

PAPER ON CONFIDENTIALITY AND MENTAL HEALTH

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The fact that an individual may have a mental illness is undoubtedly very personal and sensitive information. It is particularly important that individuals have trust in their health care practitioners and that they are not deterred from seeking treatment because they fear that the confidentiality of their personal information may be shattered through unauthorised disclosure. The promise of confidentiality has long been a fundamental obligation of health care practice. From the Hippocratic Oath onwards professional ethical codes have habitually contained statements on confidentiality. This is reinforced by law through the law of breach of confidence and express statutory provisions. In certain instances confidentiality requirements are also contained in contracts of employment. After the Human Rights Act 1998 comes into force Article 8 of the European Convention of Human Rights, which contains provisions regarding the privacy of home and family life is likely to be used with the aim of safeguarding confidential information. A right to privacy has the potential to encompass protection for information which is confidential in nature¹. Article 8 provides that

- “1. Everyone has the right to respect for his private and family life his home and correspondence.
2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.”

The Convention on Human Rights and Biomedicine, produced by the Council of Europe, which the UK government is presently contemplating becoming a signatory, provides that

- “1. Everyone has the right to respect for private life in relation to information about his or her health.
2. Everyone is entitled to know any information collected about his or her health. However, the wishes of individuals not to be so informed shall be observed.
3. In exceptional cases, restrictions may be placed by law on the exercise of the rights contained in paragraph 2 in the interests of the patient.

Nonetheless while confidentiality is of importance this does not mean that health care information can never be disclosed to others. Some disclosure may be simply essential for effective care and treatment. As the above statements make clear, the right to privacy is not absolute in nature. The obligation of confidentiality itself is not regarded as absolute, either in the context of health care professional practice or by English law, as we shall see below. The decision as to whether to disclose is one which may lead to difficult dilemmas for health care professionals. Should confidence be broken if others may be at risk of harm, whether threatened or anticipated, from a patient? Should confidence be broken to facilitate care in a team setting? In such a setting sharing professional information is necessary for efficient patient care, yet determining the boundaries of disclosure may be difficult to achieve. Some of these issues were highlighted in a position paper issued by the Royal College of Psychiatrists in 1982²

- “i. Changes in the way that medicine in general and psychiatry in particular are practised have led to a much more widespread sharing of general information obtained from a patient by a doctor, for example, within multi-disciplinary teams.
- ii. Personal information is also very much more widely disseminated. Notes may be photocopied and sent to other professionals, who may include them in their notes which may be available to further professionals. In practice, it is increasingly difficult to preserve strict confidentiality.
- iii. The consent of patients to the disclosure of information about themselves may sometimes be implied – if, for example, they have referred a third party such as a housing

¹ See J. Wadham and H. Mountfield *Human Rights Act 1998* London: Blackstones (1999).

² Royal College of Psychiatrists: London (1989). This statement is currently under review by the Royal College.

authority or an employer to the doctor for information. However, even in these cases, it is good practice to receive in writing the consent of the patients to disclose such information and to specify what should or should not be included.

iv. Two further problems arise with psychiatric case notes. They contain much information given by third parties and they contain many opinions – they are not solely factual records. There are moves towards allowing patients access to their own records and there is no likelihood of any reversal of any of these trends, nor a return to a previous pattern of practice where a patient saw, and was treated by a single doctor, without consultation with other doctors or other professionals. It is therefore necessary to reconsider the degree of confidentiality that can be offered to a patient.”

This paper begins by considering the statements in professional ethical guidelines regarding confidentiality provided by professionals working in the area of mental health. It will be seen that while these guidelines provide for confidentiality to be respected they also sanction a series of exceptions to the principle. The second part examines the legal safeguards provided for patient confidentiality. It considers the operation of the law of breach of confidence, the situations in which disclosure of confidential information may be legitimately disclosed – with consent, under statutory requirements and in the public interest. Brief reference is made to safeguards which exist against the unauthorised disclosure of patient information which is held on computerised records. Finally, some proposals which have been made for reform of the law regarding confidentiality are considered. The paper is designed to provide a brief overview of the area and I am happy to clarify issues in greater depth with members of the Review in due course.

I. HEALTH CARE PROFESSIONALS' ETHICAL CODES AND CONFIDENTIALITY

Statements requiring confidentiality are featured in all the ethical codes of the major health care professional bodies. For example, the General Medical Council provides that

- “1. Patients have a right to expect that you will not disclose any personal information which you learn during the course of your professional duties, unless they give permission. Without assurances about confidentiality patients may be reluctant to give doctors the information they need in order to provide good care. For these reasons:
- * When you are responsible for confidential information you must make sure that the information is effectively protected against improper disclosure when it is disposed of, stored, transmitted or received;
 - * When patients give consent to disclosure of information about them, you must make sure they understand what will be disclosed, the reasons for disclosure and the likely consequence;
 - * You must make sure that patients are informed whenever information about them is likely to be disclosed to others involved in their health care, and that they have the opportunity to withhold permission;
 - * You must respect requests by patients that information should not be disclosed to third parties, save in exceptional circumstances (for example, where the health or safety of others would otherwise be at serious risk);
 - * If you disclose confidential information you should release only as much information as is necessary for the purpose;
 - * You must make sure that health workers to whom you disclose information understand that it is given to them in confidence which they must respect;
 - * If you decide to disclose confidential information, you must be prepared to explain and justify your decision.”³

Similarly the United Kingdom Central Council on Nursing, Midwifery and Health Visiting ethical code provides that:

“As a registered nurse, midwife or health visitor you are personally accountable for your practice and in the exercise of your professional accountability, must:

10. protect all confidential information concerning patients and clients obtained in the course of professional practice and make disclosures only with consent, where required by order of a court and you can justify disclosure in the wider public interest.”

Breach of the ethical code of such organisations may result in a health care professional being subject to disciplinary proceedings and they may, ultimately, be struck off the professional register.

THE ROYAL COLLEGE OF PSYCHIATRISTS

Further guidance to the particular problems of confidentiality and mental health were highlighted in the position statement issued by the Royal College of Psychiatrists upon the issue of confidentiality⁴. This statement recognised the complex interdisciplinary nature of professional practice. It provided that

³ *Doctors Duties: Confidentiality* London: GMC (1995).

⁴ See also Royal College of Psychiatrists “Confidentiality; Current Concerns of Child and Adolescent Psychiatric Teams” (1987) 11 *Bulletin of the Royal College of Psychiatrists* 170-1.

“In order to provide the best service for patients, sharing of information between professionals is inevitable and indeed essential. This is a two-way process and doctors cannot expect other disciplines to share information if doctors are not prepared to share with them. Information should be shared only if it is essential for the welfare of the patient or the safety of others and if its confidential nature is made clear.”⁵

The statement provided that

“All staff concerned with patient care should have a contractual obligation to maintain confidentiality and should be trained accordingly and reminded of this responsibility in staff handbooks.

(ii) Medical members of multi-disciplinary teams should accept only professional members known to have undertaken to maintain confidentiality.”⁶

It also contained the following recommendations regarding case conferences

“Case conferences which may involve a large number of people from a variety of disciplines, pose particular problems. A balance has to be struck between the proper exchange of sometimes sensitive information necessary for the proper care and management of the individual, and the requirements of confidentiality. The confidential nature of the proceedings should be made clear to all attending at the onset. Circulation of reports of case conferences should be restricted to key personnel. Psychiatrists should indicate quite clearly any information given verbally which they do not want recorded in the case conference report. The practice by some Social Services Departments of circulating the draft report with requests for comments before wider circulation is to be commended.

ii. Psychiatrists should use their judgement as to what information to divulge or withhold in relation to the nature and composition of the case conference.”⁷

These guidelines are returned to below in the context of legal issues regarding the disclosure of personal information.

