CONFIDENTIALITY

PG Cert Dental Law and Ethics pre-reading

ABSTRACT

An overview of the law of confidentiality in healthcare

Len D'Cruz

[Course title]

CONFIDENTIALITY

Ibn Gabirol (1021-1058) a Spanish poet captured the essence of confidentiality with

"Your secret is your prisoner; once you reveal it you become its slave."

Consider the following:

A uniformed police officer comes to the practice requesting the dental records for a patient he believes has been treated by the practice. He wants the records in connection with an assault.
A solicitor writes to you requesting a dental report for their client following a road traffic accident.
A purse is stolen from a patient's coat hanging up in the waiting room and the only suspect is another patient. The victim of the theft wants the details of the suspect patient. A school phones up wanting to know if a pupil has had a dental appointment that day.

These are common problems faced by practitioners, the answers to which are sometimes complex, sometimes surprising but are all underpinned by common principles. Once these principles are understood it becomes easier to approach issues of confidentiality in general dental practice.
The dentist-patient relationship is based on trust and one of the most powerful expressions of this is the expectation that everything that takes place in the dental surgery will be kept confidential by the practice staff. This expectation however is not an absolute one and exceptions to this exist as we will see later.

One of the most fundamental ethical obligations owed by a doctor to his patient is to respect the confidences of his patient. That this has long been a central premise in our approach to medicine and can be seen from the fact that the Hippocratic oath states:

Whatsoever things I see or hear concerning the life of men, in attendance on the sick or even apart therefore, which ought not to be noised abroad, I will keep silence thereon, counting such things as sacred secrets[1].

Confidentiality is grounded in the patients right to autonomy and enables the patient to have an open and honest dialogue with his or her dental professional, with benefits to the individual and the general public health

In the context of this chapter **confidentiality** is defined as the statutory and professional duty to safeguard personal information by preventing its improper disclosure.

The Data Protection Act 1998 says “personal data” means data which relate to a living individual who can be identified from those data whereas
“sensitive personal data” means personal data consisting of information as to—
(a)the racial or ethnic origin of the data subject,
(b)his political opinions,
(c)his religious beliefs or other beliefs of a similar nature,
(d)whether he is a member of a trade union
(e)his physical or mental health or condition,
(f)his sexual life

For the purposes of dental records only e) would normally apply although racial and ethnic background are collected especially in NHS practices.

Both personal data and sensitive personal data is information which dentists and their teams learn in a professional capacity and from which individuals can be identified, either directly or indirectly. These have the quality of confidentiality about them.

The duty to observe the rules of professional secrecy extends to all members of staff in a dental practice irrespective of whether they are registered with the General Dental Council and it is important that training is provided on this subject.

The team approach to confidentiality is often overlooked. An analysis by Garbin et al (2008) stated “…the absence of orientation of dental assistants about professional confidentiality occurs due to negligence or lack of knowledge of the importance to do so.”[2]

GDC Standards for the dental team

You must:
4.1 Make and keep contemporaneous, complete and accurate patient records.
4.2 Protect the confidentiality of patients’ information and only use it for the purpose for which it was given.
4.3 Only release a patient’s information without their permission in exceptional circumstances.
4.4 Ensure that patients can have access to their records.
4.5 Keep patients’ information secure at all times, whether your records are held on paper or electronically.

Confidentiality, as a human right, is protected by the Human Rights Act 1998.
Article 8 of the European Convention on Human Rights provides:

1. Everyone has the right to respect for his private and family life, his home and his correspondence
2. There shall be no interference by a public authority with the exercise of this right except such as in accordance with the law and is necessary in a

democratic society in the interests of national security, public safety or the economic well being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

When deciding whether a breach of Article 8 has occurred the court will decide whether the interferences are justified a) in accordance with domestic UK law b) there was a legitimate aim in breaching this right to privacy and that c) it was necessary in a democratic society.

This three stage test was the basis of making a judgement in *Z v Finland* [3] which ruled on the confidentiality of Z's medical records which were disclosed in the course of an investigation into sexual assaults carried out by X, who was HIV positive and married to Z, a Swedish national.
The Court had this to say
The Court will take into account that the protection of personal data, not least 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 of 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 service in general.

Since the case in question related to HIV infection it is worth noting what the judges had to say, as this has direct relevance to general dental practice.

The disclosure of such data [a person's HIV infection] may dramatically affect his or her private and family life, as well as social and employment situations, by exposing him or her to opprobrium and the risk of ostracism. For this reason, it may also discourage persons from seeking diagnosis or treatment and thus undermine any preventive efforts by the community to contain the pandemic. The interest in protecting the confidentiality of such information will therefore weigh heavily in the balance in determining whether the interference was proportionate to the legitimate aim pursued. Such interferences cannot be compatible with Article 8 of the Convention unless justified by an overriding requirement in the public interest.

It would be hard to conceive of a situation therefore in the context of general dental practice where the disclosure of such confidential information such as HIV status of a patient would be in the interest of the public. The converse however is not true and HIV and Hepatitis B/C positive healthcare workers who *would* be classed a risk to patients and by therefore by definition, the public. The issues surrounding the duty of confidentiality is a different one and one to which we will return later on.

To disclose or not to disclose?

Essentially it can be seen that the basic premise is that all information relating to a patient's dental care remains confidential but the decision to disclose some or all of

it to a third party without their consent will depend on public interest. It should also be considered on a case by case basis.

The starting point is that, with the patient's consent, confidential information can be disclosed to a third party. This may be in relation to a dental insurance claim, release of records to do with an accident or dental trauma, a dental negligence claim or to another practitioner who maybe taking over future dental care at another practice. It is important that these requests are accompanied by a signed form of authority from the patient (or their legal guardian in the case of a child) allowing the practice to disclose the relevant confidential documents.

The key factors in deciding whether or not to share confidential information are *necessity* and *proportionality.*

The test of **necessity** is whether the revelation of the information is essential in protecting the public interest. The test of **proportionality** is necessary to meet the requirements of the European Convention of Human Rights Article 8(2). The guidance also suggests that "health professionals must objectively assess public interest….and not their own subjective views of what constitutes a public interest."[4]

The following guidance is a useful summary of the factors that dental team members may use in deciding on the appropriateness of disclosing confidential information:

Decisions about disclosures of confidentially sensitive information must be made on a case-by-case basis. In considering whether to disclose information staff should consider the merits of each case however, certain considerations will need to be taken in all cases:

• Extent of the information which is to be disclosed – it will be easier to justify disclosure of demographic data or the fact that someone attended a practice rather than detailed health information.
• The nature and impact of the crime or harm justifying the disclosure - it will be easier to justify disclosure of information relating to a physical attack against a person than it would be for shoplifting for example .
• Whether the disclosure is for detection or prosecution of crime or harm to others or whether it is preventative - it may be more justifiable to disclose information to support prosecution in relation to a crime that has occurred than to prevent a crime which has not yet occurred.

