

Interpretation of medical information acts by UK occupational physicians

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| Background | Difficulties arise in applying the Data Protection Act 1998 and the Access to Medical Reports Act 1988 in occupational health practice. There is no guidance on detailed aspects of applying these Acts in practice and consistent advice has proved difficult to obtain. |
| Aims | To audit the understanding and practice of UK occupational physicians to see if a consensus view existed. |
| Methods | A postal questionnaire sent to all UK-based Society of Occupational Medicine (SOM) members between December 2005 and June 2006. Responses were analysed using the SPSS 13.0 software. |
| Results | Responses were received from 726 SOM members, a response rate of 48%. The study revealed wide variation and a limited consensus in practice. Significant differences existed between doctors with a Diploma in Occupational Medicine and those with higher Faculty qualifications, between part-time and full-time practitioners and between doctors who qualified pre- and post-1974. |
| Conclusions | The audit revealed wide variation in responding to clinical scenarios in relation to both the Access to Medical Reports and the Data Protection Acts. The findings have implications for clinical practice, policy and research. The majority of respondents reported that national guidance is needed. |
| Key words | Access to Medical Reports Act; audit; consent; Data Protection Act; Occupational Medicine, reports. |

Introduction

The Access to Medical Reports Act 1988 (AtMRA) gives individuals in the UK a right of access to medical reports relating to themselves provided by medical practitioners for employment or insurance purposes [1]. Employees are entitled to input into reports prepared by a medical practitioner responsible for their clinical care. Care is defined in the Act as follows: 'Care includes examination, investigation or diagnosis for the purposes of, or in connection with, any form of medical treatment' [2].

The Data Protection Act 1998 (DPA) [3] gives individuals a right to obtain information that forms part of their health record. A health record [4] is information relating to their physical or mental health that has been made by or on behalf of a health professional (not only a doctor) in connection with the care of that individual.

These two Acts do not specifically refer to occupational physicians (OPs) and the application of the law

with respect to their practice is unclear. Unnecessary application of the AtMRA could lead to problems ranging from delays in case management to a potential compromise of the impartial status of OPs [5]. However, failure to comply may have legal consequences, so clarification of when this Act applies in practice is needed. The DPA also leads to difficulties, particularly when employees wish to obtain a copy of an employer's referral letter directly from an occupational health (OH) professional, rather than from their employer.

The primary objective of this study was to audit the current practice of UK OPs with regard to these statutes. The secondary objective was to evaluate factors associated with any differences in practice.

Methods

No currently available assessment tool for this project was identified from the literature or from canvassing key opinion leaders in the field. A specific questionnaire was devised from interviews with experts in the field and was field tested for face and content validity with a group of National Health Service (NHS) and private OPs. This led to minor wording amendments. The questionnaire was not subjected to more formal assessment primarily because those on whom it was piloted reported discussing

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it among themselves and reviewing their textbooks precluding any test–retest and reliability evaluations. Part A contained seven real anonymized OH scenarios and Part B tested knowledge of the Acts and local procedures. Respondents were asked to select from three possible answers ‘No/Never’, ‘Sometimes’ and ‘Yes/Usually’. Part C contained demographic and professional questions about the respondents.

A survey of UK-employed OPs who were members of the Society of Occupational Medicine (SOM) was subsequently carried out between December 2005 and June 2006 using the questionnaire, which was distributed by post for self-administration, with an assurance of confidentiality. A reminder letter was sent out in March to increase the response rate.

Data were processed and analysed using SPSS-13.0 software. Frequencies and proportions were calculated to summarize the data. Associations of demographic variables including the number of years since qualification in medicine (divided by quartiles), the highest occupational medicine (OM) qualification, the type of employing organization and the working hours against the answers were investigated and the variations in response analysed with chi-square test or chi-square test for trend, depending on whether the answers, were nominal or ordinal.

P-values <0.01% were considered significant to allow for a conservative estimation of significant differences. Consensus of opinion was deemed to be present when there was at least 80% agreement.

Results

A total of 726 out of 1500 questionnaires were returned, giving a response rate of 48%. In total, 610 of the questionnaires were analysed. Others were excluded for various reasons such as working abroad, working in a different medical speciality or retirement (23), blank returns (76) and late arrivals (17).

