

The occupational physician

BMA



British Medical Association
bma.org.uk

The BMA occupational medicine committee

The committee's terms of reference are:

'To consider and report on matters affecting the health, safety, and welfare of persons at work and the practice of medicine in industry and allied occupations. To advise the Association on the implementation of health, safety, and welfare legislation as it affects its members and their working environment.'

This standing committee of the BMA has ten members:

- Five elected annually by the representative body (voting), one of whom must be in an approved occupational medicine training post
- Three by BMA Council (voting)
- One nominated by the Council of the Society of Occupational Medicine (SOM) and the Board of the Faculty of Occupational Medicine and (FOM)
- One elected by the public health medicine committee (PHMC)

- The four chief officers of the BMA (President, Chair of the Representative Body, Chair of Council, and Treasurer) and the elected member of Council representing doctors in Occupational Medicine are also ex officio members of the committee (non-voting).

Members of the committee usually include full time and part-time occupational physicians from large and small organisations, as well as from NHS occupational health services. The chair of the occupational medicine committee reports regularly on the activities of the committee to the BMA Council and the Representative Body.

The committee is a reference point for consultative documents put out by international organisations, the government and the Department of Health, and such bodies as the Health and Safety Executive. In addition, the committee acts as an advisory panel on matters concerning principles or refers enquiries to suitable individuals.

The occupational medicine committee has compiled this guidance booklet and further information about the committee can be found on the [BMA website](#).

Preface

The first edition of this booklet (formerly published under the title *The doctor in industry*) was published in 1980. The booklet aims to formalise the guidelines and advice that the BMA has offered to its members, to Government departments and to other organisations on matters affecting occupational health.

The booklet acknowledges and incorporates some of the published views of other organisations – the General Medical Council (GMC) and the Faculty of Occupational Medicine amongst others. Reference is also made, as far as possible, to the main legislation that governs a large part of health and safety practice at work.

Occupational health focuses on enhancing and maintaining:

- the health of people at work, ensuring they operate safely; and
- the organisational effectiveness of enterprises by providing expert advice to management.¹

A modern occupational health service often employs a number of occupational health professionals e.g. doctors, nurses, and allied professionals.

Only some of the work in occupational medicine requires the expertise and competencies of a doctor who is trained to consultant level. Whichever doctor provides a service, the level of expertise needs to be appropriate to the work to be performed. Further information is provided in chapter 16.

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1

Occupational health for all

The Universal Declaration of Human Rights

states that everyone has the right to favourable conditions of work. People spend one third of their adult life at work, contributing actively to the development and wellbeing of themselves, their families and society.

Work may impact on health positively or adversely. In favourable conditions work provides income for meeting life's needs and has a positive impact on social, psychological, and physical health and wellbeing.²

The Constitution of the World Health Organisation (WHO), the WHO Global Strategy on Health for All and the International Labour Organization (ILO) Conventions on Occupational Safety and Health and on Occupational Health Services stipulate the fundamental right of each worker to the highest attainable standard of health. To achieve this objective, the WHO Global Strategy on Occupational Health for All states that:

'every citizen of the world has a right to healthy and safe work and to a work environment that enables him or her to live a socially and economically productive life'²

In 2007, the World Health Assembly endorsed the Workers' Health: Global Plan of Action on Workers Health (GPA) (2008-2017) and urged member states to improve the performance of and access to occupational health services and to:

'work towards full coverage of all workers to basic occupational health services for the primary prevention of occupational disease and injury.'

Workers' Health: Global Plan of Action.

WHO, Geneva (2007).

The BMA supports the principle of **occupational health services for all working people**. It is BMA policy that all employees in the NHS and elsewhere must have access to specialist led occupational health services.

2

Work, health and wellbeing

Work is an integral part of life. An independent review, *'Is work good for your health and wellbeing?'* reported that there is strong evidence that work is generally good for physical and mental health and wellbeing, taking into account the nature and quality of work and its social context.⁵ There is also strong evidence that long periods of worklessness are associated with poorer physical and mental health and increased mortality.

The Health & Safety Executive, in their 2021/22 [Annual Statistical Review](#), estimate that 36.8 million working days are lost in Great Britain each year from work related injury and illness. As noted by the TUC in [Work and Wellbeing](#), if an employer wants to improve the health of the workforce they should first address the issue of illness and injury caused by work, as that is what they have most control over, and that is where the real gains are to be had.

The best way of improving wellbeing in the workplace – and too often the message heard is that individual workers should change their lifestyle by exercising more or eating better – is by changing how work is organised and managed, with proper risk assessment and risk management, supported by Occupational Health specialist expertise.

The BMA believes in the principle that work is good for health and wellbeing and recommends that doctors work closely with all interested parties to facilitate their patients' safe and timely return to the most suitable and meaningful employment.

Overall, the beneficial effects of work outweigh the risks of work and are greater than the harmful effects of unemployment. Work can also reverse the adverse health effects of unemployment. All doctors should discuss with their patients the health benefits of work and the ill effects of prolonged periods of being out of work.⁴

3

The aims of an occupational health service

The joint International Labour Organisation (ILO) and World Health Organisation (WHO) Committee on Occupational Health describe the aims of occupational health as:

'the promotion and maintenance of the highest degree of physical, mental, and social well-being of workers in all occupations.'

Occupational health services also have an important role in rehabilitating employees back into work, after sickness or injury.

A comprehensive occupational health service is multidisciplinary and aims to protect and promote workers' health through actions related to both the work environment and the workers themselves.

Occupational health service standards and accreditation

A review of the health of Britain's working age population '[Working for a Healthier Tomorrow](#)' published in March 2008 advocated clear standards of practice and formal accreditation of all providers who support people of working age. The Government's response to the review '[Improving health and work: changing lives](#)' endorsed that recommendation.

The Faculty of Occupational Medicine developed the Safe Effective Quality Occupational Health Service (SEQOHS) Standards and launched the [SEQOHS voluntary accreditation scheme](#) for occupational health services in 2010. The scheme aims to help to raise the overall standard of care delivered and identify to purchasers of services those occupational health providers who have demonstrated that they meet the standards.

4

Benefits for business

Occupational health is good for business. Enterprises appreciate that occupational health prevents people from being harmed or made ill through work, and that it is also an essential part of a successful business.⁵

The value of occupational health within the workplace has been highlighted by several surveys and studies. Research from financial protection firm Unum has argued that employees who feel well cared for are 27% more likely to stay with their current employer for more than five years, compared with those employees who feel only adequately or poorly looked after. A further 26% said poor workplace wellbeing would make them less likely to stay with an employer long term and 21% said this would make them feel less motivated and productive.⁴

The cost of ill health in the workplace is high and is an issue that employers cannot afford to ignore. Poor health of the workforce is a cost to employers through both increased absenteeism and lowered job performance.

For some employers the costs of ill health may be enough to justify a comprehensive wellness scheme. Furthermore, occupational health has a significant role in helping to keep an increasingly ageing workforce in productive work, as identified by the wide ranging [NHS Working Longer Review: Extending working life](#) published in 2013.

As well as improving retention, performance, and attendance there are also financial incentives for businesses that use occupational health services. Employers are able to claim a deduction against business profits in making payments to employees, provided the expenditure is wholly and exclusively for the purpose of business. If significant alterations or improvements result from the work done, the expenditure is not deductible but may qualify for capital allowances.