SOCIAL WORKERS⁸

Social workers may also be in the possession of confidential health information. In social worker much use has been made of the practice of “negotiated confidentiality” where professional and client negotiate as to the boundaries of disclosure⁹. Social workers are not presently regulated by statute, as is the case regarding registered nurses and doctors. It should be noted that this position is likely to change in the light of recent government proposals (see below in discussion of issues of reform). Guidance regarding the use of confidential information is provided for example, in the form of the Code of Ethics of the British Association of Social Workers. This states that

“They will recognise that information clearly entrusted for one purpose should not be used for another purpose without sanction. They will respect the privacy of clients and others with whom they come into contact and confidential information gained in their relationships with them. They will divulge such information only with the consent of the client (or informant) except where there is clear evidence of serious danger to the client, worker, other persons or the community or in other circumstances, judged exceptional, on the basis of professional consideration and consultation.”¹⁰

This Principle was published some years’ ago in the Association’s Discussion Paper No. 1 on Confidentiality in Social Work. The sanction referred to in the first sentence of the Principle is the sanction of the person giving the information to the social worker. The Paper provides that “In all the

⁵ Para 5.1 i.

⁶ Para 6.2.

⁷ Para 7.

⁸ See generally on the question of confidentiality and social workers Terry Thomas *Privacy and Social Services* Aldershot: Arena (1995.)

⁹ See also discussion by I. Thompson “The Nature of Confidentiality” (1979) 5 *Journal of Medical Ethics* 5.

¹⁰ Principle 11.

foregoing circumstances the breach of confidence must remain limited to the needs of the situation at that time and in no circumstances can the worker assume a carte blanche to reveal matters which are not relevant to that particular situation.” The Association has a Disciplinary Board which is established by its constitution. This can deal with allegations of professional misconduct. The new draft document on confidentiality has now been issued by the Association. This provides that staff at every level should be aware of the need to maintain confidentiality and that this should be part of the contract of employment, while recognising that confidentiality may need to be breached in various situations.¹¹ Further reference is made to this document later in this paper.

¹¹ Para 1.4.

CONFLICTING PROFESSIONAL OBLIGATIONS: IMPLICATIONS FOR CONFIDENTIALITY

The health care professional may be faced with tensions between the requirement of patient confidentiality and facilitating patient care. This may be because disclosure may be required to facilitate “team” care, as mentioned in some of the statements referred to above and as discussed below in the context of the legal analysis. Difficulties may arise where the health care professional is faced with conflicting obligations within their ethical code. For example, the UKCC professional code of ethics provides that

“As a registered nurse, midwife or health visitor you are personally accountable for your practice and, in the exercise of your professional accountability, must:

11. report to an appropriate person or authority having regard to the physical, psychological and social effects on patients and clients any circumstances in the environment of care which could jeopardise safe standards of practice;
12. report to an appropriate person or authority any circumstances in which safe and appropriate care for patients and clients cannot be provided;
13. report to an appropriate person or authority where it appears that the health and safety of colleagues is at risk, as such circumstances may compromise standards of practice and care.”

There have been instances when for example, a nurse has been torn as to whether to disclose information in accordance with the code, but thereby possibly endanger patient confidentiality. A notable example was the case of Grahame Pink who blew the whistle, as to what he regarded as poor standards of care given to elderly patients in a hospital in Stockport¹². Relatives of some of the patients claimed that the patients were identifiable through some of the details given to the press even though no names were used. Pink was eventually dismissed. He challenged his dismissal in a claim for unfair dismissal before an industrial tribunal. The claim was ultimately settled. Subsequently the DOH published a code of practice regarding disclosures by health care professionals within the NHS (see appendices). These guidelines spell out the boundaries of disclosure. The health care professional who discloses details of abuse of mentally ill patients to the press may find that they are subject to disciplinary proceedings by their employer and ultimately to dismissal¹³.

The Employment Rights Act 1996 has now been amended by the Public Interest Disclosure Act 1998. This Act, when in force, will safeguard any workers who make what are “protected disclosures”. Disclosures are protected where these are regarding the commission of a criminal offence, breach of any legal obligation, miscarriage of justice, risk to health and safety or damage to the environment¹⁴. While this statute may provide some safeguards, in practice, the implications of such legislation are limited. It is rare that employees are reinstated as a consequence of a finding of unfair dismissal and “going public” must be realistically regarded as a step which may be viewed as the last resort. It is important that an employee can feel that they can raise concerns with the management or with an independent organisation, such as the Mental Health Act Commission.

II. PROTECTION OF CONFIDENTIALITY: LEGAL SAFEGUARDS¹⁵

¹² J.V. McHale “Whistle Blowing in the NHS” (1992) Vol 5, *Journal of Social Welfare and Family Law* 363 and J.V. McHale “Whistle Blowing in the NHS Revisited”, (1993) *Journal of Social Welfare and Family Law* 52. On whistleblowing generally see G. Hunt *Whistleblowing in the NHS* Arnold (1994).

¹³ See generally discussion by V. Beardshaw *Conscientious Objectors at Work* (1981) London: Social Audit.

¹⁴ S43B Employment Rights Act 1996. “Protected disclosures” may be made to the individual’s employer, to the person having legal responsibility for the matter which is disclosed, a disclosure in accordance with what is the employers whistleblowing procedures, disclosure to the employees legal advisors, if the individual is/works for a ministerial appointee then a disclosure to that minister. Disclosure is also allowed where this is to a person who is prescribed in regulations made under the Act, however at present no such regulations have been made.

¹⁵ For general discussion see L. Gostin *Mental Health Services Law* London: Shaw and Sons (1985 and supplements) paras 20.30; M. Brazier *Medicine Patients and the Law* (1994) London: Penguin, chapter 2, J.K. Mason and R.A. McCall Smith *Law and Medical Ethics* (4th edn) London: Butterworths (1994) chapter 8, J. McHale and M. Fox (with J. Murphy) *Health Care Law Text and Materials* London: Sweet and Maxwell (1997) chapter 10, J. Montgomery *Health Care Law* Oxford: OUP (1997) chapter 11.

The equitable remedy of breach of confidence used to safeguard commercial information has, in recent years, been used to restrain disclosure of health care information. As Lord Goff stated in *AG v Guardian Newspapers (No 2)*¹⁶

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

The application of the duty of confidence to health care professional-patient relationships was confirmed by the courts in *X v Y*¹⁷, concerning restraint of further publication by a national newspaper of the health care information of two general practitioners with AIDS and in the subsequent case of *W v Egdell*¹⁸ (discussed below). It can apply both to a health care professional involved in a the regular care and treatment of the patient and also to for example a psychiatrist commissioned explicitly to prepare a particular report. An application may be made in such a situation for an injunction to restrain further disclosure. More problematic is the award of damages for emotional distress suffered consequent to a breach of confidence. In *W v Egdell* Scott J., at first instance, commented that it was “open to question” as to whether the shock and distress occasioned by a breach of confidence could lead to an action in damages. The Law Commission recommended in 1981 that damages for mental distress caused by breach of confidence should be awarded, but this report has never been enacted.¹⁹

It should also be noted that there is the possibility that confidentiality of health care information may be safeguarded through the operation of the tort of negligence. It can be argued that the doctor owes a patient a duty of care to safeguard the confidentiality of patient information and that unauthorised disclosure of such information should thus be actionable in damages. Indeed the tort of negligence has been used to found liability in New Zealand.²⁰ However Montgomery has commented that here also the damage may be embarrassment rather than pecuniary loss, with consequent difficulties in obtaining recovery of damages. Furthermore it is the case that as the standard of disclosure for negligence is that of the responsible body of professional practice those standards would almost certainly legitimate disclosure.²¹

Below I consider first, who can bring an action for breach of confidence, secondly in what situations can information be legitimately disclosed? Information may be disclosed with the consent of the patient, express or implied. In addition information may be disclosed where it is deemed to be in the public interest to do so.

PROTECTING CONFIDENTIALITY WHERE A PATIENT’S COMPETENCE MAY BE UNDER QUESTION

A degree of legal uncertainty surrounds the question of the protection of health care information of minors and of mentally incapacitated adult patients. Similar legal issues arise in both situations, however, there are various differences not least the fact that the *parens patriae* jurisdiction does not apply in the context of the adult patient.