A public interest justification for disclosure can be considered, in situations where:

• Disclosure would be in the public interest AND
• The purpose of the disclosure cannot be achieved with anonymised information AND
• There is no statutory basis for disclosure AND
• Patient consent has not been given because:

o It is not practicable to ask the patient(s) for consent e.g. because, for example, there are no up-to-date contact details for the patient, or the matter is urgent and the patient cannot be contacted; OR
o It would be inappropriate to ask the patient(s) because, for example, they lack the capacity to give consent, or they are suspect(s) who should not be informed that they are under criminal investigation; OR
o The patient(s) have been asked for consent and refused.[5]

Disclosure of confidential information on economic grounds

Disclosure can be justified by Article 8(2) in certain circumstances other than those identified by Z v Finland above where the grounds were "preventing crime" and "protecting the rights and freedoms of others".

In *MS v Sweden* [MS v Sweden (1997) 45 BMLR 133 (EctHR)] ,a case that was heard at the European Court of Human Rights, medical records of MS were disclosed to the Social Insurance office following her claim for compensation under the Industrial Injury Insurance Act in Sweden. The medical records from her doctor revealed much about her past history and her claim for compensation was rejected by the Social Insurance Office on the grounds that her sick leave had not been caused by an industrial injury.

Here it was argued by MS that the information collected and stored at her doctor's surgery in connection with medical treatment should not have been passed on since this communication, to another government department albeit to assess her claim, served a different purpose and one to which she had not consented.

In finding against her application the court relied on the need to "protect the economic well being of the country". Since the other agencies that received the medical information were also under a similar duty as the doctor's clinic to treat the data as confidential it was argued that the disclosure was limited in any case.

This has relevance in general practice in two specific examples. The first is the relationship of HMRC (Her Majesty Revenue and Custom) known also as the Inland Revenue to patient records and the second relates to patients waiving their rights to confidentiality specifically in signing the NHS form FP17:

a) Inland revenue investigations

HMRC, in order to verify the veracity of a dentist's accounts are empowered under the Taxes Management Act 1970 Section 19a to serve a notice requiring the dentist to:
"produce to the officer such documents as are in the taxpayers possession or power and as the officer may reasonably require for the purpose of determining whether and , and if so, the extent to which..(i) the return is incorrect or incomplete"

Case law offers little confirmation whether the financial affairs between a dentist and a patient has the necessary quality of confidence about them but the profession has commonly regarded any information sought by the Revenue from which patient's identity is ascertainable, should be classified as confidential information. This will include record cards, patient's names from NHS schedules, receipt books and appointment diaries and may be required to confirm the basis of a practitioner's taxable earnings and allowances.
The issue of a formal notice under Section 19A of the Taxes Management Act according to *Guyer v Walton*[6] overrides the dentists duty of patient confidentiality and oblige the release of the records where they are the most effective way of working out the true amount of tax liability.[7]

Disclosure of confidential information without patient consent is permitted only when

a) required by law and
b) when disclosure of the information is in the public interest.

Disclosure required under a) is under compulsion therefore and the duty of confidence is automatically overridden by the duty to comply with the law of the land [8]and also *Hunter v Mann*[9]. In this latter case a doctor was compelled under Section 168 of the Road Traffic Act 1972 to provide the name of a patient who was a dangerous driver.

Article 8 of the Human Rights Act confers qualified rights to the patient to have respect for their private lives but disclosure is authorised where it is potentially for the economic well being of the country and could assist in the prevention of crime (tax fraud). Thus the Human Rights Act actually confers legitimacy on the action of HMRC to pursue disclosure of the patient's records.

Similarly, the Data Protection Act, whilst recognising that the dental records may contain sensitive data (as defined in Section 2 of the Data Protection Act 1998) disclosure is allowed without consent of the patient if required by law or any enactments, by any rule of law or by order of a court. The Taxes Management Act 1970 is just such a rule of law and therefore the Data Protection Act offers no protection of the records from disclosures.

HMRC officers themselves are under their own duty of confidentiality and will in any case only request records as a last resort for the prevention or detection of a crime, usually fraud.

Thus is can be seen that if the Inland Revenue decided to conduct an enquiry under Sec 9A of the Taxes Management Act 1970 into the accuracy of a dentist tax returns, so long as certain notice formalities are complied with, a notice may be served.

Even if the dental records requested contain only one, or even no valid entry necessary to check the accuracy of the tax return, a request for disclosures of the whole dental record, including the medical history could be validly be made.

HMRC may also require details of treatment or appointment when investigating the tax affairs of patient themselves and may seek this confidential information from the practice. They require and will expect you not to notify the patient of their enquiry. They are able to do this under Section 29(1) of the Data Protection Act 1998 where the information they are requesting is concerned with the prevention or detection of crime and or the apprehension or prosecution of offenders and where failure to provide it would prejudice the investigation.

A dental record is thus disclosable to the Inland Revenue. Defence organisations now suggest that in order to protect confidential information being disclosed in any tax investigation the financial transactions are kept separate from the treatment records. Computer programmes are capable of doing this and therefore a request for a print out with just the patients name and details along with the financial transactions can be disclosed without fear of breaching patient confidentiality. The GDC would expect dentists to comply with the law and assist government officials whose job it is to enforce the law.
For manually kept records a separate card/log for financial transactions should be kept. This card should carry both NHS and private financial transactions with dates of payments but no treatment details.

b) Patient declaration made by NHS patients

As part of the administration of an NHS course of treatment a patient has to sign various forms one of which is a claim form, an FP17 or PR (Practice Record form). The FP17 manual claim form is sent to the payment agency, the Dental Practice Board to confirm what treatment has been provided by the dentist and to enable payment to be claimed.

A claim can also be generated electronically by computer and transmitted to the Dental Practice Board by an EDI link in which case the PR form remains in the practice as a record of the patient's attendance for treatment.

