# CHAPTER SEVENTEEN

## Serious Professional Misconduct and Seriously Deficient Performance: Problems of Definition

### Introduction

17.1 In Chapter 15, I explained that the General Medical Council (GMC) conduct or disciplinary procedures were, for many years, founded on the issue of whether the doctor concerned had been guilty of serious professional misconduct (SPM). The meaning of that phrase had been defined in general terms from time to time. However, the Inquiry was told that opinions about what types of conduct amounted to SPM varied considerably and that the debate between eminent members of the medical profession as to whether the conduct of a doctor in a particular case amounted to SPM could become both heated and emotional. As SPM was the basis of the conduct procedures, it is apparent that, if views about what amounted to SPM differed, then the standards that were applied by the GMC must have been inconsistent and its decisions unfair to some doctors. The corollary of that unfairness is that some decisions on misconduct must have been too lenient and may have failed to provide adequate protection for patients and the public. It is of vital importance that any disciplinary process should be based upon standards that can be applied consistently in all cases.

17.2 The GMC performance procedures, which were introduced in 1997, were founded on the issue of whether the professional performance of the doctor in question had been 'seriously deficient'. Although the history of cases under the performance procedures was much shorter than that of cases under the conduct procedures, it appears that there were difficulties with the definition and recognition of seriously deficient performance (SDP), as there were with SPM. The absence of any clear definition of, and standards for, SDP gave rise to the same problems as I outlined above. These problems were of such importance that I propose to devote this Chapter to a discussion of them and their histories.

17.3 I shall not discuss the concept of serious impairment of fitness to practise by reason of a physical or mental condition, which was the foundation of the GMC health procedures, as this does not appear to have given rise to similar difficulties.

### Serious Professional Misconduct

#### 'Infamous Conduct in a Professional Respect'

17.4 The term **'serious professional misconduct'** was substituted by the Medical Act 1969 for the phrase **'infamous conduct in a professional respect'**, which had appeared in the previous legislation.

17.5 In 1894, **'infamous conduct in a professional respect'** had been defined by Lord Justice Lopes in Allinson v General Council of Medical Education and Registration[1] in the following terms:

[1] [1894] 1 QB 750.

> **'If a medical man in the pursuit of his profession has done something with regard to it which will be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competency, then it is open to the General Medical Council, if that be shown, to say that he has been guilty of infamous conduct in a professional respect.'**

17.6 In 1930, Lord Justice Scrutton stated in R v General Council of Medical Education and Registration of the United Kingdom[2] that:

> **'... ''infamous conduct'' ... means no more than serious misconduct judged according to the rules written or unwritten governing the profession'**.

**The Blue Book**

17.7 For many years, ending in 1993, the GMC provided to all doctors on the medical register a guide to its functions, procedures and disciplinary jurisdiction. This guide was known as the 'Blue Book'. It described the more common types of misconduct which had in the past been regarded as grounds for disciplinary proceedings. In the main, they related to what might be termed 'wilful' or deliberate misconduct (e.g. termination of pregnancy in contravention of the law, drug abuse, canvassing for patients) or breach of medical ethics (e.g. abuse of professional confidence). Disregard of professional responsibilities to a patient (e.g. by failing to visit or to provide treatment for a patient when necessary) was also mentioned.

17.8 All editions of the Blue Book from 1975 (the earliest in the Inquiry's possession) to 1993 set out the two definitions I have quoted above and stated that, in proposing the substitution of the expression **'serious professional misconduct'** for **'infamous conduct in a professional respect'**, the GMC had intended that the phrases should have the same significance.

17.9 The Blue Book made clear that the question whether any particular course of conduct amounted to SPM was one which fell to be determined by the Professional Conduct Committee (PCC) after considering the evidence in an individual case. It emphasised that the categories of misconduct described within it could not be regarded as exhaustive. It stated (I quote from the final edition, published in December 1993):

> **'Any abuse by doctors of any of the privileges and the opportunities afforded to them, or any grave dereliction of professional duty or serious breach of medical ethics, may give rise to a charge of serious professional misconduct.'**

17.10 The 1985 edition of the Blue Book had included for the first time a statement of the standard of medical care that the public was entitled to expect. It stated:

> **'The public are entitled to expect that a registered medical practitioner will afford and maintain a good standard of medical care. This includes:**

[2] [1930] 1 KB 562.

(a) **conscientious assessment of the history, symptoms and signs of a patient's condition;**

(b) **sufficiently thorough professional attention, examination and, where necessary, diagnostic investigation;**

(c) **competent and considerate professional management;**

(d) **appropriate and prompt action upon evidence suggesting the existence of a condition requiring urgent medical intervention; and**

(e) **readiness, where the circumstances so warrant, to consult appropriate professional colleagues.'**

17.11 It seems that this statement had been formulated following the notorious case of Alfie Winn, which had been heard by the PCC in March 1983. In 1982, Alfie Winn, who was eight, became ill with vomiting and a high temperature. His general practitioner (GP) was called and attended three hours later. He asked Alfie to open his mouth. The boy seemed comatose and his mother said, 'He can't hear you.' The doctor replied, 'If he can't be bothered to open his bloody mouth, I shall not bloody well look at 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 PCC found the facts proved and regarded the doctor's behaviour as falling below acceptable standards. Nevertheless, it considered that there had been no SPM. The doctor went on to be found guilty of SPM by the PCC in a different case the following year. During the intervening period, he had continued to practise.

