CHAPTER NINETEEN

The General Medical Council's Conduct Procedures: Screening

Introduction

19.1 In Chapter 18, I described how, under the 'old' conduct procedures, when complaints and reports of convictions were received by the General Medical Council (GMC), they were subjected to a filtering process which was carried out by members of the GMC staff, exercising the legal powers of the Registrar. Only about 35% of cases survived that initial filtering process. I shall now consider the next step in the conduct procedures, which was known as 'screening'.

19.2 From the end of the nineteenth century, GMC Rules stipulated that convictions and complaints referred to the GMC should undergo initial consideration in order to determine whether or not they should be referred on for further action. Individuals who performed this function became known as 'screeners'. For many years, the President of the GMC, who was always a prominent member of the medical profession, acted as the sole screener. If, for any reason, he was unable or unwilling to do so, he would nominate another medically qualified member of the GMC to take his place. Complaints were few and it was possible for one man to consider them all. Conduct that the President regarded as potentially 'infamous in any professional respect' (later serious professional misconduct (SPM)) would go forward to a disciplinary hearing. The President himself would chair that disciplinary hearing. By virtue of his dual roles, the President of the GMC was, in effect, the arbiter of what conduct was and was not acceptable in a member of the medical profession. That this degree of power and influence should be reposed in one individual seems extraordinary to modern eyes. Of course, the system has changed but, in examining the functions of the present day screener, it is helpful to understand the origin of the role.

19.3 Over recent decades, as I shall describe, the number of screeners increased. The President ceased to undertake this role, which was thereafter performed by several individuals. After 1990, lay people participated in the screening process. Until July 2003, the Rules provided that only members of the GMC could act as screeners. When the size of the GMC was reduced, in July 2003, that changed; after that time, it was possible for non-members to be appointed to act as screeners. From mid-2004, the existing screeners were replaced by case examiners, who had been appointed for the purposes of the new fitness to practise (FTP) procedures. The intention was that they should fulfil the roles of screeners pending the introduction of the new procedures.

19.4 Cases referred on by the screeners went for further consideration to one of the GMC's FTP committees. Until 1980, that committee was the Penal Cases Committee (PeCC); after 1980, it was the Preliminary Proceedings Committee (PPC). The function of the PPC was to decide whether a case should go to the Professional Conduct Committee (PCC) (formerly the Disciplinary Committee (DC)) for a disciplinary hearing.

19.5 The importance of the screener's role as a filter was demonstrated by the statistics produced by the GMC. Screeners were responsible for 'screening out' a large proportion

of the cases referred to them. In most years from 1987 to 1998, between 82% and 89% of cases referred to screeners were screened out and closed. The public was not generally aware of this. The screening process took place in private and, as I shall explain, was not open to scrutiny by anyone, not even by other members of the GMC.

19.6 In this Chapter, I shall examine the role of the medically qualified and 'lay' screeners and the developments in the screening process which took place over the years. I shall discuss the tests applied by the screeners at various times and the guidance which was available to assist them when applying those tests. I shall discuss some individual screening decisions, including that relating to complaints against Shipman which were reported to the GMC in 1994 and some of those which have been the subject of proceedings for judicial review. I shall consider the light shed on the screening process by the work undertaken by the Policy Studies Institute (PSI). I shall also consider some specific problems which have arisen in connection with the screening process.

Witnesses

19.7 The Inquiry heard oral evidence from Dr Krishna Korlipara, who was a medically qualified screener dealing with conduct and performance cases (a 'medical screener') from 1998 to 2004, and from Dr Arun Midha, who is not medically qualified and was appointed a 'lay' screener in July 2001. Dr Robin Steel, a medical screener between 1987 and 1999, and Dr Joan Trowell, who was appointed a medical screener in 1999, provided witness statements to the Inquiry. Mr Blake Dobson, Head of Casework for the GMC's Fitness to Practise Directorate (FPD) and Head of the FPD Audit Team, also provided a witness statement. Professor Isobel Allen, Emeritus Professor of Health and Social Policy, University of Westminster PSI, provided a witness statement and gave oral evidence. During the late 1990s, she and a team of colleagues examined several aspects of the GMC's work, including the screening process.

The Role of the Screener from the 1970s until 1996

The 1970s

The Treatment of Convictions

19.8 Rule 5 of the General Medical Council Disciplinary Committee (Procedure) Rules Order of Council 1970 (the 1970 Rules) provided that all criminal convictions (save those excepted by a direction of the PeCC) should be referred by the Registrar to the President. The PeCC made an exception for minor motoring offences not involving the abuse of alcohol or drugs; no action was, therefore, taken in relation to such convictions. They were not required to go forward for screening by the President.

19.9 In practice, despite the requirement in the 1970 Rules that all convictions (save excepted convictions) should be referred to the President, it appears that this did not happen. Mr Robert Gray, Assistant Registrar in 1976, when the GMC considered Shipman's conviction, told the Inquiry that he thought that, by that time, the then President, Sir John (later Lord) Richardson, had arranged with members of the GMC staff that only the most serious convictions should be referred to him. These would include convictions for which

a custodial sentence had been imposed and second or third drink driving convictions. The purpose of referring the most serious convictions was not, as I understand it, because there was any doubt as to whether they should be referred to the PeCC; rather, it was because the President wanted to be kept informed about such cases. Other convictions (save for excepted convictions) were to be referred by staff direct to the PeCC. The effect of these arrangements was that all criminal convictions (save for minor motoring offences) were automatically referred for consideration by the PeCC.

The Treatment of Conduct Cases

19.10 By rule 5(1) of the 1970 Rules, the Registrar was also required to refer to the President any complaint made in writing that appeared to him to raise a question as to whether the conduct of the doctor in question constituted SPM. Such cases would be referred to by the GMC as 'conduct cases'. Rule 5(1) of the 1970 Rules was the forerunner of rule 6 of the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules Order of Council 1988 (the 1988 Professional Conduct Rules), the operation of which I discussed in the last Chapter.

19.11 Rule 5(2) of the 1970 Rules provided that, in a conduct case and **'unless it appears to him that the matter need not proceed further'**, the President should set in motion the disciplinary procedures. The question whether a case did or did not **'need'** to proceed further – and of how to interpret the word **'need'** – was for the President to decide. The Rules contained no criteria to be applied when making the decision. It seems to me that it was implicit in the Rules that, notwithstanding the fact that the Registrar had referred the case for screening (and must therefore have considered that it raised a question whether the doctor's conduct amounted to SPM), the President might take the view that the complaint could not, in fact, amount to SPM. In that event, there would be no **'need'** for the matter to proceed. Other types of consideration spring to mind; for example, if the doctor complained about had already retired from practice, that might provide a sensible reason why there was no **'need'** for the complaint to proceed. The presence or absence of a '**need'** for a case not to proceed further continued to be the test to be applied by medical screeners until August 2000. The test allowed the President/medical screener a wide discretion. Despite the fact that the wording of the test was framed so as to require a case to proceed unless there was a reason why it should not, a high proportion of cases were screened out. This suggests that the screeners might have applied the test in reverse – by screening a case out unless there was an identifiable reason for allowing it to proceed. Evidence received by the Inquiry suggests that the test was indeed applied in reverse. Mr Antony Townsend, Deputy Head, then Head, of the Conduct Section between 1994 and 1998, told the Inquiry that, until the mid-1990s, the 'old view' had been that a reason had to be found for referring a case to the PPC.

After Screening

19.12 If the President/medical screener decided that a case **'need not proceed further'**, the case was closed and no further action was taken. No 'second opinion' was sought. If s/he considered that the case should go forward, rule 5(2) of the 1970 Rules required

him/her to direct the Registrar to write to the doctor, notifying him/her **'of the receipt of a complaint or information, and stating the matters which appear to raise a question whether the practitioner had committed'** SPM. The complainant (if there was one and if s/he was a private individual) would be required to provide a statutory declaration and that would be sent to the doctor. The doctor would be informed of the date of the next meeting of the PeCC and would be invited to submit an explanation of his/her conduct. Once these steps had been taken, the President/medical screener would refer the case to the PeCC.

The Screeners

19.13 Until 1973, it was normal practice for the President not only to deal with the screening of cases but also to chair the PeCC and the DC. Lord Cohen of Birkenhead, President from 1961 until 1973, fulfilled all three roles until he fell ill in about July 1973. After that time, Professor Sir Denis Hill, a prominent member of the GMC, was appointed by the President to act as medical screener. Two other members of the GMC also chaired meetings of the DC.

19.14 Over the years, there had been dissatisfaction in some quarters about the arrangement whereby the President decided whether a complaint should be referred to the PeCC, then adjudicated on the same complaint at the PeCC and again at the DC. In 1973, the GMC accepted that it was undesirable for the President to continue to fulfil all three roles. Thereafter, the new President, Sir John Richardson, chaired the DC and Sir Denis was again appointed to act as medical screener and to chair the PeCC. In 1975, the President resumed the roles of medical screener and Chairman of the PeCC. He delegated chairmanship of the DC to another member of the GMC, Mr (later Sir) Robert Wright.

19.15 In 1975, the Merrison Committee recommended that the preliminary sifting (i.e. screening) of cases should be undertaken by the President, assisted by GMC staff and by the proposed investigation unit which I mentioned in Chapter 18. The reason for entrusting the task to the President was, the Committee said, **'the vital nature of the initial sifting task'**. The Committee also recommended that the President should be a member of the new Complaints Committee (subsequently entitled the PPC), which was to replace the PeCC. This was so that the President's knowledge of a case, derived from his previous screening of it, could be available to the PPC. The Committee recommended that a person other than the President should chair the DC (which was to become the PCC).

The 1980s

The Health Procedures

19.16 The Medical Act 1978, together with the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules Order of Council 1980 (the 1980 Professional Conduct Rules), brought into effect many of the changes recommended by the Merrison Committee.

19.17 At the same time, the General Medical Council Health Committee (Procedure) Rules Order of Council 1980 (the 1980 Health Rules) came into effect and governed the operation of

the new health procedures. They provided that the Council should appoint the President or some other GMC member to undertake the initial consideration (i.e. screening) of cases which raised a question whether the doctor's fitness to practise was seriously impaired by reason of his/her physical or mental condition. If the President chose to chair the Health Committee (HC), or if for other reasons he did not wish to be appointed as screener for health cases, he was to nominate another member of the GMC for appointment by the Council. The person fulfilling this screening role, who would be medically qualified, became known as a 'health screener'.

19.18 The 1980 Professional Conduct Rules provided that, in any conviction or conduct case where it appeared to the President/medical screener that the doctor's fitness to practise might be seriously impaired by reason of a physical or mental condition, the President/medical screener should direct the Registrar to inform the doctor of the fact and to invite the doctor to furnish medical evidence of his/her fitness to practise. That evidence would then be available to the PPC when it considered the case. The 1980 Professional Conduct Rules also permitted the President/medical screener in such a case to remit the case to the health screener for action under the voluntary health procedures.

The Treatment of Convictions

19.19 The 1980 Professional Conduct Rules required the Registrar to refer all convictions to the President/medical screener save for those (i.e. minor motoring offences not involving the abuse of alcohol or drugs) which the PPC had directed need not be referred. In principle, the President/medical screener was required to refer to the PPC every conviction case which had been referred to him. It was, however, open to him to remit a case to the health screener for action under the voluntary health procedures as an alternative to referring the case to the PPC.

19.20 The 1980 Professional Conduct Rules introduced an arrangement whereby doctors in conviction cases were invited at an early stage to submit their observations to the GMC. Those observations were then put before the President/medical screener at the time the case was screened. Where the doctor had submitted medical evidence, this might give rise to the case being remitted to the health screener rather than being referred to the PPC. Doctors in conduct cases were not asked for their observations until after the case had been screened so that, in general, the President/medical screener would not have the doctor's response to the complaint made against him/her.

The Screeners

19.21 The 1980 Professional Conduct Rules provided that the President should continue to perform the role of medical screener as before. However, if the President chose to sit either on the PCC or on the new HC or if, for other reasons, the President did not wish to undertake the screening of cases, it was open to him to **'nominate some other member for appointment'** by the Council as medical screener. Later, the 1988 Professional Conduct Rules provided that the Council **'shall appoint'** the person nominated by the President. In effect, therefore, the appointment was in the hands of the President. The 1988 Professional Conduct Rules also provided that the President could nominate (and

the Council was required to appoint) other members of the GMC to act as additional medical screeners in cases where the President or the appointed medical screener was unable to act.

19.22 In 1980, Sir Robert Wright became President. He chaired the PCC until his death in 1981. Sir Denis Hill was again appointed medical screener, both for conduct cases and for cases being dealt with under the new health procedures. He chaired the PPC. In February 1982, Sir John (later Lord) Walton became President. From the beginning of his Presidency until November 1984, he chaired the HC. Initially, Sir Denis continued as screener and Chairman of the PPC. Following the death of Sir Denis in May 1982, the President nominated Dr John Fry, a general practitioner (GP), as medical screener for conduct cases. Dr Fry also chaired the PPC. In November 1984, Sir John ceased to be a member of the HC and became screener for both the conduct and the health procedures. He was assisted by the previous medical screener, Dr Fry. Sir John also chaired the PPC. In November 1987, Dr Steel was appointed as an additional medical screener. Sir John was the last President to act as medical screener.

19.23 Sir Robert (later Lord) Kilpatrick succeeded to the Presidency in February 1989. He chose to chair the PCC. Dr Fry was appointed medical screener, assisted by Dr Steel and Dr (later Dame) Beulah Bewley. Dr Fry also chaired the PPC. From about this time, the medical screener for conduct cases became known as the 'principal' medical screener, in order to differentiate him/her from the additional medical screeners. It is apparent that, at least until this time, screening had been the province of very few members of the GMC and all involved had been personally selected by the President of the day.

Chapter XV Procedures

19.24 I have said that, under the 1970 Rules, if the medical screener decided that the complaint need not proceed further, it would be closed. That was also the case under the 1980 Professional Conduct Rules. In May 1981, an informal mechanism for warning a doctor about his/her conduct was introduced. This was intended to permit the GMC to mark its disapproval of conduct that fell short of SPM but was, nevertheless, regarded as unacceptable. The relevant procedures appeared in Chapter XV of the revised version of the GMC Standing Orders published in August 1981.

19.25 The procedures could be used if the medical screener decided that the complaint need not proceed to the PPC but nevertheless considered that the doctor appeared to have behaved in a manner that could not be regarded as acceptable professional conduct. The medical screener also had to be satisfied that the matter was not trivial and that it was desirable, in the public interest, or in order to maintain the reputation of the medical profession, that the GMC should act. In the Annual Report presented to the Council by the PPC in November 1993, the Chapter XV procedures were described as being **'designed as remedial – to encourage a doctor to review what may have led to a complaint, and preventive – to give advice aimed at avoiding recurrence in future of similar conduct'**.

19.26 Before taking action under the Chapter XV procedures, the medical screener was required to consult two members of the PPC: one medical member, who was engaged in

the same specialty as the doctor in question, and one lay member. If the doctor's conduct had not already been the subject of an investigation by a court, medical service committee (MSC) or statutory tribunal, the members consulted had to be satisfied of the adequacy of the evidence. Although it was not required by the GMC Rules, the practice was that, when the relevant complaint came from a private individual, the complainant would be asked to submit a statutory declaration before the Chapter XV procedures were started. If a preliminary decision was taken that the Chapter XV procedures should be invoked, the doctor's observations were invited. The letter seeking the doctor's observations made clear that no formal disciplinary proceedings were contemplated in respect of the matter about which observations were being sought. The initiation of the procedure effectively ruled out, therefore, the possibility of disciplinary action, even if the doctor's response was unsatisfactory.

19.27 Once the doctor's observations were received (or if s/he did not respond), it was open to the medical screener, with the agreement of the other two members, to direct that a letter should be sent to the doctor, containing such advice as the members (including the medical screener) thought fit. The letter would inform the doctor that, if another complaint were to be received subsequently, the present case would be reviewed. If an enquiry about the doctor's fitness to practise was made to the GMC subsequently, the fact that s/he had received a Chapter XV letter would not be disclosed.

19.28 The Chapter XV procedures could not be used where there had been no previous finding of fact and where the doctor did not accept that there was any foundation for the complaint. In those circumstances, there was nothing the GMC could do, since, when embarking on the Chapter XV procedures, the medical screener would have already decided that formal disciplinary procedures were not appropriate.

19.29 Statistics relating to the number of cases in which action under Chapter XV was taken were reported by the PPC annually to the Council. The statistics show that the Chapter XV procedures were used extensively, particularly in dealing with complaints of poor treatment or substandard clinical practice and with complaints involving allegations relating to the doctor's personal behaviour. Although, until 1985, the number of cases in which Chapter XV letters were sent remained below 20 a year, the numbers increased markedly thereafter. In the year to 31st August 1994 and in 1995, 6% of all doctors in respect of whom the GMC received complaints were sent Chapter XV letters. In 1997, 10% of cases screened (i.e. 192 cases) were the subject of Chapter XV action.

The 1988 Professional Conduct Rules

19.30 The 1988 Professional Conduct Rules left the screening test unchanged. The relevant provision was rule 6(3) which provided:

> **'Unless it appears to the President** (*i.e. the medical screener*) **that the matter need not proceed further, he shall direct the Registrar to write to the practitioner**
>
> **a) Notifying him of the receipt of a complaint or information and stating the matters which appear to raise a question whether the practitioner has committed serious professional misconduct ...'**.

The Period from 1990 to 1996

The Introduction of Lay Screeners

19.31 Until 1990, members of the GMC who were not medically qualified were not involved in the screening process. In 1990, the 1988 Professional Conduct Rules were amended to provide for the nomination by the President (and appointment by the Council) of a non-medical member of the GMC to act as a lay screener. In May 1990, Mr (later Sir) Roger Sims was appointed as a lay screener. In November 1991, he was joined by Sir Maurice Shock. Sir Maurice was later replaced by Professor Christine Chapman. The lay screeners did not screen cases alone. They were required to consider only those conduct cases where the medical screener had made a preliminary decision to close the case. If the lay screener did not agree with that decision, a discussion would take place between the two screeners. Ultimately, if no agreement was possible, the case would be referred to the PPC despite the views of the medical screener. Once the performance procedures were introduced in 1997, lay screeners were involved also in screening cases in which the medical screener had made a preliminary decision that the case did not raise a question either of SPM or of seriously deficient performance (SDP). It is perhaps surprising that lay screeners never played any part in the screening of convictions, particularly since, after May 1990, screeners were given a rather wider discretion in connection with their treatment of convictions: see paragraph 19.33. I shall discuss the role of lay screeners more fully later in this Chapter.

The Medical Screeners

19.32 In November 1992, Dr Steel replaced Dr Fry as principal medical screener for conduct cases and as Chairman of the PPC. Dr Bewley continued to act as an additional medical screener. Dr Michael Wilson was also appointed as an additional medical screener for conduct cases. In September 1995, Sir Donald Irvine became President of the GMC. The screening arrangements continued as before.

The Treatment of Convictions

19.33 In May 1990, the PPC made a direction giving the medical screeners further discretion in relation to convictions. The direction authorised the medical screeners to exercise their discretion in deciding whether to refer to the PPC convictions which related to any offences committed more than five years before notification to the GMC. Discretion was also given to the medical screeners not to refer a conviction to the PPC if the offence was:

> **'... an extremely minor offence which was not ostensibly related to any aspect of the doctor's professional practice and did not involve conduct likely to bring the medical profession in general into disrepute'**.

19.34 In January 1995, the PPC endorsed the direction issued in May 1990. However, the terms of the direction were slightly different from those of May 1990. On this occasion, the medical screeners were given authority to exercise their discretion when deciding whether or not to refer to the PPC:

'... convictions of minor offences not ostensibly related to a doctor's professional practice, nor involving a degree of dishonesty such as to bring disrepute upon the medical profession'.

19.35 In June 1997, a Note was produced for the guidance of new members of the PPC. The Note stated that the PPC had agreed that **'minor motoring offences such as speeding'** need not be referred to it (in fact, it had directed that such cases should not even be referred to the medical screener), but that **'other convictions must be referred'**. In fact, this Note, which was designed to be for the benefit of members of the PPC and was not apparently directed to screeners, was not consistent with the 1995 direction. By that direction, screeners had been given a discretion not to refer to the PPC other types of minor convictions, including some minor cases of dishonesty which they judged insufficient to **'bring disrepute upon the medical profession'**. This may have resulted in members of the PPC having the impression that they were receiving all conviction cases (except minor motoring offences) when in fact they were not.

The Lack of Information about Screening Processes

The Extent of Knowledge among Members of the General Medical Council

19.36 It is evident from what I have said that, up to this time, very few members of the GMC had been involved in the screening process. The process took place in private and was shrouded in a degree of secrecy. Mr Townsend told the Inquiry that screening 'had traditionally been the preserve of only a very few people'. The Council itself had 'really very limited information' about how the screening function was undertaken.

19.37 In 1988, Mrs Jean Robinson, then a lay member of the GMC, expressed concern about the lack of information about the screening process in her publication 'A Patient Voice at the GMC'[1]. She said:

> **'From the time I was appointed to the GMC, and was elected to the Preliminary Proceedings Committee, I was asking for further details of rejected cases.**
>
> **I seemed to be the only member of Council who wanted to know. My request for basic information about the majority of complaints the Council received was sometimes interpreted as distrust of the Screener, who is always an eminent and respected doctor. My view is that I do not care if the Angel Gabriel is Preliminary Screener. Members of the Council and the public have a right to know what kind of complaints the Council receives, whether some kinds are increasing or decreasing, and which get further investigation and which do not.'**

Mrs Robinson was concerned also at the lack of lay involvement in screening decisions and at the absence of anyone within the GMC with the power to review or query screening decisions.

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

19.38 The lack of lay involvement in screening was addressed, as I have said, in 1990, when a non-medical member of the GMC was, for the first time, appointed as a lay screener. However, other members of the GMC continued to receive little information about the screening process. They did not see cases which had been 'screened out'. The GMC had agreed no criteria for the guidance of screeners when deciding which cases should and should not go forward. There was no internal audit or review of the quality of screening decisions. The only hard information available to members consisted of the statistics relating to the cases dealt with by the GMC, which were published on an annual basis. These statistics shed no light on the seriousness of individual allegations. They did, however, show that the proportion of complaints referred by the screeners to the PPC was small. During the period from 1993 to 1995, no more than 15% of the complaints received by the GMC each year (all of which were at that time referred to a medical screener) were referred by the medical screener to the PPC.