Children

In the case of a child who is under 16 years of age s/he has no statutory right to consent to treatment.²² After the decision of the House of Lords in *Gillick v West Norfolk and Wisbech AHA* it is recognised that a child under 16 may be competent to give consent to medical treatment.²³ Competency here is dependent upon an assessment of the child’s maturity. It appears that such an analysis would be applicable in the context of disclosure of health care information. A child of sufficient maturity may determine the basis on which information could be disclosed. However, the position of the immature

¹⁶ [1988] 3 All ER 545.

¹⁷ [1988] 2 All ER 648.

¹⁸ [1990] 1 All ER 835.

¹⁹ Law Commission *Breach of Confidence* Cmd 838, 1981, para 6.5 and 6.114.

²⁰ *Furniss v Fitchett* [1958] NZLR 396.

²¹ See J. Montgomery *Health Care Law* Oxford: OUP (1997) at page 252.

²² Section 8 of the Family Law Reform Act 1969 gives children over 16 the power to give consent to surgical, medical or dental treatment.

²³ [1985] 3 All ER 402.

minor is more uncertain. One approach is that of a “status” approach, the fact that the duty of confidence to the patient arises by virtue of that particular relationship. Kennedy and Grubb have questioned this approach.

“Should a doctor choose to tell the parent he will need to demonstrate that his breach of confidence falls within one of the recognised exceptions justifying disclosure of confidential information. But a doctor must usually inform the parents of a young child what he discovers in order to obtain consent for further treatment and so enable the parents to carry out their duty to care for that child. Thus this view, based as it is on status, seems out of consonance with the legal and actual reality flowing from the parent’s responsibilities to their child.”²⁴

They suggest that the relationship arises only where the child is competent to form such a relationship and suggest that this is in line with the general approach of English law to this issue as shown by the *Gillick* case and other provisions in the Children Act 1989. In contrast, Montgomery has argued that as a child who approaches her doctor without telling her parents is expecting that any disclosure which is made will be treated as confidential then the “very action evidences the maturity required before the law will recognise this expectation.”²⁵ A further possibility is that the child may be owed an obligation under the law of contract. The contract may be enforceable by the child where health care is given privately if it can be shown that the contract was manifestly to the advantage of the child.²⁶ Where advice/treatment is given within the NHS then there is no direct contract between patient and practitioner. The existence of a contractual obligation in such a situation is questionable. One suggestion however is that an independent contract arises between patient and doctor regarding a promise to maintain confidentiality.²⁷

Mentally Incapacitated Adults

There is no decided authority as to application of the law of confidentiality in relation to mentally incapacitated adults. (It should be emphasised that an individual who is mentally ill is likely to be owed an obligation of confidence as their capacity is unlikely to be totally eroded for these purposes.) Kennedy and Grubb²⁸ have argued that, as with the child patient, no duty of confidence is owed to the mentally incapacitated adult and that a court cannot stop disclosure of health care information, simply because it is not in the interests of the patient to disclose that information. They comment that

“There are two solutions to this unsatisfactory state of affairs. Either the court should be given back the *parens patriae* power over adults that it lost in 1960, or the court more radically could recognise that the relationship between doctor and patient is a fiduciary relationship from which would flow, of course, an obligation not to disclose information when it is not in the patient’s interests to do so.”

If this view is wrong, and an obligation of confidence is owed in such a situation by virtue of the individual’s status some disclosure of information will of course be necessary in relation to their care. This issue is explored further below.

The Deceased Patient

Question marks surround the issue of the confidentiality of health care information of a deceased patient.²⁹ It is certainly the case that many health care professional bodies, such as the GMC, envisage preservation of confidentiality in such a situation. It appears however, that at present an action could not be brought for breach of confidence on behalf of the deceased. Analogies can be drawn with the law of defamation where an action may not be sustained after the persons death. But the nature of the action for breach of confidence differs from that of defamation. The essence of an action for breach of confidence is not that the disclosure would necessarily damage the person in question at all, indeed it

²⁴ I. Kennedy and A. Grubb *Medical Law Text and Materials* (2nd edn) London: Butterworths (1994) at page 640 and see also A. Grubb and D. Pearl “Medicine, Health, Family and the Law” (1986) *Family Law* 101.

²⁵ J. Montgomery “Confidentiality and the Immature Minor” [1987] *Family Law* 101.

²⁶ *Clementis v London & North Western Railway Co* [1894] 2 QB 482 and see Montgomery *op cit*.

²⁷ See Montgomery *op cit* c/f Grubb and Pearl *op cit*.

²⁸ *Op cit* at page 643.

²⁹ See the discussion in J.K. Mason and R.A. McCall Smith *Law and Medical Ethics* (4th edn) Butterworths: London, at page 188. Where an action for breach of confidence was brought before the death of the patient this may be continued by the executors.

may enhance their reputation if it were, for example, disclosed that they had struggled on in a public role while suffering in silence from a serious illness.

THE BASIS FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Disclosure by consent

Confidential information may be disclosed by the consent of the person confiding the information. While this may appear, at least at first glance, as self-evident, on further examination it is more problematic. In their guidance “The Protection and Use of Patient Information” the Department of Health have commented that

“2.5 It is neither practicable nor necessary to seek a patient’s (or other informant’s) specific consent each time information needs to be passed on for a particular purpose. The public expects the NHS, often in conjunction with other agencies, to respond effectively to its needs; it can do so only if it has the necessary information. Therefore, an essential feature of the relationship between patients and the NHS is the need for patients to be fully informed of the uses to which information about them may be put.”

The Guidance goes on to state that

“3.1 All NHS bodies must have an active policy for informing patients of the kind of purposes for which information about them is collected and the categories of people or organisations to which information may need to be passed. Where other bodies are providing services for or in conjunction with the NHS, those concerned must be aware of each other’s information policies.

3.2 Subject to some important common elements ..., the premise arrangements for informing patients are for local decision, taking account of view expressed by community health councils, local patient groups, staff and agencies with which the NHS body is in close contact. However, those concerned, should bear in mind that:

- i. as a general rule, patients should be told how information would be used before they are asked to provide it and must have the opportunity to discuss any aspects that are special to their treatment or circumstances;
- ii. advice must be presented in a convenient form and be available both for general purposes and before a particular programme of care and treatment begins.

3.3 Methods of providing advice include;

- * leaflets enclosed with patients’ appointment letters or provided when prescriptions are dispensed;
- * GP practice leaflets and/or notification on initial registration with a GP;
- * routinely providing patients with necessary information as part of care planning;
- * identifying someone to provide further information if patients want it.”

Information may be disclosed for management purposes. However in practice it is unclear as to the extent to which patients will necessarily be appreciative of the existence and scope of such guidance and therefore whether disclosure in such a situation can truly be regarded as disclosure with the patient’s consent.

A “need to know”?

As was noted earlier it may be the case that the mentally incapacitated person, whether adult or child, is not owed a duty of confidence. But if an obligation exists then there is still the question of, in what circumstances can information be disclosed to third parties, such as family members or carers. This shades into the issue discussed below of the sharing of information within the health care team as that “team” may itself include the carers.

Disclosure may take place on a “need to know” basis to facilitate the patient’s care. Such disclosure may be regarded as justifiable because of the patient’s implied consent or because it is in the public

interest to do so. The “public interest” exception is discussed below. Disclosure on the basis of “need to know” as stated in para 2.6 of the Department of Health Guidance, includes NHS purposes where

“the recipient needs the information because he or she is or may be concerned with the patient’s care and treatment (or that of another patient whose health may be affected by the condition of the original patient such as a blood or organ donor)”.