Table 1 below summarizes the general characteristics of the study group. Not all categories add up to 610 because of occasional missing data points. The mean time since qualification in medicine was 27 years (SD = 9.1, range 7–62 years). Those members with the Diploma in Occupational Medicine (DipOccMed) worked predominantly part time in OH practice. No statistically significant differences in responses were found between different sectors of employment.

There was a widespread variation in practice and no consensus with regard to any of the questions evaluating AtMRA-related knowledge and practice. Only five of 21 questions, all concerning the DPA, achieved consensus. The detailed results and the questionnaire are available as Supplementary data at *Occupational Medicine* Online.

Length of medical service was analysed in quarters. The first quarter qualified before 1974, the second be-

Table 1. Characteristics of the respondents

| Variables | | <i>n</i> (%) |
|---|---------------------------|--------------|
| Years in OM | <5 | 79 (13) |
| | 5–10 | 126 (21) |
| | >10 | 387 (65) |
| Specialist registrar status | Yes | 81 (14) |
| | No | 501 (86) |
| Specialist General Medical Council registration | Yes | 301 (52) |
| | No | 281 (48) |
| Highest OM qualification | FFOM | 134 (25) |
| | MFOM | 163 (30) |
| | AFOM | 118 (22) |
| | DipOccMed | 133 (24) |
| | DIH | 3 (1) |
| Type of organization | DDAM | 11 (2) |
| | NHS | 111 (19) |
| | Academic | 9 (2) |
| | Private | 258 (45) |
| | Public | 67 (12) |
| Working hours | Armed forces | 33 (6) |
| | Combined | 93 (16) |
| | Full time | 338 (55) |
| Memberships/affiliations | Part time | 245 (42) |
| | SOM | 610 (100) |
| | FOM | 443 (75) |
| | Royal Society of Medicine | 115 (19) |
| | | |

DIH, Diploma in Industrial Health; DDAM, Diploma in Disability Medicine.

tween 1974 and 1980, the third 1980–85 and the fourth after 1985. There were differences in responses to questions between doctors qualifying before 1974 and the other quarters of respondents qualifying after 1974, of which two were statistically significant (Table 2).

Eight out of 21 questions showed statistically significant differences between respondents with the DipOccMed and respondents with a higher Faculty of Occupational Medicine (FOM) qualification (Table 3). Table 4 contains definitions of qualifications.

Differences between part-time and full-time members also reached statistical significance in 10 out of 21 questions (Table 5).

Over 72% of respondents reported that they would welcome more guidance that would be ‘defendable in law’, ‘supported by the FOM/SOM’ and ‘in line with the GMC requirements’.

Discussion

This study demonstrated widespread variation in understanding of, and no consensus regarding duties created under the AtMRA and limited understanding and consensus regarding the DPA, as tested using real case

Table 2. Questions which elicited significant differences in response between doctors who qualified in medicine before 1974 and those more recently qualified

| Clinical scenarios | Answers | <1974 <i>n</i> (%) | 1974–80 <i>n</i> (%) | 1980–85 <i>n</i> (%) | 1985 <i>n</i> (%) | <i>P</i> value |
|--|-----------|-----------------------|-------------------------|-------------------------|----------------------|----------------|
| A patient is referred for a retirement assessment on the grounds of ill health. He is subsequently dismissed from work as your assessment shows failure to satisfy the pension fund criteria. Three months later you receive a letter from his solicitors requesting (with written consent) copies of his complete OH record. ● If there had not been a consent form enclosed would you still be obliged to release copies? | Yes | 23 (14) | 5 (3) | 6 (4) | 3 (2) | <0.01 |
| | Sometimes | 6 (4) | 10 (7) | 8 (6) | 8 (6) | |
| | No | 136 (82) | 140 (90) | 125 (90) | 129 (92) | |
| A manager writes insulting comments about Mr X in the referral letter. The manager believes that his letter is confidential and cannot be seen by an employee without his consent. At the end of your consultation Mr X requests, in writing, a copy of the manager's letter under the DPA. ● Would Mr X be entitled to a copy of this letter? | Yes | 114 (73) | 131 (86) | 117 (86) | 118 (85) | <0.01 |
| | Sometimes | 12 (8) | 12 (8) | 10 (7) | 10 (7) | |
| | No | 30 (19) | 9 (6) | 9 (6) | 11 (8) | |

