

5 - Confidentiality guidance - Annex B

**Confidentiality**

**DRAFT**

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## About this guidance

1. Being registered with the General Medical Council gives you rights and privileges. In return, you have a duty to meet the standards of competence, care and conduct set by the GMC.
2. *Good Medical Practice* makes clear that patients have a right to expect that information about them will be held in confidence by their doctors. This guidance sets out the principles of confidentiality and respect for patients' privacy that you are expected to understand and follow.
3. You must use your judgement to apply the principles in this guidance to the situations you face in your own practice. The purpose of this guidance is to help you identify the relevant legal and ethical considerations, and to help you make decisions that are in the best interests of your patients and that also benefit the wider community of patients and the public. If in doubt, you should seek the advice of experienced colleagues, Caldicott Guardian or equivalent, or your professional or regulatory body.
4. Supplementary guidance is available on our website explaining how these principles apply in situations doctors often encounter or find hard to deal with. We propose to review that supplementary guidance regularly to keep it up to date and relevant to the problems doctors face.
5. Serious or persistent failure to follow this guidance will put your registration at risk.

## Principles

6. Confidentiality is central to trust between doctors and patients. Without assurances about confidentiality, patients may be reluctant to seek medical attention or to give doctors the information they need in order to provide good care. But appropriate information sharing is essential to the efficient provision of safe, effective care, both for the individual patient and for the wider community of patients.
7. You should make sure that information is readily available to patients explaining that their personal information may be disclosed for the sake of their own care and for local clinical audit, unless they object. Patients usually understand that information about them has to be shared within the healthcare team to provide their care. But it is not always clear to patients that others who support the provision of care might also need to have access to their personal information. And patients may not be aware of disclosures to others for purposes other than their care, such as service planning or medical research. You must inform patients about disclosures for purposes they would not reasonably expect, or check that they have already received information about such disclosures.

8. Confidentiality is an important duty, but it is not absolute. You can disclose personal information where:
  - a. it is required by law (see paragraphs 17 to 23)
  - b. the patient consents – either implicitly for the sake of their own care (see paragraphs 25 to 31), or expressly for other purposes (see paragraphs 32 to 35),
  - c. it is justified in the public interest (see paragraphs 36 to 49).
9. When disclosing information about a patient, you must:
  - a. use anonymised or coded information if practicable and if it will serve the purpose
  - b. be satisfied that the patient:
    - i. has ready access to information that explains that their personal information might be disclosed for the sake of their own care, or for local clinical audit, and that they can object, and
    - ii. has not objected
  - c. get the patient's express consent if identifiable information is to be disclosed for purposes other than their care or local clinical audit, unless the disclosure is required by law or can be justified in the public interest
  - d. keep disclosures to the minimum necessary, and
  - e. keep up to date with and observe all relevant legal requirements including the common law and data protection legislation.<sup>1</sup>
10. When you are satisfied that information should be disclosed, you should act promptly to disclose all relevant information.
11. You should respect, and help patients to exercise, their legal rights to:
  - a. be informed about how their information will be used and
  - b. have access to, or copies of, their health records.<sup>2</sup>

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<sup>1</sup> Doctors working in a managed environment will do this largely by understanding and following corporate information governance and confidentiality policies.

<sup>2</sup> The *Data Protection Act 1998* provides for exceptions in some circumstances and allows charges to be made. You can find out more about this in guidance from the [Information Commissioner's Office](#) and the UK health departments.

## Protecting information

12. You must make sure that any personal information about patients that you hold or control is effectively protected at all times against improper disclosure. The UK health departments publish guidance on how long health records should be kept and how they should be disposed of, which you should follow whether or not you work in the NHS.<sup>3</sup>

13. Many improper disclosures are unintentional. You should not share identifiable information about patients where you can be overheard, for example in a public place or in an internet chat forum. You should not share passwords or leave patients' records, either on paper or on screen, unattended or where they can be seen by other patients, unauthorised healthcare staff, or the public.

14. Unless they have a relevant management role, doctors are not expected to assess the security standards of large-scale computer systems provided for their use in the NHS or other managed healthcare environment. You should familiarise yourself with and follow policies and procedures designed to protect patients' privacy where you work and when using computer systems provided for your use. This includes policies on the use of laptops and portable media storage devices. You must not abuse your access privileges and must limit your access to information you have a legitimate reason to view.

15. If you are responsible for the management of patient records or other patient information, you should make sure that they are held securely and that any staff you manage are trained and understand their responsibilities. You should make use of professional expertise when selecting and developing systems to record, access and send electronic data.<sup>4</sup> You should make sure that administrative information, such as names and addresses, can be accessed separately from clinical information so that sensitive information is not displayed automatically.

16. If you are concerned about the security of personal information in premises or systems provided for your use, you should follow the advice in *Good Medical Practice* on raising concerns about patient safety, including concerns about confidentiality and information governance.

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<sup>3</sup> The [NHS Code of Practice: Records Management](#) includes schedules of minimum retention periods for different types of records. You should also consider any legal requirement of specialty-specific guidance that affects the period for which you should retain records. You should not keep records for longer than necessary.

<sup>4</sup> You should follow the technical guidance of the [Information Commissioner's Office](#). The ISO 27001 Security Management Standard and the Code of Practice for Information Security Management in ISO 27002 give more detailed guidance, as does the Departmental technical guidance for NHS organisations. NHS Connecting for Health publishes an [Information Governance Toolkit](#) for NHS organisations. It aims to bring together, in a single framework, all the requirements, standards and best practice on handling personal information, allowing implementation of Department of Health (England) guidance and compliance with the law.

## Disclosures required by law

### *Disclosures required by statute*

17. You must disclose information to satisfy a specific statutory requirement, such as notification of a known or suspected case of certain infectious diseases.<sup>5</sup>
18. Various regulatory bodies have statutory powers to access patients' records as part of their duties to investigate complaints, accidents or health professionals' fitness to practise. You should satisfy yourself that any disclosure sought is required by law or can be justified in the public interest. Many regulatory bodies have codes of practice governing how they will access and use personal information.
19. Whenever practicable, you should inform patients about such disclosures, unless that would undermine the purpose, even if their consent is not required.
20. Patient records or other personal information may be required by the GMC or other statutory regulators for an investigation into a healthcare professionals' fitness to practise. If information is requested, but not required by law, or if you are referring concerns about a health professional to a regulatory body, you must seek the patient's express consent before disclosing personal information, wherever that is practicable. If a patient refuses to consent, or it is not practicable to seek their consent, you should contact the appropriate regulatory body, to help you decide whether the disclosure can be justified in the public interest.<sup>6</sup>

### *Disclosures to courts or in connection with litigation*

21. You must disclose information if ordered to do so by a judge or presiding officer of a court. You should object to the judge or the presiding officer if attempts are made to compel you to disclose what appears to you to be irrelevant information, such as information about a patient's relative who is not involved in the proceedings.
22. You must not disclose personal information to a third party such as a solicitor<sup>7</sup>, police officer or officer of a court without the patient's express consent, unless it is required by law or can be justified in the public interest.
23. In Scotland, the system of precognition means there can be limited disclosure of information in advance of a criminal trial, to both the Crown and Defence, without

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<sup>5</sup> Different diseases are notifiable in different UK countries and the reporting arrangements differ. You can get advice from the Health Protection Agency in England and Wales, Communicable Disease Surveillance Centre in Northern Ireland and Health Protection Scotland.

<sup>6</sup> See the legal annex for more information about the statutory powers of bodies regulating the provision of health care and healthcare professionals to require disclosure of information, the courts and about other legal duties to disclose.

<sup>7</sup> You may disclose information to your own legal adviser if that is necessary to prepare a defence, take legal action against another party or otherwise take their advice where the legal adviser is bound by legal professional privilege.

the patient's express consent. The disclosure must be confined solely to the nature of injuries, the patient's mental state, or pre-existing conditions or health, documented by the examining doctor, and their likely causes.

### **Disclosing information with consent**

24. Seeking a patient's consent to disclosure of information shows respect, and is part of good communication between doctors and patients.

#### *Circumstances in which patients may give implied consent to disclosure*

##### Sharing information within the healthcare team or with others providing care

25. Most people understand and accept that information must be shared within the healthcare team in order to provide their care. You should make sure information is readily available to patients explaining that, unless they object, personal information about them will be shared within the healthcare team, including administrative and other staff<sup>8</sup> who support the provision of care.