The Information Given to Complainants

19.39 Until 1988, the Professional Conduct Rules did not specify whether complainants should receive notification of the fact that their complaint had been screened out or, if so, what information they should be given. The 1988 Professional Conduct Rules provided that a complainant should be notified of a decision by the President/medical screener not to refer his/her complaint to the PPC. However, complainants were to have no right of access to any document related to the case that had been submitted to the GMC by any other person. Moreover, they were not to be entitled to any explanation of the reasons for the decision not to refer, if the President/medical screener directed that no explanation should be given. This power to refuse to give an explanation continued until 2000, when the Rules were changed: see paragraph 19.118. In practice, after 1988, complainants were usually given some explanation of why their case had not been referred to the PPC, although it was not always very comprehensive.

19.40 Neither doctors nor complainants have ever had any right of appeal against, or review of, a decision of a screener, save by means of judicial review. That is an expensive process and one which may be intimidating to many. It was not until 1997 that judicial review was used to challenge a screening decision. Then, for the first time, some light was thrown onto the screening process and screeners were given some idea of whether they were approaching their task in the correct way. For the first time, the GMC gave its screeners authoritative guidance. By the time several cases had gone to judicial review, the GMC and the public were able to gain some insight into the way in which the task was being performed and the criteria, if any, that were being applied.

The Approach to the Screening Process

19.41 I have referred in Chapter 18 to the Training Manual compiled in 1994 by Mr Alan Howes, who worked in the Conduct Section more or less continuously between 1980 and 1994 and was Head of the Section from 1987 until 1994. The 1994 Training Manual was intended to provide training material for new staff in the Section after Mr Howes' move from there in 1994. It provides a useful insight into the practices of the time. Part of the 1994

Training Manual set out guidance on initial procedures and on the role of the preliminary (i.e. medical) screener, based on an internal guidance note for new screeners. That guidance note is no longer available.

19.42 The guidance in the 1994 Training Manual stated that, when assessing whether an individual complaint raised any question of SPM, the staff and screeners had to consider two questions:

> **'(i) Does the behaviour which is the subject of the complaint relate to the doctor's professional work or position?**
>
> **(ii) Is the alleged behaviour so serious that it might justify taking action in relation to the doctor's registration?'**

If the answer to both questions was 'yes', the 1994 Training Manual advised that the case was **'potentially one which falls within the Council's jurisdiction'**. No guidance was given on the criteria to be used when assessing seriousness.

19.43 The 1994 Training Manual went on to say that it was then necessary for screeners to **'look at the case forensically, i.e. to consider whether the available evidence in the case** (*emphasis in original*) **would be sufficient to justify referring the matter for a formal inquiry'**. It observed that the issue of sufficiency of evidence was **'largely a matter of common sense, rather than law'**. The 1994 Training Manual then proceeded to discuss the issue of evidence in a passage which I have already quoted in Chapter 18. In short, the guidance in the Training Manual appears to have created a much 'finer filter' than was envisaged by rule 6(3), which required the screener to refer a case to the PPC **'unless it appears to** (*him/her*) **that the matter need not proceed further ...'**.

A Report about Shipman: the Cases of Mr W and Mrs B

19.44 In Chapter 6, I described the two complaints made locally about Shipman in 1990 and 1992. In the first, relating to Mr W, the Tameside MSC found Shipman to be in breach of his terms of service; he was warned to comply more closely with them in future. He had made a serious error in prescribing an excessive amount of Epilim to an epileptic patient. The MSC's finding was not reported to the GMC at the time it was made. In 1993, another MSC found Shipman to be in breach of his terms of service again, this time in respect of an elderly stroke patient, Mrs B. In 1992, he had refused to visit her in response to a request from her relatives and the MSC found that he had not put himself in a position to exercise proper professional judgement about the need for a visit. The case was referred to the Family Health Services Appeal Unit (FHSAU). In May 1994, Shipman was warned again and a recommended withholding of his remuneration of £800 was confirmed. Shipman now had two MSC findings against him. The FHSAU reported Shipman to the GMC and sent the GMC all the papers.

19.45 The GMC papers show that a caseworker prepared a detailed memorandum for submission, first to Mr Howes and then to Dr Steel, the principal medical screener. The memorandum noted Shipman's convictions in 1976 and the fact that he had been warned by the GMC on that occasion. It set out the facts of both of the more recent cases. In respect of the second case, that of Mrs B, the summary stated that the facts were in issue.

The relatives were saying one thing and Shipman another. The summary did not, however, record that the MSC had preferred the evidence of the relatives or why they had done so, matters that were clearly stated in the papers. The MSC had found that Shipman had failed to put himself in a position to find out whether Mrs B needed a visit. The caseworker said that, in view of the disputed evidence, s/he was quite sure that the case would **'not be a candidate for action within the Rules'**. Later, s/he expressed the view that it would be **'virtually impossible'** to take such action. Nor would there be **'very much point'** in taking action under the Chapter XV procedures; Shipman would only repeat his version of events. The caseworker also noted, however, that it would be unusual for the GMC to do nothing in a case where the MSC had recommended a withholding of £800, which, I infer, was considered at that time to be a substantial sum and to be indicative of a serious breach of the GP's terms of service.

19.46 Mr Howes wrote on the memorandum:

> **'The earlier case is too old for us to act now. The more recent case revolves round evidence which is now obscured by time. It would be difficult to unravel this at this stage. An error of judgment clearly occurred, but the MSC have now dealt with the matter and that seems to me to be sufficient.'**

19.47 Dr Steel noted:

> **'I am in agreement First case is too late and minor second case is borderline Nothing** (*short word indecipherable, possibly 'in'*) **Chapter XV. The latter would be flawed because of lack of admission. Agree no action.'**

19.48 At this time, the GMC was preparing for the introduction of performance procedures and was seeking to discover how many cases might arise. In this connection, Dr Steel appears to have completed a performance assessment form relating to the report about Shipman. The form asked three questions. The first was **'Is there evidence of seriously deficient performance?'** To that, Dr Steel answered **'yes'**. The second asked, **'If so, is there evidence of a pattern of poor performance (as opposed to isolated incidents)?'** To that, Dr Steel answered **'yes – only 2'**. The third asked whether there was also evidence of SPM pointing to conduct proceedings rather than performance action. To that, Dr Steel answered in the negative.

19.49 The case did not go to the PPC. In my view, it should have done. First, although Dr Steel said on the performance assessment form that the case did not show evidence of SPM, he had said in his screening decision that Shipman's conduct in the case of Mrs B was **'borderline'**. That must, in my view, mean that some people would take the view that it did amount to SPM. It seems to me certainly arguable that the facts found by the MSC in the case of Mrs B fell into the category of cases described in the early editions of the Blue Book (the GMC's professional discipline guide) as a serious disregard of professional responsibility or a neglect of a professional duty. The examples of this given in the Blue Book were of failing to visit or to provide treatment for a patient when it was necessary to do so. Moreover, the reliance on the conflict of evidence as a reason not

to proceed was quite unsatisfactory. Even recognising that, at the time, it appears to have been thought correct for screeners to consider the strength of the evidence, the medical screener's decision was plainly wrong. There had been no evidential difficulty for the MSC and there was no reason to suppose that there would be an evidential problem for the GMC if it chose to act. However, the case was closed. I cannot see from the file any sign that closure was agreed by a lay screener as was required by the 1988 Professional Conduct Rules.

Developments in the Screening Process from 1996 to 1997

A Cultural Change

19.50 Mr Townsend said that, prior to the second half of the 1990s, the 'old view' had been that reasons had to be found for referring a case to the PPC. This would suggest that, instead of a presumption that a case would go forward unless it appeared to the medical screener that it **'need not'** proceed further (as provided for by the Rules), the presumption was that a case would not go forward unless there was a positive need for it to do so. It appears that the handling of the report in 1994 about Shipman's conduct in the cases of Mr W and Mrs B was an example of this approach. Mr Townsend said that that view changed in the mid-1990s. He attributed the change in part to the publication of 'Good Medical Practice' in 1995, which he thought had represented a 'cultural change'. This cultural change had, he said, led to a 'greater willingness' on the part of both GMC staff and screeners to allow cases to go forward to the next stage, rather than ruling them out immediately. I am not sure whether that view is borne out by the statistics. Until 1999, of those doctors referred to the screeners, the percentage that were referred on by them to the PPC remained steady at no more than 15%. The proportion referred to the PPC rose sharply (to 25%) in 1999 and again the next year, but that followed (and may be explained by) a significant reduction in the number of cases referred to the medical screeners, with many more cases being closed by the GMC staff. There were other factors also which would have had the effect of increasing the proportion of cases referred to the PPC by screeners in 1999.

19.51 Mr Townsend also said that, in the mid-1990s, there had been a 'review of the legal basis of screening', prompted partly by the formal challenge of a screening decision by means of judicial review and partly by consideration in the GMC office. I think it highly likely that the judicial review to which Mr Townsend referred was the case of R v General Medical Council ex parte White[2]. I shall discuss the decision in that case, which was given in March 1997, later in this Chapter.

The 1996 Policy Studies Institute Report

The Practical Arrangements

19.52 I have already referred to research carried out by the PSI. The PSI team, led by Professor Allen, carried out an analysis of cases dealt with by the GMC during the 12 months from September 1993, which was reported in the 1996 PSI Report. At the time of that Report, screening was carried out by three medical screeners, Dr Steel, Dr Bewley and Dr Wilson.

[2] 18th March 1997 (unreported).

Most of their screening work was carried out at their homes or practice premises, not at the GMC offices. They would fit their screening work around their other professional commitments. The PSI team found that the principal screener, Dr Steel, dealt with 60% of referrals to screeners during the 12 months for which they analysed data. The GMC statistics showed that there were 2294 referrals to screeners in that period (that figure included some cases which were referred to a medical screener more than once). On that basis, Dr Steel must have dealt with about 1376 referrals. Some cases would have been very straightforward. However, in others, there might have been a considerable amount of detail. This obviously represented a very substantial workload, over and above Dr Steel's work as a GP and his commitments as a member of the GMC and Chairman of the PPC. The other screeners handled about 30% and 10% of referrals respectively. Usually, only one of the medical screeners saw each case. Sometimes, however, a medical screener would seek a second opinion from another medical screener or from another medically qualified GMC member whose specialty was relevant to the complaint. As principal medical screener, Dr Steel would give advice and guidance to the other medical screeners, both generally and in relation to specific cases. He would also act as a mentor to new medical screeners.

19.53 A medical screener would receive the case papers, together with a memorandum prepared by the GMC staff. In the case of a complaint from a private individual, the papers might consist of only a single letter. There might or might not be any supporting evidence. If the complaint was from a public body, it might contain a large bundle of evidence collected during a local investigation, together with a report of a MSC hearing. The PSI team noted that the GMC staff would often write long memoranda, containing many comments and giving very clear views about the way in which the case should be handled. I interpose to say that the caseworker had done so in the 1994 case involving Shipman. The screener would record his/her decision on the top sheet of the case papers. The decision might consist of a single word, denoting agreement with the course of action proposed in the memorandum. On occasions, the screener might write a longer comment, giving reasons for his/her decision. In the 1994 Shipman case, Dr Steel gave brief, but intelligible, reasons. There was no obligation for a medical screener to state his/her reasons and, in many cases, they did not. There was no standard form for the screener's response.

Possible Screening Outcomes

19.54 The 1996 PSI Report explained that, if the medical screener was able to make a decision on the information available, there was a range of possible outcomes. First, the medical screener might decide that the complaint raised a *prima facie* case of SPM and should be referred to the PPC. Second, s/he might decide that the complaint did not raise a *prima facie* case of SPM but that the doctor's behaviour nevertheless appeared to have fallen below acceptable standards. In that event, the medical screener might decide that a letter of advice should be sent to the doctor in accordance with the Chapter XV provisions; I have already described the procedure for this. Third, the medical screener might decide that the complaint did not raise a *prima facie* case of SPM and that no further action should be taken in relation to it; in this event, the case would be referred to a lay screener. Only

if the lay screener confirmed the decision of the medical screener to take no further action would the case be closed. If the lay screener disagreed with the medical screener, the case would be referred on to the PPC.

19.55 The analysis carried out by the PSI team in the late summer of 1995 showed that just over half the cases dealt with by the screeners during the year to 31st August 1994 had resulted in one of the three outcomes I have described. The remainder of the cases referred to the medical screeners had been dealt with in a variety of other ways. There was a significant proportion of cases in which a medical screener had approved the recommendation of the GMC staff that a complainant should be advised to direct his/her complaint to NHS or other local complaints procedures. At the time of the PSI research, there was also a sizeable proportion of cases in which the medical screeners had felt unable to make a decision. In such cases, the medical screener would request the staff to seek further information or would ask for the papers to be shown to another screener or a medical expert. Decisions as to whether further information was required were, at this time, left to the medical screeners, rather than being taken by the staff at an early stage. Requests for further information were often made by GMC staff to complainants and sometimes went unheeded. As I explained in Chapter 18, Professor Allen and her colleagues were worried that cases were getting 'lost', particularly when the onus was placed on complainants to take their cases back to local complaints procedures or to provide further information.

19.56 If there appeared to be an issue relating to the doctor's health, a medical screener might send the case to a health screener, who would advise whether it was suitable to be dealt with under the voluntary health procedures. If it was adjudged suitable, it was open to the medical screener to remit the case to the health screener. This course did not require the agreement of a lay screener.

After Screening

19.57 If the medical screener judged that a case warranted no further action, s/he would often approve a draft letter of response to the complainant, which would have already been prepared by a caseworker. If the case was judged suitable for referral to the PPC, the caseworker would write to the complainant (if s/he was a private individual), asking him/her to provide at least one statutory declaration in support of his/her evidence. Upon receipt of the statutory declaration, a letter would then be written to the doctor (pursuant to rule 6 of the 1988 Professional Conduct Rules), notifying him/her of the receipt of the complaint and setting out details of the charges that s/he would face before the PPC. At the time of the PSI Report in 1996, that would be the first time that the doctor had been informed by the GMC of the complaint and had been asked to respond to the complaint. At the time of the screening decision, the screener would not usually have before him/her any response from the doctor. If, however, the referral to the GMC had been preceded by a local investigation, it is likely that the doctor's response to the allegations would appear in the papers relating to that investigation. In those circumstances, it would be available to the screeners.

The Outcomes of Cases Handled by Different Medical Screeners

19.58 The PSI team examined the outcomes of cases handled by individual medical screeners. The principal medical screener, Dr Steel, had been the only medical screener in 67% of

the cases that went forward to the PPC. Comparable figures for the other two screeners were 14% and 6%, respectively. (These percentages do not add up to 100% since some cases had been seen by two – even all three – medical screeners.) In fact Dr Steel had been involved at some stage of the screening process in 77% of the cases which went to the PPC. There was clearly extensive reliance by the other screeners on his advice. Professor Allen and her colleagues concluded, from the discussions they had had with screeners and staff, that cases that appeared more serious were sent to Dr Steel, as principal medical screener. By reason of their seriousness, those cases would be more likely to be referred to the PPC. Thus, it was not surprising that Dr Steel had referred a higher percentage of cases to the PPC than might have been expected had the cases been distributed randomly between screeners.

Reasons for Rejecting a Case

19.59 I have said at paragraph 19.54 that one of the possible outcomes of the screening process was said to be that the medical screener would decide that the complaint did not raise a *prima facie* case of SPM and that no further action should be taken in relation to it; in this event, the case would be referred to a lay screener. The PSI team was told by members of the GMC staff that there were two distinct grounds on which a complaint might be rejected by the screeners as 'not SPM'. The first was where the complaint was judged insufficiently serious or as not relating to professional misconduct (i.e. not occurring in a professional context). The second was where the allegation, if made out, would have been capable of amounting to SPM, but there was, in the screeners' view, insufficient supporting evidence to enable it to be proved. The PSI team observed that, when noting their decisions on cases, screeners rarely commented on the seriousness of the complaint or on the quality of the evidence.

19.60 The Annual Reports of the PPC show that, in 1997, screeners rejected 54% of the 1919 cases referred to them on the grounds that they were **'Not SPM/SDP'** and 18% on the grounds of **'Insufficient evidence SPM/SDP'**. Of the 1203 cases involving allegations of poor treatment, 57% were rejected on the grounds of **'Not SPM/SDP'** and 20% on the grounds of **'Insufficient evidence SPM/SDP'**. Of the 142 decisions made by screeners in cases involving allegations of dishonesty and criminality, 23% were rejected as **'Not SPM/SDP'** and 11% on the grounds of **'Insufficient evidence SPM/SDP'**. The 1998 statistics show that the screeners rejected 28% of the cases referred to them on the grounds of insufficient evidence of SPM or SDP.

The Criteria Used by Screeners

19.61 Professor Allen and her colleagues noted that there were no guidelines or written criteria for assessing the seriousness or gravity of a complaint, or for assessing the adequacy or weight of the evidence in support of it. In an attempt to establish how the screeners were making their decisions, they discussed with GMC staff and screeners what criteria the screeners were using in order to determine whether a complaint raised a *prima facie* case of SPM. The discussions revealed that SPM was generally regarded as having a **'high threshold'**, although some people regarded the threshold as higher than did others. The PSI team reported that there was a **'consensus'** that a decision was reached by:

> **‘(a) ... considering the nature of the allegation and assessing its seriousness or gravity, (b) weighing up the amount, type and nature of the evidence, with particular attention to whether there are witnesses or other corroboration, (c) looking at the past relevant history of the doctor concerned and (d) always bearing in mind that the doctor’s fitness to practise is under consideration with the ultimate sanction being the removal of the doctor’s registration’**.

Other factors considered by some (but not all) of those involved were:

> **‘(e) the importance of assessing the extent to which there was risk to patients or to the public, and (f) whether the action or actions were committed deliberately or with intent rather than by accident or default’**.

It would appear from this that some members of staff or screeners did not have in mind the GMC’s primary duty of protecting patients.

19.62 Professor Allen and her colleagues noted that it was clear from the criteria identified by members of staff and screeners that the weight and quality of the evidence was generally believed to be an important factor in determining whether a complaint raised a *prima facie* case of SPM. They noted also that some of the people to whom they had spoken gave more weight than others to the question of whether the allegation **‘would stand up in a court of law and could be proved beyond all reasonable doubt’**. They believed that this emphasis on the weight and quality of the evidence might have accounted, at least in part, for the rejection by screeners of a high proportion of complaints from private individuals. In cases brought by such individuals, the evidence was likely to have been sparse, and less well ordered and presented than evidence produced by public bodies. There might have been no witness statements or other corroboration.

19.63 Professor Allen and her colleagues recommended the development of guidelines about what constituted SPM, both generally and in particular types of case. They recommended that a **‘hierarchy of gravity’** should be developed for each category of behaviour that might amount to SPM. They also suggested that the GMC should develop and put into use a method of demonstrating how screening and other decision-making had been carried out in a particular case. The object of these recommendations and suggestions was, first of all, to promote consistency in the treatment of all complaints at all stages of the decision-making process. The PSI team was also anxious that the GMC should be in a position to demonstrate, if called upon to do so, precisely how – and by reference to what criteria – a particular decision had been reached. In other words, the PSI team wanted the GMC’s decision-making to be made more ‘transparent’. Only in that way would the GMC be able effectively to defend itself against any allegation of bias, whether racial or otherwise. The PSI Report noted, however, that there was **‘no enthusiasm’** among those whom they had interviewed for developing such written guidelines or criteria or for applying techniques of structured decision-making.

Changes to the Arrangements for Screening following the 1996 Report

19.64 The 1996 PSI Report recommended a number of changes to the arrangements for appointing and training medical and lay screeners. In particular, it recommended

increasing the number and diversity of background of the medical screeners. It suggested appointing as medical screeners some doctors who had dedicated time available to carry out the task of screening, i.e. who would not have to fit in screening around other professional commitments. It also recommended the introduction of training and refresher courses for all screeners and of feedback to them of information about the results of their screening.

19.65 In November 1996, two new medical screeners, Dr (later Professor) Hilary Thomas and Dr Pearl Hettiaratchy, were appointed. Another lay screener, Mrs Rani Atma, was appointed in February 1997. This increase in numbers was partly in response to the recommendations contained in the 1996 PSI Report and partly because of an anticipated increase in the screeners' caseload. The performance procedures were to be introduced in July 1997 and it was recognised that this would place further demands on the screeners, in particular the medical screeners.

The Case of White

The Complaint

19.66 In March 1997, the first judicial review of a screening decision took place in the case of R v General Medical Council ex parte White[3]. The case arose out of the death of a young child who suffered from *spina bifida*. In September 1993, when the child was about 12 months old, he became unwell and his parents took him to hospital. It was thought that he had a urinary infection. He had been vomiting and was dehydrated. He was kept in overnight and was allowed home late the next day. The day after that, his condition deteriorated and his parents summoned their GP. He arrived at about 3pm, examined the child, observed that the child's chest was **'a bit noisy'**, advised that he should take Calpol and fluids and promised to revisit the next day. Shortly after the GP's departure, the child's condition deteriorated further. The child was taken to hospital but died at about 4pm. The cause of death was bronchopneumonia.

19.67 In due course, the parents made a complaint about the GP to the GMC. Initially, they were advised to pursue their complaint locally, but the time for so doing had expired. Then the GMC wrote asking if the parents really wished to pursue their complaint. They did; their medical expert considered that the GP's failure to realise that the child was critically ill at 3pm amounted to **'gross professional misconduct'**. The case was referred to Dr Steel, who screened the case out. The letter explaining his decision, written in November 1995, said that, before disciplinary action could be justified, there had to be clear evidence (to the standard required by a criminal court) that the doctor had failed to put himself in a position to assess the child's condition, or evidence that he had deliberately disregarded his responsibilities to the child in some way. As it appeared that the doctor had examined the child and had exercised his clinical judgement, the screener took the view that there was no evidence of SPM. On 3rd January 1996 (which, I observe, was shortly after the decision of the Privy Council in McCandless v General Medical Council[4], to which I referred in Chapter 17), the parents' solicitors replied saying that the screener's approach

[3] 18th March 1997 (unreported).
[4] [1996] 1 WLR 167.

was wrong. Their point was that negligence, if serious enough, could amount to SPM. The doctor had examined the child but had failed to realise that the child was dying, although the signs must have been obvious. A month later, the GMC replied, saying that the case had been reconsidered but that this had led to the same conclusion as previously. Errors in diagnosis, made in good faith, did not of themselves raise an issue of SPM. The fact that the child had died within a **'certain'** period following examination could not, of itself, be regarded as evidence of SPM. Mr Justice Collins, who heard the application for judicial review, was critical of that reply because, as he observed, it suggested that negligence *per se*, in the absence of bad faith, could not raise an issue of SPM. That was wrong and he could understand why the parents had sought judicial review.