The declaration which the patient signs states:

"To enable the NHS to prevent and detect fraud and mistakes, and to secure the effective and efficient delivery of NHS and related services, I consent to the disclosure of relevant information to and by the NHS Business Services Authority, NHS England, Department for Work and Pensions, HM Revenue and Customs, The Health and Social Care Information Centre, local authorities, and bodies performing functions on their behalf"

The wording of these declarations change as NHS contracts develop and also include information about private treatment provided as an alternative to NHS care which may also be shared with other bodies. The consent by the patient to disclose information is a very narrow one and relates only to the patient's status as either a patient who pays the full NHS charge or one who is claiming exemptions for dental

charges which fall into several categories. The consent does not extend to confidential information on the dental records but may be extrapolated on the basis of the wide discretion on consent given in the wording of this declaration.

Common law obligation of confidence

The common law basis of confidences is based on the courts examination of cases from the fields of contract, equity and property.

Lord Goff in the Spycatcher case argued that *The duty of confidence will arise from a transaction, often a contract, in which event the duty may arise by reason of either an express or an implied term of that contract.*[10]

In addition to common law there is also a statutory basis to the obligation of confidence which we will come to in more detail later

In general, the four classes of information that have traditionally been protected by law or whose use has been restricted by the enforcement of confidences are

a) Personal information confided in the context of a professional relationship of trust
b) Trade secrets
c) Government information and
d) Artistic and literary confidences.

Scope of the duty of confidence

*The doctor is under a duty not to disclose [voluntarily], without the consent of his patients, information, which he, the doctor, has gained in his professional capacity (Hunter v Mann [*1974] QB 767)

Thus the obligation extends to all information received by the clinician about the patient and would extend to reports from third parties. This information may come directly from the patients or the dentist's own consultation with the patient or it may come from a third party in circumstances in which the third party knows of the dentist-patient relationship. This occurs commonly in referral letters. For example, a consultant to whom a general practitioner has referred will copy his letters to other specialists back to the GDP to keep them informed about treatment and investigations of the referred patient.

What then does actually constitute a breach of confidence?

If confidential information is disclosed does it have to be deliberate to be a breach of confidence? It has been argued that intention is not a factor and still constitutes a legal wrong if the confidential information is disclosed inadvertently.

In summary the obligations in keeping confidences are these:[11]

a) There is an important public interest in maintaining clinical confidentiality
b) That interest is so strong that the law imposes a duty on clinicians to maintain confidences
c) The duty to keep confidences is not an absolute-sometimes the public interest in disclosure may override it or statute or the disclosure process in litigation requires it.

Audit and the use of anonymised information

Anonymised patient information is used for research, audit and quality assurance and for management purposes in practices. It is also used for teaching purposes and in publications and presented in a way that does not allow identification. There is an implicit assumption that in an anonymised form there is no breach of patient confidences since they cannot be identified.
This issue was discussed in *R v Department of Health, ex parte Source Informatics Ltd* (1999) 52 BMLR 65 CA . In this case Source Informatics were a data collecting company seeking to persuade GP's and pharmacists to allow then to collect data as to the prescribing habits of GPs. They believed this information would be of commercial value to drug companies, and would provide useful data for those interested in monitoring prescribing patterns.

The proposal was that, with the consent of the GPs, the pharmacist would, for a fee, and using software provided by Source Informatics, download onto disc the name of the GP and the identity and quantity of the drugs prescribed, but nothing which could identify the patient. The dispute arose because the Department of Health felt that anonymisation did not, in their view, remove the duty of confidence towards the patients who are the subject of the data and argued that doctors involved in this scheme would be breaching patient confidentiality.

In making his conclusion the judge argued that whilst the consultation leading to the prescription and the information on the prescription handed in to the pharmacist was confidential it ceased to be so when it was anonymised and became purely statistical, carrying with it no information of a personal or private nature. Thus no actual disclosure was made since the personal information could not be related to an individual patient and the patient's personal privacy was maintained.

The key therefore in processing personal information for use other than for the patient's direct treatment or diagnosis is to anonymise the data.

In this context a useful definition of personal information has been provided by Professor Wacks[12]
"Personal information consists of those facts, communications, or opinions which relate to the individual and which it would be reasonable to expect him to regard as intimate or sensitive and therefore want to withhold or at least restrict their collection, use or circulation"

More importantly an essential element in any claim for breach of confidence is that the claimant should have suffered detriment and the patient could suffer no detriment as long as anonymity is secured.

The breach of confidence, even if it can be considered as such with anonymised information could be acceptable if it was in the public interest though in this particular case that was never argued.

Statute protection

Two aspects of the Data Protection Act 1998 allow a practitioner holding the dental records (as a data controller) to process the information they hold for a number of "legitimate" purposes.

Schedule 2 6(1) The processing is necessary for the purpose of legitimate interest pursued by the data controller or by the third party or parties to whom the data are disclosed, except where the processing is unwarranted in any particular case by reason of prejudice to the rights and freedoms or legitimate interests of the data subject.

This condition allows disclosure for the purposes of research, financial accounting, management, audit, preventing fraud within the NHS, for maintaining professional standards or pursuing legal action against another or defending action brought against a NHS body. [13]The second protection for audit comes from Schedule 3 paragraph 8 of the Data Protection Act

8(1) the processing is necessary for medical purposes and is undertaken by-

(a) A health professional, or
(b) A person who in the circumstances owes a duty of confidentiality which is equivalent to that which would arise if that person were a health professional

(2) In this paragraph "medical purposes" includes the purposes of preventative medicine, medical diagnosis, medical research, the provision of care and the management of healthcare services.

Caldicott Guardians

The Caldicott Committee was established by the Chief Medical Officer in England to review all patient identifiable information that passes from NHS organisation to other NHS or non-NHS bodies for purposes other than direct care, medical research or where there is statutory requirement for information. The purpose was to ensure that only the minimum necessary information is transferred in each case.

The report summarised the responsibilities in six key principles but which were modified in 2013

Principle 1. The use and transfer of personal confidential data should be defined and clearly justified and regularly reviewed

Principle 2. Personal confidential data should not be included unless it is essential.
Principle 3. Only use the minimum necessary personal confidential data
Principle 4. Access to personal confidential data should be on a strict need-to-know basis
Principle 5. Everyone with access to personal confidential data should be aware of their responsibilities
Principle 6. Comply with the law
Principle 7. The duty to share information can be as important as the duty to protect patient confidentiality

Central to the implementation of this standard is the appointment of an individual with responsibility for taking this work forward and overseeing its continual development-the Caldicott guardian.

It is unlikely that any but the largest dental practices or groups would need to appoint their own Caldicott guardians and compliance with data protection rules will be sufficient. Compliance with the NHS Information Governance toolkit to Level 2 is required for any practices in England providing NHS care and there are specific requirements to fulfil this.

