CHAPTER TWENTY ONE

The General Medical Council Conduct Procedures: the Professional Conduct Committee

Introduction

21.1 As I have explained, under the old fitness to practise (FTP) procedures, the Professional Conduct Committee (PCC) was the disciplinary committee of the General Medical Council (GMC). In this Chapter, I shall describe the function and powers of the PCC and will examine its procedures and the sanctions available to it. I shall consider some of the PCC's decisions on sanction, particularly as they relate to issues of interest and concern to the Inquiry. I shall consider the review of the PCC procedures and decisions undertaken by a Working Group in 1999. I shall consider the impact of decisions of the Judicial Committee of the Privy Council (and more recently of the High Court) upon the operation of the PCC. I shall also examine other recent developments, including changes to the arrangements for restoration to the register. In conclusion, I shall discuss some of the major difficulties which have been encountered by the PCC in the past and how those difficulties might be dealt with in the future.

Evidence

21.2 Professor Sir Graeme Catto (President of the GMC), Mr Finlay Scott (Chief Executive) and Sir Donald Irvine (immediate past President) all gave evidence in relation to some of the issues under discussion in this Chapter. Dr Krishna Korlipara, who has been a member of the GMC since 1984 and was a member of the PCC at various times between 1984 and 1997, also gave evidence. Dr Joan Trowell, Chairman of the Fitness to Practise Committee, provided a witness statement. Professor Isobel Allen, Emeritus Professor of Health and Social Policy, University of Westminster Policy Studies Institute (PSI), and her team undertook an analysis of outcomes of PCC cases, the results of which appeared in their 1996 and 2000 Reports and in their 2003 Paper. In writing this Chapter, I have drawn upon their work and also upon many documents disclosed by the GMC. Among these documents were the Report of the PCC Working Group produced in May 1999 and the Indicative Sanctions Guidance (ISG), first published in 2001 and updated in 2003 and again in 2004. This guidance was designed to assist members of the PCC in reaching consistent decisions on sanction and is intended to provide similar assistance to members of FTP panels under the new procedures.

The Composition of the Professional Conduct Committee

21.3 From its inception in 1980, the composition of the PCC was governed successively by the General Medical Council (Constitution of Fitness to Practise Committees) Rules Order of Council (the Constitution Rules) 1980, 1986 and 1996. Between 1980 and 1986, the PCC

was composed of the Chairman, Deputy Chairman, 16 medical members and two lay members of the GMC (i.e. 20 members in all). The legal quorum of the PCC was five. The Constitution Rules provided that no more than ten members of the PCC should be invited to sit on panels for the hearing of cases. Those invited to attend a panel hearing had to include either the Chairman or the Deputy Chairman or both, eight medical members and one lay member of the PCC. Subject to those requirements, panel members were to be chosen, so far as was practicable, in rotation from all the members of the PCC.

21.4 From 1980, the Constitution Rules permitted the President to choose whether to sit as Chairman of the PCC. If the President chose not to do so, he was required to appoint another member of the GMC as Chairman. Between 1980 and 1996, the Constitution Rules also required the President to appoint one member of the GMC as Deputy Chairman of the PCC. From 1980, any appointments to the Chairmanship and Deputy Chairmanship of the PCC were subject to the approval of the full Council. Members of the PCC (except for the Chairman and Deputy Chairman) were elected annually.

21.5 In 1986, 1987 and 1994, the Constitution Rules were amended to permit increases in the membership of the PCC. By 1994, the PCC had 34 members, comprising 26 medical members (including the Chairman and Deputy Chairman) and eight lay members. The number of members invited to sit on a hearing was reduced to eight. Two of those eight had to be lay members of the PCC. The legal quorum for a PCC panel was five, to include at least one lay member.

21.6 In 1994, the Constitution Rules were further amended to provide for the situation where insufficient members were available to achieve a quorum. The President was given the power to appoint temporarily to the PCC any member of the GMC who would have been eligible to stand for election to the PCC. In 1996, the Constitution Rules were again amended to reduce the membership of the PCC to 30. From that time, the President was required to appoint two members of the GMC as Deputy Chairmen, who would chair hearings in the absence of the Chairman. There had been a significant increase in the number of cases referred to the PCC during the mid-1990s and the appointment of an additional Deputy Chairman allowed a greater number of hearings to be conducted by differently constituted panels of the PCC. From 1996, the total membership of the PCC comprised 23 medical and seven lay members.

21.7 In 2000, the Constitution Rules were amended to reduce the legal quorum of a PCC panel to three, including at least one medical and one lay member. I have already explained that, also in 2000, the GMC was given the power to co-opt non-members or 'associates', both medically qualified and lay, to sit on its FTP committees. At that time, the PCC had a large backlog of cases and there were serious delays in bringing cases to the hearing stage. The appointment of a large number of associates made it possible for multiple panels of the PCC to sit simultaneously. In 2000, PCC panels sat for a total of 129 days. In 2001, that rose to 242 days and, in 2002, to 631 days. In 2003, the figure dropped slightly to 595 days. Since July 2003, when the number of Council members was reduced to 35, members have not sat on PCC panels unless it has proved impossible to find an adequate number of associates to do so.

The Function and Powers of the Professional Conduct Committee

21.8 The function of the PCC was to adjudicate on disciplinary cases.

Conviction and Conduct Cases

21.9 Section 7(1) of the Medical Act 1978 (which came into force in August 1980) set out the powers of the PCC. It provided:

> **'Where a fully registered person –**
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> **(a) is found by the Professional Conduct Committee to have been convicted (whether while so registered or not) in the United Kingdom or any of the Channel Islands or the Isle of Man of a criminal offence; or**
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> **(b) is judged by the Professional Conduct Committee to have been (whether while so registered or not) guilty of serious professional misconduct;**
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> **the Committee may, if they think fit, direct –**
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> **(i) that his name shall be erased from the register;**
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> **(ii) that his registration in the register shall be suspended (that is to say, shall not have effect) during such period not exceeding twelve months as may be specified in the directions; or**
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> **(iii) that his registration shall be conditional on his compliance, during such period not exceeding three years as may be specified in the direction, with such requirements so specified as the Committee think fit to impose for the protection of members of the public or in his interests.'**

These powers were reproduced in section 36(1) of the Medical Act 1983 (the 1983 Act) and remained essentially unchanged. Thus, it was the function of the PCC to determine first whether a doctor referred to it had been guilty of serious professional misconduct (SPM) or had been convicted of a criminal offence. If so, it had to go on to consider what, if any, sanction was appropriate.

The Procedure at a Hearing before the Professional Conduct Committee

21.10 The procedure to be adopted by the PCC at the hearing of a case was set out in Schedule 4 to the 1983 Act (formerly Schedule 4 to the Medical Act 1978) and in the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules Order of Council 1988 (the 1988 Professional Conduct Rules). The 1988 Professional Conduct Rules largely reproduced the provisions which had previously been contained in the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules Order of Council 1980. I shall summarise the procedure as it was at the time of the Inquiry's hearings in November and December 2003.

A Public Hearing

21.11 The 1988 Professional Conduct Rules required that, save in exceptional circumstances, the proceedings of the PCC should be held in public. Panel members could, however, deliberate (i.e. discuss their findings and their decisions on sanction, together with any other matters that arose in the course of the hearing) in private.

The Role of the Legal Assessor

21.12 I referred in Chapter 20 to the role and duties of the legal assessor. Members of PCC panels were advised at hearings by a legal assessor. Any advice given to the PCC panel by the legal assessor had to be tendered in the presence of the parties attending the hearing or their representatives. The legal assessor was permitted to accompany members of the PCC panel while they deliberated in private and to give advice as appropriate. However, the legal assessor was required to inform the parties or their representatives publicly of any advice given (and of any question which had given rise to that advice) as soon as possible after the advice had been provided. The advice given to the parties by the legal assessor had to be recorded and a copy of the record given to every party or representative. If members of a PCC panel did not accept the advice of the legal assessor, a record had to be made of the question referred to him/her, the advice given and the refusal to accept the advice, together with the reasons for refusing it. A copy of that record had to be given to every party, or person representing a party, at the hearing.

The Quasi-Criminal Proceedings

21.13 The procedures of a PCC panel resembled those of a criminal court. The hearing was adversarial rather than inquisitorial. In other words, the two sides competed, each side seeking to persuade the panel of the truth of its evidence and the soundness of its contentions. The 'prosecution case' (whether a complaint or a conviction) was usually presented by a solicitor or counsel instructed by the GMC. Under the old procedures (and in a conduct case only), it was open to a complainant, whether personally or through a legal representative, to conduct his/her own case. This was sometimes done, but it was more usual, where the complainant was a private individual, for the GMC to 'take over' the complaint and to conduct the case at the hearing before the PCC panel. Doctors appearing before a PCC panel were usually legally represented, in general through their medical defence organisations.

Evidence

21.14 Witnesses could be subpoenaed and evidence was given on oath. Rule 50 of the 1988 Professional Conduct Rules provided that the PCC could receive oral, documentary or other evidence of any fact or matter which appeared to it relevant to its inquiry into the case before it. Rule 50 was subject to the proviso that, where any evidence was tendered that would not be admissible in criminal proceedings in England, it should not be received unless, after consultation with the legal assessor, the PCC was satisfied that its duty of making due inquiry into the case before it made the reception of that evidence desirable. I referred in Chapter 20 to the observations of Mr Justice Sullivan in the case of R v General

Medical Council ex parte Richards[1] about the way in which he would have expected the PCC to exercise its discretion in admitting evidence which would otherwise have been inadmissible. Sullivan J pointed out that the PCC is not in precisely the same position as a criminal court. It has an important investigatory and regulatory role in the public interest and must, therefore, take into account the public interest in having complaints thoroughly investigated. However, it seems to me, from an examination of the case of Richards and of other cases I have looked at, that, whatever the PCC's attitude to inadmissible evidence, the view of those making decisions at the earlier stages of the FTP procedures was that, if evidence was hearsay, it was unlikely to be received by the PCC or, if received, it would be accorded little weight. It is possible that some had experienced this approach when sitting on the PCC in the past.

21.15 Rule 50(4) of the 1988 Professional Conduct Rules gave the PCC power to cause any person to be called as a witness in any proceedings before it, whether or not the parties consented. The PCC also had power to put questions to any witness itself or through the legal assessor. The doctor was entitled to give oral evidence but was under no obligation to do so.

Conviction Cases

21.16 In a conviction case, once the conviction had been proved (usually by production of the certificate of conviction), the facts giving rise to it did not have to be proved at the hearing. The 1988 Professional Conduct Rules permitted the GMC's representative to adduce evidence about the circumstances leading up to the conviction and about the character and previous history of the doctor.

21.17 The words 'previous history' were a reference to the doctor's FTP history, i.e. any previous sanction imposed on the doctor by the PCC, the Health Committee (HC) or the Committee on Professional Performance (CPP). The PCC would, of course, have no information relating to such matters as past complaints to the GMC about the doctor which had been closed by the GMC staff, or which had been closed by the screeners or rejected by the Preliminary Proceedings Committee (PPC). Nor would the PCC have any information about past complaints to, or disciplinary action by, any NHS body, unless the complaint or action had been directly connected with the subject matter of the conviction or complaint with which the PCC was currently dealing. The result was that the PCC might well have an incomplete picture of the doctor's past history.

21.18 The doctor or his/her representative was then entitled to address the PCC by way of mitigation and to adduce his/her own evidence about the circumstances leading up to the conviction and about his/her character and previous history. The doctor might give evidence him/herself but was not obliged to do so and, in practice, often did not do so. It was usual for the doctor to submit testimonials from patients and/or colleagues. The ISG, which, as I said, was first produced in 2001, contained a warning that care should be taken when drawing inferences from such testimonials. It warned, in particular, that some testimonials were written by persons who believed that the doctor concerned was not guilty of the misconduct alleged; the validity of such an opinion was plainly questionable

[1] [2001] Lloyd's Rep Med 47.

if the doctor had since been found guilty. Also, the ISG warned that there might be cultural reasons for the absence of testimonials. Panel members should not assume that testimonials would not be available if requested.

21.19 The PCC panel would then proceed to consider the question of sanction. I shall return to the imposition of sanctions later in this Chapter.

Conduct Cases

21.20 In a conduct case, the doctor would face a charge, or series of charges, each containing one or more factual allegations. Some allegations or whole charges might be admitted and others denied. All might be admitted or all denied.

The 'Prosecution Case'

21.21 The GMC's representative (or the complainant) would adduce evidence of the facts alleged which had not been admitted by the doctor.

Submission of No Case

21.22 As in a criminal trial, at the close of the 'prosecution case', it was open to the doctor to submit that no sufficient evidence had been adduced in respect of any or all of the facts which were in dispute, so that the PCC panel could not find those facts proved. The doctor might also submit that, in respect of any charge, the facts about which evidence had been adduced or which had been admitted were insufficient to support a finding of SPM. The GMC's representative (or the complainant) then had an opportunity of answering the submission and the doctor had an opportunity to reply. The PCC panel would then determine whether the doctor's submission should be upheld. If the submission was upheld, the finding of the PCC panel would be that the doctor was not guilty of SPM in respect of the matters to which the relevant charge related.

The 'Defence Case'

21.23 If the doctor made no submission (or if s/he made a submission but it was unsuccessful), s/he (usually through his/her representative) then had the opportunity to address the PCC panel concerning any charge which remained outstanding and could at that stage adduce evidence, whether oral or documentary, in his/her defence. As I have said, it was open to the doctor to give evidence him/herself.

Further Evidence and Submissions

21.24 At the close of the evidence called by or on behalf of the doctor, the GMC's representative (or the complainant) could, with the permission of the PCC panel, adduce evidence to rebut any evidence that had been adduced by the doctor. The GMC's representative (or the complainant) was then permitted to address the PCC panel. The doctor (or his/her representative) had the final word. At this stage, the parties' submissions would be directed at persuading the PCC panel what findings it should make in relation to the facts

which formed the basis of the allegations against the doctor and in relation to whether those facts which the PCC panel might find proved or were admitted would be insufficient to support a finding of SPM. Those were the two issues which the PCC panel was required to resolve at this stage of the proceedings.

The Panel's Decision on the Facts and on Insufficiency

21.25 Those two issues were identified in rule 27(2) of the 1988 Professional Conduct Rules, which required the PCC to consider and determine, in respect of each charge:

> **'(i) which, if any, of the remaining facts alleged in the charge and not admitted by the practitioner have been proved to their satisfaction, and**
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> **(ii) whether such facts as have been so found proved or admitted would be insufficient to support a finding of serious professional misconduct ...'**.

21.26 The PCC panel was first required to reach a decision on the facts. Although the Rules did not specify the standard of proof to be applied, in practice the GMC has always taken the view that factual allegations must be proved to the criminal standard of proof, i.e. that members of the PCC panel should be satisfied so that they are sure that the facts are as alleged. There is Privy Council authority to support the view that the criminal standard of proof is appropriate in disciplinary cases. In Bhandari v Advocates Committee[2], the Privy Council held that the criminal standard of proof was appropriate in proceedings against an advocate who was alleged to have deliberately deceived and misled the Court. Again, in the case of McAllister v General Medical Council[3], the Privy Council drew a distinction between cases in which the allegation being considered by the disciplinary body amounted to a serious criminal charge (in which case the standard of proof should be that of a criminal trial) and one where it did not. In the latter case, it was **'neither necessary nor desirable'** that the charge should be proved according to the standards and procedures of a criminal trial. What mattered was that the proceedings should be fair to the doctor in all respects.

21.27 Rule 52(3) of the 1988 Professional Conduct Rules set out the system of voting. A bare majority of the PCC panel was sufficient for a decision. If the votes were equal, the rule provided that the question must be deemed to have been resolved in favour of the doctor. If the PCC panel found that none of the facts alleged in the charge had been proved to the required standard, a finding of 'not guilty' would be made.

21.28 It should be noted that there is not and never has been any requirement for the PCC to give reasons for its findings of fact. Reasons are now required for conclusions but not for the findings of primary fact.

21.29 Sub-paragraph (ii) of rule 27(2) required that the PCC panel should then consider and determine, not whether the facts which had been proved or admitted amounted to SPM, but whether they were **'insufficient to support a finding'** of SPM. At this stage, the PCC

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[2] [1956] 3 All ER 742.
[3] [1993] AC 388.

panel was asked to make a decision (the insufficiency decision) on the basis of the available evidence and, if it decided that the facts proved would be insufficient to support a finding of SPM, the proceedings were at an end. If the PCC panel decided that the facts would not be insufficient to support a finding of SPM, the case would continue. However, there would not yet have been a decision by the PCC panel that the facts which it had found proved or which were admitted did amount to SPM.

21.30 This insufficiency decision was taken in the absence of any information about the doctor's past FTP history. It was possible that a PCC panel might have found, for example, that a doctor had failed to attend a patient who was in need of treatment but that the facts were **'insufficient to support a finding'** of SPM. That would be unfortunate if, in fact, the doctor had previously been warned about a similar failure. A repetition of such misconduct would have been more serious than an isolated occurrence. It seems to me that this process of making a preliminary decision as to whether the facts were **'insufficient to support a finding'** of SPM required a very careful direction by the legal assessor. The direction should have been that the PCC panel should not find the facts **'insufficient to support a finding'** of SPM unless it was satisfied that, even if relevant information were later to be presented which was seriously adverse to the doctor, it would still not find that the facts proved or admitted amounted to SPM. In other words, the insufficiency decision should have been taken on the assumption that, when set in context, the doctor's conduct might appear far more serious than it did at the time the decision was being made. I am pleased to see that, under the new procedures, a FTP panel will not be required to make this preliminary insufficiency decision, which, to my mind, was both difficult and rather artificial and was likely to lead to cases being dismissed when they should not have been. In my view, it is doubtful whether panel members understood and applied the legal assessor's direction correctly. Also, I cannot see why there was any need for the insufficiency decision. It seems to me that it merely provided another hurdle for the prosecution and another bite at the cherry for the defence.