Table 3. Scenarios which elicited statistically significant differences in response between doctors with DipOccMed and those with higher FOM qualifications

| Clinical scenarios | Answers | DipOccMed <i>n</i> (%) | FOM <i>n</i> (%) | <i>P</i> value |
|---|-----------|---------------------------|---------------------|----------------|
| Following your one and only occupational health assessment of Mr X you send the report to his employer. Mr X disagrees with its content and he complains to your professional body. ● Is your report subject to the AtMRA? | Yes | 67 (51) | 135 (33) | <0.01 |
| | Sometimes | 11 (9) | 50 (12) | |
| | No | 52 (40) | 224 (54.8) | |
| You refer a nurse with signs of chronic latex allergy to a dermatologist for further investigation and treatment. The nurse specifically asks you to mention the clinical details in the report written to her employer. ● Does the AtMRA apply to the referral to the dermatologist? | Yes | 83 (62) | 172 (42) | <0.01 |
| | Sometimes | 4 (3) | 21 (5) | |
| | No | 46 (35) | 213 (52) | |
| A nursery worker is signed off work by her GP for another three months. Your examination reveals signs of mechanical back pain and you encourage her to return to work as soon as possible, perhaps with initial adjustments. You communicate this to her GP as well as to her employer. ● Is she entitled to see the letter written to her GP under the AtMRA 1988? ● Is she entitled to have a copy of the letter written to her GP under the AtMRA 1988? | Yes | 76 (58) | 178 (44) | <0.05 |
| | Sometimes | 8 (6) | 29 (7) | |
| | No | 48 (36) | 201 (49) | <0.01 |
| | Yes | 74 (56) | 164 (40) | |
| | Sometimes | 10 (8) | 31 (8) | |
| No | 48 (36) | 211 (52) | | |
| A patient is referred for a retirement assessment on the grounds of ill-health. He is subsequently dismissed from work as your assessment shows failure to satisfy the pension fund criteria. Three months later you receive a letter from his solicitors requesting (with written consent) copies of his complete occupational health record. ● Are you obliged to release copies of the medical records under the DPA? | Yes | 102 (79) | 362 (89) | <0.05 |
| | Sometimes | 8 (6) | 13 (3) | |
| | No | 19 (15) | 30 (7.4) | |
| After ruling out the diagnosis of the Hand Arm Vibration Syndrome, you refer a worker to a rheumatologist for further tests. ● Is the specialist's subsequent reply to you subject to the AtMRA? ● Is your subsequent report to his employer subject to the AtMRA? ● Would a treating physiotherapist's letter to you be subject to the AtMRA? | Yes | 104 (78) | 277 (68) | <0.01 |
| | Sometimes | 2 (2) | 36 (9) | |
| | No | 27 (20) | 95 (23) | |
| | Yes | 63 (48) | 165 (40) | <0.01 |
| | Sometimes | 23 (17) | 37 (9) | |
| | No | 46 (35) | 205 (50) | |
| | Yes | 107 (81) | 269 (67) | <0.05 |
| | Sometimes | 6 (5) | 32 (8) | |
| | No | 20 (15) | 103 (26) | |

Table 4. UK OM qualifications

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|-----------|---|
| FFOM | Awarded to consultant OPs who have made a distinguished contribution to OM. |
| MFOM | Awarded once Higher Specialist Training is complete (4 years minimum), the AFOM is passed and a dissertation is accepted. This qualification allows access to the UK General Medical Council Specialist Register. |
| AFOM | The examination for AFOM is usually part of Higher Specialist Training in OM. |
| DipOccMed | An introductory level qualification aimed at doctors such as general practitioners who are not OM specialists but wish to develop some knowledge and skills in this area. |

Table 5. Responders' qualifications and working hours in OM

| Qualifications | Part-time work | Full-time work | Total |
|----------------|----------------|----------------|-------|
| FFOM | 34 | 98 | 132 |
| MFOM | 40 | 122 | 162 |
| AFOM | 44 | 69 | 113 |
| DipOccMed | 103 | 28 | 131 |
| Total | 221 | 317 | 538 |

scenarios. This illustrates real practical dilemmas for OPs practicing in the UK. The study identified significant differences in opinion between doctors with DipOccMed and those with higher FOM qualifications, as well as between subjects who qualified in medicine before 1974 and those more recently qualified.