The Judicial Review

19.68 In the course of the proceedings for judicial review, the caseworker's memorandum was produced; in it, the caseworker had expressed the view that, as it was clear that the doctor had examined the child, it could not be said that he had failed to put himself in a position to assess the child or had deliberately disregarded his responsibilities to him. Mr Townsend, who was then the Head of the Conduct Section, noted on the file that, unless the doctor should **'beyond doubt'** have made an immediate referral to hospital, no question of SPM arose. (I interpose to observe that it appears from this that Mr Townsend was of the view that the screening process was intended to apply a very fine filter and that only clear cases of SPM should be referred to the PPC.) The note of Dr Steel's screening decision said that he agreed with Mr Townsend. This was a one-off failed clinical judgement. He continued:

> **'It can be seen in hindsight the baby was poorly but there is no evidence that the doctor disregarded responsibilities.'**

19.69 In an affidavit sworn for the judicial review proceedings, Dr Steel set out all the criteria that he generally took into account in deciding cases at the screening stage. He then applied those criteria to the facts of the case and said that he had formed the view that the doctor had made an error of clinical judgement, which might give rise to a claim in negligence. However, although he was **'well aware'** that negligence might be so serious as to amount to SPM, in his judgement this was not such a case. The Judge accepted that Dr Steel had approached the matter in the way he described in his affidavit, despite the fact that this was not the way in which his views had been represented in correspondence. He decided that the approach did not disclose an error of law and dismissed the application for judicial review.

19.70 It is worth noting that rule 6(3) of the 1988 Professional Conduct Rules, which governed the screener's decision, was not analysed in the judgement. It does not appear that the applicant's case was based upon the GMC's failure to apply the correct statutory test. Rather, the argument was that the screener had wrongly directed himself that negligence, however serious, could not amount to SPM. Once the Judge was persuaded that the screener had not thought that and had applied his mind to the seriousness of the negligence, the case was over. It was not until the case of R v General Medical Council ex parte Toth[5] that the meaning of rule 6 came under scrutiny at judicial review.

[5] [2000] 1 WLR 2209.

The 1997 Screeners' Handbook

19.71 In July 1997, the GMC issued, for the first time, a Screeners' Handbook (the 1997 Screeners' Handbook). According to the Annual Report of the PPC, presented to the Council in May 1997, the Handbook was intended to **'set out explicit, published criteria for the main screening decisions'**. Presumably, it was intended to meet the PSI recommendations. Its production was timed to coincide with the introduction of the new performance procedures. The Preface, written by Dr Steel, indicated that the purpose of the 1997 Screeners' Handbook was to assist the GMC in its work and to explain to those outside the GMC the principles which were applied by screeners when making decisions. Mr Townsend, who was Head of the Conduct Section at the time the Handbook was published, said that the fact that the 1997 Screeners' Handbook was a public document was a 'noticeable change', part of a move by the then President of the GMC, Sir Donald Irvine, to 'open up' the GMC's decision-making processes. It seems to me, having read the judgement in the case of White, in which extracts from Dr Steel's affidavit are cited, that the contents of the Handbook were to some extent informed by that case.

19.72 The 1997 Screeners' Handbook explained the framework within which the screeners worked. It emphasised that:

> **'Complaints are screened out rather than in, that is, the fitness to practise procedures are based on the premise that the GMC will take action, but, if it cannot, it must justify not doing so.'**

Mr Townsend observed that the Handbook reflected the change in the approach to screening which I have already mentioned. He said:

> **'... previously, at least psychologically I think, the question had been ''Does the complaint jump over the first hurdle to enable it to proceed to the PPC?'' That was replaced with the view, which I think is reflected quite clearly in the first edition of the Screeners' Handbook, that there had to be cogent and explained reasons why a case was not to proceed; in other words, that the screening was a coarse sieve simply to get rid of the complete non-starters as distinct from a more sophisticated filter.'**

19.73 The 1997 Screeners' Handbook gave guidance on the order in which issues of health, conduct and performance should be considered by the screeners and on the various steps open to screeners to obtain further information or advice or expert opinion before taking a decision. The 1997 Screeners' Handbook advised:

> **'In each case, the medical screener's initial task is to consider whether a question of spm arises in relation to a doctor's conduct. The GMC's Rules state that a case which appears to raise a question of spm shall normally be referred to the PPC.'**

The reference to the **'GMC's Rules'** is presumably a reference to rule 6(3) of the 1988 Professional Conduct Rules and to the fact that a case should be referred to the PPC unless it appeared to the medical screener that it **'need not proceed further'**. Rule 6 is not quoted in the Handbook.

19.74 Screeners were advised that, in order to keep abreast of what the PCC considered to be SPM, they should read the minutes of the PCC as they were published. They were also advised that they should be aware of any Privy Council decisions concerning the meaning of SPM. (It was not long since the important decision in McCandless.) They were further advised to 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.'**

These were most of the criteria that had appeared in Dr Steel's affidavit in the case of White and which had, in effect, been approved by the Judge (although without his having considered the statutory provision). Dr Steel had also included **'the detail and nature of the evidence and the length of time since the relevant events occurred'**. Those were not included as criteria in the 1997 Screeners' Handbook. The Handbook contained no guidance about how grave a negligent act or omission had to be before it was capable of amounting to SPM. Nor was any guidance given as to the relative weight to be attached to the various criteria listed above.

19.75 It was noted that the existence of previous complaints, incapable of substantiation, should not be taken into account. Previous complaints could be taken into account only if, for example, they indicated that the complainant was malicious or disturbed, or if they indicated that the doctor might be the subject of some form of vendetta. They could also be taken into account if they had already been the subject of formal GMC disciplinary action. Thus an unsubstantiated complaint of indecent assault would be left out of account if a second complaint of a similar nature were received. There does not appear to have been any recognition of the possibility that an unsubstantiated account might be true or any realisation that the receipt of more than one complaint of a similar nature, even if unsubstantiated, ought to give rise to concern.

19.76 Screeners were advised that, if a question of SPM arose, if the case complied with the necessary procedural requirements (one such requirement would be the provision by a complainant of a statutory declaration) and if no further evidence in support was required at the screening stage, the case should be referred to the PPC as soon as possible. There were two circumstances when that should not be done. The first of these was where referral to the PPC should, for some good reason, be deferred and this could be done without harm to the public interest. Deferral would be appropriate, for example, where a case was to be referred back to local complaints procedures or for investigation by the

police or some other organisation. The second circumstance was that some wholly exceptional reason existed why the PPC did not need to consider the complaint. This might arise where the doctor was terminally ill or where there was a risk that the bringing of disciplinary proceedings would amount to an abuse of process.

19.77 The 1997 Screeners' Handbook also dealt with the situation where a screener found that a case raised a question of SPM but that there was insufficient evidence to support the allegation. In this connection, screeners were advised:

> **'... it is not the role of the screener to attempt to decide whether any, or all, of the facts alleged in a case are true. It is for the PCC alone to make findings of fact.**
>
> **It is not possible to lay down precise criteria about the type, the quantity or the apparent quality of evidence required to justify referral of a complaint to the PPC, as that will inevitably depend on the nature and circumstances of each case. In many cases it will be sufficient to inform the complainant what further information or evidence (which may simply be a sworn statement) appears to be required, and ask the complainant to provide it.**
>
> **In all cases where it appears to the screener that a question of spm arises the screener must bear in mind that:**
>
> - **The Rules simply require that it must appear to the screener that there is a ''question whether the practitioner has committed spm''.**
> - **The screener should not, at the screening stage, attempt to resolve conflicts of evidence between the doctor and the complainant.**
> - **The PPC has the power to adjourn a case for further evidence, and evidence may also be obtained following referral of a case by the PPC to the PCC.**
> - **If in doubt, and if further inquiries or consultation with other screeners cannot resolve the doubt, the case should be referred to the PPC.'**

19.78 It appears that the 1997 Screeners' Handbook recognised that Dr Steel's inclusion (in his affidavit in White) of the consideration of the detail and nature of the evidence as one of his criteria had been wrong. Screeners were advised that complaints involving allegations that were obviously irrational, or self-evidently untrue, need not be taken forward, even if a question of SPM would arise if the allegations were true. However, screeners were also reminded that they must not, in any other circumstances, attempt to decide whether any, or all, of the facts complained of were true. They were warned that if there was **'*any* doubt at all'** as to the rationality of an allegation, the case should be considered as one which appeared to require action by the GMC, but where there was insufficient evidence to proceed at that stage. Further evidence should then be sought until it became clear whether or not there was a valid issue about the doctor's fitness to practise for the GMC to consider.

19.79 The 1997 Screeners' Handbook stated that, where further information was requested from a complainant and the request had not been complied with, there should be an effort to persuade the complainant to provide the necessary information, bearing in mind that GMC action might be necessary to protect other patients or the public and that the complainant might not be the only person affected. This advice reflected the concerns of the PSI team that complaints were being 'lost' because of the failure on the part of complainants to respond to requests by the GMC to provide further information.

19.80 The 1997 Screeners' Handbook also signalled a change of procedure in relation to the informing of doctors about complaints made against them. Up to 1997, doctors were not in general informed of complaints unless and until a decision had been taken to refer a case to the PPC and (in the case of a complaint by a private individual) unless and until a statutory declaration had been obtained from the complainant. At that stage, the doctor would be invited to submit any explanation s/he had to offer. (The position in relation to convictions was different: see paragraph 19.20.) The 1997 Screeners' Handbook advised that screeners were to decide, at an early stage, whether a complaint should be copied to the doctor. In most cases, that would be done before a decision was taken whether to refer the case to the PPC. The effect of this was that, from 1997, screeners would often have the doctor's response to a complaint available to them when considering a complaint. At that time, there was no opportunity for the complainant to see and comment on the doctor's response. A complaint would not be copied to the doctor before screening if it was clear from the outset that the case should be referred to the PPC. In that event, the doctor would be informed about the complaint and asked for his/her response at the same time as s/he was notified that the case had been referred to the PPC.

19.81 The contents of the 1997 Screeners' Handbook make it plain that the GMC had recognised that, in the past, the screening process had not been carried out in accordance with the Rules. The filter applied had been far too fine; too many cases had been 'screened out'. The 1997 Screeners' Handbook represented a real attempt to change that culture. However, it appears that some aspects of the advice that were designed to change the culture were either ignored or quickly fell into disuse. Moreover, there was no attempt to keep the advice up to date and to remind screeners of the principles on which they should act. Despite the many important changes that took place in the following years, the Inquiry has been told that no further version of the Screeners' Handbook was produced until as late as November 2002.

Developments in the Screening Process since 1998

19.82 Additional medical screeners were appointed, making a total of seven in post during most of 1998 and 1999.

The Case of Toth

The Complaint

19.83 Despite the advice given in the 1997 Screeners' Handbook, it is clear that some screeners at least did not apply the tests it set out. In March 1998, a medical screener considered a

complaint by the father of Wilfred Toth, a five year old boy who suffered from glycogen storage disease. Wilfred had become hypoglycaemic and his father, Mr Arpad Toth, had called the family's GP, Dr Jarman, who made a home visit. Mr Toth alleged that he and his partner had told Dr Jarman of Wilfred's condition and of their opinion that he was in urgent need of intravenous glucose. Dr Jarman failed to administer glucose and instead treated Wilfred with sedative drugs. Dr Jarman later denied that he had been informed of Wilfred's condition or of his need for intravenous glucose. Mr Toth alleged that his untreated condition led to Wilfred's death a week later. Mr Toth had complained in the first instance to the local Family Health Services Authority (FHSA). A MSC hearing had followed, at which the MSC found Dr Jarman in breach of his terms of service in failing to take account of Mr Toth's knowledge of Wilfred's condition. No sanction was imposed. Some time later, a claim for damages in respect of Wilfred's death was settled on payment by Dr Jarman of the sum of £10,500, a sum which implies an admission of full liability. Mr Toth complained to the GMC about Dr Jarman's conduct.

The Screening Decision

19.84 Having considered the papers, the medical screener decided not to refer the case to the PPC. A lay screener confirmed that decision. A letter was written to Mr Toth (on 23rd March 1998, i.e. within a year of the production of the 1997 Screeners' Handbook) explaining the decision:

> **'There is a clear conflict of evidence between your version of events and that of Dr Jarman's** (*sic*) **on the** (*matter of disclosure of the need for intravenous glucose*)**. The standard of proof which the GMC works to, by law, is that of beyond reasonable doubt ... Therefore, unless you are able to provide further evidence of a legal standard ... the members have concluded that there is no prospect of your allegations being proved to the required standard, and no further action can be taken.'**

I interpose to say that either the medical and lay screeners or the caseworker who drafted the letter, or possibly all three, seem to have been unaware of the contents of the 1997 Screeners' Handbook insofar as it related to the approach which screeners should take where there existed a conflict of evidence. If aware of it, they had not heeded its contents. Mr Toth made further representations but, four months later, the same medical screener made a second decision confirming the first decision. On that occasion, the lay screener was not consulted.

The Judicial Review

19.85 Mr Toth sought permission to apply for judicial review in respect of both decisions. The GMC obtained legal advice on the application. The advice was received in August 1998 and was to the effect that the screeners had not followed the correct procedure in making their first decision. It was not the role of the screeners to resolve conflicts of evidence. Moreover, the medical screener had had no jurisdiction to reconsider the complaint after the first decision had been made. Nor, as the Judge subsequently found, was the second decision valid, since no lay screener had concurred in it. Having received that advice, the

GMC consented to an order quashing the decisions and directing a reconsideration of the case by a different medical screener. The case went before the High Court because Dr Jarman objected to the reopening of his case on the grounds that it would be unfair to him. Judgement in the case was given in June 2000.

19.86 The Judge, Mr Justice Lightman, considered the meaning of the words used in rule 6(3) of the 1988 Professional Conduct Rules to describe the duty of the screener. That duty was, as I have said, to decide whether the matter **'need not proceed further'**. He contrasted that duty with the function of the PPC, which was, by section 42(2) of the Medical Act 1983, to decide whether the case **'ought to be referred for inquiry by the Professional Conduct Committee or the Health Committee'**. He said that the screener's role was:

> **'... to decide whether a negative state of affairs exists, namely whether the complaint need not proceed further (as in the ordinary course it would) to the PPC: the only conclusion on the merits of the complaint required of him before he allows the complainant to proceed is that (as the screener is required to inform the practitioner) the matters stated ''appear to raise a question whether the practitioner has committed serious professional misconduct'' '**.

19.87 The Judge construed the 'need' referred to in rule 6(3) as being 'the need to honour the legitimate expectation that complaints (in the absence of some special and sufficient reason) will proceed through the PPC to the PCC'. He went on to say:

> **'The absence of ''need'', of which the screener must be satisfied before he can halt the normal course of the complaint to the PCC, connotes the absence of any practical reason for the complaint so proceeding and that for the complaint to proceed to the PCC would serve no useful purpose. There may be no need because there is nothing which in law amounts to a complaint; because the formal verification** (*i.e. the statutory declaration*) **is lacking; because the matters complained of (even if established) cannot amount to serious professional misconduct; because the complainant withdraws the complaint; or because the practitioner has already ceased to be registered. Wider questions as to the prospects of success of the complaint as to whether the complainant is acting oppressively or as to the justice of the investigation proceeding further do not lie within the screener's remit. So far as they may go to the issue whether the complaint ought to proceed they fall within the remit of the PPC. It is not for the screener to arrogate to himself the role of the PPC and decide whether the complaint ought to proceed further, still less to arrogate to himself the role of the PCC and weigh up conflicting evidence or judge the prospects of success. He must respect the role assigned by the Rules to the PPC (for which the PPC is armed with investigative powers) and recognise that his duty is only to act as a preliminary filter before the more substantive role as filter is exercised by the PPC.'**

19.88 He observed further:

> **'In the exercise of their respective jurisdictions the screener and PPC should be particularly slow in halting a complaint against a practitioner who continues to practise; as opposed to one who has since retired, for the paramount consideration must be the public's protection in respect of those continuing to practise; and they should at all times bear in mind the role of the HC whenever questions arise of impairment of fitness to practise by reason of physical or mental condition.'**

19.89 The Judge's conclusion, in the end, was that it would not be unfair to Dr Jarman if the screener's decision were set aside and Mr Toth's complaint were reopened. However, the importance of the case lay in the Judge's analysis of rule 6(3) and of the screening function. In effect, it threw retrospective light on the process of screening as it had been carried out during the past 30 years, and possibly even longer. It demonstrated that screeners had exceeded their powers when they had based their decision on their view of whether the complaint amounted to SPM (as opposed to whether it could do so) and of whether the evidence was sufficient to prove the case. That is not to criticise them personally. They were not lawyers. They had been doing the job as others had done it before them. But it is surprising that, until 1997, nobody in the GMC had apparently felt handicapped by the absence of any guidance as to how screeners should approach their important task.

19.90 Following the decision in Toth, which was handed down in June 2000, the screening test was changed in August 2000: see paragraph 19.120. However, no corresponding change was made to the 1997 Screeners' Handbook. Mr Robert Nicholls, a lay member of the GMC who was Chairman of the PPC between November 1999 and June 2003, told the Inquiry that it was his impression that the proportion of cases referred by the screeners to the PPC increased after the decision in Toth because screeners became more cautious about closing cases. That impression is not borne out by the statistics. It is true that the GMC statistics show that the proportion of cases referred by screeners to the PPC rose from 30% in 1999 to 39% in 2000. However, the proportions dropped back again to 27% and 25% in 2001 and 2002. In 2003, 33% of cases were referred. However, the numbers of referrals went up from 466 in 2000 to 600 in 2001. It may be that it was this increase in numbers which gave Mr Nicholls the impression that the proportion of cases referred had increased.

Further Work by the Policy Studies Institute in 1998

19.91 In 1998, Professor Allen and her colleagues were commissioned to carry out a follow-up study. Before starting that follow-up study, they conducted an 'intervention phase', during which they advised the GMC on certain changes of procedure which should be introduced, including changes to the screening procedures. The idea of the intervention phase was to identify changes which should be made to the procedures before the PSI team carried out the research which was to form the basis of its 2000 Report.

19.92 In an attempt to cut down the screeners' workload and to avoid duplication of effort, it was agreed that, from March 1999, screeners should not be sent cases which were

considered by the GMC to be clearly outside its remit. Instead, those cases would be dealt with by the GMC staff without reference to a screener. This process of 'filtering out' cases by the GMC staff had the effect of increasing (in fact, almost doubling) the proportion of cases referred to screeners which were sent on by them to the PPC. The PSI's figures show that, in 1999, the screeners referred 25% of the doctors they dealt with to the PPC; in 2000, the proportion was 22%. In 1997 and 1998, the figures had been about 11% and 12%. In the GMC FTP statistics for 1999, this increase was attributed in part to a change in the approach to evidence, which, it was said, had taken place in March 1999, as a result of legal advice (possibly advice received in connection with the case of Toth). From March 1999, screeners no longer considered whether there was **'sufficient evidence to substantiate the allegation'**. Instead, they **'could decide to close a case only if there was no prospect of obtaining probative evidence'**. There does not appear to have been any amendment of the 1997 Screeners' Handbook to reflect this changed approach. However, if such a change of approach had been instituted in March 1999, it might have contributed to the increased proportion of cases referred by screeners to the PPC.

19.93 In September 1998, it was agreed between the GMC and the PSI team that, unless there appeared to be a risk to the public, screeners should be sent cases only when there was sufficient information available to enable them to make a substantive decision. Members of the administrative staff, rather than the screeners, would assume primary responsibility for identifying any further information that was required and for obtaining it. Only when that had been done would the case be submitted to the medical screener, if appropriate. It was also agreed that, in the absence of a perceived risk to the public, cases involving doctors whose identities had not been established would not be sent to the medical screeners. Before 1998, virtually all complaints received by the GMC were referred to the medical screeners. As a result of these various changes, the percentage of complaints received by the GMC which were referred to the medical screeners decreased. The PSI's figures show that, in 2001, only 41% of complaints went to the medical screeners. The GMC's own figures reveal that the percentage dropped to about 35% in 2003.

19.94 In addition, the GMC agreed that a more structured approach to screening should be adopted. Standard forms, to be known as screening decision forms (SDFs), were designed by the PSI team in consultation with the GMC. The SDFs were intended for use by caseworkers and screeners as a prompt to ensure that they followed the essential steps of the decision-making process. They were intended also to be a record of that process and, thus, a tool for analysis in the future. It was hoped that they would promote clarity, consistency and transparency.

19.95 The structure of the SDFs divided complaints into four main categories, namely:

(a) complaints which were suitable for closure by GMC staff without reference to a medical screener

(b) reports of convictions, which were to be referred by medical screeners to the PPC except when they were referred into the health procedures

(c) complaints which 'by definition' raised issues of SPM ('SPM by definition' cases). These comprised complaints involving dishonesty, dysfunctional conduct, sexual

assault or indecency and violence. A requirement was introduced that all such complaints should be referred automatically by medical screeners to the PPC unless the screener felt that there were overwhelming reasons for not doing so.

(d) complaints which required the exercise of discretion on the part of the screeners in deciding whether or not they should be referred to the PPC or to the performance procedures ('SPM or SDP by discretion' cases).

19.96 Cases falling within category (d) were, in the main, complaints about poor treatment/substandard clinical practice. Screeners were permitted to exercise their discretion in deciding whether to refer such cases to the PPC. The purpose of the introduction of 'SPM by definition' was to reduce the proportion of complaints in respect of which screeners were permitted to exercise discretion and, thereby, to promote consistency and to guard against bias and accusations of bias. I shall describe the history of the operation of the 'SPM by definition' category later in this Chapter.

19.97 The SDFs also required medical screeners to record, in relation to those cases referred to them, an assessment of whether they believed that there was a current or imminent risk to the public arising from the complaint or conviction. The primary reason for this was to assist in the decision whether an interim order (suspending or imposing conditions on a doctor's registration pending his/her appearance before a FTP committee) might be necessary. At the time the SDFs were first introduced, medical screeners were also required to record their assessment of the seriousness of the doctor's alleged conduct using a four-point scale. This assessment was intended to form the basis for analysis of screening decisions in the future. If the medical screeners decided that a case did not raise an issue of SPM or SDP, they were required to record their reasons on the SDF.

