

---

## Research papers

# Medical privacy: Aligning the need to breach patient confidentiality with data protection in the public interest

Received (in revised form): 5th August, 2024



### Andrew Harvey

Director of Information Governance, Cyber and Compliance/Data Protection Officer,  
Graphnet Health Limited

Andrew, an ambitious and highly respected information governance and data protection professional, has worked with various healthcare information processes since 2005. His experience spans the NHS, private sector, provider organisations, shared businesses and commissioning. Having started in summer 2023, he currently works for IT supplier Graphnet Health Limited and was the former Head of Information Governance/Data Protection Officer at what is now University Hospitals Sussex NHS Foundation Trust. Andrew works passionately to maintain the confidentiality, integrity and availability of patient and staff data. He believes that expert management enhances patient care and contributes to an organisation's reputation. Andrew is an Accredited Member of the Information and Records Management Society. He received the 2018 Author of the Year Award and was honoured with a Fellowship in 2020 for his expertise and seniority in the field.

Tel: +44 (0)7736 930849; E-mail: [andrew.harvey@graphnethealth.com](mailto:andrew.harvey@graphnethealth.com)

**Abstract** This paper takes an overview of case law legislation and professional guidance to assess when it may be acceptable for medical practitioners to breach patient confidentiality and data protection law in the public interest. It looks at the implications of making such decisions in both a positive and negative light because of what happens if confidentiality is breached in the public interest, but also the implication, on occasion, if it is not. The paper synthesises the often contradictory considerations of the Data Protection Act 2018 and UK General Data Protection Regulation with the wider implications of breaching the common law duty of confidentiality and professional guidance offered by the likes of the British Medical Association, General Medical Council and right back to the Hippocratic Oath. In doing so, it creates a framework in which it is acceptable in many circumstances to breach patient confidentiality while demonstrating that due care and attention are required to ensure the appropriate decisions are made.

**KEYWORDS:** case law, confidentiality, consent, direct care, health care, public health, public interest

**DOI:** 10.69554/FBHQ5964

### INTRODUCTION

This paper critically considers whether there is enough legislation to support clinicians in balancing decisions to maintain patients' confidentiality against any potential public interest in breaching it.

Some definitions are needed to support discussion around the guidance and its potential for third party harm. The Department of Health's Confidentiality NHS Code of Practice explained in 2003 that a duty of confidentiality arises 'when one

person discloses information to another (eg patient to clinician) in circumstances where it is reasonable to expect that the information will be held in confidence'.<sup>1</sup>

The same document also defines public interest as 'Exceptional circumstances that justify overruling the right of an individual to confidentiality in order to serve a broader societal interest'.<sup>2</sup> These interests include tackling serious crime, child abuse, drug trafficking and other activities placing people at serious risk.<sup>3</sup>

The subject matter concentrates on the consequences of breaching the common law duty of confidentiality. This is the principle that if an individual has shared their personal information with an expectation that it would remain confidential, it should not be disclosed without legal authority or justification. There are, however, multiple laws and guidance, meaning that any discussion will more critique its quality, rather than quantity.

There is also an interaction to consider (see Figure 1). Case law and legislation are both law, albeit created in different ways. Legislation and guidance are both guidance, albeit the former with an obligation to be followed, where the latter is best defined as 'good practice'.

### EARLY EXPLORATION OF THE NEED FOR CONFIDENTIALITY

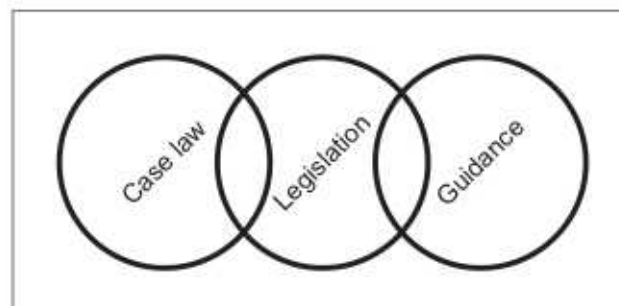
Taking case law first, early exploration of the need for confidentiality and its definition

come from the *Spycatcher* case, *Attorney General v Guardian Newspapers Ltd*, which Shaun Pattinson highlights in 'Medical Law and Ethics',<sup>4</sup> and cemented the legal principle of confidentiality. Lord Goff summarised:

The law has long recognised that an obligation of confidence can arise out of particular relationships. Examples are the relationships of doctor and patient, priest and penitent, solicitor and client, banker and customer. The obligation may be imposed by an express or implied term in a contract but it may also exist independently of any contract on the basis of an independent equitable principle of confidence [. . .].<sup>5</sup>

Goff's conclusions are central to this paper, that 'there is a public interest that confidences should be preserved and protected by the law, nevertheless that public interest may be outweighed by some other countervailing public interest which favours disclosure'.<sup>6</sup>

Moving to specifics, there are several instructive cases where a breach of confidentiality has been claimed. In *R v Crozier*, the court concluded that there was no such breach given the disclosure was demonstrably in the public interest. The situation here was that following the death of his wife, the appellant had attempted to murder his sister in a dispute over the administration of a trust fund. A psychiatrist initially concluded he was sane and safe for release, whereas a second opinion, which was



**Figure 1:** Conceptual relationship between case law, legislation and guidance

not made available to the appellant's counsel, disagreed. The judge, believing there were no medical issues, sentenced him to nine years.

Accordingly, the second psychiatrist made the prosecution aware of his finding, and the Judge, unusually, changed the sentence. Although technically a breach of confidence due to it removing the decision on the use of evidence from the appellant, it was deemed permissible. M. A. Crook from the University of Greenwich summarised in a *Science and Engineering Ethics* paper that the rationale was to protect the public from danger based on decisions made with partial information.<sup>7</sup> The court held that the duty of confidence did not prevent the psychiatrist sharing to prevent a violent patient being released.

A further case, *W v Edgell*, concerned a prisoner held in a secure hospital for violence and murder, who was making an application to be moved. The psychiatrist, Edgell, provided a confidential opinion that W remained a risk. With the knowledge that this would not be included in the patient's medical record, and therefore not considered in the application, the psychiatrist passed a copy to the hospital's Medical Director and the Home Office. As a result, the patient brought an action for breach of confidence.

Lord Bingham declared that the public interest in disclosure outweighed W's private confidentiality interests,<sup>8</sup> clarifying that a public interest test must be met:

- (a) That such a risk is real, immediate and serious; (b) that it will be substantially reduced by the disclosure; (c) that the disclosure is no greater than is reasonably necessary to minimise the risk; and (d) that the consequent damage to the public interest protected by the duty of confidentiality is outweighed by the public interest in minimising the risk.<sup>9</sup>

This test remains instructive and supportive as to when it is permissible to breach confidentiality in the public interest.

Although the context is very different, *Gillick v West Norfolk and Wisbech Health Authority* has implications regarding confidentiality of another demographic, that of minors. It concerned a girl below the age of sexual consent whose mother raised the issue that her daughter was given contraceptive advice from a GP. The court concluded that, in some circumstances, a minor can without parental knowledge give consent for treatment. Lord Scarman asserted that such competence should be based on the child demonstrating 'sufficient understanding and intelligence to understand fully what is proposed'.<sup>10</sup> This is a concept that has become known as 'Gillick competence'. The result is that if a minor is sufficiently competent to consent to treatment, clinicians must also respect their confidence.