The study has a number of limitations. First, the questionnaire was not subjected to full evaluation which may limit its reliability. Only two simple assessments of validity were made. As with any vignette-based evaluation (or questionnaire of any type), the respondents may misunderstand what is being asked which would contribute to variation in results (although this difference in understanding is also part of what the study was trying to evaluate). We have no reason to assume that this would be anything but random misclassification which would have the effect of reducing real differences.

The survey also generated a response rate of only 48%. This is, however, a good rate for a postal survey, reflecting the anecdotal reports that this area is of interest to SOM members. We were only able to assess one aspect of response bias as the SOM could not furnish us with demographic details. However, the proportions of respondents with different levels of specialist qualifications in OM [76% Associateship of the FOM (AFOM), Membership of the FOM (MFOM) or Fel-

lowship of the Faculty (FFOM) and 24% DipOccMed] reflect that of the SOM (75% AFOM, MFOM or FFOM and 25% DipOccMed). We excluded non-UK members and so cannot comment upon such laws in other jurisdictions.

The different aspects of each vignette and the responses warrant further individual exploration:

Case 1 revealed consensus on providing a copy of the referral letter to an employee who requests it. However, there was disagreement on whether an employee should be allowed to see a referral containing derogatory comments and whether a manager should be regarded as 'another person' or a 'third party' under the DPA. A majority believed that an employee would be entitled to a copy of this management referral.

The Information Commissioner's (IC) office indicates that the management referral is a document created by an employer who is the data controller. The data subject is a patient/client or any individual who is the subject of personal data. An OP is the data processor dealing with a case on behalf of or under the instruction of the data controller.

A request for a copy of the management referral should therefore be made to the employer (the data controller), rather than to an OP. However, the moment a referral becomes part of the OH computer or paper record, not a health record *per se* but personal data under the wider definition of the DPA, the author of the referral becomes a third party or another person and the OP becomes the data controller. Third party principles should then apply [6], meaning that the third party should consent to disclosure. Where a third party declines consent, release of the referral should be made after proper consideration of the potential conflict between a data subject's right of access and respect for a third party's privacy or a potential duty of confidentiality. The IC's office recommends case-by-case management with a clear policy based on local agreement of all stakeholders. The latest FOM Guidance on Ethics for Occupational Physicians (May 2006) also recommends a written policy and guidance on data protection [7]. The employees' means of access to this management referral may therefore depend in practice on any contractual agreement with an employer or an agreed local policy.

In Case 2, the issue of interpretation of the AtMRA in day-to-day OH reports to management was summed up by a comment from one of the respondents: 'At what stage does contact with patients constitute care so that the AtMRA therefore applies?'

Current British Medical Association (BMA) guidance overrides previous contradictory web-based advice from 1995 which stated that 'experts or doctors not involved in patients' clinical care were excluded from this legislation but OPs who even counselled workers on their suitability for a job in relation to their health or who advised on individual fitness for work would be subject to the

AtMRA'. The BMA's most up-to-date view is that AtMRA does not apply to internal communications between doctors and managers, as long as the OP is not providing clinical care but acts as an independent medical examiner [8].

The latest FOM Guidance on Ethics states that 'the main additional rights through the Act relate to the specific timescales and wording' and 'most of the rights conferred by the Act in 1998 are now available to individuals through other legislation or developments in ethical guidance. Release of information to a third party can only take place with consent' [9]. The UK Department of Health states that reports prepared by other medical practitioners, contracted by the employer or insurance company, are not covered by the AtMRA [10].

The study showed that almost a fifth of responders would not allow an employee to see the management report before it was sent to the manager, whereas some send a copy to the employee automatically and others recommend that it should be offered. Whether OP reports are covered by the Act remains unclear, hence the request for guidance specific to OH practice. The issues around amendments and disagreements are discussed in relation to Case 6.