17.12 Following these events, there were demands that the GMC should reduce its threshold for taking disciplinary action to 'professional misconduct', without the requirement that such misconduct should be 'serious'. The GMC set up a Working Group, which reported in 1984 that it could find no justification for lowering the threshold of SPM. The GMC instead proposed the formulation of detailed guidance on the circumstances in which failure to provide a sufficient standard of medical care might give rise to SPM. The statement contained in the 1985 Blue Book was the result. However, that statement constituted advice only, and a failure to meet the standards set out in the statement did not thereafter automatically give rise to disciplinary action by the GMC. Nor was the statement particularly detailed. The statement remained unchanged throughout the remaining period for which the Blue Book was published.

### The Case of Doughty

17.13 In the case of Doughty v General Dental Council[3], an appeal from a decision of the General Dental Council (GDC) heard by the Judicial Committee of the Privy Council in 1987, the Privy Council defined SPM as:

**'... conduct connected with his profession in which the dentist concerned has fallen short, by omission or commission, of the**

[3] [1988] AC 164.

> **standards of conduct expected among dentists and that such falling short as is established should be serious'**.

17.14 The Privy Council said that the test that had been applied by the GDC (and which the Privy Council implicitly approved) was that:

> **'... judged by proper professional standards in the light of the objective facts about the individual patients that were presented in evidence to the Committee, the dental treatments criticised as unnecessary would be treatments that no dentist of reasonable skill exercising reasonable care would carry out'**.

17.15 The Privy Council observed further that the relevant Committee of the GDC was particularly well qualified to reach a view on whether the relevant misconduct was serious. It made clear that the findings against the appellant did not import any moral stigma. Nevertheless, the failures found were of a kind which the GDC had been entitled to consider sufficiently serious to warrant erasure of the dentist's name from the register.

17.16 The observation that the profession (in the Doughty case, the dental profession, but in other instances the medical profession) is particularly well qualified to judge what is and is not 'serious' has been repeated often in the courts. The problem is that, save in the most obvious cases, there was no agreement within the profession about what type of conduct was capable of amounting (or did amount) to SPM. In 1988, Mrs Jean Robinson, a lay member of the GMC who sat at various times on both the Preliminary Proceedings Committee (PPC) and the PCC, observed in her monograph, 'A Patient Voice at the GMC'[4], that there were frequently a number of different medical views as to whether a particular case might or might not amount to SPM. As I shall explain in Chapter 20, Professor Isobel Allen, Emeritus Professor of Health and Social Policy, University of Westminster Policy Studies Institute (PSI), and her colleagues observed similar divergences of view when they attended meetings of the PPC in 1999 and 2000. Sir Donald Irvine, President of the GMC between 1995 and 2002, told the Inquiry that, in his experience of the PCC, the most contentious and difficult parts of the decision-making process were the issues of whether a doctor's conduct (based on facts which had been admitted by the doctor or proved to the satisfaction of the PCC) amounted to SPM and, if so, what sanction should be imposed. He said that those were the issues that generated the 'heat' and the 'emotion' among members of the PCC panels when debating their decisions. These issues presented particular difficulties in cases involving allegations about poor treatment or substandard clinical practice. I shall discuss those difficulties later in this Chapter.

### 'Good Medical Practice'

17.17 In the mid-1990s, there was concern that the Blue Book was too negative, concerned as it was with 'bad doctors'. There was a desire to develop instead a more positive statement defining good practice. This gave rise to the development of a list of 14 'Duties of a Doctor', contained within a booklet, 'Good Medical Practice'. The booklet, which was issued in 1995 to all doctors on the register, set out the basic principles of good medical practice,

[4] Robinson, Jean (1988) 'A Patient Voice at the GMC'. London: Health Rights.

and was described as **'guidance'**. Later editions of 'Good Medical Practice' made a clear link between its contents and the fitness to practise (FTP) procedures. The edition of July 1998 stated:

> **'If serious problems arise which call your registration into question, these are the standards against which you will be judged.'**

The third and most recent version of 'Good Medical Practice', published in May 2001, is at Appendix G of this Report. The first page of the publication warns:

> **'Serious or persistent failures to meet the standards in this booklet may put your registration at risk.'**

17.18 The Blue Book had been intended to be read by doctors, not by members of the public. Indeed, members of the GMC staff were discouraged from sending copies of the Blue Book to members of the public for fear they would 'scour' it to find examples of misconduct which a doctor might have committed. Mr Antony Townsend, Deputy Head, later Head, of the Conduct Section between 1994 and 1998, said that this discouragement was 'a reflection of the culture at the time'. By contrast, 'Good Medical Practice' was made available to the public. Plainly, it was not intended that a single departure from the standards set out in 'Good Medical Practice' would necessarily be the subject of disciplinary action. The difficulty for those reading the publication in the disciplinary context – whether they were doctors, members of the public or others – was to know how **'serious'** or **'persistent'** a departure from the standards had to be before it would amount to SPM.

17.19 Professor Allen told the Inquiry that, while 'Good Medical Practice' was 'absolutely fine' for the purposes for which it was intended, it was not suitable for use as guidance about what might or might not amount to SPM. She said:

> **'... ''Good Medical Practice'' is a mixture of things which really must not be transgressed and which would be very serious, and other points which are, for example, being polite to your patients. This on its own could not raise an issue which ought to affect a doctor's registration presumably; so that you've within ''Good Medical Practice'' a lot of different things at different levels of seriousness.'**

What was needed, she said, was detailed guidance for those making decisions, with examples of different types of case which might reach different thresholds, thus creating a 'hierarchy of seriousness'.