#### **RISK OF LEGAL ACTION IF SOMEONE SUFFERS AS A RESULT OF CONFIDENTIALITY PROACTIVELY NOT BEING BREACHED**

Another consideration is the risk of legal action if someone suffers as a result of confidentiality proactively *not* being breached. This was claimed in *ABC v St George's Healthcare NHS Trust, South West London and St George's Mental Health NHS Trust, Sussex Partnership NHS Foundation Trust*. It is highlighted by Jennifer Peterson in the *Postgraduate Medical Journal*, that this case has the peculiar context of 'potential risk to future life'.<sup>11</sup>

ABC had repeatedly and unsuccessfully claimed that the NHS Trusts had breached her duty of care, and her Human Rights Act 1998 right to private and family life, by failing to inform her of the risk she had inherited Huntington's disease from her father.<sup>12</sup> She claimed if she had known she would have terminated her pregnancy. The risk of third party action is remarkable as the Trusts did not override the father's refusal on public interest grounds to tell her, which Mrs Justice Yip concluded was supported by a

'responsible body of medical opinion'.<sup>13</sup> She also believed that on a balance of probability, ABC would not have proceeded with the termination. The importance here is that although there was legal action against the trusts for maintaining confidentiality, given it was not upheld, there was little impact on them or the clinicians for their decisions.

Most case law concerns living individuals, whereas *Lewis v Secretary of State for Health* relates to similar concerns with the sharing of data regarding those who have passed away. Here the High Court deliberated the disclosure of deceased patients' medical records being released to Inquiry, with Mr Justice Foskett arguing that unless proved otherwise, and based on both medical confidentiality guidelines and patients' expectations, it is eminently defensible that the duty of confidentiality continues after death.<sup>14</sup> It was also noted by Foskett that the Information Tribunal had reached very similar conclusions in *Bluck v The Information Commissioner*.<sup>15</sup>

In critiquing these cases, they give clear parameters for managing balancing decisions in the public interest; these are summarised as points 1–6 in the conclusion.

#### **APPLICATION OF THE UK GENERAL DATA PROTECTION REGULATION AND THE DATA PROTECTION ACT 2018**

Moving to current legislation, specifically the UK General Data Protection Regulation (GDPR) and the Data Protection Act 2018 (DPA18), neither prohibit sharing patients' information in their best interests, nor with a variety of other rationale.

The GDPR defines that an Article 6 condition for processing personal data must be met before processing Article 9 special categories of personal data. Health data itself is a special category, relating to 'the physical or mental health of a natural person',<sup>16</sup> and there are multiple ways in which public interest sharing is permitted.

It is acceptable to share personal data under Article 6 in the public interest if, for example, the Article 6(1)(c) condition is met. This is 'compliance with a legal obligation to which the controller is subject', and includes, for example, reporting infectious diseases, such as COVID-19, to the UK Health Security Agency, under the Public Health (Control of Disease) Act 1984 and the Health Protection (Notification) Regulations 2010. Health providers are legally obliged to do this.

However, Article 6(1)(e) specifically mentions the 'performance of a task carried out in the public interest or in the exercise of official authority'. This is a condition that would be better described as 'the public good', rather than risk reduction. All public sector bodies *should* naturally be meeting this in discharging their duties.

Article 6(1)(d) is probably the most significant GDPR condition for processing personal data in the public interest. This is that processing of data is 'necessary in order to protect the vital interests of the data subject or of another natural person'. Whereas the Information Commissioner's Office is clear that this 'is very limited in its scope', and 'only applies to matters of life and death',<sup>17</sup> it is relatively apparent that it may be applied in some of the scenarios discussed above at common law where life and limb were at risk. It would, for example, be acceptable to breach a conversation to a mainline gas provider if a patient disclosed that they had knowingly left gas on in a house where someone else present could be harmed by an explosion.

When it comes to doctors breaching special category data in the public interest, the vital interests condition holds, with an addition at Article 9(2)(c) that it must be 'where the data subject is physically or legally incapable of giving consent'. This makes it potentially more limited in scope. Article 9, however, flourishes when there is a need to share such data at Article 9(2)(g), in cases of 'substantial public interest'. The

most relevant of these, as given in DPA18 Schedule 1, are preventing or detecting illegality, public protection, regulatory requirements, fraud prevention, financing terrorism and safeguarding people at risk.<sup>18</sup> These are similar to the list given in the introduction to this paper.

Similarly, Article 9(2)(i) concerns processing for 'public interest in the area of public health', reflecting the Article 6 processing condition around notifiable diseases. It demonstrates that, contrary to popular perception, data protection allows appropriate public interest sharing of personal data, and in so doing it would not be considered a breach. Indeed, it works alongside case law as it is risk management that permits it.