5

The occupational physician

An occupational physician may be employed by an organisation to work in an in-house occupational health service or may be employed by a third-party occupational health provider to deliver contracted services, or he/she may be self-employed.

The only doctors who should use the title occupational physician are those who:

1. have a relevant higher postgraduate qualification in occupational medicine recognised by the [Faculty of Occupational Medicine](#), **and**
2. can demonstrate that they have achieved the desired competencies in occupational medicine through training and experience, **and**
3. maintain these competencies through continuing professional development (CPD) **and**
4. complete annual appraisal relevant to their practice in occupational medicine.

The term **specialist** has a legal meaning in Retained EU law, only those doctors who have completed formal higher specialist training in occupational medicine and are included on the GMC's specialist register are entitled to use this term. A more detailed description of the skills and knowledge which accredited consultant level specialist Occupational Physicians can offer to employers, employees and government bodies is included in [Appendix 1](#). This is also intended to help define the areas of overlap and the boundaries of skills and knowledge with other disciplines.

The occupational physician appointed to provide a service must have appropriate medical qualifications and clinical competence to fulfil the needs of the business and to ensure the optimum health of all employees. In addition, occupational physicians should have a good understanding of:

- how the business operates
- leadership skills
- workplace law
- hazard and risk

6

The duties of an occupational physician

The precise duties of an occupational physician will be determined by the requirements of the employer or customer.

These duties may include to:¹

- visiting the workplace and advising on the provision of safe and healthy conditions by informed scientific assessment of the physical and psychological aspects of the working environment
- promoting compliance with relevant health and safety legislation
- helping to develop policies, practices and cultures that promote and maintain the physical, mental, and social wellbeing of all workers
- assessing the fitness of workers for specific tasks, ensuring a satisfactory fit between person and job, recommending suitable adjustments to enable a person to undertake the work they have been selected to perform safely and effectively, considering any health issues or disabilities they may have
- monitoring the health of workers who are potentially exposed to hazards at work through health surveillance programmes
- analysing data from surveillance programmes using sound epidemiological methods to identify trends in worker health and recommend any remedial measures necessary to improve worker health
- advising employees and employers regarding work-related health issues
- assessing potential cases of occupational injuries and illness; investigating, managing, and reporting individual cases appropriately and establishing if this is a single case or if there is wider incidence
- managing immunisation programmes for workplace biological hazards and for business travellers
- working with employers to promote best practice in physical and mental health in the workplace to help prevent sick leave
- case manage workers who are on sick leave, working with other health professionals to ensure the earliest return of functional capacity and return to work

- recommending suitable alternate work in circumstances where a worker cannot perform their normal job, either temporarily or on a permanent basis because of a health problem
- determining whether employees satisfy the medical criteria for ill health retirement under the terms of the relevant pension fund rules
- ensuring people have the necessary health information to undertake their work safely and to improve their own health.

(See also [Appendix 1](#), which sets out the skills and knowledge of a specialist occupational physician.)

It is important to understand that the physician has dual responsibilities to the patient and their employer. The role is therefore different to every other branch of medicine where the physician's primary responsibility is to the patient.

7

Health assessments

A health assessment is any procedure or combination of procedures used to assess an individual's health. It may include questionnaires, review of medical records, consultation with a health professional, or tests of physiological function or health effect.

In an occupational setting, the purpose of health assessments is to detect and measure any effect of:

- a. health on work (e.g. medical fitness for work assessments)
- b. work on health (e.g. health surveillance)
- c. and to act on the findings accordingly.

Post-offer health assessments

Post-offer health assessments are undertaken after a person has been offered a job and before they commence duties, usually in safety critical work, to ensure that any health condition from which the individual suffers does not present a hazard to themselves or to other persons, e.g. for airline pilots, air traffic control officers, armed forces personnel, seafarers, divers, licensed

goods vehicle drivers etc. In some of these cases, assessment of medical fitness for work may be a statutory requirement.

In general, it is unlawful to ask health questions pre-job offer. Post offer assessments and the questions asked in questionnaires must be justified and relevant. A specimen post offer health and capability declaration is attached at [Appendix 2](#). The Faculty of Occupational Medicine's Ethics Guidance for Occupational Health Practice provides further advice.⁶

Health surveillance

Health surveillance includes the periodic targeted medical examination of workers exposed to specific hazards at work with the objective of protecting them from, or preventing, occupational disease. The purposes of health surveillance are to:

- detect any special vulnerability to particular hazards, e.g. pre-existing hearing loss in someone who will be exposed to loud noise at work
- establish baseline health status for future review

- detect any departure from health at an early and reversible stage and to instigate remedial measures
- provide assessment of the effectiveness of control measures
- comply with relevant legal requirements for specific occupations or hazards.

Periodic examinations required by law (by HSE Appointed Doctors) include those defined in:

- The Control of Lead at Work Regulations 2002
- The Ionising Radiations Regulations 2017
- The Control of Asbestos Regulations 2012
- The Control of Substances Hazardous to Health Regulations 2002
- The Control of Vibration at Work Regulations 2005
- The Control of Noise at Work Regulations 2005
- The Work in Compressed Air Regulations 1996

Employers and prospective employers are entitled to know whether an individual is medically fit for the proposed post or for continuing service in that post. They have no legal right to medical information about an individual without that person's signed informed consent.

Other health assessments

An occupational physician may assess the health of a worker who has a health condition to either help them return to their own job or another job if necessary, with reasonable adjustments or, when all else fails, to assess their suitability for ill health retirement. [See chapter 8](#), Sickness absence.

Occupational health services may also offer voluntary health and lifestyle screening as part of a broader health promotion programme. Such 'well-person' health assessments monitor general health, unrelated to employment.

Advice on VAT

'Pre-employment' medicals are taxable supplies as they are primarily for the purpose of enabling a prospective employer to take a decision on recruitment. This includes medicals (and reports) for the purpose of determining whether a person is medically fit enough to join a professional register.

Post-employment medicals – where these are to:

- assess whether proposed work could adversely affect their health and to make

- recommendations to minimise any risk accordingly
- comply with health and safety legislative requirements
- determine whether early retirement on ill-health grounds is appropriate,
- then the principal purpose is protecting the health of the individual concerned and the supply is exempt (however, where the medical is undertaken to determine whether a person can join a pension scheme, the supply is taxable as the principal purpose is to enable a third party to take a decision).

Management request consultations

Except in an emergency, only written requests for medical assessment should be accepted.

A formal management request for a report ought always to be in writing. The request should include:

- the reason for the referral
 - a clear statement of the questions being asked
 - the names of the persons who will receive the report
- a statement confirming that the actions which may result from the report and the possible implications for the employee have been explained to the employee by the manager making the request
 - confirmation that the employee consents to the assessment.

When the employee attends, the relevant member of occupational health staff should satisfy themselves that the above points have been met and that the employee understands the purpose of the consultation.

The written referral shall be shown to the employee on request.

At the end of the consultation the employee should be informed of the result (or the next steps) and told that no clinical information will be disclosed without their consent.