The guidelines issued by the General Medical Council also discuss a “need to know” exception

“Disclosure in the patient’s medical interests

10. Problems may arise if you consider that a patient is incapable of giving consent to treatment because of immaturity, illness or mental incapacity, and you have tried unsuccessfully to persuade the patient to allow an appropriate person to be involved in the consultation. If you are convinced that it is essential in the patient’s medical interests, you may disclose relevant information to an appropriate person or authority. You must tell the patient before disclosing any information. You should remember that the judgement of whether patients are capable of giving or withholding consent to treatment or disclosure must be based on an assessment of their ability to appreciate what the treatment or advice being sought may involve, and not solely on their age.
11. If you believe a patient to be a victim of neglect or physical or sexual abuse, and unable to give or withhold consent to disclosure, you should usually give information to an appropriate responsible person or statutory agency, in order to prevent further harm to the patient. In these and similar circumstances, you may release information without the patient’s consent, but only if you consider that the patient is unable to give consent, and that the disclosure is in the patient’s best medical interests.
12. Rarely you may judge that seeking consent to the disclosure of confidential information would be damaging to the patient, but that the disclosure would be in the patient’s medical interests. For example, you may judge that it would be in a patient’s interests that a close relative should know about the patient’s terminal condition, but that the patient would be seriously harmed by the information. In such circumstances information may be disclosed without consent."

It should be noted that the courts have in the past made reference to the professional codes suggesting those circumstances in which information may be disclosed.

Disclosure and the Multi-Disciplinary Team

The reality of health care provision today is that this is provided in a team context and as we noted above the multi-disciplinary team plays an important role in the area of mental health. A further important issue is the extent to which information may be disclosed to carers (whether family members or others). In many situations disclosure of information is crucial to enable effective care to be given. The difference between professional and non-professional carer is that in the case of the former it is likely that they will themselves be governed by their own obligation of confidentiality. Nonetheless in practice in the context of for example, hospital care, the degree of disclosure of information may be considerable³⁰ and the prospect for unauthorised disclosure also increases the more persons have access to particular information. In such a situation it could be argued that some disclosure is being undertaken with implied consent as part of the team caring for the patient. It could also be the case that disclosure in such a situation may be deemed to fall within the general head of disclosure sanctioned in the public interest which is discussed below.

In their guidelines to doctors, published in 1995, the GMC provide that:³¹

- “3. Modern medical practice usually involves teams of doctors, other health care workers, and sometimes people from outside the health care professions. The importance of working in teams is explained in the GMC’s booklet “Good medical practice”. To

³⁰ See M. Siegler “Medical Confidentiality: A decrepit concept” (1982) 307 *New England Journal of Medicine* 1518.

³¹ *Confidentiality: Guidance from the General Medical Council* GMC London (1995).

provide patients with the best possible care, it is often essential to pass confidential information between members of the team.

4. You should make sure – through the use of leaflets and posters if necessary – that patients understand why and when information may be shared between team members and any circumstances in which team members providing non-medical care may be required to disclose information to third parties.
5. Where the disclosure of relevant information between health care professionals is clearly required for treatment to which a patient has agreed, the patient's explicit consent would not be needed where a general practitioner, discloses relevant information to a medical secretary to have a referral letter typed, or a physician makes relevant information available to a radiologist when requesting an X-ray.
6. There will also be circumstances where, because of a medical emergency, a patient's consent cannot be obtained, but relevant information must in the patient's interest be transferred between health care workers.
7. If a patient does not wish you to share particular information with other members of the team, you must respect those wishes. If you and a patient have established a relationship based on trust the patient may choose to give you discretion to disclose information to other team members, as required.
8. All medical members of a team have a duty to make sure that other team members understand and observe confidentiality.”

Such exceptions have to be interpreted sensitively. One approach which can be taken to obviate the problem that patients may be unaware of the potential for disclosure of their personal information is that of “negotiated confidentiality”. Commenting on such an approach the Royal College of Psychiatrists in their 1989 paper stated that

“One possible solution is that patients should have the situation concerning confidentiality more clearly explained to them. This would enable the patient to decide for himself how much information he would be prepared to give. However, some psychiatric patients are incapable of understanding the position and therefore their consent to any particular course of action cannot be obtained. Another possibility is to guarantee the patient complete confidentiality and for the doctor to keep separate notes not divulged to anybody. This makes normal treatment impossible (is treatment by a multi-disciplinary team with whom the information is shared.)”

The British Association of Social Workers in their draft guidance in 1998 provide that “Increasingly social workers are co-operating with personnel from other agencies and professions to provide a comprehensive service to individuals and families. Although discussions will usually, at the discretion of the worker and with the agreement of the client, include the sharing of information, the sharing of the total record will not be necessary.”³² The draft guidance emphasises the importance of disclosure being limited on a “need to know” basis.

³² Draft code para 2.9(a).

DISCLOSURE IN THE PUBLIC INTEREST

The legal obligation to maintain confidentiality is not absolute. Information may be disclosed where it is in the public interest to do so. In determining what amounts to the public interest the courts have made reference to the guidelines issued by the General Medical Council in their “Blue Book” *Fitness to Practice* and it can be anticipated that reference would be made to appropriate professional guidelines in relation to professions other than the medical profession such as nurses and social workers. Some judicial guidance exists regarding what will be deemed to be disclosure in the public interest. In *Gartside v Outram* Wood VC stated that “there is no confidence as to the disclosure of iniquity”.³³ “Iniquity” extends beyond such matters as disclosure of information relating to a crime. In *Beloff v Pressdram*³⁴ Unged Thomas J. held that disclosure of information relating to “matters medically dangerous to the public” is justified. It has been argued that in order to maintain that there is a public interest in disclosure it is not necessary to establish that there is danger to the public as a whole rather than to one specific individual.³⁵ As we shall see in a moment in ascertaining the scope of legitimate disclosure in the public interest, reference has been made by the courts to guidance contained in health care professional ethical codes.

The Department of Health in their document “The Protection and Use of Patient Information”, Guidance from the Department of Health³⁶ provide that;

“5.8 Passing on information to help tackle serious crime may be justified if the following conditions are satisfied:

- i. without disclosure, the task of preventing, detecting or prosecuting the crime would be seriously prejudiced or delayed;
- ii. information is limited to what is strictly relevant for a specific investigation;
- iii. there are satisfactory undertakings that the information will not be passed on or used for any purpose other than the present investigation.

The General Medical Council Guidelines state that

“Disclosure in the interests of others

18. Disclosures may be necessary in the public interest where a failure to disclose information may expose the patient or others to risk of death or serious harm. In such circumstances you should disclose information promptly to an appropriate person or authority.
19. Such circumstances may arise, for example, where:
 - * A patient continues to drive, against medical advice when unfit to do so. In such circumstances you should disclose relevant information to the medical adviser of the Driver and Vehicle Licensing Agency without delay ...
 - * A colleague, who is also a patient is placing patients at risk as a result of illness or another medical condition. Guidance on this issue, and on the rights of doctors who are ill, is contained in the GMC’s leaflet “HIV infection and AIDS: the ethical considerations” and in a separate note about the GMC’s health procedures.
 - * Disclosure is necessary for the prevention or detection of a serious crime.”³⁷

Similar provisions are contained in a circular issued by the DHSS circular issued in 1988 to social services departments.³⁸

³³ (1857) 26 LJ Ch (NS) 113, 114

³⁴ [1973] 1 All ER 241 at p 260.

³⁵ See M. Jones “Medical Confidentiality and the Public Interest” (1990) *Professional Negligence* 16.

³⁶ DOH 1996.

³⁷ GMC *Duties of Doctors: Confidentiality* (1995)

The fact that disclosure may be justified in the public interest does not mean that disclosure to the public at large would in such a situation be legitimate. In *Initial Services v Putterill*³⁹ Lord Denning held that disclosure would only be permitted if it was made to someone who had a proper interest in receiving the information and in *Lion Laboratories v Evans* Lord Wilberforce confirmed that there is a difference between something interesting to the public and which was in the public interest to know.⁴⁰ This is a matter to be determined on a case by case basis.

