Malpractice, Criminality and Medical Regulation: Reforming the Role of the GMC in Fitness to Practise Panels

A recent Law Commission Review emphasised that medical fitness to practice panels (also called medical practitioners tribunals) are an important legal mechanism for ensuring that public trust in medical regulation is maintained when a complaint is made against a doctor. This paper examines trends over time in panel outcomes to identify their effectiveness in ensuring public protection. Although a rise in complaints, and a change from the criminal to civil standard of proof, has not led to more doctors being struck off the medical register, increasingly action is being taken to provide advice, issue warnings and agree rehabilitative forms of action with doctors. It is argued that these trends are congruent with the broader adoption of a risk-based approach to professional regulation. Legal reforms to maintain public trust must ensure that the shift towards risk-averse forms of professional accountability do not sacrifice public safety and due process for the sake of political pragmatic exigency.

Key words: Complaints, fitness to practise, General Medical Council, medical regulation, medical practitioners tribunal, Medical Practitioner Tribunal Service.

I. INTRODUCTION

The question of how best to legislate to protect the public in the United Kingdom (UK) from the ethically dubious, incompetent and criminal actions of doctors has long been of fundamental significance and interest to lawyers and beyond.[1] However, over the last two decades in particular there has been heightened political, legal and public attention paid to the field of doctors' fitness to practise as a result of a series of medical regulatory failings in prominent medical malpractice cases, such as the respective Bristol and Alder Hey cases, as well as medical acts of criminality, including multiple homicide in the case of the general practitioner Harold Shipman.[2] In the UK, a doctor must be registered on the register of approved practitioners if they wish to practise medicine in the National Health Service (NHS). In 2015 they were 273 854 individuals registered on this database.[3] The register is overseen by the General Medical Council (GMC) under the aegis of the Medical Act 1983. The GMC, therefore, represents the principal formal legal mechanism for medical regulation within the UK and is the statutory body responsible for responding to complaints about the fitness to practise of doctors.[4] Only the GMC has the authority to remove doctors from the register by instigating disciplinary proceedings[5] via what, since the end of December 2015, have been called Medical

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[1] See C. A. Erin and S. Ost, *The Criminal Justice System and Health Care* (Oxford: Oxford University Press, 2007); H, Biggs, *Healthcare Research Ethics and Law: Regulation, Review and Responsibility* (London: Routledge-Cavendish, 2009); M Brazier and D. Griffiths,' Doctors in the Dock' (2011) *Manchester Memoirs*, 148: 22 - 23; D. Griffiths and A. Sanders, *Bioethics, Medicine and the Criminal Law II*: *Medicine, Crime and Society*. (Cambridge: Cambridge University Press, 2013); M. Brazier and S. Ost, *Bioethics, Medicine and Criminal Law III*: *Medicine and Bioethics in the Theatre of the Criminal Process* (Cambridge: Cambridge University Press, 2013)

[2] K. Soothill and D. Wilson, 'Theorising the puzzle that is Harold Shipman' (2005) *Journal of Forensic Psychiatry and Psychology* 16: 685 - 698.

[3] General Medical Council, *List of Registered Medical Practitioners - Statistics.* Available at: *http://www.gmc-uk.org/doctors/register/search_stats.asp* (Accessed 25th January 2016).

[4] H. Quirk, 'Sentencing White Coat Crime: The Need for Guidance in Medical Manslaughter Cases' (2013) *Criminal Law Review* 11: 871 - 888.

[5] The GMC is one of a number of bodies which deal with complaints against medical practitioners. NHS Hospital Trusts, Primary Care Trusts; alongside the National Clinical Assessment Service, the Healthcare Commission and the Parliamentary and Health Service Ombudsman, are all important points of contact for dealing with medical malpractice and patient complaints. But the GMC remains

Practitioners Tribunals (MPT).[6] As a result, growing public and political concern with the regulation of doctors in light of a series of high-profile medical malpractice and negligence cases has focussed on the need to reform the organisational structure and operational culture of the GMC.[7] In particular, attention has been paid to addressing the contention that the medical regulatory system in the UK has frequently served to mask medical mistakes rather than first and foremost protect the public interest.[8]

This paper is concerned with key changes made to the MPT process as part of this reforming agenda. Inquiries of high profile scandals at Bristol Royal Infirmary, Mid-Staffordshire NHS Trust and Morecombe Bay NHS Foundation Trust very publicly brought to the foreground questions about the willingness of a practitioner to report a colleague's underperformance. They also reinforced to medical elites and NHS leaders the importance of, in principle, supporting reforms to medical regulatory and complaint processes.[9] The Royal Colleges and British Medical Association collectively acknowledged that although (as they see it) some form of professionally-led regulatory process is necessary given the specialist nature of medical expertise, a more open and accountable system needs to be inculcated within the GMC and its day to day operation.[10] Against this background, the paper critically examines the operation of the GMC complaints procedure and provides an analysis of statistical trends over time in the outcomes of MPTs to ascertain the impact of changes made, if any.

Under the Health and Social Care Act 2008, the standard of evidence required to secure an impaired fitness to practise verdict and remove a practitioner from the medical register was reduced from a criminal to a civil standard of proof. This reform was justified on the grounds that, historically, the GMC had often been unable to remove a doctor from the medical register to protect the public, even when doubt existed over their clinical performance, because the standard of proof required was unduly high.[11] A key concern here is that legal reforms have been introduced to the MPT process for reasons which might fail to fully account for the esoteric and situational nature of medical discretion when decisions are made, and as a result they may unintentionally serve, in particular types of cases, to undermine the principles of swift, proportionate and effective legal response(s) to ensure public protection.[12] This is because, as the paper will discuss, bound up with the reforming regulatory agenda is the advocacy of a risk-based approach to professional regulation which possesses a tendency to seek to minimise clinical risk and cost through the transformation of medical work into a series of routine 'step-by-step' rules and procedures against which individual clinician performance can be measured and judged.[13] Although a focus on minimising medical risk in this manner is understandable, the paper discusses how MPT outcome data supports the contention that risk-based regulation could be problematic as a model for governing professional forms of expertise.[14] This

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the only body able to remove a doctor from the medical register and as a result stop them from practising medicine in the UK.

[6] Previously MPTs were referred to as Fitness to Practise Panels, which remains part of the regulatory socio-legal nomenclature.

[7] General Medical Council, *Raising and Acting on Concerns about Patient* Safety (London: GMC, 2013).

[8] J. M. Chamberlain, *The Sociology of Medical Regulation: An Introduction* (Springer: New York and Amsterdam, 2012); P. Gooderham, 'No-one Fully Responsible: A 'Collusion of Anonymity' Protecting Health-care Bodies from Manslaughter Charges?' (2011) *Clinical Ethics* 6: 68 – 77.

[9] J.M. Chamberlain, *Medical Regulation, Fitness to Practise and Medical Revalidation: A Critical Introduction* (Bristol: Policy Press & Chicago: University of Chicago Press, 2015)

[10] General Medical Council, *Our Response to the Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry* (London: GMC, 2013).

[11] P. Case, 'Putting Public Confidence First: Doctors, Precautionary Suspension and the General Medical Council' (2011) *Medical Law Review* 19: 339 - 371

[12] M. Brazier and E. Cave, *Medicine, Patients and the Law* (Lexis-Nexis and Penguin, 2007).

[13] M. Power, *Organised Uncertainty: Designing a World of Risk Management* (Oxford: Oxford University Press, 2007).