The employee should be offered proper disclosure of or a copy of any report that will be sent to their employer. The employee should be told that they have the right to comment on any part of the report that they believe is inaccurate or misleading. However, the employee should be told that the occupational health opinion cannot be changed in the report. Employees should be told that they have a right to withdraw consent having seen a written report.

Consent

GMC guidance sets out the principles of confidentiality and respect for patients' privacy that doctors are expected to understand and follow.

The guidance accepts that, in many circumstances, doctors may wish to gain verbal rather than written consent to the content of their reports to avoid unnecessary delays.

It is recommended that, wherever possible, the patient signs a consent form demonstrating their agreement to the involvement of occupational health and a report being provided to management. Doctors should also record the employees consent in the clinical notes.

The GMC has advised that the patient has the option to preview an occupational health report before it is provided to management. An occupational health service should have a process demonstrating how they deal with consent and how they deal with the situation whereby an employee withdraws their consent for a report to be released.

8

Sickness absence

Control of absence attributed to illness is a management responsibility. It is generally for the individual to determine whether they are sufficiently well to attend work; and it is for the employer to accept (or not) the evidence presented, and to ensure that they are not negligent when assigning tasks to the individual (i.e. that the individual is fit for the task). Occupational health services can advise employers and employees to help them understand and minimise sickness absence on an individual basis and in the organisation.

Certification and monitoring

National Insurance regulations permit self-certification for the first seven calendar days of absence. Thereafter a Statement of Fitness for Work must be submitted. The purpose of this is stated explicitly as 'for Social Security and Statutory Sick Pay purposes only'.

Further information is available from the Department for Work and Pensions for [general practitioners](#) and other doctors and for [occupational health professionals](#). A 'fit note' chart is attached as [appendix 3](#).

Advice to employers on absence

The occupational physician should be familiar with the rules on occupational and statutory sick pay. The employer may ask for advice about an employee who has had long-term (i.e., greater than 20 working days) or frequent short-term sick leave, depending on the organisation's policy. Issues that the occupational physician should address in a report to employers may include the following.

- If currently unable to perform their normal duties, will they be able to in future, and over what time scales? Secondly, is the employee able to perform some form of work? And if so:
- What temporary or permanent adjustments are needed to facilitate return to work?
- What is the likelihood of return to work within a specified period?

- Is there likely to be any residual disability at that time?
- What is the likely term of that disability?
- Is it possible that the condition might qualify as a disability under the [Equality Act 2010](#)?
- Will it be necessary for the individual to have time off work to attend medical appointments?
- Is it likely that the individual will qualify now or in the future for ill health retirement under the pension fund rules?
- Is there any other way in which management can help?
- To what extent is this a management issue rather than a medical issue?
- Is there an underlying medical reason which may contribute to an unsatisfactory attendance record?

To answer these questions, the occupational physician should normally consult the employee and, where appropriate, contact the GP or specialist with the employee's written and informed consent (see **Access to Medical Reports Act 1988**⁷ or the **Access to Personal Files and Medical Reports (Northern Ireland) Order 1991**).⁸ The occupational physician should ensure that the purpose of the assessment, including the occupational physician's role as an impartial and objective adviser and their duty of confidentiality, is understood at the start of the consultation, and be satisfied that the employee consents to proceed. Good communication between the occupational physician and the GP or the specialist helps the occupational physician to give clear and sensible advice to both the employer and the employee and helps the treating GP or specialist who has clinical care to understand the nature of their patient's work and the opportunities for rehabilitation.

Answers to the questions above aim to inform the employer without breaching medical confidentiality and help the physician to avoid providing vague advice. The occupational physician should be as precise as possible regarding any adjustments recommended. The use of vague phrases such as 'light duties' or 'restricted duties' should be avoided unless qualified and quantified with further information on the employee's ability to e.g. lift, bend, stand, sit, walk, work at heights, climb ladders, operate lift trucks or motorised vehicles, work with moving machinery, work shifts, work alone, etc.

When properly supervised by an occupational physician, an early return to work after illness or injury will:

- facilitate recovery and assist rehabilitation of the employee
- maintain the employee's basic earnings and thus minimise financial hardship
- shorten the period of sickness absence.

If an employee is prevented from performing their normal job on a long-term basis, they may require periodic assessments to determine the need for ongoing adjustments of duties, redeployment to other work or ill health retirement.

9

Ill health retirement

The occupational physician should be aware of the terms and conditions of the employer's pension scheme(s) and especially the rules on entitlement to early retirement due to ill health or disability.

Assessment

If early retirement due to ill health is being considered, an occupational physician may be asked to examine that employee to determine whether the degree of ill health satisfies the rules of the occupational pension scheme, and to advise management and the employee concerned. Where the occupational physician provides occupational healthcare to the employee and also advises the Pension Fund trustees, they must be assiduous in acting and being seen to act impartially.⁶

The occupational physician must ensure that they have sufficient objective medical evidence from occupational health clinical records and/or factual and objective reports of the individual's health condition from the patient's GP and/or consultant, with the worker's written informed consent (see Access to Medical Reports Act 1988⁷ or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991)⁸ or, if necessary, an independent examination and report. The Faculty of Occupational Medicine's Ethics guidance for occupational health practice⁶ provides further advice.

The occupational physician can be asked to provide advice on the impact of the individual's health on their medical capability to do their current job until retirement age. Occupational physicians can also, depending on the criteria of the pension scheme, be asked to provide an opinion on medical capability to undertake any other job in the future. Advice from the occupational physician should always be based purely on medical factors and the medical capability of the individual for the requirements of the work.

The GMC maintains that doctors should only express opinions that fall within their professional competence. The patient's ability to obtain work in the future may be affected by their mental, physical, social, and educational capabilities in the absence of the illness, the availability of work and the economic circumstances. None of these factors, whilst relevant to an individual obtaining work, fall within the professional competence of the occupational physician.

10

Occupational health records

The occupational clinical health records (OHCs) of workers, maintained for professional use by a doctor, in this case the occupational physician, are confidential documents. Access to them by personnel outside the occupational health department is only allowed where the worker provides written informed consent, unless exceptional circumstances arise, e.g. where there is a grave risk of serious harm to others, or where ordered by a Court or Tribunal.

OHCs should be distinguished from Health Records required for statutory periodic examinations ([Chapter 7](#)), for example, to record the outcome of health surveillance under the Control of Substances Hazardous to Health 2002 Regulations (COSHH). Health Records maintained for statutory periodic examinations should not contain any medical information and should be held by the employer separately from OHCs.

All occupational health clinical staff are responsible for the safe custody of OHCs. Further information is available in the GMC's publication [Confidentiality](#)⁹ and the Faculty of Occupational Medicine's Ethics guidance for occupational health practice.⁶

As well as providing a factual record of consultations and health assessments, OHCs are a powerful research tool for investigating work-related diseases. Occupational physicians undertaking research using information contained within OHCs should refer to the GMC guidance [Good Practice in Research and Consent to Research](#).

Disclosure without consent

If in exceptional circumstances an occupational physician has good reason to provide information without the patient's consent or against the patient's wishes (e.g. disclosure in the interests of preventing a risk of serious harm to others), they should first seek advice from their professional indemnity insurer, and be prepared to justify their decision to the patient and, if called to do so, the

GMC and the courts. Further guidance on this issue can be found in [“Access to Health Records”, guidance from BMA Ethics](#), 2014.

