THE ROLE OF THE GENERAL MEDICAL COUNCIL

AND THE BOUNDARIES OF PROFESSIONAL CONDUCT

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I should first like to thank **Dr Priyo Ghosh (Priyo) – Consultant Psychiatrist, North Lambeth Promoting Recovery Team, South London and Maudsley NHS Foundation Trust** for inviting me to give this talk, and Lambeth Hospital for the arrangements and making possible for it to be given remotely by Microsoft Teams.

I realise that I am addressing a group of distinguished psychiatrists and those with considerable expertise of working in mental health. When sitting as a judge in the Crown Court I often read reports and heard evidence from psychiatrists and made a number of hospital orders under the Mental Health Act 1983 in the case of mentally disordered persons. I was always fearful that the expert who was giving evidence may have thought that it was I who should be certified under the legislation! They were always too kind to suggest anything like that and I was always grateful for the help I unfailingly received. So it is with great pleasure that I come to talk to you today.

The subject of my talk is: ***The Role of the General Medical Council and the Boundaries of Professional Conduct.*** In expressing my views in this talk, let me say straightaway that they are my personal views, and should not be taken as necessarily those of any regulator or other body.

The General Medical Council (GMC) is a statutory body that takes its rise from and can trace its history back to the Medical Act 1858.

Medical Act 1858

The 1858 Act was passed to regulate the qualifications of practitioners in medicine and surgery. It brought together the disciplinary processes of the Royal College of Physicians that was chartered in 1518, the College of Surgeons established in 1745, and other medical bodies such as the Society of Apothecaries. It provided for the establishment of the General Council of Medical Education and Registration in the United Kingdom, the predecessor of the GMC.

The Royal College of Psychiatrists has existed in various forms since 1841, having started life as the *Association of Medical Officers of Asylums and Hospitals for the Insane.* In 1865 it became the *Medico-Psychological Association.* In 1926, the Association received its Royal Charter, becoming the *Royal Medico-Psychological Association.* Finally, in 1971, a Supplemental Charter accorded the Association the status of the *Royal College of Psychiatrists.* Today, the College stands alongside the other great Royal Colleges of medicine in providing, amongst other things, medical research and public information about mental health problems in society. The public should be grateful to it.

The Medical Act 1983, as amended, is today's overarching statute for the medical profession.

Medical Act 1983

Section 1 sets out the GMC's objectives.

> "1A. The over-arching objective of the General Council in exercising their functions is the protection of the public.
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> 1B. The pursuit by the General Council of their over-arching objectives involves the pursuit of the following objectives – (a) to protect, promote and maintain the health, safety and well-being of the public, (b) to promote and maintain public confidence in the medical profession, and (c) to promote and maintain proper professional standards and conduct for members of that profession.
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> 3. The General Council shall have the following committees – (g) the Medical Practitioners Tribunal Service, (h) one or more Medical Practitioners Tribunals."

Under sub-section 3, you will see reference to the Medical Practitioners Tribunal Service (MPTS), which operates through one or more Medical Practitioners Tribunals. That is where I come in as a chairman of the Tribunal, sitting with at least one doctor and a lay member. The MPTS is the only body that can erase, suspend or impose conditions on a doctor's right to practise medicine. Whilst one reads in the press about cases coming before the Tribunal, and the case of Dr Bawa-Garba is perhaps the most recent one that received huge public attention as well as concern expressed by many in the medical profession, it is important to put matters into context. The overwhelming majority of doctors will rarely, if ever during their professional career, receive a letter of complaint from the GMC raising concerns about their behaviour, and the number of cases in any year that end up before the Tribunal is small.

The GMC's Annual Report 2018 is the most recent and it gives details of the numbers of licensed doctors and the outcome of cases heard by the Tribunal.

