FACULTY OF OCCUPATIONAL MEDICINE

PROFESSIONAL COMPETENCE SCHEME

CLINICAL PRACTICE AUDIT

ETHICS IN OCCUPATIONAL HEALTH

2011

v1

Prepared by Dr Paul Gannon on behalf of the Faculty and the Educational and Professional Development Committee with reference to the Faculty of Occupational Medicine, UK, Ethics guidelines.

1. Introduction

Ethics is the term used to describe ways of examining and understanding moral life – how we decide what is right or wrong and why we come to these conclusions.

The four main principles of Bioethics are:

1. Respect for the autonomy of the individual
2. Doctors should do no harm
3. Doctors should do good
4. All individuals have equal rights and responsibilities distributive justice)

The Faculty of Occupational Medicine expects the highest standards of professional behaviour and practice from its members. These standards also apply to all those who work in occupational medicine at any level, whether or not they hold a faculty qualification.

2. Relationships with others

yes/no

2011 2012

1) Doctors	• Some doctors provide both primary care services and occupational health services for patients. It is **particularly important** for such doctors to be clear about their **distinct roles** and how to keep them separate. It is vital that these issues are explained clearly to both patients and the employer. • In normal circumstances, and subject to the consent of the individual, the occupational physician **should inform the general practitioner**, who is responsible for maintaining continuity of the patient's medical care, of work related facts which may have a bearing on the health of the individual. • The patient **should be referred back to their own doctor** for matters of general medical care. • Occupational physicians requiring a report on an individual from another doctor **must obtain the individual's consent**. **A copy of the consent should be sent to the physician** from whom the enquiry is being made. The consent applies only to the time, condition and circumstances when it was obtained.	*2011*	*2012*

	• **Consent is also necessary for discussion** of an individual on the telephone, except in an emergency. • Except in an emergency**, referral to a hospital consultant for treatment will normally be the responsibility of the general practitioner** rather than of the occupational physician. The latter may sometimes make a referral with the agreement of the general practitioner. • Occupational physicians **may refer an individual directly to a specialist for an independent opinion for employment purposes**. • The general practitioner **should, with the patient's consent, be informed** about such a referral.	*2011*	*2012*
2) Nurses	• Occupational physicians **should discuss ethical issues openly with nursing staff.**		
3) **Health and Safety Professionals**	• **No other staff should have access to medical records** or information without the consent of the individual.		
4) Managers	• The distinction between the responsibilities and duties to the employer, and the obligations concerning such matters as confidentiality **should** be clarified. **Consideration should be given to the inclusion of a clause in the contract of employment** (or contract for services) recognising these difficulties. • Management has a **legal obligation to maintain certain health records**, such as the results of health surveillance and the records of exposure to hazardous substances. These records **should** be kept separate from the clinical records. • If the employee withholds consent for the report to be sent to the employer, the doctor **must ensure the employee understands the potential consequences** of this decision.		
5) **Safety representatives and Trade Unions,**	• It **should be** normal practice of occupational physicians to discuss matters relating to health and work with trade unions' safety representatives and other groups of employees	*2011*	*2012*
6) Government and Official Agencies	• Occupational physicians **should** be prepared to assist representatives of these bodies on matters affecting the health and safety at work of individuals.		
7) The public and	• Occupational Physicians, in circumstances where safety or public health may be		

the environment	endangered, may legally and ethically breach confidentiality provided that the risk to the public is sufficient.		
8) Occupational Physicians managing occupational health staff	• It is <u>**ethically unsound**</u> to be the line manager and the occupational physician for a group of occupational health professionals and support staff. • Health surveillance and health screening records for occupational health staff <u>**should not**</u> **be accessible** to the occupational physician or other staff in the department. • Occupational Physicians <u>**should**</u> **ensure that policies and procedures** are in place to ensure that staff comply with guidance, including that from their own professional bodies		

