

Official position paper

MEDICAL PROFESSIONAL SECRECY AND THE PROTECTION OF THIRD PARTIES

**Reflections and proposals after the Germanwings disaster in the
French Alps on March 24th 2015**

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Far from being a privilege of doctors, professional secrecy is an obligation adopted by the medical community to preserve the rights of individuals to privacy. This right is especially important in matters of health. It is not only an obligation that doctors have towards the ill; it is an obligation we, as a profession, have towards society. It is part of an unspoken pact (or “social contract”) that entails not only the guarantee that we possess sufficient knowledge and professional capabilities, but also a certain professional demeanor. The obligation to keep confidential “everything the doctor is told by the patient, whatever they may have seen or deduced, and all of the documentation produced in executing their responsibilities” is one of the values associated with our profession, and has been deeply rooted for centuries.

In the unfortunate Germanwings disaster that occurred on March 24th, 2015, a mentally ill copilot voluntarily crashed an airplane in the French Alps, resulting in the death of 150 individuals. When it became public that the copilot had concealed from the airline that he had been prescribed medical leave for psychiatric illness, the public was astonished that such a thing could have been possible, and felt understandably vulnerable. What failed, beyond the sanity of the co-pilot? Was it the exchange of information between the medical sector and the airline’s department of human resources? Is this exchange always impeded by the medical obligation to professional secrecy? If this is so, can this professional secrecy place others in danger?

This is, of course, an exceptional case. However we feel it is necessary to reflect on it, despite the virtual insignificance of similar cases among the many dangers we are faced with on a daily basis, because of the case’s media impact and frequent suggestions that the control mechanisms aimed at certain patients failed the victims. As in this unfortunate case, most situations of this nature are related to individuals with serious mental illnesses. However, there are also other situations (such as the risk of exposing others to certain contagious illnesses) that deserve the same treatment and consideration through the reflections and proposals made below.

This document aims to reflect on the debate between safety and privacy that often arises in the execution of medical workers’ professional responsibilities. This is a continuation of the debate on “professional secrecy and the protection of third parties” that took place at the Medical Association of Barcelona (Col·legi de Metges de Barcelona or CoMB) on April 14th, 2015. It also aims to take a look at the relationship between personal medical professionals and company doctors, especially in cases of psychiatric illnesses and in those professions and activities where a potential risk to third parties is present.

Finally, we would like to state that the Code of Ethics and Deontology of the Catalan Medical Council (Consell de Col·legis de Metges de Catalunya or CCMC), as well as certain legislation affecting the sector and case law doctrine mark the limits of the obligation to professional secrecy so that it does not make third parties vulnerable.

Privacy *versus* safety

This debate is very much present in modern-day life, when we address issues such as citizen safety and the fight against terrorism. Certain events can cause this ever-present debate to resurface, provoking spur-of-the-moment reactions that are not always well thought-out and proportionate. This is the case of the Germanwings accident, which brought medical confidentiality under fire. This case has driven us to deliberate on the limits of individual freedom versus citizen safety, causing us to ask ourselves if we need to re-draw the boundaries of confidentiality.

And so, we would like to consider four relevant questions:

- 1- The debate on “privacy *versus* security” conflict should take place on a middle ground, equidistant from prejudices that can derive from giving preference to one or the other. We need to address this issue as if we did not know which of these two positions we, as individuals, might find ourselves in the future.
- 2- We need to consider not only the benefits of redrawing the limits of an established right (in this case, the right to confidentiality), but also the potential dangers of the same. Patients come to us with their problems and they do so knowing that, as doctors, we have an obligation to confidentiality. We need to consider the importance of this fact: how many people would trust their doctor if they could not rely on them to protect their right to privacy? What negative impacts might this have on their health?
- 3- We need to consider the general consequences of the decisions we make. In other words, not only the impact on the safety of third parties, but also the symbolic importance of a social order that diminishes or negates personal responsibility and choice in significant areas. We need to be aware of how certain measures can drive us closer to a paternalistic or authoritarian society.
- 4- It is just as important that we remember that justice is part of ethics. In other words, as an important regulator of life in society, justice needs to be preserved in the final decision we make. This is equivalent to taking a step that is difficult for a professional: to inform their patient that they can no longer maintain their confidentiality because of their responsibility towards third parties. This exceptional circumstance needs to be treated with justice, as we will see below when we address the principle of proportionality.

