CHAPTER TWENTY

The General Medical Council Conduct Procedures: the Preliminary Proceedings Committee

Introduction

20.1 From 1951, General Medical Council (GMC) Rules provided for a further filtering process, to take place after that carried out by the screeners, as described in the last Chapter. Under the old fitness to practise (FTP) procedures, all complaints and reports of convictions which survived the filtering processes carried out by the GMC staff and by the screeners had to pass through a third filtering process if they were to be referred for a public disciplinary hearing. Before 1951, this third filtering process was carried out informally. Between 1951 and August 1980, the Penal Cases Committee (PeCC) assumed responsibility for the third filtering process. In August 1980, the Preliminary Proceedings Committee (PPC) replaced the PeCC and carried out the same function. Until 1980, the GMC committee responsible for holding public hearings in disciplinary cases was the Disciplinary Committee (DC). In 1980, the Professional Conduct Committee (PCC) replaced the DC.

20.2 In this Chapter, I shall describe the powers and functions of the PPC. I shall discuss the test applied by the PPC when deciding whether it should or should not refer a case to the PCC, and the guidance that was available to members of the PPC to assist them when making such decisions. I shall consider the evidence about how the PPC operated in practice. In particular, I shall examine some decisions of the PPC which have been the subject of judicial review. I shall also examine the decisions in a number of cases dealt with by the PPC, in respect of which files have been obtained by the Inquiry. I shall consider the light shed on the operation of the PPC by the work undertaken by the Policy Studies Institute (PSI). No complaint relating to Shipman ever reached the PPC. However, the operation of the PPC over the last 24 years is an important indicator of how the GMC conducted its FTP procedures in the past and is, therefore, of relevance to the Inquiry's task of making recommendations for the protection of patients in the future. As in previous Chapters, I shall focus particularly on evidence relating to patient protection.

Witnesses

20.3 Dr Robin Steel was a medical member of the GMC from 1984, an additional medical screener from 1987 and the principal medical screener and Chairman of the PPC between June 1992 and November 1999, when he retired from the GMC. He provided a witness statement but was not well enough to attend to give oral evidence to the Inquiry. Mr Robert Nicholls, a lay member of the GMC and Chairman of the PPC from November 1999 until June 2003, provided a written statement and also gave oral evidence. In addition, the Inquiry heard oral evidence from other witnesses with knowledge of the PPC, including Professor Isobel Allen, Emeritus Professor of Health and Social Policy, University of Westminster PSI. In the course of her research into the conduct procedures, Professor Allen observed 11 meetings of the PPC between June 1999 and January 2000.

The Annual Reports of the Preliminary Proceedings Committee

20.4 From 1981, the PPC was required by GMC Standing Orders to present a report on its activities to the full Council of the GMC at least once a year. By convention, the Annual Reports also covered the activities of the screeners. For many years, the Reports contained information (sometimes very detailed) about the numbers and types of complaints received by the GMC and about the outcome of those complaints at the pre-screening, screening and PPC stages. The Annual Reports also gave information about recent changes in practice and procedure. They provide a very useful source of information about the early stages of the GMC conduct procedures during the 1980s and the early 1990s.

20.5 During the late 1990s, the form of the PPC's Annual Reports changed. They contained less information about practice, procedures and outcomes for specific types of case. Instead, they became more concerned with statistical information. After 2001, the Annual Report of the PPC was subsumed into a document containing statistics for the conduct, health and performance procedures (the annual FTP statistics). The same annual FTP statistics also contain data about performance against service standards.

20.6 The Annual Reports did not contain reference to, or discussion of, any standards, criteria or tests being applied by staff, screeners or the members of the PPC when making decisions about the disposal of a case.

The Composition of the Preliminary Proceedings Committee

20.7 The composition of the PPC was governed successively by the General Medical Council (Constitution of Fitness to Practise Committees) Rules Order of Council 1980, 1986 and 1996 (the Constitution Rules). Between 1980 and 1996, the PPC was composed of the Chairman, eight medical members and two lay members of the GMC (i.e. 11 members in all). With the exception of the President of the GMC, members were not permitted to sit concurrently on more than one of the GMC's FTP committees (i.e., at that time, the PPC, the PCC and the Health Committee (HC)).

20.8 Until 2000, the Constitution Rules provided that the President (or the medical member nominated by him and appointed by the Council to act as medical screener in his place) should chair the PPC. In practice, save for a period between 1984 and 1989, when the President acted as medical screener and chaired the PPC, the PPC was chaired by the medical screener appointed in the President's place. That medical screener came to be known as the 'principal' medical screener to distinguish him/her from the additional medical screeners who were appointed to assist in the screening process.

20.9 Other members of the PPC were elected by the Council annually. As more medical screeners (and, from 1990, lay screeners) were appointed, it was usual for at least some of them also to be members of the PPC. Medical and lay screeners who were not elected members of the PPC were nevertheless invited to attend meetings of the PPC as observers. Although they had no vote, they might be called upon to address the PPC in relation to cases that they had screened. The legal quorum of the PPC was five.

20.10 The medical member of the GMC appointed to screen cases which raised a question whether a doctor's fitness to practise was seriously impaired by reason of his/her physical or mental condition was known as the health screener. By 1984, it was established practice for the health screener, if s/he was not an elected member of the PPC, to attend PPC meetings in order to advise upon cases where the health of a doctor was in issue. In 1986, the Constitution Rules were amended to provide that the health screener should automatically become a member of the PPC unless s/he had already been elected as such.

20.11 In 1994, the Constitution Rules were further amended to provide for the situation where fewer than five members were available to attend a meeting of the PPC, so that a legal quorum could not be achieved. The President was given the power to appoint temporarily to the PPC any member of the GMC who would have been eligible to stand for election to the PPC. In 1996, membership of the PPC was reduced from 11 (including the Chairman) to seven, although the quorum remained five. Five members of the PPC were to be medical members and two were to be lay members. The Constitution Rules continued to provide that the PPC should be chaired by the President or, if he chose not to act in that capacity, by the medical screener appointed in his place. If the Chairman of the PPC was not available to chair a meeting, the President had the power to appoint another member of the PPC to act as Chairman.

20.12 From 1996, the Constitution Rules no longer obliged the health screener to be a member of the PPC. However, notes produced by the GMC in June 1997 for the use of new members of the PPC indicated that, in practice, the principal health screener was treated as an *ex officio* member of the PPC. The second health screener attended meetings as an observer. The legal quorum continued to be five, to include at least one lay member. As the workload of the PPC increased, further GMC members were co-opted to sit on the PPC, using the power which had been conferred on the President in 1994. In addition, 'observer' screeners were sometimes called upon to deputise for members of the PPC who were absent, so as to ensure that there was a legal quorum.

20.13 In November 1999, the GMC decided, in anticipation of the coming into force in October 2000 of the Human Rights Act 1998, that the functions of the screeners and of the PPC should be separated. From November 1999, screeners (medical, health and lay) were no longer eligible for election to the PPC. Medical and lay screeners no longer attended meetings as observers. The Chairman of the PPC was to be the President or, if he chose not to act in that capacity, some other GMC member appointed by him. Mr Nicholls, a former lay screener, became acting Chairman of the PPC in November 1999. His appointment was confirmed in January 2000. In August 2000, the Constitution Rules were amended to reflect the changes which had already been put in place. Although the health screeners were no longer eligible for election to the PPC, at least one of them continued to attend meetings of the PPC whenever possible, to offer advice in cases where the health of a doctor was in issue. The health screeners had no vote.

20.14 As I have explained in Chapter 15, in 2000, the GMC was given the power to co-opt non-GMC members, both medical and lay, to sit on its FTP committees. A pool of such persons, who were known first as 'adjudicators', then as 'associates', was soon recruited.

Also in 2000, the Constitution Rules were further amended to give the President power (subject to the approval of the Council) to appoint a member of the PPC as Deputy Chairman, to perform the duties of Chairman in the Chairman's absence. This power, together with the power to co-opt onto the PPC other members of the GMC and associates, made it possible for differently constituted panels of the PPC to sit far more frequently than would have been feasible when it had a small static membership. In November 2002, the quorum of the PPC was reduced to three, to include one medical and one lay member.

Meetings of the Preliminary Proceedings Committee

20.15 The PPC met in private and considered only documentary evidence and written submissions. Neither the complainant nor the doctor was invited to attend its meetings. An exception to that general rule existed between 1980 and 2000, during which period the PPC had the power to suspend or impose conditions on a doctor's registration pending his/her appearance before the PCC or the HC. In such cases, the doctor would be notified in advance if the PPC was considering making an interim order. He or she (and/or his/her representative) was then entitled to attend the meeting at which his/her case was considered and to make representations on whether or not an interim order should be made.

20.16 From its inception in 1980, the PPC was always advised during its meetings by a legal assessor, who was appointed by the GMC and had to be a barrister, advocate or solicitor of at least ten years' standing. In practice, the role was usually filled by a junior barrister with significantly more than ten years in practice, by a Queen's Counsel or by a retired judge. It was the duty of the legal assessor to advise on any questions of law which might be referred to him/her by the PPC. The legal assessor also had a duty to inform the PPC immediately of any irregularity in the conduct of proceedings before the PPC which might come to his/her knowledge and to advise the PPC on his/her own initiative where it appeared to him/her that, but for such advice, there was a possibility of a mistake of law being made. There was no requirement (as was the case with legal advice given by a legal assessor to the PCC) that that advice (and any refusal by the PPC to accept it) should be made known to the doctor or to a complainant. Until the early part of 2000 at least, one or more representatives of the GMC's solicitors also attended meetings of the PPC in an advisory capacity. However, it seems that their attendance was subsequently discontinued. Members of the GMC staff also attended meetings in order to provide secretarial and other administrative support.

The Functions and Powers of the Preliminary Proceedings Committee

20.17 Section 13(2) of the Medical Act 1978 (which came into force in August 1980) defined the functions of the PPC. It stated:

> **'It shall be the duty of the Committee to decide whether any case referred to them for consideration in which a practitioner is alleged to be liable to have his name erased ... or his registration suspended or made subject to conditions ... ought to be referred for inquiry by the Professional Conduct Committee or the Health Committee.'**

This subsection was reproduced in section 42(2) of the Medical Act 1983 and continued unchanged thereafter.

20.18 Rule 11(1) of the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules Order of Council 1980 (the 1980 Professional Conduct Rules) provided:

> **'Where a case has been referred to the Preliminary Proceedings Committee ... that Committee shall consider the case and, subject to these rules, determine:**
>
> **(a) that the case be referred to the Professional Conduct Committee for inquiry, or**
>
> **(b) that the case shall be referred to the Health Committee for inquiry, or**
>
> **(c) that the case shall not be referred to either Committee.'**

20.19 The 1980 Professional Conduct Rules also gave the PPC the power to adjourn a case for further investigations to be made, or in order to obtain legal advice before making its determination. These provisions were reproduced in the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules Order of Council 1988 (the 1988 Professional Conduct Rules) and remained virtually unchanged thereafter.

20.20 No criteria were ever stated in the Medical Acts or in the Rules for the guidance of the PPC when deciding whether a case **'ought to be referred'** to the PCC or the HC or to neither. It is to be noted that the wording of rule 6(3) of the 1980 Professional Conduct Rules (later rule 6(3) of the 1988 Professional Conduct Rules) which governed the decisions of screeners was very similar to that of section 13(2) of the Medical Act 1978, later section 42(2) of the Medical Act 1983. Rule 6(3) 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 ... stating the matters which appear to raise a question whether the practitioner has committed serious professional misconduct.'**

20.21 As I shall later explain, the similarity between the wording of rule 6(3) and section 42(2) led Professor Allen to conclude that there was no real difference between the two filtering processes carried out by the screeners and the PPC. One decided whether a matter **'need not proceed further'** and the other decided whether it **'ought to be referred'** to the PCC. The distinction appeared to be a fine one.

20.22 At the time of the introduction of the performance procedures in 1997, the PPC was not given the power to refer a case to the Committee on Professional Performance (CPP). Nor was it able to refer a doctor for a performance assessment or for consideration to be given by a medical screener to the possibility of directing such an assessment. That represented a significant gap in the powers of the PPC. Mr Nicholls said that the lack of such powers had 'caused quite a lot of heart searching in the PPC' during his time as Chairman.

The Possible Outcomes of the Consideration of a Case by the Preliminary Proceedings Committee

Referral to the Professional Conduct Committee

20.23 As I have said, the PPC had to decide whether a case **'ought to be referred'** to the PCC. Until 1988, once the PPC had decided that a case ought to be referred to the PCC, rule 11(2) of the 1980 Professional Conduct Rules applied. Rule 11(2) provided:

> **'When referring a case to the Professional Conduct Committee the Preliminary Proceedings Committee shall indicate the convictions, or the matters which in their opinion appear to raise a question whether the practitioner has committed serious professional misconduct, to be so referred.'**

The 1988 Professional Conduct Rules amended rule 11(2) to make clear that the **'convictions'** or **'matters'** indicated by the PPC were those which would form the basis of the charges which the doctor would have to answer at the hearing before the PCC.

Referral to the Health Committee

20.24 The 1980 Professional Conduct Rules provided that, if the PPC was considering referring a case to the HC, it could seek medical evidence about the doctor's condition before taking the decision whether to refer, and could adjourn the case pending receipt of such evidence. Alternatively, the PPC could refer the case to the HC and invite the doctor to undergo medical examination(s) before the case came before the HC. When referring a doctor to the HC, the PPC was required to indicate the nature of the physical or mental condition(s) that made it appear to the PPC that the doctor's fitness to practise might be seriously impaired.

20.25 If the PPC referred a case to the HC and the referral proved inappropriate for some reason (e.g. because, on examination, no health problem was identified), the HC had no jurisdiction to act, nor any power to send the case back to the PPC. In those circumstances, the GMC would be powerless to act. This was a *lacuna* in its powers which was never remedied. In practice, however – no doubt because members of the PPC were aware of the potential problem – very few cases were referred by the PPC direct to the HC. The Inquiry was told that, on the rare occasions when a case was referred to the HC, medical evidence would invariably have been obtained before the referral was made.

Adjournment for Further Investigation

The Use of the Power to Adjourn in Conduct and Conviction Cases

20.26 It does not appear that the PPC's power to adjourn for further investigations was used frequently for the purpose of instituting investigations about substantive issues relating to the conviction or conduct under consideration. This is surprising given that the amount of

evidence put before the PPC seems, in most cases, to have been the same evidence as was put before the screener. The amount of evidence required for the screening decision was said to be 'minimal'. I infer therefore that, in many cases, the amount of evidence put before the PPC will also have been minimal. The practice was that the PPC reached a decision to send a case to the PCC 'for inquiry' and formulated the charges that the doctor was to face on the basis of quite limited evidence. The file was then referred to the GMC's solicitors to be prepared for the hearing; this process would sometimes involve evidence gathering. As Mr Finlay Scott, Chief Executive of the GMC, told the Inquiry, this involved 'putting the cart before the horse'. The adverse consequences of late investigation are obvious. First, some cases were probably not referred to the PCC because their seriousness had not been fully appreciated and/or because the PPC had the impression that the evidence available would not be adequate. Second, it sometimes transpired that the evidence that was eventually gathered by the solicitors did not adequately support the charges that had already been formulated. This resulted in the dropping of some, or even all, of the charges against the doctor. On the other hand, the evidence collected might disclose that the allegations were rather more serious than had been thought and that the charges required amendment. Ideally, investigation should take place at an early stage. But, if it had not taken place at the very outset, it should, I would have thought, at least have taken place before the PPC reached its decision.

Adjournment in Health Cases

20.27 It was not uncommon for the PPC to adjourn a case in order to initiate investigations into a doctor's health. There was a good reason for this.

20.28 If, at the screening stage, the medical screener did not refer the doctor to the PPC, but instead remitted the case to the health screener, the doctor might then be invited to agree to undergo medical examinations. If, as a result of those examinations, it appeared appropriate to the health screener, the doctor could be invited to enter into voluntary undertakings as to his/her future conduct and as to any restrictions on his/her practice that the health screener might deem necessary. The process of dealing with doctors by means of voluntary undertakings became known as the 'voluntary health procedures'. I shall explain their operation in Chapter 22. Provided that the doctor complied with his/her undertakings (and that his/her health did not deteriorate), s/he would not be required to attend a formal hearing and would not be at risk of suspension, which was the most serious sanction available in a 'health case'.

20.29 By contrast, if a doctor was referred by the PPC to the HC, the voluntary health procedures were not available. The doctor would be subjected to a hearing before the HC that, although not held in public, was nevertheless formal in nature. He or she would, in theory at least, be at risk of suspension. Thus, a doctor who was referred by the PPC to the HC was in a disadvantaged position when compared with a doctor whose case had been remitted to the health screener by a medical screener. Recognising the potential unfairness of this, the PPC was concerned to prevent doctors from being disadvantaged in this way. Thus, in a case where it was considered that a doctor's fitness to practise might be impaired through ill health, the PPC would use its power to adjourn the case for further investigation. It would then remit the case to the health

screener. The health screener would arrange for the doctor to be medically examined and, depending on the contents of the examination reports, would assess the doctor's suitability to be dealt with by means of the voluntary health procedures. If the doctor was considered suitable to be dealt with under the voluntary health procedures, the PPC would adjourn the case *sine die* to allow this to be done. If the doctor proved for some reason unsuitable to be dealt with under the voluntary health procedures (perhaps because no health problem was found or because s/he refused to enter into voluntary undertakings), the health screener would refer the case back to the PPC. The PPC was then able to consider the case again and decide how to deal with it. The options of referring the case to the PCC or to the HC were still open to it. This facility – whereby a case could be referred by the PPC to the health screener who could, if necessary, pass it back to the PPC – made it preferable for the PPC (save in very rare cases) to use its power to adjourn for investigation rather than referring the case to the HC.