An illustration of disclosure being sanctioned in the public interest was provided by the case of *W v Egdell*.⁴¹ W had been convicted of the manslaughter of five people. He was detained in hospital under a restriction order made under section 60 and section 65 of the Mental Health Act 1959. Subsequently he applied to a Mental Health Review Tribunal for discharge from the hospital (section 41 of the Mental Health Act 1983). Dr Egdell, a psychiatrist was commissioned to examine W and to compile a report on him. The report was unfavourable, it was suggested that W had an abnormal personality which could be of a psychopathic nature and expressed his concern at W's interest in what W called fireworks by which he meant such things as tubes of piping packed with explosive chemicals. On receipt of the report W's solicitors decided to withdraw his application to the tribunal. Dr Egdell asked W's solicitors for a copy of the report to be put in W's hospital file. They refused. Dr Egdell himself then decided to disclose the contents of the report to W's responsible medical officer and later the report was disclosed to the Home Office. After his own application to the tribunal had been withdrawn, W's case then came up for review under automatic reference by the Home Secretary under section 67 of the Mental Health Act. W's solicitors obtained an injunction to restrain Dr Egdell from disclosing the contents of the report at the hearing. At the hearing the Home Secretary put forward the information obtained by Dr Egdell. An action was later brought claiming breach of confidence.

W v Egdell was considered in the later case of *R v Crozier*.⁴² The defendant had pleaded guilty to attempted murder and proceedings had been adjourned for medical reports. Dr M was instructed to examine C, however the report did not reach defence counsel at the time of the hearing. The defendant was sentenced to nine years in prison. Dr M arrived late. Approaching counsel for the prosecution he informed him that in his opinion the defendant was suffering from a psychopathic disorder under the Mental Health Act 1983. He also said that another doctor who had originally been of the view that the defendant was not suffering from that mental disorder had changed his mind. The prosecution applied for and obtained variation of sentence. The judge quashed the original sentence. An order was made under section 37 of the Mental Health Act 1983 and a restriction order under section 41. The defendant's appeal was rejected. The Court of Appeal said that Dr M had been in very much the same position as had Dr Egdell. Both doctors had believed that they were acting in the public interest.

As Gostin has noted the cases provide only limited guidance regarding the scope of future disclosure. As he comments what of the situation where the plaintiff does not have a history of previous violence "Must the prospective harm be real, immediate and serious? Must there be identifiable individuals at risk of harm? Must disclosure significantly reduce the risk of harm? Is the damage to the public interest protected by the duty of confidentiality outweighed by the public interest in protecting third persons?"⁴³ While judicial reference has been made to the exceptions contained to the general obligation of confidentiality contained in the General Medical Council's code of professional ethics it is to be speculated as to what extent these would, be sanctioned by the courts. The breadth of disclosure authorised by professional ethical guidelines is considerable and it is the case that while disclosure may be made benevolently in the patient's interests some patients may be adamantly opposed to broader disclosure or, despite the DOH guidelines, simply not appreciate the extent to which their personal information may be used. These exceptions need reconsideration. (This issue is returned to when considering the issue of reform.)

DISCLOSURE REQUIRED BY LAW

The confidentiality of health care information may be overridden in legal proceedings. There has been rejection by the English courts that a privilege be introduced allowing doctors to refuse to disclose

³⁸ Circular LAC(88) 17 and see discussion in H. Brayne and G. Martin *Law for Social Workers* (5th edn) London: Blackstone Press (1997) at pages 29-30.

³⁹ [1967] 3 All ER 145.

⁴⁰ [1984] 2 All ER 47.

⁴¹ [1990] All ER 835.

⁴² (1990) *The Guardian* 8th May.

⁴³ *Supra* at para 20.32.

confidential health information.⁴⁴ In addition the remedy of breach of confidence may not be used to restrain the disclosure of confidential information in a court of law.⁴⁵ Nonetheless the Court of Appeal in *R v McDonald* suggested that in a situation in which an issue which was being tried was non-medical the court should attempt to adduce it from the doctor only in exceptional circumstances.⁴⁶ The confidentiality of documents relating to the welfare of children will be protected save where for example, the information is required as part of the defence in a criminal prosecution.⁴⁷ In addition some health care information may be protected from disclosure where protected by legal professional privilege or public interest immunity. “Legal professional privilege” which protects information passed between lawyer and client may be used to restrain disclosure of certain communications between a lawyer and an expert witness.⁴⁸ “Public interest immunity” is the term used to describe exclusion of evidence on public policy grounds such as the disclosure of sources of information to the National Society for the Prevention of Cruelty to Children.⁴⁹ This does not apply simply where information is disclosed in confidence, it applies in a situation in which there is a clear public interest in safeguarding the confidentiality of the information, as in relation to the NSPCC in relation to their involvement in ensuring that steps can be taken to ensure that children are not neglected or ill treated.

Health care information may be required to be disclosed for the purposes of criminal investigation.⁵⁰ In some instances specific special safeguards which need to be complied with before disclosure is undertaken. The Police and Criminal Evidence Act 1984 provides that disclosure of “excluded material” – including personal records which relate to an individual’s physical and mental health and held in confidence can only be obtained with the authorisation of a warrant which has been given by a circuit judge.⁵¹ Disclosure of health care information may be required for the purposes of litigation under the Administration of Justice Act 1970, sections 31 and 32.⁵² Disclosure of psychiatric records may be in issue in a wide variety of litigation, ranging from child custody disputes to personal injury actions.

LIABILITY FOR FAILURE NOT TO DISCLOSE

One issue is whether a health care professional would ever be held liable in tort were s/he not to disclose confidential health care information to third parties and third parties suffers harm as a consequence. Comparisons can be drawn with the celebrated US case of *Tarasoff v Regents of the University of California*.⁵³ Poddar was a university student who sought out-patient care in a psychiatric hospital. He had been suffering deep depression following his rejection by Tatiana Tarasoff with whom he had fallen in love. He informed a psychologist at the hospital of his intention to kill Miss Tarasoff. After discussions with a psychiatrist, the psychologist decided that Poddar should be detained in a mental hospital. The campus police were informed. They detained Poddar but then released him when he appeared to be rational. However two months later Poddar killed Miss Tarasoff. The murdered woman’s family brought civil proceedings against the therapist. The Californian Supreme Court held that the therapist was under a duty to warn both the victim and her family. He was therefore liable for his failure to do so. This case caused great controversy, not least amongst the psychiatric associations in the USA. It was argued that this was not only contrary to the obligation of confidentiality but it also meant that the therapist was left having to predict the unpredictable.

The decision was considered by the court 18 months later. They modified the duty upon therapists. It was held that

“The discharge of this duty may require the therapist to take one or more of various steps depending on the nature of the case. Thus it may call for him to warn the intended victim or other likely to apprise the victim of the danger, to notify the police, or to take whatever steps

⁴⁴ *Duchess of Kingston’s case* (1776) 20 State Trials 355, and see also J.V. McHale *Medical Confidentiality and Legal Privilege* Routledge (1993).

⁴⁵ See P. Matthews “Legal Privilege and Breach of Confidence” (1981) 1 *Legal Studies* 77.

⁴⁶ *R v McDonald* [1991] *Crim L Rev* 122.

⁴⁷ See eg *Re D (Minors) Conciliation: Disclosure of Information* [1993] *Fam* 231.

⁴⁸ See eg *Lee v South West Thames RHA* [1985] 2 All ER 385. This privilege however, does not apply to the document on which an expert based an opinion which was expressed, see *R v King* [1983] 1 WLR 411.

⁴⁹ *D v NSPCC* [1978] AC 1717 and for a discussion of the question of disclosure of information concerning health policy see *Re HIV Haemophiliac Litigation* [1990] *NLJR* 1349.

⁵⁰ Prevention of Terrorism (Temporary Provisions) Act 1989 s18.

⁵¹ Section 9 and schedule 1.

⁵² And see also the Supreme Court Act 1981 sections 33 and 34.

⁵³ (1976) 17 Cal 3d 358.

are reasonably necessary under the circumstances The protective privilege ends where the public peril begins.”

What would the position be in English law were the courts to be faced by a similar case? In *W v Egdell*, at first instance, Scott J held that

“In my view a doctor called upon as Dr Egdell was to examine a patient owes a duty not only to his patient but also a duty to the public. His duty to the public would require him in my opinion to place before the proper authorities the results of his examination if in his opinion the public interest so requires.”

