MDU briefing for House of Lords
- Health & Social Care Bill

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Summary of key points

Clauses 93-105 & Schedule 7 (4) (pages 2-5)

The Office of the Health Professions Adjudicator will not be wholly independent of GMC

Clause 95(4) - Legal chairs for OHPA FTP panels (pages 6-8)

We suggest that sub-section 4 of this clause is amended to remove the provision to allow pilot schemes where persons who are not legally qualified act as chairs of FTP panels.

Clause 107 – Civil standard of proof in FTP proceedings (pages 8-15)

We oppose the introduction of the civil standard of proof for fitness to practise (FTP) proceedings for doctors which we consider to be unnecessary given that the GMC already has powers that supporters of the civil standard suggest it would provide. Further, little or no account seems to have been taken of the legal challenges that are likely to follow and the undermining of confidence in the regulator's proceedings.

Clause 116 (1) (a) - sharing information between prescribed bodies (pages 16-19)

We are concerned that the requirement to share information, proposed in subsection (1) (a), may result in designated bodies sharing of information that is incorrect, unsubstantiated and damaging to healthcare professionals. We hope it may be possible for the Government to agree to safeguards that are enshrined in this primary legislation.

Additional documents

1. **MDU response to GMC proposal on the Standard of Proof** ***(Abridged version – 28 November 2007)***
2. **Leading counsel's advice on proposed S35ZA of Medical Act 1983**

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Introduction

1. The MDU is a mutual, non-profit making, organisation providing a wide range of medico-legal services to its members who include over 50% of the UK's doctors in hospital and primary care, and 30 % of dentists. We

have been providing medico-legal services to our members since we were founded in 1885. In exchange for payment of an annual subscription, members receive medico-legal benefits that include an insurance policy providing indemnity for clinical negligence claims, and access to advice and assistance with matters such as GMC and employers' disciplinary investigations into matters arising out of their provision of care to patients.

2. The MDU has taken part, on behalf of its members, in the consultation exercises that preceded the publication of the Health and Social Care Bill and expressed concern about a number of proposals that feature in the Bill that is presented to the House of Lords. They are:

The Office of the Health Professions Adjudicator
Clauses 93-105 & Schedule 7 (4)

3. In the interests of fairness and justice, if the GMC is to be the 'prosecutor' in the context of complaints, it should not also be the judge and dispenser of sanctions. It is reasonable for the GMC to set standards of conduct, policy and procedural rules and to investigate complaints and to present them; but the adjudication function should be wholly independent of the GMC, since as setter of standards and prosecutor, it cannot be independent as an adjudicator. Thus we agree with the principle that formal adjudication should be undertaken by a separate and independent tribunal with legal, medical and lay representation and support the principles behind clauses 93-105 which allow for a new Office of the Health Professions Adjudicator (OHPA).

4. However, we are advised by leading counsel that one of the changes proposed in the Bill in respect of the OHPA potentially undermines the defendant doctor's right (under Article 6 of the European Convention on Human Rights) to a fair hearing before an independent and impartial tribunal. (A copy of leading counsel's advice is provided as a separate document)

OHPA not wholly independent of GMC - Schedule 7 paragraph 4

5. This paragraph inserts a new section 35ZA into the Medical Act 1983 which provides for the General Medical Council to publish guidance on what are currently known as 'indicative sanctions', that is what type of sanctions should apply to the doctor, depending on the facts that are found by the adjudication panel. Further, the OHPA 'must take account' of this guidance and, a new S40A of the Medical Act, set out at Schedule 7 paragraph 11, provides the GMC with powers to refer decisions to the relevant court on certain grounds, for example, leniency.

6. Although it is the intention that the OHPA is a separate and independent adjudicatory body, the clauses above will have the effect of allowing the GMC to continue to determine the sanctions that should apply in fitness to practise decisions, and in effect of compelling the OHPA to take account of such guidance in making its determinations. The new system would perpetuate the perceived unfairness of the existing system.

