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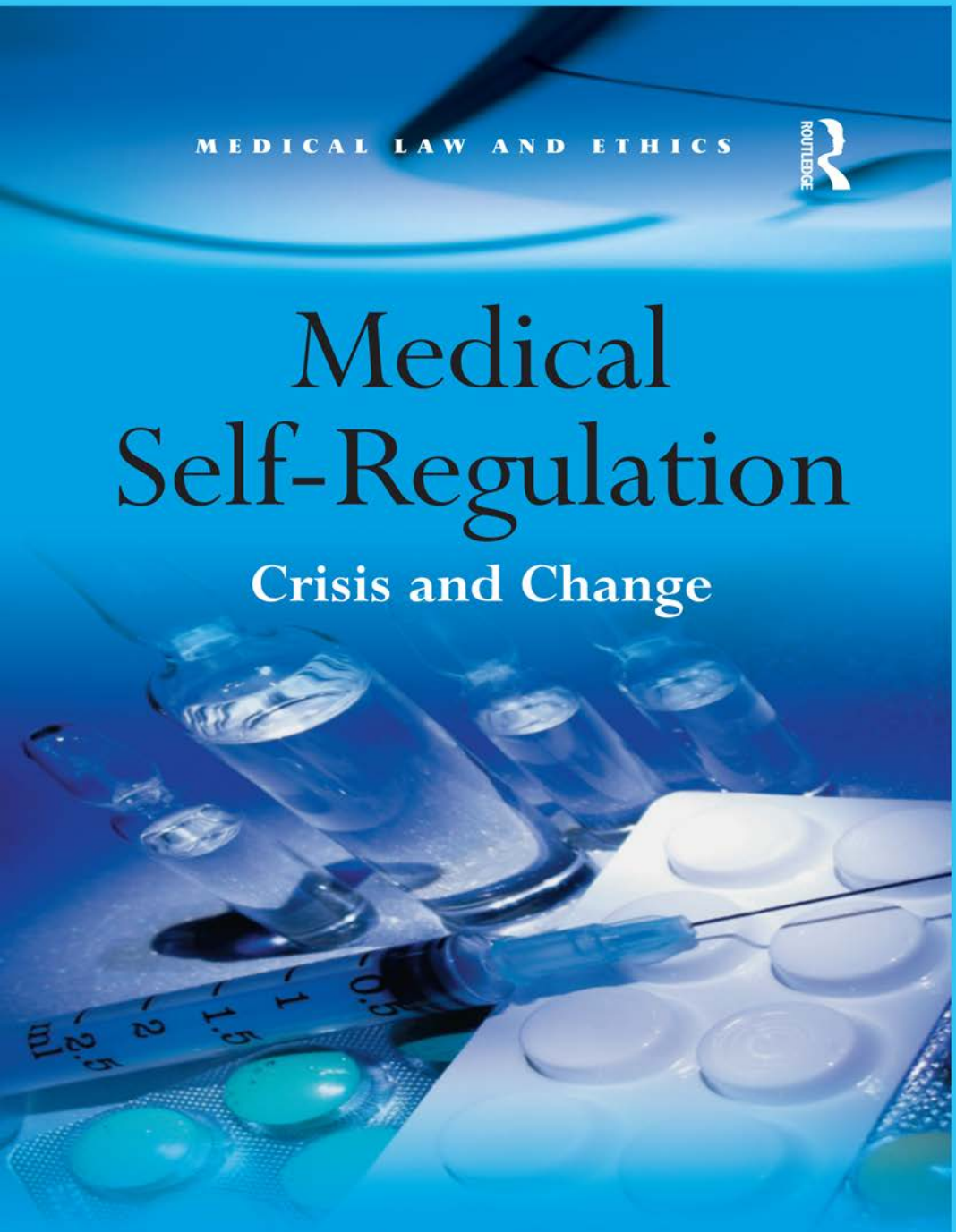

Medical Self-Regulation

Crisis and Change

MARK DAVIES

MEDICAL SELF-REGULATION

Medical Law and Ethics

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Crisis and Change

MARK DAVIES
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List of Abbreviations

ARC	Assessment Referral Committee
AVSD	Atrio Ventricular Septal Defect
BMA	British Medical Association
BRI	Bristol Royal Infirmary
CHI	Commission for Health Improvement
CHRE	Council for Health Regulatory Excellence
CHRP	Council for the Regulation of Health Professions
CPD	Continuing Professional Development
CPP	Committee on Professional Performance
CRB	Criminal Records Bureau
CRHCP	Council for the Regulation of Healthcare Professionals
DHSS	Department of Health and Social Security
DoH	Department of Health
ECHR	European Court of Human Rights
EKHA	East Kent Health Authority
FHSA	Family Health Services Authority
FHSAU	Family Health Services Appeal Unit
FPC	Family Practitioner Committee
FSA	Financial Services Authority
FTP	Fitness to Practise
GMC	General Medical Council
GP	General Practitioner
HA	Health Authority
HC	Health Committee
HDU	High Dependency Unit
HRA	Human Rights Act 1998
ICAS	Independent Complaints Advocacy Services
ICU	Intensive Care Unit
IOC	Interim Orders Committee
IOP	Interim Orders Panel
LMC	Local Medical Committee
LSA	Legal Services Authority
LSB	Legal Services Board
LSO	Legal Services Ombudsman
MCCD	Medical Certificate of Cause of Death
MDO	Medical Defence Organisation
MOT	Ministry of Transport
MSC	Medical Services Committee
NAO	National Audit Office
NCAA	National Clinical Assessment Authority

NCAS	National Clinical Assessment Service
NHS	National Health Service
NICE	National Institute for Clinical Excellence and subsequently the National Institute for Health and Clinical Excellence
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning System
NSF	National Service Framework
PALS	Patient Advice and Liaison Services
PCC	Professional Conduct Committee
PCS	Paediatric Cardiac Surgery
PCT	Primary Care Trust
PIDA	Public Interest Disclosure Act 1998
PIWG	Performance Issues Working Group
PPC	Professional Proceedings Committee
PSI	Policy Studies Institute
RCGP	Royal College of General Practitioners
RCSE	Royal College of Surgeons of England
RDP	Registration Decisions Panel
RHA	Regional Health Authority
RMO	Regional Medical Officer
RMS	Regional Medical Services
SDP	Seriously Deficient Performance
SEADOC	South East Kent and East Sussex Doctors on Call Ltd
SHO	Senior House Officer
SPM	Serious Professional Misconduct
SRS	Supra Regional Services
UBHT	United Bristol NHS Trust
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting
WHH	William Harvey Hospital

Preface

Self-regulation continues to play a central role in the legal framework governing the medical profession in Britain. When such regulation fails to operate effectively, the impact on individual lives and upon the wider community can be devastating. The object of the first part of this book is to consider the crisis in medical self-regulation, brought about by the numerous cases in recent years in which patients have been needlessly harmed or even killed at the hands of their doctor. From the murderous activities of Harold Shipman to the incompetence and arrogance of Rodney Ledward, these and other cases paint a picture of a self-regulatory process which had seriously lost direction. In the second part of the book I consider whether the changes and proposals for change have or are likely to result in change for the better. Will restructuring within the General Medical Council facilitate a sufficiently radical shift in day-to-day regulation? Can periodic revalidation of doctors ensure that they are all fit and competent? Or, does the profession continue to view the behaviour of its members through rose-tinted spectacles? That the latter may continue to present a significant obstacle to effective regulatory progress is of significant concern. In the final part of the book I consider the additional changes which might more effectively put medical self-regulation on the road to reform.

I am indebted to many people for their support in helping me complete this work. To colleagues in the Sussex Law School for providing me with research leave to finish the book in a timely manner and to Craig Barker, Jo Bridgeman, Peter De Cruz and Laurence Koffman for their constructive comments on earlier drafts. Also to the anonymous reviewers who made helpful comments about both the original book proposal and the first draft of the completed manuscript. Any omissions or errors do, of course, remain my own.

Mark Davies
July 2006

For Chris

PART I
Crisis

In the opening chapters of this book I consider the crisis which has confronted medical self-regulation in the United Kingdom in recent years. In particular, the role of the General Medical Council and, in general terms, the extent to which it has adequately performed this role.


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Chapter 1

The Background to Medical Self-Regulation

Introduction

In recent years the medical profession has come under intense scrutiny as a result of a number of scandals in both hospital medicine and general practice. These range from the unnecessary deaths of children at the Bristol Royal Infirmary, the improper retention of organs at Alder Hey, to the unlawful killing of over 200 patients by Harold Shipman. Clifford Ayling was imprisoned in 2000 for abusing female patients over a period of at least seven years, during which time he had been dismissed by a number of employers without action being taken against his registration. In addition to these high profile cases, over a four-year period at least seven GPs were reported to have been jailed for sexually assaulting patients.[1] The high profile cases have resulted in inquiries and reports, and the government and profession have responded by reviewing and changing aspects of the regulatory process. However, these cases are likely to be the tip of the iceberg. A former President of the GMC, Sir Donald Irvine has suggested that in excess of 11,000 doctors may be unfit to practise, 5 per cent of the total number of doctors on the medical register. Reasons include failing to keep up to date or other manifestations of incompetence, ill-health and deliberate wrongdoing. The Chief Medical Officer, Sir Liam Donaldson, said in 2001 that among hospital doctors the figure could be 6 per cent, while the Royal

1 For example, a number of incidents were reported by the BBC 1 programme, *Real Story*, Monday, 8 November 2005. This programme used a number of cases to illustrate problems with the current regulatory system. One case involved a doctor who had been using drugs and vaccines which were significantly out of date. Some patients had to be re-vaccinated and, presumably, were at risk of contracting serious illness in the interim. No effective action was taken after an initial report by the practice manager. Only after the third complaint did the GMC act, imposing restrictions on the doctor but not removing her from practice. Another pair of serious cases involved GPs using and profiting from patients as guinea pigs for clinical trials without their informed consent. Some of the patients involved suffered serious side effects. These doctors were suspended temporarily from practice, but not struck off. The case of a doctor who had restrictions placed on his practice (preventing him treating women alone) by the GMC after being found guilty, inter alia, of having asked a schoolgirl 'to touch his penis and guess its size', was also highlighted. The relatively lenient penalty was contrasted with the likely treatment by the criminal courts of a similar offender who was in a position of trust and responsibility over children.

