Part D [of the December 1999 consultation paper]

Disclosure of Information Concerning Doctors Before a Formal Finding by a Fitness to Practise Committee

Introduction

1. This paper sets out proposals under which, in advance of the outcome of a formal process, the GMC would disclose information concerning a complaint about a doctor to those with a legitimate interest in receiving the information provided that certain criteria apply.

2. We recognise that the disclosure of information to third parties in this way by us, in advance of a decision on the matter by a fitness to practise committee, raises difficult and competing considerations of fairness, defamation and duty of care.

3. On the one hand, we have a duty to ensure that complaints against doctors are dealt with fairly. When allegations of unfitness are made against them, doctors have the right to a fair hearing before an independent and impartial body. Their livelihood is at stake. They have the right to be presumed innocent of such allegations unless and until the allegations are made out. They also have the right to respect for their private life (including reputation and personal privacy). These rights are contained in Articles 6 and 8 of the European Convention on Human Rights, which will become part of UK law from 2 October 2000 when the Human Rights Act 1998 comes into force.

4. Fairness includes taking all reasonable steps to protect the doctor from the damage caused if allegations which may prove to be unfounded are disclosed before they have been properly considered. (Fairness means also making sure that a malicious or unfounded complaint is not taken forward. That may require some limited disclosure of it to others, but that is a separate matter from the issues raised by this paper.) On the other hand, one of our paramount duties is to protect patients and the public from harm caused by doctors who are not fit to practise.
5. We attach great importance to both to the rights and interests of patients and to the rights and interests of doctors complained about. There may be circumstances where the requirements of fairness to doctors and protection of patients have to be balanced against each other. When this balance involves the limited release of information about a doctor, we will of course take reasonable care to ensure that the information is accurate and give appropriate warnings about the extent to which reliance can be placed upon information which has not yet been the subject of full investigation. As discussed below in greater detail, these principles represent the criteria by reference to which we have formulated the proposals contained in this discussion document.

6. This dilemma is not unique to the GMC. The NHS operates a system of 'alert letters', the arrangements for which were formalised in 1997. The alert letter system is intended to ensure that information about doctors who have been dismissed, are under suspension from NHS employers, who have been referred to us or in respect of whom an issue of public protection may otherwise arise, is disseminated appropriately so that patients are protected while the matter is under investigation. The letter, which is issued by a Regional Director of Public Health, asks Health Authorities and Trusts who may be considering employing the doctor concerned, to contact the originating NHS employer.

7. However effective the alert letter system may be, it cannot offer protection to the public in respect of doctors who are not practising in the NHS. We, on the other hand, are responsible for every doctor on the Medical Register regardless of the circumstances in, or the terms on, which the doctor may practise.

8. We have powers to impose interim suspension or interim conditions on a doctor's registration pending consideration of the matter by the Professional Conduct Committee (PCC) or Health Committee. These powers enable us to protect the public by preventing the doctor from practising at all, or only subject to strictly defined conditions, until the matter has been fully investigated under our procedures. We are required under the Medical Act 1983 to give the doctor at least 28 days' notice that an order for interim suspension or conditions is being considered, and to invite the doctor to appear at a hearing to decide upon the matter. If an interim order is made, details of the sanctions (although not the reasons for them) are disclosed to enquirers.
9. There are two particular categories of case in which we feel it may be in the public interest to disclose information about a doctor not subject to interim suspension or interim conditions:

   a. There are a handful of cases each year where there appears from the complaint or information to be such an immediate and serious risk to patients that it may not be safe for the doctor to continue in practice during the period (at least 28 days and possibly up to two months) before an interim order could be made.

   b. Routinely there are cases involving allegations which are not so serious as to justify an interim order but where it would be in the public interest to disclose to a legitimate enquirer (such as a potential employer) that our fitness to practise procedures are underway or are about to get underway.

10. We know from discussions and correspondence with the NHS Executive and with a number of health providers in the private sector that there is a need for a clear and settled policy about this matter. This paper sets out proposals under which, in advance of the outcome of a formal process, we would disclose certain information about a complaint, but only to those with a legitimate interest in receiving the information, in the following circumstances:

   a. In response to an enquiry, if a decision had been made (or was clearly required) to take action under the fitness to practise procedures and there could be a real question about the safety of a patient or patients.

   b. On our own initiative, if a decision had been made (or was clearly required) to take action under the fitness to practise procedures and there were strong grounds to consider that the doctor might pose a serious and imminent danger to a patient or patients.