Evidence and Findings on the Issue of Serious Professional Misconduct

21.31 Rule 28 of the 1988 Professional Conduct Rules provided that, where a PCC panel found the facts, or some of the facts, alleged in a charge proved or admitted (and, presumably, that they were not insufficient to support a finding of SPM), it should then invite the GMC's representative (or the complainant) to address it:

> **'... as to the circumstances leading to those facts, the extent to which such facts are indicative of serious professional misconduct on the part of the practitioner, and as to the character and previous history of the practitioner. The Solicitor or the complainant may adduce oral or documentary evidence to support an address under this rule.'**

21.32 The doctor (or his/her representative) was then invited to address the PCC panel in mitigation and to adduce evidence in support if desired. After that, the PCC panel would deliberate again. It would consider whether the facts proved did amount to SPM and, if so, what sanction should be imposed. In my view, these were both matters of judgement for the PCC panel, rather than a matter of proof. However, there are indications in the GMC

documents that some people were of the view that SPM must be proved **'beyond reasonable doubt'**. For example, in a document entitled 'Establishing the appropriate standard of proof for GMC hearings into conduct, performance and health: key issues for consideration', produced by the King's Fund in October 2000, which was designed to form a framework for discussion about the appropriate standard of proof to be applied at FTP hearings, it was said that the standard of proof might be applied at any of three stages: when making findings of fact, when assessing whether the facts amounted to SPM and when deciding the penalty if SPM was proved. In my view, only the facts were a matter for 'proof'; the other issues were matters of judgement. In a Consultation Paper in March 2001, the GMC said that opinions differed on whether the criminal standard of proof should apply to the decision whether the facts found proved amounted to SPM and to sanction. I understand that the GMC now takes the view that only the facts need be proved to the criminal standard, and that whether the facts which have been found proved amount to SPM is a matter of judgement.

21.33 Having found the facts (or some of them) proved, the PCC panel might have come to the conclusion that the doctor's behaviour amounted to professional misconduct of a nature which was unacceptable, but not so unacceptable as to amount to SPM. In that event, the panel could take no action. It could not itself issue a warning. It could not remit the case to the PPC with a view to a warning letter or letter of advice being issued. In those circumstances, the PCC panel (and, therefore, the GMC) was, to all intents and purposes, powerless to act. It was pointed out in the report of the PCC Working Group in 1999 that, pursuant to rule 34, a PCC panel could, if it wished, comment on the doctor's conduct, even if it had found that the conduct did not amount to SPM. Of course, that was right; the panel could comment. However, such a comment did not amount to an official warning or reprimand and would not form part of the doctor's FTP history. I note that, under the new procedures, a FTP panel will have the power to issue a warning in cases in which it finds that a doctor's fitness to practise is not impaired.

The Effect of Mitigation

21.34 The practice, as permitted by rule 28 of the 1988 Professional Conduct Rules, of receiving evidence about the doctor's background at the stage before the PCC panel decided whether the doctor's conduct amounted to SPM caused me considerable concern. It seems to me highly likely to have led to the PCC panel, when deciding whether the doctor was guilty of SPM, taking into account material which was, as a matter of logic and principle, irrelevant to that issue. Any evidence (including, of course, evidence in mitigation) which affected the seriousness of the conduct under consideration was relevant to the question of whether that conduct amounted to SPM. It is right also that, in making a judgement about whether the doctor's actions amounted to SPM, those actions had to be viewed in context. Evidence of context would usually have been introduced during the first stage of the evidence. After the decisions on the facts and on insufficiency had been made, evidence relating to other matters might well have been introduced. For example, following a finding that the doctor had breached a patient's confidentiality, it would have been appropriate for the PCC panel to hear evidence that, on a previous occasion, the doctor had been found guilty by a PCC of similar misconduct. That would

have made the breach of confidence under consideration more serious. However, evidence that the doctor had been found guilty by the PCC of misconduct arising from a serious prescribing error would not have been relevant to the seriousness of the breach of confidence under consideration. It would have made it neither more nor less serious. Nor would the fact that the doctor had not been the subject of any previous complaint to the GMC have made the breach of confidence more or less serious.

21.35 Similarly, some forms of evidence in mitigation were relevant to the seriousness of the misconduct in question and others were not. For example, the fact that a doctor had apologised to the patient immediately after the breach of confidence occurred would have been relevant to the seriousness of the misconduct. But the fact that many of the doctor's patients found him/her to be attentive, caring and sympathetic would not. Such evidence about the doctor's character would have been relevant only to sanction. Rule 28, however, permitted the doctor to put before the PCC panel, not only any mitigation relating to the offence that s/he had not advanced earlier, but also purely personal mitigation, which might well have been quite irrelevant to the issue of SPM. For example, it was very common for the doctor to produce testimonials from patients and colleagues about his/her general abilities and character. Those matters might well have been relevant to sanction but they were quite irrelevant to the question of whether the doctor was guilty of SPM. Taking such material into account could have resulted in a finding that the same conduct amounted to SPM in the case of one doctor and not in another. When considering whether the conduct which had been proved amounted to SPM, the PCC panel should, as a matter of principle, have focussed only upon the seriousness of the conduct. Yet I have seen decisions in which it is apparent that, in deciding whether the doctor was guilty of SPM, the PCC panel took into account purely personal mitigation from testimonials.

21.36 A case in point was Kissen, which was decided by a PCC panel early in 2004. The PCC panel found that, over a period of months, the doctor (a general practitioner (GP)) had failed adequately to examine his patient and had failed to heed the complaints of symptoms made by the patient herself and by members of her family. He had attributed the patient's condition (which was, in fact, lung cancer, with symptoms of significant weight loss and the coughing of blood) to rhinitis, aggravated by psychosomatic factors. He admitted that his conduct had been inappropriate, not in the patient's best interests and below the standard of care to be expected of a registered medical practitioner. He denied that his conduct had been irresponsible but the PCC panel found that it had been. However, notwithstanding that finding, the PCC panel found that the conduct did not amount to SPM. In reaching that conclusion, the PCC panel took into account (in addition to some relevant mitigating factors relating to the misconduct itself) some factors amounting to no more than purely personal mitigation. These included a number of testimonials saying that the doctor was a good and caring practitioner. It mentioned the doctor's insight into his failings and the fact that he had taken steps to remedy his deficiencies. All of these matters would have been relevant to the issue of sanction, but were quite irrelevant to the issue of whether the conduct had amounted to SPM.

21.37 I do not criticise PCC panellists who took such material into account. Rule 28 permitted such material to be put before them and it was natural that they would be influenced by it. They were not lawyers. Moreover, the practice of taking irrelevant personal mitigation into

account when deciding whether conduct amounted to SPM was encouraged by some decisions of the Privy Council. In the case of Rao v General Medical Council[4], a PCC panel had imposed conditions on the doctor's registration following a finding of SPM. The doctor had failed to visit a patient in circumstances when he should have done so; he had questioned the patient's wife over the telephone, had concluded that there was nothing seriously wrong, and had offered reassurance. In fact, the patient's wife had reported symptoms of cyanosis and the patient was very ill and died during the night. The PCC panel found that the doctor had made a **'fundamental error'** which was not compatible with good medical practice; in its view, that error amounted to SPM. The doctor appealed to the Privy Council, alleging that the PCC panel had been wrong to find him guilty of SPM. He admitted that he had acted negligently but contended that his negligence was not such as could amount to SPM. He contended that the advice given to the panel by the legal assessor had been misleading as to what might constitute SPM in the context of the case. The Privy Council considered, first, the role of the legal assessor and, then, what was required for a finding of SPM in the context of a case of negligent treatment. In that context, two passages were cited from the Privy Council case of Preiss v General Dental Council[5]. The first was the passage at paragraph 28 of the judgement in that case, which stated:

> **'It is settled that serious professional misconduct does not require moral turpitude. Gross professional negligence can fall within it. Something more is required than a degree of negligence enough to give rise to civil liability but not calling for the opprobrium that inevitably attaches to the disciplinary offence.'**

21.38 In the judgement in Rao, this citation from paragraph 28 of Preiss was followed immediately by a passage taken from paragraph 29 of the judgement in Preiss as follows:

> **'That for every professional man whose career spans, as this appellant's has many years and many clients, there is likely to be at least one case in which for reasons good and bad everything goes wrong – and that this was his, with no suggestion that it was in any way representative of his otherwise unblemished record'**.

In Rao, this passage was cited as if it were part of the judgement of the Court. In fact it was not; it was a quotation from the submission of Counsel for Mr Preiss, in which the Privy Council thought that **'there was some force'**. The citation in Rao of that extract from paragraph 29 of Preiss immediately after the passage from paragraph 28 of Preiss, which deals with the seriousness of negligence which might amount to SPM, seems to suggest that the Privy Council in Preiss was saying that an unblemished record was relevant to the issue of whether the conduct in question amounted to SPM. In fact, the Privy Council was saying no such thing. However, there was no discussion of that issue at that point in Rao, and the judgement moved on to consider whether the advice given by the legal assessor was confusing or wrong. The finding was that the advice was ambiguous and misleading and may have undermined the validity of the PCC panel's decision.

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[4] [2003] Lloyd's Rep Med 62.
[5] [2001] 1 WLR 1926.

21.39 The Privy Council in Rao then listed the factors which the PCC panel should have taken into account in deciding whether the conduct amounted to SPM. It was said that the PCC panel should have started from the premise that this was a borderline case of SPM based upon a single incident. The decision continued:

> **'There was undoubted negligence but something more was required to constitute serious professional misconduct and to attach the stigma of such a finding to a doctor of some 25 years standing with a hitherto unblemished career.'**

21.40 In the event, their Lordships were not convinced that, if the legal advice had been correct, the PCC panel would inevitably have decided that the conduct amounted to SPM. They considered that the PCC panel's finding of SPM should be set aside. The words that I have quoted above seem to imply that it would be proper for the PCC, in deciding whether the misconduct amounted to SPM, to take into account the doctor's 25 years' standing with an unblemished record. In my view, if the Privy Council was suggesting that personal mitigation was relevant to the issue of whether conduct amounted to SPM, that would be contrary to general principle. As I have said, personal mitigation is relevant to sanction but should not, as a matter of principle, affect whether the conduct proved in a particular case amounts to SPM.

21.41 The decision in the case of Rao does not clearly say that an **'unblemished career'** should be taken into account when considering whether or not conduct amounts to SPM, although it does imply it. I thought it necessary to draw attention to this point because, four months after Rao, in Silver v General Medical Council[6], the Privy Council explicitly stated that a past good record should be taken into account when considering whether misconduct amounted to SPM. In the case of Silver, the PCC panel found the doctor guilty of SPM and imposed conditions for a period of 12 months. The allegation, which the PCC panel found proved, was that the doctor had persistently failed, over a period of nine days, to visit an elderly patient who was in need of care and, eventually, of referral to hospital. The doctor was a sole practitioner. It was found that the failure to visit arose from serious managerial, organisational and communications failures within the practice. In short, despite several requests to the practice for a visit – not only from the patient's family but also from other healthcare professionals – Dr Silver never received the message and never attended the patient. The PCC panel found that, as a sole practitioner with responsibility for management of the practice, he was responsible for these failures and that they amounted to SPM.

21.42 The doctor appealed on several grounds, most of which need not be mentioned as they were not successful. The ground which succeeded, and which is relevant to the point under present discussion, was that the conduct found proved did not amount to SPM and that the PCC panel's approach had been **'heavy handed and unfair'**. It was said that the conduct was an isolated lapse and that there was no allegation against the doctor of a broad-ranging nature. It appears from its decision that the PCC panel had considered the seriousness of the conduct, had concluded that it amounted to SPM and had then gone on to consider various matters in mitigation. The first was that the doctor worked in a

[6] [2003] Lloyd's Rep Med 333.

deprived area where it was difficult to get staff. That mitigation was clearly relevant to the gravity of the misconduct. Second, the PCC panel mentioned that the doctor had a large list of patients whom he had served for 40 years as a sole practitioner. It may be that the size of the doctor's list could be a factor to be taken into account in mitigation of the offence if he was under-staffed and over-stretched. However, it is clear that the fact that he had been a sole practitioner in the area for 40 years was purely personal mitigation. Third, the PCC panel mentioned that this was the first complaint recorded against the doctor and that he had produced a large number of testimonials. That was purely personal mitigation. Despite the mitigation, however, the PCC panel found the doctor guilty of SPM.

21.43 Far from criticising the PCC panel for taking personal mitigation into account at this stage, the Privy Council held that the PCC panel had paid insufficient attention to the personal mitigation in deciding whether the misconduct amounted to SPM. In giving the judgement of the Judicial Committee, Sir Philip Otton said that it was **'axiomatic'** that, once the findings of fact had been made, all the relevant circumstances must be considered *before* a finding of SPM could be made. That of course was right. However, their Lordships went on to say that, in their view, all the mitigation was relevant to the decision on SPM.

21.44 In support of this proposition, their Lordships cited a passage from the case of Roylance v General Medical Council[7], which discussed the constituent elements of SPM and referred back to the case of Doughty v General Dental Council[8], which I cited in Chapter 17. The passage from Roylance says nothing about mitigating factors. Their Lordships then cited the same passage from paragraph 28 of the judgement in Preiss and ran it together with the same extract from Counsel's submission quoted in paragraph 29, which I have quoted above. Once again, as in Rao, by running these two passages together, the Privy Council implied that Preiss was authority for the proposition that evidence of good past record was relevant to the question of whether certain conduct amounted to SPM. However, examination of the report of Preiss shows that the Privy Council was not saying that. At paragraph 28 of that case, Lord Cooke of Thorndon said, as I have cited, that SPM does not require moral turpitude, that gross negligence can amount to SPM and that something more is required than the degree of negligence that can give rise to civil liability. That is indisputably right. However, in paragraph 29, Lord Cooke turned to the question of sanction and it was in that context that he observed that Counsel's submission (about the man of many years' standing who has one case where everything goes wrong) had **'some force'**. It is clear that he was saying that evidence of long and blameless service was relevant to sanction. That is plainly right. However, it appears to me that, in both Rao and Silver, the citation from Preiss was taken out of context and was misunderstood. In my view, when asking the question whether an incident or specific course of conduct amounts to SPM, the fact that the doctor had been otherwise blameless for 10, 20 or 40 years was irrelevant. It was, however, highly relevant to what sanction should be applied if it was decided the conduct did amount to SPM.

21.45 Finally, in the case of Silver the Privy Council cited its own decision in Rao. However, as I have just said, that decision too was based upon a misreading or misinterpretation of what Lord Cooke had said in Preiss. In neither Rao nor Silver did the Judicial Committee

[7] [1999] Lloyd's Rep Med 139.
[8] [1988] AC 164.

expressly rely on the GMC Rules as permitting a practice that would otherwise be contrary to principle; it either implied (in Rao) or stated (in Silver) that personal mitigation was relevant to whether conduct amounted to SPM. With great respect to the eminent members of the Judicial Committee, I must say that, in my judgement, the decisions (insofar as they relate to that issue) in Silver and Rao are wrong.

21.46 Under the old FTP procedures, PCC panels received all sorts of material in mitigation before they decided whether the doctor's conduct amounted to SPM. Taking into account material which was irrelevant to the issue 'muddied the waters' and inevitably resulted in cases of serious misconduct being excused because the doctor had a good past record. This must have resulted in some doctors who were in fact guilty of SPM avoiding a finding to that effect, with obvious implications for patient safety. It must also have caused great distress to patients and families who will have had the impression that the misconduct which had been demonstrated was somehow acceptable to the GMC. Such poor decisions reduce public confidence in the GMC and lead to allegations that it is 'too soft on doctors'.

21.47 This problem of taking irrelevant mitigation into account should not arise under the new procedures, where the question for the FTP panel will not be whether the conduct found proved was serious enough to amount to SPM but whether, in all the circumstances, the doctor's fitness to practise is impaired and, if it is, whether the impairment is sufficient to justify action on registration. Thus the panel must take a view 'in the round' of the doctor's fitness to practise and all mitigation is relevant.

Cases in Which the Health of the Doctor Was in Issue

21.48 Schedule 4, paragraph 4 to the Medical Act 1983 reproduced the provisions of Schedule 4, paragraph 4 to the Medical Act 1978. It dealt with the situation where, during the course of a PCC hearing, a question arose as to whether a doctor's fitness to practise might be seriously impaired by reason of his/her physical or mental condition. When such a question arose, the PCC panel had power to refer the question to the HC for determination. The doctor would be medically examined and the HC, having considered the results of the examination, would form a judgement about whether the doctor's fitness to practise was seriously impaired. If, in the HC's judgement, there was no serious impairment, it was required to certify its opinion to the PCC. The PCC panel would then resume its consideration of the case and dispose of it. If, on the other hand, the HC's judgement was that the doctor's fitness to practise was seriously impaired by reason of his/her condition, the HC was required to certify its opinion to the PCC and then to proceed to dispose of the case. The PCC would then cease to exercise its functions in relation to the case. By referring a case to the HC for its opinion, therefore, the PCC did not necessarily lose its jurisdiction over a case. If no serious impairment of fitness to practise was found, the PCC could proceed to deal with the case. The PCC had no power to refer a case to a health screener to be dealt with by means of the voluntary health procedures.