In addition to data protection, there are provisions that allow clinicians to temporarily waive the duty of confidentiality in the public interest. The first is s.251 of the National Health Service Act 2006, which largely concerns research, and falls into the broader definition of public interest, given the usage has a health promotion context. Decisions on whether to waive consent and the public interest are made on the recommendation of a Confidentiality Advisory Group by the Secretary of State for Health and Social Care. Importantly, however, although it sets aside the common law duty of confidentiality, the need for data protection compliance remains, specifically for transparency in collecting information, meaning that transparency notices are required in healthcare settings where information may be collected for direct care and later potentially reused for alternative s.251-agreed purposes.

#### **HEALTH CARE (CONTROL OF PATIENT INFORMATION) REGULATIONS 2002**

A second similar piece of legislation is the little-known Health Care (Control of Patient Information) Regulations 2002.

Initially laid out under the Health and Social Care Act 2001, it now falls under the National Health Service Act 2006, similarly making provision to lay aside the duty of confidentiality when using patients' information for medical purposes, including research, where it would not be practical to achieve it in another way. It allows clinicians in emergency and time-limited situations, as specified by the Secretary of State for Health and Social Care, such as COVID-19, to use confidential patient information relatively freely to manage the situation effectively. The COVID-19 notification, for example, was published in March 2020 and allowed the use of information in this way for many months.<sup>19</sup>

The opposite is the case with some legislation that defines when public sector organisations cannot share personal information, even in the public interest. The Freedom of Information Act 2000 (FOIA), for example, has two relevant clauses. Section 40(2) states that the release of any personal information about anyone other than the requestor is a qualified exemption.<sup>20</sup> This means that a public interest test must be undertaken to establish whether withholding information is in the greater interest of the public, not the organisation, than disclosing it. Unfortunately, however, the term public interest is not well defined, nor are the mechanics of the test.

Similarly, there is an absolute confidentiality exemption at s.41,<sup>21</sup> in that any information received from a third party that is truly confidential may not be for any reason released to a requestor. Generally referring to corporate rather than personal confidentiality, it becomes clear that simply marking a piece of information as 'confidential' to 'con' the system would not suffice to actually make it confidential.

Comparable protections for individuals are given by the Human Rights Act 1998, specifically Article 8(1), which outlines that 'Everyone has the right to respect for

his private and family life, his home and his correspondence'.<sup>22</sup> Doctors must be aware of this when considering breaching a confidence in the public interest, especially as Article 8(2) goes on that '[t]here shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society'.<sup>23</sup>

The limitations here are demonstrably like those at common law and data protection, that they are in place to prevent the risk of harm to others.

### ACCESS TO HEALTH RECORDS ACT 1990

Similarly comparable to common law is the legislation that defines how healthcare organisations may release information about deceased patients. This is laid out in the Access to Health Records Act 1990. At s.3(1)(f) it states that only 'the patient's personal representative and any person who may have a claim arising out of the patient's death' have a statutory right to apply for access to information in the medical record of the deceased. The DH's guidance advises, however, that there is scope to release information to other people where there is no apparent legal basis, and that this 'should be in the public interest, be proportionate, and judged on a case-by-case basis'.<sup>24</sup>

In critiquing the legislation, it too provides clear parameters for managing balancing decisions in the public interest. These are summarised as points 7–11 in the conclusion.

### PROFESSIONAL GUIDANCE AVAILABLE TO CLINICIANS FOR MAKING BALANCING DECISIONS TO SHARE PERSONAL INFORMATION IN THE PUBLIC INTEREST

The paper now turns to current professional guidance available to clinicians for making balancing decisions to share personal information in the public interest. For

thousands of years doctors have been required to follow the Hippocratic Oath. This was updated in 1964, continuing to contain the obligation to 'respect the privacy of my patients, for their problems are not disclosed to me that the world may know'.<sup>25</sup>

Fifty years on, Dame Fiona Caldicott, the then National Data Guardian for Health and Social Care, demonstrated the progression of thinking in the second of her three 'Caldicott Reports' on the use of patient data. She updated her original six 1997 Caldicott Principles in 2013, adding a seventh to support better practice. This was the edict that 'The duty to share information can be as important as the duty to protect patient confidentiality', in the best interests of the patient where there is good justification.<sup>26</sup> And so it was written down.