7. We are advised that for the GMC to retain the power to provide guidance of which the OHPA is required to take account cannot make the OHPA properly independent and potentially contravenes the right to a fair hearing under Article 6 of the European Convention on Human Rights. We note that the explanatory note to the Bill has attempted to address this at paragraph 598 but we have been advised by leading counsel that the basis underpinning the opinion received by the Department of Health is flawed.

8. By arguing that the GMC's guidance on sanction is only relevant at the sanction stage and thus does not compromise the adjudicator's independence in determining the facts, the Department of Health is tacitly accepting that the requirement to take in to account the GMC's guidance on sanction may compromise the adjudicator's independence at the sanction stage.

9. In determining civil rights, Article 6 gives a right to a fair hearing by an independent and impartial tribunal. The hearing includes the totality of the case: both the fact-finding stage and the sanction stage. It is the sanction that affects the doctor's civil rights. Thus under Article 6 a

doctor is entitled to a fair hearing by an independent and impartial tribunal at the sanction stage also.

10. It is irrelevant that the range of sanctions has been laid down by legislation and not the GMC. What is in issue is the choice of sanction out of that range. The GMC's guidance on sanction is intended to influence the adjudicator's choice of sanction. That guidance will have the practical effect of fettering the adjudicator's discretion.

11. The GMC's guidance on sanction will be perceived to have an in-built prosecution bias. There is no requirement for that guidance to take a balanced view.

12. The flawed basis for the Department of Health's position is easily seen by analogy with the criminal justice system. The prosecution and the defence both adduce evidence and make submissions to the court about sentence. However, the court is impartial and independent. It is not compelled to take account of any prosecution guidelines on sentence, nor does it do so.

13. There is a clear and compelling need for the OHPA to have written, published guidelines on sanctions and warnings. Such guidelines promote consistency and transparency in decision-making, but we suggest that, to demonstrate true independence from the GMC, the OHPA should draw up its own guidelines. These guidelines could be issued following consultation, for which OHPA is already provided with powers under the Bill. Clause 103 provides the OHPA with a duty to consult various bodies, including bodies representing the medical profession 'on matters relevant to the exercise by it of its functions' and this would allow the OHPA to consult the GMC and CHRE, as well as other interested bodies such as the medical defence organisations. The guidelines could also encompass court decisions relevant to sanction.

14. If the OHPA were to produce guidelines on sanctions for the healthcare professionals for whom it provides adjudication functions, initially doctors and optometrists and opticians, this would have the merit of

providing consistency among these professions, as far as it was appropriate to do so. Currently CHRE is consulting widely on the lack of consistency among the healthcare regulators in terms of sanctions and is expected to provide recommendations to promote greater consistency. If, at a future date, it is proposed that OHPA extends its adjudicatory remit to provide such functions for other healthcare professionals, following the logic that it is preferable for adjudication to be provided by a body independent of the regulator, there must be merit in its setting sanctions guidelines. It would be possible for OHPA to do so after consultation and with appropriate professional input, and bearing in mind that some sanctions may be relevant to findings in respect of some groups of healthcare professionals, but not others.

15. One further point. Some commentators have confused the guidance the GMC publishes for doctors, where it sets standards in *Good Medical Practice;* with the guidance it currently provides for its own FTP panels on sanction, and which the Bill, unless amended, will allow it to produce for the OHPA. The latter guidance is commonly known as indicative sanctions guidance. These are two different types of guidance and should not be confused. It is right that the GMC, as the medical regulator, will retain responsibility for setting standards for all registered doctors, and that it should publish clear and up to date guidance as it does in *Good Medical Practice* and in its other guidance publications on topics such as Confidentiality and Consent. However, the guidance at issue with the proposed new S35ZA of the Medical Act is quite different. It is indicative sanctions guidance: that is, guidance that the GMC provides for FTP panels to 'help them reach their decisions' and that the Bill proposes it will continue to produce for the OHPA.

Legal chairs for OHPA FTP panels – clause 95(4)

We suggest that sub-section 4 of this clause is amended to remove the provision to allow pilot schemes where persons who are not legally qualified act as chairs of FTP panels.

16. This clause provides for the 'selection in specified circumstances of a chair who is legally qualified for the purposes of section 96(2)(a)' for OHPA FTP panels and, further, 'may provide for pilot schemes under which chairs who are legally qualified for those purposes are, or are not, selected for such proceedings as may be determined in accordance with the rules'.

