THE MEDICAL PRACTITIONERS TRIBUNAL SERVICE: ONE YEAR ON [1]

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Abstract: *In June 2012, the General Medical Council (GMC) instituted a series of new rules that reformed their fitness to practise work. The most significant change to disciplinary proceedings was the formation of a Medical Practitioners Tribunal Service (MPTS) which is led by a former Deputy High Court Judge. Aimed at safeguarding patient safety, the MPTS is an autonomous part of the GMC which will now adjudicate on all cases relating to doctors whose fitness to practise is called into question. With the new development, the GMC will continue to collect evidence and carry out the investigations, but the cases will be adjudicated by the tribunal which is empowered to impose sanctions against doctors' registration. The fitness to practise panels which sit on these hearings are made up of medical and lay members who receive specific training and are regularly appraised. The hearings are conducted in public and the tribunal is accountable to Parliament. The GMC had hoped that the change would bolster public and professional confidence that these hearings are impartial, fair and transparent. They have described the change as "the biggest shake-up of fitness to practise hearings since they were first established in 1858" (GMC Press Release, 11 June 2012). This paper takes a look at the profile of the cases which the MPTS heard in the first year of its operation and assesses its scope for improving patient safety.*

I. Introduction

> "[T]he General Medical Council (GMC) was 'doctor-centred'. It appeared to assume that all doctors were good, competent and conscientious until proved otherwise. It would deal with the profession's 'bad apples' for the sake of the profession. It would do so in its own way and did not welcome scrutiny. Its procedures were designed to be fair to doctors and to ensure that no doctor would lose his/her right to practise without very good cause. It did not focus on the reasonable expectations of the public and it did not see itself as having a duty to ensure that all members of the medical profession were willing and able to provide a proper professional service [4]."

This was the stern verdict of the Shipman Inquiry which was set up in 2001 to investigate the issues arising from how a British general practitioner — Dr Harold Shipman — managed to kill, without detection, more than 200 of his patients over a period of 24 years (1974-1998). In its report, the Inquiry highlighted that since the GMC is the only authority that can erase or suspend a doctor's right to practise medicine in the country, its Fitness to Practise (FTP) procedures are effectively the "teeth"

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[4] Smith, J., *The Shipman Inquiry: Fifth Report — 'Safeguarding Patients: Lessons from the Past — Proposals for the Future'*, Command Paper Cm 6394 (2004), chapter 15, paragraph 47.

behind all other monitoring and disciplinary structures available in the health care system [5].

The Council has since introduced a number of changes to its FTP procedures [6] in order to restore public faith in its ability to safeguard patient safety and to counter the perception that it is overly protective of doctors. One of the most recent initiatives was the setting up of the Medical Practitioners Tribunal Service (MPTS) in June 2012. Led by a former Deputy High Court Judge, with panels that consist of medical and lay members who receive specific training and who are regularly appraised, the MPTS would be an autonomous part of the GMC that adjudicates on all FTP cases that are brought to the Council's attention. For this, it would be accountable to Parliament. The service, which was launched with the declared aim of protecting patients by making independent and impartial decisions concerning a doctor's fitness to practise [7], has been described by the Council as "the biggest shake-up of fitness to practise hearings since they were first established in 1858 [8]." This paper studies the profile of the FTP cases that were heard in the first year of its operation (i.e from 1st August 2012 to 31st July 2013). Through this, it aims to assess the MPTS' potential and limitations in protecting patients.

The next section will provide an overview of the historical development of professional discipline in British Medicine. It seeks to show that although the GMC was authorised to discipline doctors from its inception in 1858, the approaches taken have largely been doctor-centred until the end of the 20th century. It was only in the 21st century that a more patient-centred orientation was adopted and that this led to the creation of the MPTS in 2012. Section III will analyse the profile of the cases which the MPTS has sat on in its first year. It assesses its scope and limitations in enhancing patient safety before bringing the discussion to a close in Section IV.