NHS/Health Authority rights of access to confidential information

General dental practitioners who provide NHS services have a contract with NHS England. This will grant NHS area teams rights of access to dental records that will by definition contain confidential information. By the nature of the contract, which is also a financial one, it will also have access to financial and administrative records including appointment schedules.
The Healthcare Commission also have statutory access granted to it through the Health and Social Care Act 2003 and this is discussed later.

The Audit Commissions Act 1998 contains provisions for dealing with access to premises, information and data in an NHS context. These provisions allow the Audit Commissions to

- Require a person holding or accountable for any such document to give him such information and explanation as he thinks necessary for the purposes of his functions under the Act and
- If necessary, require the person to attend before him in person to give the information or explanation or to produce the document.

Failure to comply is an offence.

Confidential information in the practice environment

The duty of confidentiality owed by clinicians to the patient also extends to the staff in the practice. This should be made clear both in training new members of staff and

in contracts with the added support of a written confidentiality policy and clause inserted into the staff employment contracts.

It is a valid assumption that patients will be aware that disclosure of confidential information will occur within the healthcare team so that typing of referral letters and all administration duties will involve the handling of dental records. The same is not necessarily true of information discussed with other dentist outside the practice team as may occur in peer review meetings or case discussions or treatment planning meetings. Consent therefore should be sought from the patient before discussing personal information with individuals not directly involved in their clinical care, or with team members whose involvement might not be readily apparent to the patient like a laboratory technician to whom clinical photographs may be sent.

Examinations on behalf of a third party

Dentists may, on occasion obtain confidential information through examination of a patient at the behest of another. This may be in the context of an insurance company for a dental report following an accident or an employer to asses their dental fitness either prior to employment or a posting abroad. This situation may also occur in the Armed Forces.
In these cases, any personal information will have the necessary quality of confidence but the scope of the duty of confidence owed to the patient is limited by the circumstances in which it is confided.
In other words, the patient ought to know, because of the circumstances of the examination, that any information will be conveyed to the employer or insurance company in the dentist's report.
Nevertheless, it is important that the patient has been told at the earliest opportunity about the purpose of the examination, the extent of the information to be disclosed and the fact that relevant information cannot be concealed or withheld. It is important also to obtain or have seen written consent to the disclosure from the patient or a person properly authorised to act on their behalf. In compiling the report include only factual information you can substantiate and in all circumstances you should check whether patients wish to see the report unless patients have clearly and specifically state that they do not wish to do so.[14]

The duty of confidentiality can be breached in only two circumstances

a) With the consent of the patient
b) In the public interest to protect others from risk of death or serious harm

There is thus a balance to be judged by the clinician between the dual obligation of maintaining confidentiality and breaching it in the public interest.
An important safeguard with respect to this disclosure of information is that the "receiver" of any confidential information is bound by a legal duty of confidence regardless of their professional obligations.

This would apply equally to the person who types the report and the employees of the insurance company that receive the report as it would do to NHS or GDC staff who handle dental records and complaints.

Children and issues of confidentiality

There is no doubt that a dentist owes a child patient a duty of confidentiality and this has been upheld in a number of cases[15],[16]
However, in keeping with the law of consent, the competence of the child and their capacity to understand and form a relationship in confidence is significant.
Therefore, when the child is incompetent to form a relationship of confidentiality the dentist is obliged to disclose the information to the parent. The laws paramount concern is the welfare of the child and in most cases the welfare of the child is best served by the parents knowing all the dental information available to allow them to make a decision or assist in care.

Children at risk

Where a child lacks the capacity to consent to treatment and also to enter into a confidential relationship, the law would expect the dentist to act in the child's best interest. If the dentist believes the child to be a victim of neglect or physical, sexual or emotional abuse, the information should be given promptly to an appropriate responsible person or statutory agency where the clinician believes the disclosure is in the patient's best interests.
In an interesting case, the House of Lords delivered its judgement in JD v East Berkshire Community Health NHS Trust[17]. This case was brought by parents who had variously been suspected of inflicting non-accidental injury, sexual abuse and Munchhausens Syndrome by proxy and alleged that various doctors had suggested child abuse when the injuries and presenting condition of their child were pathological . The courts held that a doctor (or dentist) should report any suspicion, formed in good faith , of child abuse to the appropriate local authority. In raising such a suspicion, the clinicians sole concern must be the welfare of the child. If the child's parents suffer harm as a result of the suspicion being raised the clinician will not be liable to the parents for any such harm be it emotional, reputation, business or financial. The case confirmed that the clinician (and social worker) does not owe a common law duty of care to the parent in these circumstances, only to the child.

Therefore if, on balance, the dentist believes the child is at risk from the parent, then they can legitimately disclose the information to someone else.
Where a child has capacity both to consent to treatment and enter into a confidential relationship obligations of confidence exist and is no different to that owed to an adult. Here a breach of duty of confidence may be justified if it is made in the public interest or the patient's best interests. In either case the dentist will need to be able to justify the disclosure.

Modification of the duty of confidence

As we have seen above in relation to children, the legal duty of maintaining patient confidentiality is not an absolute one and may be subject to exceptions.

There are three main exceptions

a) Where consent by the patient has been given to allow disclosure
b) Where the law compels disclosure
c) In the public interest

[A] Consent to allow disclosure

Where a patient gives consent, the dentist is no longer under an obligation to keep the confidence. The consent requires, as it does for patients consenting for treatment, that the patient

1) has the capacity to decide
2) has sufficient information to make a decision and
3) is acting voluntarily with no undue influence exerted on them

In reality, as with consent, the stumbling block will be how much information constitutes a sufficient amount. The ethical requirement as well as the legal standards would anticipate that the patient is informed in a broad way about what is to be disclosed and for what purposes that disclosed information might be used. Most consent is expressed but could also be contractually where information, particularly financial, is used for administrative and probity reasons where taxpayers money is involved in NHS treatment.
If there is a practice of disclosure in these circumstances, for the patients consent to be implied, the patients must at least be aware of the practice, be given an opportunity to object and does not do so for that implied consent to be valid. Express consent to disclose confidential information would not be required in the context of a receptionist typing referral letters or a specialist to whom the patient has agreed to be referred.

[B] Public interest

There are some occasions where the need to disclose confidential information with or without the patient's consent is done in the public interest and outweighs the public interest in protecting the individuals right to confidence.

There is therefore a judgement to be made in balancing the two interests and deciding which is favoured i.e. the harm that might arise from non-disclosure of the information against that possible harm to the patient and to the overall trust that exists between dentists and patients if the information is released.

