Freedom of Information Act 2000 (FOIA)

Decision notice

Date: 24 November 2015

Public Authority: The Parliamentary and Health Service Ombudsman

Address: Millbank Tower
Millbank
London
SW1P 4QP

Decision (including any steps ordered)

1. The complainant has requested the details of a particular psychiatrist who is employed by the Parliamentary and Health Service Ombudsman (PHSO) as a clinical adviser. The complaint to the Commissioner focussed on the complainant's right of access to the name and General Medical Council (GMC) number of that psychiatrist. The PHSO refused to provide these details under section 40(2), the exemption relating to personal information.

2. The Commissioner's decision is that the PHSO is entitled to rely on section 40(2) to withhold this information.

3. The Commissioner does not require the public authority to take any further action in this matter.

Request and response

4. On 24 January 2015, the complainant sent three emails to the PHSO containing a number of information requests relating to the identity, qualifications and experience of its clinical advisers. One email contained a request made in the following terms:

> "I want to know the psychiatrists details including their year of each qualifications and details of NHS previously and currently

worked for and any other private, locum or freelance work undertaken."

5. Another of the emails contained the request below:

> "I would like the GMC numbers of the psychiatry doctors working for PHSO giving erroneous and deficient advice about capacity which needs to be taken to the GMC."

6. The PHSO responded to both these and other requests on the 19 February 2015. It provided some information on the qualifications held by its clinical advisers together with the year each of them qualified. These details were anonymised. The name of the doctors and their GMC numbers were withheld under section 40(2).

7. The complainant asked for an internal review which the PHSO completed on the 14 April 2015. It upheld its decision to withhold the names and GMC numbers of the doctors in question under section 40(2).

Background

8. Amongst other things, the PHSO looks into complaints about the service individuals have received from NHS bodies.

9. The complainant complained to a local NHS Trust about the care it was providing to one of his relatives. Normally the consent of the individual concerned is required before a complaint can be made on their behalf. In the circumstances of this case, the Trust had to consider whether his relative had the mental capacity to manage their own affairs and, if so, whether they had given their consent to the complainant acting on their behalf in this matter. It was decided that the relative did have the necessary mental capacity and as they had not given their consent to the complainant acting on their behalf the Trust was reluctant to correspond with the complainant over his concerns. This led to the complainant making a complaint to the PHSO about the Trust's failure to deal with his concerns over the care his relative was receiving. This inevitably involved consideration of the capacity assessment that the Trust had carried out.

10. The PHSO carried out an investigation but the complainant was dissatisfied with the conclusion that the Ombudsman reached.

Scope of the case

11. The complainant corresponded with the PHSO about this and related matters over a period of time, during which he made a number of requests for information. These included subject access requests for his own personal data under the Data Protection Act 1998 as well as more general requests made under FOIA. When the complainant raised concerns over how these requests had been handled there was initially some confusion over which responses related to which requests and whether those responses had subsequently been reviewed. In his letter of complaint to the Commissioner the complainant provided a copy of one particular email which he had sent the PHSO on the 24 January 2015. This contained the first request, as referred to in paragraph 4 above. The Commissioner is satisfied that although the request was prompted by the complainant's dissatisfaction with the PHSO's conclusion in respect of the complaint he had raised with them, the request did not itself relate to that specific complaint; it was more general in that it sought information about any psychiatrist acting as clinical advisers for the PHSO.

12. The complainant later narrowed the scope of his request down to focus upon the name and GMC number of the PHSO psychiatrist who reviewed the Trust's decision regarding the capacity of his relative.

13. The Commissioner is satisfied that the request initially bought to his attention by the complainant is wide enough to include the name and GMC number of that psychiatrist as it seeks, "…the psychiatrists details …". The request may go onto focus on their qualifications and experience, but this is not necessarily to the exclusion of the name and GMC numbers of the psychiatrists, including the one of who gave advice on the case bought by the complainant.