II. The Historical Development of Professional Discipline

The connection between professional discipline and patient protection has not always been clear nor consistent throughout the history of the medical profession in the UK. In the early days, public protection was predicated on the integrity of the professional. This was illustrated by the Royal College of Physicians (RCP)'s founding charter of 1518 which described the college's formation as "necessary to withstand in good time the attempts of the wicked, and to curb the audacity of those wicked men who shall profess medicine more for the sake of their avarice than from the assurance of any good conscience, whereby very many inconveniences may ensue to the rude and credulous populace [9]." However, since the primary drive behind the establish-

[5] *Ibid.*, Summary, paragraph 3.

[6] See discussion below.

[7] MPTS, 'The role of the MPTS', available at http://www.mpts-uk.org/about/1595.asp.

[8] GMC Press Release 11 June 2012, available at http://www.gmc-uk.org/news/13286.asp.

[9] The Founding Charter from King Henry VIII, 1518 in G.N. Clark & A.S.A. Briggs, *A History of the Royal College of Physicians of London: Volume 4* (Oxford : Oxford University Press, 2005) p. 1573.

ment of the college was to ensure that power was vested in leading physicians of the time to grant licences to those qualified to practise Medicine [10], it would appear that the sentiments captured in the charter was as much about professional self-interest as it was about patient safety.

With the inauguration of the GMC in 1858 [11] as the regulatory body of the medical profession in the UK, the public was able to distinguish between the "legally qualified or duly qualified [12]" doctors from those who are unqualified, through the Medical Register which this statutory body maintained. Although the Council was authorised to take actions against the doctor's registration, this part of the discussion seeks to highlight that it was not until the 21st century that a shift began to be made to a more patient-centred approach to professional discipline.

A. The 19th and 20th Centuries

The GMC was known as the General Council of Medical Education and Registration of the United Kingdom [13] when it was set up in 1858. The name reflects its two chief duties: to establish proper educational standards for the medical profession and to maintain a register of qualified practitioners [14]. From the outset, it was authorised to erase the names of those convicted of a criminal offence or those judged, after due inquiry by the Council's Disciplinary Committee, to have been guilty of infamous conduct in any professional respect [15]. Whilst acknowledging that it was impossible to compile an exhaustive list of what could amount to "infamous conduct in a professional respect", the GMC indicated that there were a number of misconducts that could raise disciplinary issues. [16] They included: adultery with patients; breach of medical confidentiality; the provision of untrue or misleading certificates; the commercialisation of a secret remedy; gross neglect in diagnosis or treatment; and improper attempts at profit at the expense of professional colleagues (e.g. by canvassing for patients and advertising for the doctor's own professional privilege) [17]. All these, interestingly, gave rise to the belief on the part of the public that the primary concern of the Council was with professional ethics and discipline [18].

Irvine nevertheless identified the role of the Council between 1858 and 1979 as being that of the traditional regulator — reactive, passive, extremely protective of doctors and unwilling to deal with poor medical practice [19]. The few disciplinary

[10] Royal College of Physicians (RCP), 'History of the RCP', available at http://www.rcplondon.ac.uk/about/history.

[11] By the Medical Act 1858.

[12] *Ibid*., section XXXIV.

[13] The name was changed to the General Medical Council in 1951.

[14] Poynter, F.N.L., 'The centenary of the General Medical Council' (1958) *British Medical Journal* 1245 at 1246.

[15] Section XXXIX, Medical Act 1858.

[16] GMC, 'Functions, procedure, and disciplinary jurisdiction' (1965) pp. 7-8.

[17] As is clear from their focus, acts and omissions which did not take place in a professional respect (other than criminal offences), were not issues that merited disciplinary attention — see S. Mills, *et. al*., *Disciplinary Procedure in the Statutory Professions* (West Sussex: Bloomsbury Professional, 2011) pp. 39-41. This, as will be seen below, stands in stark contrast to the approach adopted by the MPTS.

[18] Finch, E., 'The centenary of the General Council of Medical Education and Registration in relation to medical education' (1958) 23(5) *Annals of the Royal College of Surgeons of England* 321.

