3.1 Confidentiality

Confidentiality is an essential part of the bond of trust that exists between doctor and patient. Failure to maintain confidentiality may mean a patient is reluctant to reveal private or sensitive information that you may need to know in order to treat them appropriately.

You have a legal and ethical duty to keep all information relating to patients securely and not to disclose any information to third parties without a patient's consent. The only exceptions are when you are required to disclose information by law or under your ethical or contractual obligations. If you decide to disclose information without consent, you should be prepared to justify your decision.

General principles

Confidentiality is a patient’s right and must be respected by the entire healthcare team.

You must get the patient’s express consent before disclosing confidential information about them, or which might identify them, to third parties, unless the law allows or requires otherwise. The patient can give consent orally or in writing.

To give consent, the patient needs to understand:

- who the information will be disclosed to
- precisely what information will be disclosed
- why the information is to be disclosed
- the significant foreseeable consequences.

When a patient gives consent, you must only disclose information the patient has agreed you may disclose, and only to the third party that requested it. No other use can be made of the information without seeking further consent from the patient.

Competent patients can give consent. This includes children under 16 who are competent to make decisions (Gillick-competent).

Defining competence

To show competence, generally the patient must:

- have a general understanding of what decision they need to make and why they need to make it
- have a general understanding of the likely consequences of making or not making the decision
- be able to understand, retain, use and weigh up the information relevant to this decision
- communicate his decision – whether by talking, using sign language or any other means.

Every patient must be assumed to have capacity unless it is established that he or she lacks it.

Patients who lack capacity (eg some patients with a mental disorder or young children) require special consideration. Any decisions to disclose information should be taken in the patient's best interests. You ought to consider what action will be likely to benefit the patient, as well as what you know about the
Introduction and principles

3.1

patient's views, values and wishes. The views of relatives, carers and close friends should be taken into account. You should also consult anyone able to make relevant healthcare decisions about the patient.

Disclosing information

Healthcare professionals who are responsible for patient information must make sure it is effectively protected from improper disclosure, intentional or unintentional, at all times – even after a patient has died.

Patient information should not be disclosed to third parties without consent except in certain circumstances (see MDU Medico-legal Guide: Confidentiality 3.3). You may be called on to justify a decision to disclose information without consent.

Before disclosing information you will need to consider your legal duty, GMC and/or other relevant ethical guidance and the Department of Health's Confidentiality: NHS Code of Practice. For expert advice, please speak to an MDU medico-legal adviser.

Where disclosure (with or without consent) is appropriate, only the minimum relevant information should be disclosed. Disclosure should be made promptly.

Disclosure of confidential information without consent or ethical or lawful justification carries the risk of legal action by the patient and/or investigation by the relevant regulatory body, healthcare trust or the Information Commissioner.

What is confidential information?

All information about a patient is confidential. This includes any information that could identify an individual, for example:

- medical records
- current illness or condition and its ongoing treatment
- personal details – name, address, age, marital status, sexuality, race, etc
- record of appointments
- audio or audio/visual recordings
- the fact that a person is or was your patient.

The legal and ethical basis of confidentiality

The duty of patient confidentiality is enforced through four principal mechanisms:

- common law
- statute
- contract of employment
- regulatory bodies.

Common law

Patients alleging breach of confidentiality may seek redress from a court in a civil action. However, it is rare for this to be the sole cause of action in a civil court case.

Statute law

The main statute governing patient confidentiality is the Data Protection Act 1998 (DPA). The DPA sets out the rights and responsibilities of data subjects and data users. It regulates the processing of information about individuals, including the obtaining, use or disclosure of information. It covers both paper and computer records. A breach of the DPA can result in civil or criminal proceedings. The Information Commissioner may also impose a Monetary Penalty Notice of up to £500,000 for reckless flouting of the data protection laws.

Rights

Data subjects (individuals who are the subject of personal data) are entitled to:

- be told that data is held about them and the purposes for which their data will be processed
- have access to the data
- have the data corrected when inaccurate.

Although in most cases patients have the right to access information held about them, there may be rare occasions when you believe that giving a patient access to the information you hold about him or her may cause serious harm to the
physical or mental health or condition of the individual or another person. This may justify refusing disclosure, but you should talk to the healthcare professional most directly involved in the patient’s care and seek advice from the MDU before doing so.

Confidential patient information which includes data about identifiable third parties (other than third parties who are themselves health professionals who have contributed to the record) should not be disclosed without the consent of the third party. Again, the MDU can advise you on any decision to disclose or not.

Responsibilities
The data protection principles require that personal data shall:

- be obtained and processed fairly and lawfully
- be held only for specific purposes
- not be used or disclosed in any other way or for any other purpose
- be adequate, relevant and not excessive in relation to the purpose for which it is held
- be accurate and kept up to date
- not be kept for longer than is necessary
- be processed according to the rights of data subjects
- be held secure.

The guidance document Use and Disclosure of Health Data, published by the Information Commissioner, is a useful source of further information.

Other statutes
Other statutes which affect confidentiality are listed on our website (themdu.com) and cover a range of areas including:

- cancer registries
- termination of pregnancy
- computer misuse
- human tissue
- tax.

Contract of employment
Confidentiality of patient information is a requirement of employment under NHS and many independent sector contracts. In the NHS, misuse of patient information is treated as a serious disciplinary matter.

GPs are required under the terms of their contract with their primary care body to designate a person to be responsible for practices and procedures relating to the confidentiality of patient information and to comply with all the relevant guidance issued by their health body or the secretary of the state.

Arrangements for keeping patient information confidential may be scrutinised and monitored – for example, during a trust inquiry, an external review of clinical performance, under GMC performance review procedures, or by the Care Quality Commission.

Registration bodies
Professional registration bodies may investigate alleged breaches of confidentiality and, where required, impose sanctions, which may include erasure from the register.

If you are in any doubt about the circumstances in which patient information may be disclosed, please call the MDU’s 24-hour helpline for expert advice.

Confidentiality checklist

1. Fully acquaint yourself and your colleagues with up-to-date legal requirements and GMC and NHS guidance on confidentiality.
2. Nominate a person to be responsible for practices and procedures for handling confidential data.
3. Train all staff to keep information confidential and reinforce the message regularly. Write a confidentiality clause into contracts of employment.
4. Keep discussion about clinical management of patients private and out of earshot of the public.
5. Ensure patients cannot read another patient’s details on computer screens.
6. Check the identity of telephone callers asking for information about a patient, if necessary by calling them back via directory enquiries.
7. Take professional advice before connecting your computer to a network and keep a record of the advice.
8. Ensure electronic means of communication such as fax and email are secure before sending information.
9. Consider use of anonymised patient data when this might satisfy a request for information.
Questions and answers

Q I gave a patient a statement of fitness to work confirming he would be unable to work for four weeks because of backache. Today, his human resources director rang and asked me to confirm that the patient would be unfit to work for 14 weeks. He faxed me a copy of the statement I had provided to the patient and it’s clear that someone has added a one in front of the four. What information can I provide?

• It is not a breach of confidentiality to tell a person who has been properly given a document by a patient that it is a document you signed. In this case, you can confirm that you did not sign the certificate as faxed through to you. The principle is that you should supply only the minimum information to answer the questions. You may also wish to contact your patient to discuss the matter with him.

Q A newborn baby was found abandoned outside our local church. A social worker has asked me for contact details of any pregnant patients with expected delivery dates of around this time. I suspect I know the mother concerned. Should I pass on this information?

• Your duty of confidentiality prevents you from releasing a blanket list of the names of all your pregnant patients. Even the fact that these are your patients is confidential. You may think you know the mother, and it may be appropriate to arrange to see her and to offer counselling and treatment.

To justify breaching the presumed mother's confidentiality, you would have to argue that failing to do so would put her or someone else at risk of serious harm or death.

Q A hospital porter slipped on a wet floor and was treated for a fracture in the hospital’s A&E department where I work. He is now pursuing a claim against the hospital (his employer) alleging that the floor cleaner was negligent by failing to put up a sign warning of the wet floor. The hospital management have asked for his records to deal with the claim. The patient has not given his consent to the release of the records. Should I, as the A&E consultant, agree to release them?