Unfortunately, however, much other centralised guidance, including the 2003 Confidentiality NHS Code of Practice very much only reflects the tone of case law and legislation, adding little:

[S]taff are permitted to disclose personal information in order to prevent and support detection, investigation and punishment of serious crime and/or to prevent abuse or serious harm to others where they judge, on a case by case basis, that the public good that would be achieved by the disclosure outweighs both the obligation of confidentiality to the individual patient concerned and the broader public interest in the provision of a confidential service.<sup>27</sup>

It sensibly stresses that data released should be proportionate to the need. This aligns with the third Caldicott Principle to use the minimum necessary information. It is also clear that consent should ideally be sought wherever possible.

Doctor-specific guidance, such as that from the British Medical Association (BMA) barely departs from the other

laws and guidance. Whereas the BMA's Confidentiality and Disclosure of Health Information Tool Kit advises that 'Ultimately, the public interest can only be determined by the courts', it proceeds to give a lengthy list of considerations for doctors when judging these decisions. It also reminds them that 'Health professionals should be aware that they risk criticism, and even legal liability, if they fail to take action to avoid serious harm'.<sup>28</sup> Such language can be unhelpful, as we have seen with ABC, as legal action is not always successful.

Interestingly, however, whereas it was not the case previously that public interest allowed disclosure of patient data without consent for research, the BMA's guidance simply cites the General Medical Council's (GMC) guidance, which it says permits it. Other acceptable reasons the BMA give for disclosure of data include:

- combatting serious crime and national security (such as with the Police and Criminal Evidence Act 1984);<sup>29</sup>
- public safety (such as reporting to the Driver and Vehicle Licensing Agency any patient who continues to drive having been advised not to for medical reasons);<sup>30</sup> and
- public health (such as a patient with a communicable illness behaving recklessly).<sup>31</sup>

The GMC, which maintains the register of doctors, deviates little from the BMA in Confidentiality: Good Practice in Handling Patient Information guidance. Although it lists six considerations to consider for public interest disclosures, there is one of note. This is 'the potential harm to trust in doctors generally', in other words, preventing a perception that doctors may all-too-readily disclose information without consent.<sup>32</sup>

Honing from the generic to very specific medical guidance, the Royal College of Physicians in its Consent and Confidentiality in Genomic Medicine (2019) stressed, as with ABC, that a 'justification [for breaching in the public interest] in genomics may

be when a failure to disclose information leaves relatives ignorant of a significant risk of a condition that might be preventable or treatable'. This very much reflects an apparent importance, given genetic and biometric's 2016 incorporation into the GDPR.<sup>33</sup>

In critiquing professional guidance available to doctors, they broadly serve to reflect and summarise both case law and legislation, with an additional consideration raised, given as point 12 in the conclusion below.

## FINDINGS OF THIS PAPER

This paper disavows any possible assertion that there is inadequate quality of advice to support doctors in decisions to breach patient confidentiality in the public interest. It has concentrated on the implications of breaching the common law duty of confidentiality, while acknowledging that there are multiple other laws and guidance that, albeit often conflicting, allow it. Although not specific to clinical professions, Lord Goff concluded in the *Spycatcher* case that there is a public interest in preserving confidences protected by the law, but that in certain circumstances public interest may outweigh this.

There are multiple instances where case law has borne this out, in different circumstances. *R v Crozier*, for example saw a clinician release medical data to a court to ensure a violent patient did not avoid incarceration. It is clear, therefore, that public interest should be broadly understood as resulting in a positive outcome for either an individual or society at large.