[14] The shift toward risk-based forms of regulation over the last decade has been noted as an emergent key feature of the governmental reform agenda within both law and medicine (for example,

proposition is particularly prescient, it is argued, in light of the highly politicised nature of the legal regulation of doctors, and given that the patient complaint system (out of necessity) provides a reactive, service user-led mechanism of professional accountability in which notions of due process, fairness and redress must be carefully balanced.[15] Furthermore, the paper embeds its critical analysis of the MPT process in the context of the Law Commission's comprehensive review of health care professionals conducted in 2014/15.[16] This noted that MPTs are a vitally important legal mechanism for ensuring public trust in medical regulation when complaints are made about a doctor. As a result, Parliament acted to strengthen the investigatory and adjudication process by legislating to ensure that MPTs are independent autonomous structures *within* the GMC. The paper concludes by questioning if indeed this is the most appropriate approach to ensuring public protection.

The next section of the paper details the background to this discussion by outlining how the MPT process operates and provides outcome data between 2006 and 2014, with data from previous years being discussed where possible.[17] Although the data outlined illustrates the operation of the GMC, it should not however be taken as representative of its total activity for each calendar year. This is because in 2013 an enquiry took on average 97 weeks to move from the initial complaint to MPT outcome stage; hence an enquiry received in 2009 may well not reach resolution until 2011. This said, having year on year comparative data does allow for descriptive statistical trends to emerge.

II. COMPLAINTS AND THE HEARING OF FITNESS TO PRACTISE CASES

The GMC is responsible for removing doctors from the medical register. It is not part of the GMC's role to encourage complaints against doctors. Nor does it respond to complaints against NHS systems (although it may respond to complaints against individuals that illustrate system failings) and

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see R. Baldwin, 'The New Punitive Regulation' (2004) *Modern Law Review* 67: 351-383; J.C. Donoghue, 'Reforming the Role of Magistrates: Implications for Summary Justice in England and Wales' (2014) *Modern Law Review* 77: 928 – 963), as well as the public sector more generally (for example, see C. Hood and P. Miller *Risk and Public Services: Report by the ESRC Centre for Analysis of Risk and Regulation* (London: The London School of Economics, 2010).

[15] P. de Prez, 'Self-Regulation and Paragons of Virtue: The Case of Fitness to Practise' (2002) *Modern Law Review* 10: 28 - 56.

[16] *Regulation of Health Care Professionals, Regulation of Social Care Professionals in England* Law Commission Consultation Paper No 202 (London: England, 2014); *Regulation of Health Care Professionals, Regulation of Social Care Professionals in Northern Ireland* Law Commission Consultation Paper No 12 (Belfast: Northern Ireland, 2014); *Regulation of Health Care Professionals, Regulation of Social Care Professionals in Scotland* Scottish Law Commission Discussion Paper No 153 (Edinburgh: Scotland, 2014).

[17] Contact was made with the GMC to discuss the availability of data, under the Freedom of Information Act (2000). It was stated that the GMC have only held fully computerised record systems since 2006 and that the resources which would need to be allocated to review stored paper files to obtain data prior to this date would exceed the appropriate limit of costs incurred under the Act. The GMC noted it was possible to obtain data on complaints for 1995, 1998 and between 1999 and 2014, as well as the hearing of fitness to practise cases for the years 2006 to 2014, from the following published reports: General Medical Council *Annual Statistics* (London: GMC 2000); General Medical Council *Annual Statistics* (London: GMC, 2001); General Medical Council *Annual Statistics* (London: GMC, 2002); General Medical Council *Annual Statistics* (London: GMC, 2003); General Medical Council *Annual Statistics* (London: GMC, 2004); General Medical Council *Annual Statistics* (London: GMC, 2005); General Medical Council *Fitness to Practise Annual Statistics* (London: GMC, 2006); General Medical Council *Fitness to Practise Annual Statistics* (London: GMC, 2007); General Medical Council *Fitness to Practise Annual Statistics* (London: GMC, 2008); General Medical Council *Fitness to Practise Annual Statistics* (London: GMC, 2009); General Medical Council *Fitness to Practise: Annual Statistics* (London: GMC, 2010); General Medical Council *Fitness to Practise: Annual Statistics* (London: GMC, 2011); General Medical Council *Fitness to Practise: Annual Statistics* (London: GMC, 2012). General Medical Council *Fitness to Practise: Annual Statistics* (London: GMC, 2013). General Medical Council *Fitness to Practise Annual Statistics Report 2014* (London: GMC, 2014).

neither does it arrange for complainants to receive an apology, an explanation of what happened, or provide help and support for compensation claims.[18] The GMC only responds to complaints that call into question a doctor's fitness to practise.[19] Under Section 35C(2) of the Medical Act 1983, alongside the guidance to good practice provided in its document *Good Medical Practice*,[20] the GMC focusses upon complaints that highlight instances where a doctor: has made serious or repeated mistakes in carrying out medical procedures or in diagnosis (for example, by prescribing drugs in a dangerous way); has not examined a patient properly or responded appropriately to their medical need; has committed fraud, dishonesty or serious breaches of a patient confidentiality; has received a criminal conviction; or has developed a physical and/or mental health issue.

All complaints made to the GMC are referred to initially as 'enquiries'. In the 2015 Parliamentary Accountability Hearing, the GMC Chief Executive, Niall Dickson, reported that the GMC publishes within its statistical return all enquiries it receives, although it only investigates complaints which fall within its remit.[21] As a result, the year-on-year enquiries outlined in Table One are regarded as the officially recorded total number received by the GMC, regardless of source.[22] Fitness to practise procedures are divided into two key stages: investigation and adjudication.[23] The purpose of the investigation stage is to make an assessment as to whether there is a need to refer an enquiry to the Medical Practitioners Tribunal Service (MPTS) for adjudication, via a MPT. During the investigative stage, a 'triage' process takes place, which involves making an initial decision as to whether or not to proceed with an enquiry. Some enquiries are clearly outside of the GMC's remit.[24] For example, an enquiry may not be concerned with an individual medical practitioner. If necessary, the GMC will refer the matter to the doctor's employer so that local procedures can be used if necessary to respond to it. The GMC has a target of eight weeks for completion of local procedures cases. If the initial information points towards the existence of a criminal conviction, then the matter will be immediately referred to a MPT for adjudication. Before discussing adjudication cases, the paper will first highlight key statistical trends found in the initial complaint data.

A. Number of enquiries made to the GMC over time

The total number of enquiries received by the GMC between 1999 and 2014 are detailed in Table One**.** This Table also shows the number of enquiries received by the GMC in 1995 and in 1998. The figures for 1995 and 1998 were obtained from published GMC documents.[25] Aside from 2006, when

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[18] n 9 above.
[19] General Medical Council, *Guidance on GMC's Fitness to Practise Rule* (London: GMC, 2004).
[20] General Medical Council, *Good Medical Practice* (London: GMC, 2013).
[21] Health Committee (2015) *Oral evidence: 2015 Accountability Hearing with the General Medical Council, HC 846 Tuesday 6 January 2015* London: House of Commons,14
[22] The origin of enquiries is broken down by the GMC into four source categories. In the 2014-15 reporting period, 65% of all enquiries came from the public, 12% from other doctors, 6% from a practitioner's employer, and 17% from other sources (e.g. the police). These proportions changed little between 2010 and 2013, when the GMC first started to break down its reporting of the source of enquiries in this manner. The data outlined in this paper pertains to all enquiries and how they progress through the GMC complaint handling system regardless of source, as year-on-year comparative outcome data broken down by complaint source was not available for the entirety of the reporting period detailed in tables one to four. The GMC noted in 2014-15 annual report that the number of enquiries it receives from doctors and employers has risen slightly over the last decade and the introduction of the new NHS duty of candour might well lead to a significant increase in enquires from NHS staff and employers in the future. It is expected that this will be examined further in future annual reports. Source: GMC (2015) *The State of Medical Education and Practice in the UK* 2014-15 London: GMC.
[23] General Medical Council, *Fitness to Practise Procedures* (London: GMC, 2014).
[24] Enquiries which are clearly outside of the GMCs remit and do not enter the investigative stage are referred to as 'stream two' enquiries and are discontinued with no further action. Table Two details the number of enquiries concluded at this stage.
[25] n 17 above.