17.20 Mr Townsend agreed that it would not be the case that a breach of one of the standards in 'Good Medical Practice' would necessarily lead to disciplinary action by the GMC. He told the Inquiry:

> **'... although ''Good Medical Practice'' was explicit, very explicit I think, about the principles of being a good doctor, what it did not and, indeed, probably could not do was define precisely how serious a departure from those principles was required before registration was called into**

> **question. That is a very difficult issue which the Council and many others have been grappling** (*with*) **for a long time.'**

17.21 A number of witnesses spoke with enthusiasm of the 'change of culture' which was signalled by the publication of 'Good Medical Practice'. Sir Donald, who had been a member of the Working Group which produced the document, described it as **'a consensus statement that brought professional and patient views on the qualities of a doctor together for the first time'**.

17.22 Mr Townsend told the Inquiry that 'Good Medical Practice' laid much greater emphasis on patients' interests and on doctors' competence. It set out what he called 'patient-centred expectations'. He said that there had been a debate at the time of its publication about whether to continue to issue the Blue Book in parallel with 'Good Medical Practice' but it had been decided that this would 'perpetuate the old regime' whereby 'the focus was upon unacceptable behaviour rather than the delivery of patient care'.

17.23 As a member of the GMC staff, Mr Alan Howes, who was involved with the Conduct Section in one capacity or another more or less continuously between 1980 and 1995, said that he had found the Blue Book useful as a guide to the type of behaviour that could lead to disciplinary proceedings. 'Good Medical Practice' was harder to use in that way and indeed was not intended to be used for that purpose. He felt that the GMC had 'lost something' with the replacement of the Blue Book by 'Good Medical Practice', despite the fact that he could see the benefits of the latter. No document equivalent to the Blue Book has been produced since 1993. 'Good Medical Practice', in its updated form, remains the GMC's main source of guidance as to the type of conduct that might come within the definition of SPM.

### The 1997 Screeners' Handbook

17.24 The 1997 Screeners' Handbook produced by the GMC advised screeners that, in reaching a view on whether a complaint was so serious as to raise an issue of SPM, the screener (whether medical or lay) should assess the information provided in the complaint against the following criteria:

> '• **The gravity of the doctor's act or omission.**
>
> • **Whether there is more than one event or alleged victim.**
>
> • **The extent of the risk to patients or the public.**
>
> • **Whether the doctor appears to have acted deliberately, recklessly, accidentally, or in bad faith.**
>
> • **Whether the doctor may have neglected or disregarded his or her professional responsibilities.**
>
> • **Whether there have been any previous complaints to the GMC about the doctor which, taken with the current complaint, suggest a course of conduct which could amount to spm.'**

This advice was helpful but there was still no guidance about how grave an act or omission had to be before it could amount to SPM. Nor was any guidance given as to the weight to be attached to the various criteria listed or as to the approach which should be taken if one or more of the criteria were satisfied.

### Further Guidance

17.25 Further guidance as to the meaning of SPM appeared elsewhere. In 'A Problem With Your Doctor?', published in November 1997 and directed at members of the public, the GMC defined SPM as **'conduct which makes us question whether a doctor should be allowed to practise medicine without restriction'**. In a document entitled 'The Conduct Procedures of the General Medical Council', issued by the GMC Fitness to Practise Directorate in July 2000, SPM was defined as **'behaviour so serious it would justify restricting the doctor's right to hold registration'**. The problem with both those definitions was that they gave no clue as to the type of behaviour which was considered by the GMC as being serious enough to justify restricting a doctor's right to practise medicine or to hold registration.

### The 1999 Report of the Professional Conduct Committee Working Group

17.26 Shortly after the establishment of the GMC Fitness to Practise Policy Committee (FPPC) in 1997, the Committee set up a Working Group to report on the activities of the PCC. One of the matters which the PCC Working Group considered was whether there should be any attempt to define SPM more precisely. One of the reasons for setting up the Working Group had been public criticism of some PCC decisions on the grounds that they were inappropriate or inconsistent. The report of the PCC Working Group recognised that the lack of a **'definitive interpretation'** of SPM was a factor which increased the risk of inconsistent decision-making by the PCC.

17.27 The PCC Working Group considered that a major advantage of the concept of SPM was its flexibility. It considered that the concept could be interpreted according to changing circumstances and expectations. The only alternative was, the PCC Working Group considered, to have a code of conduct, specifying every single offence with which a doctor might be charged. Members of the PCC Working Group did not believe that a code of conduct would offer any real benefits. On the contrary, they felt it would have significant disadvantages. In particular, they thought it would lead to **'interminable legal wrangling'** about whether the details of the alleged misconduct in an individual case fitted the circumstances defined in the code.

17.28 The PCC Working Group noted that SPM was sometimes described as being **'conduct ... so serious as to call into question a doctor's registration'**. Its report observed:

> **'While that is technically accurate, it is a circular statement which gives no real clue as to the kind of misconduct likely to be involved.'**

I wholly agree with the observation that this description or definition of SPM was unhelpful because of its circularity. The definition immediately provoked the questions 'And how

serious is that?' and also 'What do you mean by ''call into question''?' Unfortunately, the GMC's new FTP procedures will depend on just such a circular definition.

17.29 The PCC Working Group noted that the courts' interpretation of SPM was:

> **'... a serious falling short from the proper standards of conduct to be expected of doctors, or, in clinical matters at least ... action or inaction by a doctor of a serious kind for which no doctor of reasonable skill exercising reasonable care would be responsible ...'**.