26. This information can be provided in leaflets, posters, on websites, and face-to-face and should be tailored to patients' identified needs as far as practicable. Posters might be of little assistance to patients with sight impairment or who do not read English, for example. In reviewing the information provided to patients, you should consider whether patients would be surprised to learn about how their information is being used and disclosed.

27. You must respect the wishes of any patient who objects to particular information being shared within the healthcare team or with others providing care, unless disclosure would be justified in the public interest. If a patient objects to a disclosure that you consider essential to the provision of safe care, you should explain that you cannot refer them or otherwise arrange for their treatment without also disclosing that information.

28. You must make sure that anyone you disclose personal information to understands that you are giving it to them in confidence, which they must respect. All staff members receiving personal information in order to provide or support care are bound by a legal duty of confidence, whether or not they have contractual or professional obligations to protect confidentiality.

29. Circumstances may arise in which a patient cannot be informed about the disclosure of information, for example in a medical emergency. In such a case you should pass relevant information promptly to those providing the patient's care. If and when the patient is capable of understanding, you should inform them how their

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<sup>8</sup> Others who might form part of the healthcare team, but with whom patients might not expect information to be shared, include prescribing advisers who review patients' medicines needs to improve safety, efficacy and efficiency in doctors' prescribing.

personal information was disclosed if it was in a way they would not reasonably expect.

#### Local clinical audit

30. All doctors in clinical practice have a duty to participate in clinical audit and to contribute to National Confidential Inquiries.<sup>9</sup> If an audit is to be undertaken by the team that provided care, or those working to support them, such as clinical audit staff, you may disclose identifiable information, provided you are satisfied that the patient:

- a. has ready access to information about how their personal information may be disclosed for local clinical audit and explaining that they have the right to object, and
- b. has not objected.

31. If a patient does object you should explain why the information is needed and how this may benefit their own, and others' care. If it is not possible to provide safe care without disclosing information for audit, you should explain this to the patient and the options open to them.

32. If clinical audit is to be undertaken, but not by the team that provided care or those who support them, the information should be anonymised or coded. If this is not practicable, or if identifiable information is essential to the audit, you should disclose the information only if you have the patient's express consent. (See the guidance on *Disclosures for secondary uses*, below.)

#### *Disclosures for which express consent should be sought*

33. As a general rule, you should seek a patient's express consent before disclosing identifiable information for purposes other than the provision of their care or local clinical audit, such as financial audit and insurance or benefits claims.<sup>10</sup>

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

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<sup>9</sup> See *Good Medical Practice* (2006), paragraphs 14 and 41.

<sup>10</sup> See the supplementary guidance on *Disclosing information for financial and administrative purposes* and *Disclosing information for insurance, employment and similar purposes*. Disclosures necessary to respond to matters raised on patients' behalf by Members of Parliament may be made without seeking patients' express consent; you should still check with the patient you think they would not reasonably expect the information to be disclosed. See the [Information Commissioner's advice](#) on the *Data Protection (Processing of Sensitive Personal Data) (Elected Representatives) Order 2002*.

- a. be satisfied that the patient has sufficient information about the scope, purpose and likely consequences of the examination and disclosure and the fact that relevant information cannot be concealed or withheld
- b. obtain or have seen written consent to the disclosure from the patient or a person properly authorised to act on the patient's behalf. You may accept an assurance from an officer of a government department or agency or a registered health professional acting on their behalf that the patient or a person properly authorised to act on their behalf has consented
- c. only disclose factual information you can substantiate, presented in an unbiased manner, relevant to the request; accordingly you should not usually disclose the whole record, although it may be relevant to some benefits paid by government departments and to other assessments of patients' entitlement to pensions or other health-related benefits
- d. offer to show your patient, or give them a copy of, any report you write about them for employment or insurance purposes before it is sent, whether or not this is required by law.<sup>11</sup>

35. If the patient refuses consent, or if it is not practicable to get their consent, information can still be disclosed if it is required by law or can be justified in the public interest (see below). If the purpose is covered by a regulation made under s251 of the *NHS Act 2006*, disclosures can also be made without patient's consent (but not if patients have objected).<sup>12</sup>

## **The public interest**

### *Disclosures in the public interest*

36. Personal information may be disclosed in the public interest, without patients' consent, and in exceptional cases where patients have withheld consent, where the benefits to an individual or to society of the disclosure outweigh both the public and the patient's interest in keeping the information confidential. You must weigh the harms that are likely to arise from non-disclosure of information against the possible

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<sup>11</sup> Reports prepared under the provisions of the *Regulation of Investigatory Powers Acts* are an important statutory exception to this duty. There may be other exceptional cases in which you would be able to justify not showing the patient your report, for example if it would be likely to undermine the purpose of a public interest disclosure. The *Access to Medical Reports Act 1988* and *Access to Personal Files and Medical Reports (Northern Ireland) Order 1991* entitle patients to see reports written about them for employment or insurance purposes by a doctor who is or has been responsible for their clinical care. The [Department for Work and Pensions](#) publishes further advice about reports for benefits purposes.

<sup>12</sup> Section 251 of the *NHS Act 2006* re-enacts section 60 of the *Health and Social Care Act 2001*. Approval under section 251 of the *NHS Act 2006* allows for disclosure despite the common law requirement to obtain consent, but would not usually authorise disclosure to which a patient had objected; disclosure might still be justified in the public interest. See also the guidance at paragraph 43, below, on the roles of the privacy advisory committees in Scotland and Northern Ireland.

harm both to the patient, and the overall trust between doctors and patients, arising from the release of that information.

37. Before considering whether a disclosure of personal information would be justified in the public interest, you must be satisfied that identifiable information is necessary for the purpose or that it is not reasonably practicable to anonymise or code it. In such cases, you should still seek the patient's consent unless it is not practicable to do so because, for example:

- a. the patient is not competent to give consent, in which case you should consult the patient's welfare attorney, court-appointed deputy, guardian or the patient's relatives, friends or carers (see paragraphs 50 to 56)
- b. you have reason to believe that seeking consent would put you or others at risk of serious harm
- c. seeking consent would be likely to undermine the purpose of the disclosure, for example by prejudicing the prevention or detection of serious crime, or
- d. action must be taken quickly, for example in the detection or control of outbreaks of some communicable diseases, and there is insufficient time to contact the patient.

38. You should inform the patient that a disclosure will be made in the public interest, even where you have not sought consent, unless to do so is impracticable, would put you or others at risk of serious harm or would prejudice the purpose of the disclosure. You must document in the patient's record your reasons for disclosing information without consent and any steps you have taken to seek their consent, to inform them about the disclosure, or your reasons for not doing so.

#### Research and other secondary uses

39. Research, epidemiology, public health surveillance, health service planning and education and training are among the important secondary uses made of patient information. Each of these uses can serve important public interests.<sup>13</sup>

40. For many secondary uses, it will be sufficient and practicable to disclose anonymised or coded information only. When identifiable information is needed, or it is not practicable to remove identifiable information, it will often be perfectly practicable to get patients' express consent.

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<sup>13</sup> See the supplementary guidance on *Disclosures for financial and administrative purposes*, such as QOF reviews. The Medical Research Council publishes a toolkit of practical advice on the legal and good practice requirements of using of personal information in research: see [www.dt-toolkit.ac.uk/home.cfm](http://www.dt-toolkit.ac.uk/home.cfm).

41. But you may disclose identifiable information without consent if it is required by law, approved under section 251 of the *NHS Act 2006* or if it can be justified in the public interest and it is either:

- a. necessary to use identifiable information or
- b. not practicable<sup>14</sup> to anonymise or code the information

and not practicable to seek consent (or efforts to seek consent have been unsuccessful).<sup>15</sup>

42. In considering whether it is practicable to seek consent you should take account of:

- a. the age of records and the likely traceability of patients
- b. the number of records
- c. the possibility of introducing bias because of a low response rate or because particular groups of patients refuse or do not respond to requests to use their information.

43. When considering whether the public interest in disclosures for secondary uses outweighs patients' and the public's interest in keeping the information confidential, you should consider:

- a. the nature of the information to be disclosed
- b. what use will be made of the information
- c. how many people will have access to the information
- d. the confidentiality and security arrangements in place to protect the information from further disclosure
- e. the advice of a Caldicott Guardian or similar expert adviser, who is not directly connected with the use for which disclosure is being considered
- f. the potential for distress or harm to the patient

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<sup>14</sup> You should consider whether the work needed to anonymise or code the information or to seek patients' consent is reasonably practicable in all the circumstances. Only if unreasonable effort is required should you go on to consider whether disclosure of identifiable information is justified in the public interest.