College of General Practitioners has put it at 15 per cent of GPs. With respect to this latter figure, at least 3 million people in Britain could have a sub-standard GP.[2] Doctors in the United Kingdom have increasingly been subject to myriad forms of regulation. These include regulation as part of their employment (for the majority of doctors this will be within the National Health Service); civil action in negligence; criminal prosecution and 'self'-regulation by the General Medical Council. All but the GMC are limited in their scope. It has been relatively easy for a doctor to escape sanction in the employment context by either moving on before disciplinary action could be taken, or by being 'eased out' by the employer by way of voluntary severance to avoid expensive and often protracted disciplinary proceedings. Civil claims depend on the claimant being able to access the resources necessary to bring a claim. The latter are also predominantly compensatory and, because damages will usually be paid by an insurer or the doctor's employer, have little or no direct disciplinary effect. Criminal prosecutions against doctors will arise rarely and only in relatively extreme cases. This leaves the GMC as the only body which can remove a doctor's right to practise irrespective of his or her employment situation. The GMC is the only body which has responsibility for doctors from the stage of initial training through to retirement and beyond. It is the only body which can deal with doctors across a significant range of misconduct types – from relatively minor infractions on the one hand to the most serious criminal matters on the other. Unlike civil actions, the penalties imposed by the GMC apply directly against the doctor. In short, the GMC is absolutely central to the regulation of doctors.

In light of this importance, I consider the role of the GMC in both its historical and current context. My core argument is that the GMC has failed to perform the role expected of it in numerous and serious respects. In the first part of this book I consider the importance of medical self-regulation, including the historical development of the GMC's role. The second part consists of case studies used to illustrate the failings of the GMC. The third part considers recent reforms, other proposals for change and draws conclusions for the future.

Contextual and Definitional Points

The GMC does have to operate within budgetary constraints and its powers are largely governed by a statutory framework. Both of these limitations may account for some of the failings identified in this book. However, the GMC should not be permitted to use these factors to more than a limited degree in its defence. As an influential body, the GMC has had the opportunity over many years, even decades, to seek to increase its statutory powers and to address areas of regulatory weakness. Until very recently it has been relatively inactive in this regard. Similarly, with respect to its funding for important investigatory and other regulatory tasks, the GMC appears to have been more or less content with the status quo. The Council is funded by the medical profession and during the period under discussion in this book has been dominated by a majority medical membership. In these circumstances, it is

2 Boseley, S., 'Doctors Failing 3m Patients', *The Guardian*, 18 December 2004, 1.

hardly surprising that the GMC has not sought significant extra funding from doctors for the purpose of imposing a more rigorous and possibly more intrusive regulatory regime on these same doctors.

Central to the thesis of this book is the argument that medical self-regulation has experienced a lengthy period of crisis. The word 'crisis' was chosen as the most descriptive shorthand for recent events in medical self-regulation. 'An unstable period; a crucial stage or turning point'[3]; 'a vitally important or decision stage; a state of affairs in which change for better or worse is imminent'.[4] As will be discussed in this book, all of these definitions aptly describe the recent history of medical self-regulation.

Professions, Power and Regulation

Professions such as medicine involve the provision of services which are of high importance to clients and require high levels of expertise and judgement by the professional. The client is frequently unable to accurately assess the quality of service. External models of regulation, it is often argued, are unsuited to many issues arising within the field of regulating professionals. This is because the discretion much professional judgement entails is beyond the understanding of those outside of the profession, and is usually undertaken away from the visible aspects of professional practice. Self-regulation seeks to address these difficulties by having the expertise of others in the profession on hand, and by seeking to guarantee the quality and integrity of those entering and remaining in the profession. To achieve this, the state strikes a bargain with the profession, whereby the profession is granted a near monopoly over the provision of its services, and in return it provides rules of conduct and associated regulatory processes: 'Professions strike a bargain with society in which trust, autonomy from lay control, protection from lay competition, substantial remuneration and high status are exchanged for individual and collective self-control, designed to protect the interests of both clients and the public at large.'[5]

Maintaining quality of professional practice is therefore an important element in resisting external control. State-granted autonomy, a near monopoly of service provision and the right to control education, entry and to regulate members of the profession gives the profession a dominant position.[6] In return, registration as a

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3 *Collins English Dictionary*, 1985, Collins, London.

4 *Oxford English Dictionary*, online edition. Accessed July 2006.

5 Rueschemeyer, D., *Lawyers and their Society: A Comparative Study of the Legal Profession in Germany and the United States*, 1973, Harvard University Press, Cambridge, Mass., 13. For further discussion, see, for example, Parsons, T., 'The Professions and the Social Structure', in *Essays in Sociological Theory*, 1954, Free Press, Glencoe, Illinois; and Larson, M.S., *The Rise of Professionalism*, 1977, University of California Press, Berkeley, CA.

6 See, for example, Secretary of State for Social Services, *Report of the Committee of Inquiry into the Regulation of the Medical Profession*, 1975, Cmnd 6018, HMSO, London; Stacey, M., 'The General Medical Council and Self-regulation', in Gladstone, D. (ed.), *Regulating Doctors*, 2000, Institute for the Study of Civil Society, London.

member of the profession should ensure both competence and appropriate standards of behaviour. Thus, *credat emptor* rather than *caveat emptor* should govern the professional–client relationship.[7]

Regulations imposed from outside may result in the alienation of the regulated. In this environment regulation may become inefficient and even unworkable. A significant advantage of professional self-regulation is the greater acceptability by the regulated, being controlled by 'one of us' rather than outsiders, who do not understand what it is like in the front line of professional practice. It has also been suggested that membership of a self-regulating profession is likely to enhance the sense of worth and from there enhance the standard of their work.[8]

In the 1970s, the Merrison Committee recognized the contractual nature of the relationship between profession and public in the context of self-regulation. Parliament was identified as the body charged with negotiating this contract on behalf of the public. The Committee warned of the need for the 'contract' to adapt to changing social circumstances.[9] It is of note that, once the general statutory structure is in place, Parliament historically has largely left the detail of the self-regulatory contract to the profession itself.

Durkheim identified professional ethics as a means of asserting moral standards in an industrial world, where the deregulation of society through the impact of individualism was leading to moral decline.[10] A core characteristic of professional power is the privilege the profession possesses to define both the content of its knowledge and the educated access to it.[11] Having largely defined the boundaries of their own knowledge base, this was subsequently institutionalized and taught by a 'professional school'.[12] In addition to legitimate distance between professional expertise and lay knowledge, the profession may also seek to 'mystify' this knowledge, adding further to lay uncertainty to the further advantage of professional power.[13] In return for monopoly power, the profession undertakes to use its expert knowledge to pursue the public good. Traditional models of professionalism therefore combined

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7 See Hughes, E.C., 'Professions', in Callahan, J.C. (ed.), *Ethical Issues in Professional Life*, 1988, Oxford University Press, Oxford, 31.

8 Stacey, M., *Regulating British Medicine: the General Medical Council*, 1992, Wiley, Chichester, 219 and 251.

9 *Report of the Committee of Inquiry into the Regulation of the Medical Profession*, 1975, Cmnd 6018, HMSO, London.

10 For further discussion, see Parry, N. and Parry, J., *The Rise of the Medical Profession*, 1976, Croom Helm, London, 248.

11 For further discussion, see Larson, M., *The Rise of Professionalism*, 1977, University of California Press, Berkeley, CA, 48. Cited by Parker, Christine, 'Lawyer Deregulation via Business Deregulation: Compliance Professionalism and Legal Professionalism', *International Journal of the Legal Profession*, 1999, Vol. 6, No. 2, 175–96, 176.

12 See Freidson, E., *Professionalism: The Third Logic*, 2001, Polity Press, Cambridge; and Beck, J. and Young, M.F.D., 'The Assault on the Professions and the Restructuring of Academic and Professional Identities: a Bernsteinian Analysis', *British Journal of Sociology of Education*, April 2005, Vol. 26, No. 2, 183–97.

13 For further discussion, see Montgomery, J., 'Medicine, Accountability and Professionalism', *Journal of Law and Society*, Autumn 1989, Vol. 16, 319–39.

elements of what the profession expected from society – high status, generous rewards, restraints on competition and autonomy – in return for which the profession promised, inter alia, competence, an ethic of service and public protection.[14]

An important element of this public good is the assurance from the profession that its members will uphold the highest standards of conduct and use the power they command over the public responsibly. Regulation, and in particular self-regulation, of the profession is central to this concept and the means of maintaining public trust in the fact that the profession is upholding its side of the bargain. As Abel put it:

> …a profession is differentiated from other occupations by the privilege of self-governance…A governing body…represents a profession and is formally recognised as doing so, it has powers of control and discipline over its members. A profession is given a measure of self-regulation so that it may require its members to observe higher standards than could be successfully imposed from without.[15]

In terms of the application of self-regulation, dominant modes are self-assessment by each practitioner or assessment by other members of the profession. One unfortunate result of this is that practitioners may be motivated to be more concerned with the way in which their colleagues view them than the impression given to the public.[16] In the modern professional context, this has become less of a concern for clients of professional groups such as solicitors, who operate in a market environment, but remains of significant concern with regard to doctors practising within the monopoly environment of the NHS.