The reference here was to the interpretation of SPM set out in the case of Doughty: see paragraph 17.13. The PCC Working Group observed that the definition **'left unanswered'** the questions of what the standards were at any one time and of what was meant by **'serious'**.

17.30 The PCC Working Group commented that one **'unintended consequence'** of substituting 'Good Medical Practice' for the Blue Book might have been **'a loss of clarity outside the GMC about the meaning of SPM'**. It commended the 1998 GMC publication 'Maintaining Good Medical Practice', which gave guidance to doctors and managers on what to do when they discovered poor practice. The publication contained examples (financial fraud, making false statements, indecency, etc.) which would justify the referral of a doctor to the GMC. The Working Group felt that the types of conduct mentioned in that publication provided a **'useful overview'** of SPM. However, my own view is that, although the 1998 guidance was better than nothing, it was not adequate because it was far too general. It was not surprising that many cases were reported to the GMC which the GMC considered were insufficiently serious to warrant action.

17.31 The PCC Working Group concluded that SPM should continue to be closely related to the need for a doctor's registration to be removed or restricted. It dismissed the possibility of widening the PCC's jurisdiction to include less serious offences, or of retaining the offence of SPM but introducing a new offence of lesser gravity, such as 'unacceptable conduct'. The Working Group observed that there was no point in the PCC hearing a case if the doctor's registration was not in question. The reason for that was that the statutory process (i.e. the quasi-criminal hearing) existed in order to ensure that a doctor was not removed from practice without due cause. Cases of lesser gravity, where the doctor's livelihood was not at stake, were, the Working Group observed, **'best dealt with in other ways'**.

### The Revision of 'Good Medical Practice' in 2001

17.32 In May 2001, 'Good Medical Practice' was being revised for the second time. A draft had been prepared and consultation had taken place. Two medical organisations had raised concerns about some of the changes and additions to the text. They argued that the guidance was too vague and that it should include explicit and measurable standards if it were to be used as a template against which doctors would be assessed. Non-medical groups, however, either supported the standards and principles set out in the draft or argued for a more assertive statement on the need for doctors to comply with the guidance in all but exceptional circumstances. Neither the medical nor the non-medical groups argued that every complaint about a contravention of the guidance, however minor,

should lead to action by the GMC. However, the consultation exposed a difference in views about the point at which a failure to meet standards should be regarded as unacceptable and, therefore, as potentially warranting action on registration.

17.33 As a consequence of this difference of views, and following discussion at a Council Meeting in May 2001, it was decided that it would be helpful to draw up a series of examples or indicators of SPM to complement the guidance in 'Good Medical Practice'. This work was to be taken forward by the FPPC and the Standards Committee; it was intended that they should work together to produce examples of conduct which would call a doctor's registration into question. It was suggested that one example might be a statement that doctors must be honest and trustworthy and that a criminal conviction for theft would call a doctor's registration into question. It was hoped that the production of examples or indicators would meet some of the concerns which had been expressed during consultation on the revised edition of 'Good Medical Practice'. However, it appears that no examples of the type which had been envisaged were produced. When, in May 2004, the Inquiry asked the GMC (through its solicitors) what had been the result of the initiative and whether it had given rise to any guidance, the GMC replied that the work had been **'taken forward'** and was **'reflected'** in the draft case examiner decision form which was at that time being prepared for use after the introduction of the new FTP procedures, and in the draft document, 'The Investigation Stage Test – Guidance on Criteria and Thresholds', which had been prepared for the use of case examiners appointed to work under the new procedures. Copies of both were provided. The draft document has now been replaced by a further draft document, 'Making decisions on cases at the end of the investigation stage: Guidance for Case Examiners and the Investigation Committee', which was produced by the GMC in September 2004 (the September 2004 draft CE/IC Guidance). I shall refer to the September 2004 draft CE/IC Guidance again below and shall describe it more fully in Chapter 25.

### Guidance for the Preliminary Proceedings Committee

17.34 Notes produced by the GMC for the use of members of the PPC, current in January 2002, stated that the GMC regarded SPM as **'behaviour which may raise issues about the doctor's registration and fitness to continue to practise'**. Here again, the GMC was using a definition or description of SPM which was circular in nature. The definition gave no clue as to what sort of behaviour might raise issues about registration or fitness to continue to practise. In any event, this particular wording might well give rise to misunderstanding. It could easily convey the idea that SPM was confined to behaviour for which the doctor might be struck off the register.

### Guidance for Screeners

17.35 The Screeners' Handbook of November 2002 contained no specific guidance about the meaning of SPM. However, a description of SPM appeared on the screening decision form (SDF), the standard form which was at that time used by GMC staff and screeners during the pre-screening and screening processes. It is not clear whether the description appeared on the SDF as originally drafted in 1999, but it had certainly been included on

the form for the previous three or four years. It related to conduct other than sexual assault or indecency, violence, dishonesty and certain types of dysfunctional behaviour. It was intended that those categories of conduct should be regarded by the screeners as automatically capable of amounting to SPM or as 'SPM by definition'.

17.36 The description of SPM which appeared on the SDF stated:

> **'SPM is action or inaction by a doctor of a serious kind of which no doctor of reasonable skill and exercising reasonable care would be responsible.'**

Quite apart from the problems of syntax and clarity of expression, this description (which was derived from the interpretation of SPM in the case of Doughty) was not very helpful in that it was not appropriate for application to many of the classes of conduct which might potentially amount to SPM. It related solely to cases of substandard clinical practice. For such cases, the test proposed was similar to that applied by the courts when deciding civil claims for negligence made against doctors. It incorporated an additional element, not present within the definition of clinical negligence applied by the courts, namely that the action or inaction by the doctor had to be **'of a serious kind'**. But there was no guidance as to how serious the negligence had to be before it could amount to SPM. The screener was left to apply his/her own view of seriousness.