20.30 I have said that, when a case was remitted to the health screener and was dealt with by means of the voluntary health procedures, the PPC would adjourn the case *sine die*. The Annual Report of the PPC presented to the Council in November 1985 indicated that, rather than leaving an adjourned case 'in limbo', a practice had by that time been developed whereby, at some later stage, the PPC would receive medical evidence and, if it thought fit, would then close the case. Mr Nicholls told the Inquiry that, between September 1999 and May 2002, when he was on the PPC, it would receive regular reports on cases that had been adjourned *sine die* to the voluntary health procedures. This enabled cases to be formally closed by the PPC. In order to comply with the 1988 Professional Conduct Rules, formal closure by the PPC was necessary if a case was not to be referred to the PCC or the HC. However, Mr Nicholls said that, from May 2002, there was a period of about nine months when reports on cases which had been adjourned *sine die* were not made to the PPC. Although Mr Nicholls was confident that the 'loose ends' were being 'perfectly well tied up' by the Health Section during that time, the PPC did not know the outcome of the adjourned cases and Mr Nicholls said that this was something he regretted. The practice of regular reporting to the PPC was, he said, subsequently reintroduced.

Decision Not to Refer

20.31 If the PPC decided not to refer a doctor to the PCC or to the HC, the Registrar (or the GMC staff exercising his legal powers) was required to inform both the doctor and the complainant (if any) of the decision in such terms as the PPC might direct.

Warning Letters

20.32 This provision was used on occasion to send a warning letter to a doctor, advising him/her about his/her future conduct. Initially, warning letters were sent mainly in conviction cases, many of them drink driving cases. A few warning letters were sent in cases involving allegations of serious professional misconduct (SPM). They were not used in cases where the facts giving rise to the complaint were disputed. In such cases, there

would be no proven misconduct about which the doctor could be warned. Warning letters were used, therefore, only in cases where the doctor had admitted the allegations in whole or in part, or where the facts were proved or were beyond dispute. Over time, a hierarchy of different warning letters (termed 'mild', 'standard' and 'strong' or 'severe') developed. They were used extensively.

Cautionary Letters and Letters of Advice

20.33 In a case where the PPC had concerns about the doctor's conduct but did not feel it appropriate to refer the case to the PCC and where there was no proof or admission of misconduct, the practice grew up of sending a 'cautionary letter' or a 'letter of advice'. In the past, it appears that the two types of letter were rather different. A cautionary letter would inform the doctor that the papers relating to the complaint would be kept in the GMC's records and would be looked into if the doctor were to be the subject of a similar complaint in the future. It would also advise the doctor as to his/her future conduct. Letters of advice merely made recommendations to the doctor about his/her future conduct. They often contained references to the publication 'Good Medical Practice' (after 1995), or to other GMC guidance. The Inquiry was told that, in recent years, the sending of cautionary letters had been discontinued. However, the PPC continued to send letters of advice in a large number of cases. In 2002, the PPC considered the cases of 546 doctors; it sent 234 letters of warning or advice. In 2003, the PPC sent letters of warning or advice to 185 of the 418 doctors whose cases it considered.

20.34 Mr Nicholls said that the increase in the number of letters of advice sent by the PPC reflected a greater appreciation by the GMC of its overall duty to attempt to raise standards of care generally. Instead of confining itself to the narrow range of very serious cases in which a doctor's registration was in issue, there was a desire to take some action in less serious cases where there had been a departure from 'Good Medical Practice'. This in itself is a laudable aim. However, I am uncertain how much can be achieved by the sending of a letter of advice in a case where the allegation has not been investigated and the doctor has not admitted any shortcoming.

The Treatment of Further Convictions or Allegations of Misconduct

20.35 Rule 14 of the 1980 Professional Conduct Rules dealt with conviction cases in which the PPC had decided not to make a referral either to the PCC or to the HC, or in which the medical screener had decided not to refer the case to the PPC. If the GMC were subsequently to receive notice of another conviction or a complaint of misconduct concerning the same doctor, it was open to the President (or the medical screener appointed in his place) to direct that the earlier conviction should be referred to the PPC, together with the subsequent conviction or complaint. In that event, the earlier conviction would be dealt with afresh, as if the PPC or medical screener had not made the earlier decision, and the PPC might refer it to the PCC or to the HC. It was in the context of the forerunner of this rule that Shipman was warned in 1976 that any repetition of his misconduct was likely to result in the reconsideration of his convictions for drug-related offences.

20.36 In 1988, the rule was amended so as to apply also to cases where the original matter considered by the PPC or the medical screener had been a complaint about a doctor's conduct, rather than a conviction. However, in such cases (but not where the original matter had been a conviction), the rule applied only if the subsequent complaint was notified within two years of the PPC's or screener's decision in the earlier matter. In 2000, the rule was changed again so as to apply the two-year limit to convictions, as well as to conduct cases. It appears to me that the two-year limit on the power to resurrect a closed case might not have provided adequate protection for patients. If, for example, Shipman had been convicted of further drugs offences (or had been found to have been abusing drugs) three – or even five – years after the case against him had been closed with a warning, I do not think it would have been satisfactory for the GMC to have dealt with him without being able to take account of the fact that the later problem represented a relapse into old habits.

20.37 At one time, as I have explained, the letters sent by the PPC sometimes warned the doctor that, although the PPC had decided not to refer the complaint to the PCC on the occasion in question, the complaint might be resurrected if the GMC received a further complaint or report about the doctor within two years. Mr Nicholls said that this was 'very unpopular'. The view was that the two-year limit was in the Rules, so that there was no need to refer to it when writing to doctors and, in any event, nothing had been proved against the doctor concerned. Because of its unpopularity, the practice of including the 'resurrection clause' in letters was discontinued. Mr Nicholls told the Inquiry that the intention of a letter of advice was to tell the doctor to 'watch it'. He did not think that putting an 'artificial time' on the advice added anything. I can see that to put an 'artificial time' on the advice would not be sensible. However, the time was not artificial; it was a provision of the Rules. If, within a specified period, a doctor was at risk that a closed case might be resurrected, s/he ought to have been told not only of the risk but also of the period for which the risk would persist. It cannot be assumed that all doctors are familiar with the small print of the GMC's Rules. I would have thought that any doctor who was not warned of the risk that a closed case might be resurrected would have had an argument for opposing its resurrection.

Interim Orders

The Position before 2000

20.38 Section 13(3) of the Medical Act 1978 and rule 12 of the 1980 Professional Conduct Rules gave the PPC the power to make an interim order suspending a doctor's registration or making his/her registration conditional on his/her compliance with such requirements as the PPC thought fit to impose for the protection of members of the public or in the doctor's own interests. Such an order could be made only after the PPC had decided that a case should be referred to the PCC or to the HC. An interim order had to be imposed for a specified period not exceeding two months. The PPC was given no power to renew the order after that period. Notice had to be given to the doctor that the PPC was considering making such an order and s/he had to be given the opportunity to be heard. Between 1980 and 1996, very little use was made by the PPC of its interim powers. Only four interim orders were made. The small number of such orders made seems very surprising. One would have expected that, over a period of 16 years, there would have been quite a lot of

cases in which an interim order would have been needed for the protection of patients. I can see that the short period for which such an order could operate might have been less than satisfactory, but an order for two months would seem to be better than nothing. If an interim order had been made, the PCC could have been asked to expedite its hearing. However, it appears from the PPC's Annual Reports that the PPC saw little need to make interim orders.

20.39 In 1996, the maximum period for which an interim order could be imposed was increased to six months and the PPC was given power to renew the order for up to three months. Thereafter, the use made by the PPC of the power to impose interim orders increased markedly. Five interim orders for suspension were made (in respect of three doctors) in 1997. Nine new interim suspension orders were made in 1998, together with one order imposing interim conditions and several renewed orders. In 1999, the number of new interim suspensions rose to thirteen, with nine new orders imposing interim conditions being made.

20.40 In the period from January until August 2000, the PPC made 17 new orders for the suspension of doctors' registration, together with 15 new orders imposing interim conditions. In August 2000, the power to impose interim orders was removed from the PPC and given to the newly created Interim Orders Committee (IOC). After that, if it appeared to the PPC that the circumstances were such that the IOC might wish to make an interim order, whether for the suspension of registration or for the imposition of conditions on registration, the PPC was required to refer the case to the IOC.

The Circumstances Leading to the Creation of the Interim Orders Committee

20.41 The IOC was created as the direct result of the GMC's inability to suspend Shipman's registration when it was informed, in August 1998, by the Greater Manchester Police (GMP), that he was under investigation for murder.

20.42 The second (and successful) police investigation into the deaths of Shipman's patients began in late July 1998. The first death to be investigated was that of Mrs Kathleen Grundy. On 10th August 1998, the GMP learned for the first time that Shipman had convictions for offences involving controlled drugs. Four days later, enquiries were made of the GMC about Shipman. A member of the GMC staff confirmed that Shipman had previous convictions, but declined to give further details, save to say that the case had not proceeded to a disciplinary hearing. Later the same day, the results of the toxicological examination of the body of Mrs Grundy were received by the police. These revealed the presence of an opiate (possibly morphine) in her body tissues.

20.43 At that point, Detective Superintendent (Det Supt, later Detective Chief Superintendent) Bernard Postles, who was leading the police investigation, notified the GMC of the position by telephone and informed a member of staff of the concerns that he had about Shipman continuing in practice. Det Supt Postles was informed that the GMC could do nothing until Shipman had been convicted of a criminal offence. On 18th August 1998, Det Supt Postles wrote to the GMC, setting out details of the ongoing investigation into Mrs Grundy's death and inviting the GMC to take any action it considered appropriate. A member of the GMC staff responded by letter, requesting Det Supt Postles to keep the GMC informed of the

progress of the investigation. It was apparent that no action was to be taken by the GMC and, indeed, its Rules at the time did not permit it to take interim action to suspend a doctor unless and until the doctor had been convicted of a criminal offence or a decision had been taken by the PPC to refer his/her case to the PCC or the HC.

20.44 By this time, it had become clear that Shipman might have killed other patients besides Mrs Grundy. Shipman was still practising and Det Supt Postles was becoming increasingly concerned about the safety of his patients. He was in contact with the West Pennine Health Authority, which was exploring the possibility of taking steps through the NHS Tribunal to suspend Shipman. It was not possible to achieve his suspension quickly by that means. Accordingly, Det Supt Postles decided that the only way to protect Shipman's patients was to arrest him. This was done on 7th September 1998, earlier than Det Supt Postles would have otherwise chosen to act. Shipman was remanded in custody from that time. Eventually, he was suspended from practice by the NHS Tribunal on 15th October. The decision took effect on 29th October. I have recounted in Chapter 7 the sequence of events that led to Shipman's suspension.

20.45 Meanwhile, the police were compiling an antecedent history for Shipman, to be placed before the court. A telephone enquiry was made of the GMC as to whether any disciplinary action had been taken against Shipman as a consequence of his convictions in 1976. A member of the GMC staff replied that the GMC had no documentary record of Shipman's case, but that the most likely course of action would have been for Shipman to have been issued with a warning letter. In fact, as is evident from Chapter 16, the GMC did have a file containing documents relating to Shipman's case in 1976. In January 2000, shortly before Shipman's conviction and in response to a request by Mr Richard Henriques QC (now Mr Justice Henriques), Leading Counsel for the prosecution at Shipman's trial, the GMC provided details from its files about its handling of Shipman's conviction in 1976 and of complaints made to the GMC about Shipman in 1985 and 1994.

20.46 The inability of the GMC to take interim action in Shipman's case was the cause of considerable embarrassment, both to it and to the Government. In November 1998, the GMC's Fitness to Practise Policy Committee (FPPC) considered a paper relating to doctors charged with serious criminal offences. The paper made clear that the problem caused by the inability of the GMC to take interim measures in respect of such doctors was not a new one. The paper observed:

> **'We often become aware of criminal proceedings, involving a doctor, before the matter goes to trial. Typically, a Health Authority or Trust will phone when a doctor is charged. There is frequently an expectation that the doctor's registration will be suspended pending the outcome of the criminal case. We also become aware of cases from press cuttings, or direct from the doctor concerned ...**
>
> **We have to explain that the Medical Act 1983 gives no power to intervene unless and until the doctor has been convicted.'**

20.47 The paper acknowledged that it was impossible to make a reliable assessment of the number of cases in which this problem arose, since the GMC would not necessarily be

aware of all cases where doctors were facing serious criminal charges. It was reported that, at the time the FPPC considered the paper, the GMC was aware of six current cases of this type. Two doctors (one of them Shipman) had been charged with murder and were in custody. Two doctors were known to be on bail and practising; one was charged with multiple offences of indecency against female patients, one with multiple offences of rape and indecent assault. A third doctor, who had been charged with an offence involving an indecent assault on a patient, was on bail and believed to be seeking work. The fourth doctor was on bail and believed to be seeking work; he had been charged with offences of rape, causing grievous bodily harm and making threats to kill. The four doctors who were on bail must have presented a serious risk to patients. The majority of the six doctors were general practitioners (GPs), since primary care organisations (PCOs) experienced more difficulty than hospital trusts in preventing doctors from practising. However, even if a hospital trust suspended a doctor, the doctor could simply move and practise elsewhere.

20.48 The paper observed that the GMC's inability to suspend registration pending the trial of a doctor charged with serious offences:

> **'... is beginning to appear unsatisfactory, whether considered from the point of view of the GMC, the Trust or health authority or, most importantly, the public interest'**.

20.49 The paper referred to the **'risks'** of suspending a doctor in these circumstances. It pointed out that criminal proceedings could be protracted and that suspension might, therefore, last for up to a year or more. It might be thought **'inherently undesirable'** for a doctor to be deprived of the means of earning his/her livelihood for such a long period and it might appear to be a **'grave injustice'** if the doctor were eventually acquitted. The paper also mentioned that an order for interim suspension might be considered oppressive by the courts and could lay the GMC open to judicial review or to claims for compensation for loss of earnings and reputation. The paper did, however, note that the UK Central Council for Nursing, Midwifery and Health Visiting (the predecessor of the Nursing and Midwifery Council) had power to impose interim suspension where it appeared necessary to do so as an interim measure for the protection of the public, or in the practitioner's interests.

20.50 The paper noted that one option was to leave it to the courts to remand in custody doctors whom they considered a danger to the public. However, it was recognised that, even if a doctor were in custody, s/he could still enjoy some of the privileges of registration, such as prescribing. The paper suggested that, as a matter of principle, the GMC should not expect the courts to discharge its responsibility to protect the public interest. It therefore recommended that the FPPC should consider whether it was desirable to have wider powers of interim suspension.

20.51 This recommendation was adopted by the FPPC which resolved to seek legal advice on various related matters. That advice was received and there the matter appears to have rested until the end of 1999, when Shipman's trial was drawing to a close. At that stage, discussions were opened with the Department of Health about what was to be done. A letter from Miss Isabel Nisbet, Head of the GMC's Fitness to Practise Directorate, written

in December 1999, mentioned other problems arising from the limitation on the GMC's existing powers. She said:

> **'... we regard it as very unsatisfactory that we have no power of interim suspension via the performance procedures for doctors about whose professional performance there are very serious concerns and who may be a danger to patients'**.

20.52 She observed that the GMC was obliged to pursue such cases through the conduct procedures in order to enable the PPC to consider the question of interim suspension. Presumably, that would not be possible in some cases. In any event, it was plainly unsatisfactory, since there was no mechanism then to get cases back into the performance procedures. Miss Nisbet also drew attention to the lack of any power to make an initial interim order within the voluntary health procedures, despite the fact that a doctor posed an ongoing threat to the safety of patients. She pointed out that, even when interim measures could be taken, the time periods allowed by the Rules meant that it was very unusual for the GMC to be able to impose interim suspension earlier than six to eight weeks after the time when it first became aware of a concern.

20.53 Miss Nisbet suggested ways in which the necessary powers might be given to the GMC. This could be done by amendment of the Rules or by the creation of a new committee with power to impose interim suspension when it appeared to be necessary for the protection of the public. This latter solution would require both primary and secondary legislation and was the solution favoured by the GMC.

20.54 Mr Scott told the Inquiry that, on 1st February 2000, the day after Shipman's conviction, there was a 'heated discussion' with the then Secretary of State for Health (SoS), the Rt Hon Alan Milburn MP. Mr Scott said that 'it was being thought in some quarters that the GMC had an abhorrence of imposing interim suspension and that simply was not the case'. He said that the problem was that its powers were 'inoperable'. He said that, prior to 1998, the GMC had not fully understood the limitation in its powers in relation to doctors who were involved in criminal proceedings. The GMC's attention had instead been focussed on the problems caused by the period for which interim suspension could be imposed. As I have explained, until 1996, the maximum period was only two months. In 1996, this was increased to six months, with the opportunity to renew the order for up to three months thereafter. Mr Scott acknowledged that the GMC had not 'spotted the problem' of doctors who were subject to criminal investigation but had not yet been convicted. The result of the discussions with the SoS was the creation of the IOC in August 2000.

20.55 It seems to me surprising that, until 2000, the GMC did not take action to extend its powers to make interim orders so as to enable it to suspend the registration of a doctor under investigation for or charged with a serious criminal offence. The need for such a power should have been obvious as is demonstrated by the contents of the paper considered by the FPPC in November 1998 and in the snapshot of doctors facing serious criminal charges at that time. It is clear that, although the GMC was generally aware of the problem, it had not considered

it necessary to take steps to protect patients from such doctors. In addition, the GMC was aware that it did not have the power to order initial interim suspension of a doctor in the health procedures (before a decision had been taken to refer him/her to the HC) or of a doctor who was being dealt with in the performance procedures. The Rules relating to the making of interim orders in the conduct procedures were changed in 1996 and it might have been expected that the GMC would have taken that opportunity to seek adequate powers to make whatever interim orders were necessary for the protection of patients. However, as Mr Scott observed, there was no recognition of the problem until it was thrown into relief in Shipman's case.