Professional self-regulation often takes two general forms – input and output. Whilst both seek ultimately to influence output (the quality of professional services), input operates by setting minimum standards of entry to the profession. Output, in contrast, focuses upon the quality of work produced.[17] The medical profession in England and Wales makes use of both approaches, but the primary focus tends to be on input – including recent revalidation initiatives – with limited concentration on outputs.

The public are frequently confused by the nature and various aspects of the regulatory process and it is often far from clear that the public appreciate or are encouraged to appreciate that professional regulation is ultimately a public gift which remains (or should remain) under democratic control.[18]

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14 See, for example, Paterson, A., 'Professionalism and the Legal Services Market', 3 *International Journal of the Legal Profession*, 1996, 137, 145.

15 Abel, R., 'The Politics of the Market for Legal Services', 1982, in Disney, J., Basten, J., Redmond, P., Ross, S. and Bell, K., *Lawyers*, 2nd ed, 1986, The Law Book Co., Melbourne, 89.

16 Wasserstrom, R.A., 'Lawyers as Professionals: Some Moral Issues', in Callahan, J.C. (ed.), *Ethical Issues in Professional Life*, 1988, Oxford University Press, Oxford, 65.

17 See Trebilock, M.J., Tuohy, C.J. and Wolfson, A.D., 'Professional Regulation', 1979, 40–43, in Disney, J., Basten, J., Redmond, P., Ross, S. and Bell, K., *Lawyers*, 2nd ed, 1986, The Law Book Co., Melbourne, 209.

18 The professional bodies tend to highlight this aspect only when it suits their interests. For example, when the GMC were unable to discipline Harold Shipman prior to his conviction

Self-regulation is an important principle for the legal profession in a democratic society, as lawyers must be free to challenge with full rigour organs of the state. This argument has less power with regard to the medical profession. It is also arguable that the medical profession has already compromised its independence, in relation to the state, because of its position in the NHS. The creation of the NHS from 1948 has been described as the high watermark of security and status for the medical profession. Whilst doctors initially feared that provision on socialist lines would undermine their position, the reality was negotiation and the development of structures which strengthened the control exercised by the medical profession over the institutions providing medical care.[19] The profession, it has been suggested, recognized that state provision was the best means of ensuring that the necessary financial resources were available to maintain the standards of medical care 'appropriate to the degree of security and levels of remuneration the profession desired'.[20] In a predominantly state-funded service, the professional–state bargain takes on an even greater role. Whilst other professions such as lawyers and accountants promise high standards of expertise and behaviour in return for a near monopoly position in the market, the medical profession in the NHS does not even have to compete in this market environment.

The recent history of the medical profession illustrates a highly selfish approach in the face of public demands for an effective NHS. The profession has shown itself willing to exert undue pressure on the government, with consultants rejecting contracts which would limit their private practice in return for greater public pay. GPs look set to do the same, securing substantial pay rises in return for reduced working hours. If professionalism is viewed as an occupational strategy primarily directed at achieving and maintaining upward collective social mobility,[21] then professional sacrifice in terms of overzealous self-regulation should be the norm if the profession is to maintain the public confidence necessary to maintain this status. Analysed from an economic perspective, doctors have strong property rights holdings in the production and consumption processes, which are protected by self-regulation.[22]

Doctors' short-term technical emphasis and the element of uncertainty in medical practice has meant that medical ethics has become dominated by the individualistic aspects of virtue and duty. A third potential element, the 'common good', has generally been neglected. This in turn has resulted in the neglect of the possible clashes

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for murder, they were quick to point out that this was because they lacked the statutory authority to do so.

19 For further discussion, see Parry, N. and Parry, J., *The Rise of the Medical Profession*, 1976, Croom Helm, London, 212.

20 See, for example, Parry, N. and Parry, J., *The Rise of the Medical Profession*, 1976, Croom Helm, London, 212.

21 Parry, N. and Parry, J., *The Rise of the Medical Profession*, 1976, Croom Helm, London, 79.

22 McGuire, A., 'Ethics and Resource Allocation: An Economist's View', in Dowie, J. and Elstein, A., *Professional Judgment*, 1988, Cambridge University Press, Cambridge, 492–507, 500–501.

between social values and individual values.[23] Self-regulation, therefore, remains focused upon individual conduct whilst modern medicine is dominated by complex structural issues. The ethical position is used to specify that the doctor will undertake all that is possible to fulfil the patient's needs. The strong ethical presumption is that the doctor is to be left alone to act in the best interests of the patient, isolated from wider structural issues.[24] The Bristol case, discussed in Chapter 7, is illustrative of this. The professional misconduct arose because the doctors in question did not try hard enough and were not honest with their patients, not because of the actual outcome. Also, whilst the report into the Bristol case recognized the importance of wider structural factors as well as professional conduct, disciplinary proceedings were concerned solely with the actions of doctors on an individual level.

The Particular Importance of Medical Regulation

The circumstances and culture surrounding the foundation of the NHS in 1948 contributed to some of the cultural attitudes within the medical profession which have been subject to criticism. For example, consultants, as the elite within the new service, exerted their dominance over the science and technology of medicine as the means to reinforce their privileged position. In so doing, they neglected the 'soft' elements of practice, notably communication.[25] Compared with the position in many other countries, consultants in the UK are specialists who have to progress through a very competitive, narrow promotion filter. The reward was a very high degree of clinical autonomy and power and contributed to a closed, elitist culture at the top of the British medical hierarchy.[26] By being aloof and virtually unaccountable, consultants soon gained the image of near omnipotence, which in turn restricted their ability to admit fallibility and error. As the teachers and mentors of the next generation of doctors, this model became the self-perpetuating institutional norm. In addition, the 'command and control' producer-focused model of the NHS allowed for sloppy management and toleration of poor medical practice.[27]

Regulation of the medical profession in England is characterized by a complex web of structures. Much of the relevant law has been dominated by the acceptance of claims of medical professionalism, allowing the profession both to define the

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23 Jonsen, A.R. and Hellegers, A.E., 'Conceptual Foundations for an Ethics of Medical Care', in Tancredi, L.R. (ed.), *Ethics of Medical Care*, 1974, Institute of Medicine, Washington. McGuire, A., 'Ethics and Resource Allocation: An Economist's View', in Dowie, J. and Elstein, A., *Professional Judgment*, 1988, Cambridge University Press, Cambridge, 492–507, 493 and 501.

24 McGuire, A., 'Ethics and Resource Allocation: An Economist's View', in Dowie, J. and Elstein, A., *Professional Judgment*, 1988, Cambridge University Press, Cambridge, 492–507, 501.

25 Irvine, D., 'The Changing Relationship Between the Public and Medical Profession', The Lloyd Roberts Lecture – Royal Society of Medicine, 16 January 2001.

26 Irvine, D., *The Doctors' Tale*, 2003, Radcliffe Medical Press, Oxford, 29.

27 Irvine, D., 'The Changing Relationship Between the Public and Medical Profession', The Lloyd Roberts Lecture – Royal Society of Medicine, 16 January 2001.

public need and how those needs are to be met. For example, in the context of medical negligence, not only have the courts been deferential to the profession, but the majority of cases are settled away from the public gaze of the courtroom.[28] Historically, this approach has been legitimized on the idealized grounds that the medical profession has brought a selfless, altruistic attitude to its practice and as a result needs to be protected from devious patients and the harshness of the free market. An alternative reality is that these traditional approaches obscure the reality that professional autonomy is actually an exercise of manipulative power.[29] Kennedy describes the inevitable nakedness, both physically and emotionally, experienced by the patient when he or she encounters the doctor. In turn 'it is hard to overstate the power which this vests in the doctor'.[30]

Brazier considers how medical misconduct compares with that of other professions:

> A solicitor who grossly overcharges, fails to keep proper records or conducts his client's business dilatorily will arouse public concern as well as private anger. But the outcry will not reach the same level of passion as that occasioned by reports of a doctor failing to visit a child when the child later dies…The cost of a medical error is such that doctors will always be expected to be better than others and the standards of the profession as a whole to be the highest.[31]

Historically, medical practitioners could offer very little in the way of effective treatments. As a result, the esteem afforded to doctors and the trust placed in them was naturally limited. In recent decades, relatively effective scientifically based medicine has become the norm. With this, the gap between specialist and lay understanding of the medical process has increased, as, arguably, has the respect from the public for mysterious but effective high tech treatments.[32] In these circumstances, medical regulation has also increased in importance, as the power of doctors has increased along with their capacity to do harm.

The Regulation of Doctors

There are a number of ways in which doctors may be held to account for their shortcomings. Becher identifies three forms of accountability: contractual accountability – this occurs in organizational settings and calls for conformity with official requirements or legal regulations; professional accountability – which denotes collegial relationships within a professional community and requires members to avoid drawing the profession into disrepute; moral accountability – this

28 See Montgomery, J., 'Medicine, Accountability and Professionalism', *Journal of Law and Society*, Autumn 1989, Vol. 16, 319–39.

29 Montgomery, J., 'Medicine, Accountability and Professionalism', *Journal of Law and Society*, Autumn 1989, Vol. 16, 319–39, 328–36.