### A Collection of Case Reports

17.37 At the Inquiry hearings, Sir Donald Irvine said that, when he was President, the idea of publishing case reports or case studies had been discussed. The idea was to illustrate by example the kinds of conduct that would and would not amount to SPM. It may be that Sir Donald had in mind the work to which I have already referred and which it had been intended should be undertaken by the FPPC and the Standards Committee. He said that, in the event, the work had not been carried out, a fact which he regarded as a matter for regret.

17.38 At the Inquiry hearings in December 2003, Professor Sir Graeme Catto, current President, and Mr Finlay Scott, Chief Executive, said that the GMC intended to publish a collection of case reports in February 2004. As I understood it, these were to be summaries of cases in which the decision taken by a PCC panel was regarded as good and as an example to be followed. I had hoped that these summaries would provide useful examples of the kind of conduct which did or did not amount to SPM, and also guidance on appropriate sanctions. In the event, publication of the case reports was delayed until September 2004, when five 'case studies' were published. They were disappointing and gave little or no useful guidance as to the threshold of seriousness at which conduct might be regarded as amounting to SPM, or be such as to warrant action on registration. I shall refer to the case studies in greater detail in Chapter 21.

### The New Fitness to Practise Procedures

17.39 As I have mentioned, under the new FTP procedures, the test to be applied when deciding whether action on a doctor's registration is required will not be whether the doctor has

been guilty of SPM, but whether his/her fitness to practise is impaired to a degree justifying action on registration. This test gives rise to the same problems of circularity as the definition of SPM to which I referred at paragraph 17.28. How are doctors, patients or others to judge what degree of impairment will, in the view of the GMC, justify 'action on a doctor's registration'? The answer is that, unless they are given comprehensive guidance on standards, they will guess. Within the GMC, how are caseworkers, case managers, case examiners and FTP panel members to make judgements about whether action on registration is justified? The answer is that, unless they are given comprehensive guidance on standards, they will apply their own individual views and the result will be inconsistent decisions with all the adverse consequences that they bring. The GMC has undoubtedly recognised the need for guidance and, as I have said, has produced draft guidance (the September 2004 draft CE/IC Guidance) for case examiners, who will have to decide whether a case should be referred to a FTP panel. It sets out a number of circumstances in which a question of fitness to practise is likely to arise. A few examples are given. It is a step in the right direction. Coupled with the regular publication of case reports, such guidance might provide a basis for more consistent and transparent decision-making. As I shall later explain, however, I believe that more must be done to establish standards that are understood and accepted by society as a whole.

**Poor Treatment and Substandard Clinical Practice**

17.40 As I have explained, it is clear that there has often been considerable difference of opinion as to whether the facts established in a particular case amounted to, or were capable of amounting to, SPM. This difference of opinion has been particularly marked in cases involving allegations of poor treatment and/or substandard clinical practice. I recognise that there will always be a risk that two tribunals will reach different conclusions based on the same facts; that is why clear guidance is essential.

17.41 In the past, as I have said, the emphasis of the Blue Book was on what might be termed 'wilful' or deliberate misconduct and on breach of medical ethics. It was unusual for the GMC to take disciplinary action in respect of substandard clinical practice. Mr Townsend told the Inquiry that, while he was at the GMC, he did a small survey which showed that, in the late 1960s, only 5% of cases reaching the PCC had anything to do with clinical care. He said that cases referred to the PCC:

> **'... were nearly always about behavioural matters, about whether a person was a fit person to be a registered medical practitioner as distinct from whether they were competent to undertake the right kinds of treatment'**.

Speaking of the same era, Mr Howes referred to the 'old-fashioned' forms of misconduct with which the GMC would have been concerned then, 'such as advertising and abortion and adultery: the three As'.

17.42 Early editions of the Blue Book had, as I have said, referred to the possibility that disciplinary proceedings might be instituted in a case where a doctor appeared to have seriously disregarded his/her professional responsibility to his/her patients or to have neglected his/her professional duties, for example by failing to visit or to provide treatment

for a patient when it was necessary. Substandard treatment – in the absence of misconduct involving a conscious decision by the doctor to act as s/he did, knowing of the possible or likely consequences – was not, however, mentioned. The 1977 edition of the Blue Book specifically stated that the GMC was **'not concerned with errors in diagnosis or treatment'**.

17.43 In the 1983 edition, that statement was amplified. The relevant passage then stated:

> **'The Council is not ordinarily concerned with errors in diagnosis or treatment, or with the kind of matters which give rise to action in the civil courts for negligence, unless the doctor's conduct in the case has involved such a disregard of his professional responsibility to his patients or such a neglect of his professional duties as to raise a question of serious professional misconduct. A question of serious professional misconduct may also arise from a complaint or information about the conduct of a doctor which suggests that he has endangered the welfare of patients by persisting in independent practice of a branch of medicine in which he does not have the appropriate knowledge and skill and has not acquired the experience which is necessary.'**

17.44 In the 1985 edition of the Blue Book, there was the addition of the statement of the standards of medical care that the public was entitled to expect. I have referred to that statement at paragraph 17.10. As I have said, the statement constituted guidance only, and a failure to meet the standards did not automatically give rise to disciplinary action by the GMC.