With this in mind, the elements to be conserved in this debate are the following:

- Privacy. Both in healthcare and occupational medicine, interventions in the health of patients require the conservation of privacy, with the appropriate nuances and limitations.
- Responsibility. It is essential that we work towards a society of responsible individuals. A society that is overzealous in guaranteeing safety can end up preventing its members from actively exercising their personal responsibility and, as a result, it can paradoxically end up restricting their freedom.

Note: In this document we decided to use “Medical Council” in the English translation although “Col·legi de Metges” has both functions of medical council and medical association.

- Justice. We have the right to policies of protection, and for these policies to prevail over individual interest. Confidentiality is not an absolute right, and we can find certain contexts in which the need to protect others prevails over the obligation to confidentiality. Of course, even in these circumstances, we need to defend the principle of proportionality. As an example, let's imagine that we were to detect a case of serious alcoholism in a bus driver. The patient in question refuses to take leave from work or to seek treatment. The doctor may think: "I could inform the authorities, but how will they respond? What use will they make of this information? What future consequences might an excessive or unwise response have for the patient?" In other words, the patient also has a right to be treated justly.

The relationship between healthcare and occupational medicine

Occupational medicine in companies is legally based on the obligation of the business or public institution to protect workers from dangers present in the workplace, as well as protect third parties from the risk of carrying out certain activities in poor sanitary conditions. This is carried out in practice by doctors with the necessary knowledge, abilities and means, and is based on not discriminating against or harming the worker. These professionals actively research and monitor signs and symptoms that an employee might present throughout their working life, but they can only do so if there is complete trust between doctor and patient. For the worker, this supervision is voluntary, except in certain regulated circumstances. However, it is always confidential and limited to the specific risks to which the employee is exposed.

We need to define, then, what kind of a relationship personal doctors and company doctors should have with one another. At first glance, it seems as if they could aid one another in helping the patient. It would seem as though it would be in the best interest of the worker for their personal doctor and their workplace doctor to exchange information. However, a worker may not want this exchange of information, even in detriment of their health, for fear that it could harm them professionally (they might be given another position, have their work hours reduced, etc.). As we have already stated, however, in normal conditions the monitoring of one's own health is voluntary, both in and out of the workplace.

The potential for conflict arises in cases where the monitoring of one's health becomes obligatory. Some professionals (in security forces, public transportation, the health sector or other activities with a potential for risk to third parties) can gravely harm themselves and others if they carry out activities under sub-optimal conditions. In some professions, workers are aware of the fact that in order to access a particular position, they must undergo medical revisions, and that they must periodically undergo aptitude tests to maintain their position. In these cases, an exchange of information between occupational doctors and personal doctors may be necessary and even desirable, with the necessary authorization from the patient or with ad hoc legal coverage.

The Spanish Constitutional Court's sentence from November 15th, 2004 (RTC 2004/196) specifies that the obligation to monitor one's personal health cannot be imposed if only the health of the worker themselves is in play. This can only be obligatory if it is strictly necessary. It does specify, however, the need to monitor one's health in occupations where a risk to third parties is present. If a worker refuses to undergo obligatory health monitoring, the matter is not the company doctors' responsibility or that of any other occupational health professionals.

Rather, it is a matter to be addressed by the employees themselves and the company, involving whatever disciplinary measures the company has established to avoid endangering third parties.

Within the framework of Social Security legislation, healthcare providers (either primary or specialized) can offer temporary incapacity to workers. This has the triple function of providing medical assistance, economic protection during this period, and a professional and functional recuperation. "Sick leave" is, then, a tool aimed at protecting the worker, prescribed by their doctor. Currently, it is the worker who is in charge of presenting the document of temporary working incapacity (sick leave) to their employer. It is somewhat surprising that with the possibilities now offered by technology, which allows for the direct and automatic communication of working incapacities between collaborating entities of Social Security, that employers are not automatically informed as well. The administration should facilitate the incorporation of this possibility. Because the diagnosis does not necessarily need to be revealed in order to inform employers of workers' sick leave, it would not be a violation of the doctor's obligation to secrecy. However, it would provide advantages in terms of both organization and safety.

In the process of protecting the employee, we still need to establish the link between the authorized centers that conduct the examinations necessary to obtain certificates of aptitude (for civil aviation, driving, arms use, etc.), healthcare providers and occupational medicine. Being informed of non-aptitude or non-renewal would help resolve possible conflicts in professions involving activities that might suppose a risk to third parties. In these cases, this link should also have a legal basis.