30 Kennedy, I., *The Unmasking of Medicine*, 1981, Allen & Unwin, London, 8.

31 Brazier, M., *Medicine, Patients and the Law*, 1992, Penguin, London, 8–9.

32 See Porter, R., *Blood and Guts: A Short History of Medicine*, 2002, Penguin, London, 153.

is owed to clients and others and derives directly from professionalism.[33] Doctors are subject to all three modes of accountability. The first two requirements will be imposed upon doctors externally, in the first case by employers or others and in the second by their own professional body in the form of codes and disciplinary sanctions. The final requirement is more subtle, deriving from deeper notions of professionalism. In practice, a patient may seek compensation in tort or, in the case of private healthcare, contract for harm suffered. In addition, the torts of assault and battery may also provide redress. For behaviour deemed to deserve punishment or other measures to address a doctor's behaviour or fitness to practise, local or national disciplinary procedures are available. In the most serious cases, the criminal law may also be invoked. In terms of these various accountability bodies, the courts have the disadvantage of lacking the technical expertise inherent within the other regulators. Regulators also have the advantage over the courts of being able to mix to optimum effect different regulatory approaches. However, these advantages come at the expense of the risk of 'capture' by regulated populations.[34]

Arguments For and Against Self-Regulation

'Self-regulation' has been described as a 'normatively loaded term'. Supporters see it as responsive, flexible, well-informed and well-targeted, all of which encourage greater levels of compliance. This in turn makes use of the internal morality of the regulated group. The supporters therefore consider that professional self-regulation ensures that individual practitioners are accountable to their peers. Peer pressure, in theory, should ensure higher standards than could be enforced by an external regulator. It is also argued that governments in Western-style democracies could not regulate effectively without a self-governing element from the regulated population.[35] A further advantage is that the regulator and regulated should merge into one, and so the problem of influencing others in regulatory terms should not arise. However, this assumption is often not borne out in practice. In large professional groups the 'self' of the regulator and the 'self' of the regulated will usually be distinct. To the individual doctor, the General Medical Council may appear to be as distant and alien as any external regulator.

Opponents, in contrast, see self-regulation as self-serving and ineffective and therefore consider that it should not be used in areas which pose high risks or which are of significant public interest.[36] From this perspective, self-regulation may be

33 Becher, T., Eraut, M. and Knight, J., *Policies for Educational Accountability*, 1981, Heineman, London; Becher, T., *Professional Practices*, 1999, Transaction Publishers, New Brunswick, New Jersey, 208.

34 See Cane, P., 'Tort Law as Regulation', *Common Law World Review*, 2002, Vol. 31, 305–31, 313.

35 See, for example, Dunsire, A., 'Modes of Governance', in Kooiman, J. (ed.), *Modern Governance: New Government-Society Interactions*, 1993, Sage, London.

36 For further discussion of these and related ideas, see Black, J., 'Decentring Regulation: Understanding the Role of Regulation and Self-Regulation in a "Post-Regulatory" World', in Freeman, M.D.A., (ed.), *Current Legal Problems*, 2001, Vol. 54, Oxford University Press,

used to serve professional, as opposed to the public interests and professional codes may focus more towards benefiting members of the profession than the public. In the same way in which doctors are generally empowered by the state as the only group which can define health and illness, self-regulation tends to empower doctors as the only group which can define medical mishaps and even misconduct. This definitional power provides the medical profession with political power in debates about standards of practice and behaviour. For instance, as medical technology has advanced, the profession itself has played a dominant part in determining the levels of mishap deemed to be inevitable. This in turn has given rise to the tendency for the profession to seek to define untoward events as part of the inherent risk of practice, rather than as a mishap.[37]

Information Economics and Self-Regulation

There are economic reasons for members of the medical profession to ensure that the regulatory process is effective. 'Information economics'[38] provides a basis for this argument. Problems arise in markets because information is asymmetric in the sense that sometimes sellers have information which buyers lack and vice versa. Cost of discovery by the deprived party is often prohibitive. A simple example is that of a poor quality car – a lemon. Often, a buyer lacks a ready means to determine whether a particular car is a lemon, but knows that some will be. At any given price, sellers of good quality cars are less willing to sell than those of poor quality cars. Knowing that some cars are lemons, buyers will be unwilling to pay a higher price for quality of which they cannot be sure. High quality products will gradually be withdrawn from the market, leaving only the lemons behind. Quality is therefore depressed and the market becomes dominated by low quality goods and services.[39] To counteract this, mechanisms can be developed to address the provision of otherwise expensive information. Typical examples include guarantees, brand names and other indicators of reputation.[40] In the context of professions, the 'brand name' value of the professional title is usually substantial and needs to be maintained by tight control

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Oxford, 103–46; Baldwin, R. and Cave, M., *Understanding Regulation*, 1999, Oxford University Press, Oxford.

37 See Sharpe, V. and Faden, A., *Medical Harm: Historical, Conceptual and Ethical Dimensions of Iatrogenic Illness*, 1998, Cambridge University Press, Cambridge; Bosk, C., *Forgive and Remember: Managing Medical Failure*, 2nd ed., 1982, Chicago University Press, Chicago; and Mulcahy, L., *Disputing Doctors*, 2003, Open University Press, Maidenhead, 58.

38 This idea won the 2001 Nobel Prize for Economic Sciences. See Stiglitz, J.E., 'Contributions of the Economics of Information to Twentieth Century Economics', 2000, 115 *Quarterly J of Econ* 1441. Cited by Hon J J Spigelman AC, 'Are Lawyers Lemons?: Competition Principles and Professional Regulation', 2003, 77 *ALJ* 44–61, 49.

39 For full discussion, see Hon J J Spigelman AC, 'Are Lawyers Lemons?: Competition Principles and Professional Regulation', 2003, 77 *ALJ* 44–61, 44.

40 Akerlof, G.A., 'The Market for Lemons: Quality Uncertainty and the Market Mechanism', 1970, 84 *Quarterly J of Econ* 488. Cited by Hon J J Spigelman AC, 'Are Lawyers Lemons?: Competition Principles and Professional Regulation', 2003, 77 *ALJ* 44—61.

of entry standards and systems to ensure ethical conduct and maintain discipline.[41] The doctor whose own behaviour is exemplary risks allowing damage to occur to the 'brand name' of the profession as a whole if she or he turns a blind eye to misbehaviour of a colleague. There are numerous examples of this in recent years.

In this book I argue that the theoretical importance of effective self-regulation on the part of the medical profession has not been matched by practical implementation. In recent years there have been numerous examples of serious failures in the self-regulatory process. The medical profession has responded with proposals for change, but it remains open to question whether such changes are likely to be effective in genuinely improving the position.

The first part of the work considers the crisis facing the self-regulatory process operated on behalf of doctors in the United Kingdom. Recent case examples which illustrate this crisis are considered in detail in the second part. The third part of the work concentrates on potential changes and the likelihood that these will be effective.

41 Hon J J Spigelman AC, 'Are Lawyers Lemons?: Competition Principles and Professional Regulation', 2003, 77 *ALJ* 44–61, 44.


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Chapter 2

The General Medical Council – Powers and Failings

Development of Medical Professionalism and Self-Regulation

The current representative, trades union, body for the medical profession, the British Medical Association, was created in 1832. The regulatory arm of the medical profession, the General Medical Council,[1] was established 26 years later by the Medical Regulation Act 1858. This Act has been described as 'a landmark in the development of the modern medical profession'[2] and crucial for the establishment of medicine as a single influential profession. It brought together previously diverse groups into a single formalized profession and focused its self-regulatory power through the General Medical Council.[3] From its inception, the GMC has been funded by its registered members. Prior to this there was no reliable means for the public to differentiate between trained doctors and 'quacks'. It has been estimated that almost one third of practitioners in the early 1840s had no medical qualifications.[4]

The GMC was empowered to control medical education and entry to the profession and to determine who should be removed from the profession.[5] These latter powers place the GMC in a fundamental position within the regulatory system, as it alone has the power to remove or restrict a doctor's registration, irrespective of the sector in which the doctor is employed. The extent of this latter power is

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1 Originally known as a 'General Council' and acquiring the title 'General Medical Council' after the Medical Act 1950. Knight, B., *Legal Aspects of Medical Practice*, 1992, Churchill Livingstone, London.

2 Knight, B., *Legal Aspects of Medical Practice*, 1992, Churchill Livingstone, London; and Stacey, M., *Regulating British Medicine: the General Medical Council*, 1992, Wiley, Chichester.

3 Prior to 1858 there had been numerous separate licensing bodies, each with limited jurisdiction. Others had engaged in medical activity outside of the remit of any licensing body. For further discussion, see Porter, R., *Quacks*, 2000, Tempus Publishing Inc., Charleston, SC.

4 See Knight, B., *Legal Aspects of Medical Practice*, 1992, Churchill Livingstone, London; and Stacey, M., *Regulating British Medicine: the General Medical Council*, 1992, Wiley, Chichester.

5 The Act did not prevent unregistered practitioners from providing medical services, as long as they did not hold themselves out to be registered. The advantages which registration has brought have included: the right to hold appointment in the National Health Service and other public bodies, to prescribe restricted drugs and to give statutory certificates.

illustrated by the fact that historically only the Privy Council (replaced more recently by the High Court) could overturn regulatory decisions of the GMC.