17. The MDU supports the provision, contained in the first part of the clause for OHPA FTP panels to be chaired by a person who is legally qualified. This does not happen currently with GMC hearings and yet it is clear from our experience of advising and assisting members with both the past and the current GMC fitness to practise procedures that there would be several advantages, to the medical profession and in the public interest, in introducing legal chairs for FTP panel hearings. Our main reasons are:

18. Disciplinary tribunals should be chaired by people who are legally qualified and who can understand the legal issues discussed and provide legal input. Legal chairs will also understand the rules of procedure and how to apply them. To give an example of a comparable body, the Family Health Services Appeal Authority can make decisions that may effectively end a GP's career, and its hearings panels normally consist of a legal chairman, a professional member and a lay member. (This tribunal determines appeals by primary care practitioners against PCT decisions to either remove them from Primary Care Trusts' lists of practitioners permitted to practise, or not to permit them to join in the first place.)

19. If OHPA panels had a legal chair, there would be no requirement for panels to be advised by a legal assessor, as is currently the practice with GMC FTP panels. A legal chair could combine both roles with a consequent saving of expense and a less disjointed process.

20. It has been argued that it may be necessary for some FTP panels, for example those that are considering concerns about health, to be chaired by a doctor. This is to misunderstand both the role of the chair and the nature of the hearing. The chair needs to understand the legal process

and can seek advice on medical matters from the medical member of the panel; but the chair needs to have a legal, not a medical qualification. The hearing itself is essentially a legal process. To draw an analogy, if a doctor were prosecuted for manslaughter in a case involving complex issues of medical causation, it would be nonsensical to suggest that the trial should be conducted by a doctor. The court would be advised on the complex medical matters by the evidence given by the medical experts. A regulatory body's adjudicatory procedure is a legal process, not a medical one, and the skills and experience required to conduct such proceedings are legal, not medical.

21. The proposed introduction of the civil standard of proof has been met with almost unanimous expressions of concern by the medical profession. The MDU does not have confidence in the GMC's proposed procedure and believes that the use of the civil standard by GMC's FTP panels (which do not have a legal chair) is likely to lead to unfair and inconsistent decisions that will not inspire confidence in the regulatory procedure, and that will be subject to legal challenge. This is not in the interests of the medical profession, nor is it in the public interest. A legal chair for OHPA FTP panels that are also to use the civil standard may go some way to allaying some of the concerns about lack of fairness and consistency.

22. However, for all the above reasons, we cannot support the provision, contained in the second part of the clause, that would allow for pilot schemes where FTP panels could be chaired by persons who were not legally qualified. If, as we suggest, it is appropriate for the panels to be chaired by persons who are legally qualified, because this would provide a more fair and consistent process, we cannot see how it would be anything other than retrograde to suggest that it may also be possible for some hearings not to have a legal chair, and yet to provide the same standard of fairness and consistency in process and decision making. For our part, and assuming that such a thing would be voluntary, we would find it very difficult to advise a member who was faced with the choice between appearing before a panel with a legal chair and one with a lay (or

even medical) chair to do anything other than to seek to appear before a legally chaired panel.

23. If a pilot was introduced, we cannot see how it could become mandatory that some doctors had to appear before a panel with a lay chair, while others could appear before a legally-chaired panel without leaving room for legal challenge. Further, we do not agree with the suggestion that certain types of hearing, such as those dealing with health or performance, may be more amenable to a non-legal chair. The process is a legal one, with a potential outcome that may be very serious for the healthcare professional involved. It follows that all panels should have a legal chair.

24. We suggest that this clause should be amended to remove the provision for pilot schemes.

Clause 107 – Civil standard of proof in fitness to practise proceedings

We oppose the introduction of the civil standard of proof for fitness to practise proceedings for doctors which we consider to be unnecessary given that the GMC already has powers that supporters of the civil standard suggest it would provide. Further, little or no account seems to have been taken of the legal challenges that are likely to follow and the undermining of confidence in the regulator's proceedings.