GMC Annual Report 2018

- Number of licenced doctors at 31 December 2018. UK 165,945, total 250,210.
- In 2028, the GMC reviewed a total of 8,573 concerns. Of these concerns 6,629 overall were closed, 1,544 met the statutory threshold for investigation into the doctor's fitness to practise, and 394 were referred to the doctor's employer.
- Outcomes from 1,208 decisions by case examiners. 700 concluded with no further action, 228 with warnings, advice or undertakings, and 280 referred to MPTS.
- Outcomes from MPTS fitness to practise panels. 247 outcomes – 41 no impairment, 25 conditions, 10 warnings, 101 suspended, 65 erased, 2 impaired but no further action, 3 voluntary erasure.

So much for the legislation and the role of the GMC.

Let me turn now to the difficult area of fitness to practise and how the MPTS goes about its business.

Section 35C of the Medical Act 1983 sets out the circumstances whereby a doctor's fitness to practise may be regarded as impaired. It is quite a long list and includes a finding against the medical practitioner of misconduct, which must amount to serious professional misconduct; deficient professional performance; a criminal conviction or caution; adverse physical or mental health; not having the necessary knowledge of English; or a determination by another healthcare body, such as the General Dental Council. An allegation may be based on events having occurred both within and outside the United Kingdom or at a time when the practitioner was not registered.

The decision as to whether a doctor's fitness to practise is currently impaired is made at the hearing and, as we have seen, only a small proportion of cases go before the Tribunal and many are concluded with less draconian orders than suspension or erasure, which are reserved for the most serious cases. In 2014 the Law Commission reported on the Regulation of Health Care Professionals.[2] In their report they recommended that misconduct as a ground on which to determine whether a person's fitness to practise is impaired should be reclassified as "disgraceful misconduct", whilst at the same time proposing greater emphasis should be placed on the concept of deficient professional performance as a ground of regulatory intervention. That, to my mind, is a sensible way forward so as to ensure a more holistic approach to cases concerning a doctor's fitness to practise.

There is no doubt that over time the concept of "misconduct" has expanded. In her Fifth Shipman Report, Dame Janet Smith described the difficulties that have been experienced over the years in defining and recognizing the concept of professional misconduct and noted that the problem had become more acute over the years.[3] As Dame Janet said in her report, until the 1990s the GMC was mainly concerned with cases of misconduct involving dishonesty, drug abuse, indecency, improper relationships with patients and breach of confidence. In effect, the GMC was concerned with deliberate or reckless misconduct, and did not generally concern itself with wider allegations such as negligent treatment of a patient or the many and varied complaints of professional misconduct received today by the GMC and other health care regulators.

[2] *Regulation of Health Care Professionals; Regulation of Social Care Professionals in England*, LC No 345. In October 2017, the Government published a consultation paper which included many of the Law Commission's recommendations.

[3] *Fifth Shipman Report – Safeguarding Patients: Lesson from the Past – Proposals for the Future,* by Dame Janet Smith DBE, Command Paper Cm 6394.

The same has happened in the legal profession. Writing in 2010 in the *Law Society's Gazette,* my colleague Gregory Treverton-Jones QC asked rhetorically *where to draw the line?* He said:

> "Time was, not very long ago, when a visitor to the Solicitors Disciplinary Tribunal would be presented with a diet of thefts from client account, serious Accounts Rules breaches, or solicitors for one reason or another could no longer run their practices. Today, the same visitor might well see decent, bewildered, and sometimes angry solicitors being hauled before the SDT. For generations of solicitors, the answer to ethical dilemmas was straightforward – if it felt wrong, it probably was wrong. Always put your client's best interests first. Never take unfair advantage. Don't put yourself in a position where your interests conflict with those of your clients. Never knowingly mislead anyone. And, above all, never, ever, dip into client account to smooth out your practice's cashflow problems."

Returning to the GMC, the current guidance on what is expected of a doctor is set out in *Good Medical Practice* (GMP). The latest edition was published by the GMC in March 2013 and was updated in April 2019.

Good Medical Practice

GMP is the GMC's core guidance for all registered doctors. It is a code of conduct and can be downloaded from the GMC's website www.gmc-uk.org. It is worth re-reading in full.