[19] Irvine, D., 'A short history of the General Medical Council' (2006) 40 *Medical Education* 202.

charges it dealt with were concerned with criminal behaviour, adultery with patients and breaches of professional etiquette [20]. Regarding the latter, the fact that canvassing for patients and advertising were deemed as professional offences signified that the emphasis of ethical conduct at the time was also directed towards issues between doctors [21]. There were no guidelines drawn up to inform doctors and the public about what constituted good practice. The Council had instead preferred to use case law as the basis for advising doctors about misconduct [22]. This allowed the profession itself to decide on what constituted a "good doctor" — and he was someone who complied with the professional norms [23] i.e. doing what was normally done, rather than what should ideally be done. Public protection was therefore not the Council's priority then [24].

Some changes were subsequently made to their disciplinary procedures in the period from 1980 to the end of the 20th century. This was in response to the hundreds of complaints which started to be received yearly from patients and official bodies about the behaviour of doctors [25]. Complaints to the GMC would now be directed through a number of committees. Cases involving conduct would undergo a three-stage process. At the first stage, a medical screener would decide whether the case should go no further or be referred for investigation. If the latter, the case will then be managed by the Preliminary Proceedings Committee (PPC) (stage two) which decided if there was sufficient merit in the case being referred to the Professional Conduct Committee (PCC)(stage three). The PCC was empowered to hold the hearing in public. A doctor whose conduct was found to have amounted to "serious professional misconduct" (SPM) can be reprimanded, be given conditions, suspended or have his name erased from the medical register [26]. Cases involving the health of the practitioner (e.g. mental illness and alcohol and/or drug abuse) would be referred to the Health Committee which would arrange a medical examination of the doctor to determine whether his health seriously impeded his ability to practise medicine. If found proved, the doctor may be reprimanded; given conditions; or suspended; but not face erasure from the register [27]. Cases involving performance were managed by an Assessment Panel that would determine if there was Seriously Deficient Performance (SDP) [28]. The doctor could accept a statement of progress and he would be supervised until it was determined that his performance was satisfactory. Failure to comply or continued unsatisfactory performance would result in referral to the Committee on Professional Perfor-

[20] *Ibid*., p. 204.

[21] Stacey, M., *The Sociology of Health and Healing* (London: Unwin Hyman, 1988) p. 85.

[22] Irvine, D., *op. cit*., p. 205.

[23] See e.g. *Allinson v. General Council of Medical Education and Registration* [1894] 1 QB 750, *per* Lopes LJ at 763 and *Bolam v. Friern Hospital Management Committee* [1957] 1 WLR 582, *per* McNair J. at 587. For discussion, see J.B. Fanning, 'Uneasy lies the neck that wears a stethoscope: some observations on defensive medicine' (2008) *Professional Negligence* 93 and D. Thomas, 'Peer review as an outmoded model for health practitioner regulation' in I. Freckelton (ed.), *Regulating Health Practitioners* (New South Wales: The Federation Press, 2005) pp. 58-59.

[24] Irvine, D., *op. cit*., p. 204.

[25] Hill, D., 'The General Medical Council: frame of reference or arbiter of morals?'(1977) 3 *Journal of Medical Ethics* 110.

[26] Section 36 of the Medical Act 1983.

[27] Section 37 of the Medical Act 1983.

[28] Medical Professional (Performance) Act 1995.

mance (CPP). Sanctions available to the Committee included suspension and placing conditions on the doctor's practice [29].

The meaning of "serious professional misconduct" [30], however, was difficult to ascertain. The GMC had never published agreed standards or the criteria and thresholds by which decisions could be taken. In time, the term had come to mean "professional misconduct of such a degree that the PCC considers it to be serious" [31]. This is a circular definition [32]. The PCC would acquit and take no action against a doctor if the available evidence did not satisfy the criminal standard of proof. According to the Shipman Inquiry, "the concept of negligence even if serious does not fit comfortably with Serious Professional Misconduct [33]." The PCC's need to feel "sure" (i.e. beyond reasonable doubt) about the culpability of the doctor meant that many doctors were allowed to continue unrestricted practice irrespective of how poor their clinical practice had been [34]. Professional discipline's concern about being "fair to doctors" thereby left patients and the public insufficiently protected [35]. Further, the presence of 3 separate routes for professional discipline was also deeply confusing for the public. This deterred complaints or caused those who did complain to grow weary as a consequence of having to "negotiate something of an obstacle course [36]".