20.56 Following Shipman's conviction, urgent steps were taken by the GMC to erase his name from the register. This was done by the PCC on 11th February 2000.

The Giving of Reasons for Decisions

20.57 Until 2000, the only record of a decision made by the PPC was a brief minute. The PPC did not formulate or record any considered reasons for its decisions. The minute would, therefore, contain, at most, only brief notes of points that had been made in discussion, in addition to a record of the decision. Minutes of the PPC were not made public.

20.58 Rule 16 of the 1980 Professional Conduct Rules provided that, where the PPC had decided not to refer a case to the PCC or the HC, no complainant, informant or practitioner was to have any right of access to any documents relating to the case submitted to the GMC by any other person. Nor was the PPC to be required by a complainant, informant or practitioner to state reasons for its decision. That rule was reproduced in the 1988 Professional Conduct Rules. Despite the rule, it became the practice from about 2000 for the complainant and the doctor concerned to receive a letter, outlining the reasons for the PPC's decision. Until that time, the reasons given in the letter had been based on the brief minute of the decision made in the course of the relevant meeting of the PPC. Since 2000, following a recommendation made by the PSI team, the practice was for members of the PPC to agree the key reasons for their decisions at the time those decisions were taken. Those reasons were recorded in writing by a member of the GMC staff. The recorded reasons were subsequently reviewed by the Chairman of the PPC and were authorised by him as an accurate report of the PPC's decision. They then formed the basis of the letters sent to the doctor and the complainant.

Review of Decisions

20.59 Decisions of the PPC whether or not to refer a case to the PCC or the HC were, as I have said, made in private. The only means of challenge available to a complainant or doctor who was dissatisfied with the decision was judicial review. As I have already observed in Chapter 19, this was an expensive and somewhat intimidating process which was little used until the late 1990s.

The Approach Adopted by the Preliminary Proceedings Committee in Some Specific Types of Case

Conviction Cases Generally

20.60 In June 1997, a Note was produced for the guidance of new members of the PPC. It set out the test that members of the PPC should apply when deciding whether to refer a conviction to the PCC. It stated:

> **'The PPC must decide whether to refer a conviction to the PCC if the conviction is serious enough to justify a public inquiry which might lead to removal or restriction of the doctor's registration.'**

Leaving aside the problems of syntax, this guidance cannot have been helpful to PPC members. It really amounts to no more than saying that 'the PCC ought to refer a conviction to the PCC if it thinks that it ought to do so'. No guidance was given as to how serious the conviction had to be **'to justify a public inquiry which might lead to removal or restriction of the doctor's registration'**. On reading this guidance, any new member of the PPC would surely have wished to know how serious the conviction had to be to justify such a public inquiry. In the absence of any guidance setting out criteria and standards and illustrating them by examples, members of the PPC would be left to take decisions on the basis of their differing personal perceptions as to when it would be appropriate to refer a conviction to the PCC.

Cases Involving Allegations of Potential Serious Professional Misconduct

20.61 As I have mentioned, the Annual Reports of the PPC did not discuss the standards and criteria which should be applied by the PPC when deciding whether a case **'ought to be referred'** to the PCC. In June 1997, the Note for new members of the PPC, to which I have referred previously, advised that the question for the PPC was not whether a doctor had committed SPM. Instead, it had to decide whether a *prima facie* question of SPM arose. If the PPC decided that a *prima facie* question of SPM did arise, it then had to decide whether all, or only some, of the allegations against the doctor should be referred to the PCC. The Note observed that there was **'no absolute definition'** of what constituted SPM. It quoted the definition given by the Judicial Committee of the Privy Council in the case of Doughty v General Dental Council[1], namely:

> **'... ''conduct connected with his profession in which the dentist** (*the Note substituted the word 'doctor'*) **concerned has fallen short, by omission or commission, of the standards of conduct expected among dentists** (*doctors*)**, and that such falling short as is established should be serious'' '**.

20.62 The Note went on:

> **'The following three questions are relevant to decisions about referral to the PCC: whether to refer all, or only some, of the allegations against the doctor; whether there is sufficient evidence for the allegations to be**

[1] [1988] AC 164.

proved – the GMC's Solicitor may be asked to advise; and whether to review referral if, after seeing the witnesses, the GMC's Solicitor advises that the evidence is insufficient to come up to proof. For example, allegations about incidents which are more than 3–4 years old might be difficult to prove for practical and/or legal reasons; the PCC does not receive the documents which go to the PPC – the allegations must be proved by the oral testimony of witnesses.'

20.63 The Note also gave examples of the circumstances in which the PPC might send a warning letter to a doctor, rather than referring his/her case to the PCC. One such example was:

> **'Where a Medical Service Committee case reveals failures which are admitted or regretted by the doctor but are not considered by the PPC as sufficiently serious to justify restricting or removing the doctor's registration, when seen in the context of the whole career.'**

That example implies that the PPC would not necessarily confine its consideration to the case before it, but would view the case in the context of the doctor's **'whole career'**. However, it is not clear what, if anything, the PPC would have known about the doctor's **'whole career'**.

20.64 The PPC would have had a limited amount of information about any previous involvement of the doctor in the GMC's FTP procedures. Legal advice received by the GMC in 1998 suggested that the PPC should have been informed of any previous complaint or report about the doctor to the GMC which had resulted in a sanction being imposed by the PCC, the HC or the CPP. It should also have been informed of a previous complaint which had resulted in the sending of a warning or cautionary letter by the PPC, or in the referral of the doctor's case by the PPC to the HC. It would not have been made aware of a doctor's previous involvement in the voluntary health procedures or performance procedures. The PPC would have had no information about cases that had resulted in an 'acquittal' before the PCC, even where the facts which formed the basis of the allegation(s) had been proved and the 'acquittal' resulted from a finding that, although unacceptable, the doctor's conduct did not amount to SPM. Nor would the PPC have had any information about a case where the PPC had decided to take no action, unless the earlier case had been 'revived' within the two-year period stipulated under the Rules. The PPC would have no access to any information about previous complaints relating to the doctor that had not been referred by the medical screener to the PPC, even where a Chapter XV letter had been sent to the doctor. The PPC was not entitled to information about any case that had previously been referred by the PPC to the PCC but had not yet been heard. Even such information as should have been available would have been put before the PPC only if the GMC data retrieval systems had enabled the relevant papers to be traced, if previous case papers had not been thrown away and if the doctor had been properly identified in any previous complaints about him/her. Even if the systems worked as they should, the information would not necessarily have provided a complete picture of the doctor's **'whole career'** in terms of any involvement which s/he had previously had with the GMC's FTP procedures.

20.65 In assessing the extent to which the PPC would have been able to consider the doctor's **'whole career'**, it is important also to consider how much the PPC would have known about any complaints made about the doctor in the locality in which s/he practised. When a doctor's employer or PCO referred to the GMC a case where there had been a medical service committee (MSC) or independent review panel (IRP) hearing or other disciplinary proceedings, the information given to the GMC by the employer or PCO sometimes included details of previous similar incidents involving the same doctor which had not been the subject of a previous referral to the GMC. The information might or might not contain details of previous complaints or concerns about the doctor which had not been the subject of a formal hearing. As I have explained in Chapter 18, it was not in the past the practice of the GMC, when a complaint was made by a private individual, to make specific enquiries of the doctor's employer or PCO about previous complaints or problems in relation to the doctor. Even if such enquiries had been made, an employer or a PCO would not necessarily have been aware of a MSC or IRP hearing or other disciplinary proceedings which had occurred while the doctor was working in another area, nor about previous complaints which had been made, or concerns which had been expressed about the doctor. There is no one source from which information about a doctor's **'whole career'** can be obtained.

20.66 It is difficult to see, therefore, how the GMC could have claimed that the PPC was able to view a case in the context of the doctor's **'whole career'**. If the PPC's view were to be based solely on information held by the GMC, it might well have been incomplete. It appears that it was the PPC's practice to receive testimonials and references submitted by the doctor. I must confess to feeling some concern at that. First, such background material was not relevant to a consideration of the question whether the evidence showed a *prima facie* question of SPM. Second, if background information was to be considered, it should have been balanced. That relating to past complaints or concerns should have been complete and information relating to the doctor's general attitude and ability should have been available from someone independent of him/her. Golden opinions from patients unconnected with the issues before the PPC should not have been received by it. They could have served only to obscure the question to be decided. Moreover, their only effect could have been to influence the PPC in the doctor's favour.

20.67 Later, the GMC produced a document entitled 'Frequently Asked Questions' for members of the PPC. The Inquiry has the version which was current in January 2002. The document addressed a number of practical and administrative questions. It also provided general information about the FTP procedures and about the courses of action open to the PPC when making its decisions. However, it contained little guidance which would have assisted in making these decisions. It described SPM in these terms:

> **'There is no statutory definition of serious professional misconduct but we describe it as behaviour which may raise issues about the doctor's registration and fitness to continue to practise.'**

The inadequecy of this guidance is obvious and accounts for much of the confusion and disagreement about SPM among members of the PPC which was observed by Professor Allen and her colleagues, to which I shall refer at paragraph 20.94.

The Workload of the Preliminary Proceedings Committee in the 1990s

20.68 During the early 1990s, the number of cases considered by the PPC rose gradually until, between 1994 and 1996, it was considering about 240 cases a year. During the period between 1994 and 1996, the PPC met about five times a year for up to a day each time. Occasional short extra meetings were necessary to consider urgent cases but there was rarely more than one such meeting a year. It is clear that the number of cases to be considered by the PPC at each of its meetings must have been very substantial.

20.69 After 1996, the increase in the use of its power to make interim orders had a significant effect on the PPC's workload. Doctors threatened with the making of an interim order often exercised their right to a hearing. Such hearings took longer than the usual consideration of a case on paper. It was not unusual for a hearing to take one or two hours or more. These factors, combined with the increased number of cases referred to the PPC generally (over 300 referred in 1998 and over 400 in 1999), resulted in a sharp rise in the number of meetings and in the amount of work to be transacted at those meetings. Mr Nicholls said that, when he joined the PPC in September 1999, there were meetings on about two days each month. Each day's meeting involved about a day to a day and a half's reading in preparation. A large number of cases were considered at each meeting.

The 2000 Policy Studies Institute Report

20.70 The PSI team carried out a detailed analysis of the numbers and types of cases dealt with by the PPC during the years 1997, 1998 and 1999. The results were set out in its 2000 Report. It also examined the outcomes of those cases. Its primary purpose in carrying out this exercise was to discover whether there was any difference between the treatment of cases involving doctors who had qualified overseas and the treatment of those involving UK and Irish (for convenience, I shall refer to both as 'UK') qualifiers. However, its findings had much wider implications.

Unexplained Differences in the Referral Rates of UK and Overseas Qualifiers

20.71 In 1997, 30% of the cases considered by the PPC were referred on by the PPC to the PCC. By 1999, this figure had risen to 40%. Throughout the period 1997 to 1999, consistently higher proportions of doctors who had qualified overseas compared to those who had qualified in the UK were referred by the PPC to the PCC. In 1999, 33% of the UK qualifiers whose cases came before the PPC were referred to the PCC, whereas 54% of overseas qualifiers were referred. The overall pattern of referrals gave rise, therefore, to the possibility that overseas qualifiers were being treated unfairly.

20.72 Of the doctors whose cases were considered by the PPC in 1997, 39% received a cautionary letter or a letter of advice. In 1998 and 1999, the proportions were 49% and 41%, respectively. In 1998 and 1999 (but not 1997), UK qualifiers were more likely than their overseas counterparts to receive a letter of caution or advice, rather than being referred to the PCC. In addition, UK qualifiers were significantly more likely than overseas qualifiers to be referred into the voluntary health procedures. Part of the explanation for this was the fact that many convictions dealt with by the PPC were for drink driving

offences and UK qualifiers were twice as likely as overseas qualifiers to have been convicted of such offences. However, that could not account entirely for the disparity. These disparities again raised the possibility that overseas qualifiers were being discriminated against by the PPC.

20.73 There was no obvious explanation for the disparities. During the course of the same study, the PSI team had discovered similar disparities in the decisions made by screeners. However, it had found a possible explanation for the higher proportion of overseas qualifiers referred to the PPC by screeners. It could be explained by the fact that cases referred to the GMC by public bodies (in which overseas qualifiers were twice as likely as UK qualifiers to be the subject of complaint) were in general more likely to be referred by screeners to the PPC than were cases originating from private individuals. Thus, it could have been the fact that a case had been referred by a public body (rather than the fact that it concerned an overseas qualifier) that accounted for its referral by the screeners to the PPC.

20.74 The same explanation could not account for the marked disparities in outcome once a case reached the PPC. Like the screeners, the PPC was more likely to refer on to the PCC cases originating from public bodies than cases from private individuals. However, among cases originating from public bodies, the PPC sent a significantly higher proportion of cases involving overseas qualifiers (55% of such cases considered by the PPC in 1999) than of those involving UK qualifiers (36% in 1999). Even among cases originating from private individuals, there was a difference in the proportion of cases referred by the PPC to the PCC when overseas and UK qualifiers were compared. Similar differences were seen in the way the PPC dealt with every category of complaint (e.g. complaints about dishonesty or criminality and about poor treatment or substandard clinical practice, etc.). Since, at that time, the PPC gave no reasons for its decisions, it was impossible for the PSI team to say why these differences were occurring.

Unexplained Differences in the Treatment of UK and Overseas Qualifiers Convicted of Criminal Offences

20.75 The PSI team examined the pattern of referral for convictions. This was important because greater uniformity of treatment might have been expected when the PPC was dealing with doctors who had been convicted of criminal offences, as opposed to doctors who had been accused of a variety of other types of misconduct. In the period from 1997 to 1999, between 17% and 23% of all the cases dealt with by the PPC were conviction cases. A substantial proportion of those convictions were for offences of drink driving. UK qualifiers represented a higher proportion of conviction cases than their overseas counterparts in all three years, both for drink driving and for other offences.

20.76 In 1997, 13% of conviction cases were sent by the PPC to the PCC. The figures for 1998 and 1999 were 16% and 29%, respectively. If drink driving cases were left out of the calculation, the proportion of conviction cases referred by the PPC to the PCC rose to 35% of cases considered by the PPC in 1997, 28% in 1998 and 58% in 1999. With or without drink driving cases, a significantly higher proportion of overseas qualifiers with convictions were referred by the PPC to the PCC than of their UK counterparts. In 1999,

the proportion of UK qualifiers with convictions (other than for drink driving) referred by the PPC to the PCC was 38%; for overseas qualifiers, the proportion was 85%. This represented a marked disparity between the treatment of UK and overseas qualifiers.

20.77 In 1997, 41% of conviction cases dealt with by the PPC were referred into the voluntary health procedures. In 1998 and 1999, the proportions were 15% and 24%. There was a change of procedure for drink driving cases in 1998. The effect of that was that some doctors who would previously have been referred by the PPC into the voluntary health procedures were instead referred into those procedures at an earlier stage, so that their cases never reached the PPC. When drink driving cases were left out of account, the proportions of conviction cases referred into the voluntary health procedures were 22% in 1997, 19% in 1998 and 19% in 1999. Significantly higher proportions of UK qualifiers than of overseas qualifiers were referred to the voluntary health procedures in all years.

20.78 In 1997, 35% of conviction cases resulted in a cautionary letter or letter of advice. In 1998 and 1999, the figures were 63% and 45%. When drink driving cases were excluded, the figures were 22%, 44% and 19%. Significantly higher proportions of UK qualifiers than of overseas qualifiers were sent letters of advice or cautionary letters in all years. Again, these results gave rise to the possibility of unequal treatment of UK and overseas qualifiers.

20.79 The PSI team acknowledged that it was possible that the offences for which overseas qualifiers had been convicted might have been more serious than the offences committed by UK qualifiers. This would explain the apparent disparities in treatment between the two groups. However, since the PPC did not give reasons for its decisions, it was impossible to confirm this. Nor was it possible to rule out the possibility that racial bias had caused the disparities. The presence of racial bias, on the evidence available, could not be proved or disproved. The PSI team observed that a detailed analysis of individual cases would be necessary in order to discover why convictions which, from the brief description that appeared on the GMC's database, sounded similar had nevertheless been treated differently. So far as the Inquiry is aware, no such analysis has been undertaken.

The Treatment of Conviction Cases Generally

20.80 The PSI team had concerns about the way in which the PPC dealt generally with conviction cases, quite apart from the unexplained disparities between the treatment of UK qualifiers and that of their overseas counterparts. In its 2001 Report, the PSI team drew attention to the variation in the pattern of outcomes in conviction cases from year to year. In 1997, as I have said, 35% of all convictions (excluding drink driving convictions) considered by the PPC had been referred to the PCC; in 1999, the proportion was 58%. This represented a considerable variation for which there was no apparent explanation. The PSI team suggested that a detailed analysis of the type mentioned above might assist in explaining why such variations were occurring.

20.81 The PSI team was concerned that its own analysis demonstrated a general lack of consistency in dealing with convictions. The 2000 PSI Report observed that, for the sake of consistency, as well as to prevent bias, it was essential that no discretion should be applied in deciding whether a conviction should be referred to the PCC. The Report

therefore recommended that all convictions referred to the PPC, other than drink driving convictions, should automatically be referred on to the PCC. It observed that there was a need to ensure efficiency and speed in dealing with convictions, since such cases might be considered automatically to call into question a doctor's registration.

20.82 Professor Allen, who led the PSI team, told the Inquiry that she and her colleagues were very concerned about the number of convictions that were not being referred by the PPC to the PCC. There were anomalies for which they could find no explanation, either from the statistics or from their observations of the PPC at work. Professor Allen said that her personal opinion was that any conviction, save for a minor road traffic offence or a drink driving conviction, had implications for a doctor's fitness to practise. She also expressed the view that, if a policy were adopted of referring all conviction cases to the PCC, that would prevent the need to justify minutely why one conviction should be sent to the PCC and another not.