3. Confidentiality and Consent ***yes / no*** ***2011 2012***			
1) General Principles *The usual therapeutic relationship between a doctor and a patient does not often apply to the work of an occupational physician.*	• Modern medical practice requires that patients are fully involved in decisions about their care, including occupational health care. This respect for the individual's autonomy requires that **the patient is given appropriate information to inform decision making.** • Occupational physicians <u>**must**</u> ensure that personal information given to them by patients is kept **confidential,** that any disclosure of the information is appropriate and, except in exceptional circumstances is nor disclosed without the **patient's consent.** • The patient <u>**must**</u> be aware of the consequences of that disclosure when giving or refusing consent. • If occupational health staff provide therapeutic care, such as investigations, immunisations or treatment, they <u>**must**</u> ensure that patients are **given all the necessary information to give consent to that procedure.** • **Consent is only for the purposes for which it is explicitly given.** Blanket consent to allow, for example, an occupational physician to write to any doctor about any mater **cannot be informed and is, consequently,** <u>**unethical.**</u>	2011	2012

Confidentiality	• Consent for an occupational physician to obtain a report from the general practitioner **should not** be assumed to be consent for disclosure of information so obtained. • **Oral** consent **should be** documented contemporaneously in the medical records. **Written** consent is used to demonstrate in the future that the subject agreed to a specified action or actions at a particular point in time. • It is helpful for all parties if occupational health services, or individual independent practitioners, develop **policies on confidentiality and disclosure of information** which can be shared with employers and their workforces to develop trust in the occupational health provider and understanding of the professional standards.		
2) Confidentiality: ethical and legal duties	• Anonymise data where unidentifiable data will serve the purpose. • Seek patients' express consent to disclosure of information where identifiable data is needed for any purpose other than the provision of care or for clinical audit, except in exceptional circumstances.	**	
3) Status of occupational health records	• An individual employee **has the right to access their clinical record** in accordance with the Data Protection. • Individuals **should be** made aware that clinical records are being created, for example by means of a **statement on the pre-employment health questionnaire.** An **explicit statement on confidentiality is recommended** together with details of **who, within the occupational health team, may access the information and for what purpose**, such as continuity of shared care.	**	
4) Disclosure of confidential information	• Wherever possible, information (such as **health surveillance data**) which is shared with any third party, whether within the occupational health team, for example for clinical audit purposes, or with the employer, their agents or employees and their representatives, **should be anonymised.** Care may be needed, especially in small groups, to avoid deductive identification of individuals. • Where disclosure of clinical information is essential this **must** only be with the consent of the patient, except as provided by the Medical Council. If consent to disclose information is withheld, the fact that the consent has been withheld may be reported to the employer and does not itself constitute a breach of confidentiality.		

	• Where information provided by a third party (medical certificates, referral letters) gives clinical information, even if the patient may have been the source of that information, for example the patient has told their manager about their illness, the occupational physician **should not** confirm such details without the **patient's consent.** • The Occupational Physician **should** ensure that all documents which form part of the occupational health record but which may be issued by the employer, such a pre-employment screening forms, are marked as **confidential** to the occupational health service. • Occupational physicians are advised not to co-operate with systems of work where medical information is sought but not handled in accordance with normal ethical rules which the individual might expect. • The **consent** of the individual will be required before clinical information can be disclosed to others, whether professionally qualified or not, including solicitors, insurers and their agents, managers or trades union representatives. • The occupational health professional **should clarify** with the individual, what they wish to disclose in the case of disclosure of records to a third party, for example a solicitor. • The occupational health professional **should** advise both parties (individual litigants or their solicitors) that full relevant disclosure **should be** made to both sides, if they authorise partial disclosureas to other parties, refusing to release relevant parts of the records. • It is good practice that such **medico-legal reports are not stored with the occupational health clinical records to prevent accidental disclosure**. The above guidance applies equally to employment tribunals.	** **	
5) Disclosures of confidential information without consent	• "**Personal information may be disclosed in the public interest**, without the patient's consent and in exceptional cases where patients have withheld consent, where the benefits to an individual or to society outweigh the pubic and patient's interest in keeping the information confidential. In all case where you consider disclosing information without consent from the patient you must weigh the possible harm (both to the patient, and to the overall trust between doctors and patients) against the benefits which are likely to arise from the release of information."		