B. The 21st Century

It was not until the 21st century that the balance between protecting doctors on the one hand and the public on the other, started to tip towards safeguarding patients. This change of emphasis was prompted by the escalation in the number of complaints received by the GMC and the emergence of a string of high profile cases which came to light at around the same time as the Shipman case. These included the scandal at the Bristol Royal Infirmary where substandard cardiac surgery on infants as performed by 2 surgeons resulted in high rates of death; the case of Dr Richard Neale who did not provide appropriate care to his patients and which resulted in 2 deaths; the case of Dr Clifford Ayling who committed indecent assault on a number of his female patients; and the case of Drs William Kerr and Michael Haslam — 2 psychiatrists who sexually abused their female patients over many years [37].

Consequently, the Fitness to Practise Rules 2004 were created [38]. The 3 types of hearing (conduct,

[29] For further discussion, see A. Samanta & J. Samanta, 'Regulation of the medical profession: fantasy, reality and legality' (2004) 97 *Journal of the Royal Society of Medicine* 211 at 216.

[30] A term which was brought in to replace "infamous conduct in a professional respect".

[31] Dalton, K. J., 'Physician licensing and disciplining in England and Europe' in American College of Legal Medicine, *Legal Medicine* (Philadelphia: Mosby, 2004) p. 690.

[32] *Ibid*.

[33] Smith, J., *op. cit.*, p. 110.

[34] Dalton, K.J., *op. cit.*, p. 690.

[35] Smith, J., *op. cit.*, chapter 6.

[36] Baker, R., 'Patient-centred care after Shipman' (2004) 97 *Journal of the Royal Society of Medicine* 161 at 164.

[37] For further discussion, see e.g. M. Dixon-Woods *et. al.*, 'Why is UK medicine no longer a self-regulating profession? The role of scandals involving "bad apple" doctors' (2011) 73(10) *Social Science & Medicine* 1452; M. Davis, *Medical Self-Regulation: Crisis and Change* (Hampshire: Ashgate Publishing Ltd., 2007) pp. 121-242.

[38] GMC, 'Reform of the fitness to practise procedures at the GMC: Changes to the way we deal with cases at the end of an investigation' (Consultation paper) p. 11.

health and performance) were amalgamated into a single test of impaired fitness to practise (FTP). The GMC would investigate the complaints received, collect evidence and hear those cases. If a doctor's fitness to practise is found impaired, then sanctions can be applied that ranged from no further action, through to warnings, conditions, suspension and erasure from the medical register. The Council also published *Good Medical Practice* which represents a set of duties jointly regarded as important by doctors and the public [39]. The document was to be the new set of guidelines against which fitness to practise was judged [40].

In 2012, the Medical Practitioners Tribunal Service (MPTS) was established by Parliament. It provides a hearing service that is fully independent in its decision-making and separate from the investigatory role of the GMC. Now, in a three stage process, the GMC sets out the allegations against the doctor and presents evidence. The case continues if, in a private session, the MPTS panel finds the facts proved. Stage two commences where the panel hears, in public evidence, from the GMC as to whether the doctor's fitness to practise is impaired. At the final stage of the proceedings, the panel makes a decision on sanctions.

Although the panellists can exercise their discretion as to the sanctions to be exercised, they are required to refer to the guidance developed by the GMC on this matter [41]. This, according to the GMC, is for purposes of promoting consistency and transparency in decision-making. [42] The primary aim of sanctions is "the protection of patients and the wider public interest (i.e. maintenance of public confidence in the profession and declaring and upholding proper standards of conduct and behaviour) [43]". According to the guidance, if a doctor's fitness to practise is not found to be impaired, the panel could conclude the case by either taking no action or by issuing a warning. When a warning is issued, this would be because the doctor's performance has departed significantly from *Good Medical Practice* or where it has given rise to significant cause for concern following an assessment [44]. The warning, which would be in relation to the doctor's future conduct or performance (rather than his health), would need to be disclosed to the complainant, the doctor's employer and any other enquirer [45]. It would also be published on the GMC website for a period of 5 years [46].

Where a finding is made that the doctor's fitness to practise is impaired, four options are available to the panel. One would be to take no action against a doctor's registration if the doctor has demonstrated considerable insight into his/her behaviour and has already undergone and completed any remedial actions which he/she would otherwise be required by the panel to undertake [47]. The panel can also impose conditions [48] on the doctor's registration

[39] Irvine, D., *op. cit.*, p. 207.
[40] *Ibid.*
[41] GMC, 'Indicative Sanctions Guidance for the Fitness to Practise Panel', April 2009 (with 7 August 2009 revisions, March 2012 revisions and March 2013 revisions).
[42] *Ibid.*, p. 4.
[43] *Ibid.*, p. 8.
[44] *Ibid.*, p.12.
[45] *Ibid.*
[46] *Ibid.*
[47] *Ibid.*, p. 14.
[48] E.g. restricting the doctor's employment to NHS posts; disallowing him from carrying out a particular procedure; or making him undergo remediation or retraining — *ibid.*, p. 17.

for a period of up to three years (but renewable for up to 36 months thereafter); suspend the doctor's registration for up to 12 months; and erase the doctor's name from the register [49]. Although the panel maintains that its "decision is not intended to be punitive" [50], it concedes that the sanctions "may have a punitive effect [51]".

III. The MPTS and Patient Safety

A. Cases from 1 August 2012 to 31 July 2013

The MPTS heard 173 cases in the period between 1st August 2012 and 31st July 2013. The hearings are open to the public. The details and outcomes of those hearings are published on the MPTS website and members of the public can access them without charge. From these, it is possible to identify, *inter alia*, the decisions of the panel as to whether impairment was present; the sanctions taken; the grounds for the investigation; the year that the registrable qualification was obtained; and the institution granting the registrable qualification.

As can be seen from the table below, the MPTS decided to take no further action for 39 of the cases heard, and 10 registered practitioners were given a warning. Thus in over 70% of the cases heard last year, the doctors' fitness to practise was found to be impaired. Conditions were imposed on the registration of 18 of those doctors while 53 others were suspended. The most serious sanction, i.e. erasure, was also applied to the registration of 53 doctors.

Outcome	Numbers	Percentage
No action taken	39	22.54
Warnings issued	10	5.78
Conditions imposed	18	10.40
Suspension of registration	53	30.64
Erasure from register	53	30.64
Total	173	100

Table 1: Outcomes of cases heard by the MPTS between 1/8/2012 and 31/7/2013

In the majority of the cases that came before the MPTS in this period (i.e. up to 119 or 69%), the medical practitioners have been qualified for 15 up to 35 years. This strongly indicates that questions over their fitness to practise bears little relation to lack of professional experience. Another notable factor is that up to 107 or 62% of the overall cases heard concerned overseas doctors i.e. those who received their medical degree from outside the UK. This seems to be a continuation of an ongoing trend. As far back as 1989, Smith has noted that although overseas doctors were under represented on the GMC, they were over represented among those appearing before the Professional Conduct Committee [52]. Other commentators have also commented on this trend in the 1990s and early 21st century [53].

[49] *Ibid.*, p. 13.
[50] *Ibid.*, p. 7.
[51] *Ibid.*

[52] Smith R, 'Profile of the GMC: Overseas doctors: diminishing controversy' (1989) 298(6685) *British Medical Journal* 1441.
[53] See e.g. F. Goodlee, 'The GMC, racism and complaints against doctors' (1996) 312 (7042) *British Medical Journal* 1314; P. Moszynski, 'GMC to look into higher number of complaints against overseas trained doctors' (2007) 335 *British Medical Journal* 320.

There is nevertheless no clear association between ethnicity and the tendency to appear before an FTP panel among UK-qualified doctors [54].