Case 3 demonstrated wide divergence of opinion on whether a referral of a nurse with signs of latex allergy to a dermatologist would be covered by the AtMRA, with 46% indicating that they believed that the Act did not apply. This appears to be a situation where an OP is involved in care and therefore the AtMRA might apply, but are they 'responsible' for clinical care? Are referrals also covered by the Act?

A supplementary question (available as Supplementary data at *Occupational Medicine* Online) about whether subsequent reports to management would be covered by the AtMRA also revealed substantial divergence of opinion. Does the Act apply to a report after such a referral? The law does not appear to be clear on this point, so this requires further discussion and guidance.

In Case 4, the majority agreed that the DPA entitles the employee to a copy of the OP's letter to a general practitioner. However, it is not clear why almost 10% of society members believed that this report would not constitute a health record under the DPA, when it clearly does.

Many respondents seemed unclear whether such a letter would fall within the scope of the AtMRA. This raises important but unanswered questions about whether examination in an OH context would be regarded as 'care' and therefore fall within the scope of the Act.

Case 5 asked about disclosure of records. Section 55 (1) of the DPA states that a person (including solicitors) must not knowingly obtain any personal data without consent, yet 6% would allow disclosure to a solicitor without written consent. Breach of this duty is a potential criminal offence under Section 55 (3). The fees chargeable for copying records are limited.

In Case 6, we asked about amendment of an OP's report by the data subject. Under the AtMRA, an individual can request an amendment [11] or append his disagreement to the report or even withhold the consent to the release of information. When asked whether an employee can amend a report written to an employer following a single OH contact, over two-thirds of respondents felt that the employee did not have this right. One-third of respondents would allow this. In this scenario (a straightforward fitness report), the AtMRA probably does not apply. In contrast, the DPA Section 41 creates 'Rights of Rectification' [12] that allows the data subject to formally request changes to a health record. When an employee can insist on altering, a report requires further guidance.

A supplementary question (available as Supplementary data at *Occupational Medicine* Online) asked whether certain information could be withheld when the employee requests copies of the report. This can be done under both Acts if the information contained in the report could cause serious harm to the patient's physical or mental health or to others. However, neither Act clearly defines 'harm' or 'others' and the interpretation is left to the doctor's discretion. Responses to this question showed a wide difference of opinion.

In Case 7, >70% of responders believed that the specialist's letter to the OP would be covered by the AtMRA, but this still did not reach our defined level for consensus. Was the OP 'responsible for clinical care' within the meaning of the Act when ruling out a diagnosis or when referring to a specialist? The answers suggest further guidance is needed.

A physiotherapist's letter to an OP is not covered by the AtMRA as physiotherapists are not medical practitioners registered under the Medical Act 1983 but Allied Health Professionals regulated by the Health Professions Council and the Health Act 2000. Their reports would be covered by the DPA. Only 22% of respondents were correct in their response on this point.

Differences were statistically significant when associations with years since qualification in medicine, working pattern and qualification status were examined. In the absence of consensus or a clear standard, it is not possible to state which of differing views were correct. As one of the respondents put it, the interpretation of the AtMRA for OP's is 'confusing and controversial not only for the doctors but also for employers, patients, unions and sometimes legal advisors'. However, this may raise questions about the effectiveness of continuing professional education for this area of practice.

This audit demonstrates a lack of consensus among UK practising OPs on the application of AtMRA to scenarios from real OH practice. The responses strongly indicated that further authoritative guidance was needed. Draft guidance has subsequently been provided and is open to consultation on http://www.facocmed.ac.uk/library/docs/atmra_may08fwd.pdf. Once accepted, this

guidance may be used as a standard against which a further audit would be desirable.

Key points

- This study revealed differences in understanding and practice among UK-employed occupational physicians with regard to the Access to Medical Reports Act and the Data Protection Act.
- Doctors with Diploma of Occupational Medicine, those working part time and those qualified longest in medicine demonstrated differences in practice in comparison with their colleagues.
- UK occupational physicians feel in need of further authoritative guidance on these matters.

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Conflicts of interest

None declared.

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