the number of enquiries reduced sharply, the figures reveal that the number of enquiries received by the GMC has increased by 640 per cent over the last seventeen years, from 1503 in 1995 to 9624 in 2014. The total of 9624 enquiries represents four per cent of all medical practitioners on the GMC register in 2014 (267,177).[26] Although the GMC did change to a fully computerised record system in 2006, the dip in enquiries that year cannot be attributed to any major change in the organisation or role of the GMC, so it may well be simply a statistical aberration, which can routinely occur in the analysis of longitudinal data. Furthermore, its presence does little to alter the significance of the longitudinal trend for increased enquiries, albeit with the proviso that the number appears to have tailed off over the last two years. In the last two decades there has been an increase in the questioning of medical authority, with the result that individuals are more likely to complain about their doctor and/or the treatment that they have received.[27] A 2014 report by Civitas noted that the number of doctors on the medical register being complained about had risen from 0.9 in 1992 to 4 per cent in 2012, with an increased willingness on behalf of the public to complain about the treatment they received underpinning this trend.[28]

[Insert Table 1 here]

B. Investigatory stage outcomes

Having examined the total number of enquiries made, it is now necessary to consider the figures relating to the progression of cases from the investigation and adjudication stages. In those instances where the triage process confirms that the enquiry requires further consideration, it will proceed to the investigative stage. At this point, the complaint is discussed with the doctor in question as well as their employer[29], in order to ensure that a complete picture of their practice can be obtained. All cases are overseen by two case examiners, one of whom is a non-medical practitioner and one is a medical practitioner. Witness statements and supportive material will be collected and analysed, including copies of patient medical records or other formal documentary material (for example, employer reports). Where there is a concern with performance or health, appropriate tests will be completed at this stage and an Interim Orders Tribunal (IOT) may be held. This may decide to suspend or restrict a doctor's practice while the investigation continues. The investigation period concludes with either no further action being taken, the issuing of a warning, a practitioner agreeing to what are referred to as 'undertakings' (i.e. training in clinical or communication skills), or a case being referred to a MPT for adjudication. On average, enquiries take twenty-nine weeks to move from the initial complaint to investigation outcome stage.[30]

It was impossible to identify comparative outcome figures for the handling of enquiries at the investigative and adjudication stages prior to 2006 from the data available, as the process by which the GMC handles enquiries changed at this time as a consequence of broader reforms introduced following the Shipman case.[31] Additionally, some information was unavailable as it was not present in the GMC reports used to obtain data.[32] Moreover, in view of the time taken for a case to reach completion, GMC outcomes generally tend to roll forward to the following reporting period. Nonetheless, the available data for 2006 to 2014, as displayed in Table Two, does reveal a key trend towards an increased investigative workload (from 12 per cent, n = 346 in 2006, to 25 per cent, n =

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[26] n 3 above.
[27] J. Archer, *Understanding the Rise in Fitness to Practise Complaints from the Public (*Plymouth: Plymouth Medical School, 2014).
[28] H. Williams, C Lees and M Boyd, *The GMC: Fit to Practise?* (London: Institute for the Study of Civil Society, 2014)
[29] Doctors can be self-employed, for example if they have entered private practice. In these circumstances, the GMC will contact a practitioner's practice partners.
[30] Professional Standards Authority, *Performance Review Report 2013-14* (London: Professional Standards Authority, 2014).
[31] n 30 above.
[32] See n 17 above

2444 in 2014) and the greater use of pre-emptive action in the case management of enquiries. Although the majority of enquiry cases are concluded before the investigatory stage by the GMC (as they are deemed to have not met the aforementioned criteria under which it operates), just as more complaints are being made than previously, more doctors are being subject to formal and informal sanction *before* being subject to a formal disciplinary hearing. Table Two suggests that the GMC is making relatively frequent use of warnings and rehabilitative undertakings, in addition to providing individual doctors (and their employers) with informal advice and guidance. It should be noted here, however, that in 2012 the GMC changed how it issued advice, as it was felt that such action should be devolved to a local NHS Trust level in the majority of cases, and this is reflected in a significant reduction in instances of its use in 2013. The validity of the conclusion that there has been a rise in investigatory action as well as pre-emptive disciplinary 'holding measures' as part of this process, is arguably further substantiated by Table Three. This displays the use of interim orders to suspend or restrict the practice of doctors *before* a formal tribunal hearing takes place. It is evident from this data that the process is seeking to either restrict a doctor's professional practice while they are under investigation, or to suspend them completely. The trend towards pre-emptive action will be returned to again in the next section of this paper, where the use of disciplinary measures will be explored further in relation to notions of due process and procedural fairness. However, attention will first be paid to detailing trends in MPT hearing outcomes.

[Insert Table 2 here]

[Insert Table 3 here]

C. Fitness to practise tribunal outcomes

The adjudication stage involves a formal hearing of a case by the MPTS via a MPT. Hearings consist of a mixture of medical and non-medical lay members. The format is adversarial, with the GMC's legal representative presenting evidence and argument in the public interest, and a practitioner's legal representative similarly presenting their own argument and evidence.[33] If necessary, MPT members will be advised by a specialist health and/or performance adviser. There are five main outcomes of a hearing: no further action; issuing a doctor with a formal warning; placing restrictions upon a doctor's professional practice (for example, imposing supervision or requiring the doctor to undertake further training); suspending a doctor from the medical register so that they may not practise for a given period of time; and erasing a doctor from the medical register. A doctor has twenty-eight days to appeal against a decision which they lodge at the High Court of Justice in England and Wales, the Court of Session in Scotland, or the High Court of Justice of Northern Ireland. The panel's decision will not take effect until either the appeal period expires or the appeal is determined. However, the panel can impose an immediate order of suspension or conditions on practice, if it believes that this is necessary to protect the public or is in the best interests of the doctor. It is the intention of the GMC that when they erase a doctor from the medical register, that this ought ordinarily to be for life. On average, enquiries generally take ninety-seven weeks to move from the initial complaint to an outcome.[34]

Table Four details the outcomes of cases heard at the adjudication stage. For year on year comparative purposes, the data has been broken down into relative percentages for each action category based on the total number of cases heard per year. This shows that although there is (as

[33] For cost reasons, some doctors choose to represent themselves at hearings (14% in 2015 and 13% in 2014). In such circumstances, the MPTS advises practitioners to, if possible, obtain free legal assistance from the Medical Defence Union. The impact (if any) of self-representation on hearing outcomes during the 2006 – 2014 reporting period detailed in this paper is not known (Source: Medical Practitioner Tribunal Service, *Report of the Chair of the Medical Practitioner Tribunal Service* (London, Medical Practitioner Tribunal Service, 2015)).

[34] n 30 above.

would be expected) a degree of fluctuation in the year on year percentages within each case disposal pathway, overall there is a strong element of comparative consistency, both between and within the different action categories, in how fitness to practise cases were managed throughout the time period 2006 to 2014. This time period has been accompanied by a growing public concern about medical error and malpractice, alongside an increasing perception within the medical profession at large that the GMC is adopting a more punitive approach to the management of fitness to practise cases.[35] In this regard, Table Four illustrates that the adjudication stage is more likely to result in high impact decisions, such as conditions being placed on a doctor's practice, suspension from the medical register, or erasure from the medical register. Relatively few doctors receive undertakings or warnings at adjudication stage, although a considerable percentage of cases result in the conclusion that there is no impairment in a doctor's practice**.** Furthermore, the shift to a civil standard of proof during this time period (i.e. from 2008 onwards) *does not* appear to have resulted in an immediate and significant increase in doctors being erased from the medical register.