<sup>15</sup> If it is not practicable to anonymise or code the information or to seek or obtain patients' consent without unreasonable effort, and the likelihood of detriment to the patient is negligible, disclosure for an important secondary purpose may be proportionate.

44. When considering applications for support under section 251 of the *NHS Act 2006* in England and Wales, the National Information Governance Board considers:
- a. the feasibility of achieving these benefits with patients' consent or by using anonymised or coded information and
  - b. whether the use of identifiable information would benefit patients or the public sufficiently to outweigh patients' right to privacy.<sup>16</sup>
45. The Privacy Advisory Committee in Northern Ireland can advise on some of the same considerations; but it has no statutory powers and so cannot give lawful authority to disclosures of identifiable information without consent. In the event of a complaint or challenge, its advice on best practice might play an important part in any assessment of the propriety of a disclosure.
46. The Privacy Advisory Committee in Scotland performs a different role and doctors there should seek the advice of Caldicott Guardians, defence organisations or professional bodies if unsure about whether disclosures of identifiable information for secondary uses can be justified in the public interest.
47. It might not be practicable for the healthcare team or those who usually support them to anonymise or code information or to seek patients' express consent:
- a. for the disclosure of identifiable information for important secondary uses or
  - b. so that suitable patients might be recruited to clinical trials or other approved research projects.
48. If that is the case:
- a. identifiable information may be sent to a 'safe haven', which has the capabilities and is otherwise suitable to process the information (including its anonymisation or coding) and to manage the disclosure of information for secondary uses or, if that is not practicable<sup>17</sup>
  - b. these tasks can be delegated to someone incorporated into the healthcare team on a temporary basis and bound by legal and contractual obligations of confidentiality.

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<sup>16</sup> Disclosures covered by a regulation are not in breach of the common law duty of confidentiality.

<sup>17</sup> The NHS Information Centre is leading development of the structures and guidance (and seeking approval under section 251 of the *NHS Act 2006*) for safe havens in England. The Information Services Division manages identifiable information about patients for many secondary uses in Scotland.

49. You should only disclose identifiable information for research that is approved by a Research Ethics Committee. You should alert Research Ethics Committees to disclosures of identifiable information without consent when applying for approval for research projects.<sup>18</sup>

#### Disclosures to protect the patient or others

50. Disclosure of personal information without consent may be justified in the public interest if failure to disclose may expose the patient or others to a risk of death or serious harm. You should still seek the patient's consent to disclosure if practicable<sup>19</sup> and consider any reasons given for refusal.

51. Such a situation might arise, for example, when a disclosure would be likely to assist in the prevention, detection or prosecution of serious crime,<sup>20</sup> especially crimes against the person. When victims of violence refuse police assistance, disclosure may still be justified if others remain at risk, for example from someone who is prepared to use weapons, or from domestic violence, when children or others may be at risk.

52. It may be appropriate to encourage patients to consent to disclosures you consider necessary for their protection, and to warn them of the risks of refusing to consent; but you should usually abide by the wishes of a competent adult patient, even if their decision to refuse consent to disclosure leaves them at risk of harm.<sup>21</sup> You should do your best to provide patients with the information and support they

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<sup>18</sup> You might seek Research Ethics Committees' advice on the ethics of disclosing and using identifiable information for research purposes. They cannot authorise unconsented disclosure or determine if disclosure is justified in the public interest.

<sup>19</sup> See the examples given at paragraph 37 in which it might be impracticable to seek consent.

<sup>20</sup> There is no agreed definition of serious crime. *Confidentiality: NHS Code of Practice* (Department of Health (England), 2003) provides some examples of serious crime (including murder, manslaughter, rape and child abuse; while serious harm to the security of the state and public order and 'crimes that involve substantial financial gain or loss' are mentioned in the same category) and of crimes that are not usually serious enough to warrant disclosure without consent (including theft, fraud or damage to property where loss or damage is less substantial).

<sup>21</sup> The *Adult Support and Protection (Scotland) Act 2007* requires Health Boards in Scotland to report to local authorities if they know or believe that an adult is at risk of harm (but not necessarily incapacitated) and that action needs to be taken to protect that person. The Act also requires certain public bodies and office-holders to co-operate with local authorities making inquiries about adults at risk and includes powers to examine health records for related purposes.

Mental health legislation provides for confidential information to be disclosed to relevant tribunals, commissions and to patients' nearest relatives and (in England and Wales) Independent Mental Health Advocates in defined circumstances. Where the legislation provides for treatment to be provided or patients to be detained, confidential information may be disclosed to the extent necessary to provide or arrange that treatment or detention.

Another exception to the duty may arise if you owe the patient's employer a legal duty of care or where the organisation you work for has a duty of care and if failure to disclose could leave you or the organisation liable to legal action. You should still inform the patient of your intention to disclose.

need to make decisions in their own interests, for example by arranging contact with agencies to support victims of domestic violence.

53. If a patient's refusal to consent to disclosure leaves others exposed to a risk so serious that it outweighs the patient's and the public interest in maintaining confidentiality, or it is not practicable or safe to seek the patient's consent, you should disclose information promptly to an appropriate person or authority. You should inform the patient before disclosing the information, if practicable and safe, even if you intend to disclose without their consent.

54. You should participate in procedures set up to protect the public from violent and sex offenders. You should co-operate with requests for relevant information about patients who may pose a risk of serious harm to others.<sup>22</sup>

### **Disclosures about patients who lack capacity to consent**

55. There is advice on assessing patients' mental capacity in our guidance, *Consent: patients and doctors making decisions together* and in the *Adults with Incapacity (Scotland) Act 2000* and *Mental Capacity Act 2005* codes of practice. There is no specific mental capacity legislation for Northern Ireland.

56. For advice in relation to children and young people, see our guidance, *0-18 years: guidance for all doctors*.

57. When making decisions about whether to disclose information about a patient who lacks capacity, you must:

- a. make the care of the patient your first concern
- b. respect the patient's dignity and privacy
- c. support and encourage the patient to be involved, as far as they want and are able, in decisions about disclosure of their personal information.

58. You must also consider:

- a. whether the patient's lack of capacity is permanent or temporary and, if temporary, whether the decision to disclose could reasonably wait until they regain capacity
- b. any evidence of the patient's previously expressed preferences

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<sup>22</sup> You should consider the assessment of risk posed by patients made by other professionals and groups established for that purpose, but you must make your own assessment and decision as to whether disclosure is justified. Your assessment of risk is a matter of professional judgement in which an offender's past behaviour will be a factor. The Royal College of Psychiatrists publishes guidance for psychiatrists about sharing information in the context of public protection, including participation in Multi-Agency Public Protection Arrangements (MAPPA) and panels.

- c. the views of anyone the patient asks you to consult, or who has legal authority to make a decision on their behalf, or has been appointed to represent them
- d. the views of people close to the patient on the patient's preferences, feelings, beliefs and values, and whether they consider the proposed disclosure to be in the patient's best interests
- e. what you and the rest of the healthcare team know about the patient's wishes, feelings, beliefs and values.

59. If a patient who lacks capacity asks you not to disclose personal information about their condition or treatment, you should try to persuade them to allow an appropriate person to be involved in the consultation.<sup>23</sup> If they refuse, and you are convinced that it is essential in their best interests, you may disclose relevant information to an appropriate person or authority. In such a case you should tell the patient before disclosing the information and, if appropriate, seek and carefully consider the views of an advocate or carer. You should document in the patient's record your discussions and the reasons for deciding to disclose the information.

60. You may need to share personal information with a patient's relatives, friends or carers to enable you to assess the patient's best interests. But that does not mean they have a general right of access to the patients' records or to have irrelevant information about, for example, the patient's past healthcare. You should also share relevant personal information with anyone who is authorised to make decisions on behalf of, or who is appointed to support and represent, a mentally incapacitated patient.<sup>24</sup>

#### *Disclosures when a patient may be a victim of neglect or abuse*

61. If you believe a patient to be a victim of neglect or physical, sexual or emotional abuse and that they lack capacity to consent to disclosure, you must give information promptly to an appropriate responsible person or authority, if you believe that the disclosure is in the patient's best interests or necessary to protect others from a risk of serious harm. If, for any reason, you believe that disclosure of information is not in the best interests of a neglected or abused patient, you should discuss the issues with an experienced colleague. If you decide not to disclose information, you should document in the patient's record your discussions and the reasons for deciding not to disclose. You should be prepared to justify your decision.

