I accept that this is already the case in public interest situations or if required by law. However, I am arguing here that the interests that could justify disclosure should be broader in scope.
110. *Mersey Care NHS Trust v. Ackroyd (No. 2)* [2007] EWCA Civ 101. Mr Ackroyd, a freelance journalist, had refused to name his source at Ashworth Hospital who had disclosed Ian Brady’s medical notes to him. The new facts included the motives of the source, which were likely not financial, and could have been ‘misguidedly’ in the public interest. The passage of time (6 years) was also reassuring in that there had been no new facts, possibly as a result of the hospital adopting better systems to protect patient confidentiality.
112. Jackson, (2013), p. 363. As previously mentioned, Campbell and subsequent cases have required a balancing exercise between Articles 8 and 10. I draw here on Jackson’s comment that the balancing exercise might also be required against ‘other interests’ (although she herself quotes ‘press freedom’).
113. See discussion later in “Is OM information confidential?” section.
OM practice in the United Kingdom

A brief description

OM is predominantly a preventative rather than curative specialty, so generally OPs do not provide treatment, except for some immunizations, but instead assess and advise on workers' fitness for work. Moreover, industry has changed from a manufacturing to a service majority over the last 20 years and this trend may continue. The main hazards have changed from dust, heat, noise and vibration to workplace pressure. The practice of OM, which had previously been mainly concerned with the effects of workplace hazards on workers' health, has changed to one that provides a reduced emphasis on health protection, with more attention now being paid to assessment of fitness for employment and the management of incapacity for work. There has also been a growing trend for OP services to be outsourced from in-house provision to external commercial providers. These developments have led to an increase in the type of OP work that would result in a written report to the commissioning party, usually the employer, for a sickness absence assessment or a pension fund manager for an ill-health retirement (IHR) application. Thus, whether OM information and reports are or are not, or should or should not be, confidential is an important consideration in this setting.

Is OM information confidential?

Why should it be?

Health information is private information, so OM information is de facto private. It can be argued that there is statutory support for this position. The Data Protection Act


116. See for example, in Faculty of Occupational Medicine, Future directions for the occupational health care in the UK. A strategic overview, 2010, p. 3, para. 4.

117. For a description of occupational physician (OP) work in the United Kingdom, see Tamir, 'Models of Occupational'. In particular, one of the roles of an OP requires 'independence' in order to conduct ill-health retirement assessments.

118. This forms a significant amount of the occupational physician's (OP) workload in the United Kingdom. For example, a survey reported in J. Ballard, 'OH Professional Practice, Part 1: Jobs, Priorities, Concerns, Threats and Opportunities', Occupational Health at Work (2011), pp. 21-27, at 22 found that 17% of OPs felt 'dealing with ill Health Retirements' among their top three priorities. The majority of these assessments are made on evidence provided only, and no face-to-face consultation takes place, as with for example the largest pension scheme, the NHS Pension Scheme. Even when a face-to-face consultation takes place, it would be rare for new information to become available, as the applicant's treating doctor will normally have provided beforehand the results of investigations that have been undertaken.

requires the information pertaining to the "physical or mental health or condition" of an individual to be classed as "sensitive personal data". The Information Commissioner has issued specific guidance on information about workers' health.

Managers should not have access to more information about a worker's health than is necessary for them to carry out their management responsibilities. As far as possible the information should be confined to that necessary to establish fitness to work, rather than consist of more general medical details.

There is also a directive to:

Act in a way that is consistent with the Guidance on Ethics for Occupational Physicians published by the Faculty of Occupational Medicine. Although this is guidance for occupational physicians rather than employers, it should give you a clear understanding of the legal and ethical constraints that apply to the exchange of information when working with occupational health professionals.

The "FOM" guidance in this regard is as follows:

Paper occupational health records must be held confidentially and be accessed only by members of the occupational health team on a need-to-know basis. The same principles apply equally to electronic records.

The Court of Appeal has also confirmed that OM information is confidential. In Hartman v. South Essex Mental Health and Community Care Trust, Scott Baker LJ commented:

... it was not right to attribute to the Trust in their capacity as employers, knowledge of confidential medical information disclosed by Mrs Hartman to the OHIP ...
Kloss argues:

There is no legal authority for the proposition that confidential information in someone's personnel file can be communicated to other members of the workforce without consent. It is a breach of the employer’s duty of trust and confidence.127

From the foregoing, there appears to be strong support, both in statute and in common law, for her assertion. However, in the subsequent section, I will aim to demonstrate that there are circumstances where OM information can legally be disclosed without consent.128

When can OM information be disclosed?

