Whistle-blowing, disclosure and patient confidentiality

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Introduction: the conflict between confidentiality and a duty to disclose

1. There is no doubt that the patient/practitioner relationship of confidentiality is one of the utmost importance. It stretches back at least to the time of Hippocrates in the 4th century BCE. It is emphasised in guidance to all healthcare professionals. It forms part of the protections afforded by Article 8 of the ECHR. The European Court stated in *MS v Sweden (1999) 28 EHRR 313* that:

   The Court reiterates that the protection of personal data, particularly medical data, is of fundamental importance to a person's enjoyment of his or her right to respect for private and family life as guaranteed by Article 8 of the Convention. Respecting the confidentiality of health data is a vital principle in the legal systems of all the Contracting Parties to the Convention. It is crucial not only to respect the sense of privacy of a patient but also to preserve his or her confidence in the medical profession and in the health services in general. The domestic law must

> *afford appropriate safeguards to prevent any such communication or disclosure of personal health data as may be inconsistent with the guarantees in Article 8 of the Convention* [para 41].

Further protection is available under Data Protection legislation. I shall not address this in the course of the talk.

2. However, confidentiality is not an absolute right in the same way as legal professional privilege. I will consider the exceptions in a moment.

3. In the course of this talk I wish to discuss the tension that exists between a 'whistle-blower' who wishes to expose bad or dangerous practice and feels only able so to do by breaching confidentiality. I will consider the statutory regime that exists and whether the problem is such that further steps need be taken. The most recent example of this case is the recent case of *NMC v Haywood*. Haywood was not alone. A BMA survey from May 2009 revealed that almost three quarters of respondents "experienced important concerns (e.g. relating to patient care, malpractice or bullying)".[1]

The duty of confidentiality

4. The reasons for imposing a duty of confidentiality are well-known. However, familiarity breeds complacency. The impact of breaching a confidence can be devastating on a patient. The reasons for the duty are well set out in

[1] See http://www.bma.org.uk/ethics/doctor_relationships/whistleblowingsurvey.jsp

Paragraph 6 of the GMC's guidance on Confidentiality (published yesterday, and due to come into effect on 12 October)[2] states as follows:

> "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."

5. Unjustified breach of confidentiality will almost certainly lead to fitness to practise proceedings. There might appear to be an anomaly when others, such as other patients on a shared ward can speak freely about their fellow patients' conditions and treatment. For example, the US healthcare debate has prompted many articles by journalists reporting on their own experience as in-patients in the NHS recounting full details of their fellow patients.

6. Nonetheless, for healthcare professionals, confidentiality must be protected unless:
   i) there is patient consent,
   ii) a legal requirement to disclose or
   iii) it is in the public interest.

Patient consent

[2] Find at: http://www.gmc-uk.org/news/docs/Confidentiality_FINAL.pdf

7. There is no difficulty with express informed consent. In addition, there is implied consent of disclosure:

- Within the healthcare team
- In a clinical audit by a care team [usually anonymised if external]

8. Express consent will usually be required for other common reasons for disclosure such as:

- Research
- Epidemiology
- Financial audit
- Administration

Disclosures required by law

9. A court order can require a practitioner to produce medical records either on application by police officers for a warrant [the test for obtaining a warrant to access confidential or 'special procedure' material is set out in the Police and Criminal Evidence Act 1984[3]] or the issuing of a witness summons to produce. In essence, the test is that the evidence will be of substantial value as evidence in the case. The reason for disclosure should be specified in some detail thereby allowing the holder of the records to identify all relevant

[3] Schedule 1, paragraph 2: The conditions are that (i) an indictable offence has been committed; (ii) that there is material which consists of special procedure material or includes special procedure material and does not also include excluded material on premises specified in the application; (iii) that the material is likely to be of substantial value (whether by itself or together with other material) to the investigation in connection with which the application is made; (iv) that the material is likely to be relevant evidence; (b) other methods of obtaining the material (i) have been tried without success; or (ii) have not been tried because it appeared that they were bound to fail; and (c) it is in the public interest, having regard (i) to the benefit likely to accrue to the investigation if the material is obtained; and (ii) to the circumstances under which the person in possession of the material holds it, that the material should be produced or that access to it should be given. See the definition of special procedure material in section 14(1) of PACE, which expressly excludes legally privileged material.

records complying with the warrant or request, and to object if irrelevant records are disclosed.

10. A statutory regulatory body may require medical records for the purpose of investigation or prosecution of a registrant's fitness to practise. Difficulties arise where the complaint is made by a third party, e.g. a GP expressing concern about the performance of a consultant. Consent should be obtained before disclosing identifiable information where practicable. Details should be anonymised where practicable.

11. There are some specific statutory requirements to disclose information, such as notification of known or suspected communicable diseases[4]. Consent is not required for such disclosure.