The Need for the Preliminary Proceedings Committee to Give Reasons

20.83 Professor Allen and her colleagues concluded the relevant section of their 2000 Report by saying that there was an urgent need for the PPC to make explicit its reasons for referring cases to the PCC and for other decisions. In the absence of explicit reasons, there were **'unexplained differences'** between the outcomes for UK and overseas qualifiers at this stage of the conduct procedures. This recommendation was implemented shortly afterwards, when the PPC adopted the practice of agreeing the key reasons for its decisions at the time those decisions were made. So far as the Inquiry is aware, there has been no subsequent analysis of the PPC's decisions, by reference to those reasons.

Analysis of the Conduct of Meetings of the Preliminary Proceedings Committee

The Observations

20.84 During the period between June 1999 and January 2000, Professor Allen and her colleagues observed 11 meetings of the PPC. In November 1999, as I have explained, there were significant changes to the composition of the PPC. Prior to that time, the PPC had been chaired by Dr Steel, the principal medical screener. Three other screeners (two medical screeners and one lay screener) were members of the PPC. Other screeners were invited to attend meetings of the PPC as observers and might be called upon to comment on cases that they had screened. Screeners who were not members of the PPC did not necessarily attend all its meetings, so that it was a matter of chance whether a screener was present to comment on his/her own screening decision. 'Observer' screeners were sometimes called upon to deputise for members of the PPC who were absent and thus to ensure that there was a quorum, which was then five. If that was not possible, other members of the GMC were called upon to deputise on an *ad hoc* basis.

20.85 From November 1999, screeners were no longer eligible for election to the PPC and no longer attended its meetings. The new Chairman of the PPC was Mr Nicholls, a lay member of the GMC and a former lay screener. None of the other members of the newly constituted PPC had any experience of screening.

20.86 Professor Allen and her colleagues noted that the papers in cases coming to the PPC frequently ran to hundreds of pages, including medical records and reports of previous hearings by NHS and other bodies. No summary of the case was provided, save for the letter to the doctor outlining the allegations against him/her. Nor did PPC members receive the screening decision form or the memorandum prepared by a caseworker for the screeners' assistance. The PPC would usually have the doctor's response to the complaint, often in the form of a letter from the doctor's medical defence organisation or solicitors. Other documents would sometimes be enclosed with the response. It was not unusual for the responses submitted by doctors to be received only shortly before the PPC meeting. Members of the PPC would often have to read a batch of such responses (together with any other material supplied) on the day of the meeting. Professor Allen told the Inquiry that this could often be an 'enormous amount' of further evidence and information. It must have been very difficult for members to absorb the new material and to place it in the context of each individual case. At that time, a complainant (whether a public body or a private individual) had no right to see or comment on the doctor's response to the complaint. Thus, there was no opportunity for a complainant to correct any inaccuracies in the doctor's account or to deal with any additional questions raised by him/her.

20.87 Professor Allen and a colleague attended six meetings of the PPC before November 1999 and five meetings thereafter. They did not see the same combination of members and co-opted members sitting on the PPC more than once. They analysed the meeting papers in advance and recorded *verbatim* accounts of the discussions. They then analysed various features of the discussions at the meetings. They interviewed the Chairman and eight members or co-opted members of the PPC as it was constituted before November 1999.

Consistency, Transparency and Fairness

20.88 In carrying out their analyses, Professor Allen and her colleagues looked to see whether the PPC was applying the principles of good decision-making and was achieving its objectives of consistency, transparency and fairness. In May 1996, the GMC had publicly committed itself to these principles. It had said:

> **'We are committed to a system of self-regulation which is open and accountable; and to developing procedures and processes that are fair, objective, transparent and free from discrimination.'**

20.89 The principles were:

> **'*consistency*:**
>
> - **there should be agreement on the criteria to be applied in reaching a decision**
> - **the criteria used in considering each case should always be the same**
> - **they should be applied within each meeting by each member for each case in the same way**

- **they should be applied across meetings in the same way**

***transparency*:**

- **it should be clear how the criteria have been applied in reaching a decision**
- **the reasons for each decision should be clearly stated**

***fairness*:**

- **each case should be treated by giving due consideration to all pieces of evidence**
- **each case should be assessed on its merits**
- **it should be made clear what weight has been applied to the different pieces of evidence.'**

20.90 The analyses carried out by the PSI team related both to the process of decision-making and to the content of the PPC's deliberations.

The Conduct of Meetings

20.91 Professor Allen and her colleagues observed that, before the significant changes to its constitution in November 1999, the PPC usually dealt with between 30 and 50 cases at each meeting. Half of the cases were dealt with in three minutes or less; 76% of cases were concluded in five minutes or less. Only 10% took ten minutes or more. After November 1999, only 13% of cases were concluded in three minutes or less and 29% in five minutes or less; 47% of cases occupied ten minutes or more. These timings did not include hearings relating to interim orders, which could take far longer, as I have explained above.

20.92 At least part of the explanation for the increase in the time taken over each case after November 1999 lay in the way in which the discussions about individual cases were conducted. The 2000 PSI Report noted that, before November 1999, participation in a discussion about an individual case was limited to the Chairman (who would introduce each case) and only one or two others. Some members were invited to participate in discussions to a greater extent than others. After November 1999, meetings were run in a more structured way that encouraged much greater and more equal participation from all members of the PPC. In general, every member was asked for his/her view in relation to every case under consideration. Inevitably, this increased the length of time spent on cases but it did mean that the opinions of all members were canvassed. Before November 1999, decisions would often be made without taking a vote, even when there was dissent about what the outcome of a case should be. It was more common for the Chairman to put forward a proposed outcome, leaving it to the dissenters to voice their disagreement if they chose. After November 1999, votes were taken more frequently.

20.93 The observations and analyses of the PSI team demonstrated that few discussions within the PPC, whether they took place before or after November 1999, adhered to the principles of good decision-making to which the GMC had previously committed itself. There was an absence of commonly agreed and applied criteria. It was often impossible

to tell why some cases were referred to the PCC and others were not. This was particularly so in cases of poor treatment and substandard clinical practice, but it was also true of convictions and other cases involving dishonesty and dysfunctional personal behaviour which had been designated 'SPM by definition' for screening purposes. Many of those cases were not referred by the PPC to the PCC.

Serious Professional Misconduct

20.94 The PSI team observed confusion and disagreement about what constituted SPM and what the threshold for SPM should be. It was suggested by some members of the PPC that **'For spm there has to be some evidence of recklessness and the action should be unreasonable ...'**. There were widely differing views of what was and was not **'unreasonable'**. Members of the PPC brought to the discussions their own views about the standards to be expected of a 'reasonable doctor' and individual members clearly applied different standards. There was also divergence of opinion about accepted margins of error. There was a tendency to speculate about why someone might have done something. Characteristics or behaviour were attributed to a doctor for which there was no evidence. Members of the PPC would speculate on how certain situations might have arisen when there was no evidence upon which to base such speculations.

20.95 One recurrent point of disagreement was whether the fact that a doctor's conduct had led to a poor outcome for a patient was relevant to the issue of whether that conduct amounted to SPM. The 2000 PSI Report quoted one exchange on this topic:

> **'Member 1: ''The outcome is totally irrelevant. Get rid of the idea that it is more serious if the patient dies than if he didn't.''**
>
> **Member 2: ''It does matter to the patient if the outcome is death. It is the duty of a doctor to sort out the urgent and important.'' '**

20.96 Considerable difficulty was experienced in dealing with expert opinion. Sometimes, the papers in a case contained expert reports obtained in the course of investigation of the complaint by another body; sometimes, the doctor produced expert evidence in support of his/her defence. In other cases, the screeners had called for an expert opinion. The experts were sometimes GMC members and sometimes not. On occasion, the experts disagreed with each other. Professor Allen and her colleagues observed real difficulty on the part of members of the PPC in knowing what weight to give to the views of the experts and how to approach a conflict in the expert evidence. Sometimes, the PPC would decide in accordance with one expert view, rather than another, without it being clear why one view had prevailed. The position became even more complicated when there was a practitioner in the relevant field at the meeting. It was a matter of chance whether there was such a practitioner present at a meeting. In any event, the weight that was given to a practitioner member's expertise varied between meetings.

Lack of Understanding of the Processes

20.97 Members of the PPC often expressed uncertainty over GMC procedures and processes. Sometimes, members did not appear to appreciate that it was not open to them to refer a

case into the performance procedures. There was a lack of understanding, on the part of some, of the difference between the voluntary health procedures and the HC. There was also uncertainty about the circumstances in which a doctor should be offered the opportunity of voluntary erasure of his/her name from the register. There were other areas of uncertainty among members which contributed to the difficulty in decision-making.

20.98 The possible existence of mitigating circumstances (e.g. systems failures, poor management, practice in a deprived area, a large patient list) were mentioned frequently in discussions. The fact that a doctor had apologised or acknowledged some fault was frequently mentioned. The PSI team noted:

> **'... it was clear that members were often looking for explanations of a doctor's behaviour. These could be directly related to the circumstances of the doctors themselves or could be related to the circumstances in which they found themselves working. They were certainly taken into account when differences of opinion occurred within a committee, particularly in relation to treatment/sub-standard clinical practice cases.'**

Considering the Strength of the Evidence

20.99 One theme which, according to Professor Allen and her colleagues, was **'never far beneath the surface'** in many of the PPC's discussions was the issue of whether the extent and nature of the evidence was such that the case would 'run' at the PCC. They observed lengthy discussions about the amount of evidence needed to send a case to the PCC. Sometimes, during these discussions, there were disagreements between members of the PPC and the legal assessor. The latter would advise that it was the PPC's function only to ensure that there was a *prima facie* case and that the PPC should not attempt to resolve differences or conflicts of evidence during the course of its deliberations on whether a case should be referred to the PCC or not. Members were unhappy about this. Despite the legal advice, members tended to discuss the sufficiency of, and conflicts in, the evidence. Later in this Chapter, I shall refer to the judicial review case of R v General Medical Council ex parte Richards[2], which illustrates the problem described by Professor Allen. In that case, the PPC had plainly discussed the conflicts of evidence and had resolved them in the doctor's favour, in circumstances in which the decision should have been to refer the case to the PCC.

20.100 Professor Allen told the Inquiry that she had been surprised at the extent to which the PPC discussed the likely prospects of success at the PCC. In particular, she was concerned about the emphasis on evidence. As I have explained, it was not at that time the GMC's practice to collect evidence (save for the response of a doctor and any evidence s/he might care to volunteer) relating to a complaint unless and until the case had been referred by the PPC to the PCC. Once a case had been referred to the PCC, there was an opportunity for the GMC's solicitors to gather more evidence in preparation for the hearing. Professor Allen said that she was concerned that the PPC was sometimes looking at cases on the basis of very limited information, and was making decisions about the

[2] [2001] Lloyd's Rep Med 47.

adequacy of the evidence at a time when it was in no position to know whether it would be possible to collect further evidence in the future.

Analysis of Outcomes and Conclusions

20.101 The analysis by the PSI team of the outcomes of PPC meetings showed that there was a marked difference between the outcomes of those that took place before and those that took place after November 1999. In the period from June to November 1999, 35% of cases considered by the PPC were referred to the PCC. Between November 1999 and January 2000, 47% were referred. The reason for this appeared to be that the post-November 1999 PPC operated a lower threshold for referring cases to the PCC. However, the 2000 PSI Report observed that it was unclear, in respect of either period, what that threshold was. The PPC, as constituted after November 1999, was more likely than its predecessor to refer cases to the PCC if there was an unresolved conflict of evidence or if the case was thought to raise an issue of SPM, even where the evidence did not appear substantial. It was less likely than the earlier PPC to decide that there was insufficient evidence to refer a case to the PCC. Otherwise, the same problems and uncertainties continued to characterise discussions of the PPC, even after November 1999. The 2000 PSI Report commented that, **'even with the greater length of discussions and the more structured approach of the new committee, there are still large areas of obscurity in the decision-making process of the PPC'**.

20.102 The 2000 PSI Report observed that the main question left unanswered was why such a small proportion of cases considered by the PPC was referred to the PCC. The Report posed this question:

> **'If a screener considers that a case raises an issue of serious professional misconduct, what is it that happens at the PPC to result in two thirds of cases considered before November 1999 and over half the cases considered after November 1999 being reassessed as not raising an issue of serious professional misconduct?'**

20.103 It is clear, as I observed in paragraph 20.21, that Professor Allen was of the view that the test to be applied by the screeners was virtually the same as that to be applied by the PPC.

20.104 The 2000 PSI Report went on to refer to the absence of any agreed standards against which a decision could be made whether or not conduct amounted to SPM. It observed:

> **'The problem which arose time and again in PPC discussions was that there was no consensus on what these standards were, particularly in relation to matters of clinical practice, and there was no agreement on the threshold of seriousness. There is clearly a need for guidelines to be established so that consistency, transparency and fairness can be demonstrated at all stages of the GMC conduct procedures.'**

20.105 The PSI team questioned whether the PPC was an appropriate forum for discussing whether poor treatment or substandard clinical practice cases raised issues of SPM. It pointed to the lack of consistency, both in the composition of the PPC (with different

combinations of people attending every meeting) and in the availability of expertise among its members.

20.106 Finally, the 2000 PSI Report recommended that the GMC should clarify the differences between the role and function of the PPC and the role and function of screeners. It observed that the roles and functions of both appeared to be very similar. It was suggested that, if the PPC was intended to apply different tests and criteria for onward referral of cases from those applied by the screeners, those tests and criteria should be defined and guidance should be given on how they should be applied. Indeed, it was suggested that the GMC should consider whether it needed to maintain the separate functions of screeners and the PPC at all. I mentioned earlier that it would be usual for the screeners and the PPC to have the same amount of information before them. In the past, there had been one significant difference: the PPC would have the doctor's explanation whereas the screener would not. That difference was removed in 1997. It may have been envisaged originally that the PPC would use its power to adjourn for investigations to be made so as to put itself in a better position than the screeners. In practice, however, this was almost never done.

Comment

20.107 The descriptions of what happened at meetings of the PPC and the discussions described by Professor Allen are strongly reminiscent of some of the evidence heard at the Inquiry. Some of the witnesses, when asked to explain a decision in a particular case, would speculate about why the doctor concerned might have acted as s/he had, often seeking to find an acceptable explanation for what had happened. It was clear that, if there had been a *lacuna* in the evidence available (as there often was in cases considered by the PPC, because so little evidence was gathered at the preliminary stages of the process), the decision-maker would fill the gap with assumptions, which were invariably favourable to the doctor against whom the allegation was made. Doctors asked by the Inquiry to express an opinion – about, for example, Shipman's conduct in the case of Mrs Renate Overton – would give a view based, in part, on speculation about what might have happened or why Shipman might have acted as he did. These were not speculations about how serious the implications of his conduct might be; they were attempts to proffer an explanation of his conduct that would render it acceptable or, at any rate, less serious. The Inquiry was told about similar tendencies which had surfaced in debates at meetings of the Medical Advisory Committee, as I described in Chapter 6. To a lawyer, the inclusion of such irrelevant material in the consideration of a case is obviously wrong. Yet it appears that, to many doctors, this is not obvious.

20.108 More generally, the analysis carried out by the PSI team into the operation of the PPC presents a depressing picture of inconsistency and lack of transparency. For important decisions such as those made by the PPC to be made on incomplete information by people who acted upon their personal views, without the benefit of any kind of framework of standards or criteria – or even a collection of old cases from which to see how decisions had been made in the past – seems to me to be a recipe for unfairness of outcome. It is plain that the GMC was not, at this time, achieving its objectives of consistency, transparency and fairness in decision-making. It may be that, on some occasions, the

inconsistency resulted in unfairness to doctors. However, on some occasions, it must have resulted in a failure to protect patients.

The Differing Roles of the Preliminary Proceedings Committee and the Screeners: the Case of Toth

20.109 The roles of the PPC and the screeners were discussed by Mr Justice Lightman in his judgement in the case of R v General Medical Council ex parte Toth[3]. That judgement was delivered in June 2000. I outlined the facts of that case in Chapter 19. The dispute in Toth related to two decisions of a medical screener. The case never reached the PPC. However, the Judge took the opportunity to give guidance on the respective roles of the screeners and the PPC.

20.110 The Judge observed that there was a difference in language between rule 6(3) of the 1988 Professional Conduct Rules, which governed the role of screeners, and section 42(2) of the Medical Act 1983, which governed the role of the PPC. He confirmed that it was an **'obvious fact'** that the roles of the screener and the PPC could not be intended to duplicate each other and that **'decisions are not intended to be made by the screener which the PPC (if necessary, after invoking their powers to investigate further) may be better equipped to make'**. The screener could filter out only those cases that it appeared to him/her **'need not proceed further'**. The only conclusion on the merits of the complaint which was required of the screener before s/he allowed a complaint to proceed was that the matters stated **'appear to raise a question'** whether the doctor had committed SPM. However, the PPC had the task of deciding whether the complaint **'ought to proceed further'**. Although the Judge regarded it as obvious that the roles of the screener and the PPC could not be the same, Professor Allen had understood that there was no real difference between them and, to be fair to her, the wording of both tests was so general that her point of view was understandable.