In the case of an OM report following a pre-employment assessment, an Employment Appeal Tribunal (EAT)129 stated:

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 provided130 without the consent of the person to whom the duty of confidence is owed.131

Dr Cooper, the OP in the above case, was held to owe a duty of confidence to Farnsworth in that she could not disclose the medical information to parties other than the employer’s decision-makers or for other purposes.132 However, this duty of confidence did not prevent her from disclosing information to the employer for the purposes of making their employment decision. This position is entirely consistent with Bingham LJ’s

128. And without requiring the public interest justification.
129. Farnsworth v. London Borough of Hammersmith & Fulham [2000] IRLR 691. Ms Farnsworth had been offered the post of residential social worker subject to a medical assessment. Dr Cooper received information from her general practitioner and hospital doctor that she had a past history of depression for which she had been hospitalized, but had been well for the last year, and wrote a report to the employer to the effect that Ms Farnsworth had had past health problems which could recur and affect her future performance and attendance, following which the offer of employment was withdrawn. Ms Farnsworth claimed that because she had not further consented to this report being sent to the employer, Dr Cooper had breached her confidence.
130. Emphasis added.
dictum in Egell.\textsuperscript{133} On the other hand, Kloss, a former employment tribunal judge, views this ruling as reflecting the general lack of knowledge of occupational health issues among the tribunals.\textsuperscript{134} She bases her criticism of this finding on the fact that ‘Miss Fernworth was unlikely to have given informed consent’\textsuperscript{135} to the disclosure of all her medical information to any manager in the London borough.\textsuperscript{136} However, this criticism seems to me to be unfair. The EAT did not suggest that disclosure could be made to ‘any manager’ but would be made specifically to the ‘decision-makers’, and the information was to be confined to that which would allow them to make their employment decision.\textsuperscript{137}

In Kapadia v. London Borough of Lambeth,\textsuperscript{138} a case where an OP was asked to assess a worker for an independent opinion, but then did not provide the employees with a report because the worker subsequently did not give consent for this report to be released, the Court of Appeal ruled that:

On the facts the Court knows, the report should, in my judgment, have been disclosed to 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. A practice under which a

\textsuperscript{133} As above, see W v. Edgell, at paras. 849. The fact that Edgell relates to a report that had to be balanced against the public interest is immaterial here. As at para. 849, Brigham LJ was clearly referring to doctors commissioned to produce an independent report, such as insurance doctors. Doctors commissioned to produce an independent report following an ill-health retirement assessment would be in an analogous situation to those instances that Brigham LJ had in mind. In addition, Egell differs from occupational medicine (OM) reports in a further important aspect, in that the contractual relationship was between W and Dr Egell, whereas for OM reports the contract will be between the occupational physician (OP) and employer or pension fund manager. In Egell, this adds a further reason why consent would have been required for disclosure of the report, although public interest was held to justify confidentiality being breached in that case. For OM reports, confidentiality is not breached if the disclosure is only to the commissioning party, and there is no issue of contractual obligations between the OP and the worker.

\textsuperscript{134} As above, see Kloss (2010), at p. 323.

\textsuperscript{135} It has been argued that the concept of ‘informed consent’ is incorrectly applied when used for disclosure of a report, as opposed to treatment. See J. Temin, ‘Can Informed Consent’. This is because of the informational flow being in opposite directions, the inability to predict the consequential outcomes as accurately as with treatment interventions (so making ‘informed’ questionable), and differences between the two ‘consenting’ processes, so that ‘permission to disclose’ is proposed as an alternative to ‘informed consent’ in the context of releasing a report.

\textsuperscript{136} As above, see Kloss (2010), at p. 323.

\textsuperscript{137} This is consistent with Egell, at para. 849, in that such disclosure of information would not be a breach of confidence, as it is disclosure “to the party at whose instance he (the professional man) was appointed to make his examination”.