21.49 The relationship between the PCC and the HC is well illustrated by the Privy Council case of Crabbie v General Medical Council[9]. A PCC panel decided to erase Dr Crabbie's name

[9] [2002] 1 WLR 3104.

from the register following her conviction for offences of causing death by dangerous driving and drink driving, for which she had been sentenced to five years' imprisonment. Before the PCC panel, evidence was adduced that Dr Crabbie's fitness to practise was seriously impaired by reason of ill health, namely alcohol dependency. It was contended on her behalf that the PCC panel should refer her case to the HC. The PCC panel declined to do so, saying that the convictions were so serious that the sanctions available to the HC were not adequate to protect the public; the case was so serious that only erasure was appropriate. The doctor appealed to the Privy Council, contending that the PCC panel had erred in refusing to refer the case to the HC and that, in any event, the sanction of erasure was wrong in principle and manifestly too severe. It was said that the case should have been dealt with by the imposition of conditions that would have ensured that the doctor could not resume medical practice until she was fit to do so. The Privy Council advised that the appeal should be dismissed. The PCC panel's reasoning disclosed no error of law and its conclusion was plainly open to it. The Privy Council expressed the view that, as the HC had no power to direct erasure, the PCC should not refer a case to the HC if erasure was **'a serious possibility'**, notwithstanding the fact that there was good evidence that the doctor's fitness to practise was impaired by reason of ill health.

Cases in Which the Performance of the Doctor Was in Issue

21.50 It should be noted also that, on the introduction of the performance procedures in 1997, the PCC was given no power to refer a case to the CPP. Nor was it given any specific power to direct that a doctor should undergo a performance assessment. In practice, this was sometimes achieved by making the undergoing of a performance assessment a condition of continued registration. If the assessment revealed that the doctor's performance was seriously deficient, the PCC panel could not direct that the doctor should be monitored by the CPP or by a performance case co-ordinator under a voluntary statement of requirements. However, the assessment could be of value in that it might have assisted the PCC panel in forming a view about any conditions that should be attached to the doctor's registration when s/he was brought back before the panel. However, the lack of a power to refer the case to the CPP (in the way that it could refer a doctor to the HC) was a *lacuna* in the powers of the PCC. This will be remedied under the new procedures where a FTP panel will be able to direct a performance assessment and act upon it.

Postponement of Determination

21.51 Once a PCC panel had decided that a doctor was guilty of SPM, or that the fact of a conviction had been admitted or proved, it would go on to consider, first, whether it was necessary and appropriate to postpone its determination on whether to impose a sanction. It could, if its members thought fit, postpone its determination to some future date in order to obtain and consider further evidence about the doctor's conduct. It is not clear to me how frequently this power was used. Such documents as I have seen suggest that it was very rarely used in the late 1990s. Where a decision was postponed, the PCC panel might invite the doctor to provide the names of professional colleagues and **'other persons of standing'** to whom the GMC could apply for confidential information as to their knowledge of the doctor's conduct since the time of the original hearing. If the PCC panel

decided that no postponement was necessary, it would then go on to consider whether a sanction was appropriate.

Conclusion of the Case without Sanction

21.52 If the PCC panel decided that no postponement was necessary, it then had to go on to consider whether it was sufficient to make no direction and to conclude the case. If it decided that question in the affirmative, it might decide to issue a reprimand. A reprimand was not a **'direction'** but, in some GMC documents, it was described as a **'sanction'**.

Issuing a Reprimand

21.53 Until recently, the term used was an 'admonishment' but, in 1999, the term was changed to a 'reprimand', as the word 'admonishment' was considered somewhat old-fashioned. The power to admonish was contained in rule 34 of the 1988 Professional Conduct Rules, which provided:

> **'The Chairman shall announce any finding, determination, direction, or revocation of the Committee under these rules in such terms as the Committee may approve and, where the announcement is one that a conviction has been proved or that the practitioner has been judged guilty of serious professional misconduct but the Committee do not propose to make any direction, may, without prejudice to the terms in which any other announcement may be made, include any expression of the Committee's admonition in respect of the practitioner's behaviour giving rise to the charge or charges in question.'**

21.54 A reprimand did not affect a doctor's registration. However, having been given at a public hearing, the reprimand was in the public domain and, if a specific enquiry was made about a doctor's FTP history, the fact that the doctor had been reprimanded should have been disclosed by the GMC.

21.55 The status of a reprimand was not entirely clear. It could not sensibly be regarded as 'action on registration'. The PPC's *aide memoire*, which I described in Chapter 20, advised members of the PPC that SPM might be considered in the context of conduct **'so grave as potentially to call into question a practitioner's registration whether indefinitely, temporarily or conditionally'**. That raised the question whether, when the PPC was considering whether or not to send a case through to the PCC, it should have had in mind that, while no restriction of the doctor's registration was likely to be contemplated by the PCC panel, the panel might well have considered that a reprimand would have been appropriate. If so, should the case have been referred to the PCC? Mr Robert Nicholls, former Chairman of the PPC, said that, for the PPC, the test was whether the relevant conduct had the potential to warrant conditional registration, suspension or erasure. Although it was recognised that a reprimand might be the outcome of a referral to the PCC, that possibility was not in the minds of members of the PPC when deciding whether to refer the case on. It appears that, if the PPC thought that a reprimand would suffice, it would issue a warning letter itself. Such a course avoided the risk, in borderline cases, that the

doctor might be found 'not guilty' of SPM, with the result that the PCC would then be unable to issue a warning or reprimand. I can see the logic of that approach in conduct cases. However, in conviction cases, the PCC would definitely have jurisdiction to impose a sanction, if it thought it appropriate to do so, and it should, in my view, have been for the PCC, rather than for the PPC, to decide on sanction. In any event, the conviction would already have been in the public domain and the public had a legitimate interest in knowing how doctors convicted of criminal offences were dealt with by the GMC and why.

21.56 The 2003 ISG, which, as I have said, was produced for the assistance of PCC panellists, advised that a reprimand might be considered where most of the following factors were present:

'• **Evidence that behaviour would not have caused direct or indirect patient harm.**

- **Insight into failings.**
- **Isolated incident which was not deliberate.**
- **Genuine expression of regret/apologies.**
- **Action under duress.**
- **Previous good history.**
- **No repetition of behaviour since incident.**
- **Rehabilitative/corrective steps taken.**
- **Relevant and appropriate references and testimonials.'**

The 2003 ISG emphasised that the list of factors was not exhaustive. In my view, all these factors were undoubtedly relevant to the issue of sanction. However, it was safe to take such matters into account only where there was a reasonable evidential basis for them. It might well have been unsafe for a PCC panel to accept, without corroborative evidence, that, for example, the incident was an isolated lapse or that there had been no repetition of the conduct since the incident. In the past, it seemed to be assumed that these things were so in the absence of evidence to the contrary. There was rarely any investigation and there was rarely, if ever, any evidence about them. They usually depended upon the assertion of counsel – made, no doubt, in good faith. It appears to me, from the cases that I have read, that assumptions were readily made in the doctor's favour, without any satisfactory evidential basis.

21.57 In considering how the GMC might have treated Shipman if his conduct in the case of Mrs Renate Overton had been reported to the GMC (see Chapter 10), the Inquiry examined a number of other cases which had been reported to the GMC in the mid-1990s and in which a drug overdose had been given with serious or fatal consequences. One such was the case of Dr JM 03, who was given a **'severe'** reprimand at the conclusion of the PCC hearing.

Dr JM 03

21.58 The doctor was a specialist registrar in anaesthesia. Late one evening, she was called upon to provide post-operative analgesia using a device known as an Abbott Provider. The doctor was unfamiliar with the equipment and re-set it wrongly (and unnecessarily) so that the patient received ten times the appropriate dose of the drug, which was fentanyl. The effect was fatal. The case was reported to the GMC but could not progress for some time because other proceedings were current. The police investigated the death but decided not to prosecute the doctor. The Coroner's inquest concluded with a verdict of unlawful killing. The Health and Safety Executive successfully prosecuted the hospital trust under the Health and Safety at Work Act 1974 for its failure to provide the doctor with adequate training in the use of the Abbott Provider. The trust was not able to discipline the doctor because, by the time the prosecution was over, she had left its employment.

21.59 In due course, the case was referred for hearing by the PCC. The allegations were that the doctor had embarked on the use of the Abbott Provider although she was unfamiliar with it; she did not seek the advice of a senior or more experienced colleague; nor did she obtain the instruction manual; she re-set the Provider when there was no need for her to do so. When she checked its operation, she failed to realise that she had miscalculated the dosage. She knew (or should have known) that to re-set the device incorrectly created a risk that the patient would receive a fatal dose. The facts of the case and the various criticisms were all admitted. The doctor expressly admitted that her actions had been reckless and irresponsible. The PCC panel found her guilty of SPM. In mitigation, it took account of the frankness of the doctor's admissions. A number of testimonials had been produced and the PCC panel found that the doctor was a **'caring and conscientious doctor held in high regard'**. The PCC panel also took into account the failure of the trust to provide the doctor with adequate training in the use of the Abbott Provider, as evidenced by its conviction. The PCC panel also expressed the view that a confusing method of describing the contents of solutions of drugs might have contributed to the doctor's error. The PCC panel said that the doctor had learned a great deal from the incident, which represented a single mistake in an otherwise unblemished career. In the particular circumstances, this decision seems to me to have been an acceptable use of the power of reprimand, although some might argue that a period of conditional registration with a requirement to undergo an educational programme might have been more appropriate.

Sanctions

21.60 If a PCC panel decided that it would not be sufficient to conclude a case without any sanction being imposed on the doctor, it then had to consider which of the available sanctions to impose.

Sanctions: Their Purpose

21.61 The GMC states that the purpose of the sanctions is not to be punitive. Rather, their purpose is to protect the public interest although, in fulfilling this purpose, they may have an incidental punitive effect. The 'public interest' includes not only the protection of

patients, but also the maintenance of public confidence in the medical profession and the declaring and upholding of proper standards of conduct.

21.62 The 2003 ISG stated that the **'public interest'** might also include **'the doctor's return to work if he or she possesses certain skills, competencies, or knowledge, for example expertise in a particular area, or language skills'**. The 2003 ISG also advised that, in deciding what sanctions to impose, the PCC panel should apply the **'principle of proportionality'**, weighing the interests of the public against those of the doctor, which latter interests include **'returning immediately to unrestricted practice or after a period of retraining'**. In addition, the 2003 ISG advised that the PCC panel would need to consider any mitigation in relation to the seriousness of the behaviour in question.

Sanctions: the Order in Which They Were Considered

21.63 Rule 31 of the 1988 Professional Conduct Rules stated that a PCC panel should first consider and determine whether it was sufficient to direct that the doctor's registration should be conditional on his/her compliance, for a maximum period of three years, with such requirements as the PCC panel might think fit to impose for the protection of the public or in his/her own interests. This sanction is usually known as 'conditional registration'. If the PCC panel decided that it was not sufficient to impose conditions on the doctor's registration, it had next to consider and determine whether it was sufficient to direct that the doctor's registration should be suspended for a maximum period not exceeding 12 months. If the PCC panel did not consider suspension to be sufficient, it then had to direct erasure of the doctor's name from the register. A PCC panel was, therefore, required to consider the available sanctions in reverse order of severity. The first it would consider was conditional registration.

The Sanction of Conditional Registration

21.64 As I have said, a PCC panel might make a doctor's registration conditional on his/her compliance with stated requirements for a period not exceeding three years in the first instance, renewable for periods of up to 12 months thereafter. The purpose of conditional registration is to enable a doctor to remedy any deficiencies in his/her practice while, in the meantime, protecting the public or the doctor from harm. The 2003 ISG stated that conditional registration would be appropriate **'where there is evidence of incompetence or significant shortcomings in the doctor's practice but where the Committee can be satisfied that there is potential for the doctor to respond positively to retraining'**. This guidance seemed to suggest that the imposition of conditions on a doctor's registration was appropriate in cases in which the proven misconduct was tantamount to seriously deficient performance (SDP). It seems to me that the PCC panels must sometimes have had difficulty in distinguishing between professional misconduct and deficient performance. However, the evidence on which a PCC panel acted was not an assessment of the doctor's overall performance, but an account of one – or at most a few – specific incident(s). The PCC panel was unlikely to have a full picture of the doctor's competence or shortcomings. In the future, the use of a performance assessment (possibly an abridged version of the present lengthy and expensive assessment) will be a useful tool for a FTP panel at this stage of the process.

21.65 The 2003 ISG advised that conditional registration might be an appropriate sanction when most or all of the following factors were apparent:

> '• **No evidence of harmful deep-seated personality or attitudinal problems.**
>
> • **Identifiable areas of doctor's practice in need of assessment or retraining.**
>
> • **No evidence of general incompetence.**
>
> • **Potential and willingness to respond positively to retraining.**
>
> • **Patients will not be put in danger either directly or indirectly as a result of conditional registration itself.**
>
> • **The conditions will protect patients during the period they are in force.**
>
> • **It is possible to formulate appropriate and practical conditions to impose on registration.'**

The 2003 ISG made clear that the list of factors was not exhaustive.

21.66 Conditions may impose exacting and far-reaching restrictions on a doctor's practice (e.g. s/he may not be permitted to practise, save under the supervision of another registered doctor) or may be far less onerous (e.g. s/he may have to take and follow guidance about a particular aspect of his/her practice).

Resumed Hearings

21.67 In a case where a PCC panel had imposed conditions on a doctor's registration, it was open to it, when announcing its decision, to announce also that it would resume consideration of the case at a hearing to be held before the expiration of the period of conditional registration. At the resumed hearing, the PCC panel could decide to revoke the conditions previously made, to vary them, or to impose a further period of conditional registration not exceeding 12 months. A resumed hearing would have afforded an opportunity to 'take stock' of the progress made by the doctor during the period since the conditions had been imposed and of considering whether the doctor had reached the stage of being fit to practise unrestricted.

21.68 The 2001 ISG made no mention of holding a resumed hearing in a case where conditions had been imposed on a doctor's registration. It might be that resumed hearings were not held, or were not held often in cases where conditional registration had been imposed. Resumed hearings were mentioned in the 2001 ISG only in connection with suspension. However, the 2003 ISG mentioned a resumed hearing as a possibility in a case where conditions had been imposed on registration, although the emphasis was still on resumed hearings in cases of suspension.

21.69 If no resumed hearing was held, it appears that, at the conclusion of the period of conditional registration, the conditions simply lapsed and the doctor returned to

unrestricted practice without more ado. I appreciate that to convene a resumed hearing would have been an additional drain on resources. However, I do think that it would have been of value to hold a resumed hearing. It would have focussed the mind of the doctor on what s/he would be expected to have achieved by the time of the resumed hearing. It would also have given the PCC panel some insight into the practical operation of the sanction it had imposed. In that way, PCC panels would have learned what worked well or less well as remediation for particular kinds of problem.

21.70 If the PCC panel did not announce that it intended to resume consideration of a case in which conditions had been imposed on a doctor's registration, the 1988 Professional Conduct Rules nevertheless permitted the case to be referred back to the PCC panel if information came to light about the conduct or conviction of the doctor since the original hearing or if it appeared that the doctor was not complying with the original conditions. The PCC panel could then consider whether the period of conditional registration should be extended, or the conditions varied or revoked, or whether the doctor's registration should be suspended or his/her name erased from the register. If an intimation had been given at the original hearing that the hearing would be resumed, the case could be brought back earlier than intended if relevant information was received.

Comment

21.71 It is clear that there are advantages in imposing conditions on a doctor's registration. They are the only means of enforcing remedial action with the prospect of achieving a result that is beneficial both to the doctor and, in the longer term, to the public. The disadvantages are that allowing a doctor to practise under conditions may expose the public to a potential risk. First, the doctor is usually allowed to practise while undergoing part-time re-education. The public may be at risk while that process is underway. It can be difficult for the GMC to monitor the doctor's compliance with conditions. Second, unless the doctor is assessed at the end of the period, there is no certainty that the exercise has been effective. Full-time remedial training for a concentrated period with assessment at the end would, in some cases, be a much more effective process – but very expensive. Third, it seems to me that the GMC should make it plain, in words and by its actions, that, if the doctor cannot demonstrate that the objectives underlying the conditions have been satisfactorily achieved, erasure will follow.

Cases Where Conditions Were Imposed on the Doctor's Registration

21.72 While examining cases that were relevant to the case of Mrs Overton, the Inquiry came across some examples of cases in which conditions had been imposed.

Dr JC 02

21.73 One such was the case of Dr JC 02, who was brought before the PCC in the early 1990s following two incidents in which he had (negligently) administered an overdose of diamorphine. Both patients had died. The Coroner had returned verdicts of misadventure in both cases and, on the second occasion, a medical service committee (MSC) had found the doctor in breach of his terms of service. The PCC found SPM proved but the

sanction was the imposition of conditions for eight months with a requirement that the doctor should undergo retraining in the use of **'therapeutics'** and should not prescribe or possess diamorphine. At the end of the period, there was to be a resumed hearing at which the doctor was to produce certificates and references to demonstrate that he had undergone retraining. At the resumed hearing, the doctor was referred to the Health Committee.

Dr JG 03

21.74 In another case, that of Dr JG 03, which was heard in the mid-1990s and to which I referred in Chapter 10, the PCC panel imposed a period of conditional registration following the doctor's conviction for perverting the course of justice and a finding of SPM. The events had taken place three years earlier. The doctor had been consulted by a patient who suffered from asthma. At the time, her asthma was not troubling her but she had been experiencing palpitations. The doctor prescribed propranolol, a drug which is contraindicated for asthmatics. The following day, the patient suffered a very severe attack of breathlessness and died. The doctor was told what had happened. He then made a number of changes in the computerised medical records, removing several references to the patient's history of asthma. In the course of the investigation that followed and when giving evidence at the inquest, he claimed that he had been unaware that the patient suffered from asthma. He claimed that he had had access only to the handwritten records on the day in question; he had not been able to read his partner's writing and had not recognised any reference to asthma. Later, it was found that he had falsified the computer records; he was prosecuted, convicted and sentenced to six months' imprisonment.