20.111 The Judge went on to draw attention to two particular features of the GMC's conduct procedures. First, he noted that the complainant had no right to see the doctor's comments on the complaint or to see any other material that was put before the PPC. Second, he observed that the **'central feature'** of the procedures was the investigation of complaints by the PCC. Only before the PCC, he noted, was there full disclosure of documents and evidence and a form of hearing whereby the complainant and the public could see, and be reassured by seeing, the proper examination of the merits of the complaint. He went on:

> **'The PPC may examine whether the complaint has any real prospect of being established, and may itself conduct an investigation into its prospects, and may refuse to refer if satisfied that the real prospect is not present, but it must do so with the utmost caution bearing in mind the one-sided nature of its procedures under the Rules which provide that, whilst the practitioner is afforded access to the complaint and able to respond to it, the complainant has no right of access to or to make an**

[3] [2000] 1 WLR 2209.

informed reply to that response, and the limited material likely to be available before the PPC compared to that available before the PCC. It is not its role to resolve conflicts of evidence. There may be circumstances which entitle it to hold that the complaint should not proceed for other reasons, but the PPC must bear in mind its limited (filtering) role and must balance regard for the interests of the practitioner against the interests of the complainant and the public and the complainant and bear in mind the need for the reassurance of the complainant and the public that complaints are fully and properly investigated and that there is no cover-up. In the case of the PPC (as in case of the screener) any doubt should be resolved in favour of the investigation proceeding.'

20.112 The Judge observed that both the screener and the PPC should be particularly slow in halting a complaint against a doctor who continued to practise, as opposed to one who had since retired. The paramount consideration must, he said, be the protection of the public in respect of those continuing to practise.

After the 2000 Policy Studies Institute Report and the Case of Toth

20.113 Mr Nicholls told the Inquiry that, as a result of the recommendations contained in the 2000 PSI Report, various changes were made to the procedures of the PPC. Most important was the change to which I have already referred, whereby members of the PPC agreed the key reasons for their decisions, which were then minuted by a member of staff. In addition, a system was introduced whereby all cases referred to the PPC were accompanied by a screener memorandum setting out the reasons for the referral. Another change was that, from July 2000, the GMC's policy was that the doctor's response to a complaint should be disclosed to the complainant, who was invited to provide comments before the case was screened. If the complainant provided comments, they were disclosed to the doctor for his/her further observations.

20.114 In his evidence to the Inquiry, Mr Nicholls said that he could understand how the suggestion that the PPC placed too much emphasis on the question of whether there was sufficient evidence for the case to 'run' at the PPC, contained in the 2000 PSI Report, came to be made. However, he suggested that the PPC's approach was, to some extent at least, vindicated by the view expressed by Lightman J in Toth, namely that the PPC was entitled to examine whether the complaint had any real prospect of success. It is clear, however, from the case of Richards, which I shall discuss below and which concerned a decision of the PPC made in March 2000, that the PPC was going far beyond its remit in the way it considered the evidence in a case.

20.115 Mr Nicholls believed that the decision in Toth caused the PPC to adjourn more often for further investigations to be made. He felt that, before then, the PPC had not adjourned enough for that purpose. It is impossible to tell from the statistics whether this was the case.

The Case of Richards

20.116 The case of Richards was decided by Mr Justice Sullivan on 18th December 2000. It concerned an application for judicial review of a decision of the PPC not to refer to the PCC a complaint made by Ms Joanne Richards.

The Complaint

20.117 The complaint related to the treatment of Ms Richards' sister, Miss Jane Wetherell, by a GP, Dr S K Pathak. Miss Wetherell had died of a pulmonary embolism on 19th January 1995, at the age of 36. She had had a number of risk factors for pulmonary embolism, including the fact that she was severely overweight, she was a smoker and she was taking the contraceptive pill. The complaint centred on a consultation with Dr Pathak which had taken place eight days before Miss Wetherell's death. The issue was whether Miss Wetherell had complained or showed signs of breathlessness or breathing problems at that consultation. Ms Richards said that Miss Wetherell had told her that she had mentioned such symptoms to Dr Pathak. A colleague of Miss Wetherell said that Miss Wetherell had made an emergency appointment on the day of the consultation specifically to discuss her breathing problems. The colleague said that she had been present at the time the appointment was made and had heard Miss Wetherell complain to the receptionist that she could not breathe properly.

20.118 Dr Pathak gave evidence at the inquest into Miss Wetherell's death. He denied that she had complained or shown evidence of breathing problems at the consultation. He said that she was complaining, not of breathlessness, but of nausea and 'strong urine'. He had referred Miss Wetherell to hospital for an endocrinology report. It is clear that the report was to be preceded by tests. His medical note recorded that she had attended him for a **'pill check'**.

20.119 In his summing-up to the jury, the Coroner observed that, had the patient complained to the doctor of breathlessness, the contraceptive pill should have been stopped. He commented on the inadequacy of Dr Pathak's notes. At the judicial review, the Judge did not say what the outcome of the inquest had been. Following the inquest, Ms Richards complained to the local Family Health Services Authority (FHSA). The MSC rejected her complaint; it is not clear if there was a hearing at that stage but it seems unlikely. Ms Richards appealed. Her appeal was heard by an appeal panel, probably convened by the Family Health Services Appeal Authority (FHSAA). Dr Pathak again gave evidence, denying that there had been any mention of breathing problems at the consultation. During his evidence, he conceded that, in fact, Miss Wetherell had not attended him for a **'pill check'**, as his note had stated. Rather, he said that she had attended a Well Woman Clinic run by his practice nurse. The nurse had referred Miss Wetherell to him, he said, because of the nausea she was suffering and because she was unable to lose weight.

20.120 Miss Wetherell's sister had by this time obtained the hospital records, including the endocrinology report. On it were the letters **'SOB'**, a common medical abbreviation for 'shortness of breath'. A hospital witness said that it was highly probable that **'SOB'** had formed part of the clinical details written by Dr Pathak on the form requesting that endocrinological tests should be carried out. Dr Pathak responded by saying that, at the time of the relevant consultation, he had had before him details of a consultation which Miss Wetherell had had with his wife (a partner in his general practice) in December 1994, when shortness of breath had been mentioned. It was probable, he said, that he had written **'SOB'** on the request form as part of the past clinical history. He remained adamant that it had not been mentioned at the relevant consultation. The original request form was

no longer available, having been destroyed by the hospital in accordance with normal procedure.

20.121 The appeal panel convened by the FHSAA, comprising a legally qualified chairman and two medically qualified members, heard evidence from 11 witnesses over four days. Dr Pathak was represented by counsel. The complainant was also represented. The appeal panel found that Miss Wetherell had made an emergency appointment and that she was significantly short of breath at the consultation. It also found that Dr Pathak's clinical note was written after Miss Wetherell's death when there had been a complaint, or when he believed that a complaint was likely to be made. The appeal panel found that Dr Pathak had been in breach of his terms of service in not referring Miss Wetherell to a consultant, although it considered this breach was **'a minor one'**. The **'most serious'** aspect of the case, it found, was the attempt by Dr Pathak to cover up the breach. The appeal panel's decision was given in June 1998, three and a half years after the death.

20.122 It appears that, as a result of the appeal panel's findings, the FHSA then referred Dr Pathak's case to the GMC. In addition, Ms Richards made complaints to the GMC about both Dr Pathak and his wife who, it was alleged, had been complicit in the falsifying of records. I shall deal only with the complaint against Dr S K Pathak.

The First Decision of the Preliminary Proceedings Committee

20.123 The complaint went to the medical screener, who referred it to the PPC. The PPC considered it in June 1999. It may be that Professor Allen was present at the meeting at which the case was discussed. Following that meeting, a letter of decision was sent to Ms Richards. The letter pointed out that the appeal panel had made its judgement on the balance of probabilities, whereas the standard of proof at PCC hearings was **'beyond reasonable doubt'**. The PPC had concluded that there was insufficient available evidence (and no likelihood of obtaining the necessary evidence) to give a reasonable prospect of proving the charge that the doctors had made alterations to the records and had misled, or sought to mislead, subsequent inquiries into the death.

20.124 The letter went on to express the concern of members of the PPC at Dr Pathak's conduct in failing to refer Miss Wetherell to hospital; they took the view that he should have done this, whatever the way in which she had explained her symptoms to him. They also considered that his notes fell short of the standards they expected to see. However, the letter indicated that the PPC did not **'consider that the circumstances were such as to warrant a public inquiry on the right of either doctor** (*i.e. Dr Pathak or his wife*) **to retain unrestricted registration as a doctor'**. Instead, the PCC had directed that Dr Pathak should be sent a letter advising him of the PPC's concerns and warning him about his future conduct. In passing, I observe that this letter simply echoed the form of words used in the Note containing guidance for new members of the PPC which had been issued in June 1997; it would not have helped the complainant to understand why the case had been closed.

20.125 In July 1999, solicitors instructed by the complainant wrote to the GMC, contending that the decision of the PPC was not reasonable and setting out reasons. They invited the PPC to reverse its decision, failing which they said that an application would be made for

judicial review. The GMC obtained legal advice which suggested that the decision of the PPC had been flawed. The GMC then agreed to a consent order, quashing the decision of the PPC. That order was approved by the Court in 1999. A statement of reasons was attached to the order, in which the parties (i.e. Ms Richards and the GMC) agreed that there were three reasons for quashing the decision. First, the PPC had applied the wrong test, in considering what was **'the likelihood'** of obtaining sufficient evidence. Second, the way in which the PPC had assessed the evidence did not support the ultimate conclusion reached; the PPC must be inferred to have accepted the findings of the appeal panel and this was enough to **'raise a question'** whether there had been SPM. Third, it was agreed that the PPC had misdirected itself on the evidence. There was some evidence that Dr Pathak had lied at the inquest, that he had fabricated Miss Wetherell's medical notes to protect himself and that, contrary to his denials, Miss Wetherell had complained of shortness of breath at the relevant consultation. It was agreed that this evidence should have been sufficient to persuade the PPC that the complaint **'raised a question of'** SPM. However, the PPC had failed to appreciate its relevance and importance. Anyone reading that statement of reasons would have inferred that the GMC had understood that the test the PPC should have been applying was whether the complaint **'raised a question of'** SPM.

The Second Decision of the Preliminary Proceedings Committee

20.126 The complaint was then remitted to a differently constituted panel of the PPC which was not told about the background of the case. In fact, since the previous PPC panel had considered the complaint, there had been a change of Chairman and of the membership of the PPC, as I have described at paragraph 20.13. The Chairman of the panel on the second occasion was Mr Nicholls.

20.127 Further submissions on behalf of both Ms Richards and Dr Pathak were made to the PPC; neither saw each other's submissions before the PPC made its decision. The PPC panel met in March 2000. A decision letter was sent to the parties in April 2000. Briefly, the PPC concluded that, even if Miss Wetherell had complained of shortness of breath at the relevant consultation, that would not have been the key to diagnosis and outcome. It would have been possible for the condition to have been undetectable, regardless of any shortness of breath. The PPC considered Dr Pathak's notes of the consultation to be genuine and adequate. (The appeal panel had, as I have said, concluded that the notes had been written after Miss Wetherell's death, at a time when Dr Pathak knew that a complaint had been made or was likely to be made.)

20.128 In accordance with the recent changes of practice, the decision letter on this occasion was much fuller. It mentioned Ms Richards' statement that Miss Wetherell had told her that she had complained of breathlessness at her consultation with Dr Pathak. It said that the statement was hearsay evidence and would, therefore, be inadmissible before the PCC. If it were admitted (the PCC had discretion to admit hearsay evidence if satisfied that its **'duty of making due inquiry into'** the case made its reception **'desirable'**), it would probably not, the decision letter observed, be **'given great weight'**. The letter said that, because of this, the PPC would not have expected the evidence of Ms Richards to make any difference to the overall outcome. In relation to the appearance of the letters **'SOB'** on

the endocrinology report, the decision letter said that members of the PPC had observed that, in their experience, it was very common for information to find its way into such reports by means other than the referring doctor writing it on the request form. The PPC did not, therefore, accept that the inclusion of **'SOB'** on the report form in Miss Wetherell's case meant that Dr Pathak had been aware of the symptoms of breathlessness at the time of the consultation. In view of the fact that the original request form was missing, and of the time that had elapsed since the relevant events, the PPC considered that there was no practical way of pursuing that issue further.

20.129 The decision letter indicated that the PPC did not accept that Dr Pathak had deliberately falsified Miss Wetherell's medical notes and had misled subsequent inquiries into the events leading to the death. The letter observed that there was nothing to falsify. Moreover, in the absence of signs of shortness of breath at the consultation, no referral for specialist treatment was demanded. The PPC did not think it right to criticise Dr Pathak for his failure to make such a referral.

20.130 The decision letter stated that the PPC disagreed with the findings of the appeal panel. As I have said, that panel had sat for four days and heard evidence from 11 witnesses, including Dr Pathak himself. The letter concluded by stating that the material before the PPC:

> **'... did not appear to raise a question whether the serious professional misconduct had been committed, taking into account (amongst other things) the criminal standard of proof to be applied by the PCC'**.

20.131 Before going further, I draw the reader's attention to the way in which this second PPC panel had resolved every issue in favour of the doctor, even in the face of conclusions reached by the appeal panel after a four-day hearing. Also, any uncertainty in the mind of the PPC (e.g. about the appearance of **'SOB'** on the endocrinology report) was resolved by the drawing of an inference favourable to the doctor.

The Judicial Review

20.132 That decision was the subject of an application for judicial review. In his judgement, Sullivan J referred to Lightman J's decision in Toth, which had been given six months earlier.

20.133 In argument before Sullivan J, the GMC attacked the decision in Toth, arguing that the PPC had a much wider discretion to consider whether a complaint **'ought to be referred for inquiry'** by the PCC than had been suggested by Lightman J. It was submitted that the PPC **'had to get its sleeves rolled up'**, and had to look at the evidence and assess its weight in order to see if a complaint was properly arguable. In doing so, the PPC was entitled, so it was contended, to resolve conflicts of evidence, especially if the evidence was largely documentary and there was little prospect of its being supplemented by admissible oral evidence at a PCC hearing. In any event, it was argued, the second decision letter of the PPC complied with the guidance given by Lightman J in Toth.

20.134 Mr Nicholls provided a witness statement for use at the judicial review hearing. In it, he detailed his experience on the PPC. He had been a member of the PPC since September

1999 and had become its Chairman, as I have said, in November 1999, just over a year before the judicial review hearing. He said that, since becoming Chairman, he had chaired 13 meetings, over a total of 28 days, at which 314 decisions had been made. In addition, he had been involved in a further 89 decisions prior to becoming Chairman. Mr Nicholls also described the expertise and experience of the medical members of the PPC who had been present at the relevant meeting. He expanded on the reasons set out in the PPC's decision letter. He explained that the question of whether Miss Wetherell had complained of, or presented with, shortness of breath at the consultation was a **'secondary issue'** once the PPC had decided that **'it was not in the least unreasonable'** for a pulmonary embolism not to have been detected or diagnosed. Even if she had been short of breath, it was said, there were not enough symptoms to make it reasonable to expect a referral to a specialist. The decision of members of the PPC (both medical and lay) had been unanimous.

20.135 Sullivan J agreed that the PPC should adopt the approach suggested by Lightman J in Toth, subject to two comments. First, Lightman J had said that the PPC should exercise **'the utmost caution'** in deciding not to refer a complaint to the PCC on the basis that it had no real prospect of being established, having itself conducted a preliminary investigation into its prospects on the documents alone. Sullivan J suggested that, while caution was required, the need for **'the utmost caution'** in every case might be debatable. However, he suggested that **'the utmost caution'** *was* necessary in a case such as Richards, where the PPC was disagreeing with the conclusion of another body with medical expertise, a conclusion that had been reached after a public hearing where oral evidence had been presented. Second, Sullivan J did not interpret Lightman J's observation that it was not the PPC's role to resolve conflicts of evidence as meaning that the PPC must never under any circumstances resolve any conflict of evidence. Sullivan J preferred to say that the PPC **'should not normally seek to resolve substantial conflicts of evidence'**. To do so, he said, would be to go beyond its screening role and to usurp the function of the PCC.

20.136 Sullivan J observed that there was a public interest in having complaints of SPM thoroughly and openly investigated by the PCC at a public hearing. Meetings (such as those of the PPC) to consider documents in private might, he said, serve to maintain standards, but would not **'ensure public confidence in the process'**. He drew attention to the number of cases dealt with at PPC meetings, which had been given by Mr Nicholls. The Judge accepted that the PPC's decision in the Richards case had received particular care and attention. Nevertheless, he said that such a throughput of cases gave some indication of the level of scrutiny that the PPC was able to give to an individual complaint. This was in contrast to the four days of oral hearing before the appeal panel.

20.137 Sullivan J found that the PPC's decision letter showed that the PPC had sought to resolve substantial conflicts of evidence. The PPC had concluded that the issue of whether Miss Wetherell was suffering from shortness of breath was not significant. That finding conflicted with the views of the Coroner, with Dr Pathak's own evidence (which was that, if there had been a complaint of shortness of breath, he would have recorded it in his notes), with the conclusion of the appeal panel and (although the second PPC panel was not aware of it) with the view of the first PPC panel. He observed that he found it:

> **'... impossible to understand how it** (*i.e. the PPC*) **could reasonably have concluded not merely that it disagreed with these conclusions of the Coroner and the Health Authority** (*by which he must have meant the appeal panel*)**, but that the existence of these very different conclusions did not appear to raise a question for the PCC'**.

20.138 Sullivan J found the PPC's conclusion that the records of the consultation were **'both genuine and accurate'** even more difficult to understand. The Coroner had concluded that the notes were inadequate. The appeal panel had concluded that the notes did not record shortness of breath which was present at the time of the consultation. Dr Pathak had accepted that the note that Miss Wetherell had attended for a **'pill check'** was inaccurate. The Judge said that he could not understand how any reasonable committee could have been so persuaded of the accuracy of the notes as to conclude that no question for the PCC was raised.