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<sup>23</sup> In some cases disclosure will be required or necessary, for example under the provisions of mental health and mental capacity legislation.

<sup>24</sup> Such as a welfare attorney, a court appointed deputy or guardian or an Independent Mental Capacity Advocate. See *Adults with Incapacity (Scotland) Act 2000* and *Mental Capacity Act 2005* and their respective codes of practice. There is no specific mental capacity legislation for Northern Ireland, where the common law duty to act in incapacitated patients' best interests endures. Independent Mental Health Advocates should also be provided with the information specified at section 130B of the *Mental Health Act 1983*.

## **Sharing information with a patient's partner, carers, relatives or friends**

62. You should establish with your patient what information they want you to share, who with and in what circumstances. This will be particularly important if the patient has fluctuating or diminished capacity or is likely to lose capacity, even temporarily. Early discussions of this nature can help avoid disclosures that patients would object to, as well as misunderstandings with, or offence to, anyone the patient would want information to be shared with.

63. If a patient lacks capacity, you should share relevant information in accordance with the advice in paragraph 50 to 56. Unless they indicate otherwise, it is reasonable to assume that patients would want those closest to them to be kept informed of their general condition and prognosis.

64. If anyone close to the patient wants to discuss their concerns about the patient's health, you should make it clear to them that, while it is not a breach of confidentiality to listen to their concerns, you cannot guarantee that you will not tell the patient about the conversation. Patients have a legal right to have access to the information you hold about them. This means that you might need to share with them information you have received from others, for example if it has influenced your assessment and treatment of the patient. You should not refuse to listen to a patient's partner, carers or others on the basis of confidentiality. Their views or the information they provide might be helpful in your care of the patient. You will, though, need to consider whether your patient would consider your discussing their care with others to be a breach of trust, particularly if they have asked you not to speak to particular people.<sup>25</sup>

### **Genetic and other shared information**

65. Genetic and some other information about your patient might at the same time also be information about others the patient shares genetic or other links with. The diagnosis of an illness in the patient might, for example, point to the certainty or likelihood of the same illness in a blood relative.

66. Most patients will readily share information about their own health with their children and other relatives, particularly if they are advised that it might help those relatives to:

- a. get prophylaxis or other preventative treatments or interventions,
- b. make use of increased surveillance or other investigations

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<sup>25</sup> The Princess Royal Trust for Carers publishes information on good practice for primary care, mental health and hospital based professionals, highlighting carers' need for information to perform their roles.

- c. prepare for potential health problems.<sup>26</sup>

67. However, a patient might refuse to consent to the disclosure of information that would benefit others, for example where family relationships have broken down, or if their natural children have been adopted. In these circumstances, disclosure might still be justified in the public interest (see paragraphs 36 to 49). If a patient refuses consent to disclosure, you will need to balance your duty to make the care of your patient your first concern against your duty to help protect the other person from serious harm. You should not disclose the patient's identity if that is practicable in contacting and advising others of the risks they face.

### **Disclosure after a patient's death**

68. Your duty of confidentiality continues after a patient has died.<sup>27</sup> Whether and what personal information may be disclosed after a patient's death will depend on the circumstances. If the patient had asked for information to remain confidential, you should usually respect 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 the disclosure of information is likely to cause distress to, or be of benefit to, the patient's partner or family<sup>28</sup>
- 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 coded
- d. the purpose of the disclosure.

69. There are circumstances in which you should disclose relevant information about a patient who has died, for example:

- a. to help a Coroner, Procurator Fiscal or other similar officer with an inquest or fatal accident inquiry<sup>29</sup>

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<sup>26</sup> See *Consent and confidentiality in genetic practice: Guidance on genetic testing and sharing of genetic information – A report of the Joint Committee on Medical Genetics* (Royal College of Physicians, 2006) for more information.

<sup>27</sup> There is an obvious ethical obligation. There may also be a legal obligation: see *Lewis v Secretary of State for Health [2008] EWHC 2196*. Section 38 of the *Freedom of Information (Scotland) Act 2002* includes deceased person's medical records within the definition of personal information, which is exempt from the general entitlement to information.

<sup>28</sup> A surviving relative's or 'next of kin's' permission is not required for and does not authorise disclosure of confidential information, although the views of those who were close to the patient may help you decide if disclosure is appropriate.

- b. when disclosure is required by law, is authorised under section 251 of the *NHS Act 2006* or is justified in the public interest, such as for education or research
- c. to National Confidential Inquiries or for local clinical audit
- d. on death certificates, which you must complete honestly and fully
- e. for public health surveillance, in which case the information should be anonymised or coded, unless that would defeat the purpose
- f. when a parent asks for information about the circumstances and causes of a child's death
- g. when a partner, close relative or friend asks for information about the circumstances of an adult's death, and you have no reason to believe that the patient would have objected to such a disclosure
- h. when a person has a right of access to records under the *Access to Health Records Act 1990* or *Access to Health Records (Northern Ireland) Order 1993*.<sup>30</sup>

70. 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.<sup>31</sup>

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<sup>29</sup> See paragraph 69 of *Good Medical Practice* (2006).

<sup>30</sup> Namely, a deceased patient's personal representative and any person who may have a claim arising out of a patient's death. This is not a general right and disclosure may be limited or refused if there is evidence that the patient would have expected that the information would not be disclosed to the applicant or if disclosure would likely cause serious harm to anyone else or if it would also disclose information about a third party (other than a health professional involved in the deceased person's care) who does not consent.

<sup>31</sup> You should contact your organisation's approved place of deposit or The National Archives, the Public Record Office of Northern Ireland or the National Archives for Scotland for further advice about storage of and access to archives of records of ongoing research or historical value. Health records of deceased patients are exempt from the Freedom of Information (Scotland) Act 2002.

## **Glossary**

This defines the terms used within this document. These definitions have no wider or legal significance.

### **Information**

**Personal information** Information about people which doctors learn in a professional capacity and from which individuals can be identified.

**Identifiable information** Information from which a patient can be identified. Name, address and full postcode will identify patients; combinations of information may also do so, even where name and address are not included. Information consisting of small numbers and rare conditions might reasonably lead to the identification of individuals.

**Anonymised information** Information from which individuals cannot reasonably be identified. Names, addresses, full post codes or identification numbers, alone or together or in conjunction with any other information held by or available to the recipient, can be used to identify patients.

**Coded information** Also known as pseudonymised information. Information from which individuals cannot be identified by the recipient of the information, but which enables information about different patients to be distinguished or to link information about the same patients over time (e.g. to identify drug side effects). A 'key' might be retained by the person or service which coded the information to enable the re-association of the information with the patient. (See *anonymised information*, above.)

### **Consent**

**Consent** Agreement to an action based on knowledge of what the action involves and its likely consequences.

**Express consent** Consent which is expressed orally or in writing. Also known as explicit consent.

**Implied consent** Agreement to disclosure where patients have been informed about the information to be disclosed, the purpose of the disclosure, and that they have a right to object to the disclosure, but have not done so.

## Other terms

<b>Clinical Audit</b>	Evaluation of clinical performance against standards or through comparative analysis, to inform the management of services. Studies that aim to derive, scientifically confirm and publish generalisable knowledge constitute research and are not encompassed within the definition of clinical audit in this document.
<b>Disclosure</b>	The provision or passing of information about a patient to anyone other than the patient, regardless of the purpose. Sharing information within healthcare teams is a form of disclosure, as is the provision of personal information about a patient to the police.
<b>Healthcare team</b>	The healthcare team comprises the people providing clinical services for each patient and the administrative and other staff who support the provision of care. See paragraph 25 and footnote 8 for more examples of who might form part of the healthcare team.
<b>Public interest:</b>	The interests of the community as a whole, or a group within the community or individuals. Paragraph 36 provides an explanation of the balancing exercise required to decide if disclosure might be justified the public interest.

## Legal annex

1. Various bodies regulating healthcare providers and professionals have statutory powers to require the disclosure of information, including personal information about patients. The following represents only a selection of these bodies, a summary of their most relevant powers and reference to codes they publish about how they use their powers.

2. There is a large number of other Acts that provide for some form of access to information, which may include personal information about patients, for purposes as diverse as the prevention of terrorism and the investigation of road or rail accidents.

3. If you are unsure about the legal basis for a request for information, you should ask for clarification from the person making the request and, if necessary, seek independent legal advice.