25. While the GMC, and in due course the OHPA should, of course, take action to protect the public if a doctor represents a danger to patients, it is important to remember that the doctor whose fitness to practise is under consideration has a right to a fair hearing. There must be safeguards in place to protect this right, especially when there is the potential for the doctor to lose his livelihood.

26. The MDU believes that the criminal standard of proof should remain for Fitness to Practise (FTP) panels because a doctor's registration is at risk. We agree that there is a need to protect patients, but this must be balanced against the right of the doctor to have appropriate safeguards

when his or her career is at stake. Unlike most other healthcare regulators, for cases that do not currently amount to impaired fitness to practise, the GMC already has the power to administer warnings where it considers it appropriate to register concerns about a doctor's behaviour or performance that indicate a significant departure from the standards set out in *Good Medical Practice*. This is a matter that will remain on the register for five years and, during that time, will be disclosed to the doctor's employer, and any prospective employer and to any other enquirer.

27. We have received leading counsel's advice on the GMC's imposition of the civil standard of proof (which informed our response to the GMC's 'consultation' on the standard of proof, a copy of which is available on page) and the advice demonstrates that the argument that the public interest justifies a switch to a lower standard of proof because public safety would be better safeguarded is flawed. It is an argument that would apply equally to criminal cases too. There is an overwhelming public interest in law and order, and the protection of the public from crime, yet the criminal standard of proof is applied across the range of offences, from minor misdemeanours to the most serious, such as child abuse, rape and murder, where the allegations (if true) may mean the defendant poses a serious threat to public safety. Nevertheless, it is widely accepted that the public interest is served by the application of the criminal standard.

28. We have seen the GMC's proposals for the introduction of a civil standard to its FTP panel determinations and have no confidence in the proposed procedure which we believe is likely to lead to unfair and inconsistent decisions which will not inspire confidence in the procedure.

29. A civil standard of proof is likely to result in considerable additional delay and expense. The GMC's Council papers for February 2008 showed there were 35 appeals outstanding and 24 judicial reviews. We expect that a change to the civil standard is likely to increase the number of legal challenges. This would not be in the public interest.

There have been various comments made about the change to the civil standard, in the House of Commons and in the wider media, which we dispute:

It has been suggested that most commentators' objections to the civil standard are based on a misunderstanding of the way the civil standard of proof can accommodate cases of significant severity and that the civil standard itself can accommodate that type of case. It is further suggested that other healthcare regulators have already introduced the civil standard and that it works well for them.

30. The MDU's concerns about the introduction of the civil standard for medical cases are based on our experience of assisting members with GMC fitness to practise proceedings. Medical cases are generally different to those arising in other specialties, and the GMC's procedure is different in several respects to those of most other healthcare regulators. It does not follow that the introduction of the civil standard will work in medical cases. We are not persuaded by those who promote the introduction of the civil standard that it will provide fair decisions because there are considerable practical difficulties that have not, as far as we can tell, been addressed. These are best exemplified in a case example provided by leading counsel who advised us on this matter:

> In response to a request for a home visit, a GP visited the patient at his home, in the presence of the patient's wife. There was a dispute about the symptoms complained of, the adequacy of the history taking and the extent of the examination. It was alleged the patient had complained of fever, abdominal pain and diarrhoea. It was alleged the GP was abrupt and dismissive of the patient's symptoms, had failed to check his temperature or examine the abdomen. The GP advised the patient had a viral illness that should begin to resolve within 48 hours.

The next day the patient's condition worsened. His wife summoned an ambulance. He was taken to hospital. A perforated appendix was diagnosed. The patient underwent emergency surgery. Widespread intra-abdominal infection was found. Despite intensive care the patient duly succumbed to sepsis.

An inquest was held at which the GP gave evidence on oath. He denied his history taking and examination had been inadequate. He said the patient had complained of diarrhoea and vomiting only, and he had carried out a careful examination that had included palpation of the abdomen but no abnormality had been detected. He produced a handwritten note to this effect that he said he had written in his car immediately after the visit. The patient's widow denied the doctor's account was true and she alleged the handwritten note was false because it did not record the main complaint of abdominal pain and the GP had not examined her husband's abdomen.