Nonetheless it may be questioned whether the English courts who have been unwilling in the past to extend liability in tort in relation to third parties would extend liability in such a situation.⁵⁴

OWNERSHIP AND ACCESS: HEALTH CARE RECORDS AND THE COMPUTER

The Department of Health has stated that it is its understanding that the ownership of medical records (and general practice records) are the property of the Health Authority in that the records are compiled on forms supplied by the Authority. Nonetheless as Montgomery has argued “For most purposes the mere fact of ownership is no longer seen as significant. Owning the records is not the same as having the right to do as you wish with them.”⁵⁵ As we have seen some control is provided through the operation of the law of breach of confidence. In addition access to health and social services records is regulated through legislation in the form of the Data Protection Act 1984, the Access to Health Records Act 1990⁵⁶ and the Access to Personal Files Act 1987. Patients have rights of access to their personal information, but this may be limited in certain situations as, for example, where disclosure would cause serious harm to a person’s physical or mental state or to that of another person.⁵⁷ Specific safeguards have existed in relation to the storage and use of information held on computer since the Data Protection Act 1984 came into force. In addition to patients’ rights of access holders of data are subject to the “Data Protection Principles” including requirements to the effect that data is fairly obtained, accurate, confidentiality should be maintained and information only disclosed to those within the scope recognised by inclusion on the Data Protection Act register. Today much health care information is held on computer. The Department of Health expressed the view that clinical data held electronically should be made available through the “NHS family”. It was envisaged that this would facilitate management and patient care. However concerns have been expressed regarding the potential for the unauthorised disclosure of health care information held on computer⁵⁸ with the NHS Executive commenting that authorised insiders may pose a considerable threat to confidentiality.⁵⁹ The Caldicott Review proposed that identified data should not be accessible to all on the “NHS Net”. In the future it is the case that enhanced safeguards will be provided to data held on patients through the operation of the Data Protection Act 1998. This, when in force, will apply to data held on computer and also extent to certain data held on manual files “in relevant filing systems” which are structured such that “specific information relating to a particular individual is readily accessible.”⁶⁰ But in this as in many other contexts the legislation can only provide a framework. It is important for the NHS to clarify and to keep under review the information regarding persons with mental illness available on computer and minimise the potential for unauthorised disclosure of such information.

REFORM OF THE LAW RELATING TO CONFIDENTIALITY

Information regarding mental illness is inherently sensitive in its nature. The stigma of mental illness cannot be ignored. The broad scope of the Mental Health Act Review may provide scope for some recommendations for reform of the law in the area which may assist practitioners and facilitate health care provision.

⁵⁴ See for example, *Smith v Littlewood* [1987] 1 All ER 710.

⁵⁵ J. Montgomery *Health Care Law* Oxford: OUP (1997) at page 251.

⁵⁶ There is no general common law right of access to information compiled prior to the statute coming into force and thus to force disclosure of such information it may be necessary to commence legal proceedings *R v Mid Glamorgan HA ex parte Martin* (1993) 16 BMLR 81.

⁵⁷ See for example, Access to Health Records Act 1990 s5(1)(a)(I).

⁵⁸ This led to the establishment of the Caldicott Review, the Report of the *Review of Identifiable Patient Information* London: DOH (1997). The Review examined the extent to which the use of identifiers on NHS patients when data was used for NHS business was justified.

⁵⁹ See G. Kelly “Editorial: Patient Data Confidentiality and electronics” 316 (1998) *BMJ* 718.

⁶⁰ S1(1) and see further P. Carey *Data Protection Act 1998* London: Blackstone Press (1998).

A number of proposals have been made in the past for reform of the law concerning confidentiality of health care information. In 1981 in their report *Breach of Confidence*, the Law Commission proposed the creation of a statutory tort of breach of confidence with a public interest disclosure defence, however this proposal was not taken further by the government.⁶¹ In 1995 a draft bill on confidentiality was produced by the British Medical Association consequent upon deliberations by a Working Party including nursing input from the UKCC. It was introduced into the House of Lords by Lord Walton. It was given a second reading. The Bill concerned information concerning a person's physical or mental health which was in the control of a health service body or that of a qualified health professional. Those circumstances in which information could be lawfully disclosed were set out and unauthorised disclosure was made a criminal offence (see appendices).⁶²

In the future the scope of protection of the confidentiality of health care information may be the subject of challenge under Article 8 of the European Convention of Human Rights in the form of the Human Rights Act 1998. The extent to which such challenges may lead to a radically different approach being taken by the English courts from the present position may perhaps be questioned. As noted above this is not an absolute right. The balance between maintaining confidentiality and disclosure of information needs to be addressed. As Gostin has stated in the context of discussion of *W v Egdell* and *R v Crozier*

“Taking the principle of confidentiality seriously ultimately serves the interests of both patient and the public. It serves the patient's interests because it encourages him or her to come forward for treatment; and it protects the public in that patients are more likely to confide their violent tendency to their doctor. The compelling public interest in confidentiality could be overridden only where a doctor had reasonable grounds for believing that an immediate and serious harm would occur in the absence of the disclosure.”⁶³

There are difficulties in leaving this area to *ad hoc* judicial development. Some statutory clarification of the boundaries of confidentiality and its applicability to particular groups such as children, the mentally incapacitated adults would be desirable. If the government enact reform of the legal position concerning the mentally incapacitated adult along the lines suggested by the Law Commission in their 1995 Report on *Mental Incapacity*⁶⁴ it is suggested that the question of confidentiality the mentally incapacitated should also be considered. Also the boundaries of disclosure to third parties, to carers etc would benefit from clarification with recognition of a standard approach across health care professions.

Any statutory reform needs to be considered in the light of the realities of the situation, namely that legislation can only provide what are, in practice, exceedingly general guidelines and many difficult decisions will still be left in the hands of the health care professionals.

⁶¹ Law Commission *Breach of Confidence* (1981).

⁶² There are few situations in which the law provides statutory safeguards for the confidentiality of health care information, venereal disease and information regarding provision of reproductive services under the Human Fertilisation and Embryology Act 1990 are two examples (National Health Service Venereal Disease Regulations SI 1974 No 29 and Human Fertilisation and Embryology Act 1990 section 33).

⁶³ *Supra* at para 20.32.1.

⁶⁴ *Mental Incapacity* (1995) Law Com No 231.

APPENDIX 1

Guidance for Staff on Relations With the Public and the Media DOH (1993)

Introduction

1. This guidance sets out the rights and responsibilities of staff when raising issues of concern about health care matters. The guidance does not affect existing guidance on statutory complaints procedures (as set out in HC(88)37), and it does not change or replace any nationally agreed terms and conditions of employment which gave particular groups of employees freedom to speak and write.
2. The guidance complements professional or ethical rules, guidelines and codes of conduct on freedom of speech, such as, for example the UKCC Code of Professional Conduct, A Midwife's Code of Practice, and the GMC Guidance on Contractual Arrangements in Health Care. It is not intended to restrict the publication of clinical or scientific research findings or Annual Reports from Directors of Public Health.

Purpose of guidance

3. This guidance aims to make plain that:
 - (i) Individual members of staff in the NHS have a right and a duty to raise with their employer any matters of concern they may have about health service issues concerned with the delivery of care or services to a patient or client in their authority, Trust or unit.
 - (ii) Every NHS manager has a duty to ensure that staff are easily able to express their concerns through all levels of management to the employing authority or Trust. Managers must ensure that any staff concerns are dealt with thoroughly and fairly.
 - (iii) NHS employers should ensure that local policies and procedures are introduced to allow these rights and duties to be fully and properly met.
 - (iv) Individual members of staff in the NHS have an obligation to safeguard all confidential information to which they have access; particularly information about individual patients or clients, which is under all circumstances strictly confidential.

