GMC guidance on confidentiality: is it ethical?

The recent GMC guidance on confidentiality [1], especially the supplementary guidance [2], has caused much consternation amongst occupational physicians. The Faculty and Society of Occupational Medicine have issued a joint statement to members [3], and a GMC representative responded on the same day [4]. However, the
unease remains unabated. Some occupational physicians fear that the implications of this guidance could even lead to the demise of occupational medicine.

The issue that has caused particular concern has been the following statement that doctors ‘should offer to show your patient, or give a copy of, any report you write about them for employment or insurance purposes before it is sent’ [reference [2], para 34 (d)] [emphasis added].

The objections by occupational physicians have so far centred on the practical consequences of such a requirement. They have cited, for example, the difficulties in meeting service level agreements for presentation of reports to the client, if the worker chose to see the report first, as this would inevitably introduce a delay before the employer could receive this report. The more serious practical, and ethical, objection may be that the effect of offering the worker first sight of a report could be that the worker simply refuses to allow the report to be sent to the employer (even if he merely disagrees with the occupational physician’s opinion, rather than any factual inaccuracies), which the GMC think is quite legitimate. However, they fail to see that such a potential for biased suppression of professional opinion formed in good faith and after due process, could in itself be unethical.

After all, one would assume that ethical guidance would be based on sound ethical argument. If the GMC have indeed weighed the ethical arguments carefully, the process is not transparent. There are on the one hand, the important ethical requirements of confidentiality of patient information, and of respect for autonomy, which is at the heart of modern day ethics. Autonomy gives rise to a requirement for consent. However, there are ethical objections to these arguments, which do not appear to have been considered. There are three main areas of ethical arguments that should be considered.

Firstly, although in full agreement with the importance of medical confidentiality, this needs a closer look in the context of an occupational physician’s report. ‘The principle of medical confidentiality—that doctors must keep their patients’ secrets—is one of the most venerable moral obligations of medical ethics’ [5]. This is true in a general medical context, but how many occupational physicians will know any ‘patient secrets’? Indeed, prior to an occupational medicine consultation taking place, the process will have been explained. So the worker will be able to be as selective as he wishes to be about what personal and sensitive information, if any, he shares with the occupational physician. Even if some truly confidential information is passed to the occupational physician, their report should only reflect their opinion on fitness to work, and maybe on workplace adjustments, but devoid of clinical details. How then could such a report be considered as a disclosure of any personal and sensitive information?

The second objection arises from an examination of the nature of the ‘normal’ (that is, therapeutic) doctor-patient relationship. This is a fidelity based relationship, and there are certain requirements on such fiduciary relationships, for example, that the doctor owes ‘undivided loyalty’ to the patient. This is often seen in practice, for example, the general practitioner or treating specialist acting in effect as a patient advocate. The occupational physician, on the contrary, is expected to be impartial and unbiased. Otherwise he could not be an objective assessor of the evidence for eligibility for a pension fund, if artificially constrained into a ‘normal’ doctor-patient relationship. The GMC acknowledges that the relationships are different, but then applies exactly the same guidance to doctors in such non-therapeutic relationships, and this is fundamentally wrong. It probably explains the moral unease occupational physicians can experience when they perform a role where independence is key, but their ethical guidance requires a duty of undivided loyalty to the patient!

The third set of arguments are consequentialist ones. One consequence of showing a report to a worker, which he then suppresses because he disagrees with the opinion, would be the potential for the biased suppression of occupational physician opinions, as previously mentioned. Another consequence could be that employers lose patience with occupational physicians, if they perceive that reports they have commissioned are unduly delayed, or they are expected to pay for a report, which they do not ever receive. They are likely to look elsewhere for such reports, and this could eventually lead to a decline in, and maybe the demise of, the practice of occupational medicine.

If there are good arguments for the GMC stance, then this is a consequence we may have to accept. However, the guidance currently does not appear to be supported by sound ethical argument.

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References

4. Keegan M. (GMC Standards and Ethics), Confidentiality (in an open communication to the President of the FOM), 12 October 2009.