The 1858 Act largely resulted from initiatives within the profession and, it has been suggested, the creation of the GMC was as much or even more in the interests of the profession than of the public – by controlling who could practise, competition was reduced.[6] Rigid admissions tests and adherence to strict professional codes would reserve professional status for only the most suitable, and in return those admitted to the profession would command the highest remuneration.[7] An essential feature, therefore, during the establishment of the modern medical profession was the desire of those who already had established status and market control, not to weaken their privileged position by permitting excessive expansion of the professional register.[8]

Some divisions did remain amongst registered practitioners – for instance in order to limit competition between hospital and general practitioners, physicians in hospitals were excluded from seeing patients directly without a GP referral, whilst general practitioners did not treat patients in hospital.[9] The general practitioner retained the patient, whilst physicians controlled the hospital.[10] This system evolved with the creation of the National Health Service in 1948. GPs retained the patient list and acted as gatekeeper to more specialist services. Therefore, although holding the status of independent contractor, GPs were and are important instruments of cost control for the state. Politicians manipulated the trust the public had in doctors by having doctors themselves undertake the rationing of healthcare. In return, the state conferred upon GPs a monopoly of primary care.[11]

From the sociological perspective, Macdonald describes the GMC as a curious mixture of self-regulation and state regulation, the Council having to make concessions to Parliament before a monopoly position would be allowed. However, since its creation, the GMC has been successful in developing effective tactics and administrative relationships with regard to its relationship with the state.[12]

Powers and Functions of the GMC

As already discussed, the GMC controls entry to the medical profession and has the power to suspend or remove a doctor from the medical register. The quality of individual newly qualified doctors is not measured directly by the GMC, rather

6 See Stacey, M., *Regulating British Medicine: the General Medical Council*, 1992, Wiley, Chichester, 20; and Irvine, D., *The Doctors' Tale*, 2003, Radcliffe Medical Press, Oxford, 26 and 44.

7 See Newman, C., *The Evolution of Medical Education in the 19th Century*, 1957, Oxford University Press, Oxford, 112; and Parry, N. and Parry, J., *The Rise of the Medical Profession*, 1976, Croom Helm, London, 133.

8 Macdonald, K.M., *The Sociology of the Professions*, 1995, Sage, London, 106.

9 Irvine, D., *The Doctors' Tale*, 2003, Radcliffe Medical Press, Oxford, 27.

10 Stevens, R., *Medical Practice in Modern England: the Impact of Specialisation and State Medicine*, 1966, Yale University Press, London.

11 Irvine, D., *The Doctors' Tale*, 2003, Radcliffe Medical Press, Oxford, 29.

12 Macdonald, K.M., *The Sociology of the Professions*, 1995, Sage, London, 106.

the Council validates educational institutions which in turn ensure that individuals reach the appropriate standard. The GMC is the principal regulator, underpinned by statute, but it does operate alongside non-statutory institutions. For instance, the Royal Colleges determine and ensure compliance with professional standards within certain specialist branches of medicine. It also operates alongside local disciplinary systems and the civil and criminal law.

In the past, the powers of the GMC have been described as 'slender and vaguely expressed' and it was hard for it to exert authority over well-established bodies such as the Royal Colleges and the BMA. Voices of opposition also came from within the Council as well as from outside.[13] For instance, when, in 1982, the BMA accepted mandatory training for GPs, they were able to successfully resist any compulsory examination. Doctors entering general practice as principles were therefore still able to do so without any compulsory test of their competence.[14] This was not merely an academic issue. Information presented to the Merrison Committee in 1973 showed that of those practitioners who chose to take the examinations (one might reasonably assume these to be the practitioners most confident of their ability), only 65 per cent passed. The Royal College of General Practitioners (who had advocated compulsory testing) expressed concern that some of the failing doctors (all of whom were free to practise) demonstrated shortcomings so fundamental that patient safety was at issue. In terms of contractual negotiations with the state, doctors, through the BMA, have tended to dominate and the state, as employer, has shown insufficient interest in protecting patients against underperforming doctors. Similarly, until relatively recently the GMC showed little commitment to seriously addressing the issue of underperforming or misbehaving doctors. Only after the recent scandals, discussed later in this book, has the GMC appeared to grasp the true extent of its obligations to the public.[15]

Four key functions are central to the role of the GMC:

1. To set general standards of good practice for doctors, reflecting the expectations of the public and the profession.
2. To maintain a register of doctors.
3. To oversee the initial training of doctors in medical schools.
4. To deal with doctors whose conduct (and more recently health or performance) may bring their registration into question.[16]

The GMC's regulatory functions have been summarized in a number of recent cases. These require the balancing of three aims:

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13 See Richardson, Lord, *The Council Transformed*, GMC Annual Report 1983, GMC, London. Cited by Irvine, D., *The Doctors' Tale*, 2003, Radcliffe Medical Press, Oxford, 44.

14 Irvine, D., *The Doctors' Tale*, 2003, Radcliffe Medical Press, Oxford, 53. The GMC had also neglected to sufficiently build primary care into the undergraduate curriculum, so could not even claim that it ensured this basic level of competence in general practice.

15 Irvine, D., *The Doctors' Tale*, 2003, Radcliffe Medical Press, Oxford, 43–4 and 55–6.

16 See GMC, *Acting Fairly to Protect Patients: Reform of the GMC's Fitness to Practise Procedures*, March 2001, 7.

1. To protect the public from doctors who are incompetent or unfit to practise.
2. To maintain the reputation of the medical profession and associated public confidence.
3. To ensure that doctors are provided with reasonable safeguards against unwarranted allegations.[17]

The GMC, in summarizing its overall purpose, has concentrated on serving the interests of patients and the 'protection, promotion and maintenance of health and safety of the community by ensuring proper standards in the practise of medicine'. Or, more succinctly, the GMC has described itself as the 'collective conscience of the medical profession'.[18]

Following the 1975 Merrison Report and the subsequent 1978 and 1983 Medical Acts, the GMC consisted of between 95 and 104 members. A significant majority of these members were doctors, most of whom were elected to the Council by the profession. Other medical members were appointed by universities with medical faculties, Royal Colleges and the Privy Council. Lay member numbers were between 11 and 13 from 1984 to 1996, rising to 25 in November 1996.[19]

Prior to 1950 the GMC exercised the disciplinary function directly and then after this date through its Disciplinary Committee. The 1978 Act replaced this with a number of formal disciplinary stages. The first stage was administrative, next came screening, and then the Preliminary Proceedings Committee (PPC) (until 1980, the Penal Cases Committee), and finally the Professional Conduct Committee (PCC) (previously the Disciplinary Committee). Only the PCC stage was held in public and a case could be closed at any stage before it reached the PCC.

Throughout the majority of its history, the regulatory powers of the GMC were disciplinary only. It was empowered by the 1858 Medical Act to erase the name of any doctor judged to have been guilty of 'infamous conduct in a professional respect'. In 1969 this was replaced by the term 'serious professional misconduct'.[20] As a result, the GMC has tended to focus primarily on the 'deviant fringe' of the profession, rather than regular inspection or monitoring of the competence and ongoing suitability of all medical practitioners. Parry observes that the focus of 'deviance' has changed over time. In the early years, the Council tended to focus on dealing with unqualified 'quacks' and maintaining the respectability of the profession, notably by seeking to control sexual misdemeanours. In the latter part of the nineteenth century the focus moved to controlling competition and self-promotion within the profession. By the time of the advent of the NHS in 1948, intra-professional competition was no longer of central concern to the profession and the focus moved to the inappropriate use of

17 See, for example, *Woods v General Medical Council* [2002] EWHC 1484, Admin; *R v General Medical Council ex parte Toth* [2000] 1 WLR 1290.

18 See Sir Graeme Catto, 'The GMC – Revalidation – What Are We Trying to Measure?', *Medico-Legal Journal*, 2003, 71(106), 2 October; and GMC, *Developing Medical Regulation: a Vision for the Future – the GMC's Response to the Call for Ideas by the Review of Clinical Performance and Medical Regulation*, April 2005.

19 See GMC, *The Draft Report of the Governance Working Group*, 18 September 2000, A31.

20 See Knight, B., *Legal Aspects of Medical Practice*, 1992, Churchill Livingstone, London, 27.

drink and drugs.[21] However, doctors who were physically or mentally ill, including those who were abusing drugs, were difficult to deal with within the disciplinary procedures. With the prospect of a public disciplinary hearing and punitive sanctions, doctors were reluctant to report colleagues who they considered to be ill. Irvine, for example, describes an occasion when he attempted to persuade a colleague whose illness was placing patients at risk to withdraw from practice. Irvine admits that had the persuasive approach failed, he would never have considered it appropriate to report the colleague to the GMC to face disciplinary charges.[22] Similarly, doctors within the GMC who were involved in the disciplinary process faced a conflict when having to choose whether to label a doctor as 'bad' when she or he was in reality ill.[23]

Serious Professional Misconduct

The attempt to find a workable definition of 'serious professional misconduct', and its predecessor term 'infamous conduct', exercised the GMC and the courts for a considerable period of time. In 1894, Lopez LJ provided the following definition:

> If a medical man in pursuit of his profession has done something with regard to it which will be reasonably regarded as dishonourable by his brethren of good repute and competency, then it is open to the General Medical Council, if that be shown, to say that he has been guilty of infamous conduct in a professional sense.[24]

The term was described by Scruton LJ, in 1930, as meaning 'no more than serious misconduct according to the rules, written or unwritten, governing the profession'.[25]

In *Roylance v General Medical Council*[26] Lord Clyde said that misconduct consists of an act or omission which falls short of what would be proper in the circumstances. This is then qualified by the addition of the words 'professional', which links the misconduct to the profession of medicine, and 'serious'. Exactly what the 'link' to medicine might be will depend on the circumstances. The closest link will occur when the practitioner is directly engaged on his or her practice with a patient. These cases may involve a serious failure to meet the appropriate standards of practice, for example, 'gross neglect of patients or culpable carelessness in their treatment, or the taking advantage of a professional relationship for personal

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21 Parry, N. and Parry, J., *The Rise of the Medical Profession*, 1976, Croom Helm, London, 245.