The case of *Gillick v West Norfolk and Wisbech Health Authority* has further demonstrated that the same stands for minors as it does for adults, that whatever their age, if they are competent to consent to treatment, clinicians must also therefore respect their confidence.

*ABC v St George's Healthcare NHS Trust, South West London and St George's Mental*

*Health NHS Trust, Sussex Partnership NHS Foundation Trust* concluded that there is consideration to be had regarding the potential of an individual's further suffering by *not* breaching a third party's confidentiality, specifically the inheritance of a congenitally debilitating condition from a parent.

Moving beyond the interests of the living, a further case, *Lewis v Secretary of State for Health*, concluded that it is eminently defensible that the common law duty of confidentiality continues post-mortem. This has become a commonly understood position regarding the personal data of the deceased.

The position is much the same for the living, whose data is covered by the GDPR and DPA18, neither of which prevents the sharing of patients' data in a variety of situations. There are certain situations where there is a legal obligation to do so, such as notifying the UK Health Security Agency of infectious diseases. Similarly, the GDPR specifies that public sector bodies, which includes most healthcare services in the UK, may process data in the discharging of their duties for the sake of the public good. Likewise, the GDPR allows the processing of personal data where not to do so would significantly harm them or another person.

Regarding breaching data in cases of substantial public interest, DPA18 allows this to prevent or detect illegality, protect the public, where there are regulatory requirements, for fraud prevention, the financing of terrorism and the safeguarding of people at risk. There is similar provision in the GDPR regarding processing for the public interest around public health.

Other legislation, including the National Health Service Act 2006 and the Health Care (Control of Patient Information) Regulations 2002 move away from the concept of data protection back to that of common law confidentiality, allowing the suspension of confidentiality when using patients' information for certain medical purposes, including research.

Conversely, some legislation, including the FOIA 2000, defines when public sector organisations cannot share personal information. There are similar provisions under the Human Rights Act 1998, which ensures that everyone has the right to privacy and family life.

In 2013, Dame Fiona Caldicott published a new Caldicott Principle which reflects both confidentiality and data protection principles. This departs from other guidance and was put in place to support better practice among clinicians and their staff, many of whom had become scared to share data, even for direct care. Now it was well-defined that in those circumstances it is as important to share data for care as it is to ensure confidentiality.

Doctor-specific guidance, such as that from the BMA and the GMC departs little from other laws and guidance.

## CONCLUSION

Based on this range of law and guidance, there are 12 clear rules that senior practitioners, lawyers, academics, policy makers and post graduate researchers should be aware of when making or advising on decisions to breach patient confidentiality and privacy in the public interest.

These are:

1. Patients' interest in confidentiality can be outweighed by the public interest.
2. Sharing must be to prevent immediate serious harm to others.
3. Minimal information must be shared.
4. Competent minors must have confidentiality maintained.
5. Not breaching confidentiality is acceptable if it will make little difference.
6. Confidentiality continues after death.
7. There is an obligation to share certain personal data to protect public health.
8. Data protection legislation allows well-defined conditions for sharing.

9. Arrangements can often be made to waive the common law duty of confidentiality for public interest research.
10. FOIA does not generally support the release of personal data.
11. Breaching an individual's right to a private life must be well justified.
12. Doctors should protect trust in their profession in the making their decisions.

Equally it is possible to rebut the view that decisions to maintain confidentiality are concerning to clinicians if they could result in legal action following a third party suffering harm as a result of their refusal. The small amount of case law does not bear this out, leaving the only conclusion to be that clinicians must follow their instincts, and be willing to defend them based on the parameters outlined in this paper.