21.75 During the course of the investigation, evidence emerged that the doctor had falsified medical records on another occasion, in order to cover up an error that had been the subject of a separate complaint to the local MSC. However, the GMC did not take proceedings in respect of the earlier occasion; it considered only the prescribing error resulting in the death of the asthmatic patient and the conviction for perverting the course of justice. The PCC panel found that the doctor's care of the patient had fallen deplorably short of a reasonable standard and amounted to SPM. Because of the period of imprisonment served and other factors regarded as mitigating the severity of the offence, it decided to impose conditions on the doctor's registration for one year. The doctor was required to consult with his Regional Adviser in General Practice, to undergo an assessment of his consultation skills, history taking and physical examination and to follow the advice of the Regional Adviser about remedying any deficiencies in knowledge and history taking and about keeping accurate and contemporaneous records.

21.76 Dr Korlipara told the Inquiry that, although he had sat on the PCC panel which heard this case, he had no recollection of it. He was surprised that the PCC panel had imposed conditions and said that it would have been more usual to direct erasure or at the very least a long period of suspension. I interpose to say that the longest period of suspension available is a year. Dr Korlipara agreed that dishonesty could not be rectified by retraining. The PCC panel reviewed this case at a resumed hearing 11 months after the first hearing.

It received correspondence from the regional adviser who said that the doctor had made satisfactory progress. The doctor was then allowed to practise unrestricted.

21.77 As a footnote to this case, about seven years later, the GMC became aware of a further complaint about Dr JG 03, who was said to have failed to diagnose meningitis in a young baby. The case was closed by the office staff because the local complaints procedures had not yet been completed. There is no indication on the file that any steps were taken to monitor or follow up the progress of the local complaint. Dr Korlipara agreed that the GMC ought to pursue such complaints proactively in the case of a doctor with a serious disciplinary history such as Dr JG 03.

21.78 In my view, the imposition of conditions in the case of Dr JG 03 was inappropriate. I find it hard to accept that the PCC panel members could have had at the forefront of their minds the need to protect the public. There were serious concerns about the doctor's honesty. I believe that many members of the public would consider that dishonesty of this kind demonstrates an unfitness to practise because the doctor cannot be trusted. I recognise that attitudes might have hardened since it was discovered that Shipman habitually falsified medical records. But, even without that, I think that the public feels that it should be able to trust doctors – not always to avoid making mistakes but at least, when one is made, not to lie about it. Sir Donald Irvine told the Inquiry that, in his view, the GMC should seek to reach consensus with the public about appropriate sanctions. It seems to me that that would be a sensible course in respect of all sanctions but especially in respect of cases of dishonesty. Dr Korlipara agreed that a dialogue with the public about such issues would be helpful.

Dr JM 04

21.79 The case of Dr JM 04 also involved a serious prescribing error but, in his case, there was no attempt to 'cover up'. The doctor was called out to see a patient who was suffering from severe pain. The doctor diagnosed renal colic and, despite the fact that the patient said that his pain had subsided, administered 75mg Voltarol and 30mg diamorphine intramuscularly. This was a gross overdose and the patient died about an hour later, owing to morphine toxicity. The police investigated the death. They were unable to find either a prescription for 30mg diamorphine or an entry in the practice controlled drugs register. In the doctor's bag at his home, they found three 30mg ampoules and one 10mg ampoule of diamorphine, as well as other drugs and a copy of the British National Formulary. It would appear therefore that the doctor kept a supply of diamorphine and had used some from his stock on the patient who had died. He had not complied with the statutory requirements governing its use. The doctor was charged and convicted of manslaughter and was sentenced to 12 months' imprisonment, suspended for two years.

21.80 Shortly after the GMC was notified about the conviction, it was discovered that Dr JM 04 had been the subject of another complaint, which had been handled locally. This incident had occurred only a few weeks after the prescribing error. He had failed to attend a patient who was ill and complaining of sweating; the patient had died of pneumonia shortly afterwards. The local health authority (HA) had taken disciplinary proceedings, at which the mother of the deceased patient had given evidence. The doctor had been found in

breach of his terms of service. The mother was willing to sign a statement for the GMC but said that she would find it too distressing to repeat her oral evidence at a PCC hearing. The decision was taken at the GMC that it would be inappropriate to issue a *subpoena* to compel her attendance and that no action should be taken on the second complaint. I interpose to say that it does not appear that any attempt was made to visit the mother or even to speak to her on the telephone to explain to her the importance of her presence before the PCC and the consequences of her refusal to give oral evidence. In any event, the GMC could have applied to the PCC panel for her evidence to be admitted in written form; the PCC panel could have accepted it. Rule 50(1) of the Preliminary Proceedings Committee and Professional Conduct Committee Rules 1988 provided that the PCC might receive oral, documentary or other evidence of any fact which appeared to them to be relevant to its inquiry into the case before it. Further, insofar as any evidence was tendered which would not have been admissible in criminal proceedings in England (and written statements of evidence are not usually admissible), the PCC could not receive it unless, after consideration, it was satisfied that its duty of making due inquiry made reception of that evidence desirable. Thus, rule 50 could have been used to found an application to introduce the written evidence of the mother of the deceased patient in this case. As it was, the panel considered only the allegation relating to the administration of diamorphine.

21.81 The PCC panel found that the doctor's actions in administering 30mg diamorphine had been highly irresponsible. The doctor's explanation, advanced through counsel, was that he had qualified abroad, in a country where diamorphine was not generally used; therefore he was unfamiliar with its properties. He had been very anxious to relieve the patient's pain and had thought that the dose he gave was appropriate. Many testimonials were produced and the panel found that the doctor was a **'caring GP who had made a tragic error'**. It was, of course, quite unaware of the findings of the local MSC in respect of the second incident. The PCC panel imposed conditions on the doctor's registration for a period of 12 months. These were conditions of general supervision, of notification of where he would be practising and of providing reports on his performance to the GMC. There was no specific condition with regard to his right to prescribe controlled drugs or to any retraining in their use.

21.82 Dr Korlipara said that the PCC panel's decision in this case had been 'sympathetic' and that erasure or a 'long' period of suspension would have been more usual. He sought to justify the PCC panel's decision on the basis that this was believed to be an isolated error in the career of a good doctor. (The GMC knew that it was not but the PCC panel was not told.) Dr Korlipara mentioned that the error of dosage would never have happened had it not been that the doctor was so caring and so anxious to relieve the patient's pain. The PCC panel had sought to protect the public by arranging supervision. He did not think it would have been necessary or appropriate for the GMC to investigate any possible concerns about the doctor's practice of keeping diamorphine in his bag (although apparently not being accustomed to using it) and about his non-compliance with the statutory requirements. That, he said, was a matter for the local NHS bodies.

21.83 Soon after the PCC panel's decision was announced, the GMC received a letter from a colleague of Dr JM 04. He was able to impart information about the circumstances surrounding the administration of diamorphine that had led to the conviction and also cast

doubt on the accuracy of some of the matters advanced in mitigation. If this information was true, it would have put a different complexion on the case and the outcome might well have been different. As I have said, it has not been the GMC's practice to contact employers or colleagues as part of its investigation.

21.84 I wish to make three observations. First, there appears to be a real possibility that the PCC panel dealt with this case on the basis of incomplete information about the circumstances of the misconduct underlying the conviction and unjustifiably favourable mitigation. The result may well have been the imposition of a sanction that did not adequately protect the public or the doctor's future patients. Second, it seems to me that it would be sensible, especially in conviction cases, for the GMC to make enquiries of the partners or colleagues of the doctor and of his/her employer or primary care trust. Otherwise, the GMC cannot set the facts of the conviction in context. Nor is it in a position to check the veracity of matters advanced in mitigation by counsel on instructions. Third, in my view, it would be preferable for a PCC panel, when considering the imposition of conditional registration, to invite the doctor to give evidence. I do not see how a panel can adequately assess the doctor's attitude towards his/her misconduct and his/her commitment to retraining on the basis of an address by an advocate.

The Case of Ghosh

21.85 The importance of hearing evidence from a doctor during PCC hearings was recognised by the GMC in the case of Ghosh v General Medical Council[10]. Dr Ghosh was found guilty of SPM in April 1998 on charges of failure to visit patients when necessary. The PCC panel imposed conditions for two years. Excellent arrangements were made for Dr Ghosh's re-education under the supervision of the Associate Dean of Postgraduate GP education. She was placed in a practice where the partners were willing to supervise her. However, there were soon signs that Dr Ghosh did not accept the need for supervision or for any change in her attitude and, in due course, it became apparent that she was not complying with the conditions imposed. Moreover a serious complaint was received in July 1999 that the doctor had not attended a patient whom she had promised to attend and who was in urgent need of attention. Soon afterwards, Dr Ghosh went abroad for two and a half months without warning the practice. Both the practice and the Associate Dean abandoned their attempts to supervise her. The Associate Dean wrote to the GMC urging it to bring the case back for review earlier than the date originally envisaged for the resumed hearing. In October 1999, the HA by which Dr Ghosh had been employed during her period of supervision dismissed her for gross misconduct in respect of the incident in July 1999. Dr Ghosh then asked the GMC for permission to work in various settings and complained that the Associate Dean would not help her **'because she was ill'**. She repeatedly failed to provide the GMC with information about her activities.

21.86 In October 2000, Dr Ghosh came back before a PCC panel. She appeared by counsel and did not give evidence. It was claimed on her behalf that she had taken appropriate steps to re-educate herself. By way of example, she produced a letter from a doctor who said that she had attended antenatal clinics as an observer during August, September and

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[10] [2001] 1 WLR 1915.

October 1999. When it was pointed out that, for much of that time, she had been abroad, it was said on her behalf that the doctor who had written the letter had made a mistake about the dates; however, she had begun attending the clinic on her return to this country and was still doing so. The PCC panel asked counsel what evidence there was of this attendance and counsel said that she was relying upon her instructions. The PCC panel indicated that that was not evidence and there followed some discussion about whether Dr Ghosh would testify. She did not do so. It is clear from the reasons given by the PCC panel for its decision that this failure on her part was a significant factor in its decision to reject Dr Ghosh's claims and to erase her name from the register. Dr Ghosh appealed against the erasure to the Privy Council, without success.

21.87 It is, I think, generally recognised that conditions requiring retraining are likely to succeed only if the doctor is genuinely committed to them. I repeat that, in my view, the PCC panel (and, indeed, other committees or panels empowered to impose conditions) should have required a doctor to answer its questions personally before deciding to impose conditions. I suspect that, in the case of Dr Ghosh, it would have been clear that she was not minded to co-operate. In such a case, if immediate erasure were thought inappropriate and conditions were the only possible course, it would surely have been preferable to arrange an early review of the case rather than leave matters for as long as two years. There is no evidence that Dr Ghosh practised in breach of her conditions but there must have been a risk that she would do so after the arrangements for supervision had broken down.

Dr JF 02

21.88 Finally in this section dealing with conditional registration, I must mention the case of Dr JF 02. The GMC received two complaints about this doctor in the early 1990s. One alleged an inappropriate internal examination, for which no chaperone was offered; the other alleged the administration of a gross overdose of diamorphine (100mg) shortly before the patient was despatched to hospital in an ambulance. The patient went into respiratory arrest but was resuscitated on arrival at hospital. Both matters were referred to a medical screener who requested immediate and urgent action in the case of the overdose and directed that the female complainant in the case of inappropriate examination should be asked to provide a statutory declaration. A letter of request was sent but no reply was received and, apart from a reference to the fact that the doctor disputed the allegation, there is no further record of this complaint in the file. In the light of subsequent events, the seriousness of the consequence of not following up that complaint will be understood.

21.89 The diamorphine complaint was referred to the PPC and the doctor was informed. His solicitors submitted his explanation, which was that he needed strong pain relief for the patient; he went to the pharmacy and asked for morphine or something similar. He was provided with diamorphine, which he had never used before. He checked the drug information leaflet and must have misread it, as he gave too much. The PPC sent the case to the PCC. Five months after the complaint had been recorded by the GMC, the doctor was found guilty of SPM and was placed on conditional registration for a period of six months, during which time he was to pursue a structured programme of retraining in the

use of controlled drugs. At the end of the period of conditional registration, the doctor was free to practise without restriction, having apparently completed his retraining.

21.90 Only two months later, the GMC received a complaint that Dr JF 02 had carried out an inappropriate internal examination on an elderly female patient. However, the GMC decided to take no action because it considered that the main issue was whether the doctor had obtained valid consent before examining the patient. The GMC wrote to the HA which had reported the matter, suggesting that the patient should take civil action through the courts and that, if it were established that the doctor had not obtained consent, it would be open to the patient to renew her complaint to the GMC. Pausing in the history there, that seems to me a wholly inappropriate response to such a complaint. The GMC should have investigated the allegation even if it had stood alone; the need to do so was even greater in view of the earlier allegation of an inappropriate examination received the previous year. The GMC now had two potential allegations of sexual misconduct, from apparently unrelated sources, and neither was investigated.

21.91 About two years later, the HA in whose area the doctor practised wrote expressing concern about a number of matters relating to Dr JF 02. His prescribing was said to show a **'seriously deficient pattern of performance'**. He had been prescribing methadone inappropriately for addicts and was also prescribing benzodiazepines to young patients over long periods. A GMC memorandum noted that these concerns might amount to SPM. However, three other complaints forwarded by the HA were thought not to raise questions of SPM and were screened out. These related to rudeness, excessive physical contact with a patient, performing an examination in an aggressive way and refusing to give assistance to a girl involved in a car accident. The HA wrote expressing its disappointment at the decisions to screen these complaints out, said that it was concerned about the welfare of patients and gave details of another specific concern. This related to a female patient, with whom it was alleged that Dr JF 02 was having a **'non-professional relationship'**; he was supplying her with prescriptions for large amounts of benzodiazepines and opiate analgesics including Oramorph solution. The PPC referred to the PCC the allegations of irresponsible prescribing of methadone. At the same time, the HA informed the GMC that Dr JF 02 had been charged with nine counts of indecent assault and 30 counts of obtaining drugs by deception. Soon afterwards, the doctor was suspended from the HA's list by the NHS Tribunal on an interim basis.

21.92 The PCC hearing was deferred pending the outcome of the criminal proceedings, which were concluded ten months later. The doctor was found guilty of one count of indecent assault and then pleaded guilty to five counts of theft of drugs. He was sentenced to eight months' imprisonment for indecent assault and four months' imprisonment for theft, both sentences to be suspended for two years. All remaining charges were 'left on the file'. That meant that they would not proceed further unless, because of some exceptional and unforeseen circumstance, the court decided that they should proceed. There was, of course, no bar on the GMC hearing evidence in relation to them and, in particular, in relation to the allegations of indecent assault, each of which must have raised a question of SPM. However, the GMC did not do so.

21.93 Shortly after the doctor's conviction, the HA intimated that further complaints about him were to be forwarded and expressed concern about the delay that had already occurred

and about the length of time it might take to bring all these matters to the PCC. It urged the GMC to take immediate action. Mr Scott, Chief Executive of the GMC, admitted in a letter to the HA that the GMC **'could have done better'** and promised that the case would be considered at the next meeting of the PPC. The following month, the HA sent details of the additional concerns. These included an allegation that the police had found pornographic material at the doctor's home and surgery. The PPC considered the issue of interim suspension at its next meeting (this was before the Interim Orders Committee (IOC) was established) but did not make an order. The case did not come before the PCC until five months later. Then, the only matters before the PCC panel were the convictions and the allegation of irresponsible prescribing of methadone to addicts. On this latter charge, a PCC panel found SPM proved. The sanction imposed in respect of the convictions and the finding of SPM was suspension for 12 months.

21.94 I must make two observations. First, even on the basis of the material before the PCC panel, this decision seems unduly lenient. The doctor was dealt with for indecency, dishonesty and irresponsible prescribing of controlled drugs. I would have thought that only erasure could provide adequate protection for the public. I think that, if such a decision were to be made today, the Council for the Regulation of Healthcare Professionals (now known as the Council for Healthcare Regulatory Excellence (CRHP/CHRE)) would refer the case to the High Court as being unduly lenient. However, the CRHP/CHRE did not exist at that time. Second, the GMC had made no attempt to resolve all the other complaints made and concerns expressed about this doctor. Several complaints had been screened out because, standing alone, they could not amount to SPM. Others, such as the allegations of indecent assault, which had not been tried at court, were simply not dealt with. It may be – I cannot say – that, if the evidence of all the other matters had been put to the PCC panel, the doctor might have been acquitted on all of them, in which case he was dealt with on a proper basis. However, in the light of subsequent events, it seems very likely that, if further charges had been put, there would have been further findings amounting to SPM. It seems to me that the GMC knowingly dealt with this doctor on the basis of incomplete information. The process by which complaints were considered in isolation, and were screened out if they could not, of themselves, amount to SPM, did not provide adequate protection to patients. A doctor who behaves unacceptably on three occasions (as for example by being rude or aggressive to a patient) may not be guilty of SPM on each individual occasion but, when all three allegations are considered together, his/her misconduct must surely be viewed in a much more serious light.

21.95 A PCC panel reviewed the case at a resumed hearing a year later and declared that it was not satisfied that it would be safe to allow the doctor to return to unrestricted practice. It imposed conditions on his registration for 12 months. The doctor was permitted to practise only under the general supervision of another doctor and was not to prescribe drugs of addiction or their substitutes to patients he knew or suspected to be drug addicts.