11. This paper sets out how these proposed arrangements would work. We would greatly welcome your views on the proposals (which have been formulated in the light of legal advice).

12. The proposals in the paper do not affect the existing arrangements for the disclosure of voluntary undertakings to limit practice given by doctors subject to our health procedures or the disclosure to enquirers of a
To whom disclosure would be made

13. Disclosure would be made only to a person or organisation with a legitimate interest in receiving the information. The breadth and diversity of medical practice is such that it is not possible to foresee and codify in advance everyone who might have such an interest. Every case would need to be considered on its own merits. However, the following suggestions are offered as a guide in respect of GPs and hospital doctors, who are likely to account for the vast majority of cases.

GPs

14. Those with a legitimate interest in receiving information concerning a GP would include:

a. Patients actually on the GP’s list or (in multi GP practices) the shared practice list or the list of another doctor in the practice. (Patients merely considering joining a doctor’s list would not have a legitimate interest in receiving information about that doctor.)

b. Consultants who receive referrals from the GP.

c. Partners or other GPs within the practice.

d. The Chief Executive, Medical Adviser or Chairman of the relevant Health Authority.

e. The Chairman or Secretary of the Local Medical Committee

f. The Chief Executive of a primary care trust (when constituted).

g. The Chief Officer (or other senior officer) of a locum agency.

h. The appropriate Regional Director of Public Health.

Hospital doctors
15. Those with a legitimate interest in receiving information concerning a hospital doctor would include:

a. The Chief Executive or Medical Director of an NHS Trust where the doctor was employed or was being considered for employment.

b. The Chairman of a medical staff committee at such an NHS Trust.

c. The Chief Executive or Chairman of the Medical Advisory Committee (or equivalent body) of a private hospital, and senior officers of any medical insurance company running a private hospital, where the doctor had, or had applied for admitting rights.

d. A referring GP.

e. A patient who had been referred to the doctor.

f. The Chief Officer (or other senior officer) of a locum agency.

g. The appropriate Regional Director of Public Health.
Those without a legitimate interest

16. It is unlikely that the following would have a legitimate interest in any circumstances:

   a. A potential patient of a doctor. The patient must normally already be a patient (for example, be on a GP’s list or in the case of a specialist practitioner have been referred to that doctor).

   b. The media.

The mechanism for disclosure

17. No information would be disclosed to an enquirer under these proposals, in any circumstances, unless the enquiry was in writing. In cases of urgency, the enquiry could be in the form of a fax. Our response would also be in writing, but in very serious and urgent cases we might also provide the information by telephone.

18. No information would be disclosed unless we were satisfied that the person receiving the information had a legitimate interest, and this would depend on the precise circumstances and on us being satisfied about the bona fides of the enquirer. In the case of an enquiry from a patient, for example, we would expect to see documentary proof that the patient was on the doctor’s list (if a GP), or (if a specialist practitioner), had been referred to him or her. Enquirers who did not have, or could not demonstrate that they had, a legitimate interest would be told, regardless of whether or not a complaint about the doctor was under investigation, that it was not our policy to answer such enquiries.

19. In health cases, particular care and safeguards will be needed to ensure that only the barest minimum is revealed and that its accuracy is checked. Often, confidential medical information will be involved.

Disclosure in response to an enquiry

20. The following criteria would determine whether disclosure should be made:

   a. Disclosure would normally be made only in circumstances where a decision had been made that the matter would be taken
forward under the fitness to practise procedures, there were believed to be reasonable grounds to consider that the complaint/information could be well founded and that, if so, there was a real question about the doctor’s fitness to practise and the safety of a patient or patients.

b. Disclosure would only be made if the enquirer had a need to know the information, that is, if the information would assist the enquirer in reaching a decision about his or her own care, or that of patients for whom he or she had responsibility.

c. The nature and extent of the information disclosed would be no greater than is necessary and proportionate to protect the safety of patients. It would be the minimum consistent with enabling the enquirer to make a decision of the kind described at b. above. In many cases, it would be unlikely to be appropriate to disclose information about the nature of the complaint; disclosure would be limited to revealing that a complaint had been received which, if substantiated, would raise an issue about the doctor’s fitness to practise and the safety of a patient or patients. This is because we recognise the importance of the presumption of innocence (until an allegation is proven), the need to ensure a fair, independent and impartial hearing of the allegation, and the need to protect so far as possible a doctor’s civil rights to reputation, to practise his profession and to preserve his privacy.