\textsuperscript{138} Kapadia v. London Borough of Lambeth [2000] IRLR 699. Mr Kapadia was pursuing a disability discrimination claim against his employer.
person who has agreed to be examined in circumstances such as those, but then claims a veto upon disclosure of the report to those who obtained it is not, in my view, a good practice. Indeed it is an impediment to the fair and expeditious conduct of litigation.130

Kloss points out that:

In fact, it may be that the information given to the Court of Appeal about the OH doctor’s report was inaccurate. The doctor in question states that he did not write a report because Kapadia had not given informed consent.131

However, in my view, whether he did not write the report or did not produce it to the employer is largely immaterial to the Court’s ruling. Once again, the legal position is that once the worker has consented to the assessment process, further consent is not required before disclosing the report to the commissioning party. This is also consistent with Edgell.132

Although it may appear at first sight that the judgement in Hartman is at odds with those in Farnsworth and Kapadia, I would suggest that it is not. OM information is confidential, so information should not simply be extracted from a worker’s OH file and passed to his employer without his knowledge and consent. On the other hand, once a worker has agreed to be assessed for the purposes of a report being produced, no further consent is required prior to information disclosure to the commissioning party, and when this is disclosed, confidence is not breached.133 If English law gives us a pragmatic and coherent answer to the issue of confidentiality of OM information and reports, unfortunately UK clinical guidance does not.

GMC guidance requires doctors to ‘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’134,135. However, I would argue that such a requirement to obtain further consent

130. Kapadia v London Borough of Lambeth, at para. 34.
140. As above, see Kloss (2010), at p. 82.
141. ‘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’, W v. Edgell, at para. 8.49. As previously mentioned, the public interest defence in Edgell does not affect my use of Bingham LJ’s dictum, as he was referring to other instances, that is, doctors commissioned to produce a report, such as insurance doctors. In addition, there is no public interest defence in Kapadia.
142. This is different to a report written by ‘a medical practitioner who is or has been responsible for the clinical care of the individual’, which would be subject to the Access to Medical Reports Act 1988, and would require patient consent and up to 21 days for the patient to view the report prior to its release.
143. GMC (2009), at p. 22. Emphasis added.
144. GMC (2009). This includes a section entitled ‘Disclosure of information for insurance, employment and similar purposes’ (pp. 22-26), which applies to those doctors with no therapeutic relationship with the patient, such as occupational physicians (p. 24). The fact the applicant can read the report before the commissioner, and withdraw consent if he chooses to suppress this report, is evidence that this guidance requires specific consent for the disclosure of this report.
before sending a report exceeds what the law requires.\(^{145}\) Firstly, disclosure of medical information in a report to the commissioner does not breach confidentiality,\(^ {146}\) so why would consent for such a disclosure be necessary? Moreover, case law involving OPs reinforces the fact that consent for disclosure of such a report to the employer's decision makers\(^ {147}\) or the courts\(^ {148}\) is not required. There is no legal authority to support the opposite view; namely, the GMC and FOM guidance that consent is required for disclosure of such a report to the commissioner.\(^ {149}\)

The practical consequence is that a worker (or ex-employee applying to the pension fund) who has been found not to meet the medical criteria for an IHR by one OP, can see this report: first,\(^ {150}\) then simply refuse consent for the report to be released to the pension fund managers, allowing him to seek a more favourable opinion from a different OP at a later date. This right of veto clearly indicates that specific consent for the report to be released is required by the GMC and FOM. This is in direct conflict with \textit{Egislit}. The FOM acknowledges that "ethical responsibilities in this area (of IHR assessments) are more complex than in much of occupational health because stakeholders include the pension scheme administrators and trustees as well as the workers and the employers".\(^ {151}\) Nonetheless, in terms of guidance, it merely repeats the GMC approach and justifies this on the basis of the "ethical principle of "no surprises"".\(^ {152}\) Those who defend this FOM position emphasize the importance of trust in the doctor–patient relationship. They claim this trust is maintained by the "patients' confidence that sensitive personal information will not normally be divulged outside the clinical team without prior consent"\(^ {153}\) and that OPs need this "high level of trust" on the part of the worker, who often enters the

\(^{145}\) Namely \textit{Egislit} and \textit{Kapadia}.

\(^{146}\) \textit{Egislit}, at para. 849.

\(^{147}\) \textit{Farrenworth}, at para. 22.

\(^{148}\) \textit{Kapadia}, at para. 34.

