

15 January 2006

Sean Doohan  
Scottish Executive Health Department  
Public Health Team  
3E(S), St Andrew's House  
Regent Road  
Edinburgh  
EH1 3FDG

Dear Mr Doohan,

**GMC Response to the Consultation on Public Health Legislation**

We thank the Scottish Executive for the opportunity to respond to the consultation on public health legislation in Scotland and hope that the enclosed submission is useful in developing policy. We will restrict our comments to aspects of the proposals which pertain to the regulation of the medical profession, as fits our remit.

I hope that this response is useful to you. If you have any questions regarding the response or the GMC please do not hesitate to contact me.

Yours sincerely

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## Public Health Legislation in Scotland: A Consultation

### Submission to the Scottish Executive Public Health Team

#### Comments on proposals in Chapter 3

1. Paragraph 3.10 proposes that the NHS would assume responsibility for taking forward any necessary legal proceedings and consequent action in relation to medically examining someone suspected of suffering from, or carrying, an organism capable of causing a serious infectious disease, if that person refuses such an examination.
2. Powers of compulsory examination already exist in law. The consultation document makes clear at paragraph 6.6 that a detained person will still be able to, as at present, refuse medical treatment. However, what is less clear from the consultation is whether the power of compulsory examination includes a power of compulsory *testing* as distinct from examination. A proposal for compulsory testing would carry serious implications. As the law currently stands taking blood from a patient without their consent may leave a doctor open to criminal charges. Any change to the law in this regard would need to be developed in the context of human rights legislation and the European Convention of Human Rights (ECHR). While the consultation document refers to the need to do this, much more detailed work will naturally require to be undertaken to explore whether and how the proposal might be made compatible with the ECHR.
3. The Scottish Executive's Working Group to address the needs of those potentially exposed to a blood-borne virus investigated similar issues in its first report *Advice to the Scottish Executive on Mandatory Blood Testing* which was published on 7 March 2006. The report recommended against mandatory testing. We had input to the report and its considerations may be worth revisiting in the context of the proposal at 3.10.
4. The proposal may also face a further problem given existing Scottish law. A key underlying principle in the Adults with Incapacity (Scotland) Act 2000 is that any proposed intervention in relation to an incapacitated adult must be in *that person's* best interests (emphasis added). It would appear that the Act does not permit testing samples from incapacitated patients solely for the benefit of a third party. It would seem logical that the same legal problem will apply to any attempt to test a patient in similar circumstances for the purpose of public health work. We are currently working

with the Patients and Quality team at the Scottish Executive to clarify the legal position, given our concerns that testing existing samples of patients with incapacity for the benefit of a healthcare professional who may have suffered a needlestick injury, for example, would currently be unlawful in Scotland.

5. Paragraph 3.22 states that the Faculty of Public Health of the Royal Colleges of Physicians has recognised that public health specialists need not be doctors, if they can demonstrate a similar level of knowledge and competency, and meet accreditation requirements, which are equivalent to those set for doctors as specialists by the General Medical Council (GMC). Proposals are made around the functions of such a role and the qualifications required to fulfill it. This proposal is a matter for public policy and as such we have no comment to make on it.

#### **Comments on proposals in Chapter 4**

6. Paragraph 4.10 proposes that a statutory duty would be placed on doctors to inform their local NHS Board and their patients of a notifiable condition. The proposal does not materially alter the current position in law. However paragraph 4.10 goes on to propose that information about individuals could be shared if necessary with a third party if the third party organisation needs to know to take measures to reduce the risk to public health.

7. We are pleased to see that paragraph 4.22 explicitly refers to our guidance *Confidentiality: Protecting and Providing Information*. Our guidance is also relevant to this proposal. Paragraphs 22 to 26, *Disclosures in the public interest*, state that in some circumstances personal information may be disclosed in the public interest without the patient's consent but that the benefits of doing so must be weighed against the possible harm to the patient and to the overall level of trust between doctors and patients. If practicable data should be anonymised and even in the case of communicable diseases, if there is sufficient time, consent should be sought.

8. In cases where a disclosure is to be made patients should be informed wherever it is practicable to do so and actions and reasons should be documented in the patient's records. We may require a doctor to justify their actions if a complaint is made about the disclosure of identifiable information without a patient's consent.

9. In relation to the proposals at 4.10, paragraph 4.11 proposes that notifications of listed conditions be made within a time limit specified in regulations and that failure to notify within the time limit would constitute an offence.

10. We are of the opinion that the first measure in trying to change or encourage behaviour is to tackle levels of knowledge and awareness and culture. A programme of education for doctors, patients and the public about the need for some of the measures proposed in the consultation may render a higher level of compliance than the threat or attempted enforcement of punitive legislation.