Confidentiality of records

Employees have a statutory right of access to their occupational health records under the [Data Protection Act 2018](#),¹⁰ or to authorise a third party, such as a legal adviser, to exercise that right on their behalf.

Relatives of deceased workers have a statutory right of access to relevant parts of the records of the deceased if they have a claim under the [Access to Health Records Act 1990](#)¹¹ or the [Access to Health Records \(Northern Ireland\) Order 1993](#).¹²

It may be necessary for clerical support staff to have access to clinical records if this is done under the supervision of occupational health clinical staff who must ensure that such personnel understand the need for confidentiality and their contractual obligation to preserve it (perhaps through the use of a signed confidentiality statement). Clerical staff not

subject to such obligations should not be allowed access to personal health information.

Confidentiality in the health sector

The confidentiality of OHCRs applies equally within the NHS and private health sector. No employee outside the occupational health department may access OHCRs, even if they themselves are health professionals. The distinction between health service body ‘patient’ records and OHCRs must be emphasised to staff.

Retention of OHCRs

Record retention varies according to the type and circumstances of the record and the retention policy of the organisation. Generally:

- OH records relating to the hire of an individual should only be kept for one year unless there are good clinical or legal reasons to keep for longer periods
- Most other OH records, unless required by or in support of specific legislation, potential litigation or for research or epidemiological purposes, should only be held for six years after the individual’s departure. Records kept for research or epidemiological purposes must

be maintained according to the protocols and data protection arrangements agreed with ethics committees, the individuals or their representatives as appropriate

- Statutory Health Records required under Regulations must be kept for longer e.g. the [Ionising Radiations Regulations](#) – 30 years, and the [Control of Substance Hazardous to Health Regulations](#) – 40 years after last exposure. As previously mentioned, these records should be kept separate from OHCRs.

The following links give detailed guidance:

- [Information Commissioner \(ICO\) Employment Practices Code](#)
- [Department of Health – Health Records Retention Schedule](#)

Archived old records may be microfilmed or computerised to save space or to improve clerical efficiency and the old records destroyed as confidential waste.

There are occasions when an employee requests their records are deleted. These requests should be carefully considered and complied with unless they must be kept for any statutory reason.

Occupational physicians should note that records may be required as evidence in future litigation, the outcome of which might be prejudiced if they have been destroyed. It is therefore not recommended that records are destroyed if there is any apparent threat of complaint to the GMC or litigation against the occupational physician or the occupational health provider as they would be unable to defend themselves.

Transfer of records

If an occupational health department is to be closed, the OHCRs should be transferred (either intact, or archived onto suitable media) to another occupational physician or occupational health nurse within the organisation or in the new occupational health provider. If there is no suitable medical or nursing guardian associated with the company, the records could be held by a doctor with links to the organisation, or offered to EMAS or to the individual, or as a last resort, destroyed.

11

Access to Medical Reports Act 1988

The main principle of the [Access to Medical Reports Act 1988](#)⁷ and the [Access to Personal Files and Medical Reports \(Northern Ireland\) Order 1991](#)⁸ is the right of access by individuals to medical reports relating to themselves for employment or insurance purposes, provided by doctors who are, or who have been, responsible for their clinical care.

GMC guidance states that doctors should offer to show patients a copy of a report written for employment or insurance purposes before it is sent.⁹

The Act gives the individual the right to see the report and to discuss, with the doctor who is providing it, matters which he/she feels to be factually incorrect or misleading. Ultimately, if the individual remains dissatisfied with the report, he/she can withhold consent for it to be provided. The Act does not give the individual the right to insist that the doctor suppresses

any relevant information in a report or change a professional opinion, although the individual can insist that the doctor attaches a statement by the individual on the areas which the doctor has declined to amend.

How the Act affects occupational physicians

Although the Act, for most practical purposes, applies to reports provided by an individual's GP or hospital doctor, it also affects occupational physicians in the following circumstances:

- a) where an occupational physician provides clinical care to the employee (care is defined in the Act as including examination, investigation or diagnosis for the purposes of, or in connection with, any form of medical treatment)
- b) where an occupational physician has previously provided medical treatment or advice to an employee (in the context of a doctor/patient relationship) and therefore holds confidential information which could influence the subsequent report

c) where an occupational physician acts as an employer's agent, seeking clinical information from an individual's GP or consultant. In this case the occupational physician, acting for the employer, should seek the employee's consent to request a report and explain their rights under the Act.

Specimen forms are attached at Appendices 4 and 5.

Occupational physicians responsible for initiating medical reports on employees or prospective employees, or who receive requests from management for such reports, should ensure that the individuals concerned are advised of their rights under the Act.

Provided that clinical care (as defined in the Act) is not undertaken, the BMA believes that the Access to Medical Reports Act does not apply to occupational physicians in the same way that it does to those doctors who provide clinical care. However, there can be differing perspectives on what constitutes 'clinical care', even as defined in the Act, so the question is not easily resolved. Workers do have access to any personal information that pertains to them under the Data Protection Act 2018.¹⁰ Similarly, the [Access to Health Records Act 1990](#)¹¹ or the [Access to Health Records \(Northern Ireland\) Order 1993](#)¹² provide a right of access to relevant parts of a health record to those who are pursuing a claim arising out of a patient's death.

The Access to Medical Reports Act 1988 Act only applies to a report prepared by the medical practitioner who usually looks after the clinical care of the person. Reports prepared by other medical practitioners, such as those contracted by the employer or insurance company are not covered by the Act (unless they too have given clinical care). Reports prepared by such medical practitioners are covered by the [Data Protection Act 2018](#).

It is good practice to discuss with the employee the content of the report, the implications of the advice given and to share written reports even if there is no statutory right of access.

If occupational physicians, exercising their professional judgement, decide to withhold access to any information or report, they must be prepared to justify such action. Advice on this matter can be obtained from medical defence organisations, from the BMA occupational medicine committee and medical ethics departments, or in the Faculty of Occupational Medicine's Ethics guidance for occupational health practice.⁶

12

General ethical guidance

In most other branches of medicine, the doctor has a straightforward duty of care to the patient. In occupational medicine, besides having professional, legal and ethical obligations to the individual, occupational physicians also have a contractual duty to the employer who has appointed them.

The occupational physician must also consider the health and safety of other workers and the general public. This dual ethical responsibility must be explained to the patient at the outset to avoid any confusion.

For more detailed guidance occupational physicians should ensure that they have access to a contemporaneous copy of the Faculty of Occupational Medicine's Ethics guidance for occupational health practice,⁶ the Faculty's guidance document: [Good Occupational Medical Practice](#), and the GMC's Good Medical Practice.¹³

Although generally considered undesirable, in certain circumstances the doctor may be both the GP and occupational physician. These two roles must be clearly distinguished – information about a patient obtained in the capacity of a GP must not be used to formulate advice to an employer without the patient's informed consent.

It is in patients' best interests that the general practitioner (GP), who is responsible for maintaining continuity of a patient's medical care, is kept fully informed. An occupational physician, (with the employee's informed consent), should inform the general practitioner of any work-related facts which may have a bearing on the health of their patients or if a patient has been referred to a specialist.¹³

Business ethics and confidentiality

Occupational physicians should not disclose facts or knowledge concerning the industrial processes, technologies, formulae, specifications and designs of products acquired in the course of their duties except with the consent of management or by order of a court or tribunal.