14. In any event during the course of the Commissioner's investigation the PHSO provided details of all the requests it had received from the complainant on 24 January 2015 and it emerged that he had made a clear request for the GMC numbers of the psychiatry doctors working for the Ombudsman. This is the quoted in paragraph 5 above.

15. Therefore the Commissioner is satisfied that the complainant made a request for information which included the name and GMC number of the psychiatrist in question on 24 January 2015. The Commissioner is also satisfied that in the terms those two requests were made they fall to be considered under FOIA, rather than being for information contained in the case file relating to his complaint about the Trust. The matter to be decided therefore is whether the PHSO is entitled to withhold the name of the particular psychiatrist under section 40(2).

16. The complainant did make requests for information contained in the PHSO's case file, but these were dealt with under the subject access provisions of the Data Protection Act. The PHSO's handling of those requests is not addressed in this notice.

Reasons for decision

17. Section 40(2) of FOIA states that the personal data of someone other than the person making the request is exempt if its disclosure to a member of the public would breach any of the data protection principles set out in the Data Protection Act 1998 (DPA).

18. For the exemption to apply the withheld information must first be personal data. Personal data is defined in section 1 of the DPA and, as far as is relevant to this case, constitutes information which relates to a living individual who can be identified from that data. The Commissioner finds that the withheld information is clearly the personal data of the psychiatrist.

19. The second element of section 40(2) is that the disclosure of this personal data must contravene at least one of the data protection principles. In this case the PHSO claims that disclosing the information would breach the first principle. The first principle states that personal data shall be processed fairly and lawfully and, in particular shall not be processed unless at least one of conditions in Schedule 2 is met. The term 'processing' includes the disclosure of information from one party to another. It is important to recognise that the test established by section 40(2) is whether disclosing the withheld information **to a member of the public** would contravene the principles. The circumstances of the actual requestor are not relevant when considering whether the disclosure would be fair and lawful.

20. The Commissioner's approach when considering the first principle is to start by looking at whether the disclosure would be fair. Only if the Commissioner finds that it would be fair will he go on to look at lawfulness or whether a Schedule 2 condition can be satisfied.

21. 'Fairness' is a difficult concept to define. It involves consideration of:

    - The possible consequences of disclosure to the individual.
    - The reasonable expectations of the individual regarding how their personal data will be used.

- The legitimate interests in the public having access to the information and the balance between these and the rights and freedoms of the particular individual.

Often these factors are interrelated.

22. The PHSO has explained that where an individual is not happy with the outcome of an investigation the clinician who provided advice on that case will often become the focus of their dissatisfaction. This is despite the fact that the clinician is not responsible for the actual conclusion; their role is limited to providing advice which is then considered by a decision maker. The final decision on a case is a corporate one and not one which the clinical adviser is personally responsible for.

23. Complaints to the PHSO are in effect the final stage of the complaint process in respect of NHS bodies and therefore those who take their concerns all the way to the PHSO have already proved themselves to be persistent in the pursuit of their grievance. There is nothing wrong in such fortitude except where that persistence becomes misdirected. The PHSO argues that where it is misdirected against an individual clinical adviser the consequences for that adviser can be significant.

24. This misdirected dissatisfaction can manifest itself in a number of ways. Complaints may be made to the GMC. The Commissioner recognises that being the subject of such a complaint would be very distressing to a clinician. However the Commissioner also assumes that the GMC investigates such complaints in a fair and proportionate manner and this should reduce the anxiety caused. Nevertheless, the Commissioner does accept that because of the nature of the work clinical advisers undertake and the fact people often hold them responsible for the PHSO's decisions, they are at risk of attracting more complaints than other medical professionals.