The 2000 Policy Studies Institute Report

The Analysis of Screening Decisions

19.98 Initially, GMC staff and screeners had difficulty in getting into the habit of recording the relevant data on the SDFs. The 2000 PSI Report described the introduction of the SDFs as **'a painful process'**. There was a four-month 'pilot exercise' in the early part of 1999. The SDFs were then brought into use on a permanent basis. In the early part of 2000, Professor Allen and her colleagues analysed the contents of the SDFs completed by the medical screeners during the period from 1st July to 31st December 1999.

19.99 The PSI team analysed 792 SDFs which had been completed during that six-month period. By that time, the number of medical screeners was seven. The analysis revealed significant variations between the medical screeners in the outcomes of their screening. One medical screener referred 10% of cases that s/he screened to the PPC, while another referred 36%. This suggested that the threshold at which medical screeners felt it appropriate to refer a case on to the PPC differed from screener to screener.

19.100 The analysis also demonstrated striking differences between medical screeners' assessments of risk and seriousness. Two medical screeners considered that there was a current or an imminent risk to the public in one third or more of the 'SPM by definition' cases they screened, while two others considered that there was no risk at all in any of the

cases they dealt with. In relation to 'SPM by discretion' cases, two of the medical screeners (the same two who had identified a risk in a high proportion of 'SPM by definition' cases) considered that more than 40% of cases they screened posed a risk. By contrast, three screeners thought that less than 10% of their cases posed a risk. One medical screener rated nearly 90% of 'SPM by definition' cases that s/he screened as **'very serious'**, while another assessed only 20% of such cases as **'very serious'**. Classification by medical screeners of 'SPM by discretion' cases as **'not at all serious'** ranged between 28% of the cases handled by one medical screener and 70% of cases screened by another.

19.101 It was difficult to draw any firm conclusions from the variations observed because, as became evident during the PSI study, the distribution of cases to screeners was not random. Thus, the differences could have been explained by bias in the distribution of cases, i.e. by some screeners deliberately being given a greater number of serious cases than others. It could also have been that, by chance, certain screeners were allocated cases of a higher degree of risk and seriousness than those allocated to other screeners. However, the PSI team regarded it as unlikely that either of those possibilities could alone have accounted for the wide range of assessments which they observed. They regarded it as likely that the variations were at least partly due to the fact that different screeners were applying different standards and criteria when judging 'seriousness' and 'risk'.

The Need for Agreed Standards and Criteria

19.102 The marked variations between screeners in terms of the outcomes of the cases screened, and the extent to which they differed in their assessments of the risk and seriousness of cases, caused Professor Allen and her colleagues to reiterate the need (which they had identified in their first Report) for all those involved in the GMC's FTP procedures to have a common understanding of the standards, criteria and thresholds to be applied at the various stages of the procedures. They believed that the lack of any such common understanding had led to inconsistency in the past. The analysis of SDFs which they had conducted suggested that screeners were applying their own personal interpretations of the threshold for SPM. As a result, cases which might have been referred to the PPC by one screener were considered not to raise an issue of SPM by another. This lack of consistency applied equally to decisions of the PPC, as I shall explain in Chapter 20.

19.103 The PSI team identified a need for detailed guidance that could be understood both by doctors and by the general public. Professor Allen told the Inquiry that, while the GMC's publication '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 ...'**.

19.104 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'. The 2000 PSI Report recommended that:

> **'The GMC should ensure that all those involved in the fitness to practise procedures have a common understanding of what does and does not constitute serious professional misconduct. Guidelines should be drawn up to ensure that a clear and agreed definition can be put into operation by all GMC staff, screeners and members of committees. These guidelines should make clear a) what factors should be taken into account in determining the outcome of cases; b) what standards should be applied in reaching decisions; c) at what point cases ''reach the threshold of serious professional misconduct'' and represent a departure from the standards of conduct expected of doctors ''sufficiently serious to call into question a doctor's registration''.'**

19.105 The PSI team recognised that the existing confusion and inconsistency about the threshold for SPM gave rise to problems not only within the GMC. It also presented a difficulty for members of the public and public bodies who might wish to make a complaint against a doctor. Accordingly, the 2000 PSI Report recommended that:

> **'The GMC should develop clear protocols defining the types of cases which do and do not come within the jurisdiction of its fitness to practise procedures. These should be made public and should be available to anyone who wishes to complain about a doctor.'**

19.106 Professor Allen told the Inquiry that it was clear that there was confusion both inside and outside the GMC about the types of case that were suitable for referral to the GMC. This was why she and her colleagues thought it appropriate for there to be clear protocols, setting out what was and was not likely to raise an issue of SPM or SDP. This would assist the GMC by relieving it of the burden of a lot of inappropriate complaints. It would also spare members of the public the disappointment of having their complaints rejected.

Problems with Complaints about Poor Treatment and Substandard Clinical Practice

19.107 Professor Allen and her colleagues considered that particular problems existed in applying the concept of SPM to complaints about poor treatment and substandard clinical practice. I agree with that view. SPM is an appropriate expression when the conduct in question comprises, for example, indecent assault, fraud or the dishonest acquisition of controlled drugs. In the context of clinical practice, the word 'misconduct' seems to imply a deliberately or recklessly wrongful act or omission. However, the law is clear that negligence, if serious enough, can amount to SPM. It seems to me that such an expression as 'deficient clinical practice' would more comfortably embrace failures which included acts or omissions that were negligent, as well as those which were deliberate or reckless.

19.108 Professor Allen reported that, during the period from 1997 to 1999, complaints about poor treatment and clinical practice accounted for about 70% of all the complaints that came to the GMC. She told the Inquiry that there was room for different interpretations

where allegations about treatment and clinical practice were concerned. Different interpretations resulted in inconsistency. At the time of writing its 2000 Report, the PSI team found **'undoubted confusion and inconsistency'** in the way that such complaints were handled. Professor Allen and her colleagues therefore recommended that clinical failures should be graded on a hierarchical scale, ranging from those which could never give rise to a question of SPM to those which would always do so. Criteria should be established by which the seriousness of a complaint should be measured. They believed that these steps would result in a much greater consistency of approach to complaints about clinical treatment.

The Reasons Given by Medical Screeners for Their Decisions

19.109 Some limited insight into the approaches of different medical screeners was given by their recorded reasons for concluding that a case did not raise an issue of SPM. Some wrote only brief comments; others gave much more detailed reasons. The most common reason (given in 26% of cases) for screening out a case was that there was **'no evidence of serious professional misconduct'**. Usually, no further reason was given. In 10% of cases, the reason given was that the case did not reach the **'threshold of SPM'**. In some cases, no further explanation was given and it was consequently not clear on what basis the medical screener had made his/her judgement.

19.110 The second most common reason (20% of cases) for screening out a case was that the treatment or management of a patient had been **'reasonable'** or **'appropriate'**. Medical screeners who gave this reason often offered a clear account of the factors that they had taken into account. By this time, the practice had been instituted of seeking a response to a complaint from the doctor complained of before the screening stage. Medical screeners who gave 'reasonableness' or 'appropriateness' as their reason for rejecting a complaint often referred to the doctor's response.

The Relevance of the Quantity and Quality of Evidence to Screening Decisions

19.111 As I have already said, the 1996 PSI Report had shown that by far the single most important factor in determining whether a complaint went forward for action by the GMC was whether the complaint came from a public body or from a private individual. Complaints from public bodies were much less likely than those from private individuals to result in a screening outcome of no SPM or SDP or of insufficient evidence.

19.112 The analysis of screening decisions in the years 1997, 1998 and 1999 carried out by the PSI team showed that this pattern was continuing. Professor Allen and her colleagues pointed out that complaints from public bodies usually contained far more evidence than those from members of the public. This was because those complaints were likely to have been subject to some form of previous investigation or inquiry, whereas the GMC would not, in general, have taken any steps to investigate a complaint made by a private individual. The result was that medical screeners were usually judging complaints from the two different sources on the basis of very different material. The PSI team noted that medical screeners were required only to decide whether a complaint raised an issue of SPM. In other words, if the allegation (if true) would amount to SPM, the case should go

forward to the PPC. The PSI team suggested that medical screeners might have attached more weight to the greater level of evidence presented by public bodies than to the apparently less well-supported allegations made by members of the public, despite the fact that the complaints from the two different sources might have raised similar issues. Also, many complaints from public bodies related to matters in respect of which there had already been findings made against the doctor by another body, such as an independent review panel (IRP). The PSI team suggested that these findings might, in some circumstances, have been regarded by medical screeners as adding weight to their judgement that a complaint raised an issue of SPM.

19.113 I can see why the PSI team was concerned about these findings and thought that they might show that medical screeners were attaching weight to the amount and orderliness of the evidence available. That would have been wrong. However, I do not think that it should be assumed that they were doing that. It seems to me likely that a higher proportion of cases referred by public bodies would be of a serious nature, simply because the public body had exercised an informed judgement about whether the case should be reported to the GMC. However, I can also see that, if the screeners had become accustomed to seeing well-prepared cases reported by public bodies giving rise to serious issues, there would have been a danger that they would underestimate the seriousness of the allegations contained in poorly prepared cases coming from private individuals. They may also have been fortified by the judgements of other bodies although, it must be said, they did not always follow them. It seems to me that the real problem was that the GMC did not investigate complaints that came in a 'raw' uninvestigated state. Such evidence as was available from private individuals was likely to be scanty and might well be poorly presented. It is not at all surprising that more of such cases should fail at the screening stage.

A Change in the Chapter XV Procedures

19.114 In 1999, the Fitness to Practise Policy Committee (FPPC) of the GMC decided that use of the Chapter XV procedures should be discontinued. Documents considered at the relevant meeting recorded that the reason for this was that the **'rather cumbersome process'** could take **'several months to reach a conclusion'**. This was undoubtedly the case. However, Professor Allen and her colleagues noted in the 2000 PSI Report that it had been clear for some time that some cases which raised issues of SPM had not been referred to the PPC but were instead being dealt with under Chapter XV. They said that the FPPC had shared their concern about this, and that this concern had been a factor in the decision to discontinue the Chapter XV procedures. The fact that the medical screeners might have been using Chapter XV procedures to deal with cases that raised issues of SPM would be particularly concerning as, for the Chapter XV procedures to have been invoked in the first place, these must have been cases in which the evidence was not disputed by the doctor concerned. Such cases should plainly have been referred to the PPC.

19.115 The July 2000 Standing Orders contained a revised version of Chapter XV. This provided for cases where the medical screener considered that the doctor's conduct or professional performance did not raise a question of SPM or SDP but where the conduct

appeared to fall short of acceptable standards as laid down in 'Good Medical Practice' or other published GMC guidance and where it was desirable in the public interest that the doctor should be given advice. In such cases, the revised version of Chapter XV provided that the medical screener should consult a lay screener on the question of whether the doctor should be given advice and, if so, on the terms of the advice to be given. If the screeners decided to send a letter of advice, this was done. There was no opportunity, as there had been under the old Chapter XV procedures, for the doctor to object. Letters of advice were confidential, save that complainants were told that a letter had been sent and were informed of the terms of the letter. A letter of advice did not form part of the doctor's FTP history, either for internal GMC purposes or in response to an external enquiry about the doctor's FTP history.

Other Changes Occurring in 1999

19.116 In November 1999, during the time that the PSI team was carrying out its study, Dr Steel retired as a medical screener and as Chairman of the PPC. Meanwhile, the GMC had decided, in anticipation of the coming into force in October 2000 of the Human Rights Act 1998, that the functions of the screeners and the PPC should be separated. From November 1999, screeners (medical, health and lay) were no longer eligible to sit on the PPC or to attend meetings of the PCC as observers. The President was to be the Chairman of the PPC or, if he chose not to act in that capacity, some other GMC member was to be appointed by him. Mr Nicholls became acting Chairman of the PPC on Dr Steel's retirement. His appointment as Chairman was confirmed in January 2000. In August 2000, the Rules were changed to reflect the changes in constitution which had already been put in place. From November 1999, the role of 'principal screener' was abolished and all medical screeners were instead given equal status.

After the 2000 Policy Studies Institute Report

19.117 The 2000 PSI Report was considered at a Council meeting on 11th and 12th July 2000. The briefing paper prepared for the meeting noted that the changes which had been made to the screening process in response to the 1996 PSI Report had **'produced substantial improvements in the robustness of the procedures'**. No direct mention was made of the variations between screeners' decisions which had been revealed by the analysis of the SDFs reported in the 2000 PSI Report. Nor was there any specific mention of the recommendation which had been central to the 2000 PSI Report, namely that it was essential, in order to achieve consistency and fairness, that standards, criteria and thresholds should be agreed and applied by all those charged with making decisions about what constituted SPM. The briefing papers for the Council meeting did, however, acknowledge that the 2000 PSI Report had concluded that GMC processes did **'not match the principles of good decision making'** and that there were **'anomalies in outcomes identified in the quantitative analysis'**. Members of the Council were invited to agree that the recommendations contained in the 2000 PSI Report should be addressed by the FPPC as a matter of urgency. I shall consider later in this Report what, if any, progress has been made on the central recommendation relating to the establishment of commonly agreed standards.

19.118 Also in July 2000, the GMC introduced a procedure whereby, before a complaint was screened, the doctor's response to the complaint was disclosed to the complainant and the complainant's comments on the doctor's response were invited. Since 1997, screeners had had the complaint and (usually) the doctor's response, but had had no comment on the doctor's response from the complainant. This could have had a somewhat one-sided effect. From July 2000, a practice was introduced whereby the complainant was invited to comment and any comments submitted by him/her were sent to the doctor for his/her further observations. The complainant's comments, as well as the doctor's further observations, would be made available to the medical screener. At about the same time, the 1988 Professional Conduct Rules were changed to remove the power of the medical screener to direct that an explanation should not be given to a complainant of a decision to reject his/her complaint.

19.119 In August 2000, the 1988 Professional Conduct Rules were amended to provide that the GMC should appoint to act as medical screeners the President (unless he wished to sit on the PPC, the PCC or the HC or for any other reason did not wish to act as a medical screener) and **'such other medical members of the Council as the President shall nominate'**. The 1988 Professional Conduct Rules (as amended) also required the President to nominate (and the Council to appoint) the lay screeners.

A Change in the Screening Test

19.120 I have already said that, after the judgement in Toth had been delivered in June 2000, steps were taken to amend the statutory screening test. This was effected on 3rd August 2000, when rule 6(3) of the 1988 Professional Conduct Rules was amended to read:

> **'The medical screener shall refer to the Preliminary Proceedings Committee every case submitted to him under this rule unless –**
>
> **(a) he decides that a question as to whether the practitioner's conduct constitutes serious professional misconduct does not arise, and a lay member appointed under rule 4(5) agrees ...'**.

The only other exceptions to the general rule were cases in which no statutory declaration had been provided by the complainant and cases referred by the medical screener to the health procedures. These cases did not have to be referred to the PPC.

19.121 It does not appear that this important change in the screening test was reflected in any amendment of the 1997 Screeners' Handbook. It seems that either the screeners must have continued to use the Handbook (despite the fact that it was by this time out of date in a number of respects) or that the Handbook must have fallen into disuse. Subsequent events suggest that the screeners (or some of them) were probably unaware of the change in the rule 6(3) test which had occurred in August 2000.

The Case of Holmes

19.122 The case of R v General Medical Council ex parte Holmes and others[6] was decided by Mr Justice Ouseley on 27th April 2001. It concerned applications for judicial review, challenging, *inter alia*, decisions by medical and lay screeners and by the PPC.

[6] [2001] EWHC 321 (Admin).

The Complaints

19.123 The case concerned complaints by the partner, Ms Caryl Nancy Holmes, and the parents (I shall refer to the three of them as 'the claimants') of Mr Derrick Marcus Dean, who died on 26th July 1995, aged 34, from a colloid cyst on the brain. The complaints related to the standard of care given to Mr Dean by his GP, Dr Rahman, and by a deputising doctor, Dr Sengupta. Mr Dean had seen Dr Rahman at his surgery two days before his death. On the evening before he died, he had been seen at his home by Dr Sengupta. He had subsequently been admitted to hospital where he died. The precise nature of the failure of the standard of care alleged by the claimants is not clear from the judgement. It seems likely that the claimants alleged failure by both doctors to appreciate the seriousness of Mr Dean's condition.

19.124 Ms Holmes made a complaint against Dr Sengupta to the FHSA. A complaint was added later against Dr Rahman. In March 1996, the MSC decided that Dr Sengupta had breached his terms of service but that Dr Rahman had not. Ms Holmes appealed to the Secretary of State (SoS) for Wales against the decision in Dr Rahman's case. In June or July 1998, the SoS for Wales notified the claimants that he had allowed the appeal and had found that Dr Rahman had breached his terms of service. The SoS for Wales directed that Dr Rahman's case should be referred to the GMC. The claimants then requested the GMC to consider Dr Sengupta's conduct also. Thus the GMC was seized of two complaints, both backed by a finding of a breach of terms of service. I do not know whether the breach by one doctor was more serious than that by the other, although it appears that the punishments imposed were different.

19.125 Some time between January and March 1999, the complaint against Dr Rahman was considered by three screeners: two medical screeners and one lay screener. They decided that the case should not be referred to the PPC. Dr Sengupta's case was considered by the same medical screeners and by a lay screener. In Dr Sengupta's case, the medical screeners decided that the case should not proceed. However, the lay screener disagreed and the case was therefore referred to the PPC. On 9th September 1999, the PPC decided that the complaint against Dr Sengupta should not proceed to the PCC. The claimants challenged that decision of the PPC; I shall deal with that part of the case in Chapter 20. They also challenged the decisions of the screeners in Dr Rahman's case.

The Decision of the Screeners in Dr Rahman's Case

19.126 At some stage, probably in the course of the judicial review proceedings, the GMC disclosed a number of documents that shed light on the reasons for the screeners' decision in Dr Rahman's case. The first was a note from a caseworker, which had probably formed part of the memorandum usually prepared by members of staff for the assistance of the screeners. In the note, the caseworker observed:

> **'Dr Rahman has been punished more harshly than Dr Sengupta. Though he should have arranged some follow up for Mr Dean, I do not think his actions constitute SPM and recommend no action in his case.'**

19.127 There was then an annotated comment from the lay screener, indicating her agreement with the observations of the caseworker. There was also a comment from a medical screener, Professor Thomas, who wrote:

> **'I think it is very difficult for us to consider a case which has not been referred to us and although this turned out to be a brain tumour neither hearing has considered this a serious breach (withholding £500). I would value the view of a GP. These events were three years ago – no history of either doctor? I am inclined to no action. In any case if we took one and not the other I think the Welsh Office** (*i.e. the Office of the SoS for Wales*) **would be rather surprised. Would Dr Steel kindly review. Many thanks.'**

19.128 I pause to note that the three years' delay in Dr Rahman's case was attributable almost entirely to the time taken (from August 1995 to June 1998) for the complaint to pass through the NHS complaints procedures. The remaining period of six months or so was attributable either to a delay on the part of the Welsh Office in referring Dr Rahman's case to the GMC or to the time taken by the GMC in dealing with the complaint. I cannot see why the delay should have been relevant to the screening test. Nor do I understand why it would be difficult to consider either case on account of the way in which it had been referred. Nor is the reaction of the Welsh Office a relevant consideration. In short, the first medical screener did not appear to have in mind the relevant considerations.

19.129 Dr Steel was the principal medical screener at the time and a GP. It was common for him to be consulted when another medical screener was uncertain how to proceed. He reviewed the case and commented:

> **'This is a lengthy read. I agree no action, not SPM as Coloid** (*sic*) **cyst is a very difficult diagnosis and Dr Rahman was GP with MRCP** (*Membership of the Royal College of Physicians*)**. I especially note the letter from hospital 2 weeks before the final consultation and I note original (?) case was no breach. Dr R & Dr S reprimand only. Happy to discuss.'**

Quite apart from the fact that Dr Steel appears to have reached a concluded view that Dr Rahman's treatment did not in fact amount to SPM, rather than expressing a view as to whether or not it could do so, he appears to have made two other serious errors. First, it cannot be relevant that a doctor is or is not a Member of the Royal College of Physicians. Second, it cannot be relevant that a MSC had decided in Dr Rahman's case that there was no breach. That decision had been shown to be wrong by the subsequent decision of the SoS for Wales. It appears that Dr Steel was still exercising a wide discretion when screening cases and did not have in mind the advice given in the 1997 Screeners' Handbook.

19.130 The decision was taken to close the case. A letter to the Welsh Office dated 8th March 1999 was drafted but, it seems, was never sent. This letter included the following passage:

> **'The members** (*i.e. the screeners*) **have carefully reviewed the actions of both Dr Rahman and Dr Sengupta in this matter. The members accept that there were shortcomings in the care that Mr Dean received from both doctors. However, they are satisfied that they are not of the gravity of**

serious professional misconduct and could not, therefore, justify the restriction or removal of their right to practice (*sic*) **medicine.**

The members have asked me to explain that a single error in the treatment or management of a patient's condition does not usually constitute serious professional misconduct. Only in cases where it can be shown that the doctor has seriously neglected or disregarded his or her professional responsibilities to a patient could issues of serious professional misconduct or seriously deficient performance arise.'

19.131 The decision not to proceed with the case against Dr Rahman was communicated to the claimants by a letter dated 22nd October 1999. They had been informed about the decision of the PPC in relation to Dr Sengupta three weeks earlier. The claimants, through their solicitors, then attempted to obtain the documents relating to the taking of the decisions. Those attempts continued until the end of July 2000 when, **'with profuse apologies'**, the GMC wrote saying that the minutes of the PPC were not discloseable. It is not clear whether the documents to which I have referred above were disclosed at that stage or later. The GMC's decision was not communicated to Dr Rahman himself until 29th December 1999. It is not known when the Welsh Office was notified, but it seems that, at some time, the SoS for Wales became aware of the decision.

19.132 The letter from the GMC to the claimants said:

'The members have considered the case against Dr Rahman very carefully and understand that Mr Dean had seen him a number of times regarding his headaches. The members were satisfied that Dr Rahman's actions were reasonable in the circumstances prior to July 1995.

The members accept the findings of the Welsh Office in respect of Dr Rahman's consultation on 24 July 1995. However, the members did not feel that the errors made on this occasion constituted serious professional misconduct.