In the context of medical confidences, the public interest in preserving confidences comes about because of the very nature of the dentist-patient relationship. Take for example a diagnosis of HIV:

X v Y [18]

In February 1987 one or more employees of the plaintiffs, a health authority, supplied the first defendant, a reporter on a national newspaper owned and published by the second defendants, with information obtained from hospital records which identified two doctors who were carrying on general medical practice despite having contracted the disease AIDS.

The second defendants made one or more payments of £100 for the information. On 28 February the plaintiffs (the doctors) obtained an order restraining the defendants from "publishing…or making any use whatsoever of any confidential information" which was the property of the plaintiffs and contained in their hospital records. On 15 March the second defendants published an article written by the first defendant, under the headline "Scandal of Docs with AIDS", which implied that were doctors in Britain who were continuing to practice despite having contracted AIDS and that the Department of Health and Social Security wished to suppress that fact.

The defendants intended to publish a further article identifying the doctors. The plaintiffs sought (i) an injunction restraining the defendants from publishing the identity of the two doctors (ii) disclosure by the defendants of their sources. The question arose whether the second defendants were justified in the public interest in publishing and using the information disclosed to the first defendant.

In giving judgement on this point Justice Rose was clear why patients, in this case who happened to be doctors, have a need to be sure confidential information is kept private. "If it [confidential information] is breached, or if the patients have grounds for believing that it may be or has been breached they will be reluctant to come forward for and continue with treatment, and in particular counselling….If treatment is not provided or continued the individual will be deprived of its benefit and the public are likely to suffer from an increase in the rate of spread of the disease. The preservation of confidentiality is therefore in the public interest"

Whilst the judge recognised the very important public interest in the freedom of the press and that there was some public interest in knowing who the doctors were, he concluded that "those public interests are substantially outweighed when measured against the public interests in relation to loyalty and confidentiality both generally and with particular reference to AIDS patients' hospital records"
He therefore granted an injunction preventing the naming of the doctors.

Campbell v MGN Ltd[19]

This case which was heard by five judges in the Supreme court revolved around the publication of photographs by the *Daily Mirror* of the supermodel Naomi Campbell revealing that she was receiving treatment for drug addiction from Narcotics Anonymous. The High Court and the Court of Appeal had found against her claim that the publication of the photographs and the accompanying article was a

fundamental breach of her rights to privacy (under Article 8 of the Human Rights Act) and in favour of the Daily Mirror freedom expression to reveal her public lies that she was in fact taking drugs contrary to her very public statement that she never took drugs unlike other catwalk models.
The Supreme Court found in her favour by 3 to 2 that the disclosure was about her private life and that she had an entitlement to confidentiality about it despite being in the public eye.

There are many celebrities and people in the public eye seeking the services of dentists to makeover their smiles and whilst it may be obvious to those who see the results, unless the person in question allows the dentist to disclose what was done , all that went on in the dental practice should remain confidential even the fact they stepped foot into the practice at all.

Whilst it may be considered proportional to release confidential information without consent it is important that consent is considered unless:

a) the patient is not competent to give consent, in which case you should consult the patient's welfare attorney, court-appointed deputy, guardian or the patient's relatives, friends or carers
b) you have reason to believe that seeking consent would put you or others at risk of serious harm
c) seeking consent would be likely to undermine the purpose of the disclosure, for example, by prejudicing the prevention or detection of serious crime, or
d) action must be taken quickly, for example, in the detection or control of outbreaks of some communicable diseases, and there is insufficient time to contact the patient[20]

Kennedy and Grubb usefully categorise the types of situation where public interest may used in justifying disclosures of confidential information into

a) where there is a danger to the health or safety of others
b) where a crime is to be prevented or detected or
c) where there is a need for research, teaching or management purposes.

A] Danger to the health or safety of others

There is a clear need to balance the needs of the individual against the needs of the public and in the case of *W v Edgell* [21]these came head to head.

This case related to W, a patient who was detained in a secure hospital without time limit as a potential threat to public safety after he shot and killed five people and wounded two others. Ten years after he had been first detained he applied to a Mental Health Review Tribunal(MHRT) to be discharged. His responsible medical officer supported the application but this was opposed by the Government acting through the Secretary of state.

In order to assist his case W's, solicitors engaged Dr Edgell, a consultant psychiatrist, to examine their client W ,and report on his mental condition. In the event Dr Edgell strongly opposed the transfer confirming the patients' continued interest in firearms and explosives.

Dr Edgell sent the report to W's solicitors who withdrew the application to the MHRT to have their client discharged. The tribunal nor the hospital looking after W therefore received Dr Edgell's report but Dr Edgell was concerned that in the patient's interest, for treatment and also the publics wider protection, the report should be seen by other parties. W discovered the report was disclosed and issued a writ against Edgell and the recipients of the report seeking an injunction to restrain them from using or disclosing the report further.

In making his judgement, Stephen Brown J pointed to the General Medical Council guidance as being particularly relevant:

81(b) Confidential information may be shared with other registered medical practitioners who participate in or assume responsibility for clinical management of the patient.
(g) Rarely, disclosure may be justified on the ground that it is in the public interest which, in certain circumstances such as, for example, investigation by the police of a grave or very serious crime, might override the doctor's duty to maintain his patient's confidence.
82. Whatever the circumstances, a doctor must always be prepared to justify his action if he has disclosed confidential information. If a doctor is in doubt whether any of the exceptions mentioned above would justify him in disclosing information in a particular situation, he will be wise to seek advice from a medical defence society or professional organisation.

Thus it can be seen that the law recognises an important public interest in maintaining professional duties of confidence but the law treats such duties, not as absolutes, but as liable to be overridden where there is held to be a stronger public interest in disclosure. In this case, on balance, it was felt that Dr Edgell was right to make the disclosure, he did so in accordance with law and it was necessary in the interest of public safety and the prevention of crime.

<u>If a confidence is to be breached what guidance is there regarding the limit of the extent of information that can be disclosed?</u>

This can be summarised as follows

1) Need to know limitation

Disclosure may only be made to those whom it is necessary to tell so as to protect the public interest. In this case this is done without consent "where a failure to do so may expose the patent or others to a *risk of death or serious harm*"[22]. It is normal however to seek consent to disclosure when at all possible.

2) The risk must be real

3) Where there is a danger of physical harm.

This may include parents or relatives abusing their children and dental practitioners may recognise oro-facial signs of abuse or be presented with unexplained injuries or bite marks.
This may also include infectious diseases such as HIV and AIDS.

Managing issues of confidentiality with HIV/AIDS patients

The potential for patients to be stigmatised by having HIV and AIDS and the impact it may have on family life and employment makes this issue particularly important when it comes to confidentiality.
General dental practitioners are unlikely to make a definite diagnosis of AIDS or HIV in their practices but they may be given the information in a medical history questionnaire.
That information is naturally confidential but you may consider disclosing information to a known sexual contact of a patient with HIV where you have reason to think that the patient has not informed that person and cannot be persuaded to do so. In such circumstances you should tell the patient before you make the disclosure, and you must be prepared to justify a decision to disclose the information[23].

Where you have made a referral and a diagnosis has been made it is likely that the patient would have been counselled about the nature of the disease and its social and occupational implications. Your duty in these circumstances would be to ensure that other health care workers such as the patients GP is also informed.
The infected person may of course be another dentist or other health care worker (HCW) but they are entitled to receive the same rights of confidentiality as any patient seeking or receiving medical care.

In any case the overall risk of transmission of HIV from infected HCW to patients is very low and this can be reduced even further by combination antiretroviral therapy (cART), if the HCW's viral load is suppressed to a very low or undetectable level.[24]

B] Prevention or detection of crime

Where prevention or detection of crime may require the disclosure of confidential information there are some circumstances when that disclosure may be justifiable.
The problem is what constitutes a crime.
The GMC defines crimes as having to be "serious" that "will put someone at risk of death or serious harm, and will usually be crimes against the person, such as abuse of children".
As in all issues of confidentiality, the decision to disclose confidential information to the police for example will depend on balancing the public interest in favour of it or against it. The less serious the crime, the less likely the patient's confidentiality should be breached.

In an attempt to reduce fraud and corruption in the NHS the Government NHS Protect.
NHS Protect is part of the NHS Business Services Authority (NHSBSA), an arm's length body of the Department of Health (DH) and works to a memorandum of understanding with the NHSBSA and DH.
They deal with a wide range of issues, including: violence against NHS staff, theft of NHS property and economic crime (i.e. fraud, bribery and corruption) affecting NHS resources which also includes dentistry.

NHS Protect, in order to carry out their investigation, will inevitably require access to relevant documents, records, including clinical records and data. They often work with the police and make use of their powers of search and arrest.

C] Teaching, research and clinical audit

There are a number of situations where confidential material obtained in practice may be used for teaching purposes. Case histories including radiographs and photographs may be used in small group teaching or in presentations and in this case express consent must be obtained if it is possible that the patient can be identified. If the information is being used for exam purposes, then written consent must be obtained.

Where records have been anonymised by the dentist or a member of the health care team the patients express consent is not required.
If a general practice is utilised for hands-on teaching purposes for other dentists, the consent of the patient must be obtained to enable non-treating clinicians to view confidential information including radiographs and study casts.

Clinical audit is an important part aspect of ensuring the delivery of high quality care in general dental practice. It is usual, where an internal audit is to carried out by the dental team that provided the care, identifiable information can be shared by the team as long as the patients have been informed that their data may be disclosed for clinical audit.
Arguably however, unless outside members of the treating team are involved in processing the raw data, such as other dentists or nurses, the existing obligation of confidentiality will exist and no further consent is required. It may be appropriate to inform patients that audit does takes place in any welcome letter or Practice Information Leaflet that is supplied to patients.

Where data is being shared outside of the practice care must be taken to anonymise any data so that the patient cannot be identified even inadvertently.

D] Statutory

There are a number of statutory provisions that create a legal duty not to disclose information relating to patients where breach under certain circumstances would be a criminal offence. Some of these will not impact on the work of a general dental

practitioner such as the *Abortion Regulations 1991* and The *National Health Services (Venereal Diseases) Regulations* 1974 (SI 1974 No 29).

The *Health Protection (Notification) Regulations 2010* similarly relate to diseases unlikely to be encountered by a GDP but the effect of them is to make certain diseases such as TB, botulism, cholera, measles and mumps or food poisoning cases notifiable by the doctor where the patients name, age and address are sent to the appropriate local office.

The *Coroners and Justice Act 2009* allows coroners access to records in the course of investigating the death of a person. The Coroner has powers to compel disclosure of information relevant to his inquiry including dental records of the deceased. Where a police officer is acting with the coroner's authority, the deceased patient's records should be disclosed as requested. This occurs when forensic dental identification may be required in a body that is not capable of being identified by any other means (e.g. badly decomposed bodies or those recovered after a flood, drowning, fire or other accident.

Police inquiry

The *Police and Criminal Evidence Act 1984* (PACE) gives the police access to dental records, deemed "excluded material" only on application to a circuit judge.
The duty of confidence rests with the holder of the personal records where the personal records are "documentary and other records concerning an individual (whether living or dead) who can be identified from them and relating to (a) to his physical or mental heath".
The police do not have an inherent right of access to confidential dental records and a dentist is only obliged to provide this if the police have a court order or search warrant.
If the police ask for records or the release of personal patient information the first step would be to obtain the consent of the patient.
If obtaining consent is impossible, or if it would be impractical or unreasonable to do so or prejudice an ongoing investigation, then any decision about disclosing information must be one that the dentist is prepared to justify.
Disclosing information without the patients consent and without a court order could result in the evidence being ruled as inadmissible in any subsequent prosecution

The provisions of PACE deal with access by the police and does not stop a dentist voluntarily disclosing the records provided this would be a justified breach of confidence, for example in the public interests. Equally where a dentist believes that he has an overriding duty of confidence to the patient and there can be no justification for the police requesting access to the records, the dentist is entitled to ask the police to obtain an order from a judge forcing him to do so. The dentist may wish to make representation to the circuit judge that an order should not be made. Robbery, assault or drugs offences are unlikely to provide sufficient grounds for disclosure without the individuals consent or a court order[25]

R v Singleton [26]
Singleton was charged with murder. After his arrest he was asked by the police to provide a sample of tooth marks because the victim had marks on her chin which were thought to have been made by a human bite. He refused, but his dentist voluntarily gave his dental records to the police.

Singleton sought at his trial to have the dental evidence excluded on the grounds that it was excluded material within the terms of section 11 of the Police and Criminal Evidence Act 1984 and as such could only be disclosed to the police by means of an application to a circuit judge under section 9 and paragraph 3 of Schedule 1 to the 1984 Act. The judge ruled that the evidence was admissible and the appellant was convicted. In the Appeal hearing the judge noted that, had Singleton's dentist refused to disclose the records which included the study models, the police would not have been successful on an application for access under PACE and the trial against Singleton for murder may have failed.

This confirms the seriousness with which the statute law regards the protection of such material and the duty of confidence placed on a dentist even in the face of an allegation of murder.

<u>Care Quality Commission (CQC)</u>

The Care Quality Commission was established under the Heath and Social Care Act 2008. It required the registration of all dental practices by April 1 2011, after which time it was illegal to provide dental services without being registered.
It also set out Essential Standards of Quality and Safety.

The Act, under Section 64, allows an authorised person to inspect, take copies of and remove from the premises any documents or records (including personal and medical records) that it considers necessary to carry out its functions of regulation and quality assurance.
In CQC's own guidance on confidentiality[27] they state that where consent has not been given by the patient or another third party they would not seek consent of relevant people in these circumstances – because refusal would prejudice their ability to properly discharge their regulatory functions.

The authorised person can interview in private any person working at the premises, any person receiving health care there who consents to be interviewed and make any other examination into the state and management of the premises and treatment of persons receiving health care there. The Act also allows access to computer records. It is criminal offence to obstruct, without reasonable excuse, any authorised person carrying out their duties under this legislation.

Confidentiality in practice

Most breaches of confidentiality are inadvertent. Being alive to the issues of confidentiality means looking at the practice environment and the management systems carefully and establishing protocols with confidentiality in mind.

Reception

It is often difficult and indeed impractical to separate the waiting area from the reception and appointment booking area in general practice. This means that patients can overhear conversations between the receptionist and patients at the desk or on the phone.
Receptionists need to be mindful of this and certainly when speaking to patients over the phone to limit the broadcasting of identifiers such as name and address where possible.

The basic problem with a telephone call is that you do not know who is on the other end. You may have breached confidentiality simply by saying "Could I speak to Miss Jones, this is High Street Dental Practice here". There are circumstances in which letting a third party know a dentist is calling them could be embarrassing and it may be safer to identify yourself once it can be confirmed that the patient is on the other end of the line.

Illustrative of the issues that can arise in reception are demonstrated by this incident

A patient was asked by her dentist/ nurse if she had received flowers on Valentine's day-she said she had received roses at work. The nurse (unbeknown to the dentist) went to reception and excitedly told the receptionists. When the patient came to reception on completion of her treatment, the receptionists enquired who the flowers were from. The patient's husband was sitting in the reception area and overheard the conversation. The flowers were not from him!
The dentist received a complaint with the patient pointing out *"that was my secret, I told you in confidence."*
The patient saw the breach of confidentiality as the dentist's responsibility- even though it was essentially the nurse that had made the disclosure.

Caution must be exercised particularly when outstanding accounts or bad debts are being pursed either by telephone by the practice or by post. In the latter case marking any correspondence "Private and Confidential" is important. Similarly staff should be careful about discussing treatment or financial transactions with other members of a patient's family without the consent of the patient.

Patients often phone up to check their appointment times or to cancel and make new ones. It is important that you are sure as you can be that you are actually talking to the patient and asking them to confirm their date of birth and address/phone number will assist this process.

Schools and employers may also telephone to confirm attendance of pupils or employees at the dentist. This is confidential information and the patients consent should always be sought before disclosing such information.

Relatives or partners also phone about appointments and often given information about times and dates of treatment. This is strictly speaking breaching confidentiality and whilst it is important that your staff do not appear overly officious the exigencies of confidentiality need to be recognised in a pragmatic but legal way.

Patients records should not be left visible on the reception desk and the computer screen should be angled away from patients or filtered with unidirectional screens so that appointments and confidential information relating to other patients cannot be viewed.

Treatment rooms

Whilst it might be appropriate for the whole family of children to be seen together husband and wives or other couples may not necessarily wish to be invited in to the treatment room together as private and confidential information may need to be discussed.

If work placement students or dental students are allowed to sit in during patient examinations the duty of confidentiality must be made clear to them or any third party that has access to sensitive, personal data via a written practice policy . The third party present must be introduced to the patient when the patient arrives and informed of their status and why they are sitting in. The patient should be allowed to decline consent to allow the third party to be present but must not be made to feel that treatment will be affected in any way by declining.

Photographs

The use of photography in dentistry has become widespread with many devices now used to capture intraoral and extra oral images from the conventional digital handheld camera, intra-oral cameras directly linked to computers to handheld devices such a mobile phones and tablets.

They are very versatile and can be used to record clinical diagnostic information, for preventive advice and education, for referrals, medico-legal purposes , teaching and marketing.

There are a number of issues relating to photography that are relevant

- Consent

  The patient should be told why the images are being taken and permission obtained before pointing a camera at the patient[28]. Written consent is advisable particularly where the patient can be identified from any image either from their facial features or by the distinctive nature of what is being photographed. Permission from parents or guardians should be sought when taking images of children.

  The specific purpose of the use of the image should be confirmed in writing where they are being used by the practice for marketing, e.g. websites

- Storage and retention of images
  As photographs are part of the clinical records, the same rules apply to retention of records and the necessity to keep them only as long as necessary. Any image whether it is anonymised or otherwise, forms part of the medical record, so this data must be stored and processed as per the Data Protection Act (1998). The use of mobile phone and tablets to capture clinical images should be avoided. They do not give the impression of professionalism and if the data is stored on a cloud you have no control over who access it where there are data breaches[29] .Dentists often take a series of photos of individual patients along with an image of their name and address for later identification and so whilst the individually clinical intra oral pictures will not have patient identifiable information on it the series will be virtue of the image of the name. These should be deleted from portable memory cards when uploaded on to secure desk based computers with appropriate passwords protection and IT security.
  It is not acceptable to be carrying images of patients on one's mobile phone or electronically sending them on. There is clearly a risk of the data being lost or stolen. and the fact remains that most individual dentists will not be registered as a Data Controller as would be required. Should the images become lost you would have a duty to notify the parctice and the patient, which would lead to difficult questions being asked and likely disciplinary action.
  If there is a clinical need or a desire to take images for diagnosis or education purposes it is not appropriate to use mobile phones. Agreement by a patient to take an image does not obviate your duties of confidentiality. There are ultimately no circumstances, save for emergencies, when taking patient images on a mobile phone, whether consented or not, is justified, so should not be done.

- Transmission
  Using a mobile phone to take clinical photos or to make a "digital" image of radiographs to transmit them either for advice from a colleague or for referral purposes are subject to data protection regulations and should be avoided especially where the date is not encrypted or transmitted on secure networks such as NHS net.