[Insert Table 4 here]

III. DISCUSSION

The preceding section of this paper has highlighted several key themes. First, that there has been an upward trend in the GMC receiving complaints over the last two decades, rising by 640 per cent from 1503 in 1995 to 9624 in 2014, with the proportion of doctors on the medical register being complained about increasing from 0.9 per cent in 1992 to 4 per cent in 2014. Second, that the GMC is investigating more complaints, with the number of complaints taken forward for investigation after the initial triage process in the last decade doubling from 12 per cent (n = 346) in 2006, to 25 per cent (n = 2442) in 2014. Third, this increase in GMC workload has led to more doctors being subject to pre-emptive formal and informal 'holding sanctions' *before* being subject to a MPT hearing, with the GMC making relatively frequent use of its powers to suspend or restrict a doctor's practice in addition to issuing warnings and agreeing rehabilitative undertakings, as well as providing individual doctors (and their employers) with informal advice and guidance. Fourth, in relation to MPT outcomes, although there is a degree of fluctuation in the year on year percentages within each case disposal pathway, overall there is a strong element of comparative consistency, both between and within the different action outcome categories. Fifth, the tribunal adjudication stage is more likely to result in high impact punitive decisions, such as conditions being placed on a doctor's practice, suspension from the medical register, or erasure from the medical register; however a proportion of cases do result in the conclusion that there was no impairment in a doctor's practice. Sixth, the shift to a civil standard of proof during this time period (i.e. from 2008 onwards) does not appear to have resulted in an immediate and significant increase in doctors being erased from the medical register. The paper will now turn to discuss and reflect upon these findings in turn.

A. Complaints and reforming the GMC

The rising number of complaints to the GMC over the last two decades and the concomitant increase in enquiry case workload is well recognised within the academic literature.[36] Analysis of the GMC's statistical data has established that the rise in complaints from members of the public has been largely consistent at regional and national levels throughout the UK, suggesting that the increase has been driven by wider social trends rather than localised factors.[37] It is therefore important to pay attention to those broader societal trends which may assist in accounting for these developments. In particular, Griffiths and Sanders note the increasingly litigious nature of modern societies, which is associated with greater willingness and confidence on the part of individuals to seek legal redress

[35] n 27 above.
[36] P. Case, 'The Good, the Bad and the Dishonest Doctor: the General Medical Council and the Redemption Model of Fitness to Practise' (2011) *Legal Studies* 31: 591- 614.
[37] n 27 above

(against businesses, institutions and private citizens) and obtain compensation. In this context, the rise in complaints against doctors may well be a consequence of the fact that increasing numbers of the public are seeking legal/financial redress when they are not satisfied with the medical treatment they receive.[38]

However, it is equally important to bear in mind that complainants are often motivated by strong emotions, such as anger, frustration and the grief of losing a loved one, and research suggests that as a result they often act out of an altruistic sense of social justice, seeing it as their personal duty to ensure that the poor care that they feel that they or their relatives have experienced does not happen to other people in future.[39] As a result, the fact that the majority of complaints the GMC receives are not taken forward (75% in 2014) raises questions surrounding its gatekeeper role when it comes to ensuring patients can seek satisfactory non-financial altruistic forms of redress, which the paper will return to later. For the moment, it is enough to note that there is considerable confusion surrounding the wider system of complaint-handling in place in the NHS.[40] The handling of complaints is divided between professional regulatory bodies, which focus on individuals' practice, systems regulators such as the Care Quality Commission, as well as healthcare providers and the health services ombudsmen. This suggests that it might well be difficult for members of the public to know where to address their complaints, and that this confusion may be driving people towards directing their complaints to long-standing organisations such as the GMC, as it may be more recognisable. Furthermore, as Brazier and Ost note, because national-level professional regulatory bodies such as the GMC may be viewed as more independent than local NHS employers, complainants may contact them as well as the police, rather than complaining to the service where they suffered a negative experience.[41]

In recent years the public profile of the medical profession and the GMC has been damaged by negative media coverage, focussed on the supposed failings of foreign doctors, stories of criminality, as well as high-profile fitness to practise cases.[42] Equally however, recent legislative reform in the regulation of doctors, which has similarly been widely reported in the media, has supported the development of a risk-based model of professional governance and this has inculcated fundamental changes in the public-facing organisational structure of the GMC.[43] At present, the GMC undoubtedly *looks* like a very different organisation from what it was previously.[44] No longer is it *the* public symbol of medical authority, status and power. The traditional doctors-only 'club mentality' has shifted to permit the inclusion of non-medical members, and it now possesses open and transparent administrative protocols, processes and outcome measures, from which its operational performance can be observed, measured and judged.[45] The rise in complaints received – regardless of whether they are suitable for GMC action or not - might well be a reflection of this change.

In the past, as a result of high profile scandals, the GMC has been accused of bias towards doctors and has been criticised for not fulfilling its statutory obligation under s.1A and s.1B of the Medical Act 1983, to protect, promote and maintain the health, safety and well-being of the public. As a result, it

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[38] D. Griffiths and A. Sanders *Bioethics, Medicine and the Criminal Law II: Medicine, Crime and Society* (Cambridge: Cambridge University Press, 2013).
[39] J. Glynne and D. Gomez, *Fitness to Practise: Health Care Regulatory Law, Principle, and Process* (London: Thomson, Sweet and Maxwell, 2005).
[40] n 30 above
[41] M. Brazier and S. Ost. *Bioethics, Medicine and Criminal Law III*: *Medicine and Bioethics in the Theatre of the Criminal Process* (Cambridge: Cambridge University Press, 2013, 255-260)
[42] J. Goodman, 'The Case of Dr Munro: Are There Lessons to be Learnt?' (2010) *Medical Law Review* 18: 564-577
[43] E. Scrivens, 'The Future of Regulation and Governance' (2007) *Journal of the Royal Society for the Promotion of Health* 127: 72 - 77.
[44] See D. Irvine, *The Doctors' Tale: Professionalism and Public Trust* (Abingdon: Radcliffe Medical Press, 2003).
[45] M. McCartney, 'Does the GMC Deserve its Current Powers?' (2014) BMJ 349: 36-38

has sought to become more transparent in its operations.[46] In this context, 'transparency' can be understood as a policy device designed to enable practices that are open to public scrutiny in order to generate greater trust and legitimacy.[47] The accumulation of regulatory failures in the last three decades prompted the government to legislate for a shift from 'professional self-regulation' to 'regulated self-regulation' whereby GMC activity is made more transparent through being subject **to** independent regulatory oversight by the Council for Healthcare Regulatory Excellence (CHRE), which since 2012 has been called the Professional Standards Authority for Health and Social Care (PSA).[48] The noted proportional rise in complaints taken forward for investigation in the last decade (rising from 12 per cent (n = 346) in 2006, to 25 per cent (n = 2442) in 2014), along with the proactive use of pre-emptive formal and informal 'holding sanctions' before a MPT hearing, arguably provide some evidence to support the conclusion that regulatory reform has led to a shift from protecting doctors, towards protecting the public. Nonetheless, pertinent questions persist concerning the legitimacy of the tribunal process.

B. The process as punishment and procedural fairness

There is a growing perception within the medical profession that the GMC itself is far less tolerant of infractions than before.[49] The data outlined in this paper lends support to the argument that the GMC is making relatively frequent use of IOTs to suspend or restrict a doctor's practice, in addition to issuing warnings and agreeing rehabilitative undertakings, as well as providing individual doctors (and their employers) with informal advice and guidance. Published research reporting the experiences of nearly eight thousand doctors found that those who had recently been the subject of a complaint were twice as likely as other doctors to report moderate or severe anxiety, and twice as likely to have thoughts of self-harm. Those referred to the GMC had especially high rates of psychological illness, with twenty-six per cent reporting moderate to severe depression and twenty two per cent reporting moderate to severe anxiety.[50] It has been suggested that pre-hearing investigative measures are traumatising for doctors who suffer from health-related problems in particular, and in some instances this is leading them to agree to high impact sanctions, namely suspension or erasure from the medical register, *before* they attend a hearing, with the hearing itself subsequently becoming a 'rubber stamp' exercise.[51] The caveat must be added that the available research does not differentiate between tribunal cases where a practitioner has contested or where they have not contested the accusations made against them. Nonetheless one hundred and fourteen doctors died while facing a fitness to practise investigation between 2005 and 2013. Twenty-four of whom committed suicide, with a further four being suspected of doing so.[52] Such findings raise legitimate questions in regards to the potentially overly punitive nature of the process.