They have asked me to explain that an issue of serious professional misconduct can arise where there is evidence that a doctor has seriously neglected or disregarded his or her professional responsibilities towards a patient. However, a complaint about an alleged error by a doctor while treating a patient – even where the alleged error has had tragic consequences – does not in itself raise an issue of serious professional misconduct.'

The Judicial Review

19.133 On 26th October 2000, the claimants issued judicial review proceedings, challenging the GMC's decisions in relation to both doctors. The doctors were joined in the proceedings as interested parties. Grounds of opposition were filed by the GMC and the doctors. In December 2000, the claimants were granted permission to apply to the Court for judicial review. That was about six months after the decision in the case of Toth. Very shortly after, the GMC informed the doctors' solicitors that it was minded to concede the claim because

of doubts as to the lawfulness of the decisions of the screeners (in Dr Rahman's case) and of the PPC (in that of Dr Sengupta). Subsequently, the GMC decided to consent to the quashing of the two decisions on the grounds that, in reaching those decisions, the wrong legal tests had been applied. A consent order was agreed between the GMC and the claimants. The doctors opposed the application. The hearing therefore took an unusual form, with the GMC and the claimants arguing that the decisions of the GMC were wrong and should be quashed and the doctors contending that the correct legal tests had been applied by the screeners and the PPC.

19.134 In his judgement, Ouseley J adopted the analysis of the legislative framework contained in the judgement of Lightman J in the case of Toth. Counsel for the GMC argued that the decisions of the screeners had not been compliant with the language of the 1988 Professional Conduct Rules. He submitted that the documents from which I have quoted, in particular the draft letter to the Welsh Office, were not couched in **'the language of preliminary consideration'**, but contained expressions of judgement. Thus, in the letter to the claimants, it had been indicated that the screeners accepted the findings of the Welsh Office in respect of Dr Rahman's consultation on 24th July 1995 but **'did not feel that the errors made on this occasion constituted serious professional misconduct'**. In the draft letter to the Welsh Office, the screeners were said to **'accept that there were shortcomings in the care that Mr Dean received from both doctors'**, but to be **'satisfied'** that these shortcomings were **'not of the gravity of serious professional misconduct and could not, therefore, justify the restriction or removal of their** (*i.e. Dr Rahman's*) **right to practice** (*sic*) **medicine'**.

19.135 Ouseley J inferred that the caseworker who wrote the letters would have been informed of the basis of the decision by the screeners and would have reflected it faithfully in her letters. He noted that the GMC had produced no evidence that the correct test had been applied, observing that **'if there had been clear evidence of the test being consistently applied ... I would have had it, even if the individual case itself could not be remembered'**. He concluded that the decision in Dr Rahman's case was probably arrived at by applying the wrong test. It was probable, he said, that the medical screeners reached the conclusion that Dr Rahman's actions did not constitute SPM, rather than the conclusion that the actions of Dr Rahman were incapable of constituting SPM. In the Judge's view, the terms of the letters sent by the GMC contained explicit judgements as to the quality of the acts as not constituting SPM, rather than judgements as to whether they were capable of doing so. Ouseley J went on to deal with the documents disclosed by the GMC:

> **'The caseworker's reference and the annotations by Professor Thomas and Dr Steel cannot be dismissed as simple annotations when one is trying to reach a conclusion as a matter of fact as to the basis upon which the decision making body reached its decision. Not merely do they not contradict the approach which is clear from the letter of 22nd October 1999, they support the inference which I have drawn. None of the material brings in the true test.'**

It is most discouraging to realise that, as recently as 1999, errors as fundamental as this were being made by the GMC. Not only had the screeners applied the wrong test, but the

administrative staff had apparently not noticed the errors and had not queried the reasons when drafting the letters.

19.136 It appears to me that these errors were not isolated failings in the application of the Rules to given situations but were indicative of a fundamental misunderstanding of the Rules and of the functions of a screener on the part of the medical screeners. I am driven to the conclusion that, in screening cases before 1999, the screeners habitually applied the wrong test. It also appears to me to be likely that screeners often took into account completely irrelevant factors. These endemic failings underline the need not only for the training of screeners, which was recognised by Mr Roger Henderson QC for the GMC at the Inquiry, but also for clear and agreed standards, criteria and thresholds to be promulgated. I recognise that it is not easy to ensure consistency of approach by different people undertaking a task such as screening. However, in the interests of fairness and consistency, it is obvious that preliminary decisions should be made in a structured way and reasons given so that they can be audited and analysed. The case of Holmes shows that, as recently as 1999, the GMC's screening work was seriously flawed.

The Case of Woods

The Complaint

19.137 The case of Woods v General Medical Council[7] came before the High Court in June 2002, although the material events took place in 2001. The claimant was the mother of a baby boy who had died and whose body had been sent for post-mortem examination to the Alder Hey Children's Hospital. Some of his organs had been retained without the claimant's consent. Following the publication, on 30th January 2001, of the Report of the Royal Liverpool Children's Hospital Inquiry (the Alder Hey Inquiry Report), the names of certain doctors who had been criticised in that Report were reported to the GMC. The medical and lay screeners decided not to refer the cases of two of the doctors to the PPC. The reason given by the GMC for these decisions was that the Alder Hey Inquiry Report did not raise issues of SPM relating to the two doctors. The claimant brought proceedings by way of judicial review, challenging the decision of the screeners. She also challenged the decisions of the PPC in respect of nine other doctors who had been referred by the screeners to the PPC but had not been referred on by the PPC to the PCC.

19.138 It is not clear when the relevant screening decisions were taken. However, solicitors for the claimant sought an explanation of them and the GMC's letter of explanation (which was undated) arrived on or about 16th August 2001. That was more than a year after rule 6(3) of the 1988 Professional Conduct Rules had been amended to change the screening test.

The Judicial Review

19.139 Leave to apply for judicial review was granted and the case proceeded to a hearing before Mr Justice Burton. The medical screener had provided a witness statement describing the process and reasoning by which he had reached his decision. That witness statement had been approved by the lay screener. The witness statement made clear that there had

[7] [2002] EWHC 1484 (Admin).

initially been disagreement between the screeners. The medical screener had been confident that the case did not raise an issue of SPM or SDP. The lay screener had disagreed with that view. After lengthy discussions, they had agreed that the case should not go to the PPC. The Judge observed that there was nothing wrong or unusual about the fact that there had been disagreement between two independent-minded screeners. He noted, however, that the eventual agreement was said to have been reached by the lay screener **'on balance'** although it was also said that both screeners had, in the end, been **'convinced'** of its correctness.

19.140 From the medical screener's witness statement, it was clear that he had applied the screening test that had been in force before August 2000. He described the medical screener's role as being to decide whether a complaint **'need not proceed further'**. The lay screener appears to have accepted that that was the test that he had also applied. Burton J drew attention to the fact that the change to rule 6(3) since the case of Toth had removed the reference to the word **'need'** in the screening test and that the question of whether it appeared to the screener that the matter **'need not proceed further'** had gone. That had been the old rule. As to the test that should be applied, the Judge observed that it appeared to him significant that, in practice, the screening process led to the formulation (by the medical screener, or by the staff, on the instructions of the medical screener) of a charge or allegation. The charge or allegation was then sent to the PPC for consideration. The medical screener had, therefore, to be satisfied that a charge could be laid. It appeared to Burton J that the decision to be made by the medical screener at that stage might simply be **'whether there is no arguable case'**. Burton J also observed that, although the 'old' test had been a narrow one, it might have been said to **'allow for an element of subjectivity or proportionality'**. By contrast, the 'new' test was **'effectively, no arguable case'**. It was clear that the wrong test had been applied. Burton J was not satisfied that, had the correct test been applied, the screeners would necessarily have reached the same decision. He therefore directed that the case should be reconsidered by the screeners, applying the correct test.

19.141 It is obviously a matter of concern that it was possible for two screeners, in the middle of 2001, to apply the old screening test so many months after it had been replaced. This was despite the regular screeners' meetings and training sessions which the Inquiry was told had been taking place since 1997. The hearing in this case took place in June 2002. The date of the medical screener's witness statement does not appear in the judgement. It may be that it was prepared some time before the hearing took place. However, it seems clear that it cannot have occurred to either the medical or the lay screener at any stage up to the time of the hearing in June 2002 that the statement was based on a fundamental error as to the screening test to be applied. The medical screener in question had been appointed a medical screener in July 2000, the month before the new screening test came into effect. He was said by the Judge to have screened over 400 cases by June 2002. Presumably, he had applied the wrong test in all those 400 cases. In many cases, it may be that the error would have had no effect on the outcome. However, it seems likely that there would have been many cases where the error might have made the difference between a complaint being referred to the PPC and being closed at the screening stage.

19.142 It seems to me that, if these two screeners were both under a misapprehension as to the correct test to apply, it is unlikely that they were the only two in that position. It is also likely

that others within the GMC would have read the medical screener's witness statement; yet it appears that no one noticed the error. There was not, of course, an up-to-date Screeners' Handbook at the time. I have not been shown any guidance for screeners which was available at this time. One might have expected that having had to concede the errors made in Toth and Holmes would have been a chastening experience for the GMC. One might have thought that, having sought and obtained an amendment of the Rules to effect a change in the test to be applied by screeners, the GMC would have given a high priority to the education and training of screeners so as to enable them to apply the test correctly and consistently. Yet it appears that this was not done.

Further Work by the Policy Studies Institute

19.143 In further work undertaken during 2002, Professor Allen and her colleagues analysed the outcomes of screening decisions made during the period from 1999 to 2001. The results appeared in their 2003 Paper. They compared the outcomes for individual screeners. This exercise showed variations in outcome as between medical screeners, with two **'hawks'** sending an average of 30% of cases screened over the three years to the PPC and two **'doves'** sending an average of less than 20%. Professor Allen and her colleagues had previously recommended that a system of random distribution of cases to screeners should be put in place. They were told that, as a result of that recommendation, a **'cab rank'** system of distribution of cases to the screeners had been in operation from the beginning of 2000. From that time, there should not have been any difference in the types or seriousness of cases handled by each individual medical screener. The PSI team suggested that, if it was indeed the fact that the distribution of cases was entirely random, the variations in outcome amounted to evidence that the medical screeners were not all applying the same standards and criteria to their decision-making.

19.144 The PSI research was directed primarily at identifying any differences between the treatment by the GMC of doctors who had qualified in the UK and the treatment of those who had qualified overseas and, if any such differences were apparent, at analysing the possible reasons for those differences. Professor Allen and her colleagues identified differences in the treatment of the two groups but had difficulty in analysing the reasons for those differences because there was **'no discernible common agreement on the criteria and threshold to be applied in reaching a judgment on the seriousness or gravity of cases'**. They pointed out that this lack of a common agreement had led to problems in ensuring consistency. These problems extended both to the treatment of different cases within the same stage (e.g. screening) of the conduct procedures and to the treatment of cases at different stages of the procedures (e.g. as between the screening and PPC stages). The PSI team referred back to the recommendations contained in its 2000 Report and observed that the continuing differences between the outcomes of FTP cases involving doctors who had qualified in the UK and those who had qualified overseas suggested that the development of guidelines to be used in the decision-making process was **'a matter of priority'**.

19.145 As I have said, during their research, Professor Allen and her colleagues had primarily been concerned to discover whether there was any racial bias in the GMC's FTP procedures. Plainly, if there was inconsistency in decision-making, it would be

impossible for them to reach any reliable conclusions on that issue. However, consistency in decision-making is also important more generally in the interests of fairness to every doctor who is the subject of complaint. Professor Allen told the Inquiry that, on the available evidence, it could not be asserted that every doctor was treated by the GMC in the same way by reference to the same criteria and the same standards. This was because there were no generally agreed or applied criteria or standards. I would add that consistency is also important from the point of view of patient protection. If there is a 'right' threshold at which action should be taken, the public may be exposed to risk if action is not taken at that threshold in some cases. Also, unless the threshold is clearly stated, the public will feel aggrieved when the lack of clarity leads to inconsistency in decision-making.

Another Change in the Screening Test

19.146 On 1st November 2002, following the decision in Woods, the screening test was changed again. Rule 6(3) of the 1988 Professional Conduct Rules was amended to read:

> **'The medical screener shall refer to the Preliminary Proceedings Committee a case submitted to him ... if he is satisfied from the material available in relation to the case that it is properly arguable that the practitioner's conduct constitutes serious professional misconduct.'**

Dr Midha told the Inquiry that this test altered the 'presumption' upon which screening decisions would be made. I think that he meant that whereas, before November 2002, a case had to be referred to the PPC unless the screeners agreed that no question of SPM arose (a negative test), under the new rule, the screener had to be positively satisfied that it was arguable that the doctor's conduct constituted SPM. In fact, the change was very slight. The language had changed but the threshold to be crossed before the case was referred to the PPC remained very low. Put another way, if carried out in accordance with the Rules, screening remained, as had always been the intention, a very coarse filter.

19.147 Also on 1st November 2002, the 1988 Professional Conduct Rules were amended to remove the requirement for a complainant to provide a statutory declaration in support of his/her complaint.

The November 2002 Screeners' Handbook

19.148 On this occasion, a new Screeners' Handbook (the November 2002 Screeners' Handbook) was issued at the same time as the change in the screening test. This was the Handbook that was in use at the time of the Inquiry hearings in December 2003. It incorporated an *aide memoire* on the interpretation of the new screening test. Screeners were advised that they should first ask whether it was properly arguable that the alleged misconduct was capable of constituting SPM. In answering the first question, screeners were advised that:

> **'i It should be assumed the allegation is true;**
>
> **ii An assessment should be made of the allegation's seriousness not credibility;**

iii The argument does not need to be likely to prevail before the PCC;

iv The issue is properly arguable if a claim can reasonably be made that the practitioner's behaviour fell seriously short of the standards of conduct expected among doctors.'

19.149 Screeners were told that, if they were of the view that it was properly arguable that the alleged misconduct was capable of constituting SPM, they should then consider whether it was properly arguable from the material available in relation to the case that the practitioner had committed SPM. In considering this question, screeners were urged to remember that:

'(i) This question addresses the factual allegations;

(ii) It identifies possibilities not probabilities;

(iii) It is based on the identification of a possibility less than any real or realistic prospect of the allegation being sustained;

(iv) Properly arguable means reasonably arguable. An allegation is not properly arguable if it is absurd, frivolous, vexatious or repeats an earlier allegation (whether made by the same or different complainants);

(v) Conflicts of evidence should not normally be resolved;

(vi) Implausible accounts unsupported by other evidence can legitimately be rejected.'

19.150 Screeners were cautioned that the evidential element of the test did not establish a **'high hurdle against the progress of a case'**. They were told that they must not make any attempt to resolve conflicts of evidence. The November 2002 Screeners' Handbook stated:

'There will be very few cases where the allegation(s) against the doctor are either fanciful, incredible or incapable of being supported by the evidence.'

19.151 I have already mentioned in Chapter 18 that the November 2002 and April 2003 versions of the FTP Casework Manual and the May 2004 FTP Investigation Manual advised that the amount of evidence required by the screeners was **'minimal'**.

19.152 In deciding whether conduct was or was not capable of amounting to SPM, screeners were told that they should bear in mind the relevant GMC guidance when exercising their discretion whether to close a case or to refer it to the PPC. The November 2002 Screeners' Handbook stated that staff would ensure that the screeners' attention was drawn to the appropriate guidance. In many cases, the 'guidance' would be the relevant passage from 'Good Medical Practice'. The November 2002 Screeners' Handbook made it clear that deviation from the published guidance would not necessarily give rise to issues of SPM. It stated:

'The key will be the degree and/or nature of deviation from that guidance.'

The Handbook further advised (in language that came perilously close to encouraging the screener to make a 'judgement' on the evidence) that:

> **'Screeners should bear in mind that if they determine that a doctor deviated from best practice, as set out in our guidance, but not by so much as to call his or her registration into question, a closing letter containing advice to the doctor may be the logical outcome.'**

19.153 The Handbook contained no criteria by which screeners were to assess the **'degree'** or the **'nature'** of the deviation from the relevant guidance that would be sufficient to call a doctor's registration into question. In my view, the use of the expression 'to call the doctor's registration into question' may have caused some confusion, in that it might have suggested to some screeners that the conduct had to be so serious as to give rise to the possibility of erasure from the register. In fact, if SPM were proved, the PCC could impose lesser forms of sanction than erasure, including the imposition of conditions. In the recent past, it became increasingly common for the GMC to use the concept of conduct which was 'serious enough to call registration into question' as an equivalent of SPM. In my view, the use of this expression did not help screeners to decide whether the conduct amounted to SPM.

19.154 In making a decision on a case, the November 2002 Screeners' Handbook advised that a medical screener had a number of options. First, s/he could (with the agreement of a lay screener) close the case. If s/he decided that that course was appropriate, s/he could elect to send a letter to the doctor, giving advice as to his/her future conduct. Second, the medical screener could refer the case to the PPC. Third, if the medical screener believed that there were grounds to suggest that the standard of the doctor's professional performance might have been seriously deficient, s/he could refer the case for a performance assessment. I shall discuss that option further in Chapter 24. Fourth, the medical screener could refer the case to the health procedures.

19.155 A fifth option for the medical screener was to request further information. However, screeners were advised that they should do this only in circumstances when further information was necessary in order to clarify what the allegation was. Screeners were warned not to request further evidence that was not necessary for this purpose. The November 2002 Screeners' Handbook stated that, if they did, and evidence was obtained in response to their request:

> **'... we** (*i.e. the GMC*) **leave ourselves open to the charge that the screeners, in seeking evidence, must have intended to take that evidence into account in making their decision and that in doing so they went beyond their legal powers and applied the wrong test (by weighing the evidence)'**.

19.156 I understand entirely why the GMC wished to discourage requests for further evidence about an allegation. However, it would have been unfortunate if screeners had been discouraged from asking that staff should find out, for example, whether other complaints of a similar nature had come to the attention of the doctor's employer or the primary care organisation on whose list s/he was included. Complaints should not be considered in

isolation; additional information might well show that an apparently isolated complaint of poor clinical practice was in fact a sign of SDP. However, it may be that, in the future, the GMC will obtain such information as a matter of routine, at least in certain cases. I shall return to this issue later.

19.157 The November 2002 Screeners' Handbook advised that, once a decision had been made to refer a case to the PPC, the medical screener should not request that further information be obtained before the case proceeded. By making the decision, the medical screener had fulfilled his/her role and had no further part in directing the case. It was open to the medical screener, in exceptional cases, to request a second opinion from another medical screener or to call for a case conference of several screeners. However, screeners were enjoined to exercise these options only when **'absolutely necessary'**, since they would have the effect of prolonging the screening process. Under the GMC's service standards, screeners had two weeks to consider each file and come to a decision. In exceptional cases (i.e. those which were highly complex or which contained large amounts of information or documentation), screeners could agree with GMC staff a longer timescale for an individual decision. Medical screeners were also advised that they should consider whether it was necessary to take steps to protect the public interest by suspending or imposing conditions on a doctor's registration, pending the final determination of his/her case. If they believed that it was necessary to take such steps, they were required to refer the case to the Interim Orders Committee.

19.158 The November 2002 Screeners' Handbook advised that a SDF should be completed and the screener should give clear reasons for his/her decision. Those reasons should relate solely to the test which screeners were required to apply. If a case was to be closed, the medical screener should approve the letters to be sent to the complainant and the doctor. The November 2002 Screeners' Handbook reminded medical screeners that the explanations to the various parties should be identically worded, except where technical terms might need to be explained to a complainant.

19.159 The November 2002 Screeners' Handbook made clear that one of the functions of caseworkers and case managers in the Screening Section was to ensure that screeners' decisions were made in accordance with the law and with the statutory process. An agreed protocol was attached to the Handbook, setting out the circumstances in which it would be appropriate for a member of staff to ask a screener to reconsider a decision which might have been made for reasons which were not legally defensible. This might arise if the medical screener requested that staff should obtain information that was not necessary for the purpose of the screening decision. More frequently, it would arise if the reasons for the decision given by the medical screener demonstrated that s/he had taken into account matters which should not have formed part of the decision-making process. An example would be if it was clear that the screener had 'weighed up' the evidence or had speculated about how the PPC or PCC might dispose of the case. The protocol pointed out that a decision taken in these circumstances might be vulnerable to challenge by judicial review. In a case where there was real concern about the potential for judicial review, the protocol suggested that the advice of the GMC's solicitors might have to be sought before a final decision was taken on the case. This was, no doubt, intended to avoid a repetition

of the situation in Toth and in Holmes, where it was immediately evident to the GMC's advisers that the decisions of the screeners were unsustainable.

The Treatment of Convictions

19.160 On 1st November 2002, rule 5(1) of the 1988 Professional Conduct Rules was amended to read:

> **'Where information in writing is received by the Registrar from which it appears to him that a practitioner has been convicted of a criminal offence in the British Islands or has been convicted of an offence elsewhere which, if committed in England or Wales, would constitute an offence**
>
> **(a) in a case of conviction for an offence which the Registrar considers to be a minor motoring offence the case shall not proceed further;**
>
> **(b) in a case of conviction where a custodial sentence has been imposed (but excepting any case where the sentence was suspended), the Registrar may refer the case direct to the Professional Conduct Committee for inquiry unless it is his opinion that such direct referral would not be in the public interest;**
>
> **(c) in any other case of conviction including any case which the Registrar has determined not to refer direct to the Professional Conduct Committee under rule 5(1)(b), the Registrar shall refer the case to the medical screener.'**

This change gave explicit legislative authority to the longstanding direction by the PPC that convictions for minor motoring offences need not be referred to the PPC or, indeed, to a medical screener. The amended rule appears to have created an expectation that convictions leading to an immediate custodial sentence would usually be referred directly to the PCC and that all others, save those for minor motoring offences, would be referred to a medical screener.

19.161 The November 2002 Screeners' Handbook dealt with the screening of convictions. It stated:

> **'A subset of conduct cases relate to doctors convicted of a criminal offence ... When we receive notification of a conviction, staff will refer the case to a screener (unless the doctor in question was imprisoned, in which case the matter will be referred direct to the PCC), who must in turn refer it to the PPC unless:**
>
> **a. it appears to the screener that the doctor's fitness to practise may be seriously impaired by a physical or mental condition and that action under the health procedures should be taken in preference to action under the conduct procedures; or**

b. the conviction is for a minor motoring offence (not involving the use of alcohol or other drugs), or a conviction for a minor offence not involving dishonesty.'