B. Patient Protection: Potential and Limitations

1. Potential

As regards the MPTS' potential for public protection, it is undoubtedly the case that a complaint dealt with within the MPTS' FTP framework has greater potential to protect the public especially when compared to the malpractice framework. For one, whilst there is a need to prove that an alleged wrongdoing has led to injury when pursuing a medical negligence case against a doctor, there is no equivalent requirement for any harm or damage to have occurred before a doctor can be disciplined by the MPTS. Taking a closer look at the profiles highlighted above, incidents which have resulted in sanctions being applied include where the doctor has: kept diaries which contained derogatory and sexualised information about his patients; [55] accessed pornographic material at work [56]; created pornographic images purporting to be of a male patient with female colleagues [57]; left another doctor who should have been under his direct supervision unsupervised [58]; demonstrated a cavalier attitude to patient care [59]; and amended his patient's medical records a number of times after receiving a letter from a solicitor regarding a possible medical negligence claim [60]. Other cases include where the doctor has: treated his patient in a brusque, uncaring and rude fashion [61]; displayed a dismissive attitude to criticism [62]; did not carry professional indemnity insurance [63]; produced a dishonest and exaggerated report for a patient's insurance claim that was not based on a clinical assessment of the patient [64]; provided dishonest information to obtain employment [65]; accepted paid clinical work as a locum general practitioner elsewhere when on authorised sick leave at his place of work [66]; rewrote and replaced some pages of a patient's medical records; [67] and demonstrated inappropriate and sexually motivated behaviour towards his colleagues [68].

Although those incidents may not have produced any direct and discernible injury to the doctors' patients, they demonstrate that MPTS' FTP hearings do not wait until something has gone wrong before actions are taken. Rather, they identify risks from the doctors' behaviour and take appropriate action proactively. Thus unlike malpractice law which acts retrospectively and offers remedies after

[54] Humphrey, C., *et. al.*, 'Clarifying the factors associated with progression of cases in the GMC's Fitness to Practise procedures' (2009) RES-153-25-0101 p. 32.
[55] Case number 2654896.
[56] *Ibid.*
[57] *Ibid.*
[58] Case number 2803157.
[59] *Ibid.*
[60] Case number 1711880.
[61] Case number 4271938.
[62] Case number 6109941.
[63] Case number 5194517.
[64] Case number 6034254.
[65] Case number 5180486.
[66] Case number 4160133.
[67] Case number 4277886.
[68] Case number 4330468.

an incident has resulted in injury [69], these hearings tend to look forward and not back [70], This preventative posture [71] also has the capacity to protect the safety of a wide pool of patients. In a successful medical negligence suit, the finding of liability would only benefit one patient (i.e. through the award of monetary compensation to the one who instituted the claim) [72]. MPTS actions, by putting a stop on acts and omissions which do not constitute good professional practice, stand to benefit everyone who is likely to be treated by the doctor in the present and the future.

Additionally, the cases heard in the first year of the MPTS' operation also demonstrate that FTP hearings deal not only with clinical, but also non-clinical matters. Cases for which sanctions were applied include situations where the doctor has: posted obscene photos of his ex-girlfriend on Facebook [73]; falsified qualifications on his CV [74]; shown paedophile tendencies [75]; taken indecent photos of women in public without their consent [76]; taken part in violent disorder at a public protest [77]; and falsely claimed on his CV that he was a contributing author on a number of publications [78]. Some of those cases came to the attention of the GMC because the offences had been dealt with by the criminal justice system [79].

In regulating doctors' behaviour both during work and outside of work, the MPTS is, as highlighted earlier, of the view that the public interest extends beyond public protection to embrace the maintenance of public confidence in the profession, and the upholding of proper standards of conduct and behaviour. The significance of this is underlined by the fact that registered medical practitioners are entrusted with clinical and non-clinical responsibilities [80]. These duties may range from signing prescriptions and death certificates, through to various other certificates such as verifying the details on passport applications. Clearly a doctor with impaired integrity in those areas that the ordinary individual might assume to be private, will always be subject to suspicions that his professional life could be compromised [81]. Consequently, *Good Medical Practice* [82] and the MPTS (and now the revalidation process [83]) all place integrity as an important component in maintaining public trust.

[69] Geraghty, C., 'Advancing patient safety in Ireland: the American model and cultural change' (2009) *Medico-Legal Journal of Ireland* 27 at 28.