11. The kinds of conditions subject to statutory notification are changed radically in a proposal at paragraph 4.18 to define a statutory reportable condition as 'a disease of public health significance or specific measurable factors leading to its occurrence, knowledge of which will facilitate the planning and delivery of services to

prevent or treat it'. A statutory duty on certain organisations to report numbers and details about those suffering from a notifiable condition is proposed. This duty would pre-empt the need for individual consent.

12. This proposal opens up the possibility that personal information on a large proportion of the population will be kept by service planners. On this matter we would again refer you to our guidance *Confidentiality: Protecting and Providing Information*. Under *Patient's right to confidentiality, Principles*, paragraph 1, in the introduction to the guidance we state that confidentiality is central to trust between doctors and patients and that without assurances of confidentiality patients may be reluctant to give doctors the information they need in order to provide good care. Paragraph 1 goes on to state that a doctor must anonymise data where this will serve the purpose for which the data is to be disclosed.

13. Paragraph 4.20 proposes that legislation similar to Section 60 of the Health and Social Care Act 2002 be adopted in Scotland. This would allow the details of individuals at risk of v CJD and other "at risk" individuals to be placed on a database for the purpose of tracking, with or without their consent. We are broadly supportive of the need for such legislation. Section 60 of the Act set up the Patient Information Advisory Group which advises government ministers on the circumstances in which patient-identifiable information should be permitted. It is a useful mechanism for decision making on such matters.

14. Paragraph 4.22 lists issues and documents to be taken into account when considering whether a condition should be made notifiable. The list includes the GMC' guidance *Serious Communicable Diseases and Confidentiality: Protecting and Providing Information*. We are pleased to see a direct reference to our guidance. However, we must inform you that *Serious Communicable Diseases* has, in fact, been made redundant by recent legislative changes. Of particular relevance are paragraphs 8 - 11 of our guidance. These stated that in certain circumstances a doctor may test existing samples for serious communicable diseases from a patient who is unconscious, refuses testing or is unable to give or withhold consent because of mental illness or disability without their prior consent. This was explicitly for the benefit of health care workers who have suffered exposure to body fluids. As was referred to at paragraph 4 of this response, a key underlying principle in the Adults with Incapacity (Scotland) Act 2000 is that any proposed intervention in relation to an incapacitated adult must be in that person's best interests. It would appear that the law does not permit testing samples from incapacitated patients solely for the benefit of a third party.

15. Our guidance, *Confidentiality: Protecting and Providing Information*, states that a doctor must disclose information to satisfy a statutory requirement, such as notification of a communicable disease (paragraph 18). Our guidance states that patients should be informed about such disclosures, wherever that is practicable, but their consent is not required.

#### **Comments on proposals in Chapter 5**

16. This chapter explores the problem of individuals or organisations withholding information which might be vital to determining the risk to others of exposure to

infection or hazard. This may happen where, for example, a doctor is afraid that the information may lead to accusations of malpractice. Paragraph 5.5 therefore proposes that triggers for divulging information are clarified and that penalties for not divulging information in such circumstances are introduced, subject to an appeals procedure.

17. As discussed in paragraph 10 of this response we are of the opinion that recourse to punitive legislation should be the last resort and that efforts to educate doctors about the need to divulge information in these circumstances is preferable.

#### **Comments on proposals in Chapter 6**

18. Paragraphs 6.11 -14 propose a power to quarantine. The consultation paper emphasises that there should be safeguards against the inappropriate use of quarantine powers and that any decision to impose a quarantine must reflect human rights. It recognises that there will often be problems in demonstrating that the use of such a power is proportionate to the threat.

19. Quarantines as proposed would be imposed by a Sheriff, be for a maximum of 3 weeks at a time and include compulsory contact with health professionals. Quarantines would be subject to an appeals process.

20. We note that the consultation document acknowledges that there are serious human rights implications arising from this proposal. We look forward to more detail on how the Executive intends to develop the proposal to comply with the ECHR.

#### **Comments on proposals in Chapter 10**

21. Paragraphs 10.3 and 10.9 discuss the transfer of information including details of patients to authorities other than NHS organisations. In England and Wales Regulation 12 of the Public Health (Infectious Diseases) Regulations (England and Wales) Act 1988 allows patient confidentiality to be overridden for the purpose of preventing the spread of disease. Paragraph 10.9 proposes that similar legislation be introduced in Scotland. The fact that such legislation must be compliant with the Data Protection Act and the ECHR is acknowledged along with the dangers in such an approach for the erosion of the trust that patients put in doctors to maintain their confidentiality.

22. As with the proposal at paragraph 18 of this response, we note that the Executive acknowledges the difficult issues associated with the proposal and we look forward to further detail.