Approaching companies for work

Occupational physicians may approach companies to offer their professional services and should write to the most senior occupational physician in the organisation or, where none exists to the managing director or director of human resources. The letter should be restricted to an inquiry about the availability of occupational health work. If such work is available, the doctor should supply a straightforward curriculum vitae. FOM's [Good Occupational Medical Practice](#) contains guidance about providing and publishing information about services.

Relationships with others

The occupational physician should apply the following principles in professional relationships with others.

With patients

- communicate frankly, politely and considerately respecting patient's dignity and privacy
- provide appropriate information regarding complaints procedures

With purchasers of services

- provide clear information about the nature and extent of the services provided and
- specify any services that are excluded
- provide details of the applicable charges and fees
- make available information regarding any complaints procedures that are available in the event of a dispute

With other occupational health professionals

- delegate professional tasks to other personnel only when that person is specifically trained and has demonstrated competence in the performance of that task

With general practitioners and specialists

- comply with all legal requirements relating to medical reports
- subject to the employee's consent, promptly inform the general practitioner of work-related facts which may have a bearing on the health of their patients
- not to refer patients to a specialist for an opinion without informing the patient's general practitioner, and not to refer to a specialist for treatment, except in the event of an emergency, without the agreement of the patient's general practitioner
- not to influence workers in their choice of doctor

13

Revalidation

Revalidation is the process for doctors to assure the General Medical Council (GMC) that they are up to date and fit to practise. Most licensed doctors have a connection with one organisation that provides them with an annual appraisal and helps them with revalidation. This organisation is called the 'designated body'. [The GMC provides an online tool to help doctors find their designated body.](#) This tool is based on rules that are set out in the [regulations for responsible officers](#) introduced by the health departments of England and Northern Ireland. These regulations cover the whole of the UK.

Further information about revalidation is available on the [BMA website](#) and the Faculty of Occupational Medicine website.

Doctors enrolled in a specialist training programme in occupational medicine will have their revalidation requirements enacted through the Annual Review of Competence Progression (ARCP). The ARCP panel will determine whether or not there are any causes for concern, and the chair of the panel will relay this to the Responsible Officer via the ARCP Outcome Form. This will happen annually, although revalidation itself is on a five-year cycle.

14

Prescribing medicines

Nurses who provide occupational health services have specific exemptions under medicines legislation to supply or administer medicines.¹⁴ These amendments allow nurses operating an occupational health service to order pharmacy medicines, general sales list medicines and prescription only medicines (POMs) in response to a written order signed by a doctor who has a licence to practice or very exceptionally by a registered nurse employed by that organisation.¹⁵ Nurses may only dispense POMs when a doctor has issued written instructions regarding the specific circumstances in which each medicine may be administered.

Clinical procedures and operational policy

The occupational physician should ensure that there are documented clinical procedures for nurses to define the POMs which they may supply or administer and the general indications for which they can be used.

The policy should separate drugs administered by injection from those administered by other routes and it should be reviewed periodically.

A specimen written instruction is attached at [Appendix 6](#).

The occupational physician must ensure that:

- the nurses required to administer medicines and vaccinations are specifically and adequately trained to undertake this work
- the medicines and drugs are such that their administration may be properly delegated to a nurse
- the competence of the individual nurses concerned is adequate to cope with foreseeable situations.

The physician should restrict products to those that are necessary for the occupational health service and must make sure that adequate records are kept of all medical products administered or supplied to individual employees.

15

Terms and conditions of service and remuneration

The occupational physician's job description and contract of employment must define the duties of the appointment considering the guidance given in this document and relevant employment legislation. Guidance for occupational physicians wishing to offer their professional services to organisations is given in [Chapter 12](#).

Occupational physicians – definitions and remuneration

This section should be read in conjunction with the [Occupational Physicians pay scales webpage](#) on the BMA website. The BMA regards occupational physicians as being in one of the following grades, described in terms appropriate to commercial organisations. The titles used reflect the comparison between each grade and its equivalent in the NHS. Individual organisations may wish to use their own titles.

In suggesting the salary ranges that appear in on the Occupational Physicians pay scales web page, the BMA takes account of the Doctors and Dentists Review Body's detailed annual review of salaries.

If occupational medicine is to attract and retain a proper proportion of able and experienced doctors, the BMA believes that the material rewards and prospects offered must be competitive with those available to the profession in other fields.

Trainee occupational physician

This grade covers doctors undergoing specialist training in a post approved by the Faculty of Occupational Medicine which normally lasts for a minimum of four years. The post is of limited tenure, to allow the doctor to receive training while under the supervision of an approved trainer, leading to the award of a Certificate of Completion of Training (CCT).

Alternatively, occupational physicians may achieve specialist accreditation through the Certificate of Eligibility for Specialist Registration

(CESR) route. The CESR route is aimed at doctors who have not completed a GMC approved training programme (or were otherwise unable to finalise specialist registration at the end of training) but who are able to show that they have undertaken similar training as would be the case in an approved post. They must demonstrate that they meet the requirements, with regard to training, qualifications and experience, by submitting their evidence of this to the GMC.

See below for more information on pay protection for doctors planning to retrain as an occupational physician.

Specialist occupational physician

This is a doctor who has a CCT. On appointment to a post in this grade, it is suggested that occupational physicians receive at least the minimum salary set out on the [Occupational Physicians pay scales webpage](#). Starting salaries should be commensurately higher where the doctor has previous relevant experience in other employment. Salary should also be related to several factors, which include the size of the organisation, the responsibility involved,

supervision of other occupational physicians and health professionals, and senior manager's salaries in the organisation. Salary should progress in line with the organisation's pay policy.

Part-time occupational physicians

Part-time occupational physicians should be paid at sessional rates not lower than those set out on the [Occupational Physicians pay scales webpage](#). Previous relevant experience and qualifications in occupational medicine should be considered when deciding the sessional rate of pay.

It is recommended that contracts or letters of appointment should include provision for regular reviews of salary scales in the light of changes in the BMA's recommended scales. Part-time occupational physicians should, where possible, be given the opportunity to contribute to and ultimately benefit from an occupational pension fund, although the rates of remuneration set out in the supplement do not assume this.

Item-of-service remuneration and ad hoc fees for a specific occupational health problem or problems are a matter for private negotiation between the occupational physician and the customer.

The suggested salaries provided on the [Occupational Physicians pay scales webpage](#) should be regarded as the minimum and should be increased where qualifications, skills and experience warrant. Employers should also take account of special circumstances such as regional variations in the cost of living. Occupational physicians should be accorded similar privileges to other senior managers and professionals of similar level in the organisation.

Contracts of employment

The Employment Rights Act 1996 gives employees the right to a minimum period of notice of termination of their employment according to length of service, and the right to receive from their employer a written statement of their main terms and conditions of employment. It is the doctor's responsibility to ensure that their contract of employment covers the BMA recommendations regarding

terms and conditions of service. Doctors must be clear whether they are being offered a 'contract of service' or a 'contract for services' and should seek legal advice on the wording of the draft contract.

