**Public Minutes of the Investigation Committee**

**Date of hearing:** 26 June 2018

<table>
<thead>
<tr>
<th>Name of Doctor</th>
<th>Dr Tuba Hussian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor’s UID</td>
<td>424961</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Committee Members</th>
<th>Mr John Anderson (Chair, Lay)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ms Toni Foers (Lay)</td>
</tr>
<tr>
<td></td>
<td>Dr Zahir Mohammed (Medical)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Legal Assessor</th>
<th>Mr David Mason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panel Secretary</td>
<td>Mr Declan Leahy</td>
</tr>
</tbody>
</table>

**Attendance and Representation**

<table>
<thead>
<tr>
<th>GMC Representative</th>
<th>Mr Alan Taylor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor's attendance</td>
<td>Attended and representation</td>
</tr>
<tr>
<td>Doctor's representative</td>
<td>Laura Stephenson</td>
</tr>
</tbody>
</table>

| Outcome             | Warning                      |
Determination

Dr Hussain,

1. At today’s hearing the Investigation Committee carefully considered all the material before it including the submissions made by Ms Laura Stephenson on your behalf, and those made on behalf of the GMC by Mr Alan Taylor. It has accepted the advice of the Legal Assessor.

Background

2. The GMC received a statement from Matron Sue Shipton at Peterborough City Hospital (‘the Hospital’) highlighting concerns raised about a Doctor (‘Mr B’) who had been on to the Critical Care Unit (‘CCU’) on the evening of 2 October 2016 and had asked for someone to access blood results for a patient (‘Patient A’) who had been transferred from the Fitzwilliam hospital on the same day. It became apparent in her conversation with Mr B that he did not have access to the ward or the IT systems as he had retired and left the Trust. At this point Mr B was not allowed access to the IT systems and was informed that he could not do that as he was not a member of the Trust. Mr B then telephoned someone else in the Trust and subsequently left the unit.

3. Matron Sue Shipton requested a copy of a Card Holder Report which shows that your access card had been used to access the CCU of the Hospital at the following times:
   - 2 October 2016 at 23:22
   - 3 October 2016 at 20:36

4. Matron Sue Shipton also requested a copy of the access report for Patient A’s blood results which showed that your user account had accessed the patient’s blood results on 5th October even though you had no involvement in Patient A’s care.

5. The GMC wrote to you on 13 July 2017 to notify you that an investigation had been opened into your fitness to practise.

6. You provided a witness statement to the GMC, dated 9 November 2017, for the purposes of a GMC investigation. In this statement you said that you were not working at the Hospital on 2 October 2016. You stated that you used your access card on that day, at 23:22 to enter the CCU, accompanied by Mr B. You stated that Mr B is a Consultant Gastrointestinal Surgeon, who worked at the Fitzwilliam Hospital and that Patient A was a patient of his at the time, who had been transferred from Fitzwilliam.
Hospital to Peterborough City Hospital (‘the Hospital’) earlier that day. You said that Mr B had explained that Patient A had been reluctant to go to the Hospital, due to a previous bad experience, and had only agreed to the transfer when Mr B had ‘reassured Patient A that he would visit her’. You stated that Mr B had also explained that the on-call General Surgeon at the Hospital had ‘expressed reservations about accepting Patient A, as... he had no experience of upper gastrointestinal tract (“GI”) cases.’ However, the General Surgeon had asked that ‘Mr B remain involved to the extent of offering advice’. She stated that Mr B had already seen Patient A in the Hospital’s CCU after her admission and had made entries in Patient A’s notes to document this. She stated that on the evening of the 2 October 2016, Mr B was concerned about Patient A and had attempted to contact the CCU Consultant at the Hospital. After not receiving a response, you agreed to accompany him to the CCU.

7 With regard to 3 October 2016, you stated that you were not doing clinical work at the Hospital, but ‘would normally be doing [your] Supporting Professional Activities’ session, so would be at the hospital. You stated that you went through the CCU to fetch a personal item from your locker, and that Mr B joined you to ‘get an update from the CCU trainee doctor and nurses in relation to Patient A.’

8 With regard to the evening of 4 October 2016, you stated that ‘Mr B’ wanted to review Patient A, so you again accompanied him to the CCU. You stated that ‘had [you] not accompanied Mr B to the CCU, he would still have been able to gain access to the CCU to review Patient A via another CCU member of staff as he had done earlier in the day.’

9 With regard to the 5 October 2016, you stated that ‘Mr B’ was concerned about Patient A, and that the CCU staff may have been too busy to check Patient A’s blood results, so he asked if you could check them. You stated that you checked them, and that you think you accessed them remotely at home, but were unsure about this.

10 On 19 February 2018 the GMC wrote to you to say that, having considered all the evidence, the case examiners were minded to issue you with a warning. They invited you to respond to this.

11 On 26 March 2018 the Medical Defence Union wrote to the GMC on your behalf. In their letter they stated that it was clear to you that other staff members on the CCU were allowing Mr B access to the unit in order to see Patient A, at her own request and with the full knowledge of the clinicians treating her. They stated that your actions at the time were an attempt to do what was in the best interests of Patient A, but that in hindsight you realise that the decision should have been made by someone independent from the Trust and ‘following proper channels’. The MDU stated that they consider a warning to be disproportionate and serve no further purpose, that the circumstances were unusual and that you had been open and honest with the GMC. They stated that you were unwilling to accept a warning and would like to exercise your right to a public hearing before the Investigation Committee.

GMC Submissions
Mr Taylor, on behalf of the GMC, reiterated the background of the case. With regard to the allegation at paragraph 3 of the particulars, that:

‘on 5 October 2016 you used your Hospital pass to give Mr B access to Patient A’s:

a medical records;

b blood test results.’

Mr Taylor submitted that the GMC’s position is that the blood results are part of the medical records, and that they ‘have no issue’ with considering the allegation only in respect of blood test results.

Mr Taylor submitted that without the use of your pass, ‘Mr B’ would not have been able to enter the hospital or ‘penetrate the first level of security’. Mr Taylor submitted that a warning would be appropriate in this case, as you allowed ‘Mr B’ unauthorised access to Patient A and disclosed confidential clinical information to him. He submitted that it is more important as you were a Caldicott Guardian at the Trust and should have known not to do this. He drew the Committee’s attention to the fact that you hadn’t spoken to Patient A, or her treating clinicians, so did not know what Patient A’s wishes were. Mr Taylor clarified that there was no suggestion of any malign purpose or malicious intent in your actions, but submitted that you allowed your relationship with Mr B to override your responsibilities and that you failed to live up to the standards expected of you.

Mr Taylor submitted that a warning is appropriate given the serious departure of the standards expected of you, specifically paragraphs 50 and 65 of Good medical practice (2013). He argued that a warning is proportionate, as the GMC are not seeking to restrict your practise but that your conduct warrants a formal response in order to highlight that this behaviour is unacceptable. He submitted that if this conduct were to be repeated, it would result in a finding of impaired fitness to practice. When questioned by the Committee, Mr Taylor submitted that once Patient A transferred from the private hospital to the Peterborough City Hospital Mr B was no longer involved in Patient A’s care.

Defence Submissions

Ms Stephenson, on your behalf, submitted that you accept that you made a mistake in allowing Mr B access to the CCU and in sharing the results of Patient A’s blood tests. She stated that you recognise that this was misguided; breached hospital policy and that you accepted that it was, or at least could be perceived to be, a blurring of professional and personal boundaries. She stated that you now know that the right thing to have done would have been to refer Mr B to another consultant or one of Patient A’s treating clinicians.

Ms Stephenson clarified that you did not simply give your pass to Mr B to allow him ‘free access’ to the CCU, but accompanied him on each occasion. She also clarified that
it is not the case that you had restricted access to the CCU, but that you worked there regularly. She submitted that Patient A had recently left the care of Mr B through the appropriate channels. With regard to the allegations at paragraph 3 of the draft particulars. Ms Stephenson submitted that this was misleading, and that the allegations should be accurate and fair. She stated that you only conveyed the results of Patient A's blood tests to Mr B, and did not give him access to Patient A's medical records.

18 With regard to a warning. Ms Stephenson submitted that a warning would not be appropriate or proportionate. She submitted that your intention was to help Patient A, who had expressed a wish to be continually monitored by Mr B. She submitted that Mr B was a long standing colleague of yours, as well as being your husband, and that for many years you had worked together successfully delineating between professional and personal relationships. She submitted that Mr B was not ‘any old doctor’ and your allowing him access was distinct from allowing access of any other doctor, given his recent involved in Patient A’s care, and the fact that he was known to the Trust as a senior colleague and recent employee.

19 Ms Stephenson submitted that whilst you were not responsible for Patient A’s care, it would not be unusual for you, in your positions, to exercise your judgement in deciding when to see or share information about a patient who was not ‘yours’. She stated that whilst this was a misguided decision, your role as a Caldicott Guardian does not only concern confidentiality, but also the sharing of information, and that in attempting to achieve the best care of the patient, you got the balance wrong. She submitted that you only acted on the basis of what Mr B had told you and that he had stated that Patient A had wanted him to continue being involved in her care, and that you understood him to visiting Patient A openly in cooperation with the medical staff on the CCU.

20 Ms Stephenson submitted that this does not constitute a significant departure from Good medical practice, and that not every deviation from Good medical practice requires a measure as serious as a warning, especially in someone whose career is as long and unblemished as yours. She submitted that a single breach alone does not justify a warning and that the conduct does not get close to approaching a realistic prospect of a finding of impairment, as your actions were misguided, they were well intentioned and in good faith. She submitted that the public’s confidence in the profession would not be affected if the Committee concluded the case with no further action. She submitted that you have shown insight, having been transparent and open, accepting that you have made a mistake, and that you have provided a sincere apology. She submitted that you gave reflected on your practice and that this is an isolated incident across an extensive and senior career. She directed the Committee’s attention to the testimonial’s provided by your colleagues which detail your meetings with them to discuss the issue and submitted that the risk of repetition in this case is very low.

21 Ms Stephenson submitted that if the Committee did decide to issue a warning, that it should clarify that ‘another doctor’ is a doctor who had recently handed over care of
Patient A to the Trust, that he was a recent employee at the Trust, that he had been monitoring Patient A’s progress following surgery he had undertaken on her and that reference to sharing medical records (in addition to blood tests) should be removed. The GMC took no position in response to this.

Committee Determination

22 ‘3. On 5 October 2016, you used your Hospital pass to give Mr B access to Patient A’s:

  c medical records;’

Found not proved.

The Committee took into account Mr Taylor’s submission that he considers blood tests and medical records to be the same thing, and took into account Ms Stephenson’s submission that you only shared information regarding Patient A’s blood tests on 5 October 2018. The Committee determined that the blood test results are considered to be part of Patient A’s medical records and therefore that it would be appropriate to simply consider the allegation with respect to the blood results, that being the more accurate and specific of the two allegations.

23 The Committee is aware that it must have in mind the GMC’s role of protecting the public, which includes:

  a Protecting, promoting and maintaining the health, safety and well-being of the public;

  b Promoting and maintaining public confidence in the medical profession, and;

  c Promoting and maintaining proper professional standards and conduct for members of that profession.

24 In deciding whether to issue a warning the Committee must apply the principle of proportionality, and balance the interests of the public with those of the practitioner.

25 The Committee determined that there had been a clear and specific breach of Good medical practice (2013), in particular paragraphs 20, 50 and 65. You clearly breached the confidentiality of Patient A by sharing her blood test results and by allowing ‘Mr B’ access to her on the CCU when he was not a member of staff at the Hospital.

26 The Committee determined that this conduct constitutes a significant departure from the standards expected of you. The rules and regulations regarding patient confidentiality are clear and well known to you as a doctor, and in particular would have been especially known to you in your role as the Caldicott Guardian for the Trust. You
did not have any direct contact with Patient A to obtain her consent for her information to be shared and relied entirely upon assurances from Mr B as to her wishes, as he who was your former colleague and husband, whose relationship to you compromised your judgment in this issue. In addition to this you were not directly involved in Patient A’s care, so were not in the appropriate position to be responsible for deciding who her information should be shared with.

27 The Committee considered the various factors of mitigation present in this case. It determined that the risk of you repeating these actions is very low. You have an otherwise unblemished record over a long career and have provided a genuine apology. You have demonstrated some reflection and insight, as you have recognised that what you have done is wrong. The Committee noted that you had engaged in remedial activities by attending courses on confidentiality and the maintenance of professional boundaries. The Committee also took into account the testimonials provided on your behalf, which speak very highly of you.

28 The Committee also considered the aggravating factors present in this case. It determined that there was a clear conflict of interest, which you should have been aware of and accounted for, when you were making the decisions as to whether or not to allow your husband access to Patient A and her blood test results. This is especially aggravated by the fact that you were the Caldicott Guardian for the Trust, a position that carries additional responsibilities and training in matters of confidentiality. The Committee noted that whilst this conduct focuses on a short period of time, it was not isolated as it did take place over multiple days and involved the breaching of confidentiality by allowing Mr B on to the ward and by informing him of the results of Patient A’s blood tests.

29 The Committee determined that if repeated, your actions would likely result in a finding of impaired fitness to practise. It took into account the fact that you were not personally involved with the care of Patient A, and the fact that you had simply taken ‘Mr B’s’ word for the fact that Patient A had provided consent to allow him access to her on the ward and for you to share her blood test results, without clarifying or confirming this with Patient A or someone responsible for her care. The Committee also took into account the fact that given your close relationship to him, you would have known that Mr B had not been an employee of the hospital for some four months.

30 The Committee determined that it would be both necessary and proportionate to issue you with a warning. The Committee determined that a warning is necessary in this case to maintain public confidence in the profession, as patient confidentiality is core and crucial to the principle of public confidence. It also determined that a warning is necessary in order to maintain proper professional standards, and that it is important to be clear what the appropriate standards are with regard to patient confidentiality, both as a reminder to yourself in the event of any future repetition and to the profession as a whole.
The Committee have therefore directed that the following warning be added to your registration:

‘On 2, 3 and 4 October 2016, you used your hospital pass to allow another doctor to gain access to a patient. On 5 October 2016 you used your hospital pass to access the patient’s blood test results and passed details of them to the other doctor. Neither you nor the other doctor had clinical responsibility for the patient as the other doctor had transferred the patient’s care on 2 October 2016.

This conduct does not meet with the standards required of a doctor. It risks bringing the profession into disrepute and it must not be repeated. The required standards are set out in *Good medical practice (2013)* and its associated guidance. In this case, paragraphs 20, 50 and 66 of *Good medical practice* are particularly relevant:

“20 You must keep records that contain personal information about patients, colleagues or others securely, and in line with any data protection requirements

50 You must treat information about patient’s as confidential. This includes after a patient has died.

65 You must make sure that your conduct justifies your patients’ trust in you and the public’s trust in the profession.”

Whilst this failing in itself is not so serious as to require any restriction on your registration, it is necessary in response to issue this formal warning.

This warning will be published on the List of Registered Medical Practitioners (LRMP) in line with our publication and disclosure police, which can be found at [www.gmc-uk.org/disclosurepolicy](http://www.gmc-uk.org/disclosurepolicy)

You will be notified of this decision in writing within the next two working days.

Signed……………………………………………….. Dated…………………………………………………

John Anderson
Investigation Committee Chair