21.96 A year later, the NHS Tribunal made a final order, removing the doctor from all NHS lists. The Tribunal considered a wide variety of allegations, including sexual assaults, sexually inappropriate behaviour, keeping obscene videos in his surgery, rudeness and arrogance, dishonesty and clinical incompetence, both generally and specifically with

regard to the treatment of drug dependency. The NHS Tribunal found that Dr JF 02 was an **'irremediably bad doctor'** who should not be allowed to treat NHS patients. It should be noted that most of the allegations considered by the NHS Tribunal had been reported to the GMC. I have read the decision of the NHS Tribunal. It is clear that it heard a great deal of evidence and approached each allegation with care. Its findings are clearly explained and appear to me to be fully justified on the evidence. More importantly, because of its willingness to hear all the matters together, the Tribunal was able to gain a holistic view of the doctor's conduct, practice and character. By dealing with allegations in a piecemeal fashion, the GMC had not been able to do that. Following the decision of the NHS Tribunal, the doctor remained free to practise in the private sector.

21.97 Subsequently, the PCC panel resumed its consideration of Dr JF 02's case. It found that the doctor had been unable to practise in the NHS owing to the ruling of the Tribunal. He was not in breach of the conditions previously imposed by the PCC panel. He was placed on conditional registration for a further 12 months. It appears that, the following year, the doctor obtained work in a cosmetic surgery clinic in the private sector. Subsequently, the clinic reported concerns about him to the National Care Standards Commission. These concerns related to the doctor's poor standards of hygiene and inappropriate sexual behaviour. The substance of these concerns was brought to the attention of the PCC panel when it reconsidered Dr JF 02's case at the expiration of his period of conditional registration. Nonetheless, the PCC panel decided to renew the conditional registration for another year, during which the doctor was to undergo an assessment of his performance. He remained free to practise in the private sector.

21.98 In a witness statement made for the Inquiry, Sir Donald Irvine described this as **'an appalling case in which the GMC has failed and continues to fail to protect the public properly'**. I agree. I am pleased to report that, subsequently, the PCC granted Dr JF 02's application for voluntary erasure from the register. I would not envisage that any application for restoration would succeed.

The Sanction of Suspension

21.99 As I have explained, if it did not consider that the imposition of conditions on a doctor's registration was sufficient, a PCC panel had next to consider whether it would be sufficient to direct that the doctor's registration should be suspended for a period not exceeding 12 months.

21.100 Suspension normally took effect 28 days after the date of the PCC's order, unless the doctor exercised his/her right of appeal to the High Court (until 2003, the Privy Council). However, if a PCC panel decided to impose a period of suspension or to erase the doctor's registration and if it appeared to the PCC panel that there might be reasons (either in the public interest or in the interest of the doctor) for imposing immediate suspension, it had the power to do this, provided that it invited representations on the question before making its decision.

21.101 The 2003 ISG advised that suspension could be used to **'send out a signal'** to the doctor, to the profession and to the public about what was regarded as unacceptable behaviour. The 2003 ISG pointed out that suspension had a punitive effect, in that it prevented the

doctor from practising and, therefore, from earning a living as a doctor during the period of suspension. The 2003 ISG continued:

> **'It is likely to be appropriate for misconduct that is serious, but not so serious as to justify erasure (for example where there may have been acknowledgement of fault and where the Committee is satisfied that the behaviour or incident is unlikely to be repeated). The length of the suspension may be up to 12 months and is a matter for the Committee's discretion, depending on the gravity of the particular case.'**

As a signal, suspension may be effective, but as a sanction it may be counter-productive. Unless the doctor has undergone a programme of re-education or has otherwise used the time productively, s/he will emerge from suspension de-skilled, demoralised and probably a less effective doctor than s/he was when originally suspended.

21.102 The 2003 ISG advised that suspension might be appropriate when some or all of the following factors were apparent:

> **'A serious incident of misconduct but where a lesser sanction is not sufficient.**
>
> **Not fundamentally incompatible with continuing to be a registered doctor.**
>
> **No evidence of harmful deep-seated personality or attitudinal problems.**
>
> **No evidence of repetition of behaviour since incident.**
>
> **Committee satisfied that doctor has insight and does not pose a significant risk of repeated behaviour.'**

The 2003 ISG made clear that the list of factors was not exhaustive.

Resumed Hearings

21.103 As with conditional registration, when a PCC panel suspended a doctor, it could state, when announcing its decision, that it would resume consideration of the case before the end of the period of suspension. The 2003 ISG did not envisage that a resumed hearing would be necessary in every case. It stated:

> **'In some cases, it may be self-evident that following the period of suspension, there will be no value in seeing the doctor again. However in most cases where a period of suspension is imposed, the Committee may need to be reassured that the doctor has a continuing commitment to practise as a doctor; has fully appreciated the gravity of the offence; has not re-offended, and has maintained his or her skills and knowledge.'**

21.104 I would have thought that it would have been a rare case of suspension in which it was not appropriate to review the position at the end of the period of suspension. I also think it appropriate that any disciplinary panel should have the opportunity to question the doctor

personally, in addition to receiving any written reports. Of course, doctors cannot be compelled to give evidence but there should be an expectation that they will submit to questioning and that adverse inferences might be drawn from a refusal to do so.

21.105 At the resumed hearing, a PCC panel had the power to direct that the period of suspension should be extended for a further period, not exceeding a period of 12 months, from the time when it would otherwise expire. It was also open to the PCC panel to impose a period (not exceeding three years) of conditional registration or, if it did not regard either of the previous alternatives as sufficient, to direct that the doctor's name should be erased from the register. Cases could be brought back to the PCC panel where no intimation of a resumed hearing had been given, or in advance of the intended date for the resumed hearing, in circumstances similar to those which applied to conditional registration.

21.106 The 2003 ISG advised that there might be cases where a PCC panel might wish to impose a period of suspension and, at the same time, to direct a resumed hearing and to recommend the type of educational programme the doctor might undergo, or the action s/he might wish to take, during the period of his/her suspension. This could be a potentially useful tool if the objectives were made clear at the start and if, at the resumed hearing, there were to be proper evidence about what had been achieved. However, the wording of the 2003 ISG, which suggested that the PCC panel might recommend an educational programme that the doctor **'might undergo'** or an action that the doctor **'might wish to undertake'**, does not sound as if it was intended that there should be a clear objective which the doctor was expected to achieve or that the consequences of failure might be serious.

Cases Where the Doctor's Registration Was Suspended

21.107 I have said that the Inquiry had an interest in cases in which doctors were found to have been dishonest. The Inquiry also had a particular interest in cases in which doctors had fabricated medical records to cover up misconduct. Shipman did this on many occasions. The Inquiry examined some such cases and found that the sanction imposed was sometimes a period of suspension.

Dr JF 04 and Dr JF 03

21.108 The linked cases of Dr JF 04 and Dr JF 03 are an example of this. Dr JF 04 and Dr JF 03 were husband and wife and were in practice together. In the early 1990s, a complaint was made to the local Family Health Services Authority (FHSA) that Dr JF 04 (the husband) had, a short time earlier, failed properly to examine patient A and had failed to refer her for specialist investigation. Also, he had allegedly been rude to the patient. Later that year, when the complaint was under investigation, Dr JF 04 produced to the FHSA patient records that had been falsified by both Dr JF 04 and Dr JF 03 for the purpose of misleading the FHSA in its investigation. Shortly after receipt of the first complaint, another complaint was received by the FHSA on behalf of patient B, who alleged that both doctors had failed to examine the patient properly, had failed to ascertain the cause of his symptoms and had failed to refer him for specialist investigation when his condition required such referral. Later that year, when the complaint was being investigated by the FHSA, the doctors

produced records that had been falsified by them both for the purpose of misleading the FHSA.

21.109 Both doctors were referred by the PPC to the PCC and their cases were heard over two years after they had first been referred to the GMC. Some of the allegations (including the falsification of records) were admitted and others were found proved. Some allegations were found not proved. A PCC panel found both doctors guilty of SPM. After the receipt of material in mitigation (which included a large number of testimonial letters from patients), both doctors were suspended from practice for three months. Pausing there, I think that this decision would strike many members of the public as unduly lenient. Indeed, in her statement to the Inquiry, Dr Trowell expressed the view that these doctors' names should have been erased from the register. She felt that the PCC panel must have been very impressed by the mitigation advanced since it imposed only three months' suspension. As we shall see, the mitigation was not all that it seemed to be.

21.110 As I have explained, suspension normally took effect 28 days after the date of the order, unless the doctor exercised his/her right of appeal to the High Court (then the Privy Council). The wife did not appeal and 'served' her period of suspension. The husband appealed to the Privy Council, thereby deferring his suspension. The appeal was withdrawn in the month in which his wife's period of suspension expired and the withdrawal was accepted by the Privy Council in July. It is clear that this was a tactical appeal, designed to ensure that the two partners were suspended at different times.

21.111 A few weeks after the PCC hearing, the GMC received information that some of the testimonial letters presented to the PCC panel had been obtained in dubious circumstances. In one case, there was evidence that the wife had asked a patient to write a letter at her dictation, without explaining why it was needed. When the patient returned to the surgery to express concern about this, the husband told her that it would not be used. In fact it was. There were six other cases in which different complaints were made. In one, the patient complained that the wife had composed the letter and the patient had felt **'pushed'** into writing it; in another, the patient had agreed to write a letter of support, at the wife's request, but was not told why it was wanted. These complaints came before the PPC three months after the expiration of the wife's suspension. Presumably the screener must have thought that they raised a question of SPM. The husband admitted the allegation against him and apologised that he had not heeded the request of the patient who had asked to withdraw her letter. So far as I can see from the file, the wife did not reply to the letter informing her of the allegations.

21.112 The PPC panel decided not to refer the new complaints to the PCC. Instead, it directed that a letter of warning should be sent to the wife and a cautionary letter should be sent to the husband. In his Inquiry statement, Dr Robin Steel, who was Chairman of the PPC at the time, said that the PPC would not have sent the complaints on to the PCC because it would have thought it most unlikely that the PCC would wish to take any additional action on registration, bearing in mind that it had already imposed a three-month suspension. He also stated that all the testimonials submitted by the doctors had been **'investigated'** and only a small proportion turned out to have been obtained in dubious circumstances. This case leaves me with the impression that these two dishonest doctors ran rings around the GMC.

Dr JP 01

21.113 Another case in which a PCC panel imposed a period of suspension upon a doctor found guilty of substandard practice and dishonesty was that of Dr JP 01. The doctor had failed to carry out an adequate examination of a patient in 2000. The patient was subsequently admitted to hospital and died. The doctor failed to make a contemporaneous note of his examination and later made false entries in the records in relation to that occasion and to a previous consultation some 16 months earlier. At the hearing in 2003, the PCC panel found that the doctor's actions were irresponsible, dishonest and intended to mislead. He was found guilty of SPM and suspended from practice for six months. Here again, I think the public would feel that this sanction was unduly lenient. My own view is that the public needs protection from this kind of doctor who cannot be trusted. In any event, I believe that there is a need for the public to be consulted about the appropriate sanctions for misconduct, particularly those involving dishonesty.

The Sanction of Erasure

21.114 The most serious sanction available to the PCC is erasure of a doctor's name from the medical register. The 2003 ISG advised that erasure from the register was appropriate where this was the only means of protecting patients and maintaining public confidence in the medical profession. It advised that erasure was likely to be appropriate when the behaviour in question was **'fundamentally incompatible with being a doctor'** and involved any of the following:

'• Serious departure from the relevant professional standards as set out in Good Medical Practice.

- **Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients.**
- **Abuse of position/trust (particularly involving vulnerable patients) or violation of the rights of patients.**
- **Dishonesty (especially where persistent and covered up).**
- **Persistent lack of insight into seriousness of actions or consequences.'**

Once again, the 2003 ISG emphasised that the list of factors was not exhaustive.

Cases Where the Doctor's Name Was Erased from the Register

21.115 I wish to discuss a few cases in which a PCC panel directed erasure from the medical register. Some of these cases were appealed to the Privy Council – some successfully, some not. These cases have been selected because they deal with issues that are of particular interest to the Inquiry in view of similarities to some aspects of Shipman's behaviour. I stress that the Inquiry has not undertaken a systematic review of PCC decisions. With that *caveat*, however, I must observe that it is difficult to detect any

consistent thread of seriousness or mitigating factors that explain why one case was dealt with by erasure while another resulted in suspension or the imposition of conditions. The impression is one of inconsistency. This was recognised by the PCC Working Group in its report of 1999.

Dr JM 08

21.116 I mentioned earlier that, because of the case of Mrs Overton, the Inquiry was particularly interested in cases in which a doctor had administered an overdose of an opiate drug. One case brought to the Inquiry's attention in this context was that of Dr JM 08. While working for a deputising service in 2000, Dr JM 08 had been called to see a patient suffering from lung cancer and bronchopneumonia. He administered 45mg morphine to the patient, who had never previously been given that drug. This was a grossly excessive dose. The patient died two hours later and the autopsy found that morphine poisoning was one of the causes of death. The police investigated the death but decided not to prosecute; they reported the case to the GMC. The PPC referred the case to the PCC and also to the IOC. About three months later, the IOC made an order imposing interim conditions on the doctor's practice. These included requirements not to work as a locum or in a single-handed practice and not to undertake out of hours work. The intention was obviously to ensure a degree of supervision of the doctor's work. He was to inform any employer of the conditions. At a review hearing three months later, the doctor claimed that he had not worked at all since the interim order was made. In fact, as it emerged at the next review hearing three months later, that was untrue. He had done locum work at a single-handed practice and had performed out of hours work. Rather surprisingly, the IOC did not impose interim suspension but allowed the doctor to continue working, subject to conditions as before.

21.117 At the substantive hearing by a PCC panel, which took place about 19 months after the case had been referred to the PCC by the PPC, the doctor was found guilty of SPM and his name was erased from the register. It is clear from the decision that a major factor in the PCC panel's reasoning was the doctor's contempt for the order made by the IOC and his willingness to mislead the GMC.

The Case of Manzur

21.118 Some of the cases where PCC panels directed erasure of a doctor's name from the register were cases involving allegations of dishonesty. One such was the case of Manzur v General Medical Council[11]. In that case, the doctor had pleaded guilty in the Magistrates' Court in May 2000 to five charges of false accounting and asked for five more to be taken into consideration. He had dishonestly obtained money from the local HA. He was fined £7500. At the GMC, his case was referred to the PCC. The PCC panel took a serious view of this misconduct and, after taking account of the mitigation advanced, decided to erase the doctor's name from the register. He appealed to the Privy Council on the ground that the sanction was too severe, particularly in the light of his long unblemished record and the many positive aspects of his career. Importantly, the Privy Council was told that there

[11] [2002] 64 BMLR 68.

had been no criticism of his treatment of patients or apparent doubts about his ability. The Privy Council allowed the appeal and substituted a period of suspension for three months.

The Case of Dey

21.119 The facts of the case of Dey v General Medical Council[12] were not unlike those of Manzur, although there was an additional feature, in that patient records had been falsified. In Dey, the doctor had been convicted in the Magistrates' Court of multiple charges of false accounting and two charges of obtaining money by deception. He had submitted to the HA applications for payment for health screening tests which he claimed to have carried out but had not. He was paid £7.10 for each test. Apparently, he had done this on over a thousand occasions. He had also made entries in patients' records, presumably recording health screening tests that had not taken place. A PCC panel erased his name from the register and the doctor appealed to the Privy Council, contending that the PCC had failed to have proper regard to the purpose of disciplinary proceedings, which was to protect the public and to maintain standards in the profession. It was claimed that it was wrong for the GMC to impose a further penalty when he had already been punished by the Court. The appeal failed. The Privy Council held that the PCC panel had been entitled to take the view that the doctor's conduct had undermined the confidence of the HA in the integrity of practitioners and that this reflected on the standards and reputation of the profession as a whole. Moreover, the falsification of records had placed patients at risk. The sanction was not excessive.

The Case of Gulati

21.120 In the case of Gulati v General Medical Council[13], the doctor had pleaded guilty to two charges involving the production of false medical reports for use in making fraudulent accident claims against insurance companies. A PCC panel erased him from the register and he appealed. In dismissing the appeal, the Privy Council said that the order of erasure was required in the public interest.

The Case of Bijl

21.121 The Inquiry also looked at some cases involving poor clinical practice where the PCC panel made an order for erasure. In the case of Bijl v General Medical Council[14], the Privy Council overturned the decision of a PCC panel to erase the doctor's name from the register. The doctor, a consultant urologist, had carried out 'keyhole' surgery to remove a kidney stone. The operation proved more difficult than expected and the patient lost a lot of blood. Transfusions were given and the anaesthetist gave advice about the abandonment of the operation. Eventually, the operation was abandoned because the patient was in a very poor state. Despite the patient's poor condition, the surgeon left the hospital and went home. Shortly afterwards, the patient suffered a severe haemorrhage. The surgeon could not be contacted. Another surgeon was found and he clamped the site

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12 [2002] Lloyd's Rep Med 68.
13 [2001] 61 BMLR 146.
14 [2001] Lloyd's Rep Med 60.

of the bleeding so that the patient's condition was stabilised. However, the patient died two days later.

21.122 The first surgeon appeared before a PCC panel, charged with two offences: failing to abandon the operation at an appropriate time and leaving the patient while she was in an unstable condition. The PCC panel found that the surgeon was guilty of SPM and directed erasure. It took the view that the surgeon's decision to leave the hospital was **'seriously irresponsible and a grave neglect of proper professional standards'**. It also considered that he lacked insight, which the Privy Council understood to relate to his attitude that it was his job to remove the kidney stone and the anaesthetist's job to keep the patient alive. It appears that there was also concern about the surgeon's failure to communicate adequately with other members of the team. Pausing there, it seems to me that the decision to erase was reasonable.