20.139 The appeal panel had also concluded (albeit on a balance of probabilities) that Miss Wetherell was significantly short of breath at her consultation with Dr Pathak. The PPC had disagreed with that conclusion. It had considered Ms Richards' evidence and excluded it as hearsay. Sullivan J found that, although the evidence would have been inadmissible in law, the PCC could have chosen to use the discretion given to it under the Rules to receive the evidence. He observed:

> **'... in exercising that discretion the PCC would no doubt bear in mind not merely the interests of the individual complainant and doctor, but also the public interest in having complaints thoroughly investigated. The PCC is not in precisely the same position as a criminal court. It has an important investigatory and regulatory role in the public interest ... Would the reception of this evidence be ''desirable'' in the interests of ''making due inquiry''? In circumstances where firsthand evidence is not available because the patient has died and it is claimed that this is due to the doctor's serious professional misconduct, it might well be in the interests of making due inquiry to admit hearsay evidence of what the patient is said to have told the doctor. The weight to be attributed to such evidence will of course depend upon all the circumstances, including the extent to which the evidence is contradicted or supported by other admissible evidence.'**

20.140 In relation to the appearance of the letters **'SOB'** on the endocrinology report, Sullivan J observed that the PPC had taken it upon itself to draw inferences (albeit on an incomplete review of the evidence) and to resolve a critical area of dispute. He noted that further information (which tended to undermine the PPC's finding) had been obtained from the hospital since the PPC's decision, and observed that this illustrated:

> **'... the dangers of reaching final conclusions on highly contentious aspects of a complaint at a private meeting where neither party is present, and without making further investigation ...'**.

20.141 The Judge observed that it was perhaps because of the PPC's expertise that it had **'set out to answer the matters in dispute rather than decide whether there was a question for the PCC to answer'**. He concluded:

'I understand the basis on which the members of the PPC reached their own (unanimous) conclusions as to clinical care and as to whether Miss Wetherell had told Dr S K Pathak about or displayed breathing difficulties. However, in the light of all of the evidence I do not understand how a body with a screening function, even one as expert as this PPC, could possibly have formed the opinion that the material before them under these two heads did not even ''raise a question whether serious professional misconduct had been committed''.'

20.142 Sullivan J quashed the decision and remitted the case to a third PPC panel. Its consideration was to be conducted in the light of all the information then available, including information about the previous two decisions of the PPC.

Comment on the Case of Richards

20.143 These two decisions of the PPC (one taken before the change of Chairmanship and one after) illustrate many of the problems of which Professor Allen and her colleagues wrote in the 2000 PSI Report and of which she spoke when giving evidence to the Inquiry. They demonstrate what happens when decisions are taken by a committee that has no clear understanding of its functions or of the limitations on its powers. They demonstrate what happens when decisions are taken in an unstructured way and without the benefit of objective standards and criteria which can be consistently applied. They illustrate what Professor Allen described and what I have observed to be a tendency to look for acceptable explanations for the doctor's actions. When these two decisions are considered in conjunction with the 2000 PSI Report, the evidence of Professor Allen and other PPC cases examined by the Inquiry, it seems clear to me that the decisions in Richards were not just unfortunate – but isolated – errors. It is evident that decision-making in the PPC must have been defective for years, if not always.

20.144 There are a number of particular causes for concern. One is that a decision to close a case was sometimes taken on the basis that the evidence was hearsay and was therefore unlikely to be admitted by the PCC. As Sullivan J pointed out, the PCC had a discretion to admit hearsay evidence, even though, in general, it applied the rules of evidence applicable in a criminal trial. Whether it is appropriate for a disciplinary body charged with the protection of patients and the public to operate under the rules of criminal procedure is a different question to be dealt with later in this Report. However, it is worrying that the PPC should base a decision, even in part, on the assumption that the PCC would take little or no heed of hearsay evidence which it could have admitted had it thought fit.

20.145 Another particular cause for concern is that, in Richards, the GMC argued that it was appropriate that the PPC should **'get its sleeves rolled up'** when considering cases. I infer from this that the GMC thought that the PPC should have a general role in resolving disputed evidence in FTP cases. As a screening body, it should not have done this usually and should never have done it where there was evidence, capable of belief, in support of the allegation. It is astonishing that the PPC should have thought it appropriate to do so in a case in which that exercise involved disagreeing with the conclusions of a medically qualified panel which had heard evidence over a period of four days.

After the Case of Richards

20.146 Mr Nicholls told the Inquiry that he remembered 'some despair' after the decision in Richards. I can understand why. To make one fundamental error of approach in dealing with an individual case would give rise to some embarrassment, but to make two in respect of the same case – in which there was such an abundance of good quality information – must indeed have created a sense of despair. Mr Nicholls recalled that there was another judicial review at about the same time. That would have been the case of Holmes, with which I shall deal later in this Chapter. The claimants in that case were granted permission to apply for judicial review shortly before the judgement was delivered in the case of Richards.

The *Aide Memoire*

20.147 In the light of the case of Richards, the GMC sought advice from counsel as to how the PPC should proceed in future. Counsel produced an *aide memoire* for the use of the PPC when making its decisions. The first version was available in January 2001. This reads as follows:

> **'1. In conduct cases the PPC's task is to decide whether, in its opinion, there is a real prospect of serious professional misconduct being established before the PCC. Serious professional misconduct may be considered in the context of conduct so grave as potentially to call into question a practitioner's registration whether indefinitely, temporarily or conditionally.**
>
> **2. The ''real prospect'' test applies to both the factual allegations and the question whether, if established, the facts would amount to serious professional misconduct. It reflects not a probability but rather a genuine (not remote or fanciful) possibility. It is in no-one's interest for cases to be referred to the PCC when they are bound to fail, and the PPC may properly decline to refer such cases. On the other hand, cases which raise a genuine issue of serious professional misconduct are for the PCC to decide.**
>
> **3. The following does not purport to be an exhaustive list, but in performing its task the PPC:**
>
> > **(1) should bear in mind that the standard of proof before the PCC will be the criminal standard (beyond a reasonable doubt);**
> >
> > **(2) is entitled to assess the weight of the evidence;**
> >
> > **(3) should not, however, normally seek to resolve substantial conflicts of evidence;**
> >
> > **(4) should proceed with caution (given that, among other considerations, it is working from documents alone and does not generally have the benefit of the complainant's response to any**

> **reply to the complaint submitted on behalf of the practitioner);** (*in fact, as I have said, GMC policy from July 2000 was that the complainant's response should be obtained and put before the screeners*)
>
> **(5) should proceed with particular caution in reaching a decision to halt a complaint when the decision may be perceived as inconsistent with a decision made by another public body with medical personnel or input (for example, an NHS body, a Coroner or an Ombudsman) in relation to the same or substantially the same facts and, if it does reach such a decision, should give reasons for any apparent inconsistency;**
>
> **(6) should be slower to halt a complaint against a practitioner who continues to practise than against one who does not;**
>
> **(7) if in doubt, should consider invoking Rule 13 of the Procedure Rules** (*i.e. the power to cause further investigations to be made before reaching a decision*) **and in any event should lean in favour of allowing the complainant to proceed to the PCC; and**
>
> **(8) should bear in mind that, whilst there is a public interest in medical practitioners not being harassed by unfounded complaints, there is also a public interest in the ventilation before the PCC in public of complaints which do have a real prospect of establishing serious professional misconduct.'**

20.148 In March 2001, the *aide memoire* was amended slightly (and re-numbered) to include the following paragraph:

> **'(8) before referring to the Health Committee, should consider any causal connection between the alleged misconduct and some potential serious mental or physical impairment and should be mindful of the PCC's own power to refer; ...'**.

20.149 This first version of the *aide memoire* was approved by Mr Justice Burton in the later case of Woods v General Medical Council[4], with a minor change in paragraph (4) to reflect the fact that there might not be a complainant in every case.

20.150 Mr Nicholls told the Inquiry that he had found the definition of SPM contained in the 1997 Note (see paragraph 20.61), which had constituted the guidance to the PPC up to this time, 'rather circular'. The difficulty centred on the word 'serious', the meaning of which was not clear. He said that, to a complainant, 'serious' might be the outcome of a case (i.e. whether the patient had died or suffered serious harm as a result of the doctor's conduct). However, to the medical profession, 'serious' meant whether the doctor's registration was going to be brought into question. He said that there were arguments in his early days on the PPC 'about serious – serious for whom and for what?' The *aide memoire* had settled those arguments. It was then clear, he said, that 'serious' meant 'sufficiently bad,

[4] [2002] EWHC 1484 (Admin).

sufficiently below the standard you expect, sufficiently poor conduct to call the doctor's registration into question'.

20.151 I can see that the *aide memoire* might have solved the particular problem that had concerned Mr Nicholls and some of his colleagues on the PPC but it did not tackle the other difficulty, namely knowing how serious a doctor's misconduct or deficient performance has to be before it calls registration into question.

20.152 When asked what conduct he would regard as calling a doctor's registration into question, Mr Nicholls said that he would look at 'Good Medical Practice', he would look at the occurrence, at the frequency of the conduct, at whether the incident was a 'one-off' or whether there was a pattern in the conduct. He would consider whether the conduct was so far below the standard expected of a doctor at that level as to raise questions about the doctor's registration.

20.153 Mr Nicholls told the Inquiry that, after the introduction of the *aide memoire* in January 2001, he felt that the PPC did achieve greater consistency than the 2000 PSI Report had suggested was the case in 1999 and early 2000. However, he said that, under the GMC's new FTP procedures, he would like to see 'much more criteria-based decision processes' which could then be monitored and quality assured. I understood him to be saying that he believed that the PPC had applied more consistent criteria since the *aide memoire* was introduced, but that this could not be demonstrated adequately. He welcomed the idea of guidelines to assist decision-makers but emphasised that there should be room for individual judgement within the process. He feared that, if there were not, the process would become 'too mechanistic'. He felt that a return to a list of published criteria setting out the types of conduct which would lead the GMC to act against a doctor's registration would be counter-productive and at odds with the GMC's other functions of raising the overall standard of practice and of educating doctors for the future. He conceded that the disparities highlighted in the PSI research could not be explained even at the time when he gave evidence to the Inquiry in December 2003, because the GMC did not have the necessary data.

20.154 Mr Nicholls said that, following the production of the *aide memoire*, the PPC 'hardly ever' made a decision in conflict with that of an IRP which had received medical advice or with that of a coroner's inquest. If it did, it had to show very clearly why it had done so.

The Workload of the Preliminary Proceedings Committee from 2000 to 2003

20.155 It is clear from Mr Nicholls' evidence in the case of Richards that the workload of the PPC in 2000 was very heavy indeed. He sat on 314 cases between November 1999 and the time when he made his witness statement for the hearing, which took place in December 2000. A large number of interim orders were made by the PPC in the period up to August 2000, at which time responsibility for making interim orders passed to the IOC. In 2000, the PPC considered 423 cases. In 2001, the number of cases considered by the PPC rose to 571 and the PPC sat for 35 days. In 2002, the PPC dealt with 610 cases over 35 days. Mr Nicholls said that the target set for the PPC was to deal with 20 cases at each meeting. The outcome for some of those cases would be very obvious and that would assist the PPC

in achieving its target. However, the PPC missed its target quite often, as a result of which backlogs of cases built up. During this time, different panels of the PPC sat with different chairmen; use was made of co-opted GMC and associate members.

20.156 Mr Nicholls said that, at the time when he first joined the PPC, the time allowed for discussion of cases at meetings was too short to give proper consideration and judgement to some cases and, in particular, to the very difficult issue of whether a doctor's conduct was sufficiently serious to call his/her registration into question. This view accords with the observations of Professor Allen and her colleagues contained in the 2000 PSI Report. Mr Nicholls said that the increase in the number of days' sitting was, in part, to allow more time for the more difficult cases. In addition, the system for ordering the papers which were given to members of the PPC improved as a result of the recommendations of the PSI team. A system of indexing the papers was adopted, which made it easier for members to find their way round what might be a large file of papers. From July 2000, the screener's memorandum, setting out the screener's reasons for referring the case, was included in the papers. However, even with these improvements, Mr Nicholls said that it still took him between one and one and a half days to prepare for a day's sitting.

20.157 That Mr Nicholls should mention that there was insufficient time for discussion of the difficult question of whether the conduct amounted to SPM suggests that the PPC was asking itself the wrong question. If, on seriousness, it had confined itself to considering whether the PCC might conclude that the conduct amounted to SPM, that would have reduced the need for long arguments. It seems to me that a useful convention for a committee such as the PPC may be that, if one member thinks that the conduct (if proved) could amount to SPM, the rest should accept that view and act upon it. A similar convention guides the Court of Appeal (Criminal Division), when considering oral applications for permission to appeal against conviction or sentence. If one member of the Court thinks that leave should be granted, the others immediately acquiesce.

Two More Cases of Judicial Review

The Case of McNicholas

20.158 In March 2001, Mr Justice Sullivan, who had heard the case of Richards, heard a renewed application for permission to apply for judicial review of a decision of the PPC in the case of R v General Medical Council ex parte McNicholas[5]. The case concerned complaints made against three doctors. I do not intend to describe the case in any detail because it did not establish any new principles. I mention it partly lest it be thought that I have focussed too closely on cases in which the GMC was found wanting and have not noticed those in which the GMC's approach was found by the Court to be correct. The other reason for mentioning it is that the Judge affirmed that which I do not think has ever been in doubt, namely that the GMC is the arbiter of what does and does not amount to SPM. In short, the Judge refused permission to seek judicial review on the ground that the PPC's decision had been taken lawfully. He found that it had not, as was alleged, resolved major conflicts of evidence; nor had it reached factual conclusions that were contrary to the findings of

[5] 13th March 2001 (unreported).

the Health Service Commissioner (and possibly an IRP) who had investigated the case. The Judge said that the case was to be distinguished from that of Richards because there was really no issue that the doctors had fallen short of the standard of care that a conscientious doctor would have provided in the circumstances. The remaining question was, he said, **'very much a matter for the professional judgment of the committee: was it arguable that their failures were so serious as to amount to serious professional misconduct'**.

20.159 The Judge pointed out that **'not every error by a medical man'** amounted to SPM. The other bodies who had looked at the case had identified, at least in the case of two of the doctors, **'particular and isolated errors rather than a course of conduct'**. The other bodies had been considering whether the standard of care given by the doctors fell short of the standard to be expected of a conscientious GP. It would have been perfectly possible to answer that question in the affirmative and yet at the same time to conclude that the failure was not such as to amount to SPM. That, the Judge said, was the reason for the PPC's conclusion. He accepted that a differently constituted PPC might have taken a different view. That was not to say that it was not open to **'this very expert committee'** to take the view that it did. He therefore refused permission to apply for judicial review.

The Case of Woods

20.160 I mention also the case of Woods, to which I referred at some length in Chapter 19. That case concerned several doctors whose conduct was the subject of criticism in the report of the Royal Liverpool Children's Hospital Inquiry (the Alder Hey Inquiry). Mr Nicholls provided a witness statement in respect of the nine doctors whose cases had been considered and closed by the PPC. He referred to the *aide memoire* and asserted that the PPC had acted in accordance with its guidance. The Judge approved the advice given in the *aide memoire* and accepted that the PPC had indeed followed its guidance. In respect of all the decisions of the PPC, the application for judicial review failed.

The Case of Holmes

20.161 In Chapter 19, I outlined the circumstances of the case of R v General Medical Council ex parte Holmes and others[6], which was decided by Mr Justice Ouseley in April 2001. It concerned applications for judicial review challenging, *inter alia*, decisions of the medical and lay screeners in respect of a complaint against Dr M M Rahman and a decision of the PPC relating to a complaint against Dr S Sengupta. The Judge quashed all the decisions. I discussed the decision in Dr Rahman's case in Chapter 19. I shall now consider the Judge's decision in Dr Sengupta's case. This case was also considered by the Court of Appeal in October 2002[7].

The Complaints

20.162 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

[6] [2001] EWHC 321 (Admin).
[7] [2002] EWCA CIV 1838.

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.

20.163 Following Mr Dean's death, Ms Holmes complained to the local FHSA about both doctors. In March 1996, a MSC concluded that Dr Sengupta had breached his terms of service but Dr Rahman had not. Ms Holmes appealed to the SoS for Wales against the decision in respect of Dr Rahman. The appeal was allowed and, in June or July 1998, the SoS for Wales directed that the complaint against Dr Rahman should be referred to the GMC. In July 1998, the claimants made a complaint to the GMC against Dr Sengupta. Some time in early 1999, the principal medical screener, Dr Steel, and another medical screener, Professor Hilary Thomas, decided that the complaints against both Dr Sengupta and Dr Rahman should not be referred to the PPC; a lay screener agreed in the case of Dr Rahman. His case was closed and, as I explained in Chapter 19, that decision was later quashed on judicial review. However, in Dr Sengupta's case, the lay screener disagreed with the medical screeners' view and Dr Sengupta's case was therefore referred to the PPC.