\(^{149}\) However, it might be argued that the General Medical Council (GMC) is seeking to affirm the importance of confidentiality and consent in all circumstances and for doctors to reflect on the need for this. Nonetheless, in the specific situation of an independently commissioned report to be disclosed to the commissioner, the courts have been very clear that subject consent is not required. GMC and Faculty of Occupational Medicine guidance ought to reflect this legal position, and currently they do not.

\(^{150}\) Current consent forms used in occupational medicine offer the worker or pension fund applicant the choice to see the report before the commissioning party (and giving them the option of withdrawing consent when they have read the report), in order to comply with the General Medical Council guidance. As stated above, the fact that the applicant has a right to see the report before the commissioner is de facto evidence that further specific consent for disclosure of this report is being sought, given that this "consent" can be withdrawn!

\(^{151}\) Faculty of Occupational Medicine (2012), p. 23, 42, para. 4.46.

\(^{152}\) GMC (2009), at p. 26.

occupational health (OH) process with a level of mistrust or apprehension in the integrity of the healthcare professional.154

However, in its guidance to all doctors, the GMC allows a breach of confidence without consent, for example, ‘if it is required by law’ or ‘if it is justified in the public interest’155 and even requires a breach of confidence in some circumstances.156 The GMC states doctors ‘must inform patients about disclosures for purposes they would not reasonably expect, or check that they have already received information about such disclosures’.157 However, either some doctors do not explain this clearly enough, or some patients do not understand it fully, the net result is the same: the doctor ends up having knowledge of a patient secret that he or she must then disclose. I assume that if patients fully understood the implications of sharing secrets that could have adverse consequences for them, they would choose not to reveal these. So, patients are being misled with a promise of confidentiality, only later to discover the ‘get out clauses’ that they had failed to appreciate fully. Therefore, this version of ‘confidentiality’, which is meant to foster doctor–patient trust, could actually involve inadvertent deception.158 For this reason, Kottow159 argues that there should be no allowed breaches at all, even in the public interest:

This postulated exemption to confidentiality is self-defeating. Firstly, if physicians become known as confidence-violators, problem-ridden patients will try to lie, accommodate facts to their advantage or, if this does not work, avoid physicians altogether. Physicians would then be unable to give optimal advice or treatment to the detriment of both the reluctant patients and their threatened environment . . .

If public interest demands a catalogue of situations where the physician would be under obligation to inform, medicine becomes subsumed to political design and stunts down a treacherous path. Should one prefer to leave the management of confidentiality to the physician’s conscience and moral judgement, public interest would not be relying on a consistent and trustworthy source of information. Fear of either political misuse160 or personal arbritrariness should make us wary of opening the doors of confidentiality for the sake of public interest.161

155. GMC (2009), p. 6. The Faculty of Occupational Medicine ethical guidance repeats the same conditions at p. 29.
156. GMC (2009), pp. 8–13, on ‘Reporting gunshot and knife wounds’.
158. O. O’Neill (2002), p. 70, suggests ‘If we want to restore trust we need to reduce deception and lies rather than secrecy’.
160. Kottow was possibly more acutely aware of political pressures in the Chile of the 1980s, but even outwith this context, I believe that his point remains valid.
161. Kottow, ‘Medical Confidentiality’, at p. 120.
I believe that Kottre makes a valid point. If the GMC and FOM aim to engender trust in doctors through the current confidentiality rules, the fact that breaches are allowed or even required, makes it possible that patients would end up mistrusting them instead.\footnote{S.J. Warwick, ‘A Vote for No Confidence’, Journal of Medical Ethics 15 (1989), pp. 183-185, argues on that basis that all doctors should not accept information in confidence.}

The second weakness in the FOM’s current position, I would suggest, is that it ignores the context of the report that is being written. In producing a report to pension fund trustees, there is an explicit requirement on the OP to be independent.\footnote{For example, the term ‘independent’ is used in the title ‘Independent Registered Medical Practitioner’ (IRMMP) in the Local Government Pension Scheme (Benefit, Membership and Contributions) Regulations 2014. The IRMMP will sign a certificate including a statement such as:

I have not previously advised, or given an opinion on, or otherwise been involved in this case, nor am I acting or have ever acted as the representative of the member, the scheme employer or any other party in relation to it.}