21.123 Indeed, the Privy Council did not say that it was not. However, after reminding its members of the traditional circumspection with which their jurisdiction to overrule the PCC in matters of judgement had usually been exercised, it nevertheless allowed the appeal. It did so because it felt that it was not **'necessary'** to erase the doctor's name in this particular case. It said that the PCC was **'rightly concerned with public confidence in the profession and its procedures for dealing with doctors who lapse from professional standards'**. But, it continued, **'this should not be carried to the extent of feeling it necessary to sacrifice the career of an otherwise competent and useful doctor who presents no danger to the public in order to satisfy a demand for blame and punishment'**. It cited a passage from 'A Commitment to Quality, A Quest for Excellence', which was a statement made on behalf of the Government, the medical profession and the NHS, in which it was said that:

> **'The Government, the medical profession and the NHS pledge ... without lessening commitment to safety and public accountability of services, to recognise that honest failure should not be responded to primarily by blame and retribution but by learning and by a drive to reduce risks for future patients.'**

21.124 No doubt all that is relevant and wise, but I cannot see that there was any evidence in the case of Bijl that the PCC panel had acted in order to **'satisfy a demand for blame and punishment'**. It is not for me to say who was right about Mr Bijl and who was wrong. Decisions of this kind are based upon the collective judgement of the individual members of the PCC panel or the constituent members of the Judicial Committee of the Privy Council. However, it is clear that differently constituted panels of the PCC will reach different conclusions about similar facts and, it appears, so will different constitutions of the Privy Council. At present, there is, in my view, far too much room for the exercise of discretion. Too much depends on impression and the differing attitudes of individual groups of decision-makers. In my view, there is an urgent need for more structured guidance in the way such decisions are taken.

The Work of the Policy Studies Institute

21.125 In previous Chapters I have explained the background of the work of the PSI team and some aspects of its work. This work included an analysis of cases dealt with by the PCC.

However, this was quantitative only. The PSI team did not carry out any observation of the PCC in action, as it did with the PPC. Nor did it undertake any analysis of the quality of decision-making of PCC panels.

The 1996 Report

21.126 In the research undertaken for the 1996 PSI Report, Professor Allen, who led the PSI team, and her colleagues found that, at the PCC, doctors who had qualified overseas were more likely than their UK counterparts to be found guilty of SPM. However, once found guilty, overseas qualifiers were more likely than UK qualifiers to be admonished or made the subject of conditional registration. The figures for suspension for both groups were very similar. Overseas qualifiers were only half as likely as UK qualifiers to be erased from the register.

21.127 The PSI team suggested a possible reason for the fact that more lenient treatment was apparently given by the PCC to overseas qualifiers found guilty of SPM. This was that the threshold of misconduct which a UK qualifier had to cross before his/her case was referred to the PCC might be higher than the threshold applicable to an overseas qualifier. If that were so, the complaints against UK qualifiers which reached the PCC (or some of those complaints) would be more serious than the complaints against overseas qualifiers and would thus be deserving of more serious sanctions. The PSI team observed that its findings would be consistent with that suggestion.

21.128 The PSI team advocated that a **'rigorous analysis'** should be undertaken of cases where findings of SPM had been made by the PCC in recent years. It was hoped that such an analysis would assist in the development of clear guidelines about what constituted SPM, both in general and in particular instances.

The 2000 Report

21.129 An analysis of the outcomes of PCC cases undertaken for the 2000 PSI Report showed that, if convictions were left out of account, the proportion of cases heard by the PCC where the doctor was found guilty of SPM was 79% in 1997. This proportion rose to 85% in 1998 and fell to 78% in 1999. In 1997, a higher proportion of doctors who had qualified in the UK than of overseas qualifiers were found guilty of SPM; in 1998 and 1999, a significantly higher proportion of overseas qualifiers were found guilty. In 1998, 71% of UK qualifiers were found guilty of SPM in comparison with 100% of overseas qualifiers. In 1999, the proportions were 70% and 87%, respectively.

21.130 So far as sanctions were concerned, the PSI team found that, in 1997, complaints against UK and overseas qualifiers had fairly similar outcomes at the PCC. In 1998, similar proportions of UK and overseas qualifiers had their names erased from the register. In 1999, however, overseas qualifiers were in general penalised more severely. The PSI team observed that the pattern of outcomes was complex. It emphasised that the outcomes might well be related to the seriousness of the cases against the doctors concerned, rather than to any bias on the part of the PCC. However, it was impossible, without qualitative analysis, to be certain of this.

21.131 The PSI team noted that doctors in conviction cases were much more likely than those in conduct cases to have their names erased from the register. Since overseas qualifiers accounted for higher proportions of conviction cases at the PCC, this increased their representation among those doctors who were erased. The 2000 Report observed that, since the PCC appeared to regard convictions so seriously, the question arose of why more convictions were not referred by the PPC to the PCC.

21.132 The Report went on to say that the PCC represented a **'much more transparent'** stage of the GMC procedures than the earlier stages. Nevertheless, it was still not always clear from the PCC's deliberations why it considered that SPM was made out in some cases and not in others. The PSI team advocated a more **'structured approach'** to the recording of reasons by PCC panels. The PSI research had shown **'marked differences in outcome'** from year to year, which were difficult to explain in the absence of any statement of the criteria on which each case was judged. The PSI team pointed out that the composition of the PCC was different on most occasions when a PCC panel sat. Moreover, the composition was likely to be susceptible to even greater change in the near future, as the GMC recruited people from outside the membership of the GMC (i.e. associates) in an attempt to reduce the backlog of cases. The 2000 Report suggested that the GMC might wish to consider whether greater consistency would be introduced by restricting membership of the PCC to a small number of permanent, highly trained individuals.

21.133 The PSI team also identified the need for a close examination of the definition of SPM. It reiterated the need for a common understanding of what did and did not constitute SPM and for clear guidelines on the factors to be taken into account, and the standards to be applied, when making decisions. It stressed the importance of consistency at the level of the PCC, so that the criteria and standards applied at the final stages of the conduct procedures could be fed back through the earlier stages.

The 2003 Paper

21.134 In its 2003 Paper, the PSI team analysed the complaints considered by the PCC during the years 1999, 2000 and 2001. In 2000, the number of doctors who appeared before the PCC (excluding resumed cases and applications for restoration) rose to 101. There was a further rise in 2001 to 122.

21.135 The PSI team found that, in all three years, overseas qualifiers were more likely than UK qualifiers to be found guilty of SPM. In its previous work, it had found that the overall proportion of doctors whose names were erased from the register by the PCC rose from 25% in 1997 to 47% in 1998. It was said that a likely contributory factor to this rise was the increase in the number of conviction cases. The proportion of doctors erased had then fallen slightly (to 43% or 45%) in 1999. In the later analysis, a further fall was observed. In 2000, the proportion was 34%; in 2001, it was 26%. In 1999, erasure was directed in a significantly greater proportion of cases involving overseas qualifiers than of UK qualifiers. In 2000, the differential was less and, in 2001, a slightly greater proportion of UK qualifiers had their names erased. In all three years, UK qualifiers were more likely than overseas qualifiers to be admonished or reprimanded, while overseas qualifiers were more likely to be suspended or to have conditions put on their registration.

21.136 Doctors in conviction cases were more likely to have their names erased than those in other types of case. The proportion of convictions dealt with by erasure was usually over 80% (73% in 1999). However, in 2001, erasure was imposed in only half the conviction cases dealt with.

21.137 The analysis found continuing differences between the outcomes of cases involving UK qualifiers and those of overseas qualifiers at the PCC. The factors causing this could not be determined without a detailed analysis of the reasons for the decisions made by the PCC.

The Professional Conduct Committee Working Group

21.138 In May 1999, the PCC Working Group, which had been established by the Fitness to Practise Policy Committee, reported on the powers and practice of the PCC. The background to its work was concern within the GMC about public and media criticism of PCC decisions as being inappropriate or inconsistent with previous decisions. One of the tasks of the Working Group was to ascertain whether there was or appeared to be inconsistency in the way sanctions were applied by the PCC.

21.139 The Working Group reviewed all decisions on sanction made by the PCC over the period from 1988 to 1997. The report said that the decisions reviewed were cases where **'SPM was found proved'**. It is possible that they also included convictions. The most common sanction (imposed in 37% of cases) was erasure of the doctor's name from the register. The Working Group expressed surprise, however, that 20% of cases were concluded with an admonishment. Members of the Working Group believed that a finding of SPM should usually lead to the imposition of a sanction unless there were **'strong mitigating factors'**.

21.140 The Working Group looked in particular at cases involving sexual misconduct (excluding consensual sexual relationships) and inadequate or inappropriate clinical care. It found that two thirds of proven sexual offences had resulted in erasure. In the remaining third, a very wide range of sanctions had been imposed by the PCC, including (in 7% of cases) an admonishment. In the case of clinical treatment, sanctions were very evenly distributed, with 26% resulting in erasure and 20% in admonishment.

21.141 The Working Group observed that the **'bare statistics'** could not show why individual decisions had been made. Neither had members of the Working Group found the official minutes of the cases, made at the time, of much help. It was not at that time the practice to include in the determination at the end of a case any more than a very brief explanation of why a particular sanction had been imposed. The report observed:

> **'There is therefore no sure way of knowing whether certain decisions which appear unexpected or inconsistent (such as merely admonishing a doctor for indecent behaviour with a patient) were genuinely aberrant, or whether there was some overwhelming mitigating factor which was not made explicit in the determination. So, while we have found no clear evidence of a pattern of inconsistent or inappropriate decision making, there is no doubt that the appearance of inconsistency and inappropriateness has sometimes been given.'**

21.142 The report rejected as unworkable the idea of using sentencing tariffs. The Working Group thought that this approach was inappropriate because, in contrast to the criminal courts, the PCC was dealing, not with a number of clearly defined offences for which a 'tariff' could be specified, but with a single offence of SPM. Furthermore, the Working Group considered that a tariff approach would **'place an undesirable restriction on the Committee's discretion'**. Instead, the Working Group recommended the development of a statement about the purpose of the sanctions generally and of each sanction in particular. It suggested that this would be a useful training aid. It was this suggestion that led, two years later, in 2001, to the production of the first version of the ISG.

21.143 Also, in a further attempt to promote consistency of decision-making, the Working Group recommended the circulation of the minutes of every meeting of a PCC panel to all PCC members. It also recommended regular meetings of legal assessors, committee chairmen and members of committees. It recommended that screeners and members of the PPC and the PCC should also meet regularly. It suggested the preparation of a training handbook and mentioned *aides memoire*.

21.144 The Working Group also advised that the PCC should give a fuller explanation of its reasons. It observed that that would enable all those with an interest in the decision – the doctor, the complainant, the public and the profession – to know why the decision had been made. It would also enable a panel which might need to consider the doctor's conduct in the future to have a fuller appreciation of the earlier panel's thinking. The Working Group did not suggest that the PCC should give reasons for its findings of fact.

Comment

21.145 The views expressed by the Working Group are similar to those I expressed earlier, namely that there was an appearance of inconsistency between decisions of the PCC. It is plainly desirable that something should be done about this. It does not seem to me that intervention by the Privy Council (which, in later years, showed less deference to the judgements of the PCC than had formerly been the case) was able to help; it did not hear enough cases to establish a framework of sanctions. The same is likely to be true of the High Court, to which appeals are now directed. The development of the ISG has obviously been a step forward in the drive for consistency. However, the ISG focusses on what type of sanction is appropriate in what type of case and does not seek to provide specific examples of what has been thought appropriate in particular cases in the past. The Working Group report said that it would not be feasible to **'make systematic use of precedents'** when reaching decisions on sanctions. The reasoning was that, because SPM covers so wide a range of possible forms of misconduct, it was not possible to categorise cases and to specify which sanctions were appropriate for which category of case.

21.146 I do not agree. The Court of Appeal (Criminal Division) is able to do so, when it lays down sentencing guidelines. True, it does so in the context of specific criminal offences. The position of a PCC panel is different from that of a judge imposing a sentence. A PCC panel has to impose sanctions in a wide variety of cases all amounting to SPM. However, the difference is more apparent than real. It appears to me that there are types of SPM which

recur time and time again. Of course, the precise circumstances vary but there are a few underlying themes. It would, in my view, be quite possible to develop sanctions guidance that relates to specific types of misconduct. Of course, such guidance must not restrict the right of a panel to exercise its discretion on the facts of the individual case, any more than the Court of Appeal seeks to inhibit the right of a judge or recorder to take individual circumstances into account when sentencing.

Recent Developments

21.147 During late 2003 and 2004, there were two developments in the way in which the GMC sought to provide guidance for its decision-makers.

The Determination Audit Sub Group

21.148 The first of these developments was the formation of the Determination Audit Sub Group (DASG). Its function was to monitor the decisions of FTP committees, to identify learning points to be fed into training sessions, to advise the President of issues arising from FTP decisions (including concerns about inappropriate decisions) and to report to the Fitness to Practise Committee at regular intervals. At its inception, the DASG comprised three experienced Council members, one of whom was a legally qualified lay member. I am unsure of the present constitution; the legally qualified lay member has recently become a judge and has left the GMC. In any event, it seems to me that the formation of the DASG was a most welcome development. There had hitherto been no systematic analysis of FTP committee decisions (save for the 'one-off' review by the PCC Working Group) and no attempt to correct or learn from decisions or practices that were unsatisfactory.

21.149 The early fruits of the DASG's labours were reported in the first edition of a new GMC publication, the Fitness to Practise Bulletin, published in May 2004. The Bulletin contains other information besides the DASG report. It will be published three or four times a year and is targeted at FTP panellists. This too is a welcome development. It is clear that the process of monitoring has led to the recognition of a number of the same problems with FTP decisions as I have noticed in the cases I have read, some of which I have mentioned in this Report. For example, the DASG reported that in some cases in which the outcome had 'appeared surprising', the reasons given by PCC panels were inadequate and did not explain the conclusions reached. It advised that adequate and legally justifiable reasons must be given. Another example was a reference to the tendency of some PCC panels to assume that, if they had not been told that a doctor had an adverse FTP history, s/he must have had a **'previously unblemished career'**. The DASG report advised that this must not be assumed, as the GMC does not have access to full information.

21.150 The main thrust of the DASG report, however, was to advise that panels hearing FTP cases must ensure that their decisions (both on what amounted to SPM or SDP and on sanctions) conform to GMC standards and policy. It said:

> **'Although panels exercise their judgment in making decisions they must do so within the framework set out by the Council. The determination of policy and the setting of standards is a matter for the Council; when**

reaching decisions on serious professional misconduct, panels must have regard to the Council's policy/standards.'

21.151 So far so good. I am delighted to see this recognition by the GMC that a framework of standards must be adhered to. The DASG report then went on to explain where this guidance was to be found. The primary source was the GMC publication 'Good Medical Practice'. In addition, it was said, the GMC had provided guidance on a number of other discrete topics, such as consent, confidentiality, research, the use of slimming drugs, intimate examinations, serious communicable diseases and several more. Lawyers presenting the GMC's case at hearings have been instructed to draw the panel's attention to any guidance relevant to the issues before the panel.

21.152 That is all very well so far as it goes. However, it does not go far enough. The GMC did not publish any material by which either doctors or FTP panellists could recognise a case of SPM or SDP when they saw one. In other words, there was no guidance on thresholds, and nothing by which anyone could tell where the line should be drawn. In Chapter 17, I described how 'Good Medical Practice' came to be written and how it superseded the old 'Blue Books'. The Blue Books used to give a few examples of the kind of conduct that would result in disciplinary action. However, these were limited in scope. I also explained that the purpose of 'Good Medical Practice' was to be 'positive' and to encourage good practice; it was to avoid focussing in a negative way on bad practice. It had at one stage been suggested that both booklets should be published but, in the event, the Blue Books were discontinued because the GMC wished to focus on its positive message. I mentioned the opinions of some senior GMC staff who said that, although they understood why these changes had been made, they felt that some clarity had been lost about the kind of circumstances in which a doctor might be disciplined. I quoted the opinion of Professor Allen, who said that 'Good Medical Practice' was 'absolutely fine' for the purposes for which it had been written but of no real assistance when it came to defining or recognising SPM.

21.153 Recent editions of 'Good Medical Practice' give this warning to doctors: **'serious or persistent failures to meet the standards in this booklet may put your registration at risk'**. But that is all that is said. Nor is the other guidance I have mentioned any more explicit. Some sources make no reference at all to disciplinary matters. Others give a general warning that certain conduct, for example giving treatment without consent, may result in a challenge in the courts or a complaint to an employer or the GMC. The strongest advice is given in connection with the trading of human organs, where it is said that involvement in such practice will render the doctor **'liable to disciplinary proceedings'**. It is true that some of the medical Royal Colleges have published more specialised guidance which applies the principles of 'Good Medical Practice' to the specialty concerned. The Royal College of General Practitioners has done so and has included a number of examples of excellent practice and, by way of contrast, of unacceptable practice. But it is not the function of the Royal Colleges to advise about misconduct and deficient performance or fitness to practise. It is for the GMC, as the regulatory body responsible for the FTP procedures, to do this. As I have said, there was nothing from which anyone could gauge whether what a doctor had done was likely to be categorised

as SPM or SDP or whether, in the future, it will be found that his/her fitness to practise is impaired. This problem must be tackled.

The Publication of Case Studies

21.154 I had thought that the GMC had recognised the need for much more specific guidance about the threshold for SPM and SDP. At the Inquiry hearings, Sir Donald Irvine said that, at the time when the performance procedures were being set up, when he was President, the idea of publishing case studies had been discussed. The idea would have been to illustrate by example the kinds of conduct that would and would not amount to SPM. He thought this was a good idea and regretted that it had not been done at that time. He mentioned how useful he had found the anonymised case summaries that are published periodically by the medical defence organisations and also said that, on occasion, when he had had to look at a law report, he had found that being able to read the detail had 'brought the case alive'. He thought such summaries would be very helpful for members of GMC committees who had to decide whether conduct amounted to SPM.