The Problem of Finding Out How Conviction Cases Were Dealt With

19.162 There is a real problem in discovering the number and nature of convictions reported to the GMC and in tracing how those convictions have been dealt with. In the GMC's annual FTP statistics, cases dealt with by medical screeners are divided into broad categories. There is no separate 'conviction' category. Some of the categories (e.g. dishonesty, sexual assault/indecency and violence) will presumably include both conviction cases and conduct cases. It is not possible, on reading the statistics, to distinguish between the two. In 2003, 28 cases involving allegations of dishonesty against doctors were closed by screeners, out of 125 such cases considered. It may be that in none of the 28 cases had the doctor been convicted of a criminal offence. It may be that a sizeable proportion had been convicted. It is impossible to tell from the annual FTP statistics. It was only when cases were referred to the PPC that the GMC statistics identified the number of conviction cases dealt with and their outcome. In my view, this is unsatisfactory. It is important for members of the GMC and the wider public to know exactly how the GMC deals with doctors convicted of criminal offences. Transparency is particularly important where concerns exist, as they do, about the disparity of treatment between different groups of doctors.

Remission of Cases to the Health Screener

19.163 Since the introduction of the health procedures in 1980, the Professional Conduct Rules have permitted medical screeners, in both conviction and conduct cases, to remit an appropriate case to a health screener to be dealt with under the voluntary health procedures, as an alternative to referring the case to the PPC. A large proportion of the cases where this course of action is considered involve abuse by a doctor of alcohol or controlled drugs.

19.164 According to the GMC annual FTP statistics, in 2001, the medical screeners remitted 31 cases (out of 2235 cases screened) to the health screener. In 2002, 13 out of 2239 cases were so remitted. In 2002, 13 out of 1884 doctors whose cases were dealt with by the medical screeners were referred into the health procedures. In 2003, the figure was seven out of 1304 doctors. It is not possible to say how many of these cases (if any) involved convictions. In any event, it is clear that in the recent past, the medical screeners have referred only a small proportion of cases into the health procedures.

Audit of Screening Decisions

19.165 While carrying out the work preparatory to their 1996 Report, Professor Allen and her colleagues had advised that screeners should receive training and should be provided with information about the results of cases they had screened. This had not happened up to that time. In response to that recommendation, regular meetings of screeners and screening casework managers were instituted. These were used to discuss issues of

common interest arising from the screening process, as well as specific screening cases, suitably anonymised. In addition, training sessions and workshops for screeners and screening caseworkers were introduced.

19.166 From about the end of 2002 or the beginning of 2003, screeners began to receive statistics about their own screening outcomes. The statistics showed how many cases the screener had closed and how many s/he had referred to the PPC. Screeners were able to compare this information with anonymised information about the screening outcomes of colleagues. The object of this was to inform individual screeners and also to enable the GMC staff to identify screeners who appeared to be outliers in some way. When the new system was introduced, it was intended that, if an outlier was identified, an explanation would be sought and any necessary remedial action taken. The Inquiry has no information about whether such action has been taken in respect of any screener. Screeners were also informed of the outcomes of the PPC's consideration of cases they had referred there.

19.167 In September 2002, Mr Blake Dobson joined the GMC. He was given responsibility for developing a programme for auditing GMC casework which could be applied to both the existing and the new FTP procedures. In January 2003, Mr Dobson became Head of the FPD Audit Team. The Team consists of three caseworkers and an administrative assistant, as well as Mr Dobson.

19.168 In August 2003, the audit of screening decision-making began. A random sample of two cases per medical screener was audited each month. The audit involved examination of the caseworker's memorandum to the screener and of the screening memorandum setting out the screener's decision and any other comments made by the screener on the file. The auditors also checked that the relevant part of the SDF had been correctly completed and was consistent with the screening decision.

19.169 A check was made to ensure that the reasons for the decision accorded with the screening test to be applied. If there was evidence which suggested that the basis of the decision was questionable – because the screener appeared to have applied the wrong test, for example, or because s/he had taken into account matters which should not have formed part of the decision – the file was referred to Mr Dobson and, if he had concerns, it was passed to the Director of the FPD.

19.170 This procedure was a most welcome development. Until its introduction, scrutiny of a screener's decision would occur only if proceedings for judicial review were taken. However, the scrutiny was still not complete. It checked that the reasons given complied with the legal test (which was plainly important) but it did not involve any evaluation of whether the decision itself was correct in all the circumstances of the case.

19.171 More recently, in May 2004, the Fitness to Practise Committee set up an Investigation Audit Sub-Group, with a view to establishing and developing a programme of audit for the investigation stage of the new FTP procedures.

19.172 There was, in the past, discussion about the appraisal of screeners. These discussions were not taken forward, largely because of the imminent changes in the arrangements for screening.

Some Problems with the Screening Process

19.173 As I have already explained, the judicial reviews have provided examples of cases in which screeners have applied the wrong screening test and have taken irrelevant considerations into account. It appears that those errors were made as the result of ignorance of the correct test and the considerations relevant to it. However, in the course of its investigations, the Inquiry has also become aware of a number of situations in which screeners have been unwilling to abide by internal GMC decisions.

'Serious Professional Misconduct by Definition'

The General Medical Council Agrees to Automatic Referral to the Preliminary Proceedings Committee

19.174 As I have explained, Professor Allen and her colleagues were anxious to promote changes in the GMC procedures which would secure greater consistency in decision-making. Accordingly, in the period before the start of their follow-up study in 1999, Professor Allen agreed with the GMC that there were a number of categories of cases which should 'by definition' be regarded by the medical screeners as SPM. The categories to which it was agreed that this approach should apply were complaints about dishonesty, about dysfunctional behaviour (e.g. abusive behaviour, soliciting money from patients, persisting in practice when the carrier of an infectious disease, etc.), about sexual assault and indecency and about violence. Cases falling within these categories were to be referred automatically by the medical screener to the PPC, unless the medical screener considered that one of two exceptions applied. These exceptions were, first, where the doctor was terminally ill and not in active practice and, second, when there was no tenable basis for taking action because the complainant had declined reasonable requests for further information, there was no probative evidence to support the allegation(s) (or any prospect of obtaining any) or the complaint was self-evidently untrue or irrational. The types of behaviour which amounted to 'SPM by definition' were clearly indicated on the SDFs which were introduced at that time to assist screeners in the decision-making process.

The Impact of Automatic Referral

19.175 The introduction of the 'SPM by definition' categories led initially to a dramatic increase in the number of complaints of dishonesty, dysfunctional behaviour, sexual assault and indecency, and violence referred by the medical screeners to the PPC. In 1997 and 1998, only about half of all complaints about dishonesty and criminality referred to the medical screeners – and far fewer complaints relating to the other categories of 'SPM by definition' – had been referred by the medical screeners to the PPC. By contrast, during the period from July to December 1999, 93% of all cases within the 'SPM by definition' categories were referred to the PPC. In the other 7% of cases, the reason given by the medical screeners for not referring the case was that **'there was no probative evidence to support the allegation nor any prospect of obtaining any'**.

19.176 The 2000 PSI Report welcomed the consistency of approach which the introduction of the 'SPM by definition' categories had produced. Indeed, it suggested that there was an

argument in favour of the GMC staff referring all complaints of dishonesty, dysfunctional behaviour, sexual assault and indecency and violence straight to the PPC on receipt, without any intervention at all by the medical screener. Professor Allen and her colleagues pointed out that, for such cases, consideration by both the medical screener and the PPC seemed to be an unnecessary duplication of effort. It also caused delays, which were a cause of concern, particularly when a case appeared to raise a question of risk to the public.

A Surprising Retreat

19.177 As I have said, the GMC had agreed to the introduction of 'SPM by definition' and suitable SDFs had been designed by the PSI team in consultation with the GMC. Mr Scott said that there had been a 'very strong commitment' to 'SPM by definition' and 'huge enthusiasm' about implementing the new procedure. In July 2000, a meeting of the Council considered the 2000 PSI Report. The briefing papers for the meeting referred to cases of 'SPM by definition' and indicated that such cases would normally be referred by the medical screeners to the PPC. This and other changes had, it was said, **'produced substantial improvement in the robustness of the procedures'**. Anyone reading those papers would have understood that the system whereby certain types of complaints were regarded by definition as constituting SPM and were referred to the PPC more or less automatically was in operation and producing benefits.

19.178 The same impression would have been gained by anyone reading the November 2002 Screeners' Handbook, which stated:

> **'In cases where the alleged behaviour is characterised as SPM by definition – and assuming that the screener agrees with the categorisation – the screener would have no choice but to refer the case on (rather than close it), unless exceptionally the low evidential test is not met.'**

19.179 When they undertook their work in 2002, Professor Allen and her colleagues understandably assumed that virtually 100% of cases in the 'SPM by definition' category and all convictions (save those specifically excepted) would have been referred by the medical screeners to the PPC. As far as they were aware, the system was still in operation as agreed with the GMC in early 1999 and they had not been informed otherwise. It was with surprise, therefore, that they discovered that, in the dishonesty/criminality category, only 47% of cases which had gone to the medical screeners in 2000 had been referred to the PPC, rising to 74% in 2001. In both years, a fifth of the cases that had not been referred to the PPC had been screened out on the ground that they did not raise a question of SPM. This is hardly consistent with their being categorised as 'SPM by definition'. In addition, 19% of cases in the dishonesty/criminality category in 2000 and 7% in 2001 had been referred by screeners to the health procedures. In the dysfunctional behaviour category, only about 70% of cases seen by the medical screeners had been referred by them to the PPC in 2000 and 2001. Again, this proportion fell significantly short of the almost 100% which had been expected.

19.180 When Professor Allen asked about these findings, members of the GMC staff explained that there had been a change of practice in mid-2001. From that time, she was told, there was no longer a requirement that complaints falling within the 'SPM by definition' category should be referred to the PPC in the absence of overwhelming reasons why this should not be done. Instead, medical screeners had been using their own discretion when deciding whether or not to refer such cases to the PPC. The contents of the SDF had even been changed to facilitate this. It is clear from the statistics that, even in 2000, medical screeners (or some medical screeners at least) had not in fact been implementing the policy in accordance with the agreement reached the year before.

19.181 Professor Allen told the Inquiry that the change of practice had seemed to her 'such an extraordinary thing to do'. Automatic referral had been an agreed policy. She had asked the GMC for an explanation for the change but had not been given one. She was, however, told that the change of practice would be reversed so as to restore the system which had been agreed upon in March 1999.

19.182 Dr Korlipara, a member of the GMC and a medical screener between 1998 and 2004, was asked about this change of practice. When he was shown the categories of conduct which it had been agreed should be treated as 'SPM by definition', he said that, if a screener was satisfied as to the strength of the allegation and if there was *prima facie* evidence to support the allegation, the screener had to refer such cases to the PPC. If one of those categories applied, he said, 'There is no question at all, they would go to the PPC.' However, when asked about the specific example of theft, Dr Korlipara said that there were circumstances in which he had decided that a case of theft need not go to the PPC. The example he gave was:

> **'If it was a small amount of money or National Health resources which is, you know, taking paracetamol or something like that having been stolen, which is technically correct, I may not take the issue further.'**

19.183 He said that he would exercise some discretion in order to distinguish between the 'frivolous' and the 'rather more serious'. Dr Korlipara did not appear to appreciate that, by doing this, he was undermining the procedure laid down for screening complaints that had been identified as amounting to 'SPM by definition'. Nor, apparently, did he appreciate that this could be a source of unfairness to doctors. If a doctor's case was screened by one of Dr Korlipara's colleagues, who was adhering to the 'SPM by definition' rule, that case would be sent to the PPC; if, however, the same doctor's case was screened by Dr Korlipara, it would be closed. Dr Korlipara's response also failed to take account of the fact that different people might take very different views about whether the theft of money (even a small amount of money), or the theft of drugs from the NHS, could ever be regarded as 'frivolous'. Indeed, the 'SPM by definition' procedure was aimed at reducing the inconsistency flowing from the fact that individuals may have differing views about the approach to be adopted to certain types of misconduct, including dishonesty.

19.184 It appears that there was what Mr Finlay Scott, the GMC's Chief Executive, termed a period of 'incomplete compliance' with the 'SPM by definition' procedure by medical screeners. During that time, medical screeners (or some of them) were not sending all the cases within the relevant categories to the PPC. The medical screeners then indicated to

members of the GMC staff that they wanted the SDF changed, and the GMC staff complied. Those changes were made without the knowledge of the Council or the FPPC and without the knowledge of Mr Scott. The first he knew of it was early in 2003, when Professor Allen drew his attention to what had occurred.

19.185 The changes to the SDF consisted of moving various types of conduct from the list of types of misconduct to be regarded as 'SPM by definition' and placing them in the list of types of conduct which might raise an issue of SPM. In the latter ('SPM by discretion') case, the screener would be permitted to exercise his/her discretion in deciding whether the conduct did raise an issue of SPM. The types of misconduct which were moved from one list to another were:

(a) in the category 'dishonesty'

- false certifications
- false reporting
- false claims about effectiveness of treatment

(b) in the category 'dysfunctional conduct'

- abusive behaviour
- driving under the influence of alcohol/drugs (where there had been no conviction)
- failure to report dysfunctional colleagues
- soliciting money from patients.

The provision of a misleading reference, which had previously been designated as a type of conduct to be regarded as 'SPM by definition', did not appear at all on the new version of the SDF.

The Reasons for the Retreat

19.186 In March 2003, after the change in the agreed policy on 'SPM by definition' had come to light, Mr Neil Marshall, who had been the Head of the Screening Section since March 2002, prepared a briefing paper for a meeting of the FPPC. He advanced two reasons for the change of practice. First, he said that the screeners had felt that some cases falling into the categories of conduct designated as 'SPM by definition' might form part of a pattern of poor performance, so that a referral to the performance procedures would be more appropriate than referral down the conduct route. If screeners were constrained to refer cases to the PPC, the opportunity of referring for a performance assessment would be lost since the PPC could not make such a referral. I can see that 'abusive behaviour' might possibly be part of a wider pattern of poor performance. However, I must say that I cannot see how such behaviour as soliciting money from patients, false certifications, false reporting and false claims about effectiveness of treatment could ever be considered as examples of SDP.

19.187 Second, the screeners had, it was said, been concerned at the loss of their discretion to close cases involving complaints about these categories of behaviour on the grounds that

the complaints did not raise a question of SPM. I must say that I find it very worrying that any medical screener should have considered that allegations of conduct such as soliciting money from patients, making false claims about the effectiveness of treatment or writing false certificates or reports could ever fail to raise a question of SPM. This is especially so since all the medical screeners were required to do was to refer such cases automatically to the PPC. The PPC provided another filtering process before a case went to the PCC. The screeners were not required to make a final judgement as to whether the conduct complained of amounted to SPM or required a public airing before the PCC.

19.188 Mr Marshall's paper set out the history of what had occurred and the steps that were to be taken to reinstate the agreed policy. In that paper, the issue of the medical screeners' concern about loss of discretion was further illustrated:

> **'... the Screeners felt that they had lost the discretion to close cases where the allegation, as stated by the complainant, might well be very serious, but where other relevant information seemed to suggest that the doctor's failings had been of a less serious nature. The example often quoted was where allegations of indecency made by the complainant seemed to the Screeners to be more a case of poor communication as to the reasons for an intimate examination being carried out.'**

19.189 As it happens, indecency was not one of the types of behaviour that was removed from the list on the SDF of misconduct to be regarded as amounting to 'SPM by definition'. Nevertheless, it seems clear that, on occasion, screeners rejected such claims on the grounds that they did not amount to SPM. To dismiss an allegation of indecency as a problem of **'poor communication'**, without hearing evidence from the doctor and from the patient, seems highly unsafe. In effect, a screener who refuses to refer such a case to the PPC is making a value judgement about the truth of, and about the weight to be attached to, the complainant's complaint and the doctor's response. That is not the function of a screener. Mr Scott told the Inquiry that, although he did not have the full facts, the conversations he had had with medical screeners suggested that they would have sought to exercise discretion in 'probably quite a small number of instances' of complaints of indecency. However, the GMC's FTP statistics for 2002 show that, of 65 cases involving allegations of sexual assault and indecency against doctors considered by the screeners, no fewer than 25 were closed by them. The other 40 such cases were referred by the screeners to the PPC. In 2003, 17 out of 40 such cases were closed by the screeners.

19.190 Mr Scott referred to an 'understandable frustration' on the part of the screeners at being part of a 'mechanical processing system' and the wish of those individuals to 'add value' by exercising their discretion. Mr Scott observed that there had been a tendency for screeners (especially those who had been used to sitting on the PCC) to 'slip into' the weighing of evidence and, in effect, to step beyond their role as screeners. He said that there was also a danger that medical screeners, who were experienced doctors (and, therefore, experienced decision-makers), would 'reach into their own experience' to see whether there might be 'an alternative explanation' for the conduct complained of. He did not believe that this was in any sense motivated by 'a positive desire to explain it away' but

he thought there might be a 'subconscious influence there'. He was not able to say whether the 'subconscious influence' invariably operated in favour of the doctor against whom the complaint had been made.

Restoring the Status Quo?

19.191 Mr Marshall's paper revealed that, at a meeting of the screeners held after receipt of the 2003 PSI Paper, there was a division of opinion among them about whether the changes to the categories of behaviour which had been designated as 'SPM by definition' (i.e. the removal of the types of conduct listed at paragraph 19.185) should be reversed. The matter was put to the FPPC, with a recommendation that all the categories of behaviour listed at paragraph 19.185 should be reinstated as 'SPM by definition'. In March 2003, a decision was taken to reinstate the policy which had originally been agreed in March 1999.

19.192 In fact, in August 2003, when the SDF was amended, only some of the types of behaviour listed at paragraph 19.185 were reinstated as 'SPM by definition'. Despite the decision of the FPPC, certain types of conduct (i.e. abusive behaviour, driving under the influence of alcohol/drugs, failure to report dysfunctional colleagues and soliciting money from patients) were left in the 'SPM by discretion' category. The offence of providing a misleading reference was not replaced in either the 'SPM by discretion' or the 'SPM by definition' category. That was the position at the time of the Inquiry hearings in December 2003.

19.193 In March 2004, the full Council was asked, in effect, to ratify the FPPC's decision to restore the policy in relation to 'SPM by definition' and to agree the types of complaint or allegation that should, for the purposes of screening, be regarded as 'SPM by definition'. The briefing paper for the Council stated:

> **'In mid-2001, changes were made to the SDFs and several sub-categories were removed from SPM by definition. However, in March 2003, the former Fitness to Practise Policy Committee, following discussion at a screeners meeting, restored the 1997** (*presumably 1999*) **position.'**

19.194 In fact, as I have said, the 1999 position had not been **'restored'**, since five of the types of behaviour which had in 1999 been classified as 'SPM by definition' were no longer so classified. There might have been a good reason why some of the categories were not restored, although I cannot think of any reason why soliciting money from patients or providing a misleading reference could ever fail to raise a question of SPM. However, the concern is that the Council was under the mistaken belief that the *status quo* had been restored when it had not.

19.195 This briefing paper made clear that the category of 'SPM by definition' applied only for the purpose of screening, and did not apply to the PPC or the PCC. Thus, it remained possible for the PPC to decline to refer to the PCC a case involving conduct amounting to 'SPM by definition'. The Council proceeded to approve the list of cases to be regarded as 'SPM by definition', thereby affirming the list set out in the August 2003 SDF.

Observations

19.196 Mr Scott told the Inquiry that he had three concerns about the manner in which the policy agreed in March 1999 had been changed unofficially. First, he felt that the change had been a retrograde step. Given the fact that there was concern about possible bias within the GMC, he felt that it was necessary for the organisation to 'seize every opportunity to place itself above suspicion'. He said that he 'deeply regretted' that an opportunity to do this had been missed during the period for which the policy had been unofficially changed.

19.197 Second, Mr Scott said that he felt that he had failed in communicating to other members of the GMC staff the importance that he attributed to the SDF as originally conceived and to the concept of 'SPM by definition'. He had been involved in the drafting of the SDF and felt strongly about it. Third, Mr Scott was disappointed that it was not, as he put it, 'so blindingly obvious to everyone' that the categories designated in the original SDF were (as they were described) types of behaviour which, by definition, must amount to SPM.

19.198 I can well understand Mr Scott's concerns. Bearing in mind that it was the inconsistencies in screeners' decisions that led to the introduction of the concept of 'SPM by definition', the unilateral decision of the screeners to revert to the old practice of exercising discretion in such cases calls into question their suitability as decision-makers in a disciplinary process where consistency of standards and treatment is essential.

Random Distribution of Cases to Medical Screeners

19.199 With effect from January 1997, the GMC had agreed with the PSI team to implement a system of random distribution of cases to screeners. The reason was to eliminate any possibility of bias in allocation. Removal of this bias would permit reliable analysis of screening decisions. Under this system, cases were to be allocated to screeners on the basis of the final two digits of the doctor's GMC registration number.

19.200 When Professor Allen and her colleagues began to carry out their analyses in 1999, no one told them that the agreed system was not being fully applied. However, it soon became obvious that it was not. Moreover, some screeners were screening a lot more cases than others. Professor Allen and her colleagues were given no clear explanation as to why the system was not being applied. Nor were they told what system of distribution was in fact being applied. Professor Allen told the Inquiry that it 'was difficult to get a straight answer' about the matter.

19.201 After discussions between the PSI team and the GMC, it was agreed that, from January 2000, a 'cab rank' system of distribution of cases to screeners would be undertaken, in an attempt to eliminate any possibility of bias in allocation. The PSI team recommended that a continuing check should be kept to ensure this was being done. The 2003 PSI Paper showed that the new arrangements for allocation had not had the effect of equalising the numbers of cases dealt with by each medical screener. In 2001, the two most active screeners dealt with twice as many cases as the two least active screeners. Pausing there, I do not see how that could easily be avoided without causing delay; some screeners would have more time to devote to the task than others. However, provided that some sort

of 'cab rank' system of distribution was being faithfully implemented, the fact that the distribution between screeners was numerically unequal would not affect its randomness. The PSI team carried out no check to ensure that the distribution of cases to screeners was being operated on a random basis. It was assured by the GMC that that was so.

19.202 It was left to the members of the PSI team to find out for themselves in 1999 that the agreed system of distribution was not being implemented. If they had not carried out their work, everyone (except those immediately concerned with the allocation of cases) would have assumed – wrongly – that the system of distribution by GMC registration number was being operated faithfully and that the distribution was random.