### References and notes

1. Department of Health (2003) 'Confidentiality NHS Code of Practice', p. 7.
2. Department of Health (2006) 'Confidentiality NHS Code of Practice', p. 6.
3. United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1996) 'Guidelines for Professional Practice', p. 27.
4. Pattinson, S. (2014) 'Medical Law and Ethics', 4th edn, Sweet and Maxwell, Myrholmroyd, p. 193.
5. Attorney General *v* Guardian Newspapers Ltd (No 2) [1990] 1 AC 109, 2.
6. Attorney General *v* Guardian Newspapers Ltd (No 2) [1990] 1 AC 109, 29.
7. Crook, M.A. (2013) 'The Risks of Absolute Medical Confidentiality', *Science and Engineering Ethics*, Vol. 19, No. 1, pp. 107–22.
8. *Ibid.*, p. 111.
9. *W. v Edgell* [1990] 1 All ER 835.
10. *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] UKHL 7.
11. Patterson, J. L. H. (2018) 'Confidentiality in Medicine: How Far Should Doctors Prioritise the Confidentiality of the Individual they are Treating', *Postgraduate Medical Journal*, Vol. 94, No. 116, pp. 596–600.
12. *ABC v St George's Healthcare NHS Trust, South West London and St George's Mental Health NHS Trust, Sussex Partnership NHS Foundation Trust* [2020] EWHC 455 (QB). ABC's previous attempts are *ABC v St George's Healthcare and others* [2015] EWHC 1394. The Court of Appeal overturned this decision, see *ABC v St George's Healthcare and others* [2017] EWHC Civ 336.
13. *ABC v St George's Healthcare NHS Trust, South West London and St George's Mental Health NHS Trust, Sussex Partnership NHS Foundation Trust* [2020] EWHC 455 (QB), paras 202–32.
14. *Lewis v Secretary of State for Health* [2008] EWHC 2196 (QB).
15. See *Bluck v The Information Commissioner and Epsom & St Helier University NHS Trust* EA/2006/0090, where the mother of a woman who had passed away sought her Medical Records under the Freedom of Information Act 2000. The hospital Trust, however, had refused to release the Medical Records without the consent of the next of kin, as upheld by the Information Commissioner and Tribunal.
16. General Data Protection Regulation, Article 4(13).
17. Information Commissioner's Office (ICO) (2019) 'Guide to the General Data Protection Regulation', p. 71.
18. Data Protection Act 2018, Sch. 1, Pt 2.
19. Letter on behalf of Secretary of State for Health and Social Care to Organisations providing Health Services, General Practices, Local Authorities, Arm's Length Bodies of the Department of Health and Social Care (20th March, 2020).
20. Freedom of Information Act 2000, s.40(2).
21. Freedom of Information Act 2000, s.41.
22. Human Rights Act 1998, Article 8(1).
23. Human Rights Act 1998, Article 8(2).
24. Department of Health (2010) 'Guidance for Access to Health Records Requests', p. 14. The same guidance offers that appropriateness and proportionality can be assessed using the following parameters:
  - Preferences expressed by the deceased prior to death.
  - Potential distress or detriment that any living individual might suffer following the disclosure.
  - Potential implications on the reputation of the deceased.
  - Views of surviving family.
  - Length of time after death, as the duty of confidentiality at common law effectively diminishes over time.
  - Whether it is necessary to release the whole record.
  - Whether it will help support the bereavement process for relatives and friends.
  - Whether it will help improve current life by providing, for example, information regarding hereditary conditions.
  - Advice and guidance from, for example, a Caldicott Guardian.
25. Shiel, W. C. 'Medical Definition of Hippocratic Oath', available at <https://www.medicinenet.com/script/main/art.asp?articlekey=20909> (accessed 9th June, 2020).
26. Department of Health (2013) 'Information: To Share or Not to Share: The Information Governance Review', p. 21.

27. Department of Health (2003) 'Confidentiality NHS Code of Practice', p. 34.
28. British Medical Association (n.d.) 'Confidentiality and Disclosure of Health Information Tool Kit', pp. 44–45.
29. British Medical Association, ref 28 above, p. 47.
30. *Ibid.*
31. British Medical Association, ref 28 above, p. 48.
32. General Medical Council (2017) 'Confidentiality: Good Practice in Handling Patient Information', p. 34.
33. Royal College of Physicians (2019) 'Consent and Confidentiality in Genomic Medicine: Guidance on the use of Genetic and Genomic Information in the Clinic', p. 10.