The mentally ill

One of the principal objectives of mental health professionals is to work towards the abolition of the prejudice and discrimination to which the mentally ill are subject. Over the last few decades, we have observed a significant reduction in racial, ethnic or gender-based discrimination, as well as in the stigma related to cancer or infectious diseases. However, prejudice and discrimination against the severely mentally ill still stubbornly persist. The negative effects of the stigmatization of the mentally ill means that they often wait longer to ask for help, they often abandon treatment, or they have trouble accessing housing and jobs and in achieving socio-economic autonomy. As a result, this prejudice is the first barrier to providing them with therapy and rehabilitation. The division between "them" and "us" often becomes an insurmountable obstacle.

While depressive disorders are fairly frequent and nearly a quarter of the population will suffer from some form of mental disorder in their lifetime, the tone of social debate has tended to consider that the individuals with these problems are potentially dangerous, and that the need to protect the rest of the population comes before their right to confidentiality. As a result, the discrimination against these individuals increases. Individuals suffering from a disorder are often seen as a danger, and this sort of attitude affects the trust-based relationship between doctor and patient. We should insist on the enormous importance of early and appropriate treatment, which is only possible if patients are not afraid of asking for help.

In Spain, there are some 2000 recognized suicides every year. By and large, these are solitary acts; the few suicides that are accompanied by murders are cases of violence against women or

are episodes where the person who commits the suicide, as a result of their despair, decides to take loved ones with them. Cases like that of the Germanwings co-pilot are extremely rare.

When the doctor who cares for a patient with some kind of mental disorder detects an elevated risk to the safety of the patient or others, they have the exceptional resource of involuntary hospitalization. These involuntary hospitalizations are legally regulated by article 763 of the Law of Civil Procedure, the Organic Law of Legal Protection of Minors and, in Catalonia, articles 212-4 to 212-6 of the 2nd book of the Civil Law of Catalonia, which oblige doctors to take the necessary measures in order to provide psychiatric assistance through involuntary hospitalization in case of a serious mental disorder that involves a risk to physical integrity or health, to the individual's family life or relationship with others, or to the individual's own interests in general. The patient can also be involuntarily hospitalized if their mental state prevents them from making a responsible decision and from preserving their own interests, or because hospitalization would be reasonably more effective and beneficial for the patient than any other, less restrictive, therapeutic alternative.

In the relationship between the doctor and the ill, confidentiality is essential and is protected by legislation. Of course, there are certain situations that can make it appropriate to violate this confidentiality, but these situations should be specific and have a clear justification, limiting this violation in order to preserve the therapeutic relationship. These situations include the concept of "protection of third parties from harm". Therefore, we are faced with a conflict of interest between the right to confidentiality, an essential value in the medical profession, and the need to protect others. Some National Psychiatric associations have made specific recommendations with respect to:

1. The incorporation of the limits of confidentiality into informed consent. Patients are informed verbally of these limits when the relationship is initiated.
2. The right to protection in the case of an imminent, identifiable risk, when this risk supposes the use of violence and intervention is urgent.

In any case, we should underline the danger of a defensive society that demands absolute protection from medical professionals, since this can result in a perverse tendency where patients lose trust in those that attend to their medical needs. This is especially serious in the case of psychotherapy in psychiatry, which requires an elevated degree of trust. A generic legal obligation to this effect could be an obstacle to proper mental care, and could in fact endanger the citizens it means to protect.

Ill doctors

In 1997, the Code of Ethics and Deontology of the Catalan Medical Council incorporated a regulation by which a doctor who is aware of their own illness must ask a colleague for help, so that they can evaluate their professional capacity. In another article, it established the obligation of all doctors to inform and warn colleagues who, because of their own health situation, might harm their patients. When necessary, doctors are also required to inform the Medical Council, and put the interests of patients first.

With this in mind, halfway through the 90s, the CoMB created the Commission for the Evaluation of Health Professionals Infected by Viruses transmitted through blood (Comissió d'Avaluació de Sanitaris Infectats per Virus transmissibles per sang or CASIV), which was

aimed at giving support to doctors who, because of certain illnesses or because of their condition as carriers of transmissible agents, might represent a risk to their patients and who, as a result, can only exercise their specialities in certain conditions.