### *Regulation of healthcare providers and professionals*

4. The [Care Quality Commission](#) has powers of inspection, entry and to require documents and information under the *Health and Social Care Act 2008*. Sections 76 to 79 govern the Commission's use and disclosure of confidential personal information. Section 80 requires it to consult on and publish a code of practice on how it obtains, handles, uses and discloses confidential personal information

5. [Healthcare Inspectorate Wales](#) has powers under the *Health and Social Care (Community Health and Standards) Act 2003* to access patients' personal information.

6. The [Scottish Care Commission](#) has similar powers in relation to registered independent healthcare providers under section 25 of the *Regulation of Care (Scotland) Act 2001*.

7. The [Regulation and Quality Improvement Authority](#) has powers under sections 41 and 42 of the *Health and Personal Social Services (Quality, Improvement and Regulation) Northern Ireland) Order 2003* to enter establishments and agencies and Health and Social Services bodies or providers' premises and inspect and take copies of records, subject to the protection of confidential information provided for in section 43.

8. The [NHS Counter Fraud Service](#) has powers under the *NHS Act 2006* and *NHS (Wales) Act 2006* to require the production of documents to prevent, detect and prosecute fraud in the NHS. The Department of Health (England) and Welsh Assembly Government have published codes of practice for the use of these powers.

9. Section 35A of the Medical Act 1983 gives the GMC power to require disclosure of information and documentation relevant to the discharge of our fitness to practise functions, provided such disclosure is not prohibited by other legislation.

10. The [Parliamentary and Health Service Ombudsman, Northern Ireland Ombudsman](#), [Public Service Ombudsman for Wales](#) and the [Scottish Public Services Ombudsman](#) have statutory powers similar to the High Court or Court of Session to require the production of documents and the attendance and examination of witnesses for the purposes of investigations about the health bodies that fall within their remits.

#### *Court orders*

11. The courts, both civil and criminal, have powers to order disclosure of information in various circumstances. The basis on which disclosure is being ordered should be explained to you; and the patient whose personal information is sought should be invited to make representations, unless that is impracticable or would undermine the purpose for which disclosure is sought.

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## Guidance supplementary to *Confidentiality*

### Reporting concerns about patients to the Driver Vehicle and Licensing Agency (DVLA) / Driver and Vehicle Agency (Northern Ireland) (DVA)

1. In our *Confidentiality* guidance, we advise that:
  36. Personal information may be disclosed in the public interest, without patients' consent, and in exceptional cases where patients have withheld consent, where the benefits to an individual or to society of the disclosure outweigh both the public and the patient's interest in keeping the information confidential. You must weigh the harms that are likely to arise from non-disclosure of information against the possible harm both to the patient, and the overall trust between doctors and patients arising from the release of that information.
2. The DVLA and DVA are legally responsible for deciding if a person is medically unfit to drive. This means they need to know if a driving licence holder has a condition or is undergoing treatment that may now, or in the future, affect their safety as a driver.
3. You should seek the advice of an experienced colleague or the DVLA/DVA's medical adviser if you are not sure whether a patient may be unfit to drive. You should keep any decision that they are fit under review, particularly as the patient's condition or treatments change. The DVLA's publication [\*For Medical Practitioners - At a glance Guide to the current Medical Standards of Fitness to Drive\*](#) includes information about a variety of disorders and conditions that can impair patients' fitness to drive.
4. The driver is legally responsible for informing the DVLA/DVA about such a condition or treatment. However, if your patient has such a condition, you should explain to the patient that:
  - a. the condition may affect their ability to drive - if the patient is incapable of understanding this advice, for example because of dementia, you should inform the DVLA immediately
  - b. they have a legal duty to inform the DVLA about the condition.
5. If a patient refuses to accept the diagnosis, or the effect of the condition on their ability to drive, you can suggest that they seek a second opinion, and help arrange for them to do so. You should advise the patient not to drive in the meantime.

6. If a patient continues to drive when they may not be fit to do so, you should make every reasonable effort to persuade them to stop. As long as the patient agrees, you may discuss your concerns with their relatives, friends or carers.

7. If you do not manage to persuade the patient to stop driving, or you discover that they are continuing to drive against your advice, you should contact the DVLA/DVA immediately and disclose any relevant medical information, in confidence, to the medical adviser.

8. Before contacting the DVLA you should try to inform the patient of your decision to disclose personal information. You should then also inform the patient in writing that you have done so.

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## Guidance supplementary to *Confidentiality*

### Disclosing records for financial and administrative purposes

1. In our *Confidentiality* guidance, we advise that:
  32. As a general rule, you should seek a patient's express consent before disclosing identifiable information for purposes other than the provision of their care or local clinical audit, such as financial audit and insurance or benefits claims.
  40. For many secondary uses, it will be sufficient and practicable to disclose anonymised or coded information only. When identifiable information is needed, or it is not practicable to remove identifiable information, it will often be perfectly practicable to get patients' express consent.
  41. But you may disclose identifiable information without consent if it is required by law, approved under section 251 of the *NHS Act 2006* or if it can be justified in the public interest and it is either:
    - a. necessary to use identifiable information or
    - b. not practicable<sup>1</sup> to anonymise or code the informationand not practicable to seek consent (or efforts to seek consent have been unsuccessful).<sup>2</sup>
2. If you are responsible for the management of patient records or other patient information, you should make sure that financial and administrative information is recorded separately from clinical information.
3. If you are asked to disclose information about patients for financial or administrative purposes you should, if practicable, provide it in anonymised or coded form, if that will serve the purpose. If identifiable information is needed, you should, if practicable, seek the patient's express consent before disclosing it.

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<sup>1</sup> You should consider whether the work needed to anonymise or code the information or to seek patients' consent is reasonably practicable in all the circumstances. Only if unreasonable effort is required should you go on to consider whether disclosure of identifiable information is justified in the public interest.

<sup>2</sup> If it is not practicable to anonymise or code the information or to seek or obtain patients' consent without unreasonable effort, and the likelihood of detriment to the patient is negligible, disclosure for an important secondary purpose may be proportionate.

4. You must draw attention to any system that prevents you from following best practice, and recommend change. Until changes are made, you should make sure that information is readily available to patients explaining that their personal information may be disclosed for financial, administrative and similar purposes, and about what to do if they object. If a patient asks, you should explain the nature and purpose of disclosures. You should do your best to act on any objections. If you are satisfied that it is not possible to comply with the patient's wishes, and still provide care, you should explain this to the patient and explain their options.
5. You should satisfy yourself that anyone who will have access to the information is bound by a duty of confidentiality not to disclose it further.
6. Disclosure may be required by law in some cases, for example in the investigation of fraud by the NHS Counter Fraud Service, or approved under s.251 of the *NHS Act 2006*.<sup>3</sup>
7. For more information on commissioners' access to personal information held by general practices for purposes such as Quality and Outcomes Framework reviews, see the relevant *Confidentiality and Disclosure of Information Directions* and *Code of Practice*.<sup>4</sup>

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<sup>3</sup> See paragraphs 17 to 20 (*Disclosures required by law*) and 39 to 49 (*Research and other secondary uses*) of the main *Confidentiality* guidance for further advice.

<sup>4</sup> *Confidentiality and Disclosure of Information: General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS) Directions 2005* and *Code of Practice* (Department of Health (England), 2005)

*Confidentiality and Disclosure of Information: General Medical Services (GMS), Section 17c Agreements, and Health Board Primary Medical Services (HBPMS) Directions 2005* and *Code of Practice* (Scottish Executive Health Department, 2005)

*Confidentiality and Disclosure of Information: General Medical Services and Alternative Provider Medical Services Directions 2006* and *Code of Practice* (Welsh Assembly Government, 2005)

*Confidentiality and Disclosure of Information: General Medical Services and Alternative Provider Medical Services Directions (Northern Ireland) 2006* and *Code of Practice* (Department of Health, Social Services and Public Safety, 2006)

## Guidance supplementary to *Confidentiality*

### Reporting gunshot and knife wounds

1. In our *Confidentiality* guidance, we advise that:
  6. Confidentiality is central to trust between doctors and patients. Without assurances about confidentiality, patients may be reluctant to seek medical attention or to give doctors the information they need in order to provide good care. But appropriate information sharing is essential to the efficient provision of safe, effective care, both for the individual patient and for the wider community of patients.
  50. Disclosure of personal information without consent may be justified in the public interest if failure to disclose may expose the patient or others to a risk of death or serious harm. You should still seek the patient's consent to disclosure if practicable and consider any reasons given for refusal.
  51. Such a situation might arise, for example, when a disclosure would be likely to assist in the prevention, detection or prosecution of serious crime, especially crimes against the person. When victims of violence refuse police assistance, disclosure may still be justified if others remain at risk, for example from someone who is prepared to use weapons, or from domestic violence, when children or others may be at risk.
  53. If a patient's refusal to consent to disclosure leaves others exposed to a risk so serious that it outweighs the patient's and the public interest in maintaining confidentiality, or it is not practicable or safe to seek the patient's consent, you should disclose information promptly to an appropriate person or authority. You should inform the patient before disclosing the information, if practicable and safe, even if you intend to disclose without their consent.
2. The guidance in *Confidentiality* applies to all violent crime, but gunshot and knife wounds raise issues that warrant special consideration. That is not to suggest that information should not be disclosed to assist in the prevention, detection or prosecution of other serious crime.
3. This guidance describes a two-stage process:
  - a. You should inform the police quickly whenever a person arrives with a gunshot wound or an injury from an attack with a knife, blade or other sharp instrument. This will enable the police to make an assessment of risk to the patient and others and to gather statistical information about gun and knife crime in the area.

