

The Profession and the GMC after Dame Janet Smith's conclusions from the Shipman Enquiry: The personal view of a Fitness to Practice panellist

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ABSTRACT The GMC has come under harsh criticism after a series of highly public cases of failing doctors or medical systems and culminating in the Shipman Enquiry. As a result the GMC has undergone fundamental reform separating the elected policy-makers from the process of adjudication. The procedures of adjudication are not widely appreciated and so are broadly described and an argument is made in defence of the reformed procedures. Caution is advised in judging the profession too harshly and bringing even more pressure on a hard pressed and still highly respected group of people, at least by their patients.

KEYWORDS Fitness to practice panels, reform of the GMC, the Shipman Enquiry

LIST OF ABBREVIATIONS Council for Healthcare Regulatory Excellence (CHRE), General Medical Council (GMC), Serious Professional Misconduct (SPM)

DECLARATION OF INTERESTS Dr Smith is a paid panellist for the GMC Fitness to Practice.

BACKGROUND

Harold Shipman, a general practitioner in Hyde near Manchester, was found guilty of killing a large number of his patients of various ages and is thought to have killed very many more. He was imprisoned, and then committed suicide. There is a sense that his patients had thought him caring and attentive until he was found out. He had had a brush with the GMC some years before over the misuse of opiates but after due enquiry he was not taken to a higher level of investigation and Dame Janet Smith had no particular criticism of the way in which the GMC had dealt with that issue.

There was public concern that the dreadful tally of murders had not been detected earlier and that some deaths might have been avoided by earlier prosecution. As a result the government appointed a senior judge, Dame Janet Smith, to enquire into the whole circumstance and after three years of enquiry she has issued several reports which have raised issues about various aspects of the monitoring of deaths, of the performance of the coroners' courts, and of the duty of doctors to be vigilant and to report suspicions of malpractice. The GMC anticipated severe criticism and criticism has now been levelled.

The media had anticipated that the GMC would be found guilty of weakness and professional cronyism and as a result might even be abolished. To a degree Dame Janet did express concerns about its structure and its performance. The profession and the public who rely upon the media for information have been left with the impression that the GMC is highly suspect, run by and for doctors and not effective in protecting patients and the public.

As a panellist sitting on the tribunals of the GMC, in judgement of doctors thought to be wanting, I have been worried that the perceptions of the public and the media, and the perceptions of the profession, are ill-informed and that an injustice has been done to an organisation that has fairly taken the brunt of enormous criticism following the Bristol Enquiry, the Alderhay events, Neale etc., but which then embarked on an extensive internal analysis of its duties, functions and structure to reach what I, as a participant in its quasi-judicial role, think is now a fair and robust system of regulation.

Without going into great detail I would therefore like to sketch out what the GMC does and how the panels (previously known as the committees) are constituted, governed by strict rules and give their honest opinion. I am not a member of the GMC, and I am the last to be an apologist for a failing organisation, but I hope that my

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readers might be less inclined to condemn Catto *et al.* as a result of understanding some basics. This is broad brush in parts and I apologise to the GMC if some details have been misrepresented.

GMC STRUCTURE

The General Medical Council is a statutory body set up under successive Medical Acts of Parliament. Until recently it was far too large and cumbersome and was perhaps rightly described as being dysfunctional. The GMC is two things; it is the organisation as a whole including its secretariat and its panellists, but precisely it is a Council of men and women who are either doctors elected from and by the profession or lay members who are appointed by the government (the Crown). The doctors outnumber the lay members but not greatly. This Council determines policies within their remit under The Act. Since early 2004, these Council Members have not been permitted to sit on the tribunals, and the policy makers have not been allowed to sit in judgement. Previously they were more numerous, they were the only people who sat in judgement and they were not trained to do so.

More recently, and in anticipation of the need to separate functions, the GMC advertised, inviting interest from doctors and the public to join the GMC as Associates to sit on the Fitness to Practice Committees. Selection was by formal interview (a harrowing experience), followed by training and further selection by performance at training. The group was enlarged stepwise and now exclusively sit on the three types of 'committee': Health, Performance and Conduct.

Since November 2004 the committees have been renamed panels and the associates therefore called panellists. Of the panellists some have offered themselves as chairmen of panels and some were selected after a rigorous selection process and then further training.

We the panellists are thus employees of the GMC. We have enlarged in number as the GMC Members were disqualified from sitting and a number of young doctors have been recruited. We are a diverse crowd. The doctors are from all branches of the profession but, in my mind, too many are retired – they are the ones with the time to sit and the only ones who can, in practice, sit on long cases which last weeks or months. The lay panellists are from every walk of life, perhaps, and inevitably, mainly middle class, but a very experienced group. It goes without saying that there is a rich diversity of ethnic background as well as of age and experience.

When we sit in panels, addressing the accusations made against the doctor by Counsel for the GMC, we are strictly governed by the Medical Act and by the detailed rules of procedure. We sit with a legal adviser who is a lawyer appointed and trained in procedure by the GMC

but, like us, independent from the GMC. He or she may be quite senior, even sometimes a judge. The legal adviser keeps the panel and the counsels for the GMC and the doctor within procedural rules and within the law and advises the panel on points of law and procedure. The panel is entitled to take that advice or to reject it but all advice is made public and a panel will be careful to explain why it rejects advice, though for obvious reasons it usually does not.