6) Consent for preparation of an occupational health report	• Difficulties arising from disclosure of information to the employer may be avoided **by ensuring** that the employee is appropriately informed about the purpose of a health assessment and consents to the process including the preparation of the occupational physician's report by **signing an appropriately worded consent form. The contents of the report should also be made available to the employee.** • "Where doctors have contractual obligations to third parties, such as companies or organisations, they **must obtain the patient's consent** before undertaking any examination or writing a report for that organisation. Before seeking consent they **must explain** the purpose of the examination or report and the scope of the disclosure. Doctors **should offer** to show patients the report, or give them copies, whether or not it is required by law." • The patient **should be** aware of the outcome of the assessment and the information which will be disclosed at the end of the process and should have agreed to the disclosure of that information. • The patient **should** also have been offered a copy of, or subsequent access to, the report, even if the law does not require it to be provided.	2011	2012
7) **Consent to seek a report from other clinicians**	• The occupational physician **should** ensure that the employee's rights are explained as part of the process of obtaining the employee's consent to obtain the report.		
8) **Consent for treatment – special situations**	• Where an occupational physician, or an associated staff member, gives treatment the occupational physician **must** ensure that **appropriate consent** is obtained for that treatment.		

4. Occupational Health clinical records ***yes/no*** ***2011 2012***			
1) Data protection	• Those delivering occupational health services **should have a written policy and guidance on data protection.** The policy should be communicated to employees and employers so that they are aware of the arrangements for safeguarding sensitive information.	**	

2) Security of records	• **Occupational health clinical records <u>should</u> be differentiated from health records**. Health records may include job histories, exposure details and advice on fitness for work, and may have specific significance to legislation, for example radiation workers. These records should be kept separate from clinical records. • All sensitive personal information **<u>must be</u>** held in accordance with the **************** • Staff who do not have a professional duty of confidentiality **<u>must have</u> training** in this area and having completed training, sign a confidentiality agreement. • **Employers have no right of access to occupational health records** and are not deemed to know information held only by their occupational physician.	2011	2012
3) Retention/archiving of records	• Retained and archived records, paper or electronic, **<u>must be</u>** treated in the same manner as "live" records; they have the same security and confidentiality requirements. • If records are transferred to other media, for example microfiche or laser disc, this **<u>must be</u>** undertaken appropriately to prevent unauthorised disclosure and, importantly, the original record media disposed of appropriately. • Recommendations for retention of non-statutory or clinical records differ between 8 – 10 years since the date of the last entry.		
4) Specific requirements for paper records	• Records, if written, **<u>should be</u>** legible, contain the minimum of abbreviations, and be clearly dated and signed. Entries should not be erased. Deletions or modifications should be dated and signed. The subject of the records should be told that a record is being created and the content should be discussed with them at the time of writing. • Paper records **<u>should not</u>** be left where other (including other patients) may view the contents. • Information **<u>should not</u>** be left on computer screens while unattended or in public places and appropriate use of automatic devices such as password protected screensavers is encouraged. • All paper records **<u>should be</u> stored in locked cabinets** and the keys to cabinets should be secured at all times. Ideally cabinets should be fire resistant.		