<u>Disclosures to protect the patient or others</u>

12. Set against the duty of confidentiality is the over-riding requirement of all regulatory bodies to protect the public, particularly the vulnerable. There is a professional obligation in certain circumstances to report colleagues or particular states of affairs. There is also the risk that acquiescence to a particularly bad state of affairs may make a person criminally liable. This tension is known to those who regulate and has led to different forms of pressure valves to enable a person to blow the whistle in the public interest (this is not limited to the medical sphere[5]). How is that tension resolved? The abovementioned GMC guidance on confidentiality states the following at paragraph 36:

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[4] The Public Health (Control of Disease) Act 1984, Public Health (Infectious Diseases) Regulations 1988 (S.I.1988 No. 1546)

[5] See the Court of Appeal ruling in *Lion Laboratories Ltd. v Evans and Others* [1985] QB 526, which related to disclosures by employees of flaws in an 'intoximeter'. It is the classic statement of the principle that all duties of confidence are subject to public interest exemptions.

> "there can also be a public interest in disclosing information: to protect individuals or society from risks of serious harm, such as serious communicable diseases or serious crime; or to enable medical research, education or other secondary uses of information that will benefit society over time."

13. It goes on to state (at paragraph 37):

> "Personal information may, therefore, be disclosed in the public interest, without patients' consent, and in exceptional cases where patients have withheld consent, if 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 to the overall trust between doctors and patients, arising from the release of that information."

14. I will turn to the safeguards and the relevant legislation. However, there is always a problem - if the person to whom you would report is part of the problem and may themselves face criminal or regulatory liability: "*quis custodiet ipsos custodies".* Notwithstanding statutory protection, there is an unhappy history of the fate of whistle-blowers with their existing employers and in obtaining future employment. The Haywood case concerned a hospital.

15. Further, the whistleblower makes his own judgement that the disclosure is in the public interest. Concerns may have built up over a long period of time. There may be personal matters that affect the decision. It is not likely to be purely logical. Whether the whistle-blower's view is shared by the courts or regulatory body will obviously not be known until it is too late.

16. It is of interest to note that the State has adopted a carrot and stick approach to disclosure of material obtained confidentially:

Money laundering and bribery legislation: the encouragement of whistle-blowing

17. By introducing the Proceeds of Crime Act 2002, the government placed a duty to report suspicious activity with criminal sanctions for failure so to do. It is designed to encourage the innocent to blow the whistle not necessarily on the on the guilty but on those suspected of guilt, with a pretty low threshold to cross to breach a confidence.

18. Another example is cartel crimes – when companies get together to fix prices – this is hard to detect and harder to prove. The law encourages the guilty to blow the whistle by guaranteeing immunity from prosecution to the first to blow the whistle, notwithstanding their personal criminality. Those who come forward thereafter might get immunity but this is not guaranteed.[6]

19. This trend is further evidenced by the section 71 the Serious Organised Crime and Police Act 2005, which came into force on 1st April 2006. That section gave to the DPP, the Director of the SFO and the Director of the RCPO the power to grant general or restricted immunities, when "considered appropriate for the investigation or prosecution of an offence." It is designed to encourage the guilty to blow the whistle and/or reveal that which has taken place.

[6] Section 190(4) of the Enterprise Act 2002 states: "Where, for the purpose of the investigation or prosecution of offences under section 188, the OFT gives a person written notice under this subsection, no proceedings for an offence under section 188 [the cartel offence] that falls within a description specified in the notice may be brought against that person in England and Wales or Northern Ireland except in circumstances specified in the notice."

See also OFT guidance on "no-action letters" at:
http://www.oft.gov.uk/shared_oft/business_leaflets/enterprise_act/oft513.pdf

20. These are examples of the use of the carrot to encourage people aware of or actually guilty of crimes to come forward

21. The stick is criminal liability. In effect, if you do not stop certain behaviour you will be criminally liable. For many years all sorts of statutes have created criminal liability for senior management if a body corporate is guilty of an offence. This is through 'consent, connivance or neglect'. For example, if a company is guilty of the road traffic offence of 'no insurance', a director may be liable if he consented, connived or was negligent to the act. That liability was limited to very senior management. The corporate killing legislation has widened the burden upon the collective failures of an organisation[7]. However, the starkest example of the 'stick' is the forthcoming corruption legislation (the Draft Bribery Bill) which in its present form places a burden upon a commercial organisation to ensure that there is no corruption in their organisation.[8]

22. The pattern is thus the extension of criminal liability from personal acts or omissions towards a state of affairs that does not allow crime or harm to be caused. This has long been the position in the health and safety legislation. Section 7 of the Health and Safety at Work Act of 1974 imposes duties on every employee (i.e. including doctors, nurses and other medical professionals) while at work:

[7] Corporate Manslaughter and Corporate Homicide Act 2007 c. 19

[8] See clause 5 of the draft bill at: http://www.justice.gov.uk/publications/docs/draft-bribery-bill-tagged.pdf and the Joint Committee Report at: http://www.publications.parliament.uk/pa/jt200809/jtselect/jtbribe/115/11502.htm

"(a) to take reasonable care for the health and safety of himself and, of other persons who may be affected by his acts or omissions at work; and

(b) as regards any duty or requirement imposed on his employer or any other person by or under any of the relevant statutory provisions, to co-operate with him so far as is necessary to enable that duty or requirement to be performed or complied with."