25. Dissatisfied individuals may also seek to challenge the decision with the clinician directly. The PHSO has stated that in cases where the clinician's details were known, attempts had been made to contact the clinician in their other places of work (most of the clinical advisers practise medicine in other areas of the NHS as well as being employed by the PHSO), or even at their homes. It is also possible for a disgruntled individual to pursue an internet based campaign against clinicians. The PHSO has experience of one of its complainant's 'naming and shaming' those involved in a case on line. Such behaviour is not only distressing to the subject of the campaign, the PHSO has argued that it can have a real impact on the ability of the adviser to carry out their other NHS roles. Internet campaigns could impact on the therapeutic relationship between the doctor and their other patients by undermining the trust between doctor and patient.

26. The Commissioner accepts the PHSO's arguments that its clinical advisers could easily become the focus of dissatisfaction in the ways described.

27. When raising its concerns over the possible consequences of disclosure, the PHSO also explained that it would struggle to recruit clinicians if it was forced to disclose their names and GMC numbers. The problems that disclosing the information would cause to the PHSO and its ability to carry out its functions are not directly relevant to the application of section 40(2). The exemption serves to protect the interests of the data subjects themselves, not the work of the PHSO. Nevertheless these concerns are indicative of the level of anxiety that the PHSO believes its clinical advisers have over the release of their personal details.

28. The reasonable expectations of the clinical adviser as to whether this information would be disclosed to the public are shaped in part by the consequences of disclosure as discussed above. They are also shaped by the working practices of the PHSO and what the PHSO has told their clinical advisers in respect of when their details will be disclosed.

29. However before looking in more detail about a doctor's expectations as to when and to whom their name and GMC number will be disclosed, the Commissioner will consider some more basic principles. As a general rule individuals should have a greater expectation that information about their professional life is more likely to be disclosed than information on their personal life. That expectation is greater still where that individual's role is public facing and where they are employed in a senior role.

30. Clearly this information relates to the psychiatrist's professional life. Furthermore it may be anticipated that they would be employed on a relatively senior grade. However the Commissioner is satisfied that clinical advisers are not decision makers within the PHSO even though the advice they provided will be often be very influential. Although the role may attract a senior grade this reflects their specialism and expertise rather than their responsibility for decision making. They do not perform a public facing role.

31. Turning to the specifics of the actual information requested which includes the clinician's GMC number, the GMC is responsible for determining whether clinicians are fit to practise in the UK. It investigates complaints about doctors and maintains a register of medical practitioners in the UK which the public can be search by use of a doctor's name or GMC number. The register includes details of the doctor's primary medical degree, their status on the register including whether they have a certificate to practise, the date they were registered, publicly available information about any complaints against

them, and whether they are listed on the general practitioner register or the specialist register. Where a doctor is on the specialist register it may also show what that specialism is, for example, psychiatry. The purpose of the register is to reassure the public that the medical professionals who treat them are qualified and registered to practise. It is understood that doctors are advised that it is good medical practise to provide their name and GMC number when asked. This would allow the patient to check the register and also to accurately identify the doctor should they wish to complain to the GMC about the care they have received. In light of this it might be assumed that doctors working as clinical advisers would expect the PHSO to provide their names and GMC numbers on request.

32. However the PHSO draws a distinction between where a doctor is actually treating a patient and therefore has a direct doctor/patient relationship with that individual and the role clinical adviser's play within the PHSO where they are merely providing advice, usually based on paper submissions, to enable another officer to make a decision on a complaint. The PHSO argues that in these circumstances there is no obligation for a doctor to provide their name and GMC.

33. The Commissioner sought the views of the GMC on this matter. The GMC advised the Commissioner that it did not produce guidance on what information about doctor's organisations such as the PHSO should disclose. They did however make the point that their guidance to doctors was that they should provide their name and GMC details to those they have contact with in their professional role. Doctors are certainly working in a professional role when providing clinical advice to the PHSO, however the Commissioner notes that they do not have direct contact with those who are either the subject of the complaint or who raised the complaint. The Commissioner finds this supports the PHSO's contention that the expectation to provide names and GMC numbers relates primarily to where there is a direct relationship between the doctor and the requestor as in a doctor/patient relationship.