• Had this patient been treated in another hospital's A&E department, his consent would have been needed for the disclosure of his records from that hospital to his employer and the same principle applies in your hospital. Hospital managers have a right to look at documents in the custody of their hospital only for the ordinary administration of healthcare and this includes records of a patient who is pursuing a claim against the hospital alleging that the treatment provided by a member of their healthcare team was negligent. But your hospital's managers cannot use their power to ask for his records just because he was treated in your hospital's A&E department. You need to seek the patient's consent to disclosure in the same way that you would if the request came from any other employer.

References

3. GMC, Confidentiality (2017), para 134-138
4. GMC, Confidentiality: good practice in handling patient information (2017)
6. Data Protection (Monetary Penalties) (Maximum Penalty and Notices) Regulations 2010
9. Confidentiality and Disclosures of Information: General Medical Services, Personal Medical Services, and Alternative Provider Medical Services code of practice (2005)

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3.2

Children over 16

Children age 16 and over are deemed capable of consenting to medical treatment, and in the same way are usually considered able to agree to the release of their confidential information.

Children under 16

Professional judgment is required when considering disclosure of information about a child under 16 years of age. The overriding consideration for the healthcare professional must always be the best interests of the child.

Defining competence

A child under 16 may be mature enough to understand what is involved in their proposed treatment (that is, the child is Gillick-competent). If so, they are also likely to be able to make a decision about the extent to which information relating to that treatment can be provided to others, who may include their parents. You should ordinarily respect their wishes if they do not want their parents to know. However, you should make every reasonable effort to persuade the child to involve his or her parents or guardians.

Should you decide to disclose information to a Gillick-competent child’s parents or guardians against his or her wishes, you should generally tell the child before disclosing the information. This applies in all but very rare cases. Any decision to disclose must be in the child’s best interests and you must be prepared to justify your decision.

Children who are not competent

In the case of a child who is not Gillick-competent, the parents or those with parental responsibility should authorise treatment and any disclosure of information on the child’s behalf.

The biological mother of a child will automatically hold parental responsibility for the child, as will the father if he was married to the child’s mother at the time of the child’s birth. Unmarried fathers named on the birth certificate of children born after 1 December 2003 in England and Wales (15 April 2002 in Northern Ireland and 4 May 2006 in Scotland) will hold parental responsibility. There are other circumstances in which fathers can gain parental responsibility and members may wish to discuss more unusual cases with the MDU.

Child protection

If you believe a child is the victim of abuse or neglect, you must promptly inform an appropriate person or statutory body, in order to prevent further harm. The information you share should be restricted to what is reasonably necessary to achieve the object of child protection.

Ideally, you should seek the consent of the child or young person (or in the case of children lacking competence, the authority of someone with parental responsibility) unless that would be detrimental to the purpose of the disclosure, or increase the risk of harm to the child, in which case the minimum relevant information should be disclosed without delay. If you believe disclosure is not in the child’s best interests, or are uncertain as to the risk
that might exist, you should discuss it with an experienced colleague, such as a designated doctor for child protection.

**Local Safeguarding Children Boards**

Local Safeguarding Children Boards (LSCBs) are responsible for co-ordinating the effective safeguarding and welfare of children locally. If a child dies unexpectedly, the LSCB may call you to a meeting to discuss the case. The MDU can advise you on how best you can contribute to the process.

The death of a child in suspicious circumstances may result in a serious case review as described in Chapter 5 of *Working Together to Safeguard Children*.

The MDU can assist you if you are involved in an investigation after the death of a child in such circumstances.

In either case, you may need to disclose the deceased child's records, but care should be taken not to disclose the notes of other family members without their consent. In some circumstances, you may be justified in disclosing limited information about other family members.

**Appointments register**

Schools may ask for confirmation that a pupil has attended an appointment at your surgery but this information can only be disclosed with the child's consent or the parent/guardian's authority. You could suggest to the school that the child takes an appointment card with him when he attends an appointment, for his GP to sign.

**Patients with mental disorders or learning disabilities**

Patients with mental disorders or learning disabilities do not necessarily lack capacity to consent to disclosure of confidential information. You should assess their capacity in the usual way. You will need to consider a number of factors including their ability to understand the consequences and effect of disclosure. If they lack capacity to authorise disclosure you should consider any reasons you think it would be in their interests to disclose information to carers, relatives or any other third party.

If a patient under 18 lacks capacity, information may be disclosed with the authority of whoever has parental responsibility.

For patients 18 and over who lack capacity, the requirements vary in England, Wales and Scotland.

**England and Wales – patients over 18**

Under the Mental Capacity Act 2005, an independent mental capacity advocate (IMCA) will be appointed for a patient who needs serious treatment but lacks capacity and has no one to speak on his or her behalf.

A competent patient may create a lasting power of attorney (LPA), giving someone the power to make general or specified health and welfare decisions at a time in the future when the patient lacks capacity.

The court of protection has powers to declare whether someone has or lacks capacity, and to appoint a deputy to make decisions on his or her behalf.

IMCAs, attorneys and deputies may need information to enable them to act or make decisions on behalf of the patient. You should provide only what is reasonably necessary to enable the person to deal with the issue in question, where there is a need to know and where the disclosure is in the patient’s best interests.

**Scotland – patients over 18**

Welfare attorneys can make decisions on behalf of adults lacking capacity and should be involved in the decision-making process.

**Best interests**

In deciding whether or not to disclose confidential information about patients who lack capacity, you must act in good faith and in the patient’s best interests. You should take into account all relevant factors relating to the individual patient including health and welfare, relationships with parents/siblings/children/carers and the position of trust you have with the patient. It is important to keep detailed
Children, adults without capacity and the deceased

• Children under 16 can consent to treatment without parental agreement if they are Gillick-competent. If the patient has the intelligence and maturity to understand the nature, purpose, benefits and risks of the treatment as well as the risk of going untreated, and any alternatives, her consent alone may be valid.

• If she has capacity to consent, she may disclose only relevant information.

• If consent was not expressly given or denied before death, you should seek written permission from the personal representative of executors of the patient’s estate. Where the patient, while alive, asked that access should not be given, you should not disclose any information.

Questions and answers

Q A 14-year old girl presented with an ectopic pregnancy. She had been given the contraceptive pill by the family planning clinic. Two months ago, I prescribed an antibiotic without knowing she was on the pill. She doesn’t want her parents to know about either the pregnancy or the treatment. What should I do?

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• If she has capacity to consent, she may disclose only relevant information.

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Deceased patients

Your obligation to respect a patient’s right to confidentiality, and their express wishes, extends beyond death. Where the patient indicated no express wishes while he or she was alive, such information as is appropriate in the circumstances can be disclosed with the authority of an executor of the patient’s will or administrator of his or her estate.

You may disclose limited information to help identify a dead person, or fuller details in certain circumstances, for example, where the information is already a matter of public record.

When a child under 16 dies, you must explain the cause and circumstances of the death to those with parental responsibility seeking information.

If a partner, close relative or friend asks for information about the circumstances leading to the death of an adult, you can disclose information as long as you have no reason to believe the patient would have objected.

Anyone who may have a claim arising out of a patient’s death may be entitled to see the patient’s clinical records. However, information may be withheld if its disclosure might cause ‘serious harm’ to an individual, or if it relates to a third party other than a health professional.

Other circumstances when you may be asked for information about a deceased patient include a dispute over a will, or where an insurance company asks for reports or copies of the patient’s records. If a patient expressly consented to this while he or she was alive, you may disclose only relevant information.

If consent was not expressly given or denied before death, you should seek written permission from the personal representative of executors of the patient’s estate. Where the patient, while alive, asked that access should not be given, you should not disclose any information.

Relatives, friends, carers and others

Sharing information with others is normally done only with the patient’s express consent. However, if the patient lacks capacity, you may need to share information with relatives, friends or carers to enable you to gather relevant information and assess the patient’s best interests, or with an IMCA, an attorney who is able to make health and welfare decisions, or a deputy appointed by the court of protection.

In Scotland, healthcare workers should discuss treatment options with and obtain authority for disclosure of information on behalf of the patient from the welfare attorney.

Uncontactable or unconscious patients

If information is released about a patient who is uncontactable or unconscious at the time of disclosure, there is a risk that the patient may later object to the disclosure. A decision to disclose should, if possible, be deferred until consent can be obtained, except when delay might cause serious harm to the patient or others, in which case limited disclosure may be justifiable.

If you are asked to disclose information about an uncontactable or unconscious patient for care or treatment purposes, the following steps should be taken, if there is time and the patient’s health and safety are not compromised.