19.203 Mr Scott said that, in the past, cases had tended to be allocated according to the specialty of the medical screener. For example, a GP would deal with complaints against GPs. When the new system was introduced, the medical screeners (or some of them) were unhappy, as they thought it more appropriate to continue with the old system. Medical screeners therefore asked to be given certain types of case. They passed cases between themselves. Some undertook more work than others. All these factors led to anomalies in the operation of the new system. Mr Scott said that there was 'a lack of understanding', on the part of those involved, of the reason behind the change of system.

Assessment of the Seriousness of the Allegations Contained in a Complaint

19.204 I have said that the 2000 PSI Report contained an analysis of medical screeners' assessments of the seriousness of the allegations in the complaints screened by them between July and December 1999. That analysis revealed significant variations between individual medical screeners in their assessment of seriousness. The analysis was made possible by the inclusion on the SDFs used by screeners of a section where the medical screener was asked to indicate his/her assessment of the seriousness of the case, using a four-point scale.

19.205 Subsequently, this section of the SDF was removed. It seems that this occurred at the same time as the changes were made to the categories of behaviour which were designated on the SDF as 'SPM by definition'. That would have been in mid-2001.

19.206 Mr Scott told the Inquiry that he had not been aware at the time that this change had occurred. He did not know how it had come about but did not think that it would have been as a result of unilateral action on the part of members of the GMC staff. Although it is not entirely clear, it seems highly likely that the change came about as a result of the wishes of the medical screeners (or some of them). It is difficult to see who else could have initiated it. It appears that, for some reason, they must have thought that the assessment of seriousness was unnecessary or unhelpful and must, therefore, have suggested to the staff that the relevant section should be removed from the SDF. Mr Scott said that he thought it would have been appropriate for the GMC to have discussed with Professor Allen in advance the likely impact that the change would have on subsequent data collection and analysis.

19.207 The removal of the relevant section of the SDF has had the effect of preventing the type of retrospective analysis which was carried out by the PSI team in 2000. It has also prevented

the GMC from conducting any continuing internal audit of screeners' assessments of 'seriousness' during the relevant period. It has, of course, been possible to carry out audits or analyses of the outcomes of screeners' decisions, e.g. of the proportions of cases closed by individual screeners or referred to the PPC. However, cases can be closed for a number of reasons not related to the seriousness of the behaviour alleged.

19.208 The apparent inconsistencies in the assessments of seriousness by individual screeners revealed by the PSI analysis in 2000 were marked. I should have thought that the GMC would have wanted to carry out further analyses to see whether a greater degree of consistency had been achieved, for example, as a result of the introduction of the 'cab rank' system of allocation. I would also have thought that assessments of seriousness would be highly relevant to the development of standards and criteria which Professor Allen and her colleagues had called for in each of the PSI Reports.

Comment

19.209 Each of the three changes mentioned above was introduced for very good reasons and with the approval of the GMC. One objective was to ensure that the PSI research would produce useful results. Professor Allen's brief was to discover whether or not there was any racial bias within the GMC procedures. That, in itself, was an important objective and it is disappointing that the screeners should have had so little understanding of or respect for that objective as to sabotage it in the way they did. However, the changes were also intended to have, and would have had, a wider beneficial effect. The introduction of 'SPM by definition' should have produced greater consistency of decision-making, to the benefit of all doctors who might be the subject of complaints to the GMC. Random allocation of cases to screeners would have enabled the GMC to scrutinise the work of different screeners and to identify outliers for self-correction or further training. The recording of degrees of seriousness would have had a similar beneficial effect and would also, as I have said, have formed a useful basis for work on standards and criteria. It is not only disappointing, but also worrying, that an important stage of the conduct procedures was being undertaken by a group of people who had no collective appreciation of the purposes and advantages of the changes introduced and who were prepared to give instructions to staff to alter the systems without referral to the appropriate committee or to Council.

19.210 It is also disappointing that the staff who received instructions to change the system from that which had been agreed should have bowed to the wishes of the medical screeners without drawing these wishes to the attention of Mr Scott. However, I do recognise that, in an organisation such as the GMC, it would be difficult for members of staff to question the propriety of an instruction given by a group of Council members.

19.211 These incidents do, however, clearly demonstrate that the GMC has been unable to control the exercise of discretion by medical screeners. It may be that the history of screening, founded in the exercise of a personal discretion by the President and perpetuated to some extent by the presidential selection of screeners for appointment, explains their attitude. It may be, as Mr Scott suggested, that medical screeners, being experienced decision-makers, were not prepared to take part in a process that allowed

as little exercise of discretion as screening should. It seems that the GMC has now realised that screening by members wishing to exercise an autonomous discretion is not appropriate.

19.212 Another feature that I find disappointing is the lack of candour displayed by the GMC when Professor Allen discovered that agreed systems either had not been fully implemented or had not remained in force. I sensed that Professor Allen felt rather embarrassed at having to report to the Inquiry that she had not been told that the agreed systems were not in force and that, when she found out about this, she had been given no explanation.

19.213 A further cause for concern is the fact that the Chief Executive of the GMC was obviously not aware of what was happening in such an important area of its FTP procedures. Members did not know that the directions given with proper authority were not being carried out. That this can happen (more than once) makes it difficult to place reliance on policy statements of the GMC. One cannot be sure that the declared policy is actually being carried out. I have said that the GMC is about to introduce new FTP procedures. The role of screening will be undertaken by case examiners, who will be susceptible to management in a way that screeners were not. However, concerns will remain that there may be a gap between what the GMC decides should be done and what happens in practice.

The Inquiry's Examination of Cases

19.214 In order to examine how the screening process worked in practice, the Inquiry decided to examine a number of individual case files. Requests were made for production of the files in the five or ten most recent cases in various categories. Most of these requests related to the decisions of Dr Korlipara, who had been suggested by the GMC as a witness suitable to describe and deal with screening issues. In this section of this Chapter, I shall comment upon those decisions, sometimes individually, sometimes collectively. I shall begin with a general account of Dr Korlipara's evidence.

The Evidence of Dr Krishna Korlipara

19.215 Dr Korlipara, a practising GP, has been an elected member of the GMC since 1984 and was a medical screener between 1998 and 2004. During his time on the GMC, he has sat on several Committees, including the PPC and the PCC. When he started as a medical screener, he 'shadowed' Dr Steel, who acted as his mentor. Dr Steel reviewed and discussed with Dr Korlipara some of Dr Korlipara's early screening decisions and Dr Korlipara was also able to read the files in some of the cases in which Dr Steel had made the screening decision.

19.216 For the first few months after Dr Korlipara began screening, the workload was heavy. In some weeks, he would deal with 18 to 20 cases. However, the workload then diminished, no doubt as a result of the measures introduced on the advice of Professor Allen and her colleagues and of the appointment of further medical screeners. It has continued to reduce since. In 1998, there were no target times for turning round screening decisions. As I have indicated, these were later introduced.

19.217 In his oral evidence, Dr Korlipara explained how he used the SDF to guide his decision-making. He agreed that the form had had the effect of directing screeners to make decisions in an orderly fashion. He also claimed that the SDF had:

> **'... helped to introduce consistency so that there is common understanding to all the screeners of the various criteria to be looked at before making a decision and to that extent, it has removed the different screeners working to the different possible criteria'**.

19.218 There seemed to be two problems with this claim. First, while the SDFs no doubt assisted in ensuring that screeners applied their minds to the correct questions in the correct order, they contained no standards or criteria to be applied when making a decision. The SDF contained a definition of SPM (see paragraph 19.220) and of SDP. It reminded screeners that they should not take into account the weight of the evidence or the intent of the doctor when reaching a decision on whether the case raised a question of SPM. It also offered assistance in assessing whether it would be appropriate for a case to proceed by way of the performance (as opposed to the conduct) procedures. A number of features that might have been indicative of SDP were listed on the form. However, there were no standards or criteria by which to judge whether an allegation amounted to SPM.

19.219 The second problem is that the 2000 PSI Report and the 2003 PSI Paper have shown that there were wide variations in the outcomes of cases between screeners in 1999, 2000 and 2001, i.e. after the introduction of the SDFs. Dr Korlipara acknowledged that the 'clear message' of the 2000 PSI Report had been that there was a lack of consistency between screeners. He said that he was anxious that consistency should be improved. He suggested that this could be done by more training, more agreed criteria and regular audits of screening decisions. He said that progress in these matters had been slower than he would have liked. He said that it was hoped that a measure of consistency would be introduced with the advent of the new case examiners.

19.220 The definition of SPM included on the SDF was:

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

Dr Korlipara described it as 'a good working definition'. However, he felt that SPM went 'a little way beyond that'. He would use the definition 'only as the starting basis'. He told the Inquiry that:

> **'... we** (*i.e. the screeners*) **have to ask ourselves whether the doctor's conduct is so serious departing from acceptable conduct that it seriously compromises the ethical standard that the profession has accepted and is so** (*un*)**acceptable that the registration of the doctor, in theory, ought to be in some way affected'**.

19.221 I have sympathy with Dr Korlipara's attempt to define SPM; it is not easy. The definition of SPM in the SDF is appropriate only in cases of alleged substandard treatment and, in such cases, the definition is not unhelpful. However, SPM embraces many different types of misconduct, of which providing substandard treatment is only one. I can understand why

Dr Korlipara would wish to describe SPM differently. The description given by Dr Korlipara of the test which he would apply when screening a case suggested that he was still (in December 2003) making decisions of the kind condemned as wrong in Holmes, i.e. by deciding whether the alleged conduct *did* amount to SPM, as opposed to whether it was *arguable* that it did. This is not a matter of personal criticism. It merely illustrates the very real problem faced by the screeners who had no standards, criteria and thresholds to apply when making their decisions. Dr Korlipara was a very experienced member of the GMC and had been a screener for five years. If he was not applying the correct test, it seems likely that there were other, less experienced, screeners who, despite the training they had undergone, had still not fully understood their role and were also operating a screening threshold higher than that permitted by the Rules.

Initial Screening Decisions

19.222 I mentioned in Chapter 18 that, under the procedures in operation as at December 2003, a casework manager had the option of submitting a case to a medical screener at an early stage for initial screening. This fast track system was used for cases which did not appear to the GMC staff to raise a question of SPM or SDP but where the complaint was about the adequacy or inadequacy of treatment or about the exercise of clinical judgement, so that some input from a medically qualified person was considered necessary before a final decision to close the case was taken. If the medical screener agreed that the case should be closed, the confirmation of a lay screener was necessary before this could be done.

19.223 In order for a case to be dealt with in this way, it had to fall within one of the categories set out in Section B of the SDF. These were as follows:

(a) the patient was demanding specific treatment/drugs and there was no suggestion that the doctor had acted unreasonably

(b) the patient was complaining simply on the basis that s/he was still ill and there was no suggestion that the doctor had acted unreasonably

(c) the patient was complaining about the side effects of treatment, where these were within acknowledged parameters and there was no suggestion that the doctor had misled the patient

(d) the patient was (only) asking the GMC to intervene in his/her treatment/care

(e) the complaint was about (only) the cosmetic outcome/failure of cosmetic surgery

(f) the complaint was about conflicting diagnoses, where there was no suggestion that the doctor had acted unreasonably

(g) the complaint was about a single and isolated error, and there was no risk that the error would lead to a serious/untoward outcome for the patient

(h) the complaint was about a failure to visit, where there had been no risk of a serious/untoward outcome for the patient and an appropriate alternative had been suggested.

19.224 The Inquiry requested the production of the files in the last five cases before 30th September 2003 that Dr Korlipara had screened out on an initial assessment of their merits. The GMC was able to find only three cases that had been dealt with by Dr Korlipara in this way during the previous 12 months. One of these, KD 01, did not in fact appear to have been an initial screening decision at all. The complaint had been received by the GMC in June 2001. The complainant had at first been advised to direct his complaint to local complaints procedures. He would not accept that advice, as he was dissatisfied with the way his complaint had been dealt with at local level. The complaint came back to the GMC and was closed by a caseworker in error in October 2001. It was reopened in February 2002 and medical records and other information were sought. The complaint was seen first by Dr Korlipara in October 2002. At that stage, he asked for an expert opinion. When that was available in November 2002, he closed the case (with the agreement of a lay screener) on the ground that it did not amount to SPM or SDP. Its closure was not, therefore, for one of the reasons set out in Section B of the SDF.

Dr KD 02

19.225 The other two cases related to cosmetic treatment. In the first (KD 02), the complainant was dissatisfied with the outcome of laser treatment she had undergone for facial capillaries. The letter of complaint did not allege substandard procedures or any worsening of her condition. It complained essentially of a breach of contract. If the complainant's account was true, the doctor's conduct was not entirely satisfactory. However, in my view, the decision to close the case was reasonable.

Dr KD 03

19.226 The other case concerned a Dr KD 03, against whom two complaints had been received, two years apart. In the first complaint, the complainant said that she had requested liposuction to improve the shape of her abdomen but, on the advice of the surgeon, had undergone an abdominoplasty (a procedure colloquially known as a 'tummy tuck'). She was dissatisfied with the outcome. She alleged that there was no improvement in the shape of her abdomen and that its appearance was worse by reason of the scarring. The doctor had said that, after the operation, she would have thin white scars, whereas, in fact, as she claimed, she had an unsightly purple scar running from one side of her abdomen to the other. A year after the operation, the doctor had agreed that the outcome had been 'not as planned' and had offered to carry out liposuction, free of charge. However, the complainant would have been obliged to pay the hospital charges. A letter written on the doctor's behalf said that the operation in dispute had been successful and that the only really satisfactory way forward was for the patient to lose weight by dieting. In any event, it was said, the doctor had counselled the patient about the 'realistic outcomes' of the surgery. There were, therefore, two contentious issues: first, whether the outcome was outside the range of what would be regarded as acceptable, and second, whether the doctor had warned the patient of the realistic outcomes or whether, as she claimed, he had told her she would have 'thin white scars'.

19.227 I have mentioned earlier that one of the grounds listed on the SDF that might justify the closure of a case at an early stage was that 'the complaint was about (only) the cosmetic

outcome/failure of cosmetic surgery'. That was the ground on which the medical screener (not Dr Korlipara) was invited to consider the closure of this case. The medical screener closed the case on that basis, saying that it:

> **'... falls completely outside the jurisdiction of the GMC. The outcome of a procedure in medicine can never be guaranteed. It appears that the doctor acted reasonably and has now offered to rectify the situation. If** (*the patient is*) **unhappy I suggest she approaches the Management of the local hospital.'**

19.228 The lay screener agreed that the case should be closed. The letter informing the patient of the decision did not say that the complaint had been rejected because it fell within a category of cases that the GMC had already decided, as a matter of principle, could not give rise to a complaint of SPM. Instead, it informed the complainant that the screeners had found **'nothing to indicate that** (*the doctor*) **seriously neglected or disregarded his professional responsibilities towards you. It appears that** (*the doctor*) **discussed all your options with you and obtained your informed consent before proceeding with the operation.'**

19.229 In short, the screeners had decided that the case did not in fact disclose evidence of SPM. The statutory provision at the time of the screening decision required that the case should proceed to the PPC unless the screeners decided that a question of SPM did not arise. It appears to me that a question of SPM clearly did arise. First, the decision to advise upon the operation might have been quite wrong or the technique by which it was performed might have been entirely incorrect. Also, there was a dispute about whether the doctor had advised the patient about 'realistic outcomes' or whether he had told her that she would have 'thin white scars'. If the doctor had given over-optimistic advice which had induced the patient to embark on surgery, that should, I think, have raised a question of SPM. Moreover, the decision to close the case was reached on the basis that the account advanced on the doctor's behalf was to be preferred to that of the complainant. It had been made plain in the case of Toth that screeners should not attempt to resolve conflicts of evidence. Leading Counsel to the Inquiry asked Dr Korlipara whether, in cases of this kind, it was the practice to ask the complainant to provide a photograph of the outcome. That would at least enable the GMC to obtain an opinion as to whether the result fell outside what was reasonable. It appears that photographs are sometimes available and sometimes not but it is not usual practice to request them in cosmetic cases.

19.230 Leading Counsel was also anxious to discover why it was the GMC's policy that complaints that concerned only the cosmetic outcome of cosmetic surgery were to be closed. Dr Korlipara said that he did not know why this category of cases was included on the list of cases to be closed but said that, as he understood it, screeners could exercise discretion and keep open a cosmetic case if they thought fit. He thought that perhaps this category of cases ought to be removed from the list. During the writing of this Report, the Inquiry team noticed that the wording of the relevant provision of the SDF had been changed at some time between July 2000 and August 2001. The version of the SDF in use in July 2000 stated that a complaint might be closed if **'the complaint is about (only) the cosmetic outcome/failure of cosmetic surgery and there is no indication that the**

care delivered was substandard'. By August 2001, the last clause had been deleted. Thus, screeners were encouraged to close cases without any real consideration of the issues, simply on the ground that the complaint related to the outcome of cosmetic surgery. It is clear that Dr Korlipara was aware that he could keep a case open if he thought fit. However, the change in the wording would result in a tendency for more cosmetic cases to be closed at an early stage than would have been the case before the change was effected.

19.231 When invited to comment on the merits of the decision itself, Dr Korlipara said that, if he had been the medical screener, he would have reached the same conclusion. He could not believe that any surgeon would have told the patient that she would be left with only thin white scars; that simply could not be guaranteed. The difficulty with that reply is that what was said was precisely the matter in issue in this case. When that was pointed out, Dr Korlipara expressed the view that, even if the doctor had unwisely made promises that he could not fulfil, it would not necessarily amount to SPM or SDP. I interpose to say, 'perhaps not necessarily', but at least it would raise a question of SPM. Dr Korlipara was then asked what his reaction would have been if a doctor had deliberately overstated the prospects of success in a cosmetic procedure with the intention of gaining private business. His response to that was that the idea 'would stop him in his tracks'. I infer from that answer that Dr Korlipara would have regarded that as a very serious matter; he had not apparently thought of the case in that way. Yet, on the basis of the information available to the GMC at the time the case was closed, that could quite possibly have been the position. Dr Korlipara was then asked (hypothetically) whether it would have made any difference to his view of the case if he had known that the hospital had had a number of other similar complaints about the doctor. That, he said, would have 'turned the case on its head'. It has not been the practice of the GMC to make such enquiries of local employers or primary care trusts (PCTs). Dr Korlipara appeared to accept that, in this type of case, there might be a case for making enquiries of the authorities in the locality in which the doctor practised.

19.232 The second complaint involving Dr KD 03 came from a patient who had undergone the removal of a facial lesion. He was dissatisfied with the outcome. The case was closed, following a decision by Dr Korlipara, with which the lay screener agreed, that the case involved only the cosmetic outcome or failure of cosmetic surgery and that there was **'nothing in the complaint which raises an issue of SPM/SDP'**. Interestingly, in the light of the previous complaint, this complainant also alleged that the doctor had advised him that he would be left with a 'faint white scar'. In his written statement to the Inquiry, Dr Korlipara said that he was informed of the earlier complaint when considering the later complaint. In that event, he appears not to have noticed the rather striking similarity between the two cases. In the second case, the patient complained that instead of a 'faint white scar' one centimetre long, he had been left with a scar that was 1.6cm long and 1.5mm wide, which he described as a 'thick red indentation'. It appeared from correspondence enclosed with the complaint that the patient had had a photograph of the scarring taken; he had sent it to the doctor when he had complained to him. Yet there is no sign that the GMC asked to see a copy of the photograph. The complainant also said that he had taken the advice of another cosmetic surgeon, who was going to carry out

remedial surgery. Apparently, this surgeon had said that the original result had been poor as the result of the operation not being performed in a 'good enough sterile environment'. In his statement to the Inquiry, Dr Korlipara said that he closed the case because he considered it to be an unjustified and trivial complaint. How he came to form the view that it was either unjustified or trivial on the material before him is not clear. He added that he saw nothing in the earlier complaint that caused him to change his mind on the second one. However, it is clear from his comments on the earlier case that his understanding of the issues was very limited.

19.233 The two cases involving Dr KD 03 give rise to real concern in my mind about the attitude of the GMC towards complaints that are 'about (only) the cosmetic outcome/failure of cosmetic surgery'. I recognise the possibility that unjustified complaints might be made by patients with unrealistic hopes and expectations. However, that apart, it seems to me that there are good reasons to examine complaints about cosmetic surgery with particular care. Much cosmetic surgery and cosmetic treatment is carried out in the private sector. There is a real danger that the advertising material used by providers of such surgery and treatment may not always be accompanied by appropriate counselling about realistic expectations. It is, as I understand it, well known that some cosmetic surgery clinics are operated by doctors with no special training as plastic surgeons. Often, the patient will not have been referred to the clinic by a GP or other doctor; s/he might well have walked in 'off the street'. The local handling of complaints by some small private providers is likely to be less than ideal. Some patients who undergo plastic surgery may be emotionally vulnerable. In my view, complaints from patients who have undergone private cosmetic surgery should be scrutinised with particular care. They should certainly not be subject to virtually automatic closure, as has evidently been the case in the past.

Cases Dealt with under the Chapter XV Procedures

19.234 The Inquiry requested papers in the last five cases before 30th September 2003 where Dr Korlipara had dealt with the case under the Chapter XV procedures. These case files, when examined, showed, first, that the caseworkers concerned were expressing appropriate and tenable views about the cases in question. Four of Dr Korlipara's decisions seemed to me to be reasonable, at least so long as the allegation was considered in isolation; the allegation, standing alone, could not arguably have constituted SPM. In two of the four cases, the doctor had failed to explain his diagnosis and treatment to the patient; in each case, he was advised to do so in the future. In a third case, the doctor had failed to 'write up' the patient's need for pain relief; as a result, the patient was left in pain for some hours. The doctor was reminded of the guidance on making an adequate assessment of a patient's condition and the need to keep a careful record of treatment. In the fourth case, the doctor was advised to be more polite to patients.

19.235 However, because it has not been the GMC's practice to make local enquiries about any other complaints against or concerns about the doctor, there remains some uncertainty in my mind as to whether it was appropriate to close these four cases with a letter of advice. For example, in the fourth case, KF 04, the complainant had alleged that the doctor had changed his medication without explaining that he was doing so or why. The new

medication had given rise to a number of unpleasant side effects. Having read the medical notes, Dr Korlipara thought that the change in medication was not unreasonable and felt that a failure to give a sufficient explanation could not amount to SPM. Standing alone, that decision seems reasonable. However, it seems to me that, for the proper protection of patients, some enquiry should have been made of the PCT to ascertain whether there were any concerns about the doctor's practice. It is possible that the PCT would have been aware of other concerns which, taken with this one (of which it might well have been unaware), could have raised a question of SDP.