5) Specific requirements for electronic records	• Occupational health organisations **must have a policy statement on computer use.** • **A confidentiality agreement should be used for IT staff** who may be required to access databases for maintenance purposes.	2011	2012
6) Transfer of records	• Peripatetic occupational health workers, ie. those who are required to transport clinical records with them when visiting multiple sites or customers, **should** ensure that records are only removed from secure storage when they are needed, during travel are secured out of sight in a vehicle and are placed back in secure storage when work is completed. Records should not be left in a vehicle overnight. • **Procedures should** be in place to facilitate transfer of records when an employee leaves an employer, retires or on death. • When providing services to companies with a number of sites, **a system for tracking records should** be put in place. If records are unfortunately lost, a process for informing the subject should be in place.		
7) **Occupational health departments ("in house" providers).**	• An Occupational Health organisation **should not hold clinical records on its own staff.** If an occupational health issue relating to a member of staff arises, another occupational health service should be used. The objective is to maintain the correct employee/ employer relationship with regard to confidentiality and removing a real/perceived conflict of interest.		
8) **Occupational health contractors ("outsource" providers).**	• There is no legal obligation to transfer records, but it is good practice and in the best interest of employer and employee.		
9) Closure of an organisation	• Health records required to be retained by statute, for example HSA**, should** be held by occupational health departments. Such records should be retained by the employer.		
10) **Destruction of records**	• Paper records **must not** be disposed of in general waste and should be shredded.		
11) Covert surveillance	• Occupational physicians **should not** be involved in the commissioning of covert surveillance.		

5. Fitness for work ***yes / no*** ***2011 2012***			
1) Doctors	• It is important that occupational physicians and others practising in the field remain up to date with new legislation and particularly decisions of employment tribunals in this field.	2011	2012
2) Pre-employment medical assessment	• Data protection principles require that information sought is “adequate, relevant and not excessive in relation to the purpose” and used only for the declared purpose. The use of health assessment must be justified. Thus asking questions about matters that do not affect the outcome of the assessment process would not be justified. • Questionnaires **should** be returned through qualified medical or nursing staff to ensure that clinical details will be handled confidentially. • The objectives of pre-employment health assessment can be met if pre-placement health questions are not raised until the stage when an offer of employment is being made. • The occupational physician owes a **legal duty of care** only to the employer when carrying out a pre-employment health assessment: the physician does however owe a **professional duty of care** to the applicant and deficient practice could lead to an allegation of professional negligence. • All documentation used to collect health data **should be** suitably marked to indicate that the information will be held in confidence. • Where it appears that an applicant has not disclosed a particular condition, which comes to light that would have made a difference to the assessment, the occupational health physician **should** reassess the risk, taking account the passage of time. - The consent of the individual **should** then be sought to notify the employer of the revised assessment with a clear explanation of the reasons for this. • Forms seeking broad consent for access to existing health data such as the entire general practitioner record **should not** be used. • When reporting to management on the outcome of a pre-employment health assessment, applications should be classified as **fit for employment or fit for employment subject to adjustments to the work.** Only in the most exceptional circumstances should an applicant be classified as unfit for employment by the		

	occupational health department. • Physicians **<u>should</u>** ensure that questionnaires are **evidence based** wherever possible, where use is still justified. • Consider the design and content of the questionnaire to ensure their suitability for disabled people. • Have an explicit statement on the form about the purpose of the PEHA. • Say on the form if it is intended to create an occupational health record. • Mark the form as confidential – when completed, the form is a medical record • Only ask questions that are relevant to the decision being made; do not collect unnecessary information. • If specific criteria will be applied to a particular job, tell applicants wherever possible. Do not ask applicants to sign a "blanket" consent allowing occupational health to "approach any Doctor you may have seen" for "any information about your health; such consent forms **<u>are unethical and without validity.</u>** • Drug testing may be included in pre-employment assessments. Prospective employees **<u>must be</u>** told in advance that the testing will take place: there must never be covert testing. Although the law means that the occupational physician does not owe a legal duty of care of prospective employees, they do owe a professional duty of care.		
3) Fitness for joining pension schemes	• Where occupational physicians are requested to provide confidential medical information to trustees of a pension scheme, **consent of the individual <u>must</u> be obtained.**		
4) Ill health retirement *It is not an employment issue but about the process of paying benefits once a decision to terminate an employee's service has been made.*	• It is essential that practitioners are fully acquainted with those applicable in a particular case and the interpretation which is applied to the wording. • When requesting independent medical examinations and/or investigations it **<u>should be</u> made clear that it is medical fact and, where appropriate, opinion on prognosis which is being sought and not a view on employment issues or pension entitlement with which the report provider is unlikely to be familiar**. • .Have **written guidelines** on application of the criteria and audit of decisions; this represents good practice. All ill health retirement processes **<u>should have</u> a complaints procedure and an appeals mechanism.**		