17.45 Mr Howes said that, during the 1980s, it became more common for cases of substandard treatment to be reported to the GMC. This type of complaint was more of a 'grey area' than complaints about other forms of misconduct. Mr Howes' interpretation of the approach taken by the GMC during the 1980s and early 1990s was that:

> **'... if you** (*i.e. the doctor*) **try your very best and your very best happens not to be good enough, then that is not serious professional misconduct. Serious professional misconduct is neglecting to do what you ought to have done or in some cases doing what you should not have done.'**

17.46 In 1994, Mr Howes compiled what he has described as 'the beginnings of a training manual' (the 1994 Training Manual). No similar document had been produced in the Conduct Section previously and Mr Howes, who was by that time Head of the Section and was aware that he would be moving to another Section in the near future, compiled this document in order to pass on his knowledge and experience for the benefit of new staff joining the Section. He explained in evidence that he did not regard it as a finished document, but had envisaged that it would be improved and overhauled from time to time and would eventually be audited by someone and given a more formal status. He assumed that the 1994 Training Manual must have been approved at the time – at least in general terms – by his immediate superior, but had no clear recollection about this. The Training Manual is a valuable document since it provides a summary of the operation of

GMC procedures in 1994, as perceived by Mr Howes, who was then a very senior and experienced member of staff. Generally, the witnesses agreed that it accurately represented the practice and thinking of the time. However, as I shall explain, some doubt was expressed about the description of the GMC's approach to cases of poor treatment and substandard practice contained in it. It was suggested that the 1994 Training Manual might not accurately reflect the approach taken by the GMC to such cases.

17.47 The 1994 Training Manual stated:

> **'We cannot investigate complaints of failure to diagnose, or failure to give what the complainant considers to be correct and appropriate treatment, or complaints about evident or alleged errors in treatment, which have allegedly resulted in damage to the patient. Such matters come into the category of medical negligence, which it is more appropriate for a patient to pursue in the civil courts, particularly if the patient wants financial redress (which we cannot give). Those matters are not, however, regarded as serious misbehaviour by the doctor concerned, such as might justify action by the Council.'**

and

> **'The types of case relating to treatment which may** (*emphasis in the original*) **justify disciplinary procedures by the Council include cases where a doctor has allegedly failed to visit a patient when necessary, or failed to conduct an appropriate examination, or failed to conduct or arrange appropriate examinations, or absented himself/herself from his/her practice or post when the doctor was supposed to be on duty, or has been drunk on duty, or has been guilty of some other culpable failure in relation to his or her responsibilities towards one or more patients.'**

The 1994 Training Manual also stated:

> **'Experience shows that few complaints about treatment would actually be serious enough even if sustained to raise any question of serious professional misconduct.'**

17.48 The wording of the 1994 Training Manual suggested a very restrictive approach to complaints about poor treatment and substandard clinical practice. A clear distinction appeared to be drawn between **'errors in treatment'** on the one hand and **'culpable failure'** in relation to professional responsibilities for patients on the other. The idea that SPM must involve some element of 'wilful' or, at least 'reckless', misconduct appeared to be perpetuated. The 1994 Training Manual appeared to suggest that falling below reasonable standards of care (as opposed to wilfully refusing to give any care at all) would not of itself amount to SPM.

17.49 Despite the fact that he was responsible for compiling the 1994 Training Manual, Mr Howes did not believe that these extracts truly reflected the thinking of the GMC as it was in 1994. He said that, at that time, the GMC often dealt with complaints about doctors failing to treat and giving incorrect treatment. However, 'errors' were not matters for the

GMC. Mr Howes appeared confident that GMC staff and members had been able to distinguish between cases which might involve SPM and those which could never do so. He did, however, agree with me that, on occasion, it was difficult to decide whether an 'error' was 'culpable' on the one hand (and, therefore, capable of constituting SPM) or 'excusable' (therefore not amounting to SPM) on the other. Dr Krishna Korlipara, who has been an elected member of the GMC since 1984 and was a medical screener between 1998 and 2004, also said that the extracts from the 1994 Training Manual did not tally with his understanding of the tests which were being applied at the time.

17.50 In December 1995, the Judicial Committee of the Privy Council delivered judgement in the case of McCandless v General Medical Council[5]. The PCC had found Dr McCandless, a GP, guilty of SPM and had directed that his name should be erased from the register. The charges had alleged errors of diagnosis in relation to three patients and a failure to refer them to hospital. Two patients had died and one had been found to be seriously ill at the time of her eventual admission to hospital. The PCC had found that the care provided by the doctor **'fell deplorably short of the standard which patients are entitled to expect from their general practitioners'**. On appeal, the PCC's findings of fact were accepted by Dr McCandless and it was also accepted that he had been negligent. However, it was argued on his behalf that poor treatment was not enough to amount to SPM. It was said that SPM meant conduct that was **'morally blameworthy'**. This could not be determined simply by deciding whether the treatment measured up to an objective standard. The doctor might have been doing his best. He might have been overworked. It was argued that it was necessary to look at why the doctor gave the treatment he did. Counsel for Dr McCandless submitted that if the treatment fell short of a reasonable standard because he had been, for example, too lazy or drunk to examine the patient properly, then he would be guilty of misconduct. But not if he had made an honest mistake.