Disclosure of information on our own initiative

21. We expect that cases where we would volunteer information to a third party would occur more rarely. All the criteria in paragraph 20 must be satisfied and in addition there would need to be strong grounds to suspect that the complaint was well founded and that the doctor might pose a serious and imminent danger to patients. It is very likely that a decision to seek interim suspension/conditions would already have been made or would be made simultaneously with a decision to disclose information.

How information would be disclosed

22. In all cases, disclosure would be made in writing. In serious and urgent cases, the information might also be disclosed by telephone.
23. The proposed terms of standard letters we would propose to use are at Appendix A.

24. We are not minded to tell the doctor, in advance, that we intend to disclose material about him and invite his comments on the disclosure. To do so would not be compatible with the need to act effectively to protect patients. In any case, as part of normal screening procedures, we will normally already have copied the material to the doctor and invited him to comment. (It might be sensible routinely to warn doctors that we may later - in the circumstances set out in this document - disclose material and invite the doctor’s comments on that possibility.)

25. Rather we would, simultaneous with disclosure, send a copy of all disclosed material and accompanying correspondence to the doctor, explaining why disclosure had been made. Both the doctor and the recipient of the information would be told that the doctor has the right to make whatever comments he wished to the recipient and to us about either the fact or extent of disclosure or the substance of the complaint itself. We would then consider any comments from the doctor and, if appropriate, revise or withdraw the disclosure.

26. We would particularly welcome comments from consultees on this aspect of the proposals.

If the doctor were later exonerated

27. If the doctor were later exonerated, every person to whom disclosure had been made at an earlier stage would immediately be notified of this in writing. In addition, after exoneration, we might also ask for recipients of information to give an undertaking that all records of it had been destroyed.

If a formal finding about fitness to practise were later made against the doctor

28. If a formal finding were subsequently made against the doctor, those to whom disclosure had been made at an earlier stage would be informed.

What action would be required by the recipient of the information
29. It would be for those in receipt of the information themselves to decide what action they should take. The purpose of disclosing the information is to enable those with responsibilities for ensuring patient safety, or where appropriate, individual patients themselves, to make a well-informed decision, in so far as information we hold is relevant to that decision. We would itself be making no decision at all - merely providing information. The information would be accompanied by warnings about the extent it could be relied upon as set out in the last two paragraphs of the proposed standard letters at Appendix A.

Enquiries about doctors about whom no complaint is pending

30. Our handling of enquiries in these circumstances will depend on whether the enquirer would have a legitimate interest in receiving information if there were a complaint under consideration. If not, the enquirer would be told that it was not our policy to disclose in response to such requests whether or not a complaint has been received about a particular doctor.

31. If the enquirer would have a legitimate interest, the enquirer would be told that no complaint was pending.

Date protection issues

32. We are aware that these proposals may raise data protection issues. We will be seeking advice about this in the context of the Data Protection Act 1998 and Directive 95/46/EC.

Timescale and implementation

33. Any substantive issues raised in the consultation process will be considered by the Fitness to Practise Policy Committee which will make recommendations to Council in May 2000.
Appendix A

Proposed text of GMC letters disclosing information about doctors subject to a complaint

‘A complaint [or information] has been received by the GMC about the fitness to practise of Dr X. It raises questions which require careful investigation.

[In response to an enquiry]:

There are, however, reasonable grounds to consider that the complaint [or information] may be well founded, and that, if it is, there may be a real question about Dr X’s fitness to practise and the safety of a patient or patients.

[Where information is volunteered by the GMC]

There are, however, strong grounds to consider that the complaint [or information] may be well founded, and that, if it is, there may be a serious and imminent danger to a patient or patients.

However, I emphasise that the investigation into this complaint is still incomplete [has not yet begun], [if appropriate] that Dr X has not yet had the opportunity to state his answer to the complaint [or information] and that no findings have yet been made. It would therefore be wrong to make any assumptions about the likely outcome of the investigation.

This information has been disclosed to you in strict confidence for the sole purpose of enabling you to make a decision about [your care] [the care of patients for whom you are responsible]. The information must not be disclosed to any other person or body of any kind, except that where information is being provided to an organisation or group with a legitimate interest it may be disclosed to and used by others within that organisation or group for the purpose for which it has been disclosed. Any other person or body wanting access to the information should apply directly to the GMC.