22 Irvine, D., *The Doctors' Tale*, 2003, Radcliffe Medical Press, Oxford, 57.

23 See, for example, discussion in the Fifth Report of the Shipman Inquiry, *Safeguarding Patients: Lessons from the Past – Proposals for the Future*, para 22.2 (www.the-shipman-inquiry.org.uk).

24 *Allinson v General Council of Medical Education and Registration* [1894] 1 QB 750.

25 *R v General Council of Medical Education and Registration of the United Kingdom* [1930] 1 KB 562.

26 [1999] Lloyd's Rep. Med. 139, at 149.

gratification'.[27] Their Lordships in *Roylance* emphasized that it was impractical to draw up an exhaustive definition of what should constitute misconduct. In *Preiss v General Dental Council*[28] Lord Cooke noted that serious professional misconduct did not require moral turpitude, but could include gross professional negligence. In *Rao v The General Medical Council*[29] the Privy Council concluded that negligent misconduct based on a single incident was not in itself sufficient. More was required to constitute serious professional misconduct.

Over the years, courts and regulatory committees have avoided establishing closed categories for SPM. The GMC made this clear in its guidance to the profession. For instance, the 1993 edition of the GMC's guide to the profession – *Professional Conduct and Discipline: Fitness to Practise* (usually referred to as the 'Blue Book') – emphasized that published categories of misconduct should not be seen as exhaustive, but that: 'Any abuse by doctors of any of the privileges and the opportunities afforded to them, or any grave dereliction of professional duty or serious breach of medical ethics, may give rise to a charge of serious professional misconduct.'[30]

Dishonesty on the part of a doctor could constitute SPM,[31] but the definition was not restricted to conduct which was morally blameworthy and so could include seriously negligent treatment or otherwise a failure to provide appropriate treatment. The GMC had formally recognized this for the first time in the 1985 edition of the Blue Book, which stated:

> The public are entitled to expect that a registered medical practitioner will afford and maintain a good standard of medical care. This includes:
> (a) conscientious assessment of the history, symptoms and signs of a patient's condition;
> (b) sufficiently thorough professional attention, examination and, where necessary, diagnostic investigation;
> (c) competent and considerate professional management;
> (d) appropriate and prompt action upon evidence suggesting the existence of a condition requiring urgent medical intervention; and
> (e) readiness, where the circumstances so warrant, to consult appropriate professional colleagues.[32]

In 1997, a GMC Working Group once again considered whether SPM should be defined more precisely. The Group acknowledged that the lack of a precise definition risked inconsistency in decision making, but felt that a significant balancing advantage was the flexibility of the existing approach. Not only would it be problematic to

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27 See comments of Lord Mackay in *Doughty v General Dental Council* [1988] AC 164, at 173.

28 [2001] 1 WLR 1926, at page 1936C.

29 (2002) Lawtel transcript.

30 See the Fifth Report of the Shipman Inquiry, *Safeguarding Patients: Lessons from the Past – Proposals for the Future*, para 17.9 (www.the-shipman-inquiry.org.uk).

31 For recent discussion, see *Nandi v General Medical Council* [2004] EWHC 2317 (Admin) at paragraph 31.

32 See the Fifth Report of the Shipman Inquiry, *Safeguarding Patients: Lessons from the Past – Proposals for the Future*, para 17.10 (www.the-shipman-inquiry.org.uk).

attempt to draft a code which tried to anticipate every single disciplinary offence, but it would lead to 'interminable legal wrangling' about whether a particular case fell within the definition.[33] However, whilst these reasons against a definitive code are justifiable, the GMC has also resisted adopting any tested alternative approach – for instance, one based upon 'common law' case authority. From September 2004 the GMC did produce summary case reports, which were intended to provide useful examples of conduct which did and did not amount to SPM and examples of the penalties imposed. Whilst, in principle, this offered the potential for progress with regard to establishing a consistent approach to SPM, in practice the examples used gave little useful guidance about the threshold for SPM.[34]

In other documents from the late 1990s and again in 2000, the GMC attempted to provide the public with a straightforward workable definition of SPM. The two versions agreed upon were: 'conduct which makes us question whether a doctor should be allowed to practise medicine without restriction' and 'behaviour so serious it would justify restricting the doctor's right to hold registration'. Neither definition provides any useful advice about the type of behaviour considered serious enough to restrict a doctor's right to practise.[35] In a paper presented to the GMC in 1999, it was considered that a good starting definition of SPM was: 'A departure from the standards of conduct expected by the profession – whether or not covered by specific GMC guidance – sufficiently serious to call into question a doctor's registration.'[36]

Recent consideration by the Privy Council saw SPM described as 'a falling short by omission or commission of the standards of conduct expected among medical practitioners, and such falling short must be serious'.[37] 'Serious' must be given appropriate weight, and so whilst it is possible for negligent conduct to constitute SPM, it will only do so when the negligence is of a sufficiently high level.[38] This latter point reflects the fact that historically the GMC showed little or no interest in behaviour on the part of a doctor which fell within the definitions of negligence. The focus has been on deliberate misconduct rather than clinical practice – whether the doctor was fit to remain on the register – rather than whether he or she was competent to undertake particular treatment. As late as 1977, guidance to the profession specifically stated that the GMC was 'not concerned with errors in diagnosis or treatment'. By 1983, the provision had been modified to say:

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33 Discussed in the Fifth Report of the Shipman Inquiry, *Safeguarding Patients: Lessons from the Past – Proposals for the Future*, paras 17.26–17.27 (www.the-shipman-inquiry.org.uk).

34 See the Fifth Report of the Shipman Inquiry, *Safeguarding Patients: Lessons from the Past – Proposals for the Future*, para 17.38 (www.the-shipman-inquiry.org.uk).

35 Contained in the GMC documents, *A Problem With Your Doctor*, 1997 and *The Conduct Procedures of the General Medical Council*, 2000.

36 See Allen, I., *The Handling of Complaints by the GMC: a Study of Decision-making and Outcomes*, 2000, Policy Studies Institute, London.

37 Per Lord Clyde in *Rylands v General Medical Council* [1999] Lloyd's Rep Med 139 at 149.

38 *Doughty v GDC* [1987] 3 All ER 843, *McCandles v GMC* [1996] 1 WLR 167, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin) at paragraph 31.

> The Council is not ordinarily concerned with errors in diagnosis or treatment, or with the kind of matters which give rise to action in the civil courts for negligence, unless the doctor's conduct in the case has involved such a disregard of his professional responsibility to his patients or such a neglect of his professional duties as to raise a question of serious professional misconduct. A question of serious professional misconduct may also arise from a complaint or information about the conduct of a doctor which suggests that he has endangered the welfare of patients by persisting in independent practice of a branch of medicine in which he does not have the appropriate knowledge and skill and has not acquired the experience which is necessary.[39]

Even in 1994, an internal GMC Training Manual stated:

> We cannot investigate complaints of failure to diagnose, or failure to give what the complainant considers to be correct and appropriate treatment, or complaints about evident or alleged errors in treatment, which have allegedly resulted in damage to the patient. Such matters come into the category of medical negligence, which it is more appropriate for a patient to pursue in the civil courts…Those matters are not, however, regarded as serious misbehaviour by the doctor concerned, such as might justify action by the Council.
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> …
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> [F]ew complaints about treatment would actually be serious enough even if sustained to raise any question of serious professional misconduct.
>
> …
>
> The types of case relating to treatment which may…justify disciplinary procedures by the Council include cases where a doctor has allegedly failed to visit a patient when necessary, or failed to conduct an appropriate examination, or absented himself/herself from his/her practice or post when the doctor was supposed to be on duty, or has been drunk on duty, or has been guilty of some other culpable failure in relation to his or her responsibilities towards one or more patients.[40]

There has therefore been a persistent notion within the GMC that SPM must involve 'wilful' or at the very least 'reckless' behaviour. Falling below a reasonable standard, rather than wilfully refusing to give care, would not constitute SPM.[41]

With the exception of the occasional judicial attempt to define SPM, the courts have tended to defer to the profession itself to determine the boundary between acceptable and unacceptable conduct. In *Ghosh v GMC*[42] Lord Millett cited with approval the following:

> The principles upon which this Board acts in reviewing sentences passed by the Professional Conduct Committee are well settled. It has been said time and again that a disciplinary committee are the best possible people for weighing the seriousness of professional

39 For further discussion, see the Fifth Report of the Shipman Inquiry, *Safeguarding Patients: Lessons from the Past – Proposals for the Future*, paras 17.41–17.46 (www.the-shipman-inquiry.org.uk).

40 Cited in the Fifth Report of the Shipman Inquiry, *Safeguarding Patients: Lessons from the Past – Proposals for the Future*, para 17.47 (www.the-shipman-inquiry.org.uk).

41 See he Fifth Report of the Shipman Inquiry, *Safeguarding Patients: Lessons from the Past – Proposals for the Future*, para 17.48 (www.the-shipman-inquiry.org.uk).

42 [2001] UKPC 29, [2001] 1 WLR 1915.

> misconduct, and that the Board will be very slow to interfere with the exercise of the discretion of such a committee ...The committee are familiar with the whole gradation of seriousness of the cases of various types which come before them, and are peculiarly well qualified to say at what point on that gradation erasure becomes the appropriate sentence. This Board does not have that advantage nor can it have the same capacity for judging what measures are from time to time required for the purpose of maintaining professional standards. …
>
> For these reasons the Board will accord an appropriate measure of respect to the judgment of the committee whether the practitioner's failings amount to serious professional misconduct and on the measures necessary to maintain professional standards and provide adequate protection to the public.