Key principles – putting patients first

4. The NHS exists to meet the needs of patients. The key principle of this guidance is that their individual interests must be paramount. Of course consultants have ultimate responsibility for the care of patients, but all NHS employees have a duty to draw to the attention of their managers any matter they consider to be damaging to the interests of a patient or client and to put forward suggestions which may improve their care. In the case of a patient or a client detained under the Mental Health Act Commission.
5. So the normal working culture of the NHS should foster openness. Staff should be encouraged freely to contribute their views on all aspects of health service activities, especially about delivery of care and services to patients or clients. Free expression of these views can contribute to improving services for patients or clients in the future. NHS Managers are therefore expected to ensure that all staff are given every opportunity to make their contribution. Moreover, they must feel that their legitimate views will be welcomed, appreciated and, where appropriate, acted on positively.
6. ***Under no circumstances are employees who express their views about health service issues in accordance with this guidance to be penalised in any way for doing so.***
7. An important principle of this guidance is that it should be for local management in consultation with all staff and local staff representatives to implement in a way that is appropriate to local circumstances. They will wish to consider how best to promote a culture

of openness and dialogue which at the same time upholds patient confidentiality, does not unreasonably undermine confidence in the service and meets the obligations of staff to their employer.

Confidentiality to patients and employers – the responsibilities of staff

8. All NHS staff have a duty of confidentiality to patients. Unauthorised disclosure of personal information about any patient or client will be regarded as a most serious matter which will always warrant disciplinary action. This applies even where a member of staff believes that he or she is acting in the best interests of a patient or client by disclosing personal information.
9. Employees also have an implied duty of confidentiality and loyalty to their employer. Breach of this duty may result in disciplinary action, whether or not there is a clause in their contract of employment expressly addressing the question of confidentiality.
10. The duty of confidence to an employer is not absolute, however. In any case involving disclosure of confidential information, it may be claimed that the disclosure was made in the public interest. Such a justification might, in a disputed case, need to be defended and so should be soundly based. As a matter of prudence then, any employee who is considering making a disclosure of confidential information because they consider it to be in the public interest, should first seek specialist advice. This could be, for example, from one of the representative or regulatory organisations mentioned in paragraph 23 et seq.
11. Any explicit confidentiality provision in an individual staff employment contract must be expressed in a way that does not conflict in any way with the principles and advice set out in this guidance.

Establishing local procedures for dealing with staff concerns

12. All NHS employers should establish procedures locally – after full consideration with staff and local staff representatives – for handling staff concerns about health care issues, other than those to which statutory complaints procedures apply, or which fall to established grievance procedures.
13. The local procedures may address in more detail any aspect of this guidance, provided that, in doing so, they do not conflict with the principles and advice set out in it. The procedures should allow for staff concerns to be considered at the highest level of local management, including the General Manager or Chief Executive of the employing authority or Trust. Procedures should include clear time limits for dealing with staff concerns.

Informal procedures

14. Of course, the aim should always be for staff concerns about the health service issues to be resolved informally – between the individual and his or her line or professional managers. Managers should always:
 - take concerns seriously; and
 - consider them fully and sympathetically; and
 - recognise that raising a concern can be difficult experience for some staff; and
 - seek advice from health care professionals where appropriate.
15. Staff who are not in a formal line management relationship (eg consultants) should discuss their concerns with relevant colleagues and then, if necessary, take them up directly with the General Manager or Chief Executive.
16. Where a staff concern can be acted upon, action should be taken promptly and the member of staff notified quickly of the action taken. Where action is not considered practicable or appropriate, the individual member of staff should be given a prompt and thorough explanation

of the reason for this. They should also be told what further action is available under local procedures.

Formal procedures

17. Where this informal approach proves ineffective, local procedures should provide for the matter to be referred up formally through the employee's management line. Where there are a number of management levels, each level of management should give the same thorough and fair consideration to the issue and advise the member of staff promptly of the outcome, within an agreed timetable. Again, the arrangements will need to be slightly different for staff not in a direct line management relationship – see paragraph 15 above.
18. Local procedures should make plain whether the employee may be accompanied or represented by his or her professional organisation or trade union representative, or other person of his or her choice, during this process.
19. The formal procedures should always provide for the employee to raise his or her concern, where necessary, with the highest level of local management. If an issue remains unresolved after it has been referred to all levels of management, the local formal procedures should provide for the individual member of staff to raise his or her concern finally with the Chairman of the authority or Trust.
20. The Chairman may choose to deal with the matter personally or, for example where the concern is about action taken or decisions made by individual senior managers, in conjunction with non-executive board members.

The designated officer

21. The procedural model set out above could prove unnecessarily cumbersome and time-consuming when dealing with concerns expressed by staff in extended management chains. As an alternative to using all the levels of the managements chain, employers might prefer, in consultation with staff and local staff representatives, to designate a senior officer to whom matters unresolved by immediate line managers could be referred directly by the member of staff concerned. This could, though need not, be the officer designated to receive formal complaints under statutory procedures.
22. In a case where this procedure has been followed and the individual member of staff remains dissatisfied, the matter will need to be referred to the Chairman of the authority or Trust for action.

Reference to other bodies

Representative and regulatory organisations

23. All staff must retain the right to consult, seek guidance and support from their professional organisation or trade union, and from statutory bodies such as the United Kingdom Central Council for Nursing, Midwifery and Health Visiting, the General Medical Council and the boards of the Council for Professions Supplementary to Medicine.
24. Managers should encourage staff to consult with representative bodies particularly if an issue seems likely to remain unresolved without reference to the Chairman of the employing body.

The Mental Health Act Commission

25. Where an NHS employee has a concern about the care of a patient or client detained under Mental Health Act 1983, he or she may be able to refer the matter to the Mental Health Act Commission, if the concern remains unresolved after pursuing it through local procedures.

The Health Service Commissioner (The Ombudsman)

26. All staff should be made aware that the Ombudsman may look into complaints by staff on behalf of a patient, provided that he is satisfied that there is no-one more appropriate, such as an immediate relative, to act on the patient's behalf. Adequate supplies of information leaflets about the Ombudsman's role and the procedures for reference to him should be readily accessible to all staff, as well as patients.

Reference to members of Parliament and the media

27. An employee who has exhausted all the locally established procedures, including reference to the Chairman of the employing body, and who has taken account of advice which may have been given, might wish to consult his or her Member of Parliament in confidence. He or she might also, as a last resort, contemplate the possibility of disclosing his or her concern to the media. Such action, if entered into unjustifiably, could result in disciplinary action and might unreasonably undermine public confidence in the Service.
28. In view of these considerations, any employee contemplating making a disclosure to the media is advised to first seek further specialist guidance from professional or other representative bodies and to discuss matters further with his or her colleagues and, where appropriate, line and professional managers. In the light of the principles set out in this guidance, however, and the fact that local procedures will have been determined in consultation with local staff and staff representatives, it is expected that proper mechanisms will exist to ensure that staff concerns can be addressed and dealt with without reference to the media.

APPENDIX 2

Extracts from Disclosure and Use of Personal Information Bill 1995

2(1) Except as provided under sections 3 and 4, a health service body which holds a patient's health information, or information for the purpose of health care which includes information relating to a person other than the patient, shall not disclose that information.

(2) Except as provided under sections 3 and 4 and subsection (3) of this section, a qualified health professional shall not disclose a patient's personal health information, or information relating to a person other than the patient, for purposes other than the provision of health care to that individual.

(3) A qualified health professional may, in the course of providing health care to a patient, disclose to a health service body personal health information relating to that patient and such information shall not be disclosed by that health service body except in accordance with the provisions of this Act.