The Decision of the Preliminary Proceedings Committee

20.164 The PPC considered the complaint against Dr Sengupta on 9th September 1999. The meeting was chaired by Dr Steel. This must have been one of the last cases where a PPC panel was chaired by the person who had also been responsible for screening the complaint. Until November 1999, this was a very frequent occurrence but, to modern eyes, was obviously unsatisfactory. A person in that position could hardly be expected to approach the case with an open mind and the chance that s/he would change his/her mind and support the referral of the case to the PCC must have been remote. Professor Allen had observed at this time that there was very little discussion of a case after the Chairman had introduced it. Not surprisingly, the PPC decided not to refer Dr Sengupta's case to the PCC but, instead, to send Dr Sengupta a warning letter. The minute recording the PPC's decision stated:

> **'W/L** (*i.e. a warning letter*) **on the basis that this is a single case, patient had been seen very recently in hospital, doctor offered review in 12 hours and condition difficult for GP to diagnose. But Ctte did not accept he'd carried out an adequate examination and also were critical of the fact that his assessment was not documented. Letter should also say Ctte reinforced decision of MSC.'**

20.165 Subsequently, the GMC wrote to the claimants' solicitors and to Dr Sengupta, informing them of the decision of the PPC. The letter to the claimants' solicitors, written by a caseworker, stated that the PPC had decided that it would not be necessary to refer the case to the PCC for further consideration of the doctor's fitness to practise. It went on:

> **'The Committee concurred with the view of the original Medical Service Committee which found that Dr Sengupta had not placed himself in an adequate position to make a clinical judgement and that the record keeping of the consultation with Mr Dean was poor.**
>
> **They felt that Dr Sengupta did not give due regard to Mr Dean's prior medical history and that his actions were inadequate in the circumstances.**
>
> **However, the Committee took into account that this was a single case and that Mr Dean had recently been seen in hospital. They noted that Dr Sengupta had offered to review Mr Dean's condition in 12 hours and the condition which Mr Dean had was, of itself difficult to diagnose.**
>
> **The Committee felt having regard to all these circumstances that this matter did not reach the threshold of serious professional misconduct.'**

20.166 The letter went on to say that the Committee had asked the author of the letter to explain that the Committee had a duty to examine the doctor's individual actions and that an error or omission (even where this had had serious consequences) might not **'justify the revocation of a doctor's license** (*sic*) **to practise permanently'**. The letter stated that Dr Sengupta had been reminded of his professional obligations and had been warned that the matter might be reconsidered should the GMC receive any further information about his practice in the next three years. The reference to three years suggests that it was contemplated that it might be taken into account in future performance (rather than conduct) proceedings. As I have explained, a two-year limit operated for the revival of conduct matters, but it seems that the GMC operated an unofficial cut-off of 3 years for performance allegations.

The Judicial Review Process

20.167 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 for judicial review. That was about six months after the decision in Toth and 13 days before the decision in Richards, which was delivered on 18th December 2000. 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 ground 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 at a hearing before Ouseley J. As I have said previously, this gave rise to an unusual form of hearing.

20.168 The reasons why the GMC agreed that the decision in Dr Sengupta's case was unsustainable were set out in a witness statement provided by a representative of the GMC's solicitors. He said that the letter to the claimants' solicitors and the doctor was in

'PCC language'. It echoed the test of the PCC and did not appear to be consistent with the test to be applied by the PPC. It indicated that the PPC had reached conclusions or findings as to the errors that Dr Sengupta had made. The witness statement continued:

> **'It suggests that they** (*i.e. the PPC*) **then reached a conclusion that these errors did not reach the level of serious professional misconduct. They did not ask themselves whether there was a ''question'' of whether that level was reached, or whether it was arguable that it might have been reached. They reached a definitive conclusion.'**

20.169 The witness statement went on to cite the reference in the GMC's letter to the power to revoke a doctor's licence to practise **'permanently'**. It observed:

> **'This is troubling since it does not appear that the PPC has considered the power to affect the right to practise temporarily or conditionally or the power to impose a lesser sanction (such as a reprimand).'**

20.170 Ouseley J noted that he had received no evidence from the GMC about the tests which had been applied by the screeners or the PPC. He observed:

> **'... if there had been clear evidence of a test being consistently applied with the relevant distinctions between the roles of the various bodies being routinely observed, I would have had it, even if the individual case itself could not be remembered. I attach weight, but not determinative weight, to the position of the GMC, knowing its decision makers and the language which is used by them, being unable to support the decisions in this case as positively showing that the correct approach had been adopted.'**

20.171 It was clear from the position taken by the GMC that it had recognised that its decision-makers had not adopted the correct approach. I refer back to the observations of Professor Allen and her colleagues that GMC decision-makers appeared to have no clear idea of their role or of the tests that they should be applying.

20.172 Ouseley J said that he was not persuaded that the part of the letter which I have quoted at paragraph 20.165, taken in isolation, evidenced an error of law. Nor was there any impermissible finding of fact, since the PPC had taken the case against the doctor at its highest. However, that left the **'seriously troubling'** matter of the use of the word **'permanently'**. He said:

> **'... I do consider that the language shows that the range of conduct capable of constituting serious professional misconduct was unduly narrowed because other and lesser penalties exist for serious professional misconduct which are relevant to the judgment of the quality of conduct as capable of constituting serious professional misconduct.'**

20.173 As a result, Ouseley J concluded that there had been an error of law and quashed the PPC's decision. Dr Sengupta applied to the Court of Appeal for permission to appeal

against the Judge's decision. Permission was initially refused but was subsequently granted at an oral hearing.

The Court of Appeal Hearing

20.174 Before the hearing of the appeal, the GMC filed a Respondent's Notice contending, as an additional reason for upholding the Judge's decision (which had, of course, been to quash the decision of the PPC), that the statement in the GMC's letter that the PPC **'felt that having regard to all the circumstances that this matter did not reach the threshold of serious professional misconduct'** set the threshold too high. Ouseley J had rejected that contention. The GMC also conceded that the entirety of the letter was couched in terms of decision-making on the merits of the case. In my view, it is greatly to the credit of the GMC and its legal team that it adopted this approach in the Court of Appeal. The GMC was in effect inviting the Court to hold that the PPC had been wrong in two respects and not only in the one respect found by the Judge.

20.175 Giving judgement in the Court of Appeal, Lord Justice Parker said:

> **'... the terms of that** (*i.e. the GMC's*) **letter, read as a whole, are consistent only with the PPC having applied the wrong legal test in reaching its decision, in that (a) it regarded itself as having a fact-finding role, and (b) it treated the range of ''serious professional misconduct'' as being restricted to conduct which would attract ''permanent'' erasure from the register of practitioners, and in doing so left out of account conduct which would justify a lesser penalty'**.

He accepted the GMC's submission that the Judge had been in error in not concluding that the PPC had assumed a fact-finding role. Also, in his view, the use of the word **'permanently'** was consistent only with the PPC having misdirected itself as to its true role. The other members of the Court of Appeal agreed with Parker LJ and Dr Sengupta's appeal was dismissed. The mistakes made by the PPC in the case of Holmes were of a fundamental nature. The errors revealed in the case of Richards had not been isolated.

Later Developments

The 2003 Policy Studies Institute Paper

20.176 Professor Allen and her colleagues analysed the outcomes of cases referred to the PPC during the period from 1999 to 2001. The results were published in their 2003 Paper.

20.177 The proportion of all doctors whose cases were referred by the PPC to the PCC had increased markedly, from 30% of all cases considered by the PPC in 1997 and 31% in 1998, to 41% in 1999 and 2000. The proportion dropped again to 34% in 2001. The proportion of UK qualifiers sent by the PPC to the PCC was much lower than the proportion of overseas qualifiers in all five years.

20.178 Over the years 1999, 2000 and 2001, the PPC had sent fewer than half of the doctors who had been convicted of criminal offences (other than drink driving) to the PCC. In all three years 1999, 2000 and 2001, the proportion of overseas qualifiers with convictions referred

by the PPC to the PCC was considerably higher than that of UK qualifiers. This was puzzling since one might have expected the PPC to adopt a consistent approach when dealing with doctors who had committed criminal offences. Once again, a greater proportion of UK qualifiers than of overseas qualifiers was referred to the health procedures, raising the possibility that overseas qualifiers were being treated unfairly as compared with those who had qualified in the UK.

20.179 On this occasion, the PSI team had been commissioned by the GMC to carry out a purely quantitative analysis. Professor Allen and her colleagues did not carry out any qualitative analysis, such as an analysis of the reasons given by the PPC for its decisions. They were unable to find any explanation for the anomalies. The continuing disproportionate referral rates of overseas qualifiers who had been convicted of criminal offences were particularly difficult to explain. In its 2003 Paper, the PSI team warned that, until there were some objective measures, which could demonstrate that the disproportionate referral rates had occurred for good reason and were fair and reasonable, the GMC remained open to accusations of bias. The 2003 Paper reiterated the need for commonly agreed criteria and thresholds to be applied when reaching judgements about the seriousness of cases and about how they should be dealt with.

20.180 Mr Nicholls told the Inquiry that the contents of the 2003 PSI Paper were very disappointing for the GMC. There was still no explanation for the disparities revealed by the analysis carried out by the PSI team. This was, of course, not surprising since, on this occasion, the PSI team had been commissioned to carry out only a statistical analysis of the cases dealt with during the relevant period. It had conducted no further research into the decision-making processes. Nor had the GMC itself carried out any such research. And, despite all the changes, the people making decisions on behalf of the GMC – of whom there were by this time hundreds – still had no standards and criteria to use in the process. What the analysis showed was that there was a continuing problem which needed addressing. The difference in treatment of convictions in particular needed an explanation. Mr Nicholls said that the PPC's view was that research should be undertaken in order to explore the reasons for the apparent disparities. Now that the PPC recorded reasons for its decisions, he said that it would be possible to carry out a retrospective study. In addition to that, there was a need for continuing monitoring and audit.

Changes in the Treatment of Convictions

20.181 On the face of it, the proportion of conviction cases referred by the PPC to the PCC seems remarkably low. As I have also explained, the PSI research highlighted a disparity between UK and overseas qualifiers in the treatment of cases where doctors had been convicted of criminal offences. The PSI team was concerned about both sets of findings.

20.182 It is true that the numbers of convictions (other than drink driving cases) referred to the PPC were small (23 in 1997, 32 in 1998 and 31 in 1999). The GMC's procedures permitted more minor convictions to be filtered out by GMC staff (in the case of minor motoring offences) and (in the case of other minor offences) by the medical screeners, so that they would not have reached the PPC. As I have said in Chapter 19, the medical screeners had for many years been authorised to use their discretion in deciding whether to refer cases

relating to offences committed more than five years before notification to the GMC. The medical screeners had also been given discretion not to refer convictions for 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. In addition, the 'conviction' cases considered by the PPC did not include cases in which an absolute or conditional discharge had been imposed by the courts. Given that the PPC would not be called upon to adjudicate on the types of case described above, it must follow that the conviction cases which the PPC was deciding not to refer to the PCC were for offences of a higher degree of seriousness.

20.183 Mr Nicholls said that there were some minor convictions (he described them as 'one-offs') where the Court had imposed a very low sentence and where the PPC might take the view that a warning letter was sufficient. A document describing the GMC's conduct procedures, published in July 2000, suggested that first convictions for 'shoplifting' would be dealt with by way of a warning letter or a letter of advice. This was presumably the type of case to which Mr Nicholls was referring.

20.184 I interpose to say that it does appear that, in the past, the GMC has tended to assess the gravity of a doctor's conduct by reference to the penalty imposed by the court. When sitting as a judge (and, before that, when appearing in court as counsel), I have heard pleas in mitigation made on behalf of doctors convicted of criminal offences, in which the court has been urged to treat the doctor leniently because his/her career – or even life – is said to be in ruins as a result of the action that will inevitably be taken by the GMC as a result of his/her conviction. The implication is that the doctor will lose his/her livelihood and will face professional disgrace. Faced with that kind of plea in mitigation, it is not surprising if a court feels constrained to impose a more lenient sentence than might otherwise be thought appropriate. The court would no doubt be surprised to learn that the GMC had later taken a lenient view of the case because the judge had imposed a lenient sentence. It seems to me that the sentence passed by the criminal court is of very limited relevance to the seriousness of the doctor's conduct from the GMC's point of view. What should matter to the GMC is the doctor's fitness to practise as a doctor and whether s/he represents a risk to patients. Those are not the issues on which the Court will have focussed. I will return to this subject later in this Report.

20.185 As I have said, the PSI team had recommended that all convictions (save those for drink driving) should be referred directly to the PCC without the intervention of the screeners or the PPC. This recommendation was not adopted. Instead, a far more limited rule was brought into force. In November 2002, the 1988 Professional Conduct Rules were amended so as to permit all convictions where an immediate (i.e. not suspended) custodial sentence had been imposed to be referred by the Registrar direct to the PCC unless he was of the opinion that such a direct referral would not be in the public interest.

20.186 Mr Scott explained that the GMC had not moved immediately to a full implementation of the PSI team's recommendation because of resistance from some members of the Council. Their belief was that there should be an opportunity for the exercise of discretion (presumably by the PPC and, to a lesser extent, by the medical screeners), even in cases where doctors had been convicted of criminal offences. Mr Scott said that, in the light of

this opposition, it had been possible to make progress only in stages, rather than in one leap. He told the Inquiry that his personal view was that the GMC should move as rapidly as possible to a position whereby all save the most minor convictions were referred to the PCC (or, in the future, to a FTP panel). However, the decision was not for him but for elected members. Mr Scott said that he had no doubt that the GMC would 'continue to shift the boundaries' and would in time implement the recommendation of the PSI team. Meanwhile, in addressing the question of why all convictions had not previously been referred routinely to the PCC, Mr Scott said:

> **'... I do not think I can honestly explain that except in the terms that decision makers exercised a discretion they were entitled to exercise and they made decisions that others might not have done'**.

Comment

20.187 If the PPC had had a good track record for exercising its discretion consistently and in a way that was appropriate in the public interest, I might have been able to understand why the GMC did not wish to move to the position recommended by the PSI team. I can see why it might be felt that not every single case in which a doctor had been convicted should go to the PCC. However, this was not so. The GMC could see from the statistics produced by the PSI team that a substantial proportion of the more serious conviction cases were not being referred to the PCC. In other words, it was clear that the PPC was not referring a lot of cases that should have been referred. Rather than allowing this state of affairs to continue, the GMC should, in my view, have laid down some clear rules as to which convictions should be referred and which need not be. As it was, the GMC allowed the *status quo* to continue and did not even provide any guidance or criteria for the PPC, let alone a clear rule. Two problems resulted from this. First, there was a real potential for unfairness as between doctors. Second (as examination of the cases reveals), cases which, in the interests of the public, of the honour of the medical profession and of the reputation of the GMC, ought to have had public hearings did not.

20.188 It was clear to me, from an examination of some of the case files produced to the Inquiry, why the PPC failed to refer conviction cases that ought to have been referred. The PPC had a tendency to focus on the circumstances of the doctor rather than on the seriousness of the offence. Of course, the circumstances of the doctor should be taken into account by the PCC when deciding upon a penalty, but not by the PPC. Take, for example, a case in which a doctor has stolen money while working in a hospital. Instead of focussing on the facts underlying the conviction and deciding whether the conduct was serious enough to warrant referral, the PPC tended to focus on aspects of mitigation. It might have taken into account the fact that the doctor was under stress, was over-worked or had personal problems. It might have received testimonials as to the doctor's clinical abilities. On those grounds, the PPC might well have decided not to refer the case. In fact, the correct approach would have been to examine the conduct which had given rise to the conviction, decide whether it warranted referral and leave issues of mitigation to the PCC. Not only would such an approach have been correct in law, but it would also have ensured that the public (or that section of the public that was aware of the case) would have known how the GMC had dealt with the doctor and why it had dealt with him/her as it had. The difficulty

for the PPC was that they had no standards to apply when considering whether the case ought to be referred.

20.189 Under the new FTP procedures, it appears that some discretion will be exercised by the office staff, case examiners and, possibly, the Investigation Committee (IC), in relation to some types of conviction. They will be able to decide, in some instances, whether or not a conviction case should go forward to a public hearing before a FTP panel. I shall describe the proposals for the treatment of convictions under the new FTP procedures in Chapter 25.

The Recent Statistics

20.190 In its 2000 Report, the PSI team had asked why such a high proportion of cases (two thirds during its observations of meetings before November 1999 and over half after November 1999) which had been referred by screeners to the PPC were not referred to the PCC. The GMC's annual FTP statistics show that only 35% of those doctors who were dealt with by the PPC in 2002 were referred to the PCC. In 2003, the percentage of doctors referred by the PPC to the PCC was 30%.

20.191 Mr Nicholls said that he did not find the proportion of cases sent to the PCC surprising. The screeners were operating a low threshold, particularly after the judicial reviews (presumably those in the cases of Toth and Holmes), when there was 'more nervousness' about their 'limited powers'. The PPC, on the other hand, was looking at whether there was a realistic prospect of proving SPM. Mr Nicholls pointed out that, in many cases which were not referred to the PCC, the PPC took 'some action in the interests of the public against the doctor' by sending a warning letter or a letter of advice. In 2002, 43% of doctors dealt with by the PPC were sent a warning letter or a letter of advice. In 2003, the figure was 44%. In 2002, 61% of conviction cases were dealt with by way of a warning letter or a letter of advice. In 2003, the total was 65%. Some of these would be drink driving cases, but it seems that other convictions were also dealt with in this way. Warning letters and letters of advice must also have been sent in conduct cases where some or all of the facts had been proved or admitted by the doctor concerned or were beyond dispute. It seems to me that the explanation for the high proportion of cases not sent through to the PCC probably lay in the continued unwillingness of the PPC to confine itself to an assessment of the appropriate issues and in its tendency to take mitigating factors into account.

20.192 In evidence, Mr Nicholls was asked about the fact that, in 2002, the PPC had referred to the PCC only 23 (28%) of the 82 cases of sexual assault and indecency that had been referred to it by screeners. These were not cases where there had been a conviction, since convictions were listed separately in the annual FTP statistics. Mr Nicholls thought that the most likely reason for a decision not to refer was the difficulty of establishing the allegations to the criminal standard of proof required by the PCC. However, he pointed out that warning letters had been sent in 21 of the sexual assault or indecency cases. Since warning letters are sent only in cases where the allegation has been proved or admitted or is beyond dispute, it is difficult to see how evidential difficulties could account for the fact that those cases were not referred. Revised figures recently produced by the GMC (based on the number of doctors about whom allegations had been received, rather than

on the number of individual allegations) show that 33% of the 51 doctors against whom allegations of sexual assault or indecency had been made were referred to the PCC in 2002. The figure for 2003 was 30%. Letters of warning or advice were sent to 45% of doctors against whom allegations of sexual assault or indecency had been made in 2002 and to 39% of such doctors in 2003.