• Ask for the request in writing and keep clear, detailed notes of all communications.

• Seek the views of those close to the patient, in particular anyone nominated by the patient, without breaching confidentiality.

• Outline to them the information required and the reasons why immediate disclosure is considered necessary.

• If there is not time, you may consider disclosing the minimum information necessary to provide care in the patient’s best interests.

• If you are unsure how to proceed, discuss the request with a colleague or call the MDU 24-hour advisory helpline.

Contemporaneous notes specifying why you concluded the patient did not have capacity to give consent and why you believe you were justified in disclosing information.

If there is any doubt about a patient’s competence to give or withhold consent, you should seek the opinion of another doctor such as the patient’s GP or senior psychiatrist in charge of the patient’s care.

Questions and answers

Q My patient brought her six-month old son to see me with an infected burn on his leg. He is small for his age and has a worrying collection of bruises over his chest wall which look
suspiciously like fingertip bruising. She is unable to account for these marks or for the delay in bringing this to our attention any earlier. I am concerned that she or her partner is abusing this little boy. Am I allowed to breach confidentiality by passing this information on?

- If you have reasonable grounds to suspect that a child is being abused then your duty of care to the child means that you should tell the appropriate authorities without delay, so that the child can be protected. You should take care that any disclosure is made to the appropriate responsible person or statutory agency and that the information provided is the minimum necessary.

Q The air ambulance organisation called to say a patient of mine has had a heart attack while abroad. She is seriously ill and needs to be flown home immediately, which a relative has authorised. The air ambulance crew has asked for details about the patient’s medical history.

- If you are unable to obtain the patient’s consent then, in considering disclosure, the overriding principle is the best interests of the patient. You can provide the ambulance crew with only the details of the patient’s medical information they need to be able to care for the patient during the flight.

References
1. Family Law Reform Act 1969
2. Working Together to Safeguard Children – A guide to inter-agency working to safeguard and promote the welfare of children, Department for Education (2015)
3. GMC, Protecting Children and Young People (2012), para 49
4. GMC, Confidentiality (2017), paragraph 137
5. Access to Health Records Act 1990, s3(1)(f)
Medico-legal guide to Confidentiality
Disclosure without consent

3.3

Important steps

If you are considering disclosure of patient information without consent:

1. Normally, you should inform the patient that a disclosure will be made and why, even if consent has not been sought – unless it would be impracticable, put others at risk of harm, or prejudice the purpose of the disclosure.

2. Disclose the information promptly to the appropriate body.

3. Disclose only the minimum information necessary.

4. Document in the patient’s record any steps you took to seek or obtain consent, your reasons for disclosing information without consent, and why you have not informed the patient if that is the case.

There are circumstances in which you may disclose confidential information without patient consent.

Public interest

It is important that patients can seek medical care safe in the knowledge that their details will remain private. There may, however, be cases where public interest overrides doctor/patient confidentiality.

You may only disclose confidential information in the public interest without the patient’s consent, or if consent has been withheld, where the benefits to an individual or society of disclosing outweigh the public and patient’s interest in keeping the information confidential.

When weighing up whether to disclose confidential information in the public interest, you must balance the potential harm to the patient, and to your relationship with the patient, against the benefit to be gained from releasing the information. If you believe it is in the public interest to disclose information, you should still ordinarily seek your patient’s consent unless to do so would be impracticable, would put others at risk of harm, or would prejudice the purpose of disclosure. If you cannot obtain their consent, or decide you should not seek it, you should disclose information promptly to the appropriate person or authority, and let the patient know that you have done so, if it would not prejudice the purpose of disclosure.

If your reason for disclosing confidential information is to protect a competent patient who makes an informed refusal to disclosure, their wishes should usually be respected, even if their decision leaves them, but no one else, at risk of harm. Ask the patient for his reasons and consider these carefully. If, in your view, disclosure is still necessary in the public interest, you should do so promptly to
the appropriate person or authority, and document your reasons.

Disclosure in the public interest without consent may be justified if failure to make the disclosure could expose others to a risk of serious harm or death. This may arise where disclosure might assist in the prevention, detection or prosecution of a serious crime. Ordinarily you should first seek consent, unless this would prejudice the purpose of disclosure or risk harm to others.

If the intention of the disclosure is to protect a patient without capacity, you would be expected to disclose relevant information. If you believe that the patient might be a victim of neglect or physical, sexual or emotional abuse you must give information promptly to an appropriate person or authority if you believe it is in the patient’s best interests or necessary to protect others from a risk of serious harm. If you think that disclosure is not in the best interests of such a patient you should discuss the issues with an experienced colleague. You should record your discussions and reasons for your decision, and be prepared to justify what you decide

The GMC also advises that practitioners should participate in procedures set up to protect the public from violent and sex offenders, and should co-operate with requests for relevant information about patients who may pose a risk of harm to others.

Anonymised data
Wherever possible or relevant, anonymised data should be used. Let your patient/s know beforehand if you intend to release anonymised information, and seek their express consent (oral or written) if the material cannot be anonymised.

Social services
From time to time, you may have to share a patient's personal information with an organisation or agency giving social care. It is important that the patient is aware of this and consents. The person to whom information is disclosed must also be bound by a duty of confidentiality and know that the information is confidential. Only share the minimum information necessary, taking care not to breach another person’s confidentiality (eg a parent, if the patient is a child).

You are expected to inform an appropriate responsible person or statutory agency (such as social services) if you believe:

- a patient is being neglected, or physically, sexually or emotionally abused and
- that patient cannot give or withhold consent for disclosure.

Only rarely would you withhold information on the grounds of the patient’s best interests.

Dentists, nurses and other healthcare practitioners who have concerns about a patient may wish to contact the patient’s GP or consultant first.

Solicitors
A solicitor acting for the patient ‘stands in the patient's shoes’. Information can be disclosed to a solicitor as though he was the patient. In practice, most solicitors will provide the patient’s signed consent when requesting confidential information.

Courts and tribunals
You may be asked to supply information to, or be summoned to appear as a witness at, a court or tribunal.

- As a witness, you may be asked for information that would breach patient confidentiality. It may be apparent that the patient consents to the provision of information – for example if you are called by the patient to give evidence. If, though, there is no consent or it is not clear if the patient consents, you should seek direction from the judge or presiding officer as to whether or not the information should be provided.
- The defendant in a criminal case may seek information from or the records of a third party who is also a prosecution witness. If you hold those records, you should first ascertain if the patient consents to the release. It may be
appropriate to liaise with the police or Crown Prosecution Service about approaching the third party before seeking consent.

- If you are asked to disclose indirectly related information – such as matters relating to the patient’s partner or relatives who are not parties to the proceedings, you should object to the judge or presiding officer.

- If appointment books and diaries are requested, disclosure may compromise the confidentiality of other patients. Information about other identifiable patients must not be submitted as evidence (original documents may be photocopied and entries blanked out before submission). Anonymised information can be used if relevant.

The coroner

The coroner (in England and Wales) or procurator fiscal (in Scotland) may need to obtain confidential patient information during investigation of a death and you must disclose clinical notes and relevant information about the deceased to the coroner, coroner’s officer or procurator fiscal on request.

You should not, however, disclose information about living patients without the express consent of each patient. The coroner may order you to disclose such information without consent, but this would be very rare.

In cases of suspected murder or manslaughter, the coroner will pass the investigation to the police. You may disclose the deceased’s medical notes to the police or Home Office pathologist if you are satisfied the notes are relevant to the enquiry.

Police

Legal obligation to disclose

There are limited circumstances in which you are legally obliged to give confidential patient information to the police. They include:

- A driver alleged to be guilty of a road traffic offence may seek treatment for an injury. You must divulge their name and address, if asked by the police.

- If you have information which you know or believe might be of material assistance in preventing the commission of an act of terrorism, or in securing the apprehension, prosecution or conviction of another person in the UK for an offence involving the commission, preparation or instigation of an act of terrorism, you must disclose it to the police as soon as reasonably practicable. Failure to do so without reasonable excuse is a criminal offence.

Knife and gunshot wounds

A gunshot wound or injury sustained from an attack with a knife, blade or sharp instrument, must be reported to the police whenever a victim arrives at hospital. Accidental injury from, or self harm with, a knife or blade will not usually require notification. Identifying details such as name and address should usually only be disclosed with the patient’s consent. If the patient refuses, the information may only be disclosed if you consider it is in the public interest, or you are required to by court order.