This approach has potentially serious implications. Research by the Policy Studies Institute found confusion and disagreement amongst decision makers within the GMC about what constituted SPM and the threshold at which it was reached. Some members considered 'recklessness' on the part of the doctor to be necessary. Others disagreed about whether particular behaviour was 'reasonable' and about acceptable margins of error within practice. This presented considerable scope for inconsistency in decision making, including the likelihood that unfit and even dangerous doctors have been allowed to remain in practice. The GMC had over-relied on the (erroneous) idea that as SPM decisions were being taken by experienced GMC members, the lack of agreed definitions were not of major consequence.[43]

Following the first PSI study, it was agreed that certain categories of case should be automatically referred by screeners as SPM 'by definition'. Cases in this category related to dishonesty, dysfunctional behaviour (for example, abusive behaviour, soliciting money from patients, persisting in practice when the carrier of an infectious disease), sexual assault, indecency and violence. Initially, this change saw a significant rise in the referral of cases – from 50 per cent or less, to 93 per cent. However, the PSI follow-up study in 2002 found that by 2000–2001 the figures had fallen back – for example, to a referral rate of 47 per cent of dishonesty cases in 2000 and 74 per cent in 2001. It appears that the GMC had backtracked with regard to the automatic referral procedures.[44]

Whatever definition of SPM individual disciplinary panels have used, it appears that the threshold for finding SPM has tended to be high, resulting in the acquittal of a significant majority of doctors about whom the GMC received complaints.[45] It has also been suggested that, in practice, neglect by a doctor of his or her duties to a patient has resulted in excessive leniency. Stacey found that in the 1980s the PCC demonstrated a reluctance to find serious professional misconduct in cases alleging disregard of professional responsibility, for instance, failure to visit, treat

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43 See the Fifth Report of the Shipman Inquiry, *Safeguarding Patients: Lessons from the Past – Proposals for the Future*, paras 17.16, 20.94 and 27.214 (www.the-shipman-inquiry.org.uk).

44 See the Fifth Report of the Shipman Inquiry, *Safeguarding Patients: Lessons from the Past – Proposals for the Future*, paras 19.174–19.181 (www.the-shipman-inquiry.org.uk).

45 Smith, R., *Medical Discipline: The Professional Conduct of the GMC* 1858-1990, 1994, Oxford University Press, Oxford.

or refer. Thirty-six per cent of such cases resulted in not guilty findings, compared with between 4 and 13 per cent in cases of dishonesty, inappropriate prescribing and other types of offences against patients.[46] The penalties imposed against those found guilty also tended to be lower. For instance, between 1970 and the mid-1980s, no doctor found guilty of disregard of professional responsibility had his or her name erased from the medical register. In contrast, 40 per cent of doctors found guilty of sexual misconduct had their names erased. There were clear questions of appropriate prioritization when adulterous doctors were treated that much more severely than the uncaring or incompetent.[47] Other evidence from the 1980s also indicated that the GMC was more concerned with doctors who were seen to be undermining the status of the profession than those whose activities jeopardized patient care. [48]

GMC Guidance to the Profession

The GMC traditionally provided guidance to the medical profession through its periodically updated guide to *Professional Conduct and Discipline: fitness to practise* (the 'Blue Book'). This was issued to doctors on qualification, although for much of its history the GMC considered it inappropriate to make the guide available to the wider public. Stacey analysed changes in Blue Book guidance between the 1970s and late 1980s. She found that the guidance in 1976 focused principally upon intra-professional matters, for example, regulation of competition and demeaning colleagues. Little guidance related to public protection. By 1987, whilst the intra-professional material was still present, the Blue Book had expanded to include more patient-focused material. The latter included guidance relating to standards of medical care and the handling of confidential patient information. External pressure, rather than proactive initiative by the GMC, appears to have been the primary motivator for these changes.[49]

In 1995 the Blue Book was replaced with *Good Medical Practice*. This new publication was intended to be more positive in tone than its predecessor – providing members of the profession with straightforward guidance about what it was to be a good doctor. As one President of the GMC described it:

> Instead of indicating all of those things that doctors shouldn't do, from 1995 onwards with Good Medical Practice, we indicate the positive aspects of medicine – what doctors

46 Stacey, M., *Regulating British Medicine: the General Medical Council*, 1992, Wiley, Chichester, 165.

47 Stacey, M., *Regulating British Medicine: the General Medical Council*, 1992, Wiley, Chichester, 159; Brazier, M., *Medicine, Patients and the Law*, 1992, Penguin, London, 14. Brazier notes that the case of *Rodgers v GMC* [1985] 1 PN 111 was the first in 15 years in which a doctor's name was erased for failing to visit.

48 Montgomery, J., 'Medicine, Accountability and Professionalism', *Journal of Law and Society*, Autumn 1989, Vol. 16, 319–39, 321.

49 Stacey, M., *Regulating British Medicine: the General Medical Council*, 1992, Wiley, Chichester, 150.

> should do. We call it Good Medical Practice, not Excellent Medical Practice or First Class Medical Practice, because it is expected that all doctors will adhere to these precepts.[50]

The first edition of *Good Medical Practice* described its contents as 'guidance'. However, subsequent editions made it clear that the contents did constitute the standards against which a doctor would be judged if a fitness to practise issue arose. For example, the 2001 edition stated: 'Serious or persistent failures to meet the standards in this booklet may put your registration at risk.' However, *Good Medical Practice* is not suitable for determining in any simple way whether particular behaviour amounts to SPM, and could not in itself be relied upon by doctors or members of regulatory panels to determine different levels of misbehaviour. As the Shipman Inquiry was told:

> ... "Good Medical Practice" is a mixture of things which really must not be transgressed and which would be very serious, and other points which are, for example, being polite to your patients. This on its own could not raise an issue which ought to affect a doctor's registration presumably; so that you've within "Good Medical Practice" a lot of different things at different levels of seriousness.[51]

Guidance, however good, is only of use if the profession takes it to heart and acts upon it. The GMC encountered difficulties in getting doctors to take sufficiently seriously the requirements of the Blue Book and then *Good Medical Practice*. Doctors have demonstrated differing awareness and attitudes.[52]

Screening

As previously noted, before a case could reach the stage of a public hearing before the PCC, it had to pass a number of preliminary stages – administrative filtering, initial screening and then screening by the PPC. For most of the GMC's history, the initial screening of complaints rested with the GMC President, who also chaired the key disciplinary committees. The power to decide what should happen to a complaint from the point it was received therefore rested with the President. From there, he[53] controlled which cases proceeded to committees he chaired and which were dismissed without a formal hearing. This gave rise to serious concerns that the President possessed far too much power and influence. These practices were modified in the 1970s, and after 1979 the offices of preliminary screener, deputy preliminary screener and preliminary screener for health were created.[54] However, even after these changes, the President (or a medical screener nominated by him) continued

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50 Sir Graeme Catto, 'The GMC – Revalidation – What Are We Trying to Measure?', *Medico-Legal Journal*, 2003, 71(106), 2 October.

51 The Fifth Report of the Shipman Inquiry, *Safeguarding Patients: Lessons from the Past – Proposals for the Future*, para 17.19 (www.the-shipman-inquiry.org.uk).

52 See Irvine, D., *The Doctors' Tale*, 2003, Radcliffe Medical Press, Oxford, 139.

53 All GMC Presidents to date have been men.

54 See Stacey, M., *Regulating British Medicine: the General Medical Council*, 1992, Wiley, Chichester, 93.

to chair the PPC. Also, the President retained the power to nominate screeners and chairmen of other committees 'and so could wield his influence vicariously'.[55] These changes did not remove the possibility that a screener could also be a member of the PPC, effectively having two bites at deciding whether a case should progress to the public arena of the PCC. The chairman of the PPC was also principal medical screener, and two other medical screeners and one lay screener were also members of the committee. This position was only changed in 1999.[56]

Historically, screening was an opaque process undertaken behind closed doors. There was no screening database, nor an effective means to track cases.[57] Whether or not a complaint progressed rested with the individual screener before whom the case happened to come. There were no set standards, no monitoring or audit to ensure consistency of decision making. There were also difficulties with the interaction between the conduct, health and performance procedures. For instance, it was possible at any stage to refer a case from the conduct or performance procedures into the health procedures, but not from health or conduct into performance. The health procedures therefore took centre stage, perhaps reflecting a preoccupation of the medical profession but not necessarily meeting public expectations in terms of priorities. Significant power was therefore in the hands of the screener, both with respect to whether a case should progress and, if so, through which route.[58]

A screener might dismiss a complaint based upon the conclusion that even if all facts alleged were true, it could not amount to SPM or that it fell outside of the jurisdiction of the Council. An alternative to complete dismissal was the issuing of a warning letter to the doctor. These were used extensively. Warning letters were, from the GMC's perspective, an easy means of disposing of some cases where the doctor had admitted allegations or the facts had been proved or were beyond dispute.[59]

Where there was no admission or proof of misconduct and the case was not considered sufficiently serious for the PCC, but the PPC remained concerned about the doctor's behaviour, it adopted the practice of sending a 'cautionary letter' or 'letter of advice'. The former notified the doctor that the case would be filed and looked at again if a subsequent similar complaint was received. The latter advised the doctor regarding future conduct. The Shipman Inquiry heard that cautionary letters had ceased to be used, but letters of advice remained widely used – for example, in 2002 and 2003 the PPC dealt with over 40 per cent of its cases in that way. There are obvious concerns that so many cases were dealt with in this way, without any thorough investigation to determine whether the doctor presented a continuing risk

55 See the Fifth Report of the Shipman Inquiry, *Safeguarding Patients: Lessons from the Past – Proposals for the Future*, para 19.260 (www.the-shipman-inquiry.org.uk).