The widow complained to the GMC. In due course the case was referred to an FTP panel with allegations that:

> At the home visit the GP had failed to obtain an adequate history of the illness and failed to carry out an adequate examination.
>
> The GP had failed to make an adequate note of the home visit.
>
> The GP had given an untruthful account at the Inquest in that he had falsely stated there had been no complaint of abdominal pain and that he had palpated the abdomen.

Each allegation of fact might be considered to raise a different degree of seriousness, raising issues both of performance and misconduct. The adequacy of the history taking and examination might be considered to be relatively

straightforward matters importing no more than a simple balance of probability in deciding whether or not the widow's account was to be preferred over the GP's account. On this decision would turn the further allegation of the adequacy of the GP's note. However, resolution of these simple factual issues would also determine whether the GP had given an untruthful account at the inquest, and thus committed perjury. The highest civil standard should apply to such a serious allegation of a crime.

An FTP panel determining these allegations might be able to resolve the facts on a simple balance of probability, finding the allegation of a complaint of abdominal pain and a failure to examine the abdomen proved. The logical consequence of such a finding would be that the GP had also committed perjury at the inquest. Yet if a high civil standard equating to a criminal standard had been applied, in a situation where it was the complainant widow's word against the GP's word, an FTP panel might think there was sufficient doubt so that they could not be sure.

If, because of the perjury allegation, the FTP panel applied the highest civil standard equivalent to the criminal standard, it might then acquit the GP of all allegations. However, if the facts were changed, so that there had been no allegation of perjury at the inquest, the GP might have been found guilty on the simple application of a preponderance of probability.

Such a result would lead to inconsistencies of approach between cases, with some doctors whose facts give rise to more serious allegations of misconduct having the protection of a civil standard equivalent to the criminal standard, whereas doctors without an allegation equivalent to a crime being in jeopardy of an adverse finding based on a lower standard.

31. We have seen nothing that persuades us that the civil standard will provide fair decisions in such cases. A key virtue of the criminal standard is its simplicity. It is a legal concept embedded in the criminal justice system that is applied day in day out by members of the public. It has withstood the test of time.

It has been suggested that the introduction of the civil standard is not going to have any significant effect at the serious end of the spectrum.

32. The case example above demonstrates that in a number of cases 'at the serious end of the spectrum' the civil standard will have a significant effect. Many cases are not straightforward and it will often be difficult to apply a flexible civil standard fairly.

It has been suggested that one problem with the existing system is that there are two extremes and because of the criminal standard, there is often reluctance to make a ruling when it is borderline; whereas the civil standard will allow a whole range of sanctions, from serious sanctions to retraining or help.

33. This demonstrates a lack of understanding of how the criminal standard is applied. It is only applied to the finding in respect of the facts – the allegations made against the doctor – to determine beyond reasonable doubt whether they are proven, or not. It is not applied when the panel decides if the facts amount to impaired fitness to practise, nor when the panel decides on the sanction. Thus, whether or not a case is 'borderline', whatever that means, is immaterial. We are not aware of any cases where there has been a reluctance to make a finding on the facts, using the criminal standard, because the case is 'borderline'.

34. Even if the facts are proven, but do not amount to impaired fitness to practise, it is still possible for the FTP panel to issue warnings, so there is no question of the FTP panel holding back because a case is 'borderline: it can issue sanctions that are less serious than erasure or suspension or, if the proven facts do not establish impaired fitness to practise, issue a warning.

35. It is clear from the full list of available sanctions set out at Schedule 7 (4) of the Bill (which exist now and which the Bill envisages will continue when the OHPA takes over the GMC's adjudicatory role) that there is no suggestion the GMC will be required to introduce any new sanctions when the civil standard is imposed. It is clear that the sanctions that are currently available when the facts are proven using a criminal standard will continue to exist when the civil standard is imposed. If an FTP panel decides that a doctor's fitness to practise is not impaired, it can still issue the doctor with a warning about future conduct or performance, which will stay on that doctor's record for 5 years and be disclosed to the current employer, and future employer and any other enquirer. If an FTP panel decides that a doctor's fitness to practise is impaired, the sanctions available now include acceptance of undertakings by the doctor, or conditions placed on registration, as well as suspension and erasure.