- b. You should make a professional judgement about whether disclosure of personal information about the patient (including their identify) is justified in the public interest.

#### *Reporting gunshot and knife wounds*

4. The police are responsible for assessing the risk posed by a member of the public who is armed with and has used a gun or knife in a violent attack. They need to consider:
  - a. the risk of a further attack on the patient
  - b. the risk to staff, patients and visitors in the A&E department or hospital
  - c. the risk of another attack near to, or at, the site of the original incident.
5. For this reason, the police should be informed whenever a person arrives at hospital with a gunshot wound. Even accidental shootings involving lawfully held guns raise serious issues for the police about, for example, gun licensing.
6. The police should also be informed when a person arrives at a hospital with a wound from an attack with a knife, blade or other sharp instrument.
7. The police should not usually be informed if a knife or blade injury is accidental, or a result of self-harm. If you are in doubt about the cause of the injury, you should if possible consult an experienced colleague.
8. Quick reporting at this stage may help prevent further incidents or harm to others. If you have responsibility for the patient, you should make sure that the police are contacted, but you can delegate this task to another member of staff.
9. Identifying details, such as the patient's name and address, should not usually be disclosed in the initial contact with the police. The police will respond even if the patient's identify is not disclosed. The police need to be informed quickly in order to respond to the risk to patients, staff and the public. They also need statistical information about the number of gunshot and knife injuries and when and where they occur to inform their own and their crime reduction partners' operational and strategic priorities.

#### *Make the care of your patient your first concern*

10. When the police arrive, you should not allow them access to the patient if this will delay or hamper treatment or compromise the patient's recovery.

11. If the patient's treatment and condition allow them to speak to the police, you or another member of the healthcare team should ask the patient whether they are willing to do so. If they are not, you should explain what the consequences, if any, might be. You, the rest of the health care team and the police must abide by the patient's decision.

#### *Disclosing personal information without consent*

12. If it is probable that a crime has been committed, the police will ask for more information. If the patient cannot give consent because, for example they are unconscious, or refuses to disclose information or to allow you or your colleagues to do so, you can still disclose information if it is required by law or you believe it is justified in the public interest.

13. Disclosures in the public interest may be justified when:

- a. failure to disclose information may put the patient, or someone else, at risk of death or serious harm, or
- b. disclosure is likely to help in the prevention, detection or prosecution of a serious crime.

14. If there is any doubt about whether disclosure without consent is justified, the decision should be made by, or with the agreement of, the consultant in charge, or the trust's Caldicott Guardian.

15. If practicable, you should seek the patient's consent to the disclosure or tell them that a disclosure has been made unless, for example, that:

- a. may put you or others at risk of serious harm, or
- b. would be likely to undermine the purpose of the disclosure, by prejudicing the prevention, detection or prosecution of a crime.

16. You must document in the patient's record your reasons for disclosing information without consent and any steps you have taken to seek their consent, to inform them about the disclosure, or your reasons for not doing so.

17. If there is no immediate public interest reason for disclosing personal information, no further information should be given to the police. The police may seek an order from a judge for the disclosure of confidential documents, under the *Police and Criminal Evidence Act 1984* (Schedule 1). They can also use powers in section 19 of this Act to seize evidence, such as clothing that may help in detecting or prosecuting a crime.

18. You should tell those responsible for the continuing care of the patient that further discussion with the patient is needed to ensure, for example, that they are fit to hold a firearms licence.

### *Children and young people*

19. Any child or young person (under 18) reporting with a gunshot wound or a wound from an attack with a knife, blade or other sharp instrument will raise obvious child protection concerns. You must inform an appropriate person or authority promptly of any such incident.

20. Knife or blade injuries from domestic or occupational accidents might also raise serious concerns about the safety of children and young people. You should consider the advice on child protection in *0-18 years: guidance for all doctors* whenever you are concerned that a child may be the victim of abuse or neglect.

21. You must be able to justify a decision not to share a concern that children or young people are at risk of abuse, neglect or other serious harm, having taken advice from a named or designated doctor for child protection or an experienced colleague, or a defence or professional body.

22. See [0-18 years: guidance for all doctors](#) for more information and advice about doctors' roles and responsibilities towards children and young people.

## Guidance supplementary to *Confidentiality*

### Disclosing information about serious communicable diseases<sup>1</sup>

1. In our *Confidentiality* guidance, we advise that:
  6. Confidentiality is central to trust between doctors and patients. Without assurances about confidentiality, patients may be reluctant to seek medical attention or to give doctors the information they need in order to provide good care. But appropriate information sharing is essential to the efficient provision of safe, effective care, both for the individual patient and for the wider community of patients.
  17. You must disclose information to satisfy a specific statutory requirement, such as notification of a known or suspected case of certain infectious diseases.
  36. Personal information may be disclosed in the public interest, without patients' consent, and in exceptional cases where patients have withheld consent, where the benefits to an individual or to society of the disclosure outweigh both the public and the patient's interest in keeping the information confidential. You must weigh the harms that are likely to arise from non-disclosure of information against the possible harm both to the patient, and the overall trust between doctors and patients arising from the release of that information.
  50. Disclosure of personal information without consent may be justified in the public interest if failure to disclose may expose the patient or others to a risk of death or serious harm. You should still seek the patient's consent to disclosure if practicable and consider any reasons given for refusal.
2. Confidentiality is important to all patients. Those who have or may have a serious communicable disease might be particularly concerned about their privacy. You should make sure that information you hold or control about a patient's infection status is at all times effectively protected against improper disclosure. All patients are entitled to good standards of care, regardless of their status, what disease they might have, or how they acquired it.

#### *Healthcare workers who have, or may have, a serious communicable disease*

3. [Good Medical Practice](#) states that:

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<sup>1</sup> In this guidance the term 'serious communicable disease' applies to any disease that can be transmitted from human to human and that can result in death or serious illness. It particularly applies to, but is not limited to, HIV, tuberculosis, and hepatitis B and C.

78. You should protect your patients, your colleagues and yourself by being immunised against common serious communicable diseases where vaccines are available.

79. If you know that you have, or think that you might have, a serious condition that you could pass on to patients, or if your judgement or performance could be affected by a condition or its treatment, you must consult a suitably qualified colleague. You must ask for and follow their advice about investigations, treatment and changes to your practice that they consider necessary. You must not rely on your own assessment of the risk you pose to patients.

4. You should raise any reasonable concern you have about any healthcare worker who has a serious communicable disease and practises, or has practised, in a way that places patients at risk of infection.<sup>2</sup>

5. You should inform the healthcare worker's employing or contracting body of your concerns, preferably through its occupational health service or, where appropriate, their regulatory body. You should inform the healthcare worker before passing the information on as long as it is practicable and safe to do so.

6. For more advice on colleagues who might pose a risk to patients, see our guidance on [Raising concerns about patient safety](#).

#### *Patients who are diagnosed with a serious communicable disease*

7. You should make sure information is readily available to patients explaining that personal information about them will be shared within the healthcare team, including administrative and other staff who support the provision of care, unless they object, and why this is necessary.

8. If a patient refuses to allow you to inform someone outside the healthcare team of their infection status, you must respect their wishes unless you consider that failure to disclose the information will put the healthcare worker or other patients at risk of infection. But such situations are likely to be very rare, not least because of the use of universal precautions to protect healthcare workers and patients, particularly during exposure prone procedures, and because of the prevalence of undiagnosed infection in the community.