19.236 In one of these five cases, KF 03, I feel some concern about the fact that the case was closed. The complaint came from an employee of an insurance company. The insurance company had received a claim under a policy on the life of one of Dr KF 03's patients who had recently died. Because the deceased's family would not agree to the disclosure of the deceased patient's medical records, Dr KF 03 had been asked to provide a medical report to the insurance company. In his report, the doctor described the deceased's medical history, as taken from the records. The description included a reference to an admission to hospital in the late 1990s following a drug overdose, and reference to the deceased's addiction to diazepam which, it was said, had been heavy since a few years earlier when he had lost his job. It appears that either of these two references would have entitled the insurance company to avoid the policy. In respect of the drug overdose, Dr KF 03 was asked by the insurance company if he could say what drug had been taken. He replied that in fact this had been an **'overdose'** of alcohol. He apologised for his earlier **'error'** but did not explain why he had made that error or why he was now able to correct it. It is clear from his letter that he had spoken to members of the family about the circumstances of the **'overdose'** since providing his original report. The letter of correction did not explain what information he was now relying on. The doctor did not refer to the hospital discharge letter which would have been written very shortly after the overdose. One would expect such a letter to specify the nature of the substance taken. Some months later, the doctor wrote to the insurance company again, volunteering the information that there had been another mistake in his original report. The deceased had apparently not been heavily addicted to diazepam until a year later than the doctor had previously reported, when he lost his job. The doctor apologised again. Again, he did not explain how he had come to make the earlier error or why he was now able to correct it. He did not make any reference to the medical records. The insurance company took the view that the doctor had acted dishonestly (by seeking to support the relatives' claim under the policy) or, at the very least, had been very careless when writing his initial report.

19.237 When the GMC notified the doctor about the complaint, his medical defence organisation wrote denying any intent on the doctor's part to deceive. The GMC caseworker was concerned about the allegations of fraud, which, if proved, would plainly be serious. He pointed out to the medical screener that the GMC had been unable to examine the deceased patient's records. The caseworker noted a conflict between the allegation and the doctor's denial. Dr Korlipara took the view that it was not for the GMC to investigate the possibility of fraud; that was for the police. The insurance company had decided not to report the case to the police. It had decided to refuse to pay out under the policy. However, it appears that there were other grounds for the insurance company to take this course,

which did not depend on the truth of the doctor's 'corrections'. Dr Korlipara decided to deal with the case on the basis that there was no evidence of fraud and that the doctor should be advised to be more careful in future when writing such reports. I can see that there was no direct evidence of fraud but there was a real suspicion of it and that should have been a matter of concern to the GMC. Many organisations, not only insurance companies, have to rely on the probity of medical reports and the GMC claims that it takes allegations of dishonesty very seriously. In my view, the GMC should be concerned when presented with evidence of something as suspicious as this. It seems to me that the attitude of the GMC to such a case should be to discuss ways and means to investigate the truth of the matter. It is not sufficient in my view simply to say that the case should be closed. I think this case should have been sent to the PPC for discussion about how best to proceed. Legal advice would have been required as to the possibility of obtaining the medical records, which might well have disclosed the truth of the matter. This case – and others to which I refer – seems to me to demonstrate a lack of determination on the part of the GMC to get at the truth. In general, it seems to have had a preference for leaving others to investigate and, if there was no one else prepared to do so, was content to leave even a potentially serious case uninvestigated.

Dr Korlipara's Screening Decisions

19.238 The Inquiry asked for disclosure of the papers in the last ten cases closed by Dr Korlipara before 30th September 2003. None of these cases gave rise to serious concern. However, it seems to me that, in the interests of patient protection, enquiries should have been made locally in some of those cases, in order to ascertain whether there were any other concerns of a similar or related nature about the doctor's practice or performance. An example is the case of Dr KE 10.

Dr KE 10

19.239 In the case of Dr KE 10, to which I refer in Chapter 18, it was alleged that the doctor had failed to diagnose the patient's terminal condition and had failed to provide her with adequate pain relief. In particular, it was said that the doctor had relied too heavily on telephone consultations instead of visits. The complaint had been pursued locally and an IRP had made a number of criticisms of the doctor, none of which would have amounted to SPM. However, if there had been other complaints or concerns about this doctor, it is possible that an issue of SDP would have arisen. To find that out, it would have been necessary to make local enquiries. In any event, it would seem to me to be appropriate for the GMC to find out what, if anything, the local PCT was doing about the criticisms made in the IRP report. In cases like this, I think that the GMC should have taken a more active role in the protection of patients, instead of simply closing the case because, standing alone, the allegations did not, in its view, amount to SPM or SDP. The GMC's attitude was that there was no need to intervene because the PCT was under a duty to act upon the IRP report and the GMC was entitled to assume that that had happened. I do not think that the GMC could reasonably have had confidence that the PCT would have taken action. A telephone call from the GMC enquiring what was known about the doctor and what steps had been taken in the light of the IRP report would have had three beneficial effects. First,

it would have enabled the GMC to satisfy itself whether there was a history of complaints or concerns which might suggest SDP. Second, if the PCT had not done anything about the IRP report, the call from the GMC would probably have had a salutary effect. Third, if the PCT had taken appropriate steps, the GMC could have told the complainant that, although it was not going to take action itself, it had satisfied itself that the PCT had matters in hand. It does not enhance the public perception of the GMC if it takes no action at all in a case in which another body, such as an IRP, has found grounds for criticism.

Dr JA 40

19.240 In addition to the ten cases mentioned in which the papers had been supplied pursuant to a specific request, the Inquiry came across another case, that of Dr JA 40, in which Dr Korlipara had screened out a complaint. The Inquiry first saw papers relating to this doctor because he had been convicted of drugs offences in the early 1980s. At that time, his case was dealt with at the GMC by the PPC, which closed the matter with a warning letter recommending continued medical supervision. A complaint against Dr JA 40 was received in the late 1990s, relating to his alleged failure to appreciate the severity of the condition of a small baby and to admit him immediately to hospital. At the time, the doctor was working for a deputising service. In essence, the mother complained that the doctor had been called out and had examined the baby who, according to the mother, was obviously ill; his breathing was abnormal. The doctor had said that there was nothing seriously amiss, that the baby had a 'sniffle' and had advised taking the baby to the GP in the morning. The mother had insisted that the baby must go to hospital and, somewhat reluctantly, the doctor had agreed and arrangements had been made for his admission. The mother said that, because the doctor had been so reassuring, she had decided that she would take the baby to hospital after she had made arrangements for the care of her other child. When the baby was admitted to hospital, about two hours later, he was found to be very seriously ill. Fortunately, he made a full recovery.

19.241 The doctor gave a different account of the consultation. He said that, on first receiving notice of the mother's concern about the baby, he had advised that she should be told to take the child to the local Accident and Emergency Department. He claimed that he believed that that was to be done. (The mother completely denied that.) He said that he nonetheless went to the house and found that the mother had waited for his arrival. After examining the baby, he agreed with the mother that the baby should be admitted to hospital. He did not make a definite diagnosis but he did not think that there was any emergency. He arranged admission and offered the mother an ambulance but she said that she wished to make childcare arrangements and would take the baby to hospital herself. He claimed that the baby's condition did not deteriorate severely until later. The mother agreed that the baby's condition had deteriorated further after the doctor's departure.

19.242 Dr Korlipara decided that the case should be closed because, he said, the doctor had acted reasonably and competently. He said that it was clear that the baby's condition had deteriorated after the doctor had left. In evidence to the Inquiry, when it was put to him that he had gone beyond his real function as a screener and had resolved the dispute between the complainant and the doctor, he said that there was a sufficient basis of undisputed

evidence to exonerate the doctor from criticism. In my view, there was not. Quite apart from the dispute about whether the doctor did in fact advise that the mother should be told to take the child to hospital even before he had visited, there was a further dispute as to whether the doctor had realised that the child was ill. If he had not, and if the child was admitted to hospital only because the mother had insisted, that might well amount to a serious failure or error of judgement on the doctor's part. In my view, Dr Korlipara resolved the conflict of evidence in the doctor's favour. He ought to have asked himself whether the allegation, if true, might amount to SPM. The case should have gone through to the PPC. This is another example of a medical screener going beyond his/her proper remit.

19.243 In this case too, as in several others, the GMC should have made local enquiries. On the file, there is an indication (as there was in the case of Dr KE 03) that the deputising service was not prepared to continue to employ the doctor. It should have been asked why. It might have taken that view because it was seriously concerned about the doctor's handling of this particular case; it might have had more general concerns about him. In the interests of patient protection, the GMC should have found out.

The Lay Screeners

19.244 Before describing a further group of cases examined by the Inquiry, i.e. those involving lay screeners, it may be helpful if I say a little more about the lay screeners' role. Screening by lay members of the GMC was introduced in 1990. The November 2002 Screeners' Handbook described their role thus:

> **'Their role is to ensure that the medical screeners, in judging doctors' behaviour against the values and standards of the profession, do not accept a lower standard than would be acceptable to society at large. The profession, through the medical screeners, regulates itself, but needs the confirmation of the public – in the shape of the lay screeners – that appropriate and generally acceptable standards are being applied.'**

19.245 Lay screeners are not required to participate in the screening of every case. Instead, they are involved only in those cases where the medical screener has decided that the case should not proceed further. As I have explained at paragraph 19.31, lay members were also involved in the 'old' Chapter XV procedures which were in operation until 1999.

The Statutory Provision

19.246 By the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) (Amendment) Rules 1990, rule 10(2) of the 1988 Professional Conduct Rules was amended to read:

> **'Subject to the foregoing rules** (*including rule 6(3)*) **and to paragraph (4)** (*which related to notification of a complainant, an informant and the doctor*) **the President** (*i.e. the medical screener*) **may direct the Registrar to refer any case relating to conduct to the Preliminary Proceedings Committee ... Provided that the President shall not decide not to refer a complaint to**

the Preliminary Proceedings Committee except with the concurrence of the lay member appointed under rule 4(5) (*i.e. the lay screener*)**.'**

The Nature and Extent of the Involvement of Lay Screeners

19.247 The 1996 PSI Report described the involvement of the lay screeners. In a case where a medical screener had decided that the case need not proceed further, the papers in the case, including the medical screener's comments, were passed to the lay screener. As I have said, the medical screener's comments might have been confined to a single word, indicating agreement with the contents of the memorandum on the case written by the GMC staff. They might have been more extensive. The lay screener would then confirm the decision of the medical screener or indicate his/her disagreement with it. If the lay screener disagreed with a decision, there would usually be a discussion between the two screeners. The lay screener might accept the medical screener's views and agree that the case should be closed. He or she might ask for further information to be obtained before a final decision was taken. The lay screener might (prior to 1999) suggest that the 'old' Chapter XV procedures should be invoked, as an alternative to closing the case immediately. If, however, after discussion, the lay screener remained of the view that the case should be referred to the PPC, this would be done.

19.248 There were limitations on the involvement of lay screeners. They played no part in the screening of conviction cases. Nor did the Rules ever require lay screeners to be involved before a decision was taken to remit cases to a health screener as an alternative to referring it to the PPC. Decisions as to whether a case should proceed along the conduct route to the PPC or by means of the voluntary health procedures were very significant. It was true that referral to the voluntary health procedures meant that a case was not being closed by the GMC at that stage. However, the effect of such a referral was to remove the possibility of the doctor's name being erased from the register.

19.249 Moreover, lay screeners have never been involved in cases in which the medical screener or a member of the GMC staff had decided that a complainant should be advised to pursue his/her complaint by means of local complaints procedures. Until 1993, and after March 1999, such decisions were dealt with by GMC staff without the involvement of medical screeners. In Chapter 18, I expressed my view that that practice was not compliant with the provisions of rule 6 of the 1988 Professional Conduct Rules. Between 1993 and 1999, there was a change of policy, whereby cases which might previously have been identified by the GMC staff as suitable to be pursued by means of local complaints procedures were first referred to a medical screener. Even then, however, lay screeners were not involved in the decision to refer such cases back to complainants to be pursued through local procedures. Apparently, this was because such cases were deemed not to be 'closed', but merely to have been deferred with the possibility that they might at some point be referred back into the GMC procedures. Thus, the thinking must have been that the medical screener had not made a substantive decision not to refer the complaint to the PPC. To all intents and purposes, however, cases that were referred back to be pursued through local procedures were 'closed', since no steps were taken to follow up their progress. Only if the complainant or a NHS body chose to refer them back to the GMC

would they be reconsidered. It seems to me that the failure to seek the concurrence of the lay screener in such cases was probably a breach of rule 10(2).

The 2000 Policy Studies Institute Report

19.250 In 2000, Professor Allen and her colleagues analysed the data contained on 792 SDFs completed during the second six months of 1999. Lay screeners were required to state on the SDF whether they agreed with the medical screener's decision. If they did not, they were required to give their reasons. The PSI team found that lay screeners had agreed with the medical screener's decision in almost 98% of the 423 cases in which a lay screener had been involved. Lay screeners had disagreed with the medical screener in only ten cases. At the time, four lay screeners carried out most of the work. The interventions of one of the four had accounted for half of those ten cases.

19.251 In August 2000, when the screening test was changed (see paragraph 19.120), the amended rule made it clear that a medical screener must refer to the PPC every case submitted to him/her unless s/he decided (and the lay screener agreed) that a question as to whether the doctor's conduct constituted SPM did not arise. The exceptions to this general rule were when a complainant who was a private individual had failed to provide a statutory declaration, and where a case was referred by the medical screener into the health procedures. By that time, GMC staff (not screeners) were responsible for making the decision to advise complainants to refer cases to local complaints procedures.

A Change in the Statutory Provision

19.252 In November 2002, when the screening test was changed again, a new rule 6(3A), dealing with the role of the lay screener, was introduced into the 1988 Professional Conduct Rules:

> **'The medical screener shall seek the advice of a lay member appointed under rule 4(5) in relation to any case submitted to him under paragraph (1) which he does not propose to refer to the Preliminary Proceedings Committee, and he shall direct that no further action be taken in the case only if the lay member so consulted agrees.'**

The effect of this change appeared to be that there would be consultation before the decision was made, rather than the medical screener making the decision first and the lay screener agreeing or disagreeing with it. It seemed to imply that the medical screener would make direct contact with the lay screener when s/he was proposing to make a decision to close a case. However, as I shall explain below, that does not appear to have happened in all cases.

The Evidence of Dr Arun Midha

19.253 The Inquiry heard evidence from Dr Midha, who has been a member of the GMC since November 2000 and was a lay screener from July 2001. Dr Midha explained that he dealt with the screening of cases in his spare time, in the evenings and at weekends. He applied the same test as did the medical screeners. He said that his practice was not to discuss the case with the medical screener before making his decision; lay screeners were given

the opportunity to speak to medical screeners before making a decision, but he did not choose to do so. He first considered the memorandum written by the caseworker and he used that to guide him through the file. Having identified the principal allegations and issues and the relevant evidence, he would then read the medical screener's recommendations. He would then make his decision. If he required an expert opinion, he would request that a report be obtained. If he had doubts about whether a case should be referred to the PPC, he would err on the side of caution and refer it. If he disagreed with the recommendation of the medical screener, he would communicate this fact to the caseworker by telephone or email. He would also communicate with the medical screener by email or ask the caseworker to contact the medical screener to inform him/her that the case would have to go forward to the PPC. He would provide reasons for his decision. He would do this as a matter of courtesy. However, he would not discuss his decision with the medical screener. This practice is rather different from that observed by the PSI team and described in their 2000 Report. It is also rather different from that apparently envisaged by rule 6(3A) of the 1988 Professional Conduct Rules.

19.254 In his witness statement, Dr Midha said that the most usual reason for disagreement with the medical screener concerned differences in judgement on whether an allegation was sufficiently serious to reach the threshold of seriousness in the screening test for SPM or SDP. In the past, medical and lay screeners worked in teams, with the same medical and lay screeners adjudicating on the same cases. By December 2003, however, distribution to the lay screeners was random so Dr Midha saw cases from all the medical screeners. He said that he had observed a 'slight variance' in the way that different medical screeners perceived what was and was not 'serious'. However, he felt that it would be difficult to set identifiable thresholds of seriousness. He did, however, acknowledge that guidelines identifying features that would aggravate or mitigate seriousness might be of value.

19.255 Dr Midha felt that the screening process had its limitations. Under the old system, as it was in December 2003, screeners had limited information on which to make decisions in some cases. He thought that there needed to be 'much more opportunity to investigate, to get much more in-depth information'. He recognised that there could be 'opportunities missed' because of lack of investigation. He hoped that more investigation would be possible under the new FTP procedures.

An Analysis of Recent Screening Decisions

19.256 Mr Marshall, Head of the GMC's Screening Section, had carried out an analysis of screening decisions taken in the 12 months to 30th September 2003. During that time, conduct and performance cases involving 1300 doctors had been screened by the medical screeners. Of those, the cases involving 750 doctors had been referred to a lay screener with a recommendation that the case should be closed. The lay screeners disagreed with the medical screeners in the cases of 50 doctors (i.e. almost 7% of cases dealt with by lay screeners). That is a rather higher incidence of disagreement between medical and lay screeners than had occurred during the six-month period in 1999 that was analysed by the PSI team: see paragraph 19.250. It suggests that lay screeners were more willing to disagree with the views of medical screeners in the period from 2002 to 2003 than had been the case in 1999.

Cases Considered by the Inquiry

19.257 The Inquiry requested that the GMC provide the papers in the last five cases before 30th September 2003 in which a lay screener had disagreed with the decision of a medical screener. In the event, it became clear that the cases provided were not the last five in which that had occurred; they had all been dealt with some time previously. It may be that they were the last five cases where the lay screener had disagreed with the medical screener's decision and where the case had already been dealt with by the PPC.

19.258 The lay screener in four of the five cases was Dr Midha. Four of the five complaints related to allegations of poor treatment and/or substandard practice, which were said to have caused the patients' deaths. All four involved complex medical issues. The fifth case was an allegation of breach of confidentiality. Four cases were subsequently closed by the PPC; the fifth was referred by the PPC to the PCC but the referral was subsequently cancelled. However, in four of the five cases, the PPC was sufficiently concerned to send a letter of advice or a warning letter to at least one of the doctors concerned. It seems to me that, in each case, the lay screener had been right to intervene; there was a real issue for discussion and decision by the PPC. In one, which concerned an allegation against an anaesthetist, the medical screener, who was a GP, wished to close the case without obtaining any independent expert evidence on an issue of anaesthetic practice. He relied on the opinion expressed in the report of an investigation carried out by the hospital employing the anaesthetist. Dr Midha asked for an independent expert report, which expressed a different opinion from that of the hospital report. The case went to the PPC, which, in the event, closed the case. Dr Midha told the Inquiry that he thought it was useful for the PPC to discuss such cases. I agree with him and, in my view, the GMC would not have been doing its job properly if that case had been closed without obtaining an independent expert report and discussing the case fully. It appears to me that there is real value in the role of the lay screener. I have the impression, however, that it must sometimes be difficult for lay screeners to take issue with a medical screener, particularly as there are no standards or criteria by which to judge whether it is arguable that the conduct constitutes SPM.

Conclusions

19.259 As has been seen, the wording of the statutory test underlying the screening process has changed in recent years. However, in practice, the test has not really changed. Screening always was, or should have been, only a preliminary filter, designed to remove from the caseload those complaints which clearly could not give rise to disciplinary action. As I have said, for many years, the test appears to have been wrongly applied. Far more cases have been screened out than should have been. It is impossible to assess how many or what proportion of cases were closed by screeners which ought to have proceeded to the PPC. Of course, the fact that a case ought to have gone to the PPC does not necessarily mean that it should necessarily have gone through to the PCC; it would have been open to the PPC to close it. But screeners and the PPC had different functions and had different tests to apply. I shall consider the work of the PPC in Chapter 20. The point I make here is that there seems to have been an ethos of early closure, which was, in my view, indicative

of an unwillingness to give complaints against doctors the consideration that they deserved. The balance between protecting patients and being fair to doctors was weighted towards the interests of the doctors. In my view, so long as members of the GMC are elected by the profession, there will always be a danger that their 'judicial' decisions will be subconsciously biased towards the interests of their electorate.

19.260 I do not wish to suggest that individual screeners were not conscientious in carrying out their work. I think they were. The problem was that, for many years, they were left to use their own discretion as to how they approached the task. This was to a large extent because of the history of the way in which their role developed. For about 75 years, screening was the sole preserve of the leader of the profession, the President of the GMC. He decided what was and was not acceptable. Even in the 1970s, when the President ceased to hold all three key roles (i.e. medical screener, Chairman of the PeCC and Chairman of the DC), he nominated the screeners and chairmen of the various FTP committees and so could wield his influence vicariously. Until 2004, the President nominated the screeners and the GMC was obliged to appoint them. It seems to me that this association with the President may have inculcated in screeners the feeling that they were in a position to exercise discretion and to make decisions on the basis of their personal views to a far greater extent than the GMC Rules actually allowed them to do. When, as the result of judicial review, it was clear that the screeners had not been applying the Rules, the medical screeners (or some of them at least) were not willing to learn and to change their practice. Also, when the PSI and the GMC agreed on measures which would have produced greater consistency of results, the medical screeners (or some of them) sabotaged the new arrangements. It may be that there was some improvement in the quality and consistency of decision-making in the last year or two of the old FTP procedures. I cannot say. However, it seems to me fortunate that screening as such will disappear under the new procedures. The preliminary filtering process is to be carried out by case examiners, who will not be elected members of the GMC and, it is to be hoped, should not feel under any subconscious pressure to lean towards the protection of doctors. It is to be hoped that there will be a fresh start with clearly defined and commonly understood standards and criteria to be applied at each stage of the process.

19.261 I shall return to the issue of standards and criteria on more than one occasion in this Report. The absence of standards and criteria seems to me to underlie many of the problems faced by the GMC in the past. In each of the PSI Reports, Professor Allen and her colleagues recommended that standards and criteria should be developed, with a hierarchy of seriousness. Only when that was done, she said, would it be possible to achieve consistency and transparency of decision-making. I agree with her completely.

19.262 My other major concern, highlighted by this examination of the screening process, is the failure of the GMC to investigate cases thoroughly before the preliminary decisions are taken and, in particular, to make enquiries of the doctor's employer or PCT. I noted in Chapter 18 that Dr Korlipara expressed the view that it was not part of the GMC's function to try to make a case against the doctor. In my view, there is a world of difference between trying to make a case against a doctor and carrying out a thorough and impartial investigation.