36. Given that all of the sanctions listed in Schedule 7 (4) will remain once the civil standard is introduced. It is wrong to suggest that the civil standard will allow the GMC to issue a different range of sanctions, or that it is not now able to address concerns even if it does not find a doctor's fitness to practise impaired. It can issue warnings at the investigation stage, and also after an FTP hearing, both in circumstances where the doctor's fitness to practise has not been found to be impaired.

37. It is misleading to say that doctors should feel much more relaxed about the civil standard than they do about the status quo, 'because there is currently a danger that some mistreatments or mistakes go unaddressed, because the options are only doing nothing, or something incredibly serious and damaging to the long-term career of the doctor'. This is simply not true: there are already a wide range of sanctions available to the GMC, which it uses frequently, that allow it to address concerns short of a finding of impaired fitness to practise.

It has been suggested that the introduction of the civil standard will not result in more doctors being found to have impaired fitness to practise.

38. This is simply not logical when the proponents of the civil standard are proposing that the civil standard will allow the GMC to make findings of

impaired fitness to practise in cases where they do not do so now because they are 'borderline'. If the civil standard will allow the GMC to make findings of fact that then lead on to an FTP panel decision that the doctor has impaired fitness to practise in a case where the same facts currently would not be proven using a criminal standard, the only logical conclusion is that there will be an increase in findings of impaired fitness to practise.

39. If the proponents of the civil standard thought it would not result in more doctors being found to have impaired fitness to practise, it is rather surprising that they are continuing to seek to impose the civil standard in the face of almost unanimous opposition from the medical profession.

It has been suggested that the civil standard will help regulators to intervene earlier with problematic doctors and that it should mean fewer extreme sanctions in the medium and long term.

40. This again shows a lack of understanding of how the current procedure works. It is already possible for the GMC to 'intervene' at an early stage as it can also issue a warning at the investigation stage if it does not believe that the allegations against a doctor will amount to impaired fitness to practise if pursued to a hearing. This warning will be disclosed to future and present employers and any other enquirer and will remain on a doctor's file for 5 years. It is wrong to suggest that the civil standard will mean fewer 'extreme sanctions' in the medium and long term because if it is easier for the GMC to prove the facts – only on the balance of probability – then it follows that there will be more findings of impaired fitness to practise as a result of the facts proven and, therefore, more 'extreme sanctions' not fewer.

41. In summary, we do not support the principle of a one-size fits all approach to the regulation of healthcare professionals. A change to the civil standard of proof for doctors will result in good doctors being found impaired when they are not. It cannot be in the public, patients' or profession's interests for this to happen and yet a lowering of the threshold of proof risks such unfairness. Further, it

will undermine confidence in the regulatory process and lead to a greater number of legal challenges.

Clause 116 (1) (a) and sharing information between prescribed bodies

We are concerned that the requirement to share information, proposed in subsection (1) (a), may result in designated bodies sharing of information that is incorrect, unsubstantiated and damaging to healthcare professionals. We hope it may be possible for the Government to agree to safeguards that are enshrined in this primary legislation.

42. Clause 116 provides for regulations to be made to require NHS trusts and other bodies to provide and share information about health care workers in circumstances where that person is likely to constitute a threat to the health and safety of patients. While there is a public interest in protecting the health and safety of patients, in the interests of fairness, this must be balanced against the rights of the healthcare worker. However the words used in (1) (a): 'which may show that the worker is likely to constitute a threat to the health and safety of patients,' are unclear but seem to suggest that the threshold for sharing such information is very low. The use of the word 'may' would seem to require such bodies to keep and pass on information in circumstances where it has not been shown to any recognised standard that the healthcare worker is a threat to health and safety of patients or, indeed, it would not require the person keeping the information on file, or passing it on, to even try to determine if the information is correct.

43. We suggest, therefore, that the threshold in the primary legislation should be made clear so that it cannot be misinterpreted, and that the threshold used should demonstrate a balance between the need to protect patients and the rights of the healthcare worker. We suggest that the clause is amended so that the phrase 'may show' is replaced with the word 'shows'. This would mean that the information would have to show that the worker is likely to constitute a threat to health and safety of patients before there is a requirement to pass it on.