6. Health screening and health surveillance yes / no **2011 2012**			
1) Health screening, health surveillance and testing	• Where one of the objectives of the testing is to assess control measures, the **need to communicate grouped results** to those with the responsibility for risk control **must be** included at the planning stage and participants must agree. • The normal ethical rules, for example about the confidentiality of clinical information and the need for consent before undertaking tests, continue to apply. • The programme must incorporate an appropriately competent physician to interpret these findings and make any necessary arrangements for further care.	2011	2012
2) Health screening in special circumstances	• Testing is sometimes undertaken not for the benefit of the individual but to ensure the safety of other people. Where a potential health problem is identifies, the individual **must be** referred for assessment and treatment.		
3) Serious communicable diseases	• Healthcare workers who undertake activities during which a serious infection could be passed on to patients (or rarely, colleagues) are subject to guidance from the Medical Council. • Occupational physicians working in this field **must ensure** that they remain up to date with current research and thinking.		
4) Immunisation	• **Immunisations must be voluntary** (that is to say the individual must give consent in the normal way) and all reasonably practicable primary prevention measures should be in place before immunisation is considered. • The occupational health physician should ensure that the employment consequences for those in whom the immunisation is unsuccessful or who decline the procedure are set out in advance and **should not unnecessarily penalise the unprotected worker**.		
5) Testing for alcohol and drugs	• Testing for drugs or alcohol, except in a clinical context, **should not be undertaken without a policy being introduced by the employer.** • From an ethical perspective, any policy that includes testing or the involvement of occupational physicians must cover the reasons for the policy, the role of the occupational health service and testing arrangements.	**	

6) Testing	• Medical advice should not be given when collecting samples for a non-clinical test. • Whether or not an occupational physician is involved in testing, the employee **must give consent** to the sample being collected and must know the consequences of agreeing to or declining testing. This must include both the employment consequences and the broader social consequences (for example in a child custody case).		
7) Specific circumstances	• Testing after an incident suggesting the possibility of drug or alcohol use – so called **"for cause" testing – <u>should only</u> be undertaken as part of a pre-existing policy.** The policy **<u>should specify</u>** the circumstances under which testing will take place: for example will all those involved in an accident be tested or only those in whom there is reasonable suspicion. Policy should not be written during a case.		

7. **Genetic testing**			
	• At the present, with the very limited exceptions of haemoglobin electrophoresis in those potentially exposed to reduced oxygen levels, **the use of genetic testing in the practice of occupational medicine is unlikely to be ethically justifiable.**		

8. Business ethics yes / no ***2011 2012***			
1) **The global business environment**			
2) **Company values and ethical codes**			
3) **Whistle blowing**			
4) **Contracted services**			

Advertising			
5) Competence	• Occupational physicians **should** describe themselves as "consultant" or "specialist" in occupational medicine only if they are eligible for inclusion in the specialist register maintained by the GMC. • Royal College of Nursing recommends that members without relevant qualifications do not call themselves occupational health nurses.		
6) **Competitive tender**			