56 Allen, I., *The Handling of Complaints by the GMC: a Study of Decision-making and Outcomes*, 2000, Policy Studies Institute, London. See also The General Medical Council (Fitness to Practise Committees) Rules 2000.

57 See Allen, I., Perkins, E. and Witherspoon, S., *The Handling of Complaints Against Doctors*, 1996, Policy Studies Institute for the Racial Equality Group of the GMC, London.

58 For further discussion, see GMC, *Acting Fairly to Protect Patients: Reform of the GMC's Fitness to Practise Procedures*, March 2001, 15.

59 See the Fifth Report of the Shipman Inquiry, *Safeguarding Patients: Lessons from the Past – Proposals for the Future*, para 20.32 (www.the-shipman-inquiry.org.uk).

to the public.[60] It is also difficult to see how letters of advice, given that the doctor has admitted the offence, constitute an appropriate penalty and deterrent.[61]

Stacey notes that in the 1970s, when she was a lay member of the GMC, the screening processes were shrouded in mystery. She was, however, able to identify a very high proportion of cases which did not proceed to a formal hearing. For instance, in 1974, of 847 complaints or convictions, less than one quarter were progressed to the stage of a formal committee.[62] The position was equally, if not more, extreme in the 1980s and 1990s. Between 1987 and 1998, between 82 and 89 per cent of cases were closed at the screening stage. There was no mechanism to appeal against a screening decision other than by way of judicial review, although no such review was undertaken until 1997.[63] Robinson, another lay member, noted that the screening process was not even subject to oversight by other GMC members:

> From the time I was appointed to the GMC, and was elected to the Preliminary Proceedings Committee, I was asking for further details of rejected cases. I seemed to be the only member of Council who wanted to know. My request for basic information about the majority of complaints the Council received was sometimes interpreted as distrust of the Screener, who is always an eminent and respected doctor. My view is that I do not care if the Angel Gabriel is Preliminary Screener. Members of the Council and the public have a right to know what kind of complaints the Council receives, whether some kinds are increasing or decreasing, and which get further investigation and which do not.[64]

Screening remained dominated by medical members of the GMC until 1990, when the Professional Conduct Rules[65] were amended to provide for the appointment of a lay screener, who would consider those conduct cases (although not criminal conviction cases) which the medical screener had determined should be closed. If agreement could not be reached between the medical and lay screeners, the lay screener's view prevailed. Whilst this did provide a useful additional safeguard, its limitations were of concern. Not only were conviction cases excluded, but so were decisions by the medical screener to refer a case to the health or performance

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60 See the Fifth Report of the Shipman Inquiry, *Safeguarding Patients: Lessons from the Past – Proposals for the Future*, paras 20.33–20.34 (www.the-shipman-inquiry.org.uk).

61 This was the view taken by Jean Robinson. Robinson, J., *A Patient Voice at the GMC: a Lay Member's View of the GMC*, Report 1, Health Rights, London.

62 Stacey, M., *Regulating British Medicine: the General Medical Council*, 1992, Wiley, Chichester, 152. On questioning the large proportion of complaints which were dismissed, Stacey recalls the only answer she received was that 'most of them came from deranged persons'.

63 See the Fifth Report of the Shipman Inquiry, *Safeguarding Patients: Lessons from the Past – Proposals for the Future*, paras 19.5 and 19.40 (www.the-shipman-inquiry.org.uk).

64 See Robinson, Jean, *A Patient Voice at the GMC: a Lay Member's View of the GMC*, Report 1, Health Rights, London; and the Fifth Report of the Shipman Inquiry, *Safeguarding Patients: Lessons from the Past – Proposals for the Future*, para 19.37 (www.the-shipman-inquiry.org.uk).

65 General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) (Amendment) Rules 1990, rule 10(2) of the Professional Conduct Rules 1988.

procedures. The latter had a significant impact on the manner in which the doctor was dealt with and the maximum penalties available. Similarly, lay screeners had no involvement in cases where administrative staff or the medical screener determined that the complainant should pursue the matter through local procedures.[66]

Research in 1993 and 1994 by the Policy Studies Institute considered the work of the, then, three medical screeners. The research found that the screeners did most of their work away from GMC premises and fitted it in around other GMC commitments and their usual work as practising doctors. Perhaps reflecting the substantial nature of each screener's workload, in a significant proportion of cases the screener followed the advice which administrative staff provided with the case paperwork. This raised issues about who the real decision makers were at this stage of the process.[67] An example of a failure in the screening process was highlighted by the Shipman case (discussed in Chapter 12). In 1990 Shipman was found to be in breach of his terms of service as a result of prescribing an excessive drug dose to a patient with epilepsy. In 1993, a similar finding was made after Shipman had failed to visit a patient. After this second case, the Family Health Services Appeal Unit reported Shipman to the GMC. A GMC caseworker produced a memorandum for screening purposes, including details of Shipman's convictions in 1976. The caseworker expressed strong reservations about the evidential strength of the case and whether the facts could give rise to misconduct of relevance to the GMC. The medical screener expressed the view that the first case was too old for the GMC to act and the second involved 'evidence which is now obscured by time' and had been sufficiently dealt with locally. Despite concluding that the second matter was 'borderline' in terms of possible SPM, the case was closed – without, apparently, the requisite referral to a lay screener.[68] Not only do these facts illustrate a highly favourable stance towards the doctor, when there is any element of doubt, but also that screeners were engaging in substantive weighing up of evidence and decision making. Only with the introduction of the Handbook for Screeners in 1997 was it expressly stated that screeners should not engage in weighing up the strength of the evidence.[69]

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66 For further discussion, see the Fifth Report of the Shipman Inquiry, *Safeguarding Patients: Lessons from the Past – Proposals for the Future*, paras 19.31 and 19.248–19.249 (www.the-shipman-inquiry.org.uk).

67 See the Fifth Report of the Shipman Inquiry, *Safeguarding Patients: Lessons from the Past – Proposals for the Future*, paras 19.53–19.55 (www.the-shipman-inquiry.org.uk).

68 See the Fifth Report of the Shipman Inquiry, *Safeguarding Patients: Lessons from the Past – Proposals for the Future*, paras 19.44–19.49 (www.the-shipman-inquiry.org.uk).

69 See the Fifth Report of the Shipman Inquiry, *Safeguarding Patients: Lessons from the Past – Proposals for the Future*, paras 19.78 and 19.81 (www.the-shipman-inquiry.org.uk). The Inquiry does note that whilst the handbook 'represented a real attempt to change that culture', some aspects of the advice were ignored by screeners or soon fell into disuse. There was also no effort made to update the contents or systematically remind screeners of the key principles.

The GMC did not seek to maintain oversight of the screening process by means of audit or other review.[70] The 2000 PSI Report considered the degree of consistency in decision making between the, then, seven screeners. Very significant variations were found between different screener's assessments of levels of seriousness with regard to behaviour they considered would place the public at risk.[71] The PSI recommended that all participants in the GMC's fitness to practise procedures should have a common shared understanding of key principles relating to public risk and other measures of seriousness.[72] Judicial review case examples also illustrate these problems. For example, in *R v GMC, ex parte Holmes*[73] two GPs, Dr A and Dr B, were reported to the GMC after they failed to diagnose a colloid cyst on the brain. At local level, the GPs had been found to be in breach of their terms of service with respect to the incident. In early 1999, Dr A's case was considered by two medical and one lay screeners, all of whom dismissed the complaint. In Dr B's case, the medical screeners decided to dismiss the case but the lay screener determined that it should proceed to the PPC. In September 1999, the PPC dismissed the case. Documents disclosed as part of the judicial review proceedings revealed that administrative advice to the screeners was that the actions were thought not to constitute SPM. Written comment from one of the medical screeners was that, due in part to the three-year delay in the case reaching the GMC, 'I am inclined to no action'. Most of this delay was due to the case needing to progress through the NHS complaints procedures. Not only should the time lapse have been irrelevant to the screening decision, but the GMC would typically insist upon local procedures having been exhausted, so were to a significant degree responsible for the delay. Of similar, if not greater, concern were comments from the other medical screener (the principal GMC medical screener at the time) which expressly stated that there was no SPM because of the difficulty with the particular diagnosis. This screener also noted that Dr A was a member of the Royal College of Physicians. The judicial review court noted that this screener fell into the trap of considering whether the behaviour *did* amount to SPM, rather than whether it *could* have. Membership of the Royal College of Physicians should have had no bearing on the decision. The Shipman Inquiry expressed concern that 'errors as fundamental as this' were still being made in 1999, that screeners habitually applied the wrong test and took into account entirely irrelevant information.[74]

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70 See the Fifth Report of the Shipman Inquiry, *Safeguarding Patients: Lessons from the Past – Proposals for the Future*, para 19.38 (www.the-shipman-inquiry.org.uk).

71 See the Fifth Report of the Shipman Inquiry, *Safeguarding Patients: Lessons from the Past – Proposals for the Future*, paras 19.99–19.101 and 19.143 (www.the-shipman-inquiry.org.uk). No simple conclusions could be drawn from these findings, as cases were not distributed randomly to screeners. However, following this report, the GMC introduced a randomized system of distributing cases, yet the PSI in a 2003 follow-up study found that this did not remove variation between screeners.

72 See the Fifth Report of the Shipman Inquiry, *Safeguarding Patients: Lessons from the Past – Proposals for the Future*, paras 19.104–19.105 (www.the-shipman-inquiry.org.uk).

73 [2001] EWHC 321 (Admin).

74 See the Fifth Report of the Shipman Inquiry, *Safeguarding Patients: Lessons from the Past – Proposals for the Future*, paras 19.122–19.136 (www.the-shipman-inquiry.org.uk).