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[46] J. Waring and M. Dixon-Woods,' Modernising Medical Regulation: Where Are we Now?' (2010) *Journal of Health Organisation and Management* 24: 540 - 555

[47] n 41 above.

[48] n 9 above

[49] D. Griffiths, A. Alghrani and M. Brazier, 'Medical Manslaughter': A Cause for Concern?' (2010) *Medical Defence Union Journal*, 26(2), 11-12

[50] T. Bourne, L. Wynants, M. Peters,C. Van Audenhove, D.Timmerman,B. Van Calster, and M. Jalmbrant, 'The Impact of Complaints Procedures on the Welfare, Health and Clinical Practice of 7,926 Doctors in the United Kingdom: A Cross-Sectional Survey' (2015) *BMJ Open* Access Available at: *http://bmjopen.bmj.com/content/5/1/e006687.full.pdf+html*

[51] T. Moberly, 'GMC is Traumatising Unwell Doctors and may be undermining Patient Safety' (2014) *BMJ Careers* 20: 10-1; C. Dyer, 'GMC and Vulnerable Doctors: Making Sure Fear Isn't a Factor' (2013) *BMJ* 347: 18-19

[52] Source: S. Horsfall, *Doctors who Commit Suicide while Under GMC Review: Internal Report* (London: GMC, 2014). In 2014 the GMC launched a review of the number of suicides of doctors under investigation (see: General Medical Council, *Chief Executive's Report* (London: GMC, 2014)).In 2015 it appointed one of the UK's leading mental health experts, Professor Louis Appleby, to provide independent advice on how it can better support vulnerable doctors. In April 2016 the GMC

It is important that the tribunal process does not become primarily focused upon 'punishment for punishment's sake' as a consequence of a risk-averse drive towards increased medical accountability and institutional transparency.[53] An apposite comparative example of why the punitive dimensions of the tribunal process must be carefully considered is to be found in Malcolm Feeley's socio-legal study of lower criminal courts, *The Process is the Punishment.*[54] Feeley highlighted that in some instances, due process procedural safeguards designed to preserve the right to trial by jury were undermined by the severity of pre-trial procedures (e.g. the economic costs associated with paying bail bondsmen or retaining counsel). He noted that these frequently served the function of punishing the defendant, with court actors other than the judge and jury, such as bail bondsmen, possessing a key role in the administration of punishment, as they often incentivised the defendant to plead guilty.

In the context of the hearing of fitness to practise cases, the evidence published in this paper and elsewhere in relation to the impact of the pre-hearing process on doctors increasingly highlights broader concerns for medical-legal scholars regarding procedural fairness within the medical tribunal process. Research suggests that both patients and medical practitioners report high levels of dissatisfaction with how the GMC responds to complaints.[55] Given the naturally competing interests of both parties, this is somewhat to be expected. However, the fitness to practise hearing is the only mechanism for providing fairness in procedure, and for achieving a balance between the competing interests of parties to ensure greater satisfaction with the tribunal process. Therefore, it is the *process* itself which is of principal importance in determining whether procedural fairness has been achieved and appropriate punishment delivered – and not the individual outcome of a given case.[56] In addition, procedural justice scholars have observed that an individual's experience of the process strongly influences the *perceived* fairness of the substantive result of a legal process.[57] As a result, legislative reformers ought not to identify a numeric increase in enquiries about doctors being investigated and called to account for their actions as a key measure from which to judge their success or otherwise in reforming medical regulation. Instead, greater attention should be paid to examining whether doctors, patients and their respective legal representatives, report greater satisfaction with the case hearing process, even when the hearing outcome does not find in their favour. Such an endeavour would be useful in generating better understanding of conceptions of fair treatment, impartiality and equity, within the domain of fitness to practise hearings.[58] This paper will now examine this matter in the context of findings relating to the impact of the shift toward the civil standard, considering as it does so the risk-focused nature of the broader regulatory reform agenda, as well as recent legislative reforms to the tribunal process.

C. The shift to the civil standard and rise of risk-based medical regulation

Thus far I have highlighted the presence of possible problems with the procedural fairness of the complaint and tribunal process from the point of view of doctors, noting how the data outlined lends support to the view that recent regulatory reform has heralded a 'punitive turn' in how practitioners are

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announced that it was changing how it communicates and works with doctors under investigation, and there will be a two-year pilot of a new support service entitled the 'The Doctor Support Service'. This service will be independently provided by the British Medical Association (see: General Medical Council, *GMC News April 6th 2016* (London: GMC, 2016); British Medical Association *The Doctor Support Service* (London: BMA, 2016)).

[53] n 11 above.

[54] M. Feeley, *The Process is the Punishment: Handling Cases in a Lower Criminal Court* (Connecticut: Russell Sage Foundation, 1979).

[55] S. Bridges, H. Ahmed, E. Fuller and H. Wardle, *Fairness and the GMC: Doctors Views* (London: National Centre for Social Research, 2014)

[56] D. J. Galligan, *Due Process and Fair Procedures* (Oxford: Clarendon Press, 1996).

[57] See T. Tyler (1988) 'What is Procedural Justice?' (1988) *Law and Society Review* 22: 103 - 35; L. B. Solum, 'Procedural Justice' (2004) *Southern California Law Review* 78: 181 - 321

[58] P. Case, 'The Good, the Bad and the Dishonest Doctor: the General Medical Council and the Redemption Model of Fitness to Practise' (2011) *Legal Studies* 31: 591 - 614.

treated by the GMC.[59] Moreover, it has been noted that although there has been a rise in the workload of the GMC, its gatekeeper role at each point in the complaint decision making and follow-up process arguably remains problematic, at least from the point of view of patients. It is pertinent to remember here that complaints from patients are less likely than those from an NHS employer or fellow practitioner, to proceed to case investigation and lead to action being taken against a doctor.[60] Indeed, although its prominent profile in the eyes of the public means that the GMC will always attract complaints which lie outside of its remit, the 2006-2014 data outlined in Table Two show that the majority of complaints it receives do not make it past the triage stage (e.g. seventy-five per cent in 2014). This is in spite of the fact that the little independent research which exists on the GMC management of complaints has in the past revealed the apparent presence of judgemental bias.[61] A more recent small-scale independent review of a sample of complaints found that: 'articulate individuals who present their complaints clearly and in detail are more likely to have their cases taken up by the GMC.[62] Similarly, the PSA's predecessor stated in light of their 2010 audit of GMC operations that: 'We consider that it [the GMC] needs to ensure that its decision makers have fully understood all the complainant's concerns, and that complainants feel that they are encouraged to submit a complaint.'[63] With this in mind, I would contend that the consistency of the hearing judgements and the lack of impact resulting from the shift to the civil standard highlight important issues regarding the use of risk-based regulatory principles within medical regulation, which furthermore are highly salient given recent governmental reforms to the tribunal process.