23. Failure to discharge that duty is a criminal offence. The maximum sentence has recently been increased from a fine to two years' imprisonment.[9] More prosecutions are expected.

24. Where does that leave the practitioner if they genuinely believe that they are working in an environment which is unsafe or harmful to patients or there is a practitioner who is dangerous for patients? A registrant who has to balance the need for employment, the fear that they may be personally liable, and their duty to protect patients? The solution is the 'whistle-blower's charter'.

Public Interest Disclosure Act (PIDA) 1998 – "the whistle-blowers' charter"

Background

25. There were a number of enquiries following disasters in late 1980s and early 1990s (Zeebrugge, Piper Alpha, Clapham Junction) which found that they may have been prevented had those who had known about safety issues had "blown the whistle". For example, the Cullen Report into Piper Alpha found that workers who knew about serious safety issues had not wanted

[9] See paragraph 1 of Schedule 3A to the 1974 Act

"to put their continued employment in jeopardy through raising a safety issue that might embarrass management".

26. PIDA amended the primary piece of employment legislation, the Employment Rights Act 1996. The Act covers all workers in the UK whether they are working in the public, private or voluntary sectors. It protects those workers from suffering any detriment once they have made a qualifying disclosure (e.g. dismissal following such a disclosure can be grounds for a claim of unfair dismissal).

Qualifying disclosures

27. In s. 43B, the Act identifies "qualifying disclosures". Of relevance for healthcare professionals will be:

- ss. (1)(a): "that a criminal offence has been committed, is being committed, or is likely to be committed"
- ss. (1)(b): "that a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject"
- ss. (1)(d): "that the health or safety of any individual has been, is being or is likely to be endangered"
- ss. (1)(f): "that information tending to show any matter falling within any one of the preceding paragraphs has been, is being or is likely to be deliberately concealed"

Tiered disclosure

28. The Act provides for a tiered disclosure regime:

- Internal disclosure (to the employer) (s. 43C)

- Disclosure to prescribed persons (s. 43F), broadly the agencies charged with promoting minimum standards in a given area, e.g. National Care Standards Commission. Not the GMC.
- Public disclosures (s. 43G)

29. Employers should have a formal policy for dealing with such concerns setting out the appropriate channels (usually the line managers leading up to Medical Director). If workplace routes have been exhausted, then consideration should be given to external complaint. Professional bodies, insurers or independent solicitors should be able to assist in this process. If that does not work the last avenue is public disclosure. This is the classic instance of whistle-blowing. Section 43G would cover disclosures such as disclosures to the press.

30. In these cases, disclosures are "protected" if

- They are made in good faith
- The worker has a reasonable belief that any information disclosed and any allegation therein are substantially true
- The disclosure is not made for personal gain
- Disclosure is reasonable in all the circumstances

AND

- (S)he has a reasonable belief (s)he will be victimised if (s)he raised the matter internally (e.g. in the Trust) or with a regulator (e.g. Care Standards Commission)
- (S)he reasonably believes that there will be a cover-up
- (S)he has already raised the matter internally or with a regulator (e.g. Care Standards Commission)

31. You will have noted that the tests are quite high:

    - Crime
    - Breach of legal duty
    - Health and safety

32. PIDA affords protection from detriment to persons covered by the Act. If the employee suffers detriment there will be recourse to the Employment Tribunal.

The Haywood Case

33. Margaret Haywood was a nurse who filmed undercover for a BBC Panorama episode entitled “Undercover Nurse”. Mrs Haywood had covertly filmed a number of patients without first obtaining their consent. Her aim was to “portray the truly appalling care given to some elderly patients” at Brighton and Sussex University Hospitals NHS Trust. In November 2008 and April 2009, her case was heard by a Panel of the Conduct and Competence Committee of the NMC. In finding that her fitness to practise was impaired, the Panel stated that:

    “[t]he patient confidentiality that she [Mrs Haywood] broke in so doing [filming covertly] concerned the care (or lack of care) which (certain) patients on that ward experienced ... and their suffering in consequence”

34. The Panel said it was:

    “sensible to the fact that there may be instances where disclosure of confidential information may be essential to protect a patient from significant harm. But it addresses the issue of whether it was essential in

this case. The panel has concluded that, for it to be "essential" for the registrant to breach confidential information, she must first have exhausted all other avenues of addressing the inadequacies on the ward; alternatively there must be an immediate need. So far as the latter is concerned, there was no immediate need since the Panorama programme would not be screened for some time after the editorial process had been completed.

