I rise to support the amendment in the name of the hon. Member for Easington, a fellow member of the Health Committee. The Minister will know that the greatest health inequalities in our society relate to people with severe mental illness. Men with severe mental illness are likely to die 20 years earlier, and for women the figure is 15 years. That is almost entirely due to physical health problems, not mental health problems. The hon. Gentleman eloquently outlined a series of issues relating to people who have been detained against their will under the Mental Health Act 1983. We need to prevent readmissions under the 1983 Act, but there are other issues that we must consider. People’s circumstances are critical, and we need to ensure that they do not drift into becoming rough sleepers.

The issue of interpretation is not irrelevant, as we saw in the case of R (Mwanza) v. Greenwich. We should remove the line in the Bill to which the hon. Gentleman’s amendment refers, and the word “both” in the line above it is also problematic, because it would mean that both those circumstances would have to be present. Somebody who assesses an individual with mental health problems may see them when they are relatively well. However, mental health conditions can be variable, and just because somebody at the point of assessment is not acutely unwell and their condition is controlled, that does not mean they are not acutely at risk. I ask the Minister to look again at the clause because there are already issues of interpretation. If we are to achieve what we want from section 117 of the 1983 Act, I urge the Minister to look at it again, because it is already causing problems and we have the opportunity to use the Bill to clarify it. I hope the Minister will address those matters in his response.

Dr Wollaston: I want to return to the earlier point about unintended consequences and the extraordinary difficulties faced by clinicians. Of course, everyone in the room and beyond wants to see a culture change so that doctors feel that openness to a discussion of issues is a marker of success and good professional practice. Such problems, however, are deeply rooted in health care.

We only need to go back to the 1990s, for example, and look at the words of Professor Bolsin, the whistleblower in the Bristol heart scandal. He said that the real scandal in Bristol was not that no one knew, but that everyone knew and did nothing about it. The point is that Professor Bolsin raised the matter individually and repeatedly, but the system refused to listen. There was a systematic cover-up. That is why having the statutory duty of candour applying to organisations is where this issue has to lie. Culture comes from the top in such organisations. The real difficulty with an individual statutory duty of candour is that we will be asking courts to make complex decisions on professional judgments made in the heat of the moment, and those are often better handled by the General Medical Council. The
General Medical Council needs to improve its act. Be under no illusion, there is nothing that spooks doctors more than an envelope from the General Medical Council. It is a major sanction to face losing the ability to practise professionally.

We need the GMC to muscle up and be more aggressive in the action it takes against doctors. It needs not only to act against doctors who are behaving in an unprofessional manner, but to make it clear that doctors are behaving unprofessionally if they knowingly look away when a colleague is behaving unprofessionally.

Mr Reed: The hon. Lady is making a genuinely telling point. However, did not Robert Francis go out of his way to point out in great detail that the system she describes did not spot the failures that happened at Mid Staffs and that, it could be argued, we still see?

Dr Wollaston: Indeed. We are all aiming for how to get where we want to be with the fewest unintended consequences. I understand that patients expect and deserve all doctors and health professionals to be open and honest with them. However, I honestly believe that we are going to get there with fewer unintended consequences through reform of the way in which the GMC handles it.

Doctors could retreat back into a defensive position if they know that, by raising professional concerns about a colleague, criminal sanctions could be involved if they have not been candid. The difficulty is where to draw the line. Clinical judgments are quite difficult. What genuinely felt like the right decision in the heat of the moment may turn out to be wrong in retrospect. At what point on that scale does the doctor discuss that with the patient? I would like to see all those issues discussed with patients, but at what point would someone be criminally liable for not doing that? Those are very difficult issues and I think they are best dealt with through the GMC and professional guidance rather than through the clunky tool of a statutory individual responsibility. Having worked in clinical practice, I think there would be unintended consequences.

Liz Kendall: I am seriously listening to the hon. Lady's points. Why does she think Francis recommended this measure?

Dr Wollaston: Of course, I have huge respect for the work of Robert Francis. I think we should take forward almost all his points; in fact, the Government are taking forward almost the entire report. Careful consideration was given to this point. The Government's job is to listen to all the other stakeholders involved.

It may be that, if the culture change we are looking for does not take place through the Bill, we have to move towards that. I think a better route to go down in the first instance is letting the GMC make changes and looking at measures that would genuinely protect whistleblowers. I accept that that might not be strong enough and that we might need to move to a statutory individual duty in future. I just think that, in the short term, we would have unintended consequences and could risk going backwards.

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