21.155 In evidence, Sir Graeme Catto echoed Sir Donald's view and expressed enthusiasm for the idea of publishing a series of case reports. On that subject he said:

> **'It is, I think, a deficiency on our part that we talk about being a learning organisation and helping to get the public and the profession to be aware of the problems arising in medical practice and yet we have been pretty deficient in doing that. I know that Sir Donald was keen to do that. I am absolutely determined that it will happen.'**

21.156 In December 2003, Mr Scott told the Inquiry that the case studies (or at least the first set of them) would be published in February 2004. As I understood it, these were to be summaries of cases in which the decision taken by a PCC panel was regarded as good and was an example to be followed. I hoped that these would provide useful examples of the kind of conduct which did or did not amount to SPM and also guidance on appropriate sanctions. I thought that they would enable those sitting on PCC panels to 'get their eye in' as to what, in the past, had been regarded as a good decision and why. On sanction, I hoped that the studies would not only help on issues of proportionality but would also illustrate the weight that had been attached to various mitigating factors. I hoped that their production would mark a real advance towards consistency in decision-making.

21.157 The first group of 'case studies' was published in September 2004. I regret to say that they are a great disappointment. First, there are only five of them and they are very limited in range. Two relate to a failure to obtain consent, two involve dishonesty and the other was a case of breach of confidentiality. The 'studies' are so brief as to be almost useless. For example, in one of the two cases of dishonesty, the doctor was convicted of nine counts of obtaining money by deception by making **'repeated fraudulent insurance claims'** and was sentenced to nine months' imprisonment. Her name was erased from the register. We are not told the nature of any dishonest misrepresentations made or whether the claims were connected with the doctor's professional practice. We do not even know the total sum involved – it might have been enormous. Nor do we know the period over which the offences were committed. We are given some unimportant information about the doctor's

failure to answer to police bail. In deciding to erase the doctor's name, the PCC panel said that **'there can be no place in the medical profession for dishonest doctors, especially where the deceit is repeated'**.

21.158 If the message to be conveyed to the reader of these 'studies' is that persistent dishonesty involving substantial sums of money will result in erasure, the reader is likely to be puzzled by the outcome of the other case of dishonesty described, in which the doctor was not erased but was suspended for a year. In that case, the doctor, a GP, dishonestly obtained nearly £36,000. He received a 'notional' rent from his HA for a flat within his surgery premises. He also let the flat to a tenant and kept the rental, so receiving two rents from one flat. It appears that he was not prosecuted but we do not know whether this was because his conduct was not reported to the police or whether it was because they took the view that his conduct was not criminal. The conduct might have been criminal; one cannot tell. In any event, it was obviously dishonest conduct and disgraceful for a doctor. Apparently, the PCC panel took the view that his behaviour had been **'dishonest, misleading and a contravention of the NHS General Medical Services statement of fees and allowances'**. I do not see how anyone reading these case studies is to understand why it was appropriate for the doctor in one case to be struck off and in the other to be suspended. If the reasoning in the first case were correct, there would have been **'no place in the medical profession'** for the doctor in the second case. I assume that there are good reasons for the difference, apart from the fact that one doctor was prosecuted and one was not. Otherwise, both could not have been advanced as examples of appropriate sanctions.

21.159 I am puzzled as to why it should have taken so long to produce these case studies and why they should have been so inadequate when they arrived. In December 2003, the President had plainly recognised the need for them and his enthusiasm was manifest. In Chapter 27, I have suggested how case studies should be prepared. The essentials are that the facts found should be summarised so that the reader can understand why the panel found that they amounted to SPM. The mitigation should be summarised so that the reader can understand why the panel decided as it did on sanction. This work still needs to be done, despite the advent of the new procedures. The new FTP panels will have to consider whether the doctor's fitness to practise is impaired and whether the impairment is of such a degree as to justify action on registration. The wording of the test is changing but the kind of behaviour that panels will have to consider will not change. The old cases will still serve as a useful guide on impairment and sanction. The process of collecting case studies should then continue under the new procedures.

Restoration to the Medical Register

21.160 Contrary to public perception, erasure does not necessarily mean the termination of a doctor's professional practice for all time. The PCC has no power to impose permanent erasure or fixed terms of erasure. A direction that a doctor's name should be erased from the register is always subject to a future application by the doctor for restoration to the register. Until August 2000, an application for restoration to the register could be made at any time after the expiration of ten months from the date of erasure. If an application was made and was unsuccessful, a further application for restoration could be made after a

further ten months had elapsed. Applications for restoration could be renewed every ten months thereafter.

21.161 In 1999, the GMC recognised that there was considerable public concern that doctors were being restored to the register too soon and too easily. In the light of the concern about the issue of restoration, the PCC Working Group undertook a review of the outcomes of applications for restoration which had been dealt with by the PCC between 1988 and 1997. During that period, 131 doctors had been erased. In the same period, 35 doctors had been restored to the register out of 80 doctors who had applied. The Working Group undertook an analysis of the types of conduct or conviction that had led to the erasure of those doctors who had subsequently been restored. Ten of those doctors had originally been erased by reason of SPM arising from clinical treatment; four each had been erased for clinical fraud, improper relationships and sexual assault. Three doctors had been erased for drugs offences and a further three for fraud (other than clinical fraud). Two doctors had been erased for false claims to qualifications and two for soliciting money; one doctor had been erased for violence, one for abusive behaviour and one for theft.

21.162 The Working Group observed:

> **'There is no question that, on the face of it, the decisions to restore some doctors appeared surprising. We felt generally that there was an appearance of inconsistency. To take just two examples, while the overwhelming majority of applicants erased for sexual assaults or indecent behaviour were not restored, four doctors guilty of behaviour of apparently similar gravity were restored. All four doctors erased for research fraud in the period were restored.'**

21.163 The Working Group pointed out that any inferences from a review of this kind must be drawn very cautiously. There was no sure way of knowing why decisions were taken or what factors, other than the nature of the offence, might (quite properly) have been taken into account. This was because it had not been the PCC's practice to provide any explanation at all about restoration decisions. The Working Group report observed that, as a result:

> **'Unfortunately, we, and more importantly the doctor, complainant and public at the time, cannot know why. In this as in other areas, it is important that the Committee explain their reasoning whether they have decided to restore, or not to restore, the doctor.'**

The Working Group recommended that PCC panels should provide an explanation of their decisions on all restoration applications, regardless of outcome. It appears that this is now done.

21.164 The review also showed that 17 out of 35 (i.e. almost half) of the doctors restored to the register had been restored within three years of erasure (seven had been restored within 17 months). Two thirds of doctors restored had been restored within three and a half years of erasure. The Working Group considered the case for recommending an extension of the minimum period of erasure before an application to restore could be made to, say, two years, but decided not to do so.

21.165 The Working Group went on to observe that a **'perennial problem'** for the PCC had been the difficulty of establishing whether a doctor applying to be restored was fit to practise and, in particular, if his/her skills, knowledge and attitudes were satisfactory. Its members discussed the view held by some that the appropriate way to address that problem was to give the PCC the power to impose conditions on the registration of a doctor who was restored. Those conditions would be lifted only if and when the doctor had demonstrated that s/he was suitable to resume unrestricted practice. In the event, the Working Group decided not to recommend that the PCC should be given such a power. Its unanimous view was that, if the power were available, there would be a real risk that doctors might be restored who were not fit to practise. The report said:

> **'There is a danger that a panel might pay insufficient regard to the gravity of the original offence by concentrating on the rehabilitation of the doctor rather than on the overriding public interest. If there is any reasonable doubt about a doctor's fitness to practise, he or she should simply not be restored. We see this as a fundamentally important point.'**

The Working Group therefore recommended that restoration should continue to be **'all or nothing'**. However, it observed that an alternative way forward was to consider whether the GMC might employ the assessment methods which had been developed for the performance procedures in order to assess the skills, knowledge and attitudes of a doctor wishing to be restored. The Working Group recommended that further work should be done to explore the viability of that proposal.

21.166 In August 2000, the Medical Act 1983 was amended to provide that no application for restoration to the register could be made before the expiration of five years from the date of erasure or within 12 months of an unsuccessful application for restoration. Following a second unsuccessful application for restoration during the same period of erasure, the PCC was given power to direct that the right to make further applications should be suspended indefinitely. Such an order could be reviewed on a three-yearly basis. It seems to me that the case for a performance assessment including a knowledge test is even stronger now than it was in 1999. The competence of any doctor who has been away from practice for five years must be questionable.

21.167 Also in 2000, a new three-stage procedure for determination of applications for restoration to the register was introduced. The first stage required the PCC panel to decide (having regard to the reasons why the doctor's name was erased from the register, to the application itself, to the doctor's conduct since erasure and to any representations made to the PCC panel) whether the doctor's name should be restored to the register, subject to his/her satisfying the PCC panel as to his/her good character, professional competence and health.

21.168 If the panel decided that question in the doctor's favour, the second stage was for the PCC to decide what assessment the doctor should undergo for the purpose of satisfying the PCC panel as to his/her good character, professional competence and health and to order that the appropriate assessment should be carried out. The third stage of the process was for the PCC panel to consider the assessment report and to decide whether the doctor's name should be restored to the register. This new procedure seems to me to be a very

good idea. I do not know how it is working. Because all erasures since 2000 must operate for at least five years, it may be that relatively few applications for restoration are being made at the present time.

Comment

21.169 Until 2000, the minimum period of erasure was extraordinarily short. What sounded like a severe sanction might amount, in effect, to no more than a year's 'suspension'. It was certainly not the draconian punishment that the public believed it to be. The new minimum period of five years is, I believe, much more in line with what the public expects when a doctor's name is erased. However, there must be a possibility, now that erasure means at least five years off the register, that FTP panels will be reluctant to impose it save in the most serious cases.

21.170 The Working Group drew attention to inconsistencies between the approach of different panels to the question of restoration. Panels need standards and criteria if they are to achieve consistency in decision-making. It should be possible to develop such criteria from actual decisions now that reasons are given for decisions. Again, the process should be to weed out inappropriate decisions and ones with inadequate reasons. The remainder should be collated and examined and could form the basis for the preparation of a set of standards and criteria. Reports or summaries of appropriate decisions would also help panel members to 'get their eye in'.

21.171 The new three-stage procedure for restoration seems an excellent idea. I hope that an assessment will be ordered in all cases. I cannot imagine any case in which it would be appropriate to allow a doctor to return to practice after five years' absence without requiring him/her to undergo an objective assessment. I can understand why the Working Group advised that restoration must be **'all or nothing'** and set its face against any period of conditional registration. I wonder whether the same objection would be raised to the proposal that, on restoration to the register, a doctor must have a supervisor or mentor, approved by the GMC, who would be required to give an undertaking to bring to the GMC's attention any concerns s/he has about the newly restored doctor's practice, conduct, performance or health. I think that would be a good idea and I would hope that the knowledge that that would happen would not cause FTP panels to lower the threshold for restoration too far.

Appeals and Referrals

Appeals by a Doctor

21.172 Appeals from decisions of the PCC were governed by section 40 of the 1983 Act. Until April 2003, a doctor who was the subject of a finding of SPM or a direction for erasure, for suspension or for conditional registration (or variation of the conditions imposed by a direction for conditional registration) had a right of appeal to the Judicial Committee of the Privy Council. After April 2003, any appeal lay to the High Court.

21.173 In the past, the process of appeal to the Privy Council resulted in the provision of helpful statements of principle and approach but did not lead to the development of a

jurisprudence on the determination of issues relating to SPM or sanction. Until about 2000, it was the policy of the Privy Council to show a great degree of deference to the professional expertise and experience of the PCC. That deference appeared to lessen in later years, possibly because of the coming into force in October 2000 of the Human Rights Act 1998. The number of appeals heard since that time has not permitted the development of a coherent framework of principles. Nor, as yet, has the process of appeals to the High Court. It is very early days.

Referrals by the Council for the Regulation of Healthcare Professionals

21.174 Under the provisions of section 29 of the National Health Service Reform and Health Care Professions Act 2002, the CRHP/CHRE had, from April 2003, the power to refer to the High Court a **'relevant decision'** of the PCC. Section 29(4) provides that the Council could do this if it considered that:

> **'(a) a relevant decision falling within subsection (1) has been unduly lenient, whether as to any finding of professional misconduct or fitness to practise on the part of the practitioner concerned (or lack of such a finding), or as to any penalty imposed, or both, or**
>
> **(b) a relevant decision falling within subsection (2) should not have been made,**
>
> **and that it would be desirable for the protection of members of the public for the Council to take action under this section...'**.

21.175 Section 29(1)(a) to (h) lists the directions and determinations made by the various disciplinary bodies to which the section applies. At (c) and (d) it includes directions made by the PCC and CPP of the GMC. They are therefore 'relevant decisions'. Section 29(2)(a) provides that section 29 also applies to:

> **'a final decision of the relevant committee not to take any disciplinary measure under the provision referred to in whichever of paragraphs (a) to (h) of subsection (1) applies'**.

The expression **'disciplinary measure'** is not defined by the Act. The Act provides that, if a case is referred for hearing by the High Court, it is to be treated as an appeal by the CRHP/CHRE.

Appeals against an Unduly Lenient Sanction

21.176 At the time of writing, only a few appeals have been heard. However, two cases, that of Council for the Regulation of Healthcare Professionals v General Medical Council and Solanke[15] and Council for the Regulation of Healthcare Professionals v Nursing and Midwifery Council and Truscott[16] show how the Court is likely to approach its task in appeals against sanction. In both, the CRHP/CHRE appealed on the basis that the sanction imposed by the regulatory body was unduly lenient. In both cases, the Court

[15] [2004] EWHC 944 (Admin).
[16] [2004] EWHC 585 (Admin).

made plain that, when considering whether a decision had been unduly lenient, it would apply the same test as is applied by the Court of Appeal (Criminal Division) when considering, on the application of the Attorney General, whether a sentence passed by a criminal court is too lenient. The test is whether the sanction imposed is outside the range of sanctions which the tribunal, applying its mind to all the factors relevant to its jurisdiction, could reasonably consider appropriate. The Court will also require to be satisfied that intervention is **'desirable for protection of members of the public'**. However, as Collins J observed in the case of Truscott, that will usually follow if the sanction is found to be unduly lenient.

21.177 In Solanke, the GMC had found the doctor guilty of SPM. He had become involved in a sexual relationship with a patient; moreover the patient suffered from depression and was rather vulnerable. The matter came to light some time after the relationship was apparently over, when the woman told another GP about it. The doctor admitted the truth of the allegation. The woman did not wish to be involved in disciplinary proceedings and the GMC had no information about when or how the relationship had begun. The doctor was also guilty of another form of misconduct. He had falsified his own birth certificate and, during his medical career, had used a *curriculum vitae* which represented that he was six years younger than he really was.

21.178 At the PCC hearing, the doctor gave evidence but was not asked any questions about how the improper sexual relationship had started. He said only that it had started and finished by mutual consent. It had lasted about six months. At the time, he said, his marriage had broken down and his wife was denying him access to his children. He acknowledged that his relationship with the patient had been wrong and said that he had taken counselling subsequently. The PCC found SPM proved and imposed a period of suspension of three months. It said that it took into account the fact that the doctor had not worked for six months as he had been suspended by the practice where he had worked.

21.179 On appeal by the CRHP/CHRE, Leveson J first established the test that should be applied and then concluded that, on the material available, he regarded the sanction imposed as lenient. His impression was that he could not say that it was unduly lenient. However, in the course of the judgement, Leveson J was critical of the GMC for the paucity of the information it had collected about the circumstances relating to this misconduct. He pointed out that it was difficult to make a reliable estimate of the risk that the doctor might repeat this kind of conduct without having some insight into the detailed circumstances in which the relationship had started and finished. The fact that the woman had been unwilling to provide information did not excuse the GMC from its duty to investigate the case properly. Although its options were limited by her refusal, it did have the opportunity to question the doctor when he gave evidence. Neither counsel for the GMC nor the members of the PCC panel had asked him about these important patient protection issues and the PCC panel had not put itself in a position to make a judgement about them. Leveson J considered whether the information available was so inadequate that he was unable to say whether the sanction had been unduly lenient, in which case he would allow the appeal and send the case back for re-hearing. He recognised that there would be no obligation on the doctor to submit to questioning for a second time. He decided that, in

the circumstances, he would not send the case back for further investigation. He found that the sanction was not unduly lenient and dismissed the appeal.

21.180 Leveson J also discussed the origin and purpose of the ISG and expressed the view that this was very useful. He made clear that, if the point arose, the ISG would not be binding on the Court. Nor did he think that it would be appropriate for the Court to suggest modifications of the ISG. However, he did think that the CRHP/CHRE was in an admirable position to take part in the process of revising the ISG.

21.181 The events giving rise to the disciplinary proceedings against Mr Truscott, a paediatric nurse, took place when he was working on a ward devoted to the care of adolescent patients of both sexes. While on night duty, he 'surfed' the internet on six separate occasions and accessed a number of sites providing pornographic material. He was dismissed from his position and reported to the Nursing and Midwifery Council (NMC). The police decided not to prosecute, apparently because it could not be shown that the material he had accessed was 'child pornography' or whether the photographs were in fact of adults who were made to look like children. Some of the material appeared to show naked children but they were not engaged in sexual acts. Another difficulty was that it was not clear how many sites the nurse had deliberately accessed and how many had been opened to him by the 'cascading' effect. In any event, whether the pornography showed adults or children, Mr Truscott's conduct clearly amounted to misconduct and the NMC found it to be so. It decided to caution him for his behaviour. The CRHP/CHRE appealed on the ground that this was unduly lenient and that only erasure could provide sufficient protection for the public. The principles underlying the approach of Collins J were the same as those to be expounded by Leveson J a few weeks later in Solanke. Collins J held that it was not clear that Mr Truscott had broken the law; nor was it clear which sites he had deliberately accessed. In those circumstances, he considered that the sanction imposed was lenient but not unduly so.