34. The Commissioner asked the PHSO to explain what it tells its clinical advisers in respect of the circumstances in which their names and GMC numbers would be disclosed. It is clear that clinical advisers are not given an absolute assurance that their details will never be released. The PHSO deals with a range of complaints about the healthcare provided by NHS bodies. The more involved cases are dealt with by the Complex Investigations Directorate and the role of the adviser in such cases will often be very prominent. As a consequence it is the expectation of clinical advisers that they will be named in the resulting report unless there is an overriding reason not to do so. These reports are provided to the individual who was the subject of the complaint and the individual who made the complaint. This is set out in the PHSO's

internal casework guidance. Both summaries of these reports and more detailed versions of the reports are published on the PHSO website but the names of any clinical advisers involved are not included in those versions.

35. The PHSO has advised the Commissioner that last year the Complex Investigations Directorate handled 209 cases, representing less than 16% of the complaints it received about NHS bodies. Only a minority of these would have required input from psychiatric clinical advisers.

36. In less complex cases, requiring less detailed advice, there is no assumption that names and GMC numbers will be released. The decision whether to include these details in the final report is taken on a case by case basis after considering the views of the adviser and any risk factors arising out of the case.

37. The Commissioner is not aware of any restrictions on the wider dissemination of reports placed on those who receive them. Therefore, in theory, it is possible that the names of at least some clinical advisers could have been communicated more widely. However the risk and consequences of this occurring would have been taken account of when deciding whether to include these details in the report. Importantly the names and GMC numbers have not been placed directly in to the public domain. From a very practical point of view this means that it is unlikely that these details will be available to those who may focus their dissatisfaction with a decision of the PHSO on the clinical adviser involved in that case. Therefore by having the ability to make case by case decisions about when it is appropriate to release names and GMC numbers the PHSO effectively safeguards the interests of the clinical advisers.

38. Furthermore the PHSO has argued that in practice the sensitive nature of its investigations and subsequent reports means that the parties involved are unlikely to share the reports more widely or make them public. Therefore the PHSO does not consider the names or GMC numbers of its clinical advisers to be in the public domain.

39. A disclosure under FOIA on the other hand is considered to be a disclosure to the world at large and if the PHSO was required to provide this information to the current complainant it would in effect have to provide these details to other applicants. This would make it available to those who would focus any grievance they had with the PHSO on the clinical adviser. The Commissioner finds that despite being aware that there are circumstances in which the requested information would be released, the clinical advisers, including the particular psychiatrist to which this request relates, would not expect their details to be released into the public domain.

40. Finally the Commissioner will balance the legitimate interests of the public in having access to the requested information against the rights and freedoms of the particular clinical adviser.

41. Providing the name and GMC number of the psychiatrist, or any other clinical adviser, would allow members of the public to confirm for themselves that the clinician was registered to practise in the UK and glean the other details of their work history that the GMC considered appropriate to publish. The PHSO has advised the Commissioner that in this case, as in others, it did provide the complainant with details of the psychiatrist's qualifications and background in order to reassure him that the clinician had the appropriate skills and experience to provide advice on his case. The willingness of the PHSO to volunteer such information goes some way to meeting this public interest. It does not however fully satisfy that interest as there remains some value in any member of the public being able to scrutinise an authoritative and independent source of information on the fitness of clinical advisers employed by the PHSO such as that provided by the GMC's register of medical practitioners. This would increase the public's confidence in the PHSO's ability to carry out its important role.

42. The complainant appears to believe that the advice provided by the clinical adviser was wrong, but has not explained in what way. Providing the name and GMC number of the adviser would enable him to raise any concerns they have over the performance of clinician with the GMC. However as explained earlier, the conclusions reached by the PHSO are not the responsibility of clinical advisers, the decisions are taken by others and the responsibility rests with the PHSO as a whole, the PHSO describe them as 'corporate decisions'. Therefore the PHSO argues that if someone is dissatisfied with the conclusion of one of its investigations the appropriate means of challenging that corporate decision is through the PHSO's internal complaints process. Therefore it appears that there are alternative means of addressing the complainant's concerns other than providing the requested details.