In her review of the GMC and its response to complaints, Dame Janet Smith, Chair of the Shipman inquiry, concluded that it was guilty of protecting the interests of doctors rather than patients.[64] The figures presented in this paper pertaining to the handling of enquiries by the GMC provide a basis upon which to analyse its administrative operational procedures in order to identify if, and how far, a cultural change in the organisation has occurred since Smith's 2005 report. The statistical data outlined confirms that focusing longitudinally on the management of enquiries and MPT outcomes is a valuable tool for assessing the impact of regulatory reform on the day to day operation of the GMC. As previously discussed, evidence exists that there has been a change in the operational culture of the GMC as it is increasingly acting informally to provide advice, give warnings and agree rehabilitative forms of action with doctors, as well as more formally to subject doctors to rehabilitative and disciplinary action. Nonetheless, the shift in the level of evidence required to meet the realistic prospect test [65] does not appear to have resulted in significantly more doctors being struck off the medical register. Yet it is the consistency of the outcome categories which arguably is most important. Comparing the year on year data reveals that even though the number of enquiries has risen by 640 per cent over the last seventeen years, the GMC has adopted a relatively consistent administrative

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[59] G. McGivern and M. Fischer, 'Medical Regulation, Spectacular Transparency and the Blame Business' (2010) *Journal of Health Organisation and Management* 24: 597-610.
[60] GMC (2015) The State of Medical Education and Practice in the UK 2014-15 London: GMC
[61] I. Allen, *The Handling of Complaints by the GMC: A Study of Decision Making and Outcomes* (London: Policy Studies Institute, 2000).
[62] J. Hughes, (2007) *An Independent Audit of Decisions in the Investigation Stage of the GMC's Fitness to Practise process* (London: King's College London, 2007), 15.
[63] Council for Health Care Regulatory Excellence, *Fitness to Practise Audit Report: Audit of Health Professional Regulatory Bodies' Initial Decisions* (London: Council for Health Care Regulatory Excellence, 2010).
[64] J. Smith, *Shipman: Final Report* (London: DOH, 2005).
[65] The 'realistic prospect' test is undertaken by the GMC when it considers if an individual case should proceed to a MPT hearing. It applies to both the factual allegations and the question whether, if established, the facts would demonstrate that the practitioner's fitness to practise is impaired to a degree justifying action on registration in order to protect the public. A MPT is required to be persuaded that the facts are more likely than not to be true: the facts need to be proven 'on the balance of probabilities'. As such, the standard of proof required corresponds to that used in civil proceedings in England and Wales. Before 2008 the facts had to be proven 'beyond reasonable doubt', which is the threshold used in criminal proceedings in England and Wales.

approach towards the management of cases in terms of the disposal pathway by which they typically progress. Importantly, this finding is congruent with the view that the organisational change underway within the GMC is underpinned by a growing reliance on formulised 'risk templates' to aid decision-making processes.

It has been observed in the context of the governance of the health and social welfare professions that we live in 'the age of risk-based regulation'.[66] Risk-based approaches supporting a regulatory shift from 'front-line professional regulator'[67] to 'regulated self-regulation' are apparent in the UK across the health and social care professions.[68] Indeed, as previously discussed, GMC activity is now subject to oversight from the PSA and a key function of this is to promote a 'risk-averse' working culture of transparency and professional accountability.[69] Key to the development of a risk-based approach to regulation is the collection and sharing of performance data to support institutional transformation and third-party audit and review. This is achieved through the proactive use of outcome data to establish clear performance standards and best-evidenced protocols and guidelines to inform decision-making processes in order to monitor organisational performance and ensure regulatory standards are being maintained[70]. In this context, therefore, outcome data becomes one of medicine's new 'visible markers of trust [which as]…tools of bureaucratic regulation fulfil [a] function as signifiers of quality'.[71]

The statistical data detailed in this paper provide supporting evidence that an organisational and cultural shift towards a risk-averse regulatory model has occurred as the GMC has been reformed in order to regain public trust in its decision making processes.[72] Rather than being a clearly defined method, risk-based regulation is best conceived of as a cluster of tools which provide rules for action and in doing so serve to constrain what action can be recorded in the first place. A computer system called Siebel is used to manage the enquiry process:

> Siebel's pre-defined decision codes are expressed as the legal rule or section that has been applied….Where identification of risks is concerned, the coding of allegations is crucial. The

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[66] C. Hood and P. Miller, *Risk and Public Services: Report by the ESRC Centre for Analysis of Risk and Regulation* (London: The London School of Economics, 2010).

[67] The term 'front-line professional regulator' is used to denote circumstances whereby elite groups within a profession possess control over the regulatory institutions that set and maintain training, practice and disciplinary standards. This is also referred to as 'professional self-regulation'. The Medical Act 1858 established de facto medical control over the GMC as its board members were primarily drawn from representatives from medical schools and the royal colleges, supplemented by a small number of elected members drawn from the rank and file of the profession. Conversely, 'regulated self-regulation' denotes circumstances whereby the state has legislated to subject the activity of regulatory institutions to independent oversight. The Medical Act 2008 not only required equal non-medical lay involvement in the running of the GMC, it also subjected it to independent scrutiny via the PSA. Both 'professional self-regulation' and 'regulated self-regulation' stand in contrast to 'state-regulation', whereby the state itself directly oversees regulatory institutions via a bureaucratic and medical-managerial elite with little involvement of elite professional groups, such as for example is the case in Russia, Brazil and Argentina. For further information see: J.M. Chamberlain, *Medical Regulation, Fitness to Practise and Medical Revalidation: A Critical Introduction* (Bristol: Policy Press & Chicago: University of Chicago Press, 2015)

[68] R. Kaye, 'Stuck in the Middle: the Rise of the Meso-regulators' (2006) *Risk and Regulation* 6: 23 - 35.

[69] n 9 above

[70] A. Samanta, M. M. Mello, C. Foster, J. Tingle and J. Samanta, 'The Role of Clinical Guidelines in Medical Negligence Litigation: A Shift from the Bolam Standard?' (2006) *Medical Law Review* 14: 321 - 366.

[71] E. Kuhlmann, 'Traces of Doubt and Sources of Trust: Health Professions in an Uncertain Society' (2006) *Current Sociology* 54: 607 - 19, 617.

[72] General Medical Council, *Raising and Acting on Concerns about Patient* Safety (London: GMC, 2013).

> allegation codes used in Siebel are designed, not to capture what is alleged, but rather to define a potential case within the GMC's powers.[73]

In its published reports, the GMC advocates a risk-based model of regulation and the use of the Siebel computer system to oversee a relatively consistent administrative approach in responding to enquiries over time (in terms of the disposal pathway by which cases typically progress, as illustrated in Table Four). This exemplifies a growing organisational reliance upon codified risk-averse procedural rules to assist in the day to day processing of enquiries.[74] Risk-based regulation relies heavily on seemingly objective decision-making processes whereby codified forms of knowledge are used to prescribe performance targets and best-evidenced judgemental norms surrounding what constitutes appropriate action in a given situation.[75] As such, these mechanisms allow the GMC to rhetorically reaffirm the primacy of patient treatment and care in the face of previous high profile instances of medical malpractice and criminality.[76] Yet there is a danger that this approach may, over time, undermine the broader professional practice community, with its preference for strong forms of discretion in professional decision-making, as they become ever more wary of the GMC and its associated bureaucratic machinery,[77]

In her discussion of how the courts respond to alleged acts of medical criminality, Quirk observes that the inherently risky nature of modern medicine means that well-intentioned attempts to promote greater certainty in clinical decision making and professional practice must remain mindful of the possibility that they could engender unintended negative consequences for doctors and patients.[78] For example, research has reported that doctors are increasingly admitting to practicing medicine more 'defensively' as a result of being investigated or witnessing the impact of investigations on colleagues.[79] One large-scale study revealed that eighty-four per cent of doctors reported 'hedging' (overcautious practice such as overprescribing, referring too many patients, or ordering unnecessary tests) and forty-six per cent reported 'avoidance' (reluctance to take on difficult patients or procedures).[80] This raises serious questions about the impact of complaints processes on patient care. Over prescribing or referral and avoiding complex patients or difficult operations because of a fear of complaints or the actions of the GMC is clearly not in the interests of patients, and may increase costs to the NHS. As a result, pertinent questions exist surrounding the role of the GMC and the impact of risk-based regulation on the continued legitimacy of the hearing process. In this context, precisely how can further regulatory reform provide a structure that is transparent, fair and enables the confidence of all parties?