<u>CCTV</u>

Many practices now use CCTV in public areas such as reception areas as well as increasingly in surgeries with audio recording to supplement clinical record keeping and actual treatment.
The use of CCTV should be clearly signed stating that CCTV recording is taking places and why[30]. Images should only be handled and retrieved by authorised staff.
Covert recording of patients is illegal and so patients explicit consent must be obtained before recording their consultation or treatment and they should be advised that they can withdraw their consent at any point. Like photographs and

radiographs recordings will be considered to form part of the records and are therefore subject to the same rules around storage, retrieval, access and disposal. Covert recording without the knowledge of the individuals being recorded can be used but only in exceptional circumstances where criminality is suspected or relate to issues of serious professional malpractice[31]

Social media

Whilst social media undoubtedly can be a force for the good it would appear that e-professionalism, or 'behaviour related to professional standards and ethics when using electronic communications' can pose a formidable challenge for dentists and dental students alike[32].
The distinction between a clinicians social and professional life is now so sufficiently blurred by Twitter, YouTube, Flickr, Facebook, LinkedIn, Instagram and a host of other platforms that the GDC has seen fit to issue guidance on the subject.[33]
This was in response to complaints about how dentist and dental students used social media which become the subject of fitness to practice investigations.
The ability to instantly express your views, share data and information to people all over the world is enticing and enthralling but in the context of confidentiality the same rules apply in the virtual world as they do in the real world. Disclosure of information that will lead to the identification of patients or clinical data about them will breach rules of confidentiality.

Some interesting cases

The following situations have all arisen in general dental practice and an advisor at a defence organisation has been asked for advice. Having read this chapter, you should be able to offer an answer.

1) A 15 year old orthodontic patient has an appointment for the dentist to adjust her fixed orthodontic appliance. The mother has phoned the practice saying she has listed her as missing but knows she has gone off with an older man. The mother wants the dentist to call the police when she arrives for her appointment. If he telephones the police he will be breaching her confidentiality. Is he allowed to do this without her consent?
2) An appointment card for a dental appointment is found at the scene of a burglary. There is no patient's name on the card but there is a date and time on the card which also has the dentist's practice details. The police telephone the practice requesting the name and details of the patient whose appointment it is in order to investigate a non-violent burglary.
3) A regular patient's car is damaged in the practice car park by another car bumping into it, scratching the whole of one wing. She knows there was only one other car in the car park - a blue car- because there are blue flecks of paint on her own white car. She wants to know the name and address of the other patient whose car it is so she can claim on insurance. Can the practice disclose this information?

4) A patient has attended the practice having had a number of drinks for lunch. He drove to the practice. After the appointment the dentist has asked the patient to leave the car behind till he sobers up but the patient declined this advice and drove off when potentially over the limit. Should she have done more to stop him and can she inform the police.
5) The dentist thinks the patient for whom he has planned an extraction is an alcoholic. He is concerned about the possibility of severe bleeding due to impaired liver function. When invited to do so the patient's general medical practitioner will not disclose anything about his patient's medical history without the patient's consent. The patient himself denies being a drinker and will not disclose anything adverse about his medical history saying he is fit and healthy. Does the medical GP have a right to withhold the information which may be of relevance to the dentist in the management of their joint patient?

FURTHER READING

1) Confidentiality: Protecting and Providing Information –General Medical Council www.gmc-uk.org/standards/secret

2) Clinical Confidentiality. C Foster, N Peacock Monitor Press 2000

3)Confidentiality NHS Code of Practice Nov 2003 33837. Department of Health. www.doh.gov.uk
4) BDA Advice Protecting personal information

---

[1] Medical Law Kennedy and Grubb Third Edn
[2] Garbin, C.A.S.,Gargin, AJI.,Saliba N.A, Lima D. and Macedo A.P.A (2008) Journal of ((Applied Oral Science, 16 (1) p1-6

[3] Z v Finland (1997) 25 EHRR 371 (EctHR)
[4] NHS code of practice (Dept of Health 2010)
[5] Confidentiality: NHS Code of Practice Supplementary Guidance: Public Interest Disclosures November 2010 Department of Health Gateway reference13912
[6] *Guyer v Walton*. Special Tax Commissioners, an appeal by a solicitor (SPC 274/01).
[7] Confidentiality- Dental Protection Limited
[8] Parry-Jones v Law Society [1968] 1 All ER 177[1969]1 Ch 1
[9] Hunter v Mann [1974] 2 Al ER 414, QB 767
[10] Lord Goff A-G v Guardian Newspaper (no2)[1990] 1 AC 109

[11] Clinical Confidentiality. C Foster, N Peacock Monitor Press 2000

[12] Personal Information Privacy and the Law. Wacks, Raymond. Clarendon Press (1989)

[13] Medical Law Third Edn 2000 Kennedy and Grubb. Butterworth's

[14] Confidentiality para 34d General Medical Council 2009
[15] Re C (a minor) (wardships: medical treatment) 1989 2 All ER 791 (CA)
[16] *Re Z (a minor) (freedom of publication*) 1995 4 All ER 961 (CA).

[17] JD v East Berkshire Community Helath NHS Trust [2005] UKHL 23
[18] X v Y [1988]2 All ER 648 (1987) 3 BMLR 1 (QBD)
[19] Campbell v MGN [2004] UKHL 22

[20] Confidentiality. para 38 General Medical Council October 2009
http://www.gmc-uk.org/Confidentiality__English_1015.pdf_48902982.pdf

[21] *W v Edgell* 1990 1 All ER 835 4 BMLR 96 (CA)
[22] Confidentiality: disclosing information about serious communicable diseases
[23] Confidentiality: disclosing information about serious communicable diseases General Medical Council September 2009
[24] The Management of HIV infected Healthcare Workers who perform exposure prone procedures: updated guidance, January 2014 PHE publications gateway number: 2013439
[25] Protecting personal information BDA Advice January 2015 p14
[26] R v Singleton [1995] 1 Cr App Rep 431 (CA)
[27] Code of Practice on confidential personal information Care Quality Commission December 2010 para 4.13
[28] Wander P . Ireland RS. Photography in record keeping and litigation BDJ 2014; 217: 133-137
[29] Jennifer Lawrence leaked nude photos: Apple iCloud password hack could be 'responsible for security breach' Daily Mirror 01/09/14
http://www.mirror.co.uk/3am/celebrity-news/jennifer-lawrence-leaked-nude-photos-4145139
[30] In the picture- a data protection code for surveillance cameras and personal information. The Information Commissioners Office 2015
[31] BDA Advice –Protecting personal information January 2015
[32] Neville P ,Waylen A, Social media and dentistry: some reflections on e-professionalism BDJ 218, 475 - 478 (2015)
[33] GDC Guidance on using social media September 2013