9. You should explain to patients how they can protect others from infection, including the practical measures that may be taken to avoid transmission and the

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<sup>2</sup> See [HIV-infected health care workers: Guidance on management and patient notification](#) (Department of Health 2005) and *Health Clearance for Tuberculosis, Hepatitis B, Hepatitis C and HIV for new Healthcare Workers with direct clinical contact with patients* (Scottish Government, 2008), which include examples of the UK Advisory Panel for Health Care Workers Infected with Blood-borne Viruses' advice on exposure prone practices.

importance of informing sexual contacts about the risk of transmission of sexually transmitted serious communicable diseases.

#### *Informing sexual contacts of patients with a serious communicable disease*

10. You may disclose information to a known sexual contact of a patient with a sexually transmitted serious communicable disease if you have reason to think that they are at risk of infection and that the patient has not informed them and cannot be persuaded to do so.<sup>3</sup> In such circumstances you should tell the patient before you make the disclosure, whenever it is practicable and safe to do so. You must be prepared to justify a decision to disclose personal information without consent.

11. Contact tracing and partner notification should be undertaken without disclosing the identity of the patient, whenever practicable.

#### *Children and young people*

12. Your patient must be your first concern; but you should consider and act in the best interests of your patients' children.

13. Most parents with a serious communicable disease will do all they can to protect their children from the risk of infection or the effects of disease. You should make sure that your patients understand the information and advice you provide, which should be tailored to their needs. You should do all you reasonably can to support them in caring for themselves and in protecting their children.

14. You should explain to patients with a serious communicable disease the importance of testing any children who may already be infected, including asymptomatic children and adolescents who might have been vertically infected with a blood-borne virus.

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<sup>3</sup> The *NHS (Venereal Diseases) Regulations 1974* and *NHS VD Regulations 1991 / Trusts and Primary Care Trusts (Sexually Transmitted Diseases) Directions 2000* state that information about patients examined or treated for a sexually transmitted disease shall not be disclosed except: '(a) for the purpose of communicating that information to a medical practitioner, or to a person employed under the direction of a medical practitioner in connection with the treatment of persons suffering from such disease or the prevention of the spread thereof, and (b) for the purpose of such treatment and prevention.' There are different interpretations of the Regulations and Directions, and concerns about their compatibility with the European Convention on Human Rights (see *Health Protection Agency & Ors v X & Ors [2005] EWHC 2989 (Fam)*). In particular there have been concerns that a strict interpretation would not permit the disclosure of relevant information other than to other doctors or those working under their supervision, either with patients' consent or to known sexual contacts in the public interest. Our view is that the Regulations and Directions do not preclude disclosure where it would otherwise be lawful at common law, for example with patients' consent or in the public interest without consent.

15. If you are concerned that a child is at risk of serious harm because their parents cannot be persuaded to protect them from the risk of infection or because they refuse to allow for the child to be tested, you should seek legal advice about whether to apply to court for a determination on the child's best interests.

16. See *0-18 years: guidance for all doctors* for more information about confidentiality and consent in respect of children and young people and about child protection, which is a responsibility of all doctors.

#### *Injuries to healthcare workers and others*

17. You should make sure that a risk assessment is made urgently by an appropriately qualified colleague if a healthcare worker, police officer or anyone else suffers a needlestick or similar injury involving a patient who has, or may have, a serious communicable disease. Post-exposure prophylaxis should be offered in accordance with that risk assessment, which should include consideration of the type of body fluid or substance involved, and the route and severity of the exposure.<sup>4</sup>

18. You should ask for the patient's consent to disclose their infection status after exposure to a serious communicable disease. If the patient cannot be persuaded to consent to disclosure, or if it is not safe or practicable to ask for their consent, you may disclose information in the public interest. This could be, for example, if the information is needed for decisions about the continued appropriateness of post-exposure prophylaxis.

#### *Recording serious communicable diseases on death certificates*

19. If a serious communicable disease has contributed to the cause of death, you must record this on the death certificate.

#### *Serious communicable disease control and surveillance*

20. You should pass information about serious communicable diseases to the relevant authorities for the purpose of communicable disease control and surveillance. You should use anonymised or coded information whenever practicable and as long as it will serve the purpose.

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<sup>4</sup> [Guidance for clinical health care workers: protection against infection with blood-borne viruses – Expert Advisory Group on AIDS and the Advisory Group on Hepatitis](#) (Department of Health, 1998); [HIV post-exposure prophylaxis: guidance from the UK Chief Medical Officers' Expert Advisory Group on AIDS](#) (Department of Health, 2008).

## Guidance supplementary to Confidentiality

### Disclosing information for insurance, employment and similar purposes

1. In our *Confidentiality* guidance, we advise that:
  7. ... You must inform patients about disclosures for purposes they would not reasonably expect, or check that they have already received information about such disclosures.
  33. As a general rule, you should seek a patient's express consent before disclosing identifiable information for purposes other than the provision of their care or local clinical audit, such as financial audit and insurance or benefits claims.
  34. If you are asked to provide information to third parties, such as a patient's insurer or employer or a government department or an agency assessing a claimant's entitlement to benefits, either following an examination or from existing records, you should:
    - a. be satisfied that the patient has sufficient information about the scope, purpose and likely consequences of the examination and disclosure and the fact that relevant information cannot be concealed or withheld
    - b. obtain or have seen written consent to the disclosure from the patient or a person properly authorised to act on the patient's behalf. You may accept an assurance from an officer of a government department or agency or a registered health professional acting on their behalf that the patient or a person properly authorised to act on their behalf has consented
    - c. only disclose factual information you can substantiate, presented in an unbiased manner, relevant to the request; accordingly you should not usually disclose the whole record, although it may be relevant to some benefits paid by government departments and to other assessments of patients' entitlement to pensions or other health-related benefits
    - d. offer to show your patient, or give them a copy of, any report you write about them for employment or insurance purposes before it is sent, whether or not this is required by law.
  35. If the patient refuses consent, or if it is not practicable to get their consent, information can still be disclosed if it is required by law or can be justified in the public interest (see below). If the purpose is covered by a

regulation made under s251 of the *NHS Act 2006*, disclosures can also be made without patient's consent (but not if patients have objected).

2. The first duty of a doctor registered with the GMC is to make the care of their patient their first concern. The term 'patient' in this guidance also refers to employees, clients, athletes and anyone else whose personal information you hold or have access to, whether or not you care for them in a traditional therapeutic relationship.

3. There are many circumstances in which a doctor might be asked to disclose information, either following an examination of a patient or from existing records, and in which they face 'dual obligations'. Most obviously, dual obligations can arise when a doctor works for, is contracted by, or otherwise provides services to:

- a. a patient's employer (as an occupational health physician)
- b. an insurance company
- c. an agency assessing a claimant's entitlement to benefits
- d. the police (as a police surgeon)
- e. the armed forces
- f. the prison service
- g. a sports team or association.<sup>1</sup>

4. Alternatively, a person or organisation you have previously had no direct relationship with, such as your patient's employer or insurance company, might ask you to provide a medical report or information about your patient. You might be offered payment for your own or your staff's time and effort, giving rise to an obligation in addition to the one you have to your patient.

#### *Extent of the disclosure*

5. You should disclose only information relevant to the request for disclosure, which means you should not usually disclose a patient's whole record. Exceptions to this general rule include benefit claims and litigation:

- a. the whole record may be relevant to some benefits paid by government departments or agencies
- b. a solicitor may need to see their clients' whole record to assess which parts are relevant, for example, to personal injury claims. If the claim goes ahead, the person the claim is made against may ask for copies of important

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<sup>1</sup> Doctors might provide their services to professional sports clubs (where the dual obligation to a professional football club, for example, will be very similar to that of other occupational health doctors) or associations (where the dual obligation might lie with a governing body or team of selectors).

documents, which could include records containing the patient's medical history. Under court rules, they can see all the patient's health records. The patient's solicitor should explain these issues to them.<sup>2</sup>

### *Writing reports*

6. When writing a report you must:
  - a. do your best to make sure that it is not false or misleading – you must take reasonable steps to verify the information in the report and must not deliberately leave out any relevant information
  - b. complete and send it without unreasonable delay<sup>3</sup>
  - c. restrict your reports to areas in which you have direct experience or relevant knowledge
  - d. make sure that any opinion you include is balanced, and be able to state the facts or assumptions on which it is based.<sup>4</sup>

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<sup>2</sup> The Law Society and [British Medical Association](#) jointly publish a model consent form authorising the release of health records to solicitors under the *Data Protection Act 1998*. The form includes notes for clients, solicitors and health professionals.