43. In support of its position the PHSO has informed the Commissioner that in the past where complaints have been made to the GMC about doctors acting in their capacity as clinical advisers, the complainants have been directed back to the PHSO and its own internal complaints procedure. It should be noted though that the GMC's position is that the decision whether to proceed with a complaint is based on the substance of the complaint. It appears that any re-direction back to the PHSO is not automatic. Therefore it is possible there may be situations where the GMC considered it appropriate to investigate concerns about a doctor acting in their role as a clinical adviser for the PHSO and so there is some legitimate interest in providing the requested information in order to facilitate complaints to the GMC. However the Commissioner

considers that the issues which it would be appropriate for the GMC to investigate are most likely to arise from an investigation which had been dealt with by the Complex Investigations Directorate, in which case the normal practice would be for the name of the clinical adviser to be disclosed to the person who bought the complaint and the subject of the complaint.

44. In his correspondence with the PHSO about his various requests the complainant has suggested that there is a suspicion of wrong doing. It is not clear whether he believes this wrong doing was on behalf of the PHSO as a body, or on the particular clinical adviser. Nevertheless the complainant has identified the suspicion of wrong doing as being a factor in favour of disclosing the information he seeks and has referred to the Commissioner's guidance on the public interest test. This guidance relates to the public interest test as set out in section 2 of FOIA. That test applies to the majority, but not all, the grounds for withholding information. Although section 40(2) is one of those exemptions which is not subject to the public interest test, the balancing of the legitimate interests in accessing the information against the rights of the individual that the information relates to, has similarities to this test. However, as explained in the Commissioner's guidance, any suspicion of wrong doing has to more than a mere allegation of wrong doing; there has to be some plausible basis for that suspicion. In the absence of any grounds in support of the complainant's suspicions the Commissioner has not given any weight to this factor.

45. There is some value in providing the name and GMC number of clinical advisers to the public, this is limited though and relates mainly to allowing the public to satisfy themselves that the advisers are on the register of medical practitioners. This has to be balanced against the intrusion disclosing the information would have on clinical advisers and in particular the psychiatrist who is the subject of this request.

46. In conclusion the Commissioner is satisfied there is a real risk that clinical advisers would be vulnerable to harassment, either by being directly contacted by those dissatisfied with the PHSO's findings or by internet campaigns. It is not simply that this would be distressing; it could also have an impact on the ability of the clinical adviser to perform their other NHS roles. As a consequence the clinical adviser would have a reasonable expectation that their names and GMC number would only be made available on a case by case basis. Although there is some public interest in disclosing this information it does not outweigh the potential consequences for the adviser. The Commissioner finds that the disclosure would be unfair and therefore breach the first data protection principle. The Commissioner does not require the PHSO to take any further action in this matter.

Right of appeal

47. Either party has the right to appeal against this decision notice to the First-tier Tribunal (Information Rights). Information about the appeals process may be obtained from:

    First-tier Tribunal (Information Rights)
    GRC & GRP Tribunals,
    PO Box 9300,
    LEICESTER,
    LE1 8DJ

    Tel: 0300 1234504
    Fax: 0870 739 5836
    Email: GRC@hmcts.gsi.gov.uk
    Website: www.justice.gov.uk/tribunals/general-regulatory-chamber

48. If you wish to appeal against a decision notice, you can obtain information on how to appeal along with the relevant forms from the Information Tribunal website.

49. Any Notice of Appeal should be served on the Tribunal within 28 (calendar) days of the date on which this decision notice is sent.

Signed .....

Pamela Clements
Group Manager
Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF