HEALTH CIRCULAR

HC(82)13

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

To: Regional Health Authorities
District Health Authorities
Special Health Authorities for the London Post-graduate Hospitals
Boards of Governors
Family Practitioner Committees
) for action

Community Health Councils - for information

July 1982

HEALTH SERVICES MANAGEMENT

PREVENTION OF HARM TO PATIENTS RESULTING FROM PHYSICAL OR MENTAL DISABILITY OF HOSPITAL OR COMMUNITY MEDICAL OR DENTAL STAFF

SUMMARY

This circular advises health authorities to request appropriate medical and dental committees to introduce procedures to help prevent harm to patients resulting from physical or mental disability, including addiction, of all medical and dental staff employed by health authorities. These comprise medical and dental staff, including honorary staff, in hospitals, in community medicine and dentistry and in the community health service. General medical and dental practitioners are included only in connection with health authority appointments they may hold in hospitals or community clinics.

GENERAL

1. The Secretary of State has considered with representatives of the professions precautionary measures which can be taken to protect patients from harm which might arise from incapacity of medical or dental staff, including locum staff, due to physical or mental disability, including addiction. It is recognised that when members of medical or dental staff have reason to suspect such circumstances it is their clear duty to do what they can to ensure that the safety and care of patients is not threatened. Authorities are asked to request the appropriate professional staff committees to consider this circular and to institute arrangements based on the recommended procedure (paragraphs 3 - 11 below) which represents the agreed views of the Secretary of State and the professions.

2. The Secretary of State fully appreciates the difficulty and delicacy of the position of medical and dental staff in the circumstances dealt with in this circular. For this reason Authorities should recognise the essentially professional nature of the responsibilities of a sub-committee set up in accordance with the recommended procedure and should rely on a sub-committee to act appropriately. If exceptionally any question concerning a sub-committee's procedure arises it should be referred by the Authority to the Special Professional Panel (see paragraph 3) which set it up. The medical and dental professions fully agree that a collective responsibility for the safety of patients rests upon the professional staff as a whole and that the professions should continue to co-operate in providing appropriate safeguards. Accordingly the professional staff as a whole has a duty to do all in its power to see that the arrangements made for dealing with these rare but potentially dangerous circumstances are fully effective.

RECOMMENDED PROCEDURE

3. For each District Health Authority, there should be a panel, the Special Professional Panel, set up by the District Hospital Medical Committee or Medical Executive Committee or other appropriate medical or dental committees, consisting of members of the senior medical/dental staff from which in each case a small sub-committee should be appointed. The sub-committee should receive, and take appropriate action on, any report of incapacity due to physical or mental disability including addiction. It does not have a duty to report back to the Panel.

4. The composition of the special professional panel will need to take into account the particular pattern of services in the District but the most suitable pattern would usually be provided by the annual election of four or five consultants from the hospital staff of the Authority (chosen so that one or more was accessible to each of the units in the District) one member of the Local Medical/Dental Committee (LMC/LDC) preferably one with a hospital appointment, one Community Physician serving in the District, and one member of the senior clinical community dental staff nominated by the appropriate Dental Committee. There should be named deputies for the member of the local Medical/Dental Committee, the Community Physician and the community dentist. One member should be elected Chairman, and another nominated to act should the Chairman be unavailable.

5. In a hospital under the management of a Preserved Board or a Special Health Authority the arrangements should be considered by the Medical Executive Committee, or, where none exists, by the Medical or Dental staff Committee, and a panel appointed from the consultant staff. For clinical support services directly managed by Regional Health Authorities such as the Blood Transfusion service, the arrangements should be considered by the Regional Medical Advisory Committee.

6. Information would normally be given in the first instance to one of the members of the panel but sometimes to the Chairman of a clinical division. It may come from a variety of sources and may relate to medical or dental staff of any grade. It will usually be given by a colleague but may be from another discipline or from a general medical or dental practitioner. Staff other than medical or dental should normally first approach the most senior member of their discipline in the unit or department.

7. The person receiving such information should immediately consult the Chairman of the panel (or his deputy if the Chairman is unable to act). The Chairman should at once call together three members of the panel of which if he wishes he may be one, to form a sub-committee to consider the information which has been received. If the subject of the inquiry is a member of hospital staff the three members should be consultants. If he is also a gp/gdp the LMC/LDC member should be added. If the subject is a community doctor or dentist one member should be the community physician or the community dental officer who is a member of the panel as appropriate. A member of the panel who is in any way involved in a case should not serve on the sub-committee which considers it. If immediate action in the interests of patient safety seems to the panel member who received the information to be necessary and other members are not available he should be prepared to take informal action on his own responsibility; the information received and the action taken should be reported to the Chairman of the panel as soon as possible.

8. The sub-committee should make such confidential enquiries as are necessary to verify the accuracy of any report. Whilst they are not required to establish positively that the possibility of harm to patients exists or to make a clinical diagnosis, nevertheless if they are satisfied that the report has substance the practitioner should be told of its contents, but not necessarily of its source, and be given the opportunity to be interviewed by the sub-committee. If the practitioner is interviewed he may, if he wishes, ask for a professional colleague of his choice to be present, and the sub-committee must make it clear to the practitioner that they are interviewing him under the terms of this circular. If the sub-committee feel that the possibility of harm to patients cannot be excluded by the exercise of their influence with the practitioner concerned, they should bring the circumstances to the notice of the Regional Medical Officer and the Medical Officer (or Dental Officer if a dental practitioner is concerned) of the employing authority, or in the case of an employee of a Board of Governors, of the Secretary of the Board.

9. It is the responsibility of the officer of the employing authority (normally a medical or dental officer) who receives a report from a sub-committee under this procedure to decide what further investigations are necessary, whether the information should be passed to the authority or discussed with the Chairman, and what further action should be taken, including informing the medical officer of any Authority for which services are provided by the relevant practitioner. If it appears that a question arises that the doctor's fitness to practise may be seriously impaired by reason of his physical or mental condition consideration should be given to whether the circumstances might justify a report to the Registrar of the General Medical Council for consideration in accordance with the procedures of the Council's Health Committee. In considering this it will be relevant to bear in mind that the Council's procedures are specifically designed to encourage a sick doctor to accept treatment. A note on these procedures, and on reports to the GMC is attached as an Annex.

10. Where a practitioner who is the subject of a report is employed or in contract with more than one Authority the officer of the Authority who receives the report should communicate its substance to the appropriate officer of the other Authority so that they can act in concert.

11. Medical and dental committees concerned are asked to include in their arrangements after consultation with appropriate clinical divisions, provision for immediate action to secure the safety of the patient should the incapacity of a practitioner become apparent in the course of an operation or other clinical procedure.

PRIVILEGE AND CONFIDENTIALITY

12. The Secretary of State is advised that an action for defamation is not likely to succeed against persons passing on information which in their opinion should be brought to the notice of the recipients, since these persons would, unless actuated by malice, be able to reply on the defence of qualified privilege. This defence applies to a statement made in pursuance of a legal, moral or social duty to a person who has a corresponding duty to receive it. However, if proceedings are brought which establish that the defendants have acted in accordance with the recommended procedure, in good faith and with reasonable care, the Authority should meet the cost of their defence and indemnify them against any damages or costs ordered to be paid in those proceedings.

13. Any communication concerning the suspected or established disability of an individual or any subsequent medical report should in each case be made and handled in strict confidence and should not be disclosed except to persons (who may, where appropriate, include the Registrar of the General Medical Council) whose duties require them to know of it. Unless otherwise ordered by a court of other authority or body which has the legal power to make such an order, such material should not be made available to any other person or body.

DRUG ABUSE

14. Nothing in this circular affects the advice on the control of Dangerous Drugs and Poisons in Hospital which was circulated with HM(58)17. The relevant paragraphs advise that it is in the interests of the employee and of the public that employing authorities should consult the police wherever they have grounds for suspecting that one of their staff is misusing or misappropriating dangerous drugs, and that the police and not the authority should make the enquiries necessary to establish whether drugs are being misused or misappropriated and if so by whom. Similar arrangements apply should suspicion arise in the community health service.

DISCIPLINARY CASES

15. The recommended procedure (above) is intended to deal with cases where disability (including addiction to drugs or alcohol) is suspected in a member of medical or dental staff which might, if not remedied, lead to harm or danger to patients. It is not intended to replace or detract from the procedures set out in HM(61)112 and Section XXXIV of the General Whitley Council Conditions of Service. However, it may be appropriate to use the procedure recommended above in cases where it is possible that disciplinary action could arise but where there is reason to suspect disability.

PUBLICITY

16. The recommended procedure described in this circular can operate only if its existence is known to staff who might be concerned. Regional Health Authorities, District Health Authorities and Boards of Governors, as appropriate, are asked to remind the relevant professional committees annually of the need to elect the panel, and to ensure that all staff liable to be concerned know of the machinery and that all medical and dental staff and heads of other services know of the identity of the panel members.

17. Although the primary purpose of these arrangements is the protection of patients, the Secretary of State considers that the National Health Service has a responsibility towards staff who become disabled, and asks employing Authorities to arrange wherever possible in such cases, for treatment, rehabilitation and, if appropriate, retraining, so that the best use practicable may be made of impaired abilities as is consistent with the interest of patients. Medical and dental staff employed by Health Authorities who have completed 5 years service as members of the NHS Superannuation Scheme are entitled, if they become permanently incapable of discharging efficiently the duties of their employment by reason of physical or mental infirmity, to retire with immediate superannuation benefits under the scheme. If the incapacity is the result of an injury sustained, or a disease contracted, in the course of National Health Service employment and earning ability is permanently reduced by more than 10% then, in addition to any superannuation benefit which might be awarded, a continuing allowance could be payable under the National Health Service (Injury Benefits) Regulations.

CIRCULARS CANCELLED

18. HM(60)45 and Dear Secretary letter DS216/74 of 23 August 1974 are hereby cancelled.

ACTION

19. **Authorities are requested:-**

i. To ask appropriate professional committees to set up special professional panels (paragraph 3).

ii. On receiving a report under this circular, to consider what action should be taken and whether the General Medical Council should be informed (paragraph 9).

iii. To give instructions to protect the confidentiality of any communication made under the provisions of this circular unless disclosure is ordered by due legal process (paragraph 13).

iv. To obtain from professional committees concerned annually the names of persons who constitute the panel and to inform all concerned who the members are (paragraph 16).

v. FPC Administrators are asked to arrange for copies of this circular to be sent to Local Medical and Dental Committees for information. Sufficient copies are forwarded for this purpose.

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Further copies of this Circular may be obtained from DHSS Store, Health Publications Unit, No 2 Site, Manchester Road, Heywood, Lancs OL10 2PZ quoting code and serial number appearing at top right-hand corner.

(HC(82)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE: PROCEDURES ASSOCIATED WITH THE HEALTH COMMITTEE

Provisions of the Medical Act 1978, which came into force on 1 August, 1980, gave the Council jurisdiction cases where the fitness to practise of a doctor is seriously impaired by reason of his physical or mental condition The Act required the Council to make rules to govern the consideration of such cases and to establish a Health Committee to which a proportion, but not all, of the cases have eventually to be referred. The rules, which were made after consultation with professional bodies and are approved by the Privy Council, are the Health Committee (Procedure) Rules, published as Statutory Instrument 1980 No. 859.

In devising procedures for the consideration of a doctor's fitness to practise, the Council was concerned to make it easier for a sick doctor's professional colleagues to exercise persuasion on the doctor to seek treatment for his condition and so wherever possible to avoid the need to refer a case to the Health Committee. Where the Council receives information suggesting that the fitness to practise of a doctor may be seriously impaired, the information is first considered by the President or other member of the Council appointed for the purpose. This member is usually known as the Preliminary Screener. If he is satisfied from the evidence that a question does arise whether the doctor's fitness to practise is seriously impaired, the doctor is then informed of this and invited to agree within 14 days to submit to examination by at least two medical examiners. These medical examiners are chosen by the Preliminary Screener from panels of examiners nominated by professional bodies. Examiners are nominated in all parts of the United Kingdom so that examinations may be arranged locally if this is considered appropriate. It is also open to the doctor at this stage both to nominate other medical practitioners to examine him and report to the Preliminary Screener on his fitness to practise and to submit observations or other evidence in regard to this.

Where a doctor agrees to submit to examination the medical examiners are asked to report on his fitness to engage in practice either generally or on a limited basis and on the management of his case which they recommend. When the Preliminary Screener has received their reports these are communicated to the doctor. He is then asked to state within 28 days whether he is prepared voluntarily to undertake to accept the recommendations of the medical examiners as to the management of his case, including any limitations on his practice which they recommend. If he does so, the Preliminary Screener will then normally request a medical supervisor who may already be treating him to monitor the doctor's progress. Provided that the Preliminary Screener is satisfied that the doctor is implementing his undertaking no further action is taken.

It is only when the doctor refuses to be medically examined, or to accept the recommendations of the medical examiners, or if having accepted them he subsequently fails to follow them, that the Preliminary Screener, after consulting at least two other members of the Council appointed for the purpose, may refer the case to the Health Committee. Cases may occasionally be referred to the Health Committee by the Preliminary Proceedings Committee or Professional Conduct Committee where a doctor has been convicted or is alleged to have committed serious professional misconduct, but it appears to either Committee that the fitness to practise of the doctor may be seriously impaired by reason of a physical or mental condition.

The Health Committee is elected annually by the Council and comprises a Chairman, Deputy Chairman, nine other medical members of the Council and one lay member. It meets in private and in most cases the principal evidence before it consists of the reports of the medical examiners. Its proceedings are regulated by rules and are of a judicial nature. The Health Committee is assisted both by a legal assessor and by medical assessors. The medical assessors are chosen by the Preliminary Screener from panels nominated by professional bodies. One medical assessor is chosen having regard to the nature of the physical or mental condition which is alleged to impair the doctor's fitness to practise; the other other is chosen from the same branch of medicine as the doctor whose case is being considered. The Health Committee may if it thinks fit either adjourn consideration of a case or, if it finds that a doctor's fitness to practise is seriously impaired, impose conditions on his registration for a period not exceeding three years or suspend his registration for a period not exceeding 12 months. Cases where conditions have been imposed or a doctor's registration has been suspended are reviewed by the Health Committee from time to time.

There is a right of appeal to the Judicial Committee of the Privy Council from decisions of the Health Committee, but only on a question of law.

REPORTS TO THE GENERAL MEDICAL COUNCIL

If it appears that a doctor's fitness to practise may be seriously impaired by reason of his physical or mental condition it is relevant to bear in mind that action to suspend him from his NHS employment would not necessarily have the effect of encouraging a sick doctor to accept treatment nor would it prevent a doctor from continuing to prescribe drugs of addiction or dependence or from engaging in other forms of medical practice even though he might appear unfit to do so.