These are also the bases of the Integral Care Programme for Sick Physicians (Programa d'Atenció Integral al Metge Malalt or PAIMM), a ground-breaking initiative in Spain, which since 1998 has given primarily voluntary assistance to doctors with mental and/or addiction problems. This program has allowed us to treat doctors who had previously avoided asking for help for fear of what would happen if their illness became known. By providing a feeling of safety to ill doctors, a significant number have received early treatment.

The existence of the PAIMM is also justified by the need to effectively control the practice of ill doctors and, as a result, we have also created the necessary measures to guarantee that, when the doctor takes up their practice again, they are in conditions to do so. The PAIMM combines the obligation of the Medical Council to monitor, promote and ensure good practice with an adequate and early therapeutic intervention, while always protecting the identity of the doctor and working to cure and rehabilitate them. In cases of conflicts or situations of risk requiring forceful interventions on the part of the Council, the monitoring of the situation through a therapeutic contract has proven to be highly efficient.

Since the creation of the PAIMM, other health professionals have been incorporated, such as nurses, pharmacists, veterinarians and, recently, psychologists and dentists. It would be advisable for other professions involving the rights and interests of third parties to come up with similar programs that allow for effective, early treatment and adequate control of their professional activities, whenever they are a potential risk for the patient or for others.

PAIMM has proven to be a very effective tool in detecting situations that might involve risk in realizing professional activities. It serves to treat the individuals who need it, and has resulted in a high degree of rehabilitation, re-inserting ill professionals in a way that is safe for both them and their patients. When needed, it has also allowed for the permanent retirement of professionals who, because of their health situation, are not in conditions to carry out their responsibilities with the necessary guarantees.

The legal and ethical limits of professional secrecy

In our legal code, professional secrecy is treated differently depending on the profession in question. For example, defence lawyers are exempt from having to communicate any confessions made to them by their defendant, and members of the clergy are also free from the obligation to reveal the confessions made to them in the course of their religious duties. Public servants, too, are bound to keep certain professional secrets, and can often only reveal certain information with permission from their superiors.

Doctors, however, are obliged to inform the Judge or the Public Prosecutor of crimes they become aware of in the course of their professional activity. Most often, this involves cases of assault or abuse.

Nevertheless, doctors still have the obligation to keep secret anything the patient may have confessed to them, anything they may have seen or deduced, and all the documentation produced in the course of their professional activities.

This obligation to maintain professional secrecy is directly derived from the patient's right to confidentiality with regards to all information related to their health, as part of their right to privacy recognized in article 23.3 of the Statute of Autonomy of Catalonia. As a fundamental right, it is also protected by the Spanish Constitution in article 18. Finally, the Medical Code of Ethics and Deontology dedicates articles 29 – 44 to regulating the obligation to secrecy and the patient's right to secrecy, specifying that the death of the patient does not free the doctor from this obligation.

Nevertheless, the patient's right to privacy and to the confidentiality of their health information is not absolute or unlimited, as the Constitutional Court has determined. In this regard, the right to privacy is limited by other constitutional rights and provisions. As a result, in some cases the individual's right to privacy may be superseded by other interests established in the constitution.

As of the current moment, legislators have not fulfilled their constitutional responsibility to clearly and legally define professional secrecy. As a result, this question is regulated by different sector-specific regulations and laws. In the case of doctors, for example, Law 412/2002, of November 14th, regulating the autonomy of the patient, and the rights and obligations in matters of clinical information and documentation; Law 21/2000, of December 29th, on the rights on information regarding the health and autonomy of the patient, and clinical documentation; and Law 44/2001, of 21 November, on the organization of medical professions.

Besides stating the obligation to professional secrecy or regulating the consequences of violating this obligation, there are no specific laws that regulate professional secrecy and define its limits. However, the Constitutional Court considers that one's right to privacy can be superseded by other fundamental rights, and that the right to privacy can be overcome by certain legally-specified reasons of public interest.

So, the protection of privacy and the obligation to secrecy can be superseded in cases where there are other prevalent interests. The legally established situations that can justify the limitation of an individual's right to privacy are the following:

- a) The existence of a constitutionally-established justification (such as the protection of health or life)
- b) The legal provision of a limiting measure
- c) The observance of the proportionality of the measure, which will require: a judgement of suitability (to decide whether the measure can indeed achieve the intended end); a judgement of necessity (to decide whether there are other, more moderate measures that can achieve the same and be just as efficient); and a judgement of proportionality in true sense (which will require that the measure be thoroughly evaluated, and that it provides more benefits for the general interest than harm to other values involved in the conflict)

As for the limits of professional secrecy, article 32 of the Code of Ethics and Deontology states that the doctor can reveal a secret using discretion, only to those individuals strictly necessary, and in the following cases:

- a) When they believe that this revelation will very probably benefit the patient.
- b) When they are certifying a birth.
- c) When they are certifying a death.

- d) When silence would very probably result in harm to the patient, to others, or would suppose a collective danger (declaring contagious diseases, certain mental illnesses, the state of health of wards of the State, etc.).
- e) In case of professional illnesses or work accidents, if the revelation can prevent other, similar cases.
- f) When serving as an expert witness, forensic doctor, investigating judge or similar.
- g) In cases of abuse against infants, the elderly, the mentally handicapped or in cases of rape (in the last case with the consent of the victim).
- h) When the doctor is unjustly harmed by having to keep a patient's secret, on the condition that no others are harmed by the revelation of the secret.

As we can see, the legal and ethical limits of professional secrecy in our country are associated with legal provisions, and with the definite existence of a risk to the professional themselves, the patient or third parties.

In the workplace, these limits are the health of workers, third parties or certain sectors, in the protection from specific risks and especially dangerous activities. In the case of potential illnesses that can place the worker or third parties in danger as a result of professional activities, the law that makes competent provision for the proportionate violation of professional secrecy is article 22 of Law 31/1995, of November 8th, on the prevention of labour risks according to which the doctor can inform the employer of the conclusions derived from the examination of workers, in relationship to their aptitude to carry out their assigned tasks. This information is not to include the diagnosis of the worker, but rather their lack of aptitude to carry out their habitual tasks.

In addition, this regulation provides for medical evaluations to verify whether the state of health of the worker can constitute a danger to them, to other workers or other individuals related to the company. This excludes evaluations of a voluntary nature meant to monitor the health of the individual that require their consent.

The problem arises, however, when a situation of this nature is not known to the occupational health professionals but is known to a private doctor or a doctor from the public healthcare system (who will prescribe sick leave to the patient after the necessary evaluation).

According to our legal system, in these cases, the doctor from the public health system is to provide the worker with two copies of their medical absence document, one of which the worker is to give to their employer.

Therefore, if the worker chooses not to deliver this information to their employer and decides to continue working, the employer may not be aware of situations that may endanger the worker themselves or other individuals.

This system seems to be based on the doctor-patient relationship, and on the mutual trust involved. However, the possibility of dishonesty on the part of the worker is present, and doctors cannot be expected to serve as labour inspectors.

To this end, as we have already suggested in other sections of this document, measures should be taken to avoid placing the decision to inform employers of the prescription of a temporary incapacity in the hands of the worker themselves. We feel it would be reasonable and convenient to promote a reform of the current regulations so that, as happens in other areas, the

employers be automatically informed of temporary work leaves prescribed by Social Security through the use of new technologies. Obviously, the same should apply for the finalization of the stated work leave.

Nevertheless, the situation is somewhat more complicated when private medicine is involved, since private doctors do not have access to the mechanisms that facilitate the communication of prescribed sick leave.

As a result, we need to consider that a doctor from any sort of healthcare is competent to offer a diagnosis and prognosis for an illness according to their own clinical judgement. In this process, if a doctor detects a risk for the patient themselves or for others (in this case, as far as the patient's professional duties are concerned) they should be proactive in a discreet, measured, deliberate and proportionate way. They should communicate this situation only to those strictly necessary to avoid the eventual harm detected, in keeping with the Code of Ethics and Deontology and the Constitutional doctrine stated above.

In cases of extreme gravity, our legal system already has emergency mechanisms in place, such as urgent involuntary hospitalization, with posterior judicial control. However, in circumstances where the situation is not completely evident and does not necessarily require hospitalization –although it does require a proactive stance on the part of the doctor– we should consider the need to provide professionals with the means they need to make communication more fluid, especially as far as the private health sector is concerned.

CONCLUSIONS AND RECOMMENDATIONS

1- Professional secrecy is an obligation that our profession has towards society in order to preserve the right of individuals to privacy. This is an inalienable value of our profession.

2- Professional secrecy is neither an absolute right nor an absolute obligation. Both the Code of Ethics and Deontology, some sector-specific regulations and case law doctrine contemplate situations, especially as far as the security of third parties are concerned, that establish limits to these obligations.

3- The debate on the “privacy versus security” conflict should take place on a middle ground, equidistant from the prejudices that can derive from prioritizing one or the other. We need to address it as if we did not know which of these two positions we, as individuals, might find ourselves in in the future. In analysing concrete cases, we should always keep the principle of proportionality in mind.

4- The efficiency of the relationship between the patient and the doctor in order to fulfil the objectives of both (to reduce suffering or cure an illness) is based on trust. The patient deposits their trust in the doctor, knowing –and trusting– that they respect their obligation to medical secrecy. By systematically prioritizing security, without sufficiently evaluating each case, we could damage patients' trust in their health professionals, and this could have negative consequences on their health.

5- The stated dilemma of “privacy versus security” comes up especially when it becomes necessary to evaluate the risks posed to third parties by the professional activities of individual with mental illnesses, or those who carry out tasks that may involve risks to others if not

realized in optimal conditions (doctors and other medical workers, public security forces, public transportation workers, and others).

6- The mentally ill need to be treated very delicately, both to avoid increasing the prejudice they already face, and to preserve the trust needed to treat them effectively. As a preventive measure when faced with the possible need to violate professional secrecy, it would be advisable to incorporate an explanation of the limits of confidentiality in documents of informed consent, so that patients are aware of them from the moment they initiate their relationship with their doctor. When the doctor (public or private) who cares for a patient with a mental illness detects an elevated risk for the patient or for others, there is the possibility of initiating an involuntary hospitalization.

7- When the sick individual is the doctor themselves, the Code of Ethics and Deontology of the Catalan Medical Council obliges doctors who are aware of their own illness to ask a colleague for help, so that they can evaluate their professional capacity. It also includes the obligation of all doctors to inform and warn colleagues who, because of their own health situation, might harm their patients. When necessary, doctors are also required to inform the Medical Council, and put the interests of patients first.

With the double aim of monitoring and conserving good medical practice and helping to rehabilitate and reinsert ill doctors, the CoMB has the Integral Care Programme for Sick Physicians (PAIMM), that other health professionals have also benefited from. It would be advisable for other professions outside of the health sector to adopt this model, if they also have a significant social impact (judges, pilots, soldiers, teachers...). This would help their sick professionals while also protecting society by ensuring the quality of the services they offer.

8- The protection of privacy and the obligation to professional secrecy can be superseded in cases where there are other prevalent interests. Existing laws demand that, for this to take place, it needs to be justified by a constitutionally legitimate end (such as the protection of health and life), that there be a legal provision for the limitation of these rights, and that it observe the principle of proportionality, suitability and necessity. In addition, article 32 of the Code of Ethics and Deontology specifies the situations in which the doctor can reveal professional secrets. They must always do so, however, in a discreet manner, only to those strictly necessary and always within the necessary limits.

9- We should consider the eventual regulation of professional secrecy on a European level, while incorporating the legal differences between different EU countries. In doing so it should be taken into account that in certain countries (such as ours) membership in a professional organization is obligatory, and the limits of professional secrecy are included in these organizations' Codes of Ethics and Deontology, to which doctors are bound. In these cases, it would be the professional organizations themselves that ensure that doctors only reveal professional secrets when absolutely necessary in a measured, discreet and proportionate manner.

Whenever a doctor is unsure whether to reveal professional secrets in order to protect the patient or other individuals, they may consult with the Medical Council, which will guide them and will give them legal support and advice to ensure they make the right decision, and, when necessary, will protect them from the possible consequences of doing so.

10- It is advisable to establish a regulatory framework that facilitates stable channels of communication between healthcare (both public and private) and company doctors. This should not be seen as a breach of confidentiality, but as a broadening of the circle of professional secrecy, to provide better service to society and to the workers themselves.

To this end, a first step would be to promote the modification of the current regulations, in order to create the channels for a bi-directional flow of information. In addition, using new technologies, prescriptions and terminations of temporary working incapacity should be transmitted directly from Social Security to employers.

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Writing team

Dr. Josep Terés (coordinator), President of the Ethics and Deontology
Commission of the CoMB

Dr. Francesc Borrell, family doctor

Dr. Eugeni Bruguera, psychiatrist

Dr. Anna Santaulària, occupational doctor

Dr. Jaume Sellarès, family doctor

Dr. Rafael Padrós, occupational doctor

Ms. Mercedes Martínez, lawyer and member of the CoMB's legal services
department



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