The following provides a brief description of the types of contracts:

A contract of service is one under which the person paying for the services has general control over the performance of those services. This type of contract is covered by the benefits of the Employment Rights Act 1996 (as amended).

A contract for services in contrast is one under which the person providing the services is free from the element of control. If, and when, the contract is terminated by due notice there is no question of unfair dismissal compensation, nor do any of the other benefits associated with the Employment Rights Act 1996 (as amended) arise. An example contract is provided in [Appendix 7](#).

A letter of appointment is a formal offer of a post. Such a letter may itself contain some, if not all, of the terms of the contract that will result from its acceptance. Advice on job descriptions and contracts of employment for occupational physicians is available to members of the BMA by contacting 0300 123 1233.

The contract of employment should contain the following:

- title of post
- hours of duty
- remuneration
- overtime arrangements
- occupational pension arrangements
- notice periods
- annual leave entitlement
- sick leave and pay arrangements
- grievance procedures
- duties and responsibilities
- arrangements for health records
- supervision/liaison with colleagues
- advisory nature of the role to the other divisions of the organisation which are also responsible for the health, safety and welfare of employees, e.g. safety committees.

Pay protection of higher grade salary for those considering an occupational physician training post in the NHS

Doctors can only commence training in occupational medicine after spending a minimum of two years in higher medical training, preferably having acquired a postgraduate qualification. Consequently, many occupational medicine trainees have worked in general practice or general medical specialties at a senior level. Career doctors returning to training in an occupational medicine post on a national contract may be entitled to pay protection, provided they meet eligibility criteria.

Principal GPs are offered protection of their pensionable income in their last complete year of practice uprated by the factor determined by the NHS Pension Scheme Regulations (as amended) or at the current rate of the second incremental point on the consultant scale whichever is the lower, provided they have sufficient service.¹⁶

Salaried career doctors (including consultants) on a national contract are offered protection of their current incremental pay point or threshold, provided they have worked 13 months or more in such a post immediately prior to re-entering training.¹⁷ This form of pay protection is also available for salaried GPs, although this can be more complex and includes restrictive criteria that can be a barrier to some. Salaried GPs in general practice have model terms and conditions with a salary range rather than a distinct set of terms and conditions and a pay scale with defined incremental points. Unfortunately, the contractual clause on this issue is not explicit in covering salaried GPs.¹⁸ Most stakeholders (including NHS Employers) interpret pay protection as being applicable to salaried GPs if they have been employed under the model terms and conditions.¹⁹

You can read more about this on the NHS Employers website. However, it is a complex and regularly disputed area, and members are encouraged to contact the BMA for advice on their particular circumstances.

Occupational pensions

Arrangements for occupational pensions vary from employer to employer, e.g., they may be either defined benefits or defined contributions; contributory or non-contributory; based on 1/50th or 1/60th of salary or some other denominator and based on final salary or for example a career average salary. The ability to transfer pension contributions on change of employment differs from one scheme to another, and occupational physicians should consider the provisions of the occupational pension scheme before entering a contract of employment.

Doctors who are well established in their career and who change employer should consult a pensions adviser. BMA members may obtain advice from the [BMA Pensions Department](mailto:pensions@bma.org.uk) at pensions@bma.org.uk

Restrictive clauses

Attempts should be resisted to include in the contract a clause to restrict the practice of an independent, part-time occupational physician during the time when he/she is not undertaking work for that company or to restrict the practice of any occupational physician for a period after the termination of his/her contract. BMA members should contact the BMA for advice where a proposed contract lays down such restrictions.

Medical indemnity

[Good medical practice](#) provides that a doctor must make have adequate insurance or indemnity cover so that patients will not be disadvantaged if they make a claim about their clinical care.

Where cover is provided by their employer the BMA advises doctors to consider their personal circumstances and decide if they need additional personal cover with a medical defence organisation.

It is important to note that medical defence organisations do not necessarily provide cover to OHP's if either the OHP or the employee is based outside of the UK borders. This area is complex and OHPs (and entities) should always ensure that they are complying with any legal or regulatory requirements that may apply to work carried out in jurisdictions outside the UK. Some medical defence organisations are willing to consider indemnity requests outside the UK on a case-by-case basis, ahead of the practitioner undertaking the work. OHPs should contact their medical defence organisation for advice before conducting any such work.

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Training and qualifications

The Faculty of Occupational Medicine is the specialty's academic body in the UK. Information on training in occupational medicine is available on the [Faculty's website](#).

Diploma in Occupational Medicine (DOccMed)

The DOccMed is aimed at doctors who do not necessarily aspire to become occupational medicine specialists but who wish to develop their skills in this area. It is typically taken by general practitioners, either to enhance their work with their own patients and or to enable them to offer occupational health sessions to local firms.

Membership of the FOM (MFOM)

The MFOM is a career specialist qualification and is required for appointment as a hospital consultant. The MFOM can only be awarded once Higher Specialist Training (HST) is complete, and the 2 part examinations passed. Alternatively, occupational physicians may wish to achieve

specialist accreditation through the Certificate of Eligibility for Specialist Registration (CESR) route.

Associateship of the FOM (AFOM)

Associateship is a mid-level qualification aimed at doctors looking to enhance their training and competencies in occupational medicine, but who are not able to fill an approved training post.

Fellowship of the FOM (FFOM)

The Faculty's Fellowship Committee awards Fellowships to those Members who have made a distinguished contribution to the specialty and who demonstrate a greater depth of experience and expertise in occupational medicine.

The European Specialist Medical Qualifications Order 1995 facilitates the free movement of doctors and the mutual recognition of their diplomas, certificates, and other evidence of formal qualifications. Those doctors who have specialized outside the UK and who have acceptable training will appear on the GMC Specialist Register as having a Certificate of Eligibility for Specialist Registration.

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Appendix 1

The skills and knowledge of specialist occupational physicians

This document is intended to clarify and describe the skills and knowledge which accredited specialist occupational physicians can offer to employers and employees. It is intended that this will help define the areas of overlap and the boundaries of skills and knowledge with other disciplines.

It is based on information contained in the Faculty of Occupational Medicine's guidance:

http://www.fom.ac.uk/wp-content/uploads/GOMP_2017_Web.pdf

Accredited Specialist Occupational Physicians possess the following skills and knowledge:

1. The skill to take and record a full medical history of all relevant conditions accurately and completely, including a history of occupation, function, impairments, and disabilities.
2. The skill to undertake a regional or full physical or mental state examination where relevant.
3. Broad knowledge of the natural history of all common medical conditions.
4. Broad knowledge of diagnostic criteria for all common medical conditions using ICD10, DSMIV or other internationally accepted diagnostic criteria.
5. Broad knowledge of the evidence-based treatment spectrum and prognosis for all common medical conditions, including side effects, contraindications, and interactions.
6. Knowledge and skills to interrogate and interpret the medical literature for evidence about diagnosis, treatment, and prognosis of medical disorders.
7. Knowledge and understanding of relevant fitness standards.
8. Detailed knowledge of relevant health and safety legislation, including the Equality Act, Data Protection Act, Health and Safety at Work Act and all secondary health and safety regulations.
9. The skill to obtain further medical evidence from treating doctors, with full understanding of the legal constraints for consent, and the conflicts of interest for therapeutic advocates.
10. The knowledge and skill to analyse, interpret, debate, and if necessary to challenge, medical evidence provided by treating doctors who have a relationship with patients as therapeutic advocates, who may lobby on behalf of patients for their patients' preferences.
11. The skill to distinguish between the subjective preferences of clients and managers (perhaps based on non-medical socio-economic factors) and objective medical necessity in the workplace.
12. The skill to reach and articulate a conclusion about fitness, on the balance of probabilities, based on triangulation between fitness standards, medical conditions and functional impairments.
13. The skill to communicate a logical, reasoned, evidence based and clear conclusion to management, expressed in terms which are comprehensible to non-medical colleagues and legal representatives, and which meets the legal standards set by case law for an expert medical opinion.
14. The knowledge and skills to advise employers, trade organisations and governments about strategic issues affecting the health of populations and groups in the workplace.
15. The knowledge and skills to prepare, present and defend expert occupational medical evidence in a formal legal setting in the UK.
16. The skills to assess occupational health risk, and propose controls to mitigate or remove risk
17. The ability to commission, interpret and provide advice on occupational hygiene as affects health risks (for example, noise, heat, cold, ergonomics, chemical & biological exposure, lasers, vibration, radiation).
18. The ability to initiate or interpret large or small scale occupational epidemiological investigations.
19. The ability to establish, analyse, interpret and advise on health data trends.
20. The knowledge and breadth of scope to unify all members of the occupational health team.
21. The knowledge and expertise to set occupational health policy and standards.

No other branch of medicine provides specialist training and experience in all of these areas of competence.

Some allied professionals have skills and knowledge which overlap with and complement those of specialist occupational physicians. Specialist occupational physicians have the key knowledge and skills for occupational health assessment of clients referred by management with complex performance or attendance problems.

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Appendix 2

Specimen health and capability declaration

ABC plc is an equal opportunities employer. We recruit and promote people irrespective of any personal factors, including gender, race, disability or sexual orientation.

ABC plc aims to promote and protect the health and wellbeing of all its people.

This declaration aims to identify people who have pre-existing health-related capability issues before they start their job, so that the company's occupational health service can advise management how to adjust people's work accordingly and help people work to their full potential. You should have had the opportunity to read the job description for the role to which you are being recruited and to discuss practical matters with your recruiting manager. Please tick the statement that you think applies to you and sign and date the declaration.

Either:

A. I am not aware of any health condition or disability which might impair my ability to undertake effectively the duties of the position which I have been offered.

Or:

B. I do have a health condition or disability which might affect my work and which might require special adjustments to my work or at my place of work.

If you have ticked B, you may provide details below and send the completed form to Occupational Health in the sealed envelope marked '**confidential for OH only**'. Occupational health staff may then contact you to discuss your health further in **confidence** in order to determine if any special measures are required to accommodate you at work:

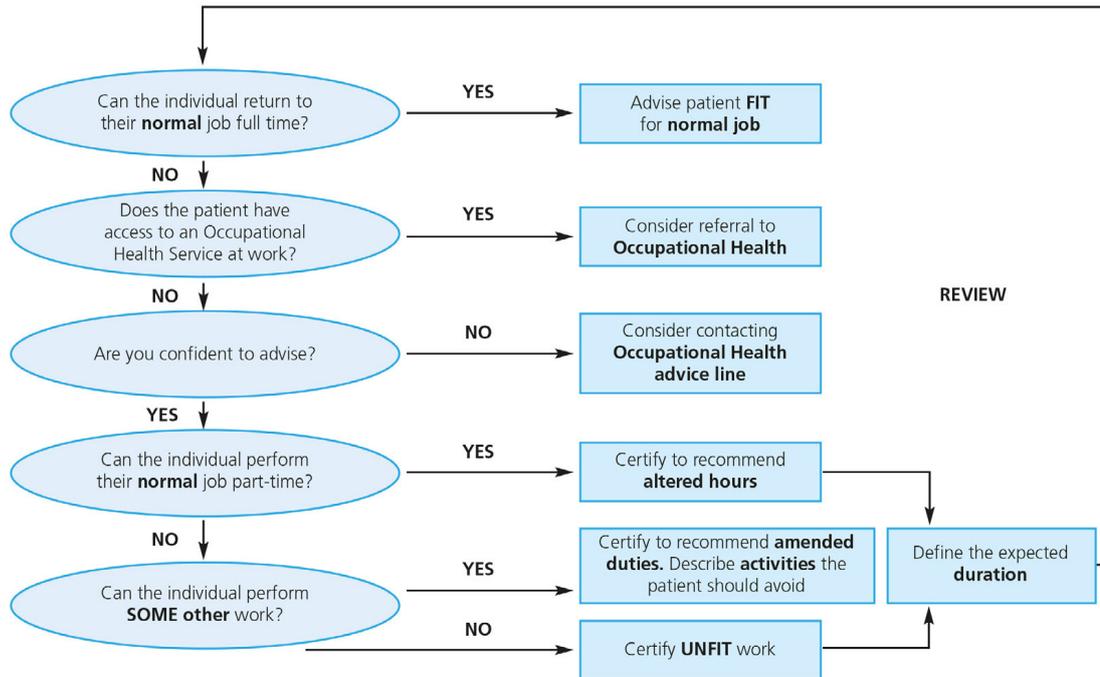
I consent to providing this information and declare to the best of my knowledge that the answers to the questions above are complete and accurate. I also understand that any false declaration may result in my service being terminated.

Signature:

Date:

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Appendix 3



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Appendix 4**Specimen form of consent in respect of an application for a report from an employee's own doctor****CONSENT TO APPLICATION FOR AND RELEASE OF PERSONAL MEDICAL INFORMATION****General**

Occupational Health (OH) wishes to write to your Doctor to request a Medical Report on you (your doctor is usually your Family Doctor but also your Hospital Doctor if you are being treated by a Hospital Specialist). This form records your formal consent and will be forwarded to your doctor. A copy will be kept by OH and a further copy will be given to you.

Under the terms of the Access to Medical Reports Act 1988 you have the following rights:

1. You can refuse to give consent if you wish.
2. If you do give consent, you have the right, if you wish, to see your Doctor's report before it is sent to OH.
3. If you want to see the report, you must ask your Doctor for sight of it within 21 days of the date on which OH has requested a report (you will be told in writing what that date is). If you do not meet this 21-day deadline the report will automatically be sent to OH (provided you have given your consent).
4. When you have seen the report, you have the right to withdraw your consent to its being sent to OH, if you wish.
5. If you consider any of the information in the report to be incorrect or misleading, you can ask for it to be amended. You must do this in writing. If your doctor does not agree that the information is incorrect or misleading, he/she does not have to amend the report. Instead, you will be invited to prepare a written statement giving your views of the disputed information. That statement will be included when the report is sent to OH.
6. You will continue to have a right of access to the report after it has been sent to OH. If you decide you want to see the report you may ask your doctor or occupational health to let you see it.
7. If you just want to see the report it will cost you nothing, but your doctor may charge you a fee if you want a copy to keep.
8. In exceptional circumstances, your doctor has the right to withhold from you any information which he/she considers may cause serious harm to your physical or mental health. In these cases the doctor may allow you to see only part of the report.