Data Protection Act

The police can request disclosure of confidential patient information to assist in the detection or prosecution of crime, citing Section 29(3) of the Data Protection Act 1998 (DPA). This provision exempts personal data from the non-disclosure provisions of the DPA. However, you are not obliged to disclose the information, and all other legal and ethical considerations relating to confidentiality still apply. If you refuse, the police may seek a court order. In such circumstances, please seek advice from the MDU.

GMC and other bodies

The GMC or other regulatory body can require you to produce information or documentation during an enquiry into one of their members and they would expect you to seek consent before disclosing identifiable patient information. If consent cannot be obtained, the MDU can advise you what to do.

Other bodies may require you to supply information. These include:

- Care Quality Commission (CQC)
- Parliamentary and Health Service Ombudsman (PHSO)
- NHS Protect
- Accountable officers (under controlled drugs regulations)

The PHSO has the power to require disclosure of confidential patient information to help it fulfil its statutory duties.

The CQC, NHS Protect and accountable officers each have a code of practice that requires the request for information to be proportionate and the minimum needed to fulfil statutory duties. It may therefore be possible for doctors to provide anonymised information. Please seek advice from the MDU on this matter.

Communicable diseases

England

You must inform the proper officer of your local council or local health protection team if you suspect a patient has contracted, or has died while infected or contaminated by, a communicable disease. Notification should be in writing to the local health protection team ‘as soon as is reasonably practicable’ or within three days of forming a suspicion about the patient’s illness.
Patient consent is not necessary but it is good practice to inform the patient, where practicable, unless to do so would undermine the purpose of the disclosure.

Operators of diagnostic laboratories must now notify Public Health England (PHE) if they identify a causative agent in a human sample. PHE can request details of the patient concerned from the person who requested the laboratory tests and this information must be provided in writing or orally within three days.

Scottish practices
Notify your health board if you have a reasonable suspicion that a patient has one of the listed communicable diseases (see Scottish Government/NHS Scotland website for the latest list). You are advised not to wait for laboratory confirmation of the suspected disease before notification – by telephone, if urgent, or in writing within three days of forming your suspicion.

Wales
Similar provisions to those applying in England apply in Wales. These are administered by the Public Health Wales Communicable Disease Surveillance Centre (CDSC) working as the epidemiological investigation arm of the National Public Health Service for Wales.

Controlled drugs
Doctors and other healthcare workers are responsible for following the legislation on controlled drugs in accordance with the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001.

Accountable officers, appointed by the primary care body, are responsible for ensuring that their organisation or those working on its behalf (such as GPs) have suitable arrangements in place for managing controlled drugs, and may carry out unannounced visits to examine controlled drug stocks and records relating to their use. If the accountable officer asks to see identifiable confidential patient information, you may refuse and request proof that the disclosure is necessary.

Her Majesty's Revenue and Customs
Tax inspectors have powers to obtain documents under Schedule 36 Part 1 of the Finance Act 2008, which allows them to request any information or document it is reasonable for them to have to assist them in checking a taxpayer’s position. The tax inspector must give notice in writing of the information he requires. If the request is for disclosure of patient identifiable information you should satisfy yourself that it is reasonable to provide that information as section 19 of the Schedule places limits on the disclosure of personal (i.e. medical) information. For further advice, please contact the MDU.

Questions and answers

Q I have had a request for information from a firm of solicitors who act on behalf of my patient’s employers. My patient is suing his employers over a back injury he got at work. Should I release this information?

Information should only be released to the employer’s solicitors with the patient's full and informed consent or a court order. If the patient refuses to consent to the release of information, the employer’s solicitors may apply for a court order to have it released. If you are served with a court order you will be obliged to comply with it.

Q One of my patients was at my surgery a week ago with lacerations to his forehead. He said that he had crashed his car the previous night. I have now been approached by the police who tell me that they know I treated this man and they want his name and address. I have told them that I cannot release any information about my patients without consent. Is this correct?

- Normally a patient's identity and address are confidential. However, under the Road Traffic Act 1988 a doctor is obliged, if asked, to give a police officer any information in his possession which may help identify a person who is alleged to be guilty of an offence under the Act. You are obliged to give the police the patient's name and address, but you should not disclose any clinical information without your patient's written consent, unless directed to do so by a presiding officer of a court.

References
1. GMC, Confidentiality (2017), para 56
2. Road Traffic Act 1988
3. Terrorism Act 2000
4. Health Protection (Notification) Regulations 2010

For individual medico-legal advice:

24-hour advisory helpline
T 0800 716 646
E advisory@themdu.com
W themdu.com
Clinical information may need to be shared with other healthcare workers in the team to ensure proper care and treatment of a patient – but not for any other reason. Information is normally shared on a need-to-know basis.

Telling patients why, when and with whom information will be shared is important. You can do this through practice leaflets or waiting room notices, or in person.

Once the patient understands how and why information may be shared, and has agreed to it, express consent is not required every time a patient is referred.

If a patient objects to the sharing of personal information, this must be respected, except where disclosure can be justified in the public interest, or if the patient lacks capacity and the disclosure would be considered in their best interests.

In the event of a medical emergency when a patient is unable to give consent or cannot be contacted, you should provide relevant information promptly to those treating the patient, unless the patient has expressly prohibited it. In doing so, you should always act in the patient’s best interests. When the patient becomes contactable or capable of understanding, you should let him or her know about the disclosure, if they might not reasonably have expected you to share the information.

Patients with a serious communicable disease

If a patient with a serious communicable disease objects to other people within or outside the healthcare team being informed of their infection status, their wishes should be respected unless a failure to disclose may put other healthcare workers or patients at risk of infection.

Such situations are likely to be very rare, not least because of the use of the precautions that are routinely taken to protect healthcare workers and patients during exposure-prone procedures.

If another person who is in close contact with a patient may be at risk of infection that is likely to cause serious harm, because the patient has not informed them and cannot be persuaded to do so, then minimal information may be disclosed to protect this person. Ideally, you should tell the patient that you intend to disclose the information and why, to give them the opportunity to tell the other person. If it is possible to protect the patient’s identity when tracing and notifying contacts, you should do so.

Exposure to risk of serious communicable infection due to injury

If a healthcare worker or anyone else suffers an exposure-prone injury (eg a needlestick) while treating a patient who has a serious communicable disease, the patient’s consent should be sought to disclose their infection status.

If the patient withholds consent, then information may be disclosed in the public interest – for example, to decide whether post-exposure prophylaxis is required.
Summary Care Records
Patients have the right to opt out of having their personal information placed on the national Summary Care Record database, and should be advised of this right by their GP or local primary care organisation.

Clinical audit
Doctors in clinical practice have a duty to participate in clinical audit and this will inevitably involve disclosure of confidential information about patients.

The GMC draws a distinction between audit undertaken by the team that provided care to the patient, and other organisations.

Audit by the team that provided care or those who supported them
Doctors may disclose identifiable information to these healthcare professionals on a need to know basis if it is not practicable to use anonymised information. You must be satisfied that patients have been informed that data may be disclosed and that they understand their right to object but have not done so.

Audit by another organisation
Information must be anonymised wherever practicable. Otherwise, express consent must be obtained from the patients concerned.

If a patient objects to information being used in this way, you should explain why the information is needed and how it may benefit their care. If withholding the information for audit would compromise safe care, you should explain this to patients and discuss the options open to them.

Third parties
Third parties, such as trusts, may request access to patient information for purposes such as rationalisation of records or updating IT information. Practices may be pressed to disclose information and while patients might have given implied consent for the sharing of information within the wider healthcare team, you need to consider whether the patient would be surprised to know to whom their notes were being disclosed and why. There is unlikely to be any specific benefit to patient care, but there may be a wider public interest – for example, in keeping disease registers up to date.

Research and epidemiology
Express consent should be sought for the use of patient information for research and it should be anonymised as far as possible.

The Health Service (Control of Patient Information) Regulations 2002 were made under the provisions of the Health and Social Care Act 2001. They enable the flow of clinical information within and from the NHS in England and Wales regarding:

- cancer registries
- medical purposes such as medical audit and research.

This legislation allows but does not compel you to disclose information under the provisions of the Health and Social Care Act 2001. However, the GMC requires doctors to disclose information if required by law, for example to notify known or suspected communicable diseases. It is advisable to continue to seek the patient’s consent to disclose patient identifiable information where practicable, or call the MDU for advice.

Financial audit and administration
Information for financial audit and administration should be anonymised wherever possible. If this is not possible, you should obtain the patient’s express consent to disclosure, informing them of the reasons for disclosure and their right to object.

It may be prudent to store financial and other administrative data separately from clinical information in computerised records so that sensitive data is not automatically displayed. This can help reduce the chance of an accidental breach of confidentiality.
The healthcare team

Primary care bodies

The General Medical Services Contract (2005) requires GPs to provide information, including patient records, to the primary care body or other authorised persons, in certain circumstances.

Practices should take adequate steps to inform patients how their data will be used and that they have a right to object. You may wish to seek express consent from individual patients before disclosing identifiable confidential information to a primary care body.

It will be your decision whether to disclose or not. Before making a decision, you will need to ensure that the primary care body has provided sufficient detail about the specific reasons and precise purpose for which the disclosure is needed.

If a primary care body seeks disclosure of clinical information against a patient's wishes and there is no statutory obligation to disclose, please contact the MDU for advice.

Care Quality Commission

The Care Quality Commission (CQC) has power to require access to patient information to help it fulfil its statutory functions. The CQC adheres to a code of practice on its use of confidential personal information, and a request to provide information necessary to fulfilling its statutory functions should be complied with. If you are in any doubt, the MDU can help you.

Question and answer

Q Do I still need consent to disclose information for research, if a research ethics committee has approved the project?

Express consent to the use of records in research must be obtained in all but the most exceptional circumstances, eg where research involves patients unable to consent or where patients cannot be traced. In such circumstances you should follow the GMC's guidance on disclosures in the public interest. Additionally, in England and Wales, section 251 of the NHS Act 2006 supports such disclosures. However, if it is possible to inform patients about the use of the data, and respect any objections, you should do so.

Further guidance is available in the GMC's guidance Good practice in research and Consent to research (2010).

References

1. GMC, Confidentiality, (2017), para. 30
2. GMC, Confidentiality, (2017), para. 32-33
A wide range of doctors provide reports about patients to third parties in the course of their work. These include occupational and sports physicians, prison doctors, forensic medical examiners, doctors in the armed forces, and doctors who work for insurance companies.

General practitioners may also be asked to provide a report about a registered patient to a third party organisation such as an employer, insurance company or benefits agency.

**Obtaining consent for the report**

Before providing a report to a third party you should satisfy yourself that the patient understands what information is being requested, the reason for the request and the potential consequences of the disclosure of information. Consent should be obtained in writing either from the patient or from their authorised representative, although a doctor can accept an assurance from an officer of a government department or agency or another healthcare professional that such informed consent has been obtained. When obtaining consent the patient should be informed that relevant information cannot be withheld from the report.

**Disclosure of reports to patients**

A patient has a right to be shown, on request, a medical report written about him for an employer or insurance company. The GMC also advises doctors to offer to show patients their reports or give them copies before disclosure, whether or not the law requires it.

**Occupational physicians**

Occupational physicians have loyalties both to patients and their employers and the usual therapeutic doctor-patient relationship often does not apply. However, the duty of confidentiality does apply – that is, you must not disclose confidential patient information to employers without the patient’s consent, other than in exceptional and justifiable circumstances.

The overriding principle which occupational physicians should apply in producing reports to employers is that of ‘no surprises’ for the patient. It is important to give the patient a full explanation at the outset about the process, the potential consequences and what happens if they want to amend the report. Consent should be obtained in writing, and clearly demonstrate the patient’s wishes regarding every stage of the process.

Where a company provides a clinical treatment service as a benefit to staff, patients have the same right to confidentiality as in any other doctor/patient relationship.

If a patient may pose a serious risk to others through being unfit to work then you may think a limited disclosure may be justified in the public interest.

**Sports physicians**

Sports physicians employed by clubs also owe a contractual duty to their employers, but have a professional ethical responsibility of confidentiality towards the sportsmen and women they treat. For example, when reporting on a
patient's health assessment to the coach or management, you may only disclose the results of the assessment, and not the patient's confidential clinical details. More details can only be disclosed with the patient's consent.

**Insurance reports**
A doctor who sees an individual for an insurance company – for example, to assess life expectancy – must make sure the person they are examining understands what the consultation is for and get permission in writing before going ahead. The person must understand the reason for the disclosure, the extent of the information to be disclosed and the fact that relevant information cannot be concealed or omitted.

The Association of British Insurers advises GPs to use the General Practitioner's Report Form to send reports to insurers, rather than sending printouts of patients' records, which may run the risk that irrelevant information is released for which the patient has not given consent.

Life insurance companies may ask for reports about dead patients, and occasionally ask to see copies of records. Unless the patient gave consent for disclosure after death, you should not agree to the request without the written authority of the personal representative of the deceased's estate. If patients have said that access should not be given after their death, this should also be respected.

**Forensic medical examiners**
(POlice surgeons)
Forensic medical examiners (FMEs) owe a duty of confidentiality to their patients. FMEs are not obliged to disclose a detainee's medical treatment records routinely to the custody officer without the detainee's consent.

For consent to be valid, the detainee must be capable of giving it. This is important because some detainees may be temporarily incapable – for example if they are drunk or under the influence of drugs at the time they are seen.

You must be satisfied that the detainee fully understands the reason for disclosure, what will be disclosed and to whom, and the fact that relevant information cannot be concealed. The detainee's written consent must be obtained, or that of someone properly authorised to act on his or her instruction.

You have a contractual obligation to tell the police if the person in custody is fit to be detained, interviewed, charged and/or transferred. Medical information that allows the police to care for the detainee properly and is in his or her best interests should be given on a strictly need-to-know basis.

**Doctors in the armed forces**
Doctors in the armed forces are responsible to their commanding officers for treating sickness and injury, maintaining health and preventing disease. In rare circumstances, you may have to disclose information to the commanding officer without the consent of the patient, or against his or her wishes – for example when the health, security, safety or welfare of the unit or the individual is at risk. If possible, patients should be told in advance that their confidentiality will be breached and why.
Questions and answers

Q I have been asked to complete an insurance report for a patient who had a transient ischaemic attack (TIA) two years ago. When I contacted him to confirm his consent, I told him that I would have to mention the TIA in the report, along with the rest of his medical history. He has asked me to withhold the information about the TIA because he has been well since and he fears the insurance company may decline his application if I mention it. I have told him that I am not able to withhold any information; is that right?

Yes. You have a duty to complete the report fully and you may not conceal or withhold any relevant information. You will need to explain to the patient that, if she consents, you have a duty to disclose the relevant medical history as that is what they are seeking. You need to explain to her the potential consequences of such a disclosure and also the fact that you may not conceal or withhold any information. If she does not agree to you sending the report, you may not do so, but she will need to know that the insurer is likely to draw its own conclusions about the absence of a medical report from the patient’s GP. If your patient agrees to the report, you are advised to show it to her in advance and to inform her that you may not amend or cross anything out though you can add any comments from her to the form.

Q I have had a request from an insurance company for details about one of my patients. He was a man in his fifties who died of disseminated carcinoma. It seems he took out the insurance policy shortly before his death, though the insurance company did not contact me for medical information at the time. Should I comply with the request?

The patient may have given the company consent for this disclosure when he applied for the policy and you may wish to check with them that he did so. However, if you are not certain that the patient gave consent, or if you believe the consent may not have been valid, then the medical report should only be disclosed with the full and informed consent of the executors of the patient’s estate or his next of kin. Although your patient is deceased, you still have an obligation of confidentiality to him.

References
1. Access to Medical Reports Act 1988 (ch 28). These rules only apply to a medical practitioner who ‘is or has been responsible for the clinical care of the individual’. They do not apply to doctors (such as experts instructed in litigation) who are asked to examine and report on people who are strangers to them and to whom they have provided no clinical care.
2. GMC, Confidentiality (2017), para 115
5. Prison Rules 1999 (updated 2020), s21(1)
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E advisory@themdu.com
W themdu.com
The rapid development of recording and communication technologies, such as texting, email and the internet, has had a profound impact on the confidentiality of patient information and patient identity. But electronic transmission of data is still not totally secure or foolproof and patients need to know that it may not be possible to send their data safely through these media.

**3.6 Video and audio recordings**

You need a patient’s consent if you intend to take any visual images (video or photographs, for example) or make audio recordings of him or her. It is important that the recordings do not compromise the patient’s privacy or dignity and are only used for the purpose for which consent was granted. They must also be stored securely.

Your patient must give their consent freely, without any undue pressure or coercion. When seeking consent, you should make clear what, if any, secondary uses the recordings will have, e.g. education, and that the recordings will be anonymised or coded for this purpose. Make a careful note of the discussion in the patient’s notes.

Recordings made for clinical purposes are part of the clinical records, and subject to the same duty of confidentiality. Clinical recordings should not be used for teaching purposes without consent if the patient is identifiable. This requirement does not extend to other media such as anonymised pathology slides or x-rays.

Recordings for teaching purposes made since 1997 require consent from the patient. Recordings for teaching purposes made before 1997 may not have been made with appropriate consent and should only be used if patients are not identifiable. Doctors with old recordings of this nature are advised to replace them with new recordings made with the patient’s consent.

**Emails, faxes and internet chatrooms**

Information should be sent and received securely. Emails, including email appointment systems, may not be a secure form of communication. You should make your email system as safe and confidential as you can, and anonymise and encrypt data if possible. You may wish to consider other means of communication if you have to transmit sensitive patient information to other medical practitioners.

Confidential faxes should utilise ‘safe haven’ systems. A safe haven is either a secure location or an agreed set of administrative arrangements in place within an organisation to ensure the safe and secure communication of confidential information.

Internet forums and chatrooms are increasingly popular. Whilst professional social media sites and closed forums can be useful places to exchange thoughts on current practice you must be careful not to breach patient confidentiality by discussing specific cases. Although individual pieces of information may not be sufficient to identify a patient, the sum
of information could be enough to identify a patient or someone close to them. Additionally it is possible that information could be copied and published elsewhere without your consent.

**Medical advice lines**

Calls by patients to medical advice lines or similar services are potentially sensitive and callers need to know that their call may be recorded. No call from a patient should be secretly recorded. You are advised to be cautious when considering taking part in this type of activity and to call the MDU for guidance.

**Television, radio, internet and print**

There are additional issues to consider when seeking patient consent to recordings for broadcast or in other media to which the public will have access.

A patient’s written permission is required for all recordings for use in publicly accessible media, including medical journals. This applies whether or not you consider the patient is likely to be identifiable.

The position is slightly different if the patient has died. Some information may be published, depending on whether:

- the information is already in the public domain
- the information can be anonymised
- the patient gave consent before death or not.

Before making any arrangements for individuals or organisations to film patients in a healthcare setting, you need to inform your employing or contracting body, and the organisation in which patients are being treated (if this is different). You should obtain appropriate permission for the recording. Within the NHS, a contract with the filmmaker will normally be required.

When a patient is to be recorded for television or other public media, you should ascertain that the patient has properly given his or her consent, even if you are not personally responsible for obtaining it.

When seeking the patient’s consent you will need to consider their vulnerability and whether they might wish to withhold consent but are reluctant to do so for fear of upsetting their treating doctor.

A patient who has agreed to the recording may also want to control how the recording is used. He or she will need to get agreement on future use in writing from the owners of the recording before recording begins.

Special consideration should be given to patients who are unable to give permission themselves. Have the programme-makers taken sufficient account of the patient’s interests, well-being, privacy and dignity? If you have concerns about any of these issues, you may wish to stop recording and consider withholding co-operation.

If you are in any doubt about the medico-legal position on confidentiality relating to photographic, recording or computer technology or dealing with the media, please call the MDU for advice.

**Responding to the press**

Personal criticism in the press or on social media can be very distressing, particularly if the comments are made by a patient or their representative. However, this does not remove your duty of confidentiality to the patient, and you must not put confidential patient information into the public domain. It may constitute a breach of confidentiality even to confirm or deny information and therefore considerable caution needs to be exercised when dealing with journalists.

If you are approached by the media for information about a patient-related matter then contact the MDU press office for further advice.

**Images for public display**

Recordings originally obtained with the patient's consent may be displayed in public without further consent provided that the recordings are effectively anonymised. This includes photographs of images from pathology slides, x-rays, laparoscopic or ultrasound images or images of internal organs. However, where the patient has an unusual condition or presentation which might identify him or her, it is good practice to seek the patient’s consent first prior to publishing.

**Questions and answers**

Q I’ve just had a call from a journalist asking me to confirm that a patient still has health problems as a result of inhaling smoke in a house fire. Apparently the patient is in dispute with the local council about re-housing. His asthma has been worse since the fire, and I want to help him if I can. What should I tell the journalist?

The law and the GMC are clear about a doctor’s duty of confidentiality, even where the patient has put the information into the public arena. The GMC says: ‘Patients have a right to expect that information about them will be held in confidence by their doctors’. This is so even if a patient puts his medical details into the public domain.

Simply to confirm that the man is a patient of yours may in itself breach confidentiality. Even if you gained the patient’s consent to talk to the journalist, you may inadvertently reveal details that the patient did not consent to being released. If you decide to go ahead, you will need to obtain your patient’s consent. You will need to satisfy yourself that the patient understands what you are going to say and you may only discuss aspects of the patient’s condition for which you have consent.

You may prefer to explain that you are unable to comment because your duty of confidentiality to all your patients prevents you from even confirming or denying that a person is a patient of yours. The MDUs press office can help you with your response.
Q I have been asked to take part in an online question and answer session about my specialist area, paediatrics. This has been set up by a local community group and I really want to help out.

If you are responding to individual letters you need to consider that you may be creating a duty of care for patients whom you have not seen or examined, in a situation where you may not have had all of the information necessary to form a clinical judgment.

If you provide only general advice, it may still be relied upon by patients and you should ensure the website includes a note stating that the medical advice you are providing is only general advice and that it should not be used as a substitute for the advice patients receive on consulting their own doctor. You may still be called upon to justify the accuracy of any advice you give.

An important consideration is that of patient confidentiality. The GMC makes it clear that you are expected to obtain express consent from patients before publishing personal information about them, whether or not you believe the patient can be identified. You will need to tell the patient exactly what you plan to publish in terms of case histories or other information such as x-rays or photographs and to respect their wishes if they do not give permission.

Also, registration with the GMC does not give you the right to practise medicine overseas. If you provide online advice to someone based overseas, you could be seen to be practising medicine in whatever place the person was when they asked you the question. If so you might need to be registered in that country. You would also need to be sure you had appropriate indemnity cover and complied with any relevant legislation, for example in relation to prescribing. It may be helpful to ask those submitting questions to tick a box confirming that they are based in the UK.

Q Last year, I filmed a consultation with a patient to use in teaching medical students. I now want to use this in a study day for non-medical healthcare workers, which will mean the video is seen by a wider audience than the patient may have originally thought. Can I rely on the patient’s original consent given that the video will still be used for teaching?

As you are aware, an audio-visual recording of a patient which identifies him may only be made with the patient's informed consent or the parent/guardian's authority in the case of a minor. To give consent, the patient must be aware of the purposes of the recording, the uses to which it may then be put and the extent to which the recording will be broadcast. The recording may only be used for the purpose and to the extent to which the patient consented. If you believe that the patient's original consent might not encompass the way you are now intending to show the video, you should discuss it with him and get his express consent for the video to be shown under these new circumstances. You must respect a refusal to give consent.

Q Is it acceptable to leave messages on patients’ answer phones?

Because of your duty of confidentiality to your patients you need to ask yourself if you can guarantee that any message you leave on a patient’s answer phone will remain confidential, assuming it even reaches him. There may be occasions when a patient has said he is happy with this method of communication but, apart from that, you would need to consider whether it would be appropriate to leave a message. You may not be certain that you have dialled the correct number and, even if you recognise the voice on the answer phone, you may not know whether somebody else could access the message. You would also need to consider if there was a better way of passing on the information that gave less scope for a breach of confidentiality. If you did decide to go ahead, you would also need to have mechanisms to follow up the patient appropriately, for example if he did not make an appointment as requested because for some reason he did not pick up the message.

References

1. GMC, Making and Using Visual and Audio Recordings of Patients (2011)
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24-hour advisory helpline
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E advisory@themdu.com
W themdu.com
Doctors have the statutory duty to notify a proper officer of the local council or local health protection team (HPT) of suspected cases of certain infectious diseases.

In England and Wales, Public Health England is responsible for checking and updating the list of notifiable infectious diseases. The current diseases (as at December 2012) are shown below but members are advised to check on the Public Health England website for the latest list.

Scotland

There are some differences in the list of notifiable infectious diseases in Scotland. Members should check with Health Protection Scotland (www.hps.scot.nhs.uk) for the latest position.

Current diseases
(as at December 2012)

- Acute encephalitis
- Acute meningitis
- Acute poliomyelitis
- Acute infectious hepatitis
- Anthrax
- Botulism
- Brucellosis
- Cholera
- Diphtheria
- Enteric fever (typhoid or paratyphoid fever)
- Food poisoning
- Haemolytic uraemic syndrome (HUS)
- Infectious bloody diarrhoea
- Invasive group A streptococcal disease
- Legionnaires’ disease
- Leprosy
- Malaria
- Measles
- Meningococcal septicaemia
- Mumps
- Plague
- Rabies
- Rubella
- SARS
- Scarlet fever
- Smallpox
- Tetanus
- Tuberculosis
- Typhus
- Viral haemorrhagic fever (VHF)
- Whooping cough
- Yellow fever
With rising divorce rates, it is increasingly common for GP practices to receive requests from estranged parents for disclosure of medical records, or other confidential information regarding their child. All such requests must be handled sensitively and correctly. Either parent might take issue with a disclosure or a refusal to disclose and make a complaint as a result.

It is important for doctors to be sure of the law and their rights and responsibilities when responding to such a request. These are the factors to take into account.

**Parental responsibility**

Anyone with parental responsibility for a child has a right to seek access to that child’s medical records1. Parental responsibility is defined in the Children Act 1989 as ‘all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property’2.

Birth mothers automatically have parental responsibility; so do married fathers. However, in both cases, this can be removed by the court.

When the father is not married to the child’s mother, his parental responsibility will depend on when the child was born. Unmarried fathers who are named on the birth certificate automatically have parental responsibility if the child was born on or after:

- 1 December 2003 in England and Wales
- 4 May 2006 in Scotland
- 15 April 2002 in Northern Ireland.

Unmarried fathers who are not named on the birth certificate do not have automatic parental responsibility. However, they can acquire parental responsibility if they obtain a Parental Responsibility Agreement from the child’s mother, or a Parental Responsibility Order from the court.

Step-parents and civil partners can acquire parental responsibility in the same way as unmarried fathers.

**Parents do not lose parental responsibility if they divorce.** However, it can be restricted by the court. If a child is adopted, the birth parents will lose parental responsibility for their child.

Representatives of the local authority have parental responsibility for a child who is in care.

A child’s testamentary guardian, special guardian or other person given a residence order also has parental responsibility.

**The child’s capacity to consent**

Although someone with parental responsibility can seek access to a child’s medical records, the child may have the capacity to decide for himself or herself whether they want the information to be disclosed. GMC guidance 0-18 years3 explains that doctors should take into account the views of a child who has capacity to be involved in such decisions.

Usually, the parents will have the child’s best interests at heart and the doctor should then encourage the child to involve them in their care and allow them access to the records.
A child or young person with capacity has the legal right to access their own health records, and to allow or refuse access by others, including their parents.

In assessing whether a young person has capacity, a doctor must ensure that the child understands the nature, purpose and possible consequences of agreeing to, or refusing, disclosure.

To have capacity to make a specific decision, the young person must be able to:

- understand, retain, use and weigh the information they are given
- communicate their decision.

Capacity does not entirely depend on the child's age. It rests more on their ability to understand and weigh up options.

In England and Wales, a young person of 16 or over can be presumed to have capacity to consent. Below this age, they may have capacity, depending on their maturity.

In Scotland, a child over 12 years old is presumed to have capacity to consent, although he or she could achieve capacity earlier or later than this.

**The child’s best interests**

GMC guidance states that a doctor may allow someone with parental responsibility to access a child’s medical records if the child or young person consents, or if he or she lacks capacity and it does not go against the child’s best interests.

However, the guidance also says: ‘If the records contain information given by the child or young person in confidence you should not normally disclose the information without their consent’.

It may also be justifiable to disclose confidential information about the child to a third party who does not hold parental responsibility providing this is clearly in the child’s best interests.

† You might receive a request to override a competent child’s refusal to share the content of their clinical records in the public interest. If this happens, members are advised to contact the MDU.

**Should you tell the other parent?**

When one parent asks the practice to disclose information about the child, there is no obligation to seek consent from the other parent, or to tell the other parent that you have received the request.

However, it may be wise to make sure the other parent is aware of the request, so that you can take into account any objection they may make and the reasons for it.

**Proof of parental responsibility**

If you feel there is any doubt that the person making the request has parental responsibility for the child, you can ask to see a copy of the child’s birth certificate and/or the parents’ marriage certificate, or a letter from the person’s solicitor confirming their parental responsibility status.

Remember that it is possible for parental responsibility to have been removed after the date of these documents.

**Third party information**

Third party information may appear in the child’s records. Before disclosure, you should consider seeking consent from the third party. If you cannot obtain consent, the information may need to be anonymised or appropriately redacted.

The Data Protection Act allows data controllers limited discretion to disclose third party information.

Section 7(4) says that if you cannot comply with a request to see the records without disclosing information relating to another individual who can be identified from that information, then you may comply with the request if:

- the third party has consented to the disclosure; or
- it is reasonable in all the circumstances to comply with the request without the consent of the third party.
The child’s address

Disclosure of a child’s address represents a disclosure of information that belongs also to a third party, namely the person with whom the child lives. For that reason, we would advise that a child’s address routinely be redacted from records that are being prepared for disclosure to the estranged parent.

Questions and answers

Q I don’t know the estranged father. Do I need proof of identity?
- You have a responsibility to satisfy yourself that the person requesting access has the right to do so, on the basis of having parental responsibility. This may require you to ask to see proof of identity, and/or evidence of parental responsibility.

Q The father is also a patient at the practice. The mother says he doesn’t have parental responsibility though he insists he does. Can we ask the mother to provide proof that the court has withdrawn his parental responsibility?
- Your priority is to act in the best interests of the child at all times. Where you have reason to doubt that an individual currently has parental responsibility, it is advisable to seek evidence. If the mother says it has been removed by the court, then you can ask the mother to show you evidence of this.

Q The father wants us to let him know every time the child attends the surgery. Do we have to comply with his request?
- A father with parental responsibility has a right to request access to the records, but the practice is not obliged to inform him each time the child attends, and should encourage the parents to communicate with each other, in the interests of their child. However, you could consider a compromise, in the best interests of the child, by asking the father to request an update at intervals, or by providing him with a summary of attendances at timely intervals. This would be particularly appropriate if the child spends time in the care of the father, and has ongoing health issues.

Q The father has just been released from prison. The mother thinks he may use disclosure of their young child’s records to find out where she lives. She feels vulnerable to physical attack. If he contacts the surgery, what can we say?
- Although a father with parental responsibility has a right to request disclosure of his child’s records, information should be withheld if disclosure would be contrary to the best interests of the child or if disclosure could lead to serious harm or be unreasonable to a third party. The address should be withheld.

Practice checklist

- Does the person requesting information have parental responsibility for the child? If in doubt, ask to see a copy of the child’s birth certificate and/or parents’ marriage certificate, or a solicitor’s letter.
- Do you have the child’s consent? Applies to young people with capacity only.
- Would it be contrary to the child’s best interests to disclose? Applies to young people lacking capacity.
- Have you considered informing the estranged partner?
- Is there third party information in the records? If so, you should consider obtaining consent from the third party.
- If no consent can be obtained from the third party, can the information be anonymised or appropriately redacted?
- The child’s GP should be involved in the decision about whether or not to disclose.
- Have you redacted the address from the notes?
- All decisions should be recorded in the medical notes.
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Case studies

Unknown caller

A practice manager received a call from a man claiming to be the father of a 10-year old patient. He asked to see the child’s records. The child lives with her mother, but according to the caller, stays with him every other weekend. The caller sent in a copy of the child’s birth certificate, which shows him to be the father. The practice manager rang the MDU advisory helpline to ascertain whether they need permission from the girl’s mother to disclose the records.

At the age of 10 it is unlikely that the child will have capacity to make a decision about who has access to her records, but this is a matter that should be considered by the practice and it could be an important factor in the case of an older child.

The next key question is whether the father has parental responsibility. If he has, then he has a right to request the records. As the child lacks capacity, it would then be for the child’s GP to decide whether disclosure would be in her best interests. It would be advisable to let the mother know about the request and what you intend to do, but this is not a requirement.

If the father does not have parental responsibility, the mother’s consent to disclosure should be sought. If she declines, then her reasons should be considered, but it may be in the child’s best interests to disclose relevant information to the father, as he has responsibility for the child every other weekend.

The father may not automatically have parental responsibility even though his name is on the birth certificate. In the case of a child born before 1 December 2003 (in England and Wales), being named on the birth certificate does not necessarily mean the father has parental responsibility, if he has never been married to the mother. However, he could have acquired parental responsibility through the courts, through a parental responsibility agreement with the mother, or by subsequently marrying. The practice might therefore wish to ask him to provide further evidence — a court document or letter from a solicitor — before considering whether to disclose.

Solicitors’ letter

A GP received a letter from solicitors acting on behalf of the father of a 13-year old patient with cystic fibrosis. The letter requested disclosure of the child’s medical records. The father was in the process of divorcing the patient’s mother who didn’t want the father to contact his daughter, on the grounds that he was unable to care for the child properly as he did not understand the girl’s condition.

The GP believed the patient had a mature understanding of her condition, and that it would be helpful for the father to see the records. She rang the MDU for advice.

The MDU adviser explained that even though the parents were divorcing, the father would still have parental responsibility for his daughter. He would have the same rights as the mother to request access to the child’s medical records.

However, there is no absolute right for parental access to records. Rather, this would be determined by what is in the best interests of the child. If the child has capacity, she can usually allow or prevent access to her records by others, including her parents.

In Scotland, anyone aged 12 or over is legally presumed to have such capacity, while in England the age is 16 years. However, capacity depends more on a patient’s ability to understand and weigh up options than on age.

The adviser suggested that the GP might see the patient on her own, to assess her capacity and to explore her views about sharing information with her father. All discussions should be fully documented in the child’s records.

References

1. Data Protection Act 1998, c29, section 7(1)
2. Children Act 1989, c41, part 1(3)
3. GMC: 0-18 years: guidance for doctors (2007), paras 44-55
4. Ibid. Para 53, in line with the Data Protection Act 1998
5. Ibid. Para 54

For individual medico-legal advice:

24-hour advisory helpline

T 0800 716 646
E advisory@themdu.com
W themdu.com
After a patient has died, GP practices are often approached by relatives, carers or officials asking for confidential information about the patient.

There are a number of reasons why they might do so. For example:

- They may wish to make a complaint about the care the patient received.
- They may want the information as part of a possible claim.
- They may be challenging the patient's will.
- They may need the information to complete official documents, for example for family members to make an insurance claim on a cancelled holiday.

It can be very difficult for practices to know what, when and to whom it is appropriate to disclose a deceased patient's records. You should be aware of both the legislation and the GMC's requirements in this area.

**Legislation**

The relevant legislation is:


Both Acts give a deceased patient's personal representative, and anyone who may have a claim arising out of the patient's death, a right of access to the patient's clinical records. This is not a general right and access may be limited to information of relevance to the possible claim.

Access can be limited or refused if:

- there is evidence the patient would not have expected the information would be disclosed to the applicant, or
- if the disclosure is likely to cause serious harm to anyone else, or
- if it would also disclose information about a third party who does not consent.

Access must be refused to records that contain a note, made at the patient's request, that they did not wish access to be given on an application under this legislation.

It can sometimes be very difficult to discern what is being requested and why. Any members who have concerns about a request being made under the above legislation, for example, where a third party believes they may have a clinical negligence claim arising out of the patient's death, should contact the MDU for individual advice.

The legislation gives the personal representative and those with a claim arising out of the death a right of access to parts of the records but it does not mean that others are barred from requesting disclosure of information after the patient's death. In certain circumstances, others may also be able to have information disclosed. Where an application for disclosure does not appear to fall under the above legislation, you should consider the GMC requirements on the subject.
Responding to a request — 8-step process

Paragraphs 134-138 of the GMC’s guidance  *Confidentiality: good practice in handling patient information* (2017) apply to disclosure of information after the death of a patient. Taken together with the relevant legislation, they can be distilled into a series of steps to follow when you receive a request for disclosure.

The steps apply when:

- a third party asks for information from the clinical records or makes a complaint, and
- where to respond would require the disclosure of information, and
- the practice is unsure about the nature of the request and/or identity of the third party.

### The 8 steps

1. You should make it clear to the applicant/complainant that, while you have no wish to be obstructive, you must consider your duty of confidentiality to the patient which is ongoing after death.

2. Ask the applicant/complainant to specify what information they are requesting, for what purpose it will be used and to confirm that they are or are not the executor of the deceased patient’s estate. This information should preferably be set out in writing.

3. You should bear in mind that the consent of the executor is not an absolute requirement for disclosure and you may provide information to individuals other than executors in certain circumstances.

4. You should explain to the applicant/complainant that if they are not the executor of the patient’s estate, you will wish to approach the executor to seek his or her views on the application for disclosure. You should ask the applicant/complainant for the name and contact details of the executor, if known to them. If the executor is known and the applicant/complainant is happy for them to be contacted, move to step 7.

5. If the applicant/complainant does not know the identity of the executor, then proceed to step 8.

6. Should the applicant/complainant object to you making the executor aware of their application/complaint, you should ask the reasons for this and explain that it may hinder your ability to respond to the request. Once the reasons are provided, move to step 8.

7. You should write to the executor making them aware of the application/complaint and seeking their views on the requested disclosure. If the executor opposes disclosure, ask them to explain their reasons.

8. Once you have all the necessary information from the applicant/complainant and the executor (where known and contactable), you should review it alongside the relevant parts of the patient’s records. You should also take into account paragraphs 134 and 135 the GMC’s  *Confidentiality: good practice in handling patient information* (2017) and form a view on whether the requested disclosure is:

   (a) required by the legislation or
   (b) reasonable under all the circumstances.

This can be a complex and confusing process and MDU members are invited to contact the MDU advisory team for individual advice and assistance.
Disclosure after death

GMC Confidentiality (2017) paragraphs 134-138

134. Your duty of confidentiality continues after a patient has died.

135. There are circumstances in which you must disclose relevant information about a patient who has died. For example:

(a) when disclosure is required by law
(b) to help a coroner, procurator fiscal or other similar officer with an inquest or fatal accident inquiry
(c) on death certificates, which you must complete honestly and fully
(d) when a person has a right of access to records under the Access to Health Records Act 1990 or the Access to Health Records (Northern Ireland) Order 1993, unless an exemption applies
(e) when disclosure is necessary to meet a statutory duty of candour.

136. In other circumstances, whether and what personal information may be disclosed after a patient’s death will depend on the facts of the case. If the patient had asked for information to remain confidential, you should usually abide by their wishes. If you are unaware of any instructions from the patient, when you are considering requests for information you should take into account:

(a) whether disclosing information is likely to cause distress to, or be of benefit to, the patient’s partner or family
(b) whether the disclosure will also disclose information about the patient’s family or anyone else
(c) whether the information is already public knowledge or can be anonymised or de-identified
(d) the purpose of the disclosure.

137. Circumstances in which you should usually disclose relevant information about a patient who has died include:

(a) the disclosure is permitted or has been approved under a statutory process that sets aside the common law duty of confidentiality, unless you know the patient has objected (see paragraphs 103-105)
(b) when disclosure is justified in the public interest to protect others from a risk of death or serious harm
(c) for public health surveillance, in which case the information should be anonymised, unless that would defeat the purpose
(d) when a parent asks for information about the circumstances and causes of a child’s death
(e) when someone close to an adult patient asks for information about the circumstances of that patient’s death, and you have no reason to believe the patient would have objected to such a disclosure
(f) when disclosure is necessary to meet a professional duty of candour (see paragraphs 100 and 101)
(g) when it is necessary to support the reporting or investigation of adverse incidents, or complaints, for local clinical audit, or for clinical outcome review programmes.

138. Archived records relating to deceased patients remain subject to a duty of confidentiality, although the potential for disclosing information about, or causing distress to, surviving relatives or damaging the public’s trust will diminish over time.

Source
1. gmc-uk.org
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