D. The Law Commission review: a progressive development?

To determine an appropriate answer to this question, the Law Commission began a consultation exercise in 2012 to reform the complaint and tribunal process in order to establish areas for further regulatory reform, particularly in relation to the GMC responses to enquiries.[81] At the same time, the

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[73] S. Lloyd-Bostock, 'The Creation of Risk-Related Information: The UK General Medical Council's Electronic Database' (2010) *Journal of Health Organisation and Management* 24: 584 - 596, 589.
[74] Ibid
[75] S. Lloyd-Bostock and B. M. Hutter, 'Reforming Regulation of the Medical Profession: the Risks of Risk-based Approaches' (2008) *Health, Risk and Society* 10: 69 - 83.
[76] The Secretary of State for Health, *Trust, Assurance and Safety – The Regulation of Health Professions in the 21st Century* (London: Stationary Office, 2007).
[77] D. Irvine, 'Success Depends Upon Winning Hearts and Minds' (2006) BMJ 333: 965-6.
[78] n 4 above.
[79] n 68 above.
[80] n 50 above.
[81] *Regulation of Health Care Professionals, Regulation of Social Care Professionals in England* Law Commission Consultation Paper No 202 (London: England, 2014); *Regulation of Health Care Professionals, Regulation of Social Care Professionals in Northern Ireland* Law Commission Consultation Paper No 12 (Belfast: Northern Ireland, 2014); *Regulation of Health Care Professionals,*

GMC established the MPTS to assume responsibility for the adjudication of cases.[82] This is not the first time that the GMC has acted pre-emptively to reform its internal organisation in the face of governmental consultation in relation to reforming its statutory powers.[83] At the centre of the Law Commission consultation sat the need to address the contentious issue that the GMC was responsible for both the investigation and the adjudication of allegations of impaired fitness to practise.[84] As arbiters of standards and prosecutor decision-making, the GMC's independence as adjudicator acting in the public interest is arguably tenuous and open to question. Two potential solutions were examined: the creation of an independent body to oversee adjudication and for the GMC to solely be concerned with investigation before passing cases on to this body, or for the MPTS to become a strengthened and independent arm of the GMC responsible for adjudication. In both instances, the PSA would retain the right to refer MPT outcomes to the High Court under section 29 of the NHS Reform and Health Care Professions Act 2002.

Parliament endorsed the second of these proposals in 2015, legislating a section 60 order [85] to amend the Medical Act 1983 and establish internal structural mechanisms within the GMC to ensure a greater degree of separation, with the MPTS becoming a clearly distinctive and autonomous organisation responsible for case adjudication.[86] Additionally, the GMC now possesses the right to appeal a MPT case decision to the High Court of Justice in England and Wales, the Court of Session in Scotland, or the High Court of Justice of Northern Ireland. It was originally argued by the Law Commission that the: 'General Medical Council's proposed right of appeal is both a consequence of, and reinforces, the independence of the new Medical Practitioners Tribunal Service'.[87] This right of appeal will be used when a sanction is considered to be unduly lenient or, in relation to a decision not to take any disciplinary action or restore a person to the register, that the decision should not have been made.[88] The intention behind establishing an 'in house' quasi-independent MPTS within the GMC's organisational structure was to remove the unsatisfactory situation of it acting as 'judge and jury' in fitness to practise cases.[89] This approach is held to be the most appropriate solution in view of concerns expressed within the medical profession and government, with regards to the utility of adopting alternative more costly approaches given the self-funding nature of the GMC and the highly specialised nature of medical expertise.[90] Furthermore, the decision to embed within statutory legislation the right of the GMC to appeal MPTS decisions, in addition to the right of the PSA to appeal decisions in a similar fashion, adds a 'double layer' of regulatory oversight to the MPT

Regulation of Social Care Professionals in Scotland Scottish Law Commission Discussion Paper No 153 (Edinburgh: Scotland, 2014).

[82] General Medical Council, *The Future of Adjudication and the Establishment of the Medical Practitioners Tribunal Service* (London: GMC, 2011).

[83] J. Waring and M. Dixon-Woods,' Modernising Medical Regulation: Where Are we Now?' (2010) *Journal of Health Organisation and Management* 24: 540 - 555

[84] Department of Health, *Fitness to Practise Adjudication for Health Professionals* (London: Department of Health, 2010).

[85] A Section 60 Order is a legislative mechanism under the Health Act 1999 for changing primary legislation concerned with the regulation of the health care and associated professions, in this case the Medical Act 1983, by means of an Order in Council through the Privy Council for consideration by Parliament.

[86] Department of Health *The General Medical Council and Professional Standards Authority: Proposed Changes to Modernise and Reform the Adjudication of Fitness to Practise Cases* (London: Department of Health, 2014).

[87] n 81 above, 211.

[88] Department of Health, *Regulation of Health Care Professionals and Regulation of Social Care Professionals in England: The Government's response to Law Commission report* (London: Department of Health, 2015)

[89] P. Case, 'The Good, the Bad and the Dishonest Doctor: the General Medical Council and the Redemption Model of Fitness to Practise' (2011) *Legal Studies* 31: 591 - 614.

[90] General Medical Council, *Our Response to the Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry* (London: GMC, 2013).

outcome process and reflects the emphasis placed by risk-averse regulatory models on minimising the possibility of harm.[91]

Although these changes are undoubtedly progressive, arguably they do not go far enough to address the conflict of interest in the GMC role which continues to exist in spite of recent regulatory reform. Questions remain not only about the adjudication process, but also about the GMC's gatekeeper role at each point in the decision making and follow-up process. A significant number of enquiries continue to fail to make it past the initial triage and investigative stages.[92] An additional cause for concern is that there is currently little by way of independent reassurance that the GMC case management system operates without bias.[93] Furthermore, embedding the MPTS within the structure of the GMC, (albeit as a devolved entity rather than acting legislatively to ensure its full independence), suggests that matters of economic efficiency and practical expediency may have taken precedence over public interest.[94] In this regard, it is worth noting that although the PSA reviews all decisions of the MPTS which have not resulted in erasure, it only forwarded four such cases in 2005, six in 2006, none in 2007, one in 2008, one in 2009, two in 2010, one in 2011, none in 2012, one in 2013, four in 2014 and one in 2015.[95]

The small number of referrals might suggest an increasingly rigorous stance on behalf of the GMC towards fitness to practise cases, at least since its decisions became subject to oversight by the PSA. But equally, they could be said to reinforce that doubts exist about the ability of PSA risk-based audit processes to secure the public interest.[96] Why, therefore, should the proposal to give the GMC the right to appeal decisions by the MPTS lead to a different set of outcomes? Would an independent scrutiny panel, with specialist input from health NGOs and patient-interest groups alongside professional medical and legal bodies, not be better suited to the task? Finally, it is important to consider the language in use here within the context of matters of due process and procedural fairness. Doctors who are subject to MPTS proceedings have the right to expect a fair hearing. Focussing on legislating for the right of regulatory bodies to appeal decisions made in tribunal as a result of the adversarial process, is indicative of a process which is becoming overly politicised and unduly weighted towards the pursuit of punishment, rather than retaining a necessary emphasis on balancing notions of fairness with redress.[97] As a result, at this moment in time, recent legislative

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[91] n 86 above.

[92] J. Miola 'On the Materiality of Risk: Paper Tigers and Panaceas' (2009) *Medical Law Review*, 17: 76 – 108

[93] n 62 above.