[70] *Meadow v. General Medical Council* [2006] EWCA Civ 1390 *per* Sir Anthony Clarke MR at paragraph 32.

[71] Geraghty, C., *op. cit.*, p. 31.

[72] Timms, M., 'Referring a doctor to the General Medical Council' (2006) *Journal of Personal Injury Law* 36 at 39.

[73] Case number 5180080.

[74] Case number 6046047.

[75] Case number 6024833.

[76] Case number 7079875.

[77] Case number 6110813.

[78] Case number 3679731.

[79] It is mandatory for doctors to notify the GMC if they come into contact with the criminal justice system as offenders — see GMC, 'Guidance on convictions, cautions and determinations' (April 2013).

[80] Hesketh, W., 'The police-health professions' protocol: a review' (2012) *Police Journal* 203 at 205; McFarlane, G., 'Clinical negligence disputes' (2003) *Journal of Personal Injury Law* 71 at 77.

[81] The MPTS' stance on this is similar to that of the Rehabilitation of Offenders Act 1974. Although this statute protects offenders from having to disclose their previous criminal convictions when applying for jobs and insurance after a rehabilitation period, this provision does not apply to doctors.

[82] GMC, *Good Medical Practice* (March 2013), paragraph 1.

[83] See e.g. GMC, 'Supporting information for appraisal and revalidation' (2012) pp. 3-4.

2. Limitations

The MPTS' role in safeguarding patient safety is nevertheless compromised on a number of fronts. Firstly, the MPTS seems to be following a redemptive model. When determining the appropriate sanction for a doctor's wrongdoing, the MPTS panels are expected to consider mitigating factors in two circumstances: where the doctor has demonstrated insight into the problem and his/her attempts to address it [84]; and evidence of his/her overall adherence to important principles of good practice [85]. Also of relevance are testimonials, personal hardship, work-related stress, lack of training and supervision at work [86]. The "insight" expected is for the doctor to be "able to stand back and accept that, with hindsight, they should have behaved differently, and that it is expected that he/she will take steps to prevent a recurrence" [87]. Assessing insight is always difficult, but in a redemptive model where the severity of sanction is linked to the degree of insight, it is important that the insight and remorse are genuine and not just words and attitudes superficially displayed to lessen any penalty that might be meted out. It goes without saying that testimonials, support and remedial training will have little effect on future practice if the doctor does not fully understand the reasons behind the initial complaint or comply with strategies to improve performance [88].

Secondly, whether a doctor's impaired fitness to practise actually comes to the GMC's and MPTS' attention depends on the assistance and cooperation of others. This means that a problem can go undetected if patients, employers, colleagues and/or other bodies are unwilling to come forward and report the doctor to the GMC [89]. Here it is pertinent to note that *Good Medical Practice* directs practitioners who have concerns that a colleague may not be fit to practise, to ask for advice from a colleague, their defence body or the GMC. If their concerns have not been addressed, they are to report the matter in accordance with GMC guidance and their workplace policy [90]. However, doctors are generally reluctant to criticise and report one another because of a sense of shared vulnerability [91]. Indeed, as pointed out recently by Robert Francis QC in the Report of the Public Inquiry into the Mid Staffordshire NHS Foundation Trust [92], there is a culture of professional disengagement among health care practitioners where many, including Consultants, had preferred to keep their heads down and not challenge or manage

[84] These could include admission of what took place; apologies extended by the doctor to the complainant; and efforts made to prevent such behaviour recurring or to rectify any deficiencies in performance — GMC (2009), *op. cit.*, p. 8.

[85] E.g. by keeping up to date; and working within his/her area of competence. Consideration could also be taken of his/her character; the circumstances leading up to the incidents; and whether this is the first time that a finding has been made against him/her — *ibid.*

[86] *Ibid.*

[87] *Ibid.*, p. 10.

[88] Case, P., 'The good, the bad and the dishonest doctor: the General Medical Council and the "redemption model" of fitness to practise' (2011) 31(4) *Legal Studies* 591 at 611-612.

