Consent for release of confidential information—ethics in context?

Dear Sir,
I read with great interest the editorial by Lloyd [1]. He reports that the Australasian Faculty do not require occupational physicians (OPs) to seek separate consent for their report prior to its release to management. Similarly, I have found that in Belgium, OPs are also not required to seek further consent and offer to show their report first to the worker [2]. Indeed, Wong and Choong [3] have pointed out that ‘the General Medical Council (GMC) appears to be the only professional body in the world that has introduced a new guidance that enables patients to gain privileged access to their occupational health reports in advance of the commissioning parties’.

I have argued that the concept of ‘informed consent’ for information disclosure is in fact the wrong one to be applied for this purpose, and it would make more sense to use a ‘permission to disclose’ concept [4]. For example, the level of information that the OP could give the worker about possible consequences of sending this report can never be as extensive and exhaustive as ‘informed consent’ for a surgical procedure.

Nonetheless, even if we continue to apply ‘informed consent’ to the release of our reports, Lloyd makes a very pertinent point. In the context of different countries and jurisdictions, the variation in the way this requirement is applied globally should at least give us cause for reflection. Could it really be that the UK regulatory bodies, namely the GMC and the Faculty of Occupational Medicine, are the only ones that are right, and the rest of the world is wrong?

Jacques Tamin
Bioethics and Medical Jurisprudence,
Centre for Social Ethics and Policy, School of Law,
University of Manchester, Manchester M13 9PL, UK
e-mail: driftamin@hotmail.com

References

Under-recording of sickness absence in doctors

Dear Sir,
We read with interest and commend Murphy’s [1] article, which highlights the very important issue of under-recording of sickness absence in doctors. We note that the study was conducted almost 13 years ago and, to supplement their literature search, readers should be aware that your journal has published research of relevance to this subject just last year, looking at occupational health sickness absence attendances compared with management reported sickness absence in doctors and dentists between 2009 and 2010 [2]. Inconsistencies and under-reporting of absences in these professional groups were highlighted, particularly for mental health-related sickness absences (all cases in doctors). Review of the wider evidence base, including these two studies, suggests that the issue of under-reporting/recording of sickness absence is ongoing, which interestingly has raised the pertinent question of who is to blame—Doctors? Management? or both?

With the emergence of doctors’ health as a specialist area of practice, specific services to manage doctors’ ill-health being established, organizations such as the UK Association for Physician Health and annual international conferences being held on the subject, hopefully awareness will be raised sufficiently to improve this situation. Accurate sickness absence recording is an important stepping stone to both identifying and meeting the specific needs of this professional group, which importantly, are both a safety critical and expensive resource within the National Health Service. Further research to assess progress in this respect is needed and should be welcomed.

Drushca Lalloo
Salus Occupational Health, Safety and Return to Work Services, NHS Lanarkshire, 14 Beckford Street,
Hamilton ML3 0TA, UK
e-mail: drushca.lalloo@lanarkshire.scot.nhs.uk
Fifty years ago: ‘Parameters of occupational health in America’

H. Beric Wright, Director, Institute of Directors’ Medical Centre

Based on a paper read to the Association on 3 April 1964 following a seven week visit to the USA in the Autumn of 1963.

The distribution of in-plant services is much the same as it is in this country, most large firms having a medical department with full-time doctors and many more using full-time nurses and part-time local practitioners. The Industrial Medical Association in America has 3000 members of whom about one-third are full-time, but this figure probably includes people in university departments. About 400 of them are Board-certified specialists.

Formerly there were 43 University departments in the USA and Canada teaching industrial medicine. It was realized that many of these were below the necessary standard and a system of inspection and reporting was instituted so that there are now about 15 Universities which run courses for doctors and industrial hygienists.

Probably unfortunately, the US specialist boards require a 3-year course for a Master’s degree, so that although a steady stream of hygienists is produced, each course seems to attract relatively few doctors. Indeed, the length of the course and the fact that salaries in industry compare on the whole unfavourably with those that can be earned in private practice, mean that industrial medicine is not on the whole attracting the right people. There is some anxiety about the fact that it is becoming rather a depressed speciality.

To conclude

All is not gold that glitters, either in America or anywhere else. Basically both the incidence and the efficacy of occupational health in the USA are much the same as here, and the problems are the same—how to get small- and medium-sized firms to ‘do the right thing’; how to attract and train the right doctors, and how far should compulsory legislation go towards enforcing reasonable standards? Americans have more money for research, better physical conditions in factories and offices (although there are also plenty of bad ‘railway arch’ workshops, totally unsupervised), but the universities tend to be disappointing and doctors in industry are in short supply. There do seem to be two overwhelming advantages in America—the willingness of central government to spend money on long-term research and the availability, through insurance companies and some States, of virtually free occupational hygiene advice. I started by saying that America is a large and disparate country. I found that it became more exciting as I got further west, until I finally left my heart in San Francisco. But apart from charm and atmosphere, the west coast is doing new things, from the Kaiser small plant service and their socialized Permanente plan, through two group practices doing nothing but industrial medicine, to the occupational health department at Washington University in Seattle, which is supported by a tax on industry matched by a contribution from the unions. This State also has a comprehensive and compulsory industrial insurance scheme. The east coast I found less dynamic and prone to worshipping its own image and past achievement, but it too will do new things and those two grand old men of industrial medicine, Kehoe in Cincinnati and Ted Hatch in Pittsburgh, are now studying health rather than disease. Hatch is trying to find out what contribution work makes to the falling off of capacity with age.


The full Occupational Medicine archive can be accessed online at http://occmed.oxfordjournals.org/.

References


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