The procedures are broadly divided into three sections

First we hear the allegations, the GMC presents evidence and the defence follows with its case just as in a court of law. Cross-examination takes place and there are closing speeches. The panel is advised of its duties by the legal adviser as would a judge to a jury and the panel retires in private (*in camera*) to decide whether the facts have been found proved. If they have not the doctor goes home without a blemish, though the enormous stress caused to the doctor and his family by the process cannot be underestimated.

If some or all of the facts are found proved, Counsel address the panel again, the GMC providing evidence of any past failing and the defence evidence of good character with such things as references from colleagues and patients, and any mitigating circumstances are proposed. The legal adviser reminds us of our duties. Now the panel retires again *in camera* and decides whether the misdemeanour or poor practice whatever is *not* insufficient (sic) to amount to SPM – and in the new procedures this term will be replaced by a wider definition – and if it is insufficient the case closes and the doctor goes home without a blemish.

If the panel think that the facts are not insufficient to amount to SPM (ie that there may be grounds to consider that they amount to SPM) they declare it in public, hear further representations then retire *in camera* again to decide whether it is the case that the facts do amount to SPM. That being the case, the panel, again *in camera*, considers what sanctions are appropriate, starting with a statutory formula and clear guidelines to consider the least sanction available and working up to more serious sanctions until the appropriate one is agreed. Finally the panel writes a determination, indicating to the doctor what has been found proved, how it is wrong, and why, in some detail, a particular sanction has been arrived at. Determinations can run to numerous pages of argument and seldom to less than three.

Unless a witness needs to have their anonymity protected or evidence is to be adduced about the doctor's health, all proceeding are in public and verbatim records are kept and produced. *In camera* discussion is not recorded and is a secret to all but the panel sitting with its legal adviser and a member of the GMC secretariat. If the legal adviser

gives legal advice, that is recorded and declared in public and Counsel have the opportunity to challenge it.

In camera, we panellists, usually a chair and four others, and made up of two doctors and three lay, or the other way round, and the chair who can be either a doctor or a lay panellist, discuss and argue at each stage. Sometimes the facts are easy to find, proved or not, but other times evidence is sifted, revisited and argued over at very great length. With few exceptions the panels work well together; argument can be passionate and opinions swayed to and fro until a consensus starts to appear and the chair feels that it is time to vote. In the second stage where the panel has to decide if the facts amount to SPM the discussions are again detailed and often prolonged. The media suggest that the doctors protect their own but this is not by any means the norm; indeed it is often the doctors who have the harshest opinions and the lay members who argue leniency both at this stage and when applying sanctions. It has been my clear impression that the process is fair in every case where I have sat. Protection of the public, the patient and the reputation of the profession are paramount, but fairness to, and sometimes the protection of, the doctor are also important elements.

What of the independence of the panels? They are independent but they function, as I have described, within strict rules of procedure. They are mindful of the fact, and often reminded so, that the condemned doctor has a right of Appeal to the High Court (previously the Privy Council), and panellists frequently receive copies of judgments by Their Lordships so that we can understand why the Appeal has failed or, less frequently, succeeded. This learning loop feeds back into the next case. This is the check against being too harsh or getting the principles wrong. Now we have another influence, the CHRE, a government watchdog which examines all GMC and other regulatory bodies' determinations and sends them to the High Court if it feels the sanction applied to have been too lenient (double jeopardy for the doctor). The GMC itself feeds through the panel chairs what we feel as subtle or not so subtle warnings not to be too lenient and many of us were appalled when the President himself referred a decision as being possibly too lenient. Many panellists think this was a vote of no confidence and a slap in the face.

In the opinion of many panellists, the GMC has reformed its procedures profoundly, carefully and thoughtfully after Bristol and other high profile problems, but in the light of Shipman and Dame Janet's ongoing enquiries, they have

become oversensitive and paranoid and have tried to exert too much influence on its panels. We panellists are a diverse group, often more lay than medical, careful to discuss, argue and decide fairly after hearing all of the evidence; we give it our best shot in a process which I believe effectively protects the public and patients. We must at all times take notice of criticism and understand it, but we must not continue to lie down to be kicked by ill-informed opinion and we have to reply robustly and with confidence when we are justified in doing so. In well-conducted annual opinion polls, the Great British public continues to vote that it is doctors whom they respect most with policemen and teachers, and that it is politicians and journalists whom it most distrusts. And is it well recognised that the NHS is worryingly short of consultants and general practitioners and that many are taking early retirement already, depriving the service of their individual and collective experience and wisdom? The increasing threats of litigation and regulatory body examination of their practice is not an inducement for doctors to stay on a few more years for a slightly better pension when so many other inordinate pressures seem to stand in the way of a happy professional life already.

Finally, that old chestnut – that the GMC is a doctor's organisation and that its justice is by peers. What nonsense. The successive reforms have moulded a much more diverse GMC, admittedly still with doctors in the majority. I do think that the medical members should be appointed and not elected; they might turn out to be more representative that way. There would be nothing much lost if we stopped paying a lot of money and the GMC became a government appointed, but independent, body. The appointment, training and appraisal of panellists has produced a well experienced body that gets better with experience and which could be used by a new GMC as its examining and judicial resource.

So I say that what we have is actually very effective and fair. Their Lordships at Appeal often draw attention to the assiduous deliberations of the panels and the CHRE appeals against leniency have not had a record of success. What Dame Janet wants, and what the public needs, is that bad doctors, poor doctors and ill doctors are recognised and their problems brought to light, and then that appropriate paths be followed so that resolution can occur to protect the public or indeed to help a doctor to become more effective. The profession also needs to be treated fairly. Generally it is trusted by patients and the public but I suspect it is too much to expect the media to be fair in the face of headline opportunities.