The need to protect patients

44. It is inappropriate to suggest that any information suggesting potential risk to patient safety should be passed on to other bodies by an employer/contracting body, unchallenged and uninvestigated. Employers/contracting bodies who become aware of 'soft information' that gives grounds for concern about issues of patient safety must investigate it to determine if the allegations are groundless, for example just gossip or arising from intra and inter-professional rivalry; or if there are serious concerns which should be acted upon. If there is 'soft intelligence' about a doctor, ie rumblings and vague concerns about potential risk to patient safety, that come to the attention of his or her employer, that 'intelligence' should be investigated locally and the doctor should be informed of its existence and allowed the opportunity to comment on it. It is in the doctor's interests and that of his patients that any concerns are properly investigated and addressed as appropriate.

45. In the interests of patient safety we do not support the concept of employers/contracting bodies keeping 'soft intelligence' on a file if it is unsubstantiated and does not amount to grounds for serious concern. If employers/contracting bodies merely keep 'soft intelligence' on file because it does not look serious, and the employer waits until further 'soft intelligence' arises, or there are more serious grounds for concern, opportunities may have been missed to prevent problems arising. We do not believe this approach would be in the interests of patient safety. If the employer/contracting body has any grounds for concern about potential risk to patient safety, even in the form of 'soft intelligence,' they should be properly investigated through appropriate channels at the time they are raised, to determine whether there is any substance to them, and if they need to be acted upon.

46. We understand this change is being proposed because in the past there have been concerns about a very few doctors that were 'below the surface' in cases where that doctor was later convicted of a serious crime. It is suggested that this change would prevent this happening in future and, if the same events happened today, any concerns would

surface. We agree entirely that if there are any concerns about patient safety, they must be raised, but they must be brought to the attention of the doctor in question and investigated. If concerns are substantiated, appropriate action will need to be taken, and if they are unfounded, they should not lie on a doctor's file and nor should they be shared without that doctor's knowledge.

47. It should also be borne in mind that since these high profile 'below the surface' cases there have been substantial changes which have tightened up the regulatory environment for doctors considerably. For example, within the NHS there are now appraisal and clinical governance systems, and new and more efficient hospital disciplinary procedures and PCT performers' list procedures have been introduced. NCAS has been set up, and is now operating nationwide, and there is ongoing change to the NHS complaints procedures. The GMC has also changed its procedures substantially so that it can look at a doctor's fitness to practise in the round and issue warnings even if the doctor is not found to have impaired fitness to practise. All these changes, and others, represent appropriate responses to such concerns because they have concentrated on improving the way in which concerns are identified, investigated and addressed, in the interests of protecting patient safety. By contrast a strategy founded upon storing and even disseminating unsubstantiated concerns has inherent within it (in addition to unfairness to the doctor or healthcare worker concerned) a delay in acting upon those concerns and a misunderstanding of the limited value of such information in terms of protecting patients or in providing valid evidence in any proceedings that may follow.

The rights of the healthcare worker

48. It is a serious failing that clause 116 (1) (a) makes no requirement for investigation of information before it is collected and shared, as this could allow dissemination of material that is inaccurate, damaging to and even defamatory of the individual concerned, without that person even knowing it is being passed on. If a healthcare worker were not notified about information that was shared:

    a. Information based on unsubstantiated gossip could be spread.

b. That information may not have been investigated, and may not be true.
c. The healthcare worker may be completely unaware of the allegation.
d. The healthcare worker would have no opportunity of 'setting the record straight', giving his or her side of the story.
e. The healthcare worker's reputation could be damaged, and action be taken on unsubstantiated information without the doctor even being aware of that information.
f. Alternatively, if there was truth in the information, the healthcare worker would have been given no opportunity to correct his or her conduct or performance and thus prevent a similar problem from arising again.

49. Such a system would not gain the confidence and support of healthcare workers. Nor would it serve the public interest. It cannot be in the public interest to have a system that secretly spreads unsubstantiated information that can undermine the reputation and confidence of competent healthcare workers.