<sup>3</sup> See [Good Medical Practice](#), paragraphs 63-69.

<sup>4</sup> See [Acting as an expert witness](#).

## Guidance supplementary to *Confidentiality*

### Disclosing information for education and training purposes

1. In our *Confidentiality* guidance, we advise that:

36. Personal information may be disclosed in the public interest, without patients' consent, and in exceptional cases where patients have withheld consent, where the benefits to an individual or to society of the disclosure outweigh both the public and the patient's interest in keeping the information confidential. You must weigh the harms that are likely to arise from non-disclosure of information against the possible harm both to the patient, and the overall trust between doctors and patients arising from the release of that information.

37. Before considering whether a disclosure of personal information would be justified in the public interest, you must be satisfied that identifiable information is necessary for the purpose or that it is not reasonably practicable to anonymise or code it. In such cases, you should still seek the patient's consent unless it is not practicable to do so ...

39. Research, epidemiology, public health surveillance, health service planning and education and training are among the important secondary uses made of patient information. Each of these uses can serve important public interests.

40. For many secondary uses, it will be sufficient and practicable to disclose anonymised or coded information only. When identifiable information is needed, or it is not practicable to remove identifiable information, it will often be perfectly practicable to get patients' express consent.

41. But you may disclose identifiable information without consent if it is required by law, approved under section 251 of the *NHS Act 2006* or if it can be justified in the public interest and it is either:

- a. necessary to use identifiable information or
- b. not practicable<sup>1</sup> to anonymise or code the information

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<sup>1</sup> You should consider whether the work needed to anonymise or code the information or to seek patients' consent is reasonably practicable in all the circumstances. Only if unreasonable effort is required should you go on to consider whether disclosure of identifiable information is justified in the public interest.

and not practicable to seek consent (or efforts to seek consent have been unsuccessful).<sup>2</sup>

43. When considering whether the public interest in disclosures for secondary uses outweighs patients' and the public's interest in keeping the information confidential, you should consider:

- a. the nature of the information to be disclosed
- b. what use will be made of the information
- c. how many people will have access to the information
- d. the confidentiality and security arrangements in place to protect the information from further disclosure
- e. the advice of a Caldicott Guardian or similar expert adviser, who is not directly connected with the use for which disclosure is being considered
- f. the potential for distress or harm to the patient

2. The use of information about patients is essential to the education and training of medical and other healthcare students and trainees. For most of these uses, anonymised information will be sufficient and should be used wherever practicable.

3. When it is necessary to use identifiable information about patients, or it is impracticable to anonymise information, you should seek patients' consent before disclosing it. You should make sure that patients are under no pressure to consent. In particular, you should avoid any impression that their care depends on giving consent.

#### Publishing case studies

4. It may be difficult to anonymise case studies about patients while retaining enough detail to make publication useful. Simply changing a patient's name will often not anonymise the information if other identifying details are included, such as age, sex, location or a detailed account of the patient's illness and treatment.

5. If you cannot anonymise the information, you should seek the patient's consent before disclosing it. When seeking the patient's consent, you must provide them with enough information about the nature and purpose of the disclosure to enable them to make an informed decision. This should include a description of the

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<sup>2</sup> If it is not practicable to anonymise or code the information or to seek or obtain patients' consent without unreasonable effort, and the likelihood of detriment to the patient is negligible, disclosure for an important secondary purpose may be proportionate.

information to be disclosed and an indication of how it will be used, for example whether it will be published in a journal or shown at a medical conference. You must then disclose that information only for the purposes for which the patient has given consent.

6. If for any reason you cannot get a patient's consent, for example because the information you want to disclose is so old that efforts to trace the patient have been or are likely to be unsuccessful, you will need to consider whether publication can be justified in the public interest.

7. You should respect a patient's refusal to consent to publication of their identifiable information.

#### Teaching and training

8. Most patients understand and accept that the education and training of medical and other healthcare students and trainees relies on their having access to information about patients.

9. If trainees<sup>3</sup> are part of the healthcare team providing or supporting a patient's care, they can have access to the patient's personal information like other team members, unless the patient objects.

10. If students need access to a patient's personal information, but are not providing or supporting the patient's care, anonymised information should be used whenever possible. That may not be practicable when they are directly involved in the provision of care (on ward rounds, for example), but it will then usually be practicable to seek the patient's express consent to disclosure.<sup>4</sup>

11. It might be both necessary to disclose personal information, or impracticable to anonymise it, and impracticable to seek patients' express consent to disclosure. In such cases, you may disclose personal information so far as it is necessary for the education of medical and other healthcare students if information has been made readily available to patients about such disclosures and of their right to object and they have not objected.

#### School and college students

12. Doctors are sometimes asked to provide work experience for secondary school or further education college students, which may include allowing them to be present during consultations with patients. You should seek your patient's express

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<sup>3</sup> In this context 'trainees' refers to registered medical practitioners in training grades, while 'students' refers to undergraduates pursuing a medical degree.

<sup>4</sup> See our guidance on *Consent: patients and doctors making decisions together*, which states that you must give patients the information they want or need about the extent to which students may be involved in their care and of their right to refuse to take part in teaching.

consent to a student's observation of their care. You should make sure that the student understands the importance of respecting confidentiality and that their school or college takes its responsibilities for students' conduct seriously. You should also satisfy yourself that the student's presence does not adversely affect patients' care, for example by inhibiting frank discussion.

#### Patients who lack capacity

13. You should not disclose personal information about patients who lack capacity for education or training purposes where you can practicably use information about other patients instead.

14. If you wish to disclose personal information about an incapacitated patient who is likely to regain capacity, you should wait and seek their consent when they can consider your request, whenever that is practicable.

15. Personal information about patients who lack capacity to consent may be disclosed where that will benefit or is in the best interests of the patient, or where disclosure is justified in the public interest.<sup>5</sup>

16. If you are asked, or want, to disclose information about a patient who lacks capacity, you should seek the views of anyone the patient asks you to consult, or who has legal authority to make decisions on their behalf,<sup>6</sup> or who has a close personal relationship with the patient. They may be able to give you an indication of the patient's previously expressed preferences, views and beliefs.

17. In the absence of any indication about incapacitated patients' preferences:

- a. you should avoid publishing information from which they can be identified in all but the most exceptional cases
- b. you may disclose personal information to medical and other healthcare students and trainees to the extent necessary for their education and training.

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<sup>5</sup> See *Adults with Incapacity (Scotland) Act 2000* and *Mental Capacity Act 2005* and their respective codes of practice. There is no specific mental capacity legislation for Northern Ireland, where the common law duty to act in incapacitated patients' best interests endures.

<sup>6</sup> Welfare attorneys, court-appointed guardians and court-appointed deputies have legal authority to make some decisions on patients' behalf. In the context of public interest disclosures, you will be seeking their views about the patient's preferences, rather than their consent to disclose.

## Guidance supplementary to *Confidentiality*

### Responding to criticism in the press

1. In our *Confidentiality* guidance, we advise that:
  6. Confidentiality is central to trust between doctors and patients. Without assurances about confidentiality, patients may be reluctant to seek medical attention or to give doctors the information they need in order to provide good care. But appropriate information sharing is essential to the efficient provision of safe, effective care, both for the individual patient and for the wider community of patients.
2. Doctors are sometimes criticised in the press by their patients<sup>1</sup> or by someone their patients have a close personal relationship with. The criticism can include inaccurate or misleading details of the doctor's diagnosis, treatment or behaviour.
3. Although this can be frustrating or distressing, it does not relieve you of your duty to respect your patient's confidentiality. Disclosures of patient information without consent can undermine the public's trust in the profession as well as your patient's trust in you. You must not put information you have learned in confidence about a patient in the public domain without that patient's express consent.
4. Disputes between patients and doctors conducted in the media often serve no practical purpose; they can prolong or intensify conflict and may undermine public confidence in the profession, even if they do not involve the unconsented disclosure of personal information. You should usually limit your public response to press reports to an explanation of your legal and professional duty of confidentiality.
5. However, from time to time, press reports have caused or might cause other patients to be concerned about your practice or that of a health service you are associated with. In such cases it may be appropriate give general information about your normal practice. You must be careful not to reveal personal information about the patient, or to give an account of their care, without their consent. If you deny allegations which appear in the press, you must be careful not to reveal, directly or by omission or inference, any more personal information about the patient than a simple denial demands.
6. You should seek advice from your professional or defence body or from a solicitor on how to respond to press criticism and, if appropriate, any legal redress available to you.