As you will see, the duties of a doctor registered with the GMC are fairly extensive. They cover:

- Knowledge, skills and performance, which means making the care of your patient your first concern and providing a good standard of practice and care.
- Safety and quality, which means taking prompt action if you think that patient safety, dignity or comfort is being compromised, and protecting the health of patients and the public.
- Communication, partnership and teamwork, which means treating patients as individuals and respect for their dignity, working in partnership with patients and working with colleagues in the ways that best serve patients' interests, and
- Maintaining Trust which means being honest and open and acting with integrity, never discriminating unfairly and never abusing your patient's trust or the public's trust in the profession.

It is said that on arriving in Chambers in the 1950s, a young barrister was told by their supervisor, then called a pupil master, to go and read the Code of Conduct of the Bar of England and Wales, adding that it was the only law book with which they need be concerned. My advice is that if you follow Good Medical Practice, hopefully you will be all right.

A particular problem that sometimes arises is where a doctor is called upon to express an opinion or act outside his or her expertise. The GMC has issued a joint statement with the statutory health and

care regulators on issues arising from the coronavirus (Covid-19) pandemic.[4] The case of Dr Squier, a consultant paediatric neuropathologist at the John Radcliffe Hospital in Oxford is more a case in point.[5] The core of Dr Squier's ordinary practice was the analysis of samples of brain tissue taken from both the living and the dead. Additionally, she had developed a medico-legal practice, providing reports as an expert neuropathologist. Between 2007 and 2010 she provided reports and gave evidence in the case of six babies, of whom five had died shortly after allegedly sustaining non-accidental head injuries. In those cases she had unfortunately expressed opinions that were outside her expertise and had made assertions that were insufficiently founded on the evidence before her, and she had purported to rely on research papers that did not support her opinions in the way she suggested. In allowing Dr Squier's appeal against the Tribunal's sanction of erasure, the High Court said that it was not in the public interest that the public at large should be deprived of her work merely because she had, in one discrete area of her practice, fallen below the standards required of her. The appropriate sanction was the imposition of conditions for 3 years preventing her from providing medico-legal reports in court cases outside her ordinary practice.

The court there clearly took a charitable view of the need to ensure the continued good services of an experienced doctor. A couple of other cases of interest.

Dr Southall was a consultant paediatrician although the circumstances of the case could equally have applied to a consultant psychiatrist.[6] He was instructed as an expert on behalf of a local authority to give a medical opinion concerning a child's death. Following an interview with the mother, M, she complained to the General Medical Council that he had accused her of murdering her son. That allegation, amongst others, was considered by a fitness to practise panel, which found that Dr Southall had made that accusation. The Court of Appeal, in allowing Dr Southall's appeal, said that the panel's reasons for preferring the mother's account of the interview were inadequate. Although entitled to conclude that the mother was an honest and credible witness, the panel did not specifically deal with the suggestion that she perceived herself to be accused, which may be entirely understandable in the circumstances but was wrong.

On the other hand, in Dzikowski v. GMC, a consultant psychiatrist was charged with prescribing a methadone mixture to a patient in circumstances that were inappropriate, irresponsible, and not in the best interests of his patient.[7] His defence that the Department of Health's publication entitled

[4] https://www.gmc-uk.org/news/news-archive/how-we-will-continue-to-regulate-in-light-of-novel-coronavirus

[5] *Squier v. General Medical Council* [2016] EWHC 2739 (Admin).
[6] *Southall v. General Medical Council* [2010] EWCA Civ 407.
[7] [2009] EWHC 1090 (Admin).

"Drug Misuse and Dependence: Guidelines on Clinical Management" was a recommendation, and not an instruction, and that he was justified in his deviation from it was held not to be a valid defence. The Orange Book, as it was called, was important guidance and should have been followed. Dr Dzikowski was aware of it and the evidence was clear that he ignored it when treating his patient.

These cases show that each case is fact sensitive and the outcome may ultimately depend on a narrow understanding and appreciation of the facts in any case.