It has been argued that in such a role, the OP is not in a fiduciary relationship with the applicant,\footnote{J. Tamir, ‘Models of Occupational Loyalty’, at p. 505. It is argued that a fiduciary relationship entails a “duty of undivided loyalty” to the patient, which is de facto incompatible with the requirement for independence in this role.} so the level of trust required need not be as high\footnote{Possibly limited to trusting that the occupational physican in the Independent Registered Medical Practitioner role has the necessary qualifications and training and will perform the assessment competently.} as in a therapeutic relationship. Furthermore, a consideration of confidentiality needs to be balanced against other competing interests.\footnote{Anon., ‘Advisory (No. 2) [2007].’}

In this context, it would need to be balanced against the benefit of having a process that allowed the production of an independent and unbiased medical report, which could not be suppressed by the applicant,\footnote{The same involved are not inconsequential. For example, one council estimates that an ill-health retirement for a 40-year-old earning £50,000 per annum would cost the employer £346,000 (accessed at www.cheshirepensionfund.org/wp-content/uploads/2011-05/HLI-LG-brochure.pdf).} so that public funds are not misused.\footnote{By withdrawing consent.}

\footnote{From an ethical point of view, this would be supported by the principle of distributive or social justice. There is also legal support for this position. In the European Court of Human Rights case of MS v. Sweden (1997) 45 BMLR 133, case 74/1996/693/883, the court held that disclosure of private medical information was necessary in a democratic society for the proper administration of public funds: the Court considers that there were relevant and sufficient reasons for the communication of the applicant’s medical records by the clinic to the office and that the measure was not disproportionate to the legitimate aim pursued (at para. 46).}
Interestingly, Pattenden misunderstands the OM process as advocated by the FOM. She includes reference to previous GMC guidance,¹⁶⁹ and the previous edition of the FOM ethical guidance¹⁷⁰ to state:

At the outset of the examination, the professional should (as a matter of ethics and of law) tell the examinee (if he is capable of understanding the information) that:

The usual seal of confidentiality in a professional relationship does not apply¹⁷¹ and (if the examinee has any choice in the matter) that he must consent to being seen on that basis.¹⁷²

In fact, although both the GMC and the FOM required the OP to explain the purpose of the consultation at the earliest opportunity (and this remains current advice), they did not intend to suggest that the ‘usual seal of confidentiality’ did not apply. It could be argued that if OPs did not accept information in confidence, this would help reduce confusion and improve transparency, which in turn would improve the trust of workers in the OH process. However, although it might be more honest not to accept information in confidence, it could be equally confusing to the worker or patient. What can be tell this doctor, if anything? Should he withhold all information? For this reason, I suggest another approach, based on ‘privacy domains’,¹⁷³ which I will next describe.

A proposed privacy paradigm: The example of an OM domain

The scenario of an independent assessment for a pension fund application for early IHR will be used to illustrate how a privacy domain, in this case an OM domain, would function,¹⁷⁴ and this will be called domain OM2.¹⁷⁵

The worker (or applicant to the pension fund) has a choice of what information is given to the independent doctor (OP); that is, what information is contained in domain

¹⁷⁰ Faculty of Occupational Medicine, Guidance on Ethics for Occupational Physicians, 5th ed. (London: Royal College of Physicians, 1999), at para 1.11.
¹⁷¹ Emphasis added.
¹⁷³ Which in turn is an approach based on Tavin’s restricted access/limited control model.
¹⁷⁴ The same process is likely to be adaptable to the therapeutic, or more generally, health information scenarios, but these settings are beyond the scope of this article.
¹⁷⁵ For a discussion of various occupational medicine roles in the United Kingdom, see Tamin, ‘Models of Occupational’. In terms of occupational physician–worker relationships, model 1 is described as ‘quasi-therapeutic’ and model 2 as ‘independent doctor’, and these would translate to domains OM1 and OM2 respectively for this article.
OM2. For example, any information that is sensitive to the applicant, but not likely to be relevant to the application could be excluded, such as abortions or miscarriages for a female applicant.\textsuperscript{176} Arguably, the applicant could also ask to see the written records in possession of the OP,\textsuperscript{177} and if there were factual errors, correct these. In practice, it may be less likely to be relevant in this scenario as the OP would only have limited information, but correction could be a useful aspect of control where more sensitive or significant information is held, such as in a GP domain. The recipients of any disclosures from this domain will be clearly specified\textsuperscript{178} to all parties. The pension fund managers would definitely be allowed to receive the report,\textsuperscript{179} whereas a newspaper definitely would not.\textsuperscript{180} Where parties are specified in this way, and it is clear whether they are entitled or not to receive information, then applicant consent is not required. On the other hand, if other situations occurred, such as the OP wishing to submit a report of the case to a learned journal, or share details with other medical colleagues, then applicant consent is required.\textsuperscript{181} In this way, by having specified and restricted access to the information contained within that domain, the applicant retains some control\textsuperscript{182} over the disclosures, but does not require complete control to protect his privacy. In this way, a privacy domain works because it restricts (and specifies who has) access to the information contained within that domain, and a reduced level of control is sufficient to ensure