Information

Please provide the following information

Surname *Title Mr/Mrs/Miss/Ms/Other

Forenames

Date of birth

Address

Postcode Telephone

Full name and address of Family Doctor

Postcode Telephone

Full name and address of your Hospital Specialist

Postcode Telephone

Please give your hospital registration number:

Declaration

Please read this declaration, then sign it to show your consent:

I consent/do not consent* to OH applying to my doctor for a medical report on me.

I wish/do not wish* to see my doctor's report before it is sent to OH.

I understand that the information given will be retained by OH on a confidential basis and that any advice given to Management will be expressed in terms of my fitness for employment and/or my fitness to carry out my duties both now and in the future. It will not include detailed information about my medical condition unless I consent.

Signature:

Date:

*Delete as necessary

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Appendix 5

Specimen letter to an employee who has requested access to a medical report

Dear

Further to the return of your Consent Form, I have today applied to Dr/Mr..... for the medical report and have informed him/her that you do/do not require access to the report before it is supplied to me. You will recall that under your expressed option in the summary on the Consent Form you have the following rights:

*You give your consent, but wish to read the report before it is issued. You should therefore arrange to visit the above named medical practitioner in order to read the report once it has been prepared.

*The above named medical practitioner will also be informed of this, and will not supply me with the report until you have read it. If the medical practitioner has not heard from you to the contrary within 21 days of this letter, he/she will assume you agree to provision of the report.

*When you read the report, if there is anything which you consider incorrect or misleading, you can request in writing that the medical practitioner amend the report, but he/she may not agree to do so.

In this situation you can:

- withdraw consent for the report to be issued
- ask the medical practitioner to attach to the report a statement from you giving your views
- agree to the report being issued unchanged.

You can also withdraw your consent if the medical practitioner will not show you the report (or part of it) because he/she considers there are special circumstances.

Yours sincerely,

Signature of applicant and position in organisation.

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Appendix 6**Specimen operating policy**

Date of issue

General written instruction/local operational policy

for the Occupational Health Nurse (Name)

of the (Organisation)

1. This instruction covers the above named nurse working in the following locations within the above organisation:

(1)

(2)

- 2.(a) The following prescription only medicines other than injectable may be supplied as indicated below:

Proprietary name Form Dosage Indications for use

.....

- (b) The following parenteral route prescription only medicines (injectable) may also be administered as indicated below:

Proprietary name Form Dosage Indications for use

.....

3. The RN who is authorised and willing to undertake treatments involving the use of prescription only medicines listed above should indicate willingness and agreement to do so by signing below:

Name Qualifications Date Signature

.....

4. The doctor or doctors giving authorisation to this instruction are:

Name Qualifications Date Signature

.....

Notes

1. This instruction should be reviewed at least once per year.
2. Any changes in legislation should be taken into account.
3. All new staff (both doctors and nurses) should be named as parties to the instruction.

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Appendix 7**Specimen contract for self-employed occupational physicians****Confidential**

An agreement made the day of 20 between whose registered offices are at (herein after called the Company) and Dr of (herein after called) for the receipt of and performance of occupational medical services described in this agreement upon the basis of a contract for services upon the following terms and conditions.

It is agreed:

1. The Company will accept and Dr will provide his/her services as Occupational Physician to the Company at the Company's premises as set out in schedule 1 for an indefinite period/period commencing and expiring on
- 1.2 This agreement may be terminated by either party at any time by giving at least months notice in writing to the other.
- 1.3 The continuation of the contract for services created by this agreement is conditional upon the Occupational Physician producing to the Company upon demand a current annual registration certificate from the General Medical Council and evidence of current membership of a medical defence organisation/malpractice insurance scheme approved by the General Medical Council.
- 1.4 Dr undertakes to discharge faithfully and diligently all the skills which may reasonably be expected of an Occupational Physician in providing the services described in schedule 2 to this agreement.
- 1.5 In the course of delivering the services described in schedule 2 Dr will ordinarily report to at the premises described in schedule 1. In any case in which Dr considers there to be an urgent issue relating to the health or safety within or related to the Company's operations or staff at the said premises or in the absence of or any period greater than one day Dr will report to the Director at the said premises or, exceptionally, the Director at the Company's registered offices.
- 1.6 Dr will be an independent contractor and nothing contained in this agreement shall be construed or have effect as rendering Dr an employee, worker, agent or partner of or any associated entity.
- 2.0 Remuneration
 - 2.1 During the continuation of this agreement the Company will pay to Dr without any deduction of tax or national insurance contributions, in return for the services provided in accordance with schedule 2 sessional fees at the rate of per day session and per night session: each session comprising 3.5 hours. Remuneration shall be payable at the end of each calendar month or on such a periodic basis as may be agreed between Dr and the Company from time to time.
 - 2.2 Dr will attend the premises set down in schedule 1 to provide the service described in schedule 2 and such attendance will comprise a total of sessions per annum allocated at a time and date as agreed with the at the respective premises.
 - 2.3 Dr shall be reimbursed an allowance of pence per mile when travelling on Company business in his private motor vehicle.
 - 2.4 Dr will be entitled to receive reimbursement of any expenses arising in addition to those paid under paragraph 2.3 above in respect of other travel undertaken at the request of the Company in connection with the discharge of the services described in schedule 2.

2.5 The amounts payable to Dr as the annual retainer/sessional fees together with the allowances in paragraph 2.3 shall be hereafter reviewed annually following discussion and agreement and taking account of the Occupational Physician remuneration supplement published annually by the British Medical Association.

3.0 Confidentiality

3.1 The Company recognises the clinical independence of the Dr, his/her duties to his/her patients, and his/her right to maintain the confidentiality of occupational health clinical records and information for which he/she is responsible.

3.2 By agreeing to the terms of the agreement Dr acknowledges that in providing services he/she will be exposed to sensitive and confidential information relating to the Company (hereinafter referred to as "information"). Such information may include, but is not limited to, facts or knowledge concerning the processes, formulae, specifications and designs of products.

It is hereby agreed that Dr will hold in confidence and not disclose to third parties, and not without the prior written consent of the Company, use for the benefit of anyone other than the Company such information. The duty of confidentiality set out above shall remain in effect for a period of 20 years following the termination of this agreement for whatsoever reason.

3.3 Dr agrees that he/she will not, without the prior written consent of the Company, which will not be unreasonably withheld, publish the results of any research undertaken by him/her which includes data which he/she has obtained concerning the Company's employees or business activities.

3.4 On termination of this agreement Dr will hand over to either his/her successor as Occupational Physician or to the at the location/locations at which he/she shall have performed his/her duties hereunder or to all records held by him concerning the Company and its employees and any item of property belonging to the Company.

In witness whereof Dr and a duly authorised officer of the Company have hereunto set their hands the day and the year first above written.

Please note: This is a contract for services provided by a self-employed occupational physician rather than a contract of employment. A self-employed occupational physician would not be entitled to go to an industrial tribunal if the contract were breached, although he/she could sue for breach of contract.

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We offer **FREE** comprehensive, impartial and authoritative advice on a huge range of employment-related issues **ONLY** for **BMA members**. Areas covered include:

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