21.182 The CRHP/CHRE appealed this decision. Their concern was that, regardless of whether or not Mr Truscott had deliberately accessed the sites which showed or appeared to show naked children, the fact that he had an unhealthy interest in pornography and was prepared to view it while working on an adolescent ward gave rise to concern about patient safety. The Court of Appeal dismissed the appeal. It approved the test applied by Collins J and said that this was a case in which it was right to show some deference to the views of the Committee of the disciplinary body, which had not made any error of principle.

21.183 I can understand why the CRHP/CHRE felt that this sanction was unduly lenient. The problem was that the case had never been put against Mr Truscott on the basis that his interest in pornographic pictures of people who looked like children even if they were adult meant that he presented a risk to his adolescent patients. A great deal of emphasis was laid on the question of whether or not he had broken the law. This is also the emphasis in the GMC's recent amendment to the ISG. This makes it plain that PCC panels should consider erasure for doctors found guilty of child pornography offences. I can see why the guidance has been drafted in that way; usually a concern about accessing pornography will arise as a result of a prosecution. However, as in Mr Truscott's case, there was no prosecution. Should that be determinative of the outcome of disciplinary proceedings?

From the point of view of a disciplinary body whose duty is to protect the public, the fact that the doctor has or has not been convicted is surely not the main question. The main question must be whether the healthcare professional's conduct shows that s/he is a risk to patients.

The Right to Appeal against an Acquittal

21.184 The position relating to the right of the CRHP/CHRE to appeal against an acquittal of a doctor on a charge of SPM has proved to be rather more problematical. In the case of Council for the Regulation of Healthcare Professionals v General Medical Council and Ruscillo[17], the doctor was charged with SPM. He admitted that he had been involved in an emotional and sexual relationship with a patient.The particulars of the charge had included an allegation that the patient had **'significant psychiatric problems'** and was therefore **'particularly vulnerable'**. It was further alleged that the doctor was aware of the patient's history. However, at the hearing, the GMC applied to amend the charge so that it was limited to a history of **'psychiatric problems'**, rather than **'significant psychiatric problems'**, and to omit the references to the patient being **'particularly vulnerable'** and to the doctor's knowledge of the history. The head of charge was duly amended and then admitted by the doctor. The only head of charge that remained in dispute was that the doctor's actions had been **'inappropriate'**, **'an abuse of the doctor-patient relationship'**, **'not in the best interests'** of the patient and had been **'likely to bring the medical profession into disrepute'**. The GMC called no witnesses and the doctor chose not to give evidence. The PCC panel found that the disputed head of charge was **'not proved in its entirety'** in that none of the allegations was made out. In announcing the panel's decision, the Chairman of the PCC made reference to a lack of evidence in the case. The panel found that the facts that had been admitted were insufficient to support a finding of SPM. The case against the doctor was, therefore, concluded. It emerged after the PCC hearing that medical records could have been made available which would have supplied the evidence necessary to prove the additional aspects of the charge and that the doctor's partners had been willing and available to give evidence before the PCC panel but had not been called. In other words, there was a concern that the case had been under-prosecuted. The CRHP/CHRE appealed to the High Court. On behalf of the doctor, a preliminary issue was raised; it was contended that section 29 did not provide for an appeal against a decision to find a doctor not guilty of SPM. The CRHP contended that it did. On the hearing of this preliminary issue, Leveson J held that a **'relevant decision'** within section 29 was not restricted to a decision as to the appropriate sanction, but included a decision to acquit a doctor of SPM.

21.185 The appeals in the cases of Ruscillo and Truscott[18] were heard together and the judgements were handed down in October 2004. The Court of Appeal held that, under section 29, the Council had the power to refer to the Court a decision of the PCC to acquit the doctor of SPM. However, the Court construed the words **'decision of the relevant Committee not to take any disciplinary measure'** in s29(2)(a) as meaning a decision not to impose a penalty or sanction. Thus, the scope of the section was, the Court said,

[17] [2004] EWHC 527 (Admin).
[18] [2004] EWCA Civ 1356.

limited to those cases in which a relevant decision has been unduly lenient whether because the findings of professional misconduct are inadequate or because the penalty does not adequately reflect the findings of professional misconduct that have been made, or both. In short, the Council will have the power to refer an acquittal to the Court only if the 'findings of professional misconduct are inadequate'. So, in the case of Ruscillo, where the Council took the view that the case had been under-prosecuted, there was the power of referral.

21.186 For the sake of completeness, I mention the most recent decision under section 29 of the 2002 Act. This was Council for the Regulation of Healthcare Professionals v General Medical Council and Leeper[19]. The Court held that the sanction imposed (the imposition of conditions on the doctor's registration) was unduly lenient and that the doctor should have been suspended. The doctor had admitted that his conduct in involving himself in an inappropriate sexual relationship with a patient had amounted to SPM. The case is of interest in that the Judge, Mr Justice Collins, made some observations about the extent of disclosure which must be given to the CRHP/CHRE in cases where the evidence has been presented to the PCC as an agreed statement of facts. That had been done in this case. The CRHP/CHRE wanted to satisfy itself that the agreed statement of facts adequately reflected the gravity of the doctor's misconduct – in other words, it wanted to be sure that the case had not been under-prosecuted. The GMC had been reluctant to disclose the original statements of the principal witnesses for reasons of confidentiality. The Judge said that the GMC must disclose them. In the event, once they had been examined, it was not alleged that the case had been under-prosecuted; the agreed statement of facts was fair to both sides. The point is that the CRHP/CHRE must be able to check that that is so.

Comment

21.187 The institution of the process of appeals under section 29 is to be welcomed. It will provide a mechanism for over-ruling decisions on sanction that are outside the band of what was reasonable in the circumstances. Although the Court of Appeal has stated in Ruscillo that section 29 gives the CRHP/CHRE the power to refer an acquittal to the Court, it observed that the section had not been well drafted. It is apparent from the judgement that the construction of the section gave rise to real difficulty. It seems to me that, when the opportunity arises, section 29 should be amended to make plain beyond argument that the CRHP/CHRE has the power to refer to the Court any decision of a disciplinary committee or panel that it considers to be wrong and in respect of which it considers that it ought to take action, in the interest of patient protection.

Discussion

21.188 It seems to me that there were a number of problems with the old procedures of the PCC. Some of these will or may be rectified under the new procedures. However, others may be perpetuated. I shall mention what appear to me to have been the major difficulties in the past.

[19] [2004] EWHC 1850 (Admin).

Criminal Procedure

21.189 It has long been established that the PCC conducts its proceedings in the style of a criminal trial. The justification for this is that, because there is a possibility that the doctor will be erased from the register, proper safeguards must be provided so as to ensure fairness to the doctor. That is understandable. However, there is another important factor to be taken into account: the protection of the public. In some respects and on some occasions, these two factors are in conflict.

The Discretion to Receive 'Inadmissible' Evidence

21.190 In the past, the PCC usually insisted that any facts that the doctor did not admit should be proved by oral evidence. That was so even where the witness had given evidence and been cross-examined by or on behalf of the doctor on another occasion. It was so even though the PCC had a discretion to admit evidence that would not otherwise have been admissible, if satisfied that its **'duty of making due inquiry into'** the case **'makes its reception desirable'**. In the case of Dr JM 04, to which I referred earlier at paragraphs 21.79–21.84, the conflict of these two interests was resolved in favour of the doctor and against the interest of protecting patients. Dr JM 04 was facing charges before the PCC in respect of the administration of a gross overdose of diamorphine which had resulted in the patient's death. He was convicted of manslaughter. Before the PCC hearing, the GMC discovered that the doctor had been the subject of another quite serious complaint, which had been dealt with locally, resulting in a finding of breach of terms of service. The allegation plainly gave rise to a question of SPM. As I have explained, the GMC decided not to take proceedings in respect of the second complaint because the main witness was unwilling to go through her evidence orally for a second time. She had already given evidence once and had been cross-examined during the local procedures. The GMC could have issued a *subpoena* but decided that it would have been insensitive to do so; it could have sought to persuade the witness to change her mind; it could have invited the PCC panel to receive a record of what had been said at the MSC hearing. It might be that, in the absence of oral evidence, the PCC panel would not have found that the doctor's conduct was to be criticised in respect of the second incident. So be it. The point is that the GMC did not try; it simply decided not to proceed on the second matter.

21.191 Under the new procedures, FTP panels will have a similar discretion to admit evidence which would not strictly be admissible at a criminal trial. It remains to be seen whether, in future, the GMC will be more ready than it has been in the past to invite panels to use these powers. It seems to me that what is needed is a greater determination to prosecute each case fully, bringing all the facts before the panel and not just those for which oral evidence is readily available.

Standard of Proof

21.192 During the hearings, I expressed my concern that the PCC always applied the criminal standard of proof when reaching conclusions on the facts. I was concerned that this high standard of proof might not be appropriate in a jurisdiction which had, as its primary purpose, the protection of the public from doctors who are not fit to practise. I had not at

that stage noticed (as I have done since) that decisions of the PCC could be taken upon a bare majority of the panel. I had noticed that Miss Jean Ritchie QC, who conducted an Inquiry into the conduct of Rodney Ledward, had recommended that the civil standard of proof should be applied at PCC hearings. Ledward was a gynaecologist who, over the years, carried out a large number of 'botched' operations and caused his patients a great deal of harm. He was eventually erased from the medical register in September 1998. As I understand it, Miss Ritchie's concern was that the public might not be adequately protected by a disciplinary body that could act only if the facts were proved to a very high standard of certainty. I share that concern.

21.193 In the light of Miss Ritchie's recommendation, in 2000, the GMC held a conference to discuss the advisability of applying a 'sliding civil standard' of proof. That would mean that the PCC panel would have had to have been satisfied to a degree of probability that was appropriate to the gravity of the allegations under consideration and the seriousness of the likely sanction. In cases where the allegation amounted to a serious criminal offence, a higher standard of proof would be required than in one where the allegation was one of, say, gross negligence. The conference decided that the PCC should continue to apply the criminal standard of proof in all cases. It was thought that it would not be fair to deprive a doctor of his/her livelihood save on evidence that reached this high standard of proof. Thus, on the face of it, the concept of being fair to the doctor was to be allowed to override the need to protect the public.

21.194 However, the problem is not exactly as I had thought it to be. I had thought that there must have been many cases in which an allegation of SPM failed because the PCC was not satisfied that the facts had been proved to the criminal standard. However, in the course of his evidence to the Inquiry, Sir Donald Irvine said that, in his years on the PCC, he had found that the difficulties and disagreements arose, not over whether the facts were proved to the required standard, but over whether those proven facts constituted SPM. He also said that there was often disagreement on sanction. I found this most surprising. My experience as a judge presiding over jury trials leads me to believe that, when a group of people have to be satisfied of facts to a high standard of proof, there are often difficulties and disagreements. It seems to me that there are three possible explanations for the apparent absence of difficulty as reported by Sir Donald. One is that only cases where the evidence was very clear ever reached the PCC. Another is that the PCC panel was not actually applying the high standard of proof, but a lower standard. Another possibility, which is quite speculative, is that the high standard was being applied but that decisions were sometimes reached, not unanimously, but by a majority; under the GMC's Rules a bare majority will suffice. As for this last possibility, the fact that a bare majority is enough is, in my view, not inappropriate in a 'protective jurisdiction'. However, it is strange that the GMC should be so concerned about maintaining the high standard of proof in order to be fair to the doctor, when a finding can be made on the basis of a bare majority. Dealing only with the findings of fact, I would have thought there would have been greater protection for the doctor in requiring all members of the panel to be satisfied to the civil standard as to what the doctor has actually done than in permitting a decision to be made where (assuming a panel of five) three members of the panel were satisfied about a set of facts to the criminal standard but the other two might even think that the doctor had done nothing wrong at all.

21.195 It seems to me that the GMC should reopen its internal discussion about the application of standards of proof and should also consider the question of majority decisions. Good decision-making should, if possible, be unanimous. An attempt should always be made to reach unanimity, and only if it proves impossible should a majority decision be acceptable. In general, in a protective jurisdiction, the civil standard of proof will be appropriate. However, it is certainly arguable that it would be appropriate to retain the criminal standard of proof where the allegation amounts to a serious criminal offence.

A Legally Qualified Chairman

21.196 In her report into the Ledward case, Miss Ritchie recommended that PCC panels should be chaired by a circuit judge or an experienced recorder of the Crown Court. Her thinking was that this would ensure that the proceedings were carried out fairly and independently. It appears to me also that having an experienced lawyer as chairman of the panel would bring greater legal rigour to the determinations than does the advice of a legal assessor. For example, such a chairman would be able to ensure that the panel did not take irrelevant considerations into account and would be able to guide them more closely on such issues as the standard of proof.

21.197 Another advantage of a legally qualified chairman would be that s/he would have many years' experience of the forensic process and would be far better able to respond appropriately to unexpected occurrences, which do sometimes happen. I have observed from some of the material used to assist PCC panellists and chairmen when sitting that it cannot be assumed that they will have any idea of what should be said or done in certain situations. They are provided with forms of words to use at the various stages of the process. There would be a real advantage, it seems to me, in having chairmen who know, from long experience, what to do and what sort of thing to say at each stage of the process. In future, FTP panels may have to consider a mixed bag of allegations, some relating to misconduct and some relating to deficient performance or even impairment of health. FTP panel hearings may be more complex in future. I fear that FTP panels may find it difficult to sort out what evidence is relevant to what issues and, as they may well have to do, to apply different standards of proof to different aspects of the case. The guidance of a legally qualified chairman would, I think, be invaluable.

21.198 I note that, as recently as May 2003, the GMC was considering the possibility of using a legally qualified chairman in the more complex cases, although this idea now seems to have been abandoned. It seems to me that that would be an eminently sensible way of proceeding. It may be found that the advantages are such that the practice could be extended to all but the most straightforward cases.

The General Medical Council's Past Inability to Take a Holistic View

21.199 In the past, the GMC was prevented by its own procedures from taking a holistic view of doctors' problems. A case had to be assigned to either the conduct, health or performance procedures. As the GMC well understands, the human condition does not lend itself to such compartmentalisation and many doctors present with a variety of

different problems. I shall not dwell upon this past difficulty because I am optimistic that it will be resolved when the new procedures come into operation very shortly.

The Lack of Standards and Criteria

21.200 I cannot take the same optimistic view for the future as I return to discuss further the need for standards, criteria and thresholds for the operation of the FTP procedures. That they have been needed in the past is clear. Professor Allen advised about this in each of the PSI Reports. Her main concern was that there was no generally agreed perception of what amounted to SPM. In his evidence to the Inquiry, Sir Donald Irvine spoke about the differences of views among professionals on SPM. The same problem existed in relation to the concept of SDP. I have also referred to the view of the PCC Working Group that there was a need for greater consistency in the application of sanctions. Consistency of decision-making is necessary: first, in order to provide an appropriate degree of protection for patients, second, in order to be fair to doctors and third, to enable the GMC to command the confidence of the public and to uphold the reputation of the medical profession.

21.201 In its submission to the Inquiry, the GMC suggested that established standards, criteria and thresholds were neither appropriate nor necessary. They have not been necessary, it says, because the decision-makers of the past were experienced and well-respected members of the medical profession and were all members of the GMC. In essence, it is said, their judgement could be trusted. The GMC also suggests that the panellists of the present and future are and will be selected on merit and trained for the task. All that may be true but they are and will be all individuals and, however conscientious they are, they will reach inconsistent decisions unless guided by established standards, criteria and thresholds. The GMC has also suggested that established standards, criteria and thresholds are not appropriate because they inhibit the freedom of the decision-maker to take account of the individual circumstances of the doctor and the case. That is simply not so. No one is suggesting a mechanistic assessment which will result in cases being put into a specific pigeonhole. What is needed is a framework within which individual circumstances can be taken into account without producing unreasonable decisions. It appears from the DASG report in the first edition of the Fitness to Practice Bulletin, to which I referred in paragraph 21.150, that some members of the GMC are beginning to recognise this.

21.202 I am firmly of the view that established standards, criteria and thresholds have been needed in the past and will be needed every bit as much in the future, possibly even more so, because, as I shall explain in Chapter 25, the tests to be applied under the new procedures are, if anything, more open to personal interpretation than those applied under the old ones. I am also firmly of the view that, if the GMC is to gain the trust and confidence of the public, members of the public and patients' representatives must be actively involved in the setting of the standards, criteria and thresholds.

21.203 So far as sanctions are concerned, the ISG is clearly helpful and the publication of appropriately detailed case studies would also be useful. However, I do not think that such measures will be sufficient to restore public confidence in the GMC's willingness and

ability to apply appropriate sanctions to erring doctors. I recognise that, in formulating the ISG (and in developing new guidance on specific topics), the GMC does, to some extent, consult with patients' representative bodies. However, in my view, what is needed is a consensus between the GMC and the public about the range of appropriate sanctions in the types of case that regularly recur. As a model for reaching consensus, I would urge the GMC to examine the operation of the Sentencing Advisory Panel, which provides advice to the Court of Appeal (Criminal Division) about particular types of case. The Panel comprises members from a wide range of backgrounds: judges, barristers, magistrates, academics and lay people. The Panel also consults more widely when it embarks on the consideration of each new topic. The Panel's reports advance an agreed view which, by reason of its origin, commands the respect of the Court of Appeal (Criminal Division) which is, in effect, the standard-setting body for the decision-makers at first instance, the judiciary and magistracy. Such views should also command public confidence. The exercise of consultation enables the criminal justice professionals to understand the public viewpoint and *vice versa*. It seems to me that this kind of process could easily be adapted so as to provide guidance to the GMC. It may be that a consultative council could be set up under the auspices of the CRHP/CHRE.