(4) Nothing in this Act prevents the disclosure of personal health information with the express consent of the person to whom it relates.

s3(1) It shall be unlawful for a health service body which holds health information obtained in connection with one purpose to use this information for any other purpose unless –

- (a) the use of the information for that purpose is authorised by -
 - (i) the individual concerned or the individual's representative
 - (ii) a court; or
 - (iii) statutory requirement
- (b) the purpose for which the information is used is directly related to the purpose in connection with which the information was obtained and is not contrary to the express refusal of the individual;
- (c) the source of the information for that purpose is necessary to prevent or lessen a serious and imminent threat to -
 - (i) public health and safety
 - (ii) the life or health of the individual concerned or another individual;
- (d) the information is to be used –
 - (i) in a form in which the individual concerned is not identified;
 - (ii) for audit purposes and will not be published in a form from which it can reasonably be expected that the individual concerned can be identified;
- (e) the information –
 - (i) is disclosed or used in a form in which the individual concerned is not identified;
 - (ii) is disclosed, collected and used for audit purposes and will not be published in a form from which it can be reasonably be expected that individual concerned can be identified; or
 - (iii) is disclosed, collected and used for research purposes (for which approval by a research ethics committee, if required, has been given) and will not be published in a form from which it can reasonably be expected that the individual concerned can be identified and the individual has not registered an objection;
- (f) non-compliance is necessary –
 - (i) to avoid prejudice to the maintenance of the law by any public body, including the prevention, detection, investigation prosecution or punishment of a serious offence; or
 - (ii) for the conduct of proceedings before any court or tribunal (being proceedings that have been commenced or are reasonably in contemplation);
 - (iii) for any purpose authorised following application to the court.

s4(1) Subject to subsection (2) it shall be unlawful for a health service body or for a health professional holding health information to disclose that information unless –

- (a) the disclosure is to –
 - (i) the individual concerned; or
 - (ii) the individual's representative where the individual is dead or is an incompetent minor or is mentally incapacitated;
- (b) the disclosure is authorised by –
 - (i) the individual concerned; or
 - (ii) the individual's representative where the individual is dead or is an incompetent minor or is mentally incapacitated;

- (c) the disclosure of the information is one of the purposes in connection with which the information was obtained;
 - (d) the source of the information is a publicly available publication;
 - (e) the information is in general terms concerning the presence, location and condition and progress of the patient in or on the premises of a health service body and the disclosure is not contrary to the express request of the individual;
 - (f) the information to be disclosed concerns only the fact of the death and the disclosure is by a health professional or by a person authorised by health service body to a person nominated by the individual concerned, or to the individual's representative, spouse, principal care giver or next of kin, close relative or other person whom it is in the opinion of the health professional reasonable in the circumstances to inform.
- (2) Subsection (1) shall not apply where it is either not desirable or not practicable to obtain authorisation from the individual concerned and –
- (a) the disclosure of the information is directly related to one of the purposes in connection with which the information was obtained;
 - (b) the information was disclosed by a registered health professional to a person nominated by the individual concerned, or to a social worker employed by the local authority or health service body, or to the principal care giver or a near relative of the individual concerned in accordance with the recognised professional practice and [that] the disclosure is not contrary to the express request of the individual, or where the individual is dead, his personal representative;
 - (c) the information is disclosed to protect the interests of a person who is unable to consent and is limited to recognised agencies who could act for that person, such as the Court of Protection or the individual's representative;
 - (d) the information is to be used -
 - (i) in a form in which the individual concerned is not identified;
 - (ii) for audit purposes and will not be published in a form from which it can reasonably be expected that the individual concerned will be identified; or
 - (iii) for research purposes (for which approval by a research ethics committee, if required has been given) and will not be published in a form from which it can reasonably be expected that the individual concerned will be identified;
 - (e) the disclosure of the information is necessary to prevent or lessen a serious and imminent threat to –
 - (i) public health and safety; or
 - (ii) the life or health of the individual concerned or another individual;
 - (f) the disclosure of the information is in general terms and is essential to facilitate the sale or other disposition of a business as a going concern and is not contrary to the express request of the subject;
 - (g) the information to be disclosed briefly describes only the nature of the injuries of an individual sustained in an accident and that the individual's identity and the disclosure is –
 - (i) by a person authorised by the person in charge of a hospital;
 - (ii) a person authorised by the person in charge of a news medium;
 for the purpose of publication or broadcast in connection with the news activities of that news medium and the disclosure is not contrary to the express request of the individual concerned or where that individual is dead, his personal representative;
 - (h) the disclosure of the information –
 - (i) is required for the purposes of identifying whether an individual is suitable to be involved in health education and so that individuals may be identified may be asked to give their authority or, where they are incapable of doing so, so that the views may be sought of a person whom they have nominated or their representative, spouse, principal care giver, next of kin, close relative or other person whom it is in the opinion of the health professional reasonable in the circumstances to ask; and
 - (ii) is by a person authorised by the health service body to a person authorised by a health training institution.
 - (j) the disclosure of the information is required for –
 - (i) the purpose of a professionally recognised accreditation of a health service;
 - (ii) a professionally recognised external quality assurance programme; or
 - (iii) risk management assessment and the disclosure is solely to a person engaged by the health service body for the purposes of assessing that body's risk and the information will not be published in any form which could be expected to identify any individual nor disclosed by the

accreditation or quality assurance or risk management organisation to third parties except as required by law;

- (iv) the purposes of examining and investigating any untoward event or side effect resulting from any medical prescription issued or procedure carried out by a registered medical practitioner employed by or in contract with a health service body;
- (v) the proper performance of any function imposed upon the health service body by the Mental Health Act 1983 or monitoring of patients for purposes ancillary to the Act;
- (vi) the investigation of a health service body or a Health Service Commissioner of any complaint or incident.

- (k) non-compliance is necessary –
- (i) to avoid prejudice to the maintenance of the law by any public body, including the prevention, detection, investigation, prosecution and punishment of a serious offence; or
 - (ii) for the conduct of proceedings before any court or tribunal (being proceedings that have been commenced or are reasonably in contemplation);
 - (iii) for any purpose authorised following application to the court;
 - (iv) for any purpose in connection with any disciplinary or legal proceedings against any qualified health professional or any person employed by or in contact with a health service body or any visitor to premises owned or occupied by a health service body;
- (l) the individual concerned is or is likely to become dependent upon a controlled drug, prescription medicine or restricted medicine and the disclosure is by a health professional to a Medical Officer of Health for the purposes of the Misuse of Drugs Act 1971.

(3) For the avoidance of doubt it is hereby declared that it shall be lawful for a health professional to disclose health care information to another qualified professional, where he believes on reasonable grounds that it is necessary for the purpose of providing or assisting in the provision of health care to the patient to whom the information relates and the disclosure is not contrary to a valid and informed refusal by the patient.

(4) In any case where disclosure of personal health information is made by a qualified health professional under this section, it shall be lawfully disclosed only if he is satisfied that there are appropriate safeguards against the information being used for any other purpose than that for which it is disclosed, and in any proceedings where the lawfulness of the disclosure is in question it shall be presumed that the qualified health professional has verified this, unless the contrary is shown.

(5) Nothing in this section affects the operation of section 11 (excluded material) of the Police and Criminal Evidence Act 1984.

(6) Where information relates to the provision of health care to any patient, this section does not apply to disclosure made –

- (a) by a person who is satisfied that it is immediately necessary to make the disclosure to avert an imminent danger to the health of the patient without whose consent that information could not otherwise have been lawfully divulged, and
- (b) where it is not reasonably practicable to obtain that patient's consent.

5(1) Where the patient is a minor, disclosure shall not be made under the provisions of this Act without the consent of the patient or, in the case of an incompetent minor –

- (a) one of his parents; or
- (b) a person having parental responsibility for him, unless -
 - (i) the health professional or the health service body proposing to make the disclosure has made such reasonable enquiry as may be practicable to obtain that consent; or
 - (ii) disclosure is essential to ensure the protection and well being of that minor.

(2) Where the patient is by reason of mental disorder unable to give valid consent to disclosure, disclosure shall not be made under the provisions of this Act unless –

- (a) the disclosure is necessary for the treatment or continuing care and supervision of that patient; and
- (b) the health professional or the health service body proposing to make the disclosure has made such reasonable enquiry as may be practicable to obtain the views as to disclosure from the patient's representative, or the disclosure has been authorised in writing by a Mental Health Review Tribunal, or the responsible medical officer certifies that the disclosure is authorised under the provisions of this Act; or
- (c) the disclosure is essential for the patient's protection and well being.