[89] Baker, R., 'Patient-centred care after Shipman' (2004) *Journal of the Royal Society of Medicine* 161; Davies, A.C.L., 'Mixed signals: using educational and punitive approaches to regulate the medical profession' (2002) *Public Law* 703 at 722.

[90] *Good Medical Practice*, *op. cit.*, paragraph 25(c).

[91] Davies, M., *op. cit.*, p. 249.

[92] Francis, R., *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (2013), Executive Summary.

with any vigour [93]. He recognised that whilst it cannot be suggested that such a passive and disengaged culture "are present everywhere in the system all of the time,… their existence anywhere means that there is an insufficiently shared positive culture [94]" which prioritises patient safety.

And neither does the current set-up, which holds hearings in public, has a punitive effect and makes available the outcomes of hearings on the internet, incentivise doctors to openly admit and voluntarily report their own substandard clinical practices, wrongdoings, mistakes or adverse incidents. For one, they would expose themselves to the possibility of fitness to practise hearings and/or legal reprisals. More importantly, as pointed out by commentators, any system which names and shames encourages secrecy and cover-up, rather than the candour needed to improve patient safety [95]. Further, since many errors in medical practice (including medication, procedures and diagnosis) can be externally induced [96] and arise from the complexity of the healthcare delivery system itself [97], the FTP hearings conducted by the MPTS that can only address an individual doctor's practice may not adequately address patient safety where the problem is of a systemic nature [98].

IV. Conclusion

The GMC, in its role as the regulator of the medical profession in the UK, has been vested since its inception in 1858 with the power to discipline doctors by taking action against their registration. However, this power has been used sparingly throughout its history and when exercised, it was not always driven by concerns over patient safety or protection. Neither have the processes involved always been clear and transparent to the public. The Shipman case and a number of other high-profile cases which emerged in the full glare of media publicity at the beginning of the 20th century have drawn attention to questions about how the GMC reacts to the increase in the number of unethical and incompetent doctors [99]. Keen to assuage rising criticism that it is overly protective of doctors, fitness to practise underwent a profound change in the last 10 years or so. One of the most recent and significant reforms is the launch of the MPTS as an independent adjudicatory body in June 2012.

In the first year of its operation, the MPTS heard 173 cases. In over 70% of those cases, the doctors' fitness to practise was found to be impaired and sanctions were meted out. These were over issues that arose in medical practice and in the doctors' private lives. As discussed, the MPTS' will-

[93] *Ibid*., paragraph 1.8.
[94] *Ibid*., paragraph 1.117.
[95] Quick, O., 'Patient safety and the problem and potential of law' (2012) *Professional Negligence* 78; Haynes, K., 'Clinical risk management: reality or rhetoric? Experience from the UK — a personal view' (2003) *Medico-Legal Journal of Ireland* 83 at 86.
[96] Reason, J., *Human Error* (Cambridge: Cambridge University Press, 1990) p. 15.
[97] Kopec, D., *et. al*., 'Human errors in medical practice: a systematic classification and reduction with automated information systems' available at http://www.scibrooklyn.cuny.edu/~kopec/research/new/Final_J_Med_Sys_10_16_02.pdf/.
[98] Timms, M., *op. cit*., p. 37.
[99] Lowe, M., *et. al*., 'Is it possible to assess the "ethics" of medical school applicants?' (2001) 27 *Journal of Medical Ethics* 404.

ingness and ability to take action in both of these spheres could certainly engender a safer environment for patients. By holding its hearings in the open and by publishing the details and outcomes of its FTP hearings on the internet, these also make the process transparent to the public and could serve as a strong incentive on the part of doctors to avoid irresponsible and unacceptable behaviour. However, the earlier discussion also expressed concern that this "name and shame" approach could be detrimental to patient safety as could the redemptive model adopted which may encourage exaggerated or feigned remorse or insight to escape a heavier penalty.

It is therefore difficult to predict, on the basis of its first year's work, whether the current framework is the best solution to the call for more effective public protection. It is too early to tell and the MPTS should be given the opportunity to prove its worth. The potential to evolve new processes, however, gives rise to optimism that the GMC can indeed meet the challenges of changes both in society and the delivery of medical services.