\textsuperscript{176} On the other hand, in MS v. Sweden [1997] 45 BMLR 133, it was held that her abortion was in fact relevant as it was deemed to be connected with her back pain, which was the basis of her claim.

\textsuperscript{177} He would have a right to this under the Data Protection Act.

\textsuperscript{178} I suggest this would be a more transparent process and remove (or at least reduce) confusion about what secrets are meant to be kept, what is to be disclosed and to whom. For example, see N. Warwick 'A Vote for No Confidence', p. 183, where she describes this uncertainty around patients' expectations of what is to be kept secret, and for what reason, in the current 'confidentiality' paradigm. P. Singleton, N. Lea, A. Tapuria and D. Kalra (Cambridge Health Informatics), General Medical Council. Public and Professional Attitudes to Privacy of Healthcare Data, A Survey of the Literature (London: GMC, 2007), p. 27, also provide empirical evidence of this public uncertainty about medical confidentiality.

\textsuperscript{179} Which would be consistent with both Egdell, at para. 849, and Kapoor, at para. 34.

\textsuperscript{180} As per Bingham LJ in Egdell, at para. 849.

\textsuperscript{181} In practice, disclosure of information from a privacy domain merely mirrors the current legal position, as expressed in Egdell and Kapoor. However, I would hope that having such a process described more explicitly in this way would make it more likely that the General Medical Council and Faculty of Occupational Medicine guidance will reflect this process in future, rather than give advice that conflicts with this legal position.

\textsuperscript{182} The difference between control and consent is that consent in this paradigm is only required if the report is intended to be disclosed to a party not previously specified, such as to a journal for publication.
that the disclosures are in line with what has been agreed between the parties beforehand.\textsuperscript{183}

Conclusion

What then are patient secrets in O&M practice? Given that health information is private, it follows that information held in a worker’s O&M record should be private. The OP also owes a duty of confidence to the worker. It matters little that the relationship between OP and worker differs from the usual doctor–patient relationship\textsuperscript{184} in a therapeutic setting. Such a duty is imparted to any professional\textsuperscript{185} or other recipient of the information by its very nature.\textsuperscript{186} However, I have argued that the present system of medical confidentiality lacks transparency and has the potential for deception,\textsuperscript{187} rather than engendering trust as it is intended to. In a privacy domain paradigm, it would be clear to all what information would be contained in each domain and to whom information could or could not be communicated. Nonetheless, even in the current paradigm, disclosing an independently commissioned report to the commissioning party does not breach the common law duty of confidence\textsuperscript{188} and disclosing such a report to the commissioner without further consent is entirely legitimate.\textsuperscript{189} I believe that current GMC and FOM guidance on this matter is unnecessarily inconsistent with the law’s requirements. Even those who may not agree with me on this point would concede that it is confusing for OPs to be in the situation where disclosure of their report to the commissioner without further consent is lawful but, according to the GMC and FOM, unethical.

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\textsuperscript{183} However, in some ways an occupational medicine (OM) privacy domain is easier to operate than other health domains. This is partly because the OM domain describes a one-off situation where the occupational physician is assessing an application for ill-health retirement. Other health situations will be more complex, as health conditions may change over time, and patients may change their minds as to what information is contained in a specific domain and who might access the domain. Although it is beyond the scope of this article to address these more complex scenarios, I would suggest that the privacy domain approach at least brings these difficult issues to the fore and, should be a more transparent way of dealing with privacy of health information.

\textsuperscript{184} See J. Tamin, “Models of Occupational”.\textsuperscript{185} R. Patenderen (2003), at p. 13.\textsuperscript{186} Campbell, at para. 145.\textsuperscript{187} For example, breaches of confidence in the public interest.\textsuperscript{188} Egdell, at para. 449.\textsuperscript{189} Fairworth, at para. 22. Kapoolla, at para. 34.
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