9. Occupational health research ***yes / no*** ***2011 2012***			
1) General principles of ethics in research	• All specialists occupational physicians undertake research as a required part of accreditation. Moreover, research needs and opportunities sometimes arise as part of occupational health practice, for example investigating a cluster of disease or emerging occupational risk factors. • There is a general ethical duty to ensure that research does not result in harm to individuals, or jeopardise their access to medical care or employment. It **should not** compromise the confidence in relationships between occupational health professionals, employees and employers. Researchers **should** ensure that their use of occupational health recourse is lawful. They **should** respect the view of subjects, and help them to make informed decisions about participation.	2011	2012
2) Legal requirements confidentiality and data protection	• Under Common Law, information provided in confidence by an individual **must only** be disclosed to others with that individual's consent, unless there is a statutory requirement to disclose or if disclosure is in the public interest. • Research that uses data collected originally for a different purpose is compatible with Data protection provided that certain "relevant conditions" are met; namely that the data will not inform decisions about the individuals and that processing is not likely to cause damage or distress to subjects. • The core principles outlined in the legal framework are that personal information collected for the purposes of research should be regarded as confidential and that, wherever possible,	**	

	subjects **<u>should be informed</u>** about it use and give explicit consent. • Personal information to be used in research **should** be anonymised (stripped of any information that might enable identification of the individual) at the earliest opportunity in a study. • Data that are already anonymised at the point of access do not fall within the scope of the Data Protection nor would disclosure of them constitute a breach of Common Law. • Occupational physicians who access personal information for research purposes **<u>must be</u>** aware of the statutory framework and be prepared to justify their actions.		
3) Confidentiality And data protection in occupational medicine	• If it is possible that routine occupational health records or personal exposure data will be used for research purposes, the occupational health provider **<u>must</u> ensure that employees are informed.** Therefore, when an occupational health record is created (at pre-employment, or at the time of first presentation), the individual should be told that their data might be used for research, how it might be used and how confidentiality will be protected. This information could be given, for example, in leaflets or letters, and reinforced by posters or notices. • If employees were not aware that their personal information might be used for research, it would be inadvisable to do so without explicit individual consent (although it might be lawful in rare cases if the justification was very strong). • If research carried out by a third party entails contact with subjects (for example questionnaires, interviews or examinations), the initial contact letter **<u>should</u>** come from the local occupational physician rather than the research team.		
4) Security	• Data held for research purposes **<u>must be</u>** kept secure from accidental or malicious disclosure. Hard copy information **<u>should be</u>** stored in secure archive facilities. Care should be taken that access is restricted, and that all staff understand their duty to protect data. All computerised information should be protected by password. • Data **<u>should be</u>** downloaded from portable computers onto secure terminals at the earliest opportunity and deleted from the portable's memory. Epidemiological research records should be kept for twenty yeas. • Linkage records are usually destroyed at the end of a study (unless required for later follow up), but records of destruction should be kept for audit	**	

	purposes. • Data that are retained must be stored under the same secure conditions as when the study was in progress.		
5) Obtaining consent	• Ensuring that consent for participation in research is properly informed is an important ethical requirement. • Studies that involve discomfort, inconvenience or risk of harm (for example venepuncture, skin prick tests or x-rays) require **formal written consent** from each subject. Consent forms **<u>should explain</u>** why subject have been selected; and must include a clear statement of what is involved for the subject including details of discomfort, the nature and size of any associated risks, and the potential benefits to the individual or their peers. • It is important that the researcher has a **plan for communication of results as part of the protocol.** The group results of research should not be withheld from participants who should be informed before, or al the same time as, wider dissemination to the general public.		