17.51 The Privy Council took the view that the legal authorities dealing with **'infamous conduct in a professional respect'** were of little assistance in the interpretation of SPM. It said that moral blameworthiness was not a necessary ingredient of SPM. Lord Hoffmann observed:

> **'... the public has higher expectations of doctors and members of other self-governing professions. Their governing bodies are under a corresponding duty to protect the public against the genially incompetent as well as the deliberate wrongdoers.'**

The Privy Council applied the objective test referred to in Doughty (see paragraph 17.13), saying that it was applicable to doctors as much as to dentists. That being the case, the appeal in McCandless failed.

17.52 Mr Townsend told the Inquiry that he believed that GMC procedures had been designed to deal with questions of professional behaviour and had not really been designed to deal with questions involving treatment. He said that there was no doubt that the GMC could act if, for example, a GP refused to visit a patient where there was sufficient evidence that someone needed a visit. He said that, over a period of years (even decades), the GMC had been 'pushing at the margins' of SPM to try to include substandard care. He said that

[5] [1996] 1 WLR 167.

the guidance contained in the 1994 Training Manual had been 'at the cautious end' of the interpretation of the Blue Book. However, at that time, the GMC was becoming less cautious. Mr Townsend made the point that it was because the GMC procedures were not really suitable to deal with substandard care that the performance procedures were introduced. As I have explained, under the performance procedures, the GMC could take action if the standard of professional performance of a doctor was seriously deficient. However, the advent of the performance procedures did not entirely solve the problem of which Mr Townsend spoke. There had to be a pattern of failure (or possibly of serious failure) to comply with relevant professional standards before SDP could be established. Where there was such a pattern, action under the performance procedures was appropriate. However, where the matter complained of appeared to be a single incident, the performance procedures were not appropriate and the issue was still whether the incident complained of amounted, or was capable of amounting, to SPM. Most complaints to the GMC came from private individuals as isolated incidents. Unless enquiries were made of the doctor's employer or primary care organisation (PCO) (which they rarely were), the GMC was not in a position to know whether the complaint was part of a pattern of similar incidents which might be sufficient to trigger the performance procedures.

17.53 There is no doubt that, during the early and mid-1990s, some complaints involving what might be termed 'errors' were judged by the GMC to amount to SPM. In Chapter 21, I have referred to a few examples of such cases, all involving the administration of manifestly excessive doses of drugs. It is clear that, in other cases, where the 'error' was not so obvious, there was uncertainty as to whether the doctor's conduct crossed the threshold of SPM. From 1995, it was possible to look at the doctor's behaviour against the background of the standards set out in 'Good Medical Practice'. However, as I have already said, a departure from those standards did not necessarily amount to SPM. The difficulty still lay in defining precisely how serious such a departure had to be before disciplinary action was appropriate.

## Seriously Deficient Performance

17.54 The Medical (Professional Performance) Act 1995, which introduced the performance procedures, did not define the circumstances in which a doctor's professional performance should be regarded as **'seriously deficient'**. In the 1997 Screeners' Handbook, 'performance' was defined as **'any professional work undertaken by the doctor, including medical administrative work'**. Screeners were advised to consider whether there was good evidence that the doctor might be **'repeatedly or persistently failing to comply with the professional standards appropriate to the work'** s/he was doing. They were advised to consider whether there might be **'a pattern of deficient performance'** as opposed to **'evidence only of one or two incidents'** of deficient performance, which could be **'isolated lapses'**.

17.55 In November 1997, the GMC published guidance, 'When Your Professional Performance Is Questioned', about the new performance procedures. The guidance stated:

> **' "Seriously deficient performance" is a new idea. We have defined it as "a departure from good professional practice, whether or not it is**

**covered by specific GMC guidance, sufficiently serious to call into question a doctor's registration''. This means that we will question your registration if we believe that you are, repeatedly or persistently, not meeting the professional standards appropriate to the work you are doing – especially if you might be putting patients at risk. This could include failure to follow the guidance in our booklet Good Medical Practice.'**

17.56 Here again, the circular test was propounded. SDP was defined as a departure from good professional practice, sufficiently serious to call registration into question. But how serious was that? In giving judgement in the case of Krippendorf v General Medical Council[6] in November 2000, the Privy Council observed that it saw no reason to criticise the general guidance given in that passage, provided that it was not regarded as exhaustive. It observed that the third sentence of the guidance should more accurately read:

> **'This means that we will question your registration if we believe that you have been, repeatedly or persistently, not meeting the professional standards appropriate to the work you have been doing – especially if you might be putting patients at risk.'**

In other words, the Privy Council was suggesting that action on registration should be based on an assessment of past – not current – performance. It seems that the guidance was subsequently changed to accord with this suggestion. In the later case of Sadler v General Medical Council[7], the Privy Council referred to the amended guidance:

> **'Although in *Krippendorf* the Board did not criticise the phrase ''repeatedly or persistently'' in the GMC's guidance, it is important to bear in mind that that guidance is a generalisation seeking to cover a very wide range of professional performance. The professional demands made on a general practitioner are very different from those made on a consultant surgeon. A continuing failure to organise the efficient management of a general practice may (in a sufficiently bad case) amount to seriously deficient performance, but in the nature of things it must be assessed on very different evidence from that relating to shortcomings of technique in major surgery. It would plainly be contrary to the public interest if a sub-standard surgeon could not be dealt with by the CPP** (*Committee on Professional Performance*) **unless and until he had repeatedly made the same error in the course of similar operations, but as a general rule the GMC should not (and their Lordships have no reason to suppose they would) seek to aggregate a number of totally dissimilar incidents and alleged shortcomings in order to make out a case of seriously deficient performance against any practitioner.'**

Here, it seems to me, the Privy Council usefully suggested that the application of a test for SDP should be approached in the context of the type of work being done. In my view, this was the right track to follow.