As to the matter of whether all other avenues had been exhausted, the panel cannot so find. The registrant did not exhaust the process of making representations as to conditions on the ward to management or senior management. She did not make disclosures to any external bodies in such a way as not to disclose confidential information. Effectively she bought into the concept of making the film, and suspended her obligations under the Code to protect and support the health of individual patients and clients by not making (sufficient) representations internally or externally in a way which would preserve patient confidentiality."

35. In making its decision to strike off Mrs Haywood, the Panel stated that in its view:

"this was a major breach of the code of conduct. A patient should be able to trust a nurse with his/her physical condition and psychological wellbeing without that confidential information being disclosed to others. Only in the most exceptional circumstances should the cardinal principle of patient confidentiality be breached. Those circumstances did not pertain here. Although the conditions on the ward were dreadful, it was not necessary to breach confidentiality to seek to improve them by the method chosen. In any event, this method was unlikely to benefit the patients that were on the Ward at the time of filming and under her care."

36. In the region of 41,000 people signed a petition in her support. The decision has been appealed; no date has yet been set for the appeal hearing.

Healthcare Professionals: how to resolve the conflict between confidentiality and public interest disclosure

37. There is no easy answer to resolve the tension between disclosure and confidentiality.

38. All the relevant codes make clear that (as the NMC CCC made clear in *Haywood*) that patient confidentiality is indeed a "cardinal principle". There are exceptions as set out above.

39. It is equally accepted that there is a professional obligation to disclose in certain circumstances and/or potential criminal liability.

40. I would suggest that if a registrant is of the view that disclosure is necessary the first question is whether the confidentiality can be protected and the disclosure made. If not, then PIDA envisages a structured approach to disclosure. If followed, there can be no real complaint against the actions of the registrant.

41. Professional bodies and insurers are also alive to this issue particularly in light of the Haywood case. The BMA have produced particularly valuable guidance[10]

[10] See http://www.bma.org.uk/ethics/doctor_relationships/whistleblowing.jsp

Conclusion

42. The principle of confidentiality in the medical sphere is a longstanding one. The Hippocratic Oath states as follows:

> "All that may come to my knowledge in the exercise of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal."

43. This duty has never been absolute, but the pace of its erosion has certainly picked up in recent years. One need only glance at the Health and Safety Act 1974, the Enterprise Act 2002 and the Public Interest Disclosure Act 1998 to see that lawmakers are increasingly placing a duty on employees to expose wrongdoing, incentivising whistle-blowing, and ensuring that those who blow the whistle are protected against unfair dismissal.

44. The new GMC guidance is in line with this trend in that it expands the categories of cases in which confidentiality can be breached and disclosures made.

45. For example, at paragraph 69 it refers to disclosures of genetic information. One case might be the discovery of the BRCA1 gene, which increases the likelihood of developing breast cancer. If it is discovered that a woman carries the gene, there may be a need to inform her siblings. As the guidance states:

> "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 56). 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. If practicable, you should not disclose the patient's identity in contacting and advising others of the risks they face."

46. The supplementary guidance[11] also refers to the reporting of gunshot and stab wounds. At paragraph 3 it states:

"(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 a patient, including their identity, is justified in the public interest."

47. What does all this mean for lawyers working in the regulatory and disciplinary spheres? What advice should be given to a professional who wishes to disclose information, and who may be at risk of criminal prosecution if they do not do so? To take the example of doctors, the BMA guidance is explicitly in line with PIDA:

"Only once you have exhausted all local workplace policies and procedures should you consider raising your concerns externally."

[11] See http://www.gmc-uk.org/news/docs/Confidentiality_FINAL.pdf

48. It goes on to state that:

> "[g]oing directly to your local elected representative (such as your relevant MP, MSP, AM or MLA) or the media is only advisable if your employer has a record of ignoring, discouraging or suppressing concerns that have been raised and this is the experience you are having even after escalating it to the highest level. You should consult the BMA or a defence body before taking this step."

49. The cardinal rule therefore appears to be that disclosure in breach of confidence must take place only after all other avenues have been pursued, and have not borne fruit. Indeed, this is the underlying principle of PIDA. The Haywood case is a stark example of the need for all practitioners to bear in mind that, while blowing the whistle is being encouraged more and more, the principle of confidentiality is one which should only be breached in exceptional circumstances.