10. Practice premises

11. Health Problems			
1) Alcohol & drugs			
2) Sick colleagues			
3) Physical and mental health			
4) Doctors with infectious diseases			

Clinical Audit 2011

Confidentiality and Consent

Occupational Health Clinical Records

	1. Policy and Procedures & Consent forms, Checklist	**Yes**	**No**	**N/A**
	Does your practice have the following policies / forms?			
1	"Policy on confidentiality and disclosure of information" for the Occupational health service			
2	Policy and procedure for right of access for employees to their clinical records			
3	Policy for dealing with Freedom of information requests			
4	Policy for individual employee to access their confidential medical record.			
5	Consent form for disclosure of information including when consent is with held.			
6	All documents which form part of the OH record but which are issued by the employer, such as pre employment screening forms are marked confidential.			
7	Appropriate - Consent forms for treatment - Consent forms for blood tests - Consent forms for vaccination –			

	Occupational Health Clinical Records (OHCRs)			
1	**OHCRs** differentiated from **health records.** Health records may include job history, exposure details and advice on fitness for work. These records should be kept separate to clinical records.	**Yes**	**No**	**N/A**
2	Health records required to be retained by statute, should not be held by the occupational health departments. Such records should be retained by the employer.			
3	An Occupational Health Organisation should not hold clinical records on its own staff.			
4	Have a written policy and guidance on data protection - Have named data controller (Data Protection) -			
5	Policy to destroy data that no longer has clinical use. Written policy on the length of time until destruction. Paper records must not be disposed of in general waste and should be shredded.			
6	Policy for peripatetic occupational health workers: Records removed from secure storage for transport when needed During travel are secured out of site in a vehicle, and are placed back in storage when work is completed.			
7	Staff who do not have clinical duty of confidentiality must have training in this area, and having completed training, sign a confidential agreement.			
8	Retained and archived records, paper or electronic, must have the same security and confidentiality requirements as ‘live records’.			
	Electronic records			
9	Policy statement on computer use – [Offence to deliberately access or modify, without authorisation, computer material]			
10	Confidentiality agreement for IT staff who may be required to access databases for maintenance purposes.			

	2. Individual Chart - Audit Checklist	**Yes**	**No**	**N/A**
1	**Records** should be legible- contain the minimum of abbreviations - and be clearly dated - and clearly signed -			
2	**Pre employment:** Is there a statement on the pre employment health questionnaire: a. That clinical records will be created - b. explicit statement that the form will be treated as confidential to the occupational health service - [An explicit statement of confidentiality is recommended together with details of who, within the occupational health team, may access the information and for what purpose, such as continuity of care]			
3	**Health Surveillance:** **A:** Has Health surveillance data, which is shared with the employer been anonymised - **B:** Are Health records (job histories, exposure details and advice regarding fitness for work) required by statute retained by employer -			
4	**Management Referral:** **A:** Is their information that the employee has been appropriately informed about the purpose of the health assessment and consents to the process including the preparation of the occupational physicians report by signing an appropriately worded consent form? **B:** Evidence of explanation to patient of the information that the occupational health physician may seek from their treating physician – [Blanket consent, to allow for example, an occupational health physician to write to any doctor about any matter cannot be informed and is, consequently, unethical.] **C:** Explanation of the nature of the information that might be disclosed to the employer. **D:** Evidence that the contents of the report were made available to the employee			

		Yes	No	N/A
5	**Consent** **A:** Appropriate consent has been obtained for treatment - **B:** Appropriate consent for vaccination - **C:** Appropriate consent for blood test – The patients has received all the necessary information to give consent to the procedure. [Consent is a continuous process. Consent should be obtained for each of a series of actions. For example, consent for an occupational health physician to obtain a report from the general practitioner should not be assumed to be consent for disclosure of information so obtained.] Oral consent documented contemporaneously in the medical record – Written consent to confirm that the subject agreed to a specific action or actions at a particular point in time -			
6	**Disclosure of confidential information**			
	A: Relevant information on restriction to work activity given without clinical information.			
	B: Disclosure to a third party, e.g. solicitor The occupational health professional should clarify with the individual the information they wish to disclose – [The individual may not realise, non-related health issues may be included in the occupational health clinical record.]			
	C: Medico legal reports are not stored with the occupational clinical record to prevent accidental disclosure.			