[94] M. McCartney, 'Does the GMC Deserve its Current Powers?' (2014) *BMJ* 349: 36 - 38

[95] Council for Healthcare Regulatory Excellence *Statistical Summary 2005* (London: Council for Healthcare Regulatory Excellence, 2005); Council for Healthcare Regulatory Excellence *Statistical Summary 2006* (London: Council for Healthcare Regulatory Excellence, 2006); Council for Healthcare Regulatory Excellence *Statistical Summary 2007* (London: Council for Healthcare Regulatory Excellence, 2007); Council for Healthcare Regulatory Excellence *Statistical Summary 2008* (London: Council for Healthcare Regulatory Excellence, 2008), Council for Healthcare Regulatory Excellence *Statistical Summary 2009* (London: Council for Healthcare Regulatory Excellence, 2009); Council for Healthcare Regulatory Excellence *Statistical Summary 2010 (*London: Council for Healthcare. Regulatory Excellence 2010); Council for Healthcare Regulatory Excellence *Statistical Summary 2011 (*London: Council for Healthcare Regulatory Excellence, 2011); Professional Standards Authority *Performance Review Report 2012-13* (London: Professional Standards Authority, 2013); Professional Standards Authority *Performance Review Report 2013-14* (London: Professional Standards Authority, 2014); Professional Standards Authority Performance Review Report 2014-15 (London: Professional Standards Authority, 2015).

[96] R. Wakeford, 'The Professional Standards Authority watches the GMC, apparently' (2015) *BMJ* 350: 451 - 452

[97] n 51 above.

developments appear to represent a missed opportunity to more fully address key systemic concerns surrounding the regulation of doctors in the UK.

IV. CONCLUSION

It is a common contention of medical elites, as well as those within academic circles, that the organisational structure and culture of the GMC is changing, resulting in more doctors being subject to investigatory and disciplinary procedures. This paper has detailed longitudinally GMC enquiry and MPT outcome data which supports this view. Nonetheless, it is not possible at present to conclude that the risk-based legislative shift from 'professional self-regulation' to 'regulated self-regulation' better protects the public interest while maintaining legal due process and procedural fairness.[98] The recent Law Commission comprehensive review of health care professionals noted that MPTs are a vitally important legal mechanism for ensuring that public trust in medical regulation is maintained when complaints are made about a doctor. In doing so, it acted to strengthen the investigatory and adjudication process by legislating to ensure that they are independent autonomous structures of the GMC.[99] Yet it is pertinent to remember that we have been here before. The Health and Social Care Act 2008 established the Office of Health Professions Adjudicator (OHPA) to take over the role of the GMC in the adjudication of fitness to practise cases. The intended objective of this change was to enhance impartiality and the independence of the fitness to practise hearing process within the Health Care Professions.[100] The OHPA became a legal entity in January 2010. Yet in the summer of 2010 the UK government concluded that it was not persuaded of the need to introduce another regulatory body to fulfil the role of adjudicator in fitness to practise cases.[101] In part, this decision was made in light of the stringent economic realities faced by public services in the UK as the government sought to respond to the financial realities of the 2008 global financial crisis.[102] But it was also a reflection of the extent to which medical elites, notably the Royal Colleges, had successfully persuaded government that they had managed to subject rank and file practitioners to greater peer surveillance and control.[103] This may well be true, but there remains a very real danger that legal reforms have been introduced to the MPT process for reasons which may unintentionally serve to undermine the principles of swift, proportionate and effective legal response(s) to ensure public protection in particular types of cases.[104]

This proposition is particularly prescient in light of the highly politicised nature of the legal regulation of doctors more generally, and given that the patient complaint system (out of necessity) provides a reactive, user-led mechanism of professional accountability in which notions of due process, fairness and redress must be carefully balanced.[105] It must, therefore, remain a strategic priority for government when it intervenes in medical regulation with reforming intentions, to ensure that the legislative system it enacts is equitable and fit for purpose. Given these considerations, it is imperative that medical and legal scholars continue to pay close critical attention to the evolving nature of legislative developments pertaining to the regulation of medical practitioners, particularly in relation to the consequences of reform for the independence of the fitness to practise tribunal process to ensure procedural fairness. The establishment of the MPTS as an autonomous entity within the organisation of the GMC seeks to balance state concerns over cost and patient anxiety over safety and

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[98] C. Hood and P. Miller, *Risk and Public Services: Report by the ESRC Centre for Analysis of Risk and Regulation* (London: The London School of Economics, 2010).
[99] n 81 above.
[100] Department of Health, *Health Care Regulation: Tackling Concerns Nationally* (London: Department of Health, 2009).
[101] Department of Health, *Fitness to Practise Adjudication for Health Professionals* (London: Department of Health, 2010).
[102] n 65 above
[103] G. McGivern and M. Fischer, 'Medical Regulation, Spectacular Transparency and the Blame Business' (2010) *Journal of Health Organisation and Management* 24: 597-610.
[104] S. McLean, *First Do No Harm: Law, Ethics and Healthcare* (Aldershot: Ashgate, 2006).
[105] n 12 above.

accountability, with a legitimate professional concern for maintaining a necessary element of strong discretion within professional regulatory frameworks. Only time will tell if this is indeed a viable alternative to the creation of a separate legislative body undertaking case hearing and adjudication. Whatever happens next in the development of the GMC and how it responds to cases that raise concern about a doctor's fitness to practise, the shift towards risk-averse forms of professional accountability must not sacrifice due process in the name of political pragmatic exigency.

List of Tables

Table 1: Number of complaints received by the GMC (1999 – 2014)

Year	Number of Enquiries
1995	1503
1998	3066
1999	3001
2000	4470
2001	4504
2002	3937
2003	3962
2004	4005
2005	4128
2006	2788
2007	4118
2008	4166
2009	5773
2010	7153
2011	8781
2012	10347
2013	9,866
2014	9,624

Table 2: Breakdown of GMC Investigatory Action outcomes (2006 – 2014)

Year	Received	Concluded	Cases under Investigation	Action – Advice	Action - Warning Issued	Action- Undertakings	Referred to MPT
2006	2788	2442	346 (12%)	Not available	86	44	216
2007	4118	3722	396	Not available	159	40	196
2008	4166	3530	636	Not available	168	109	359
2009	5773	4015	1758	428	212	95	319
2010	7153	5087	2066	458	183	102	314
2011	8781	6451	2330	736	199	148	212
2012	10347	7639	2708	844	182	143	216
2013	9,866	7399	2467	208	152	173	258
2014	9,624	7180	2444 (25%)	267	110	136	218

Table 3 Interim Orders Tribunal outcomes

Year	**Suspension**	**Conditions**
2006	104	Not available
2007	152	Not available
2008	132	Not available
2009	156	Not available
2010	144	214
2011	158	236
2012	207	336
2013	125	375
2014	127	374

Table 4: Medical Practitioners Tribunal outcomes (2006- 2014)

Case Outcome	**2006**		**2007**		**2008**		**2009**		**2010**		**2011**		**201**
Cases heard	N= 221	100 %	N= 257	100 %	N= 204	100 %	N= 270	100 %	N= 326	100 %	N= 242	100 %	N= 208
Impairment – no action	8	4%	13	5%	4	2%	4	1%	4	1%	2	1%	6
No Impairment – no action	47	21%	36	14%	28	14%	44	16%	65	20%	33	14%	48
Voluntary Erasure	3	1%	2	1%	0	0%	3	1%	7	2%	1	>0.5 %	2
Undertakings	4	2%	4	2%	3	1%	3	1%	5	2%	1	>0.5 %	1
Reprimand	1	1%	1	1%	0	0%	1	1%	0	0%	0	0%	0
Warning	14	6%	8	3%	22	11%	22	8%	29	9%	23	10%	12
Conditions	38	17%	55	21%	30	15%	48	18%	37	11%	24	10%	20
Suspension	69	31%	78	30%	75	37%	77	29%	106	33%	93	38%	64
Erasure	37	17%	60	23%	42	20%	68	25%	73	22%	65	27%	55