1. The duty of confidentiality
Confidentiality is an essential requirement for the preservation of trust between patients and health professionals and is subject to legal and ethical safeguards. Patients should be able to expect that information about their health which they give in confidence will be kept confidential unless there is a compelling reason why it should not. There is also a strong public interest in maintaining confidentiality so that individuals will be encouraged to seek appropriate treatment and share information relevant to it.

2. What is confidential?
All identifiable patient information, whether written, computerised, visually or audio recorded or simply held in the memory of health professionals, is subject to the duty of confidentiality. It covers:

- any clinical information about an individual’s diagnosis or treatment
- a picture, photograph, video, audiotape or other images of the patient
- who the patient’s doctor is and what clinics patients attend and when
- anything else that may be used to identify patients directly or indirectly so that any of the information above, combined with the patient’s name or address or full postcode or the patient’s date of birth, can identify them.
Even where such obvious identifiers are missing, rare diseases, drug treatments or statistical analyses which have very small numbers within a small population may allow individuals to be identified. A combination of items increases the chance of patient identification.

Whilst demographic information such as name and address are not legally confidential, it is often given in the expectation of confidentiality. Health professionals should therefore usually seek patient consent prior to sharing this information with third parties.

3. Using and disclosing information
From time to time, the duty to preserve confidentiality can present health professionals with an ethical or legal dilemma, commonly when a third party requests information about patients or their treatment. A number of factors must be considered including:

• patients must be properly informed as to how identifiable information about them is used
• data should be anonymised wherever possible
• explicit consent should be sought for the use or disclosure of personal health information, unless it is clearly implied
• occasionally, when it is not practicable to obtain consent, information may be disclosed where the law requires or where there is an overriding public interest, eg where child abuse is suspected
• disclosures should be kept to the minimum necessary to achieve the purpose
• when patients withhold consent to disclosure of their information, their wishes should be respected
• health professionals must always be prepared to justify their decisions about the use of personal health information.

4. Consent
Consent to disclosure may be explicit or implied. It may also be consent to disclosure of specific information to a particular person or body for a particular purpose or it may be consent to general future disclosure for particular purposes. In either case consent should be informed and freely given.

Explicit or express consent is achieved when a patient actively agrees, either orally or in writing, to a particular use or disclosure of information which has been discussed with the patient. Explicit consent is the ideal as there is no doubt as to what has been agreed.

Patient agreement can also be implied, signalled by the behaviour of an informed patient. Implied consent is not a lesser form of consent but in order for it to be valid it is important that patients are made aware that information about them will be shared, with whom it will be shared, and of their right to refuse. Health professionals bear responsibility for the disclosures they make, so when consent is taken to be implied, they must be able to demonstrate that the assumption of consent was made in good faith and based on good information. If not, it is no consent at all and some other justification will be needed for its
disclosure. In addition to information provided face to face in the course of a consultation, leaflets, posters and information included with an appointment letter from a hospital or clinic can play a part in conveying to patients the reality and necessity of information sharing. Clearly, a combination of methods provides greater security that patients have understood. It should be noted that the more sensitive and detailed the data, the more likely it is that explicit consent will be required, eg sexual health information.

5. Anonymisation
Information may be used more freely if the subject of the information is not identifiable in any way. Usually, data can be considered to be anonymous where clinical or administrative information is separated from details that may permit the individual to be identified such as name, date of birth and postcode. Even where such obvious identifiers are missing, rare diseases, drug treatments or statistical analyses which have very small numbers within a small population may allow individuals to be identified. A combination of items increases the chances of patient identification. When anonymised data will serve the purpose, health professionals must anonymise data to this extent and, if necessary, take technical advice about anonymisation before releasing data. Whilst it is not ethically necessary to seek consent for the use of anonymised data, general information about when their data will be anonymised should be available to patients.
6. Pseudonymisation

Pseudonymisation is sometimes referred to as reversible anonymisation. Patient identifiers, such as name, address or NHS number, are substituted with a pseudonym, code or other unique reference so that the data will only be identifiable to those who have the code or reference. Where those who are using data have no means to reverse the process, and so no way to identify an individual from the data they have, the data may be treated as anonymised and there is no common law requirement to seek consent for their use. For those who have access to both pseudonymised data and the means to reconstitute them, they should be treated as identifiable. The use of pseudonymised data is common in research. As with anonymised data, patients should generally be informed when it is intended that their information will be pseudonymised.

7. Sharing information with other health professionals

In the absence of evidence to the contrary, patients are normally considered to have given implied consent for the use of their information by health professionals for the purpose of the care they receive. Information sharing in this context is acceptable to the extent that health professionals share what is necessary and relevant for patient care on a ‘need to know’ basis. Health and social care, although often closely related, do not always fall into the same category, and disclosure of information to social services usually requires explicit consent from competent patients. Sometimes two competing interests come into
conflict, such as the patient’s informed refusal to allow disclosure and the need to provide effective treatment to that person. A patient’s refusal to allow information-sharing with other health professionals may compromise patient safety, but if this is an informed decision by a competent person it should be respected.

8. Multi–agency working

Health professionals during the course of their treatment of patients will have contact with partner organisations from time to time. These include social services and housing and benefits agencies. In community settings many integrated teams have been established, which include workers from health, social services and non-statutory bodies. Health professionals should from the outset discuss with patients the desirability of sharing information with other agencies where appropriate. Other agencies may wish to be involved in discussions about patients at various points in their treatment or to attend case conferences or multi-disciplinary meetings. Health professionals may also be invited to attend external case conferences organised by partner organisations to discuss the health and welfare of patients. In all these circumstances confidential information should be shared with explicit consent or, in the absence of consent, where disclosure is required by law or there is an overriding public interest in disclosure.