Let me end with two cases, which both attracted wide public attention. Each concerned a child who tragically died. One is the case of Dr Bawa- Garba.[8] But first let me tell you about the notorious case of Alfie Winn.[9] In 1982, Alfie Winn, a child aged eight years, became ill with vomiting and a high temperature. His general practitioner was called and attended upon Alfie, who was asked to open his mouth. The boy seemed comatose and the doctor said that if Alfie could not be bothered to open his mouth, he would not examine him. He prescribed an antibiotic. Two hours later, the family called an ambulance and Alfie was taken to hospital. He died four days later of meningitis. The professional conduct committee of the GMC found the facts proved and held the doctor's behaviour did fall below acceptable standards. Nonetheless, it considered it did not cross the threshold for a finding of serious professional misconduct. The case was reported in the press and led to questions in Parliament. As a result the GMC's then guidance was amended to emphasise that the public are entitled to expect that a registered medical practitioner will afford and maintain a good standard of medical care.

Dr Hadiza Bawa-Garba faced criminal proceedings of gross negligence manslaughter resulting from the death of a child. In February 2011, Dr Bawa-Garba was a junior doctor specialising in paediatrics and had recently returned to practise as a registrar at Leicester Royal Infirmary following maternity leave. Jack Adcock, a six year old boy, was on the morning of Friday 18 February 2011 admitted to the hospital by his GP as an urgent referral, arriving at the hospital unresponsive and limp. Jack had been diagnosed from birth with Downs Syndrome and required long-term medication and in the past had been admitted to hospital for pneumonia. For the following 8 – 9 hours he was under the care of Dr Bawa-Garba and was treated initially for acute gastro-enteritis and dehydration, and then after an x-ray for a chest infection with antibiotics. In fact he was suffering from pneumonia which caused his body to go into septic shock. The sepsis resulted in organ failure and, at 7.45 pm, caused his heart to fail. Dr Bawa-Garba was charged with gross negligent manslaughter and was found guilty and sentenced to 2 years imprisonment suspended for 2 years. Her appeal against conviction and

[8] *Bawa-Garba v. General Medical Council* [2018] EWCA Civ 1879.
[9] Fifth Shipman Report, Dame Janet Smith DBE.

sentence was dismissed by the Court of Appeal, Criminal Division. The trial judge in his sentencing remarks said that there was a limit to how far the circumstances in which the offence took place and that the children's unit where Dr Bawa-Garba was working at the time was a busy ward could be explored in a criminal trial, although there may be force in the argument that her responsibility was shared with others.

The role of the criminal courts is very different to that of the Tribunal in professional conduct proceedings. The task of the jury is to decide on the guilt or absence of guilt of the defendant having regard to their past conduct. The task of the Tribunal, looking to the future, is to decide what sanction would most appropriately meet the statutory objectives of the regulator.[10] This aspect was explored further in the subsequent fitness to practise proceedings in Dr Bawa-Garba's case and figured extensively in the Tribunal's determinations on impairment and sanction. The Tribunal found that her actions marked a serious departure from GMP but there were also multiple systemic failures by the Trust and other failings including an absence of a mechanism for an automatic consultant review. The Tribunal suspended Dr Bawa-Garba's registration for 12 months. As is well known, that decision was reversed by the High Court who directed that Dr Bawa-Garba should be erased from the medical register. The Court of Appeal later restored the suspension and remitted the case to the MPTS who imposed conditions on Dr Bawa-Garba's registration.

These cases, therefore, are a stark reminder of how difficult it is to judge the outcome of fitness to practise proceedings and that each case turns on its own facts. However, the themes are clear. The Medical Act 1983 sets out today's overarching objective of the GMC which is the protection of the public. Many complaints either fall away or involve no further action or are referred for disposal at local level to the doctor's employer. The number of cases that are determined in any year by the Medical Practitioners Tribunal Service involve a minority of professionals when compared to the number of doctors in practice in the United Kingdom. The Tribunal is concerned with the reputation or standing of the profession rather than any punishment of the doctor. Finally, Good Medical Practice is a key document that sets out the standards and core responsibilities that are expected to be followed by every doctor. And I am sure we can all agree that the system for the investigation and determination of complaints must be just, fair and transparent both for the good of the public and the medical profession.

[10] [2018] EWCA Civ 1879 at paragraph 76.

I hope that this talk will have given you a better understanding of the role of the GMC and the boundaries of professional conduct.

Thank you.

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