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[6] [2001] 1 WLR 1054.
[7] [2003] 1 WLR 2259.

17.57 Also in the case of Sadler, the Privy Council indicated that it did not consider negligence to be a relevant or useful concept for consideration at a performance hearing before the CPP. It observed that SDP meant:

> **'... a much wider concept since ... it can extend to such matters as poor record-keeping, poor maintenance of professional obligations of confidentiality, or even deficiencies (if serious and persistent) in consideration and courtesy towards patients. It does not depend on proof of causation of actionable loss. (On the other hand one isolated error of judgment by a surgeon might give rise to liability in negligence but would be unlikely, unless very serious indeed, to amount by itself to seriously deficient performance.)'**

17.58 The 1999 version of the SDF completed by medical screeners stated that:

> **'SDP is normally indicated by a repeated or persistent failure to comply with relevant professional standards ...'**.

However, in the August 2001 version of the SDF, the words **'a repeated or persistent failure'** were replaced by the words **'a pattern of serious failure'**. This change introduced the concept of **'a pattern of serious failure'** as opposed merely to **'repeated or persistent failure'** to comply with relevant standards. This is not just a matter of semantics, as the August 2001 wording suggested that the failures themselves must be serious as well as repeated. The August 2001 wording was reproduced in later versions of the SDF.

17.59 The August 2001 version of the SDF also contained a list of **'criteria'** which, it was suggested, might assist medical screeners in assessing whether the conduct or the performance procedures were appropriate. The SDF made clear that the list of **'criteria'** was not exhaustive, but stated that it (by which was presumably meant the presence of one or more of the **'criteria'**) might be an indicator of SDP. The list of **'criteria'** was as follows:

'• **a doctor who has a tendency to use inappropriate techniques**
- **a lack of basic knowledge/poor judgement**
- **a lack of familiarity with basic clinical/administrative procedures**
- **a doctor who has failed to keep up to date records**
- **a lack of insight**
- **a range of inadequacies:**
  - **outdated techniques**
  - **attitude**
  - **inadequate practice arrangements**
  - **concerns over referral rates**

- **poor record keeping**
- **inadequate hygiene arrangements.'**

These **'criteria'** were reproduced in later versions of the SDF. The **'criteria'** were helpful only to the extent that they pointed to relevant considerations. The actual standards to be applied were still at large, for the individual screener to make up his/her own mind about.

17.60 Following the case of Krippendorf, which I have mentioned above and which I shall describe in detail in Chapter 24, the GMC sought amendment of section 55 (the interpretation section) of the Medical Act 1983. After December 2002, when the amendments came into force, the expression **'professional performance'** included professional competence. However, it does not appear that this change was reflected in the guidance provided for screeners or more generally for members of Assessment Panels or panels of the CPP. The amendments also made clear that an assessment of a doctor's professional performance might include an assessment of the doctor's professional performance at any time prior to the assessment, as well as of his/her professional performance at the time of the assessment.

## Conclusions

17.61 It appears that, in the past, there has not been a clear and common understanding about the type and seriousness of misconduct or deficient professional performance which was likely to result in action on registration. This has given rise to difficulties, examples of which I will examine in the ensuing Chapters. The GMC is about to introduce its new FTP procedures. Although, in future, these will not operate in the separate 'silos' of conduct, health and performance, as they have done in the past, the decisions that will have to be made by FTP panels will still involve issues of misconduct, deficient performance and ill health. Indeed, in future, issues of misconduct and deficient performance are likely to arise together in the same case. It is, in my view, vital that the GMC should establish clear standards upon which these new procedures are to be based. This is important for a number of reasons.

17.62 First, it is obviously desirable and fair that doctors themselves should know what type of conduct or deficiency of performance is likely to result in action on their registration and that they should be able to regulate their behaviour accordingly. Of course, it is to be hoped that most doctors would aim rather higher in their professional life than just to avoid disciplinary action, but it is only fair that they should understand the circumstances in which they might fall foul of their professional regulatory body.

17.63 Second, if, as has been the case in the past, it is to remain open to patients, relatives and others who have complaints against doctors to refer them to the GMC, they must have a clear understanding of whether the GMC is the right body to deal with their complaints. If they do not, their complaints will be rejected by the GMC, they will become disappointed and frustrated and the GMC's reputation will suffer.

17.64 Third, it is important that those with responsibility for referring cases to the GMC – such as doctors' employers, PCOs, private healthcare bodies, other healthcare professionals and

such bodies as the Commission for Healthcare Audit and Inspection (now known as the Healthcare Commission) – are aware of the types of case that they should refer. If they are not, they will refer the wrong cases or fail to refer the right ones, resources will be wasted and patients may be inadequately protected.

17.65 Fourth, once a case has reached the GMC, it is important that all those responsible for making decisions in the future should understand the standards to be applied and should apply them consistently. Otherwise, the system will be unfair both to the doctors against whom complaints are made and to those who make the complaints.

17.66 It is now some years since the GMC was advised that it should devise standards, criteria and thresholds for the consistent operation of its FTP procedures. Professor Allen and her colleagues so advised in 1996, 2000 and 2003. Yet the GMC has still not grasped the nettle. The problem will not go away with the new procedures; indeed, I think it will become even greater. I say at once that I recognise that the task of formulating standards, criteria and thresholds is not easy. However, it must be tackled and, in my view, the public must be involved in the process. The GMC will not command public confidence unless there is consensus about the standards that are to be applied. I shall discuss two possible approaches to the problem in Chapter 27.