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A nation of box tickers and informants — does that sound like a police state?

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Prime Minister Tony Blair may well be anxious about the nature of his "legacy" to the nation but that left by Harold Shipman is clear and unambiguous: never again will those in positions of authority or in the regulatory bodies or, indeed, fellow pharmacists, neighbours and friends be allowed to overlook failings in the behaviour or competence of health care professionals.

Pharmacists are probably now aware of the radical proposals in the White Paper on regulation of health professionals to create a General Pharmaceutical Council (GPC). What they are less likely to have appreciated is the additional detail in the Shipman-related White Papers issued at the same time. When these are taken together, I am reminded of the remark made by Dame Janet Smith at the British Pharmaceutical Conference in 2005 after she had outlined the proposals made in the fourth and fifth reports under her chairmanship of the Shipman Inquiry: "And if that sounds like a police state, well, so be it."

Few of us would argue that patient safety is not a paramount consideration in the provision of health care. Conversely, many of us may have thought that the activities of Shipman were a one-off. Well, a study of the report covering the inquiries held on Drs Ayling, Neale, Kerr and Haslam may disabuse us of that belief. The same tolerance of poor performance and eccentric behaviour, the same failure to ask proper questions or to link related information and, overall, an unwillingness to contemplate the unthinkable — that a health professional could be capable of deliberate harm to patients — occurs throughout them all. So we have in response an enormous "action programme" to address these shortcomings within which the separation of the Royal Pharmaceutical Society is merely a minor component. True, the White Papers are at pains to stress that "it will never be possible to give complete protection but [this programme will] make it highly unlikely that any future criminal could continue for long without detection". References are made to the human rights of health professionals and the need for balance in the disclosure of information about their alleged failings but there are many features in the White Papers and in our own Pharmacists and Pharmacy Technicians Order that should give us pause for thought.

The action programme is big on whistle-blowing and the sharing of "concerns" about the activities of health professionals. Much attention is given to the duty on all health professionals to report each other, including proposals to discuss with regulators and universities how this duty can be further emphasised, especially to undergraduates. The Society (or its successor GPC) already has remarkable powers, unaltered despite many objections during consultation, to require anyone — be they spouses, relatives, friends or colleagues — to provide information relating to a pharmacist's fitness to practise. Failure to comply with such a requirement within 14 days may see a pharmacist in court. No matter that he or she may have sought advice from the Listening Friends helpline or a defence association: unless the information disclosed was to a lawyer in anticipation of legal action (the so called legal privilege), disclosure can be demanded.

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Where, then, is the anxious pharmacist to obtain help and guidance? Certainly not from his NHS trust or primary care trust, which will be collating ad hoc "expressions of concern" (valid or not) in the files they will be required to hold on "each of their professional employees or for health professionals performing services to patients for whom they are responsible". Health care bodies already have a legal duty to share "concerns" about health professionals and possible misuse or diversion of Controlled Drugs; it is proposed to extend this duty to include potential threats to patient safety. Approaching the Society in its current format (or the GPC in the future) would also be unwise. Once the Society is in possession of information that suggests that the fitness to practise of a pharmacist might be impaired, it is obliged to inform the pharmacist's employer or contracting PCT and the relevant Government minister. Extraordinarily, this happens before the investigations committee even gets as far as determining that there is prima facie evidence of a case to answer. Maybe these measures will be implemented with compassion and common sense but they are hardly consistent with the legal tenet of being "presumed innocent before being proved guilty" or a human right to a private life.

The complaints regulations are to be amended to allow patients to complain to PCTs about GP practices although "natural justice" would mean in general they would not be able to maintain their anonymity; health professionals should have the opportunity to respond to any allegations made against them. Although not explicitly stated, this approach should certainly apply to complaints about pharmacists made to the PCTs (and to the Society) which is not always the case. Plans to introduce training for those trust employees who undertake investigations, to involve the Council for Healthcare Regulatory Excellence in developing this training, to encourage employers (and the Society) to consider "remediation" and to place less reliance on suspension are all to be welcomed. Rather less welcome (at least in the world of community pharmacy) are proposed requirements that the chief executive of every health care organisation — including those in the private or voluntary sectors — "produce and publish an annual report to its board on the lessons learned from medical errors and complaints and the action that has been put in place as a result", and a proposal that PCTs should be "guaranteed unfettered access to all patient records" albeit with a later caveat about agreeing criteria and safeguards in a code of practice.

Pharmacists in the managed service should already be accustomed to audit by the Healthcare Commission against core and developmental "Standards for better health". The Government proposes to extend the application of these standards to "providers of non-medical health care" and to require registration of all providers of health care, including GP practices; community pharmacies are not mentioned. Innovative treatment is to be monitored with a requirement for clinical governance committees to be aware of (and presumably sanction) "all new and innovative treatments" used by clinicians.

It may be that this action programme will prove to be a proportionate and workable response to the scandals of Shipman and his fellow rogue doctors. It may be that the sweeping powers given to regulators and health care bodies will be used in accordance with proper "risk based proportionality, accountability, consistency, transparency and targeting". It may be that the 56 bodies identified by the NHS Confederation as having a role in inspection, assessing and monitoring the NHS will work with each other and will not become over-burdensome. I just doubt it.