SCOTTISH HOME AND HEALTH DEPARTMENT
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Please reply to The Secretary

Circular No. 1982(PCS)8.....

Previous Circular
Cancelled/Amended NHS Circular No 1974 (PCS)54

Our Reference NUE/10/1 Pt A

Date 2 April 1982

Secretaries of Health Boards
Secretary of the Common Services Agency

Dear Sir

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

1. This Circular reminds Health Boards of the procedures to help to prevent harm to patients resulting from physical or mental disability, including addiction, in any medical or dental staff employed in the National Health Service, and revises the guidance contained in NHS Circular No 1974(PCS)54. It covers all medical and dental staff, including honorary staff, in hospitals, in community medicine and dentistry and in the community health service, and includes general practitioners who hold hospital, community medicine or community health appointments; it also includes locum staff.

2. The Secretary of State has considered with representatives of the profession precautionary measures which can be taken to protect patients from harm which might arise from incapacity of medical or dental 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. Action to protect the patients should be taken at the earliest possible stage.

3. The Secretary of State appreciates the difficulty and delicacy of the position of medical and dental staff in the circumstances covered in this Circular. 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 ensure that appropriate action is taken promptly in the circumstances visualised in this Circular.

RECOMMENDED PROCEDURE

4. Most cases can be dealt with on the following lines:-

(a) As soon as a practitioner's colleagues believe that there are reasonable grounds for apprehending a risk of this kind, they, or one of them, should endeavour to give him such confidential advice

as might prevent the risk arising. This advice will be given as from a friend and colleague, and if taken, no further action may be necessary.

(b) If it seems that a practitioner is already a risk, or if the preliminary personal approach as above is unavailing, colleagues should immediately inform the Chairman of the Area Medical Committee, or the Chairman of the Hospital Staff Committee, and the Chief Administrative Medical Officer. (Staff other than medical and dental should normally first approach the most senior member of their discipline in the unit or department). It is for these officers to make such confidential enquiries as are necessary to verify the information and assess the situation. If they are satisfied that the information has substance, the practitioner should be told of the results of the enquiry, but not necessarily of its source, and be given the opportunity to be interviewed by the Chairman of the AMC and the CAMO together. If interviewed, the practitioner, if he wishes, may ask for a professional colleague of his choice to be present, and the CAMO must make it clear to the practitioner that he is being interviewed under the terms of this Circular.

(c) If the Chairman of the AMC and the CAMO agree that there is a risk it should be for the CAMO, after such further consultations as he considers necessary, to decide what, if any, action should be taken. The CAMO should have available to him, assuming the Health Board has implemented the suspension procedures contained in paragraphs 7 and 8 of SHM49/1968, the power to suspend a practitioner from duty where disability is suspected but disciplinary action may not necessarily be envisaged, including the power to take action without consultation where an immediate risk presents itself (see paragraph 5 below).

(d) In areas where there are Districts the information should be given to the Chairman of the District Medical Committee and to the District Medical Officer; if they agree that there is a risk, the CAMO should be informed immediately. The Common Services Agency should make appropriate arrangements after consultation with senior medical staff employed by the Agency.

(e) In the case of dentists, references to the Chief Administrative Dental Office and the appropriate Dental Committees should be substituted.

5. Health Boards are asked to include in their arrangements, after consultation with the 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.

GENERAL MEDICAL COUNCIL

6. Once any immediate risk has been averted, the CAMO should consider whether, in relation to a doctor's employment, 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. In the case of dentists the CADO should consider whether a report to the Registrar of the General Dental Council is justified.

PRIVILEGE AND CONFIDENTIALITY

7. 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 Health Board or the Agency since those persons would, unless actuated by malice, be able to rely 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 Health Board or the Agency will meet the cost of their defence and indemnify them against any damages or costs ordered to be paid in those proceedings.

8. 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 or the Registrar of the General Dental Council) whose duties require them to know of it. Such material should not be made available to any other person or body unless so ordered by a Court or other Authority which has the legal power to make such an order.

DRUG ABUSE

9. Nothing in this Circular affects the advice on the Control of Dangerous Drugs and Poisons in Hospitals contained in the Report of the Joint Sub-Committee of the Central Health Services Council (published by HMSO in 1958, SO Code No 32-447) and commended to Health Boards in SHM 59/2. Paragraphs 86-93 advise that it is in the interests of the employee and of the public that Health Boards should consult the police wherever they have grounds for suspecting that one of their staff is misusing or misappropriating controlled drugs and that the police and not the Health Board should make the enquiries necessary to establish whether drugs are being misused or misappropriated and if so, by whom. Similar action should be taken should suspicion arise in the community health services.

DISCIPLINARY CASES

10. 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 SHM 49/1968 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

11. The recommended procedure described in this Circular can operate only if its existence is known to staff who might be concerned. There is evidence that procedures established after the issue of the 1974 Circular which this replaces are now not known to junior members of the professions. Health Boards are therefore asked to give publicity to such arrangements and periodically to remind those who need to know of them.

12. 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 Health Boards 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 interests of patients. Medical and dental staff employed by Health Boards 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.

13. Any enquiries regarding this Circular should be directed to Miss H Nish, Room 155, (ext 2373) or Mr D Wyman, Room 152 (ext 2632) St Andrew's House, Edinburgh EH1 3DE.

Yours faithfully

M. Maclean

MISS M MACLEAN

Annex

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 in 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 the 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 Prelinary 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 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 Judical Committee of the Privy Council from decisions of the Health Committee, but only on a question of law.

Reports to 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.