20.193 Mr Nicholls was also asked about the fact that, on the basis of the figures available at the time, it seems that, in 2002, the PPC had referred only 38 (55%) of the 69 dishonesty cases (again non-convictions) to the PCC. In 15 such cases (22%), a warning letter had been sent and, in eight cases, a letter of advice. Again, Mr Nicholls suggested that, since there had been no conviction in these cases, there might have been evidential problems in satisfying the criminal standard of proof. However, this could not account for cases in which a warning letter had been sent. Mr Nicholls said that there would be some 'very minor' offences in the dishonesty category. The revised figures show that 45% of doctors who faced allegations of dishonesty in 2002 were referred by the PPC to the PCC in 2002 and that 35% were referred in 2003. In 2002, 43% of such doctors were dealt with by way of a warning letter or a letter of advice. In 2003, that figure was 57%.

The Cancellation by the Preliminary Proceedings Committee of Hearings before the Professional Conduct Committee

20.194 Rule 19 of the 1980 Professional Conduct Rules provided:

> **'(1) Where, after a complaint or information has been referred to the Committee** (*i.e. the PCC*) **for inquiry, it appears to the President that the inquiry should not be held, he may after consultation with the members of the Preliminary Proceedings Committee who made the determination to hold the inquiry and in accordance with the opinion of those members or the majority of their opinions (including his own opinion) direct that the inquiry shall not be held ... Provided that in any case where there is a complainant the President shall, before he consults with members of the Preliminary Proceedings Committee as aforesaid, communicate or endeavour to communicate with the complainant with a view to obtaining the observations of the complainant as to whether the inquiry should be held.**
>
> **(2) Where the opinions of the members of the Committee are equally divided the question shall be deemed to have been resolved in favour of the practitioner, and the President shall direct that the inquiry shall not be held.**
>
> **(3) As soon as may be after the giving of any such direction the Solicitor** (*appointed by the GMC*) **shall give notice thereof to the practitioner and to the complainant (if any).'**

In this connection, the function of the President could be exercised by the member appointed to act as medical screener in his stead.

20.195 In the 1988 Professional Conduct Rules, rule 19 was changed. From that time, the function of the President could be exercised by the member appointed to act as medical screener in the President's place only if s/he had also been appointed Chairman of the PPC. The President (or the Chairman of the PPC) had to consult the PPC about a cancellation. However, the PPC was not required to meet for the purpose of this consultation. If the PPC agreed, the President (or the Chairman of the PPC) had the power to direct that the hearing by the PCC should not take place. In the event of the votes being equally divided, the President or Chairman of the PPC would have had an additional casting vote. The obligation to consult the complainant was preserved. In practice, however, this was done only if the complainant was a private individual. If the doctor had been referred to the GMC by a public body such as a NHS trust, that body would not have been consulted.

20.196 In 2000, the power to initiate the procedure for cancellation of a PCC hearing was given to the Chairman of the PPC. In November 2002, as I have said at paragraph 20.185, the 1988 Professional Conduct Rules were amended so as to permit all convictions where an immediate custodial sentence had been imposed to be referred by the Registrar direct to the PCC unless he was of the opinion that such a direct referral would not be in the public interest. At the same time, a new rule 19(3) was added:

> **'Where, after the Registrar has referred a conviction to the Committee for inquiry, it appears to him that the inquiry should not be held, he may direct that the inquiry shall not be held.'**

20.197 So far as the Inquiry is aware, no guidance was given or criteria set down as to the circumstances in which the Registrar or the GMC staff exercising his legal powers should use this power to cancel a PCC hearing in a conviction case which had been referred directly to the PCC by the Registrar or staff. I can see that it may be appropriate for a hearing by the PCC to be cancelled if a doctor's appeal against a criminal conviction is allowed, or if the doctor dies or is found to be terminally ill. However, it is not clear whether it was intended that the power should be exercised in any other circumstances.

20.198 Nor does there appear to have been any indication of the criteria which the PPC should apply when deciding whether to cancel a hearing by the PCC in a conduct case. Such decisions were taken in private and did not need to be taken at a meeting although, in practice, it appears that cancellations were considered at, and recorded in the minutes of, meetings of the PPC.

20.199 For most years, no figures showing the number of cancelled PCC hearings appear in the GMC's annual FTP statistics. At the Inquiry's request, the GMC provided information about the number of cases where an initial referral by the PPC of a case for hearing by the PCC was subsequently cancelled under the provisions of rule 19. That information shows that the hearings in 13% of the cases referred by the PPC to the PCC in 2000 were subsequently cancelled. The subsequent figures are 15% of the cases referred to the PCC in 2001, 20% of those referred to the PCC in 2002 and (as at the beginning of August 2004) 11% of the case referred to the PCC in 2003.

20.200 The GMC provided a breakdown of the reasons for the cancellation of hearings as recorded in the relevant files. The most common reasons were said to be

'unwilling/unreliable complainant or witness' and **'other evidential difficulties'**. In a significant proportion of cases, it was said that the expert reports which had been obtained did not support the case. In a few cases, the reason given was **'new information'**, and in two cases criminal appeals had succeeded. One doctor had died. There was one case (cancelled in 2000) where the reason given was **'unlikely to reach the threshold of SPM'**. The information provided by the GMC showed that doctors sometimes requested that the hearing in their cases should be cancelled for evidential or other reasons. If a first request was refused, the doctor might renew his/her request at a later stage.

Comment

20.201 These statistics seem to me to require further consideration by the Council. It may be that a changed approach by the PPC (with less emphasis upon consideration of whether the evidence was likely to stand up before the PCC) resulted in the PPC passing through some cases which, on further examination by the GMC's solicitors, were found to have serious evidential difficulties. If so, that would be reasonable although, if that were the case, it would underline the need for improved evidence gathering at an earlier stage of the process. However, 20% is a very high proportion of cases to be cancelled. The figures were not usually reported to the Council in the annual FTP statistics.

20.202 As many as 30 cases cancelled in 2002 were said to involve an unwilling complainant or witnesses. This might have been because of delay, because the complainant or witnesses had previously given evidence at another hearing, or because s/he felt intimidated in some way. One would have thought that the GMC would have been concerned that cases were being 'lost' because of unwilling complainants and witnesses and would have wanted to know what was behind this. It is possible that such witnesses might be assisted in the future by the vulnerable witnesses provisions which are proposed in the new FTP procedures. Better investigation earlier might also eliminate some cases which have no prospects of success. However, there is cause for concern because the proposals for cancelling cases are much more lax under the new FTP procedures. In my view, the full statistics should be published annually, showing clearly the percentage of cases referred which have subsequently been cancelled. The reasons for the cancellation, as well as the statistics, should be readily available. Research should be conducted into the reasons why cases are failing at this stage and steps should be taken to reduce such cases to a minimum.

The Inquiry's Examination of Cases

20.203 The Inquiry requested the disclosure of the files relating to certain classes of case considered by the PPC. The request related to three particular issues which the Inquiry had to address. First, the Inquiry wished to discover how, over the years, the GMC had handled the cases of doctors who had been convicted of controlled drugs offences (such as those of which Shipman had been convicted in 1976) and of those whose misconduct was thought to involve the abuse of controlled drugs. Many such cases were referred to the PPC. Second, the Inquiry wished to know how the GMC (and, in particular, the PPC)

had handled cases of alleged substandard clinical treatment during the 1990s, when Shipman was reported to the GMC following two adverse findings by a MSC. In addition, the Inquiry was interested to discover how the PPC would have dealt with a complaint, if one had been made, arising out of the case of Mrs Renate Overton, which I described in Chapter 10. The following discussion does not deal with all the case files disclosed. It focusses on those cases which have some similarity to the circumstances of Shipman's referrals, or which raise an issue of patient protection of concern to the Inquiry.

Cases Involving Controlled Drugs

20.204 As will be seen, the general theme underlying all the cases involving the abuse of controlled drugs is that the PPC would refer the doctor into the voluntary health procedures, even if s/he had been guilty of quite serious misconduct affecting patient safety or welfare. One recent case, that of Dr JO 09, which is typical of the way in which the PPC dealt with drug abusing doctors, is described in Chapter 23.

Dr JO 04

20.205 In most cases in which the PPC referred a doctor into the voluntary health procedures, there was some evidence of addiction or dependence such as would justify that referral. However, in the case of Dr JO 04, there was no evidence of addiction and no evidence which, to my eyes at least, could justify a referral into the voluntary health procedures. Yet that was the outcome. While working as a senior house officer at Hospital A, Dr JO 04's conduct gave rise to a suspicion that he was stealing fentanyl and injecting himself. No action was taken at the time. The doctor left that hospital and started work at Hospital B. Some time later, a member of staff at Hospital A informed Hospital B of the concerns and suspicions that had arisen. A few months later, the doctor was confronted with these suspicions in an interview attended by a member of staff from each hospital. He admitted that he had abused fentanyl in the past although, he claimed, this had never compromised his care of patients. He refused to give a hair sample for testing, claiming that he had taken cannabis at a party four days earlier. He was suspended or sent on sick leave and reported to the GMC.

20.206 After initial consideration, the case was referred to a medical screener, who recommended that the case be referred to the PPC and the IOC. He observed that there were concerns about SPM and about patient safety. At the hearing before the IOC, counsel for the doctor said that the doctor had retracted his admission that he had abused fentanyl. His case was that he had once taken the drug on the tongue (not by injection) while at Hospital A, but any suggestion that he had used it over a period would be strongly denied. The IOC imposed conditions on the doctor's registration for the protection of patients. It considered that there was **'cogent and credible prima facie evidence of substance misuse'**. It is clear that there were in existence letters from witnesses from Hospital A where the drug abuse had occurred.

20.207 Later that week, the case came before the PPC, which adjourned the case for medical reports. The first medical report was a remarkable document in which the examiner went well beyond the giving of a medical opinion. First, he noted, quite properly, that the

allegation of the abuse of fentanyl had been denied by Dr JO 04 and that no drugs had been detected on a recent hair test. However, the examiner then went on to discuss the strength of the evidence in relation to Dr JO 04's past abuse of drugs. He mentioned the witness evidence from Hospital A and the fact that Dr JO 04 had avoided taking a hair test at Hospital B when offered the chance to demonstrate that he was drug-free. The examiner then went on to say that the evidence was **'finely balanced'** but concluded, on the balance of probabilities and in the light of the doctor's retraction of his admission, that the evidence was not sufficient to suggest that Dr JO 04 had a present or past problem with the misuse of drugs that would affect his ability to practise. However, Dr JO 04 had admitted to using cocaine in the past and the examiner considered that he should be kept under observation to ensure that he was not using substances illicitly.

20.208 Another medical report said that the examiner found it difficult to draw firm conclusions about Dr JO 04's drug abuse. However, because of the high risk to patients that would arise if he were to abuse drugs, he recommended that the doctor should remain suspended until a full hearing could assess the evidence. A third report recommended medical supervision.

20.209 The minutes of the resumed consideration of this case by the PPC give rise to concern. First, there appears to have been discussion about the propriety of the conduct of the staff at Hospital A. It appears that they had been aware of concerns some time before Dr JO 04 had left Hospital A, but had nevertheless sanctioned his promotion within the hospital. The concerns had not been raised properly until Dr JO 04 had moved on to Hospital B. On the face of it, that did not appear satisfactory, but it was wholly irrelevant to the issue of whether Dr JO 04 had been abusing drugs and, if so, what should happen to him. The PPC then discussed the fact that there was not much evidence of drug abuse now that the admissions had been withdrawn. They noted that the admissions had been made without the benefit of legal advice. All the other evidence was said to be hearsay. The prospect of proving the allegations at the PCC was felt to be poor. The PPC noted that the medical examiners had recommended supervision. In fact, they had not. Only one had done so. Apparently, Dr JO 04 was willing to undergo supervision. One is bound to wonder why he should have done that, if he did not have and had never had a drug problem. The PPC's decision was to adjourn *sine die* to enable the doctor to be dealt with under the voluntary health procedures.

20.210 When giving evidence about this case, Mr Nicholls was asked to explain why the PPC had thought that the only evidence of drug abuse was (and presumably could only ever be) hearsay. He said that the PPC thought that the prospects of the case being proved at the PCC were very poor. There had been delay and no local investigation. When it was suggested that evidence would have been available about the circumstances in which the doctor had made his admission and the terms of his admission, Mr Nicholls said that he thought it would be a 'hard struggle' to obtain further evidence about the admission. He agreed that the effect of the PPC's decision was that the issue of whether the doctor had been abusing drugs had never been resolved. He also accepted that there was no medical evidence that the doctor had any medical or psychiatric problem such as would justify referral into the voluntary health procedures. Mr Nicholls explained the PPC's decision on the basis that there was a possibility that the doctor had been abusing drugs,

so that it was preferable, in the interests of patient safety, that he should be made subject to some voluntary supervision than that the case against him should fail completely at the PCC.

20.211 I can see that the PPC's solution must have appeared to be a pragmatic way of dealing with an evidential problem which, I am sure, it regarded as insuperable. However, this case shows the PPC misdirecting itself in several respects. First, the discussion about the conduct of the staff at Hospital A was quite irrelevant to the issues before the PPC. Second, its assessment of the availability and cogency of the evidence available was wrong. It was, incidentally, quite different from the assessment that had been made of the same evidence by the IOC. It is no personal criticism of Mr Nicholls or of any member of the PPC if I say that it appears to me that they did not understand the hearsay rule; they are not lawyers. But the trouble is that they made decisions based on their misunderstanding of that rule. The PPC should not have based its decisions on the strength or availability of evidence save in the most obvious and straightforward circumstances.

Dr JO 10

20.212 Another case which gives rise to some concern was that of Dr JO 10. The doctor was an anaesthetist who was found to have been abusing a variety of anaesthetic drugs. Initially, he took drugs left over from the clinical procedures in which he had taken part. He would order larger ampoules than were needed for the patients. Later, he took to drawing off part of the contents of an open ampoule and replacing what he had taken with water. Thus, the patients received less than they should have had. When eventually confronted about these matters, he admitted them. The case was referred to the GMC. The Medical Director of the hospital at which Dr JO 10 worked considered that patients had been put at risk not only because they had not received appropriate medication but also because the doctor had been under the influence of drugs while on duty.

20.213 No conviction had been recorded against the doctor. The case went to the medical screener as one of 'SPM by definition'. The screener, very properly, referred it to the IOC and the PPC. The IOC imposed a series of interim conditions. When the case came for consideration by the PPC, there was a psychiatric report which said that the doctor had been self-administering drugs for over a year and was using between 10 and 15 injections per day; the size was not specified. However, the report said that the doctor was not suffering from any physical or any discernible psychiatric disorder. The prognosis was said to be good. The PPC referred the case into the voluntary health procedures. The Inquiry does not know what the reasons were for this decision. The doctor entered into voluntary undertakings as to the conditions under which he practised and the interim conditions imposed by the IOC were later revoked.

20.214 When giving evidence about this case, Mr Nicholls, who chaired the PPC panel which decided the case, said that he felt 'uncomfortable' about this decision. He now felt that it should have been referred to the PCC. He agreed that there was clear evidence of SPM and no evidential difficulties. In my view, he is right; the case should have been referred to the PCC. This doctor did not, on the evidence, have a health problem. His dishonesty

was never addressed. Nor was his willingness to involve patients in his drug taking activities and to endanger patients while working under the influence of drugs. The PCC might or might not have thought it appropriate to impose conditions that would have required the doctor to undergo medical supervision. But the matter would have been considered openly and thoroughly in the presence of the doctor, instead of in a private procedure which is, by its nature, far less thorough and transparent.

Dr JO 06

20.215 Dr JO 06 stole prescription forms from the surgery at which he worked as a locum. He issued prescriptions for diazepam, in the names of fictitious patients, forging the signature of the GP from whom the prescriptions had been stolen. He was not prosecuted. It is not clear why not; it seems to have been suggested that there was no direct evidence but, in fact, the forged prescriptions were eventually recovered. Moreover, Dr JO 06 wrote to the doctor from whom he had stolen the prescriptions, admitting what he had done and apologising. In any event, the case was reported to the GMC and the medical screener, Dr Krishna Korlipara, referred the case to the PPC. On the first occasion on which the PPC considered the case, it received a psychiatric report, which said that the doctor was doing well. However, the PPC decided to obtain two more psychiatric reports. When these were available, the PPC reconsidered the case. The doctor had admitted to both psychiatrists that he had been addicted to benzodiazepines for about five years and had stolen prescription forms and forged another doctor's signature in order to obtain supplies. Both psychiatrists were of the view that the doctor was fit to practise subject to medical supervision. The minute of the PPC's decision records, first, that the doctor did not appear to pose a threat to patient safety but that it was in his own interests to continue medical supervision under the voluntary health procedures. It then recorded that, after taking into account the mitigating circumstances and the letters of support submitted on behalf of the doctor, it would be appropriate to send the doctor a warning letter and adjourn *sine die* to enable him to be dealt with under the voluntary health procedures, where he was to be supervised by the psychiatrist who had provided the original report. That is what happened.

20.216 The case gives rise to concern because the PPC seems to have lost sight of its primary function. This was a bad case of dishonesty, which clearly amounted to SPM. Yet the PPC minute does not mention that. Instead, it seems to have focussed on the medical aspects and the mitigation submitted, including letters of support. Mr Nicholls did not chair the PPC panel on this occasion. However, he sought to assist the Inquiry by explaining what was likely to have been in the PPC's mind. He said that the PPC would have considered the doctor's dishonesty to be a symptom of his ill health. The PPC would have noted that his actions had had no adverse effect on patients and that he had displayed insight and was responding well to treatment. Mr Nicholls thought there might well have been evidential difficulties; he was under the impression that the prescriptions had been destroyed. It might be that one forged prescription had been destroyed but, certainly, there were three within the GMC files. It seems to me that this was a case in which there really could be no proper course of action for the PPC other than referral to the PCC. This was a clear case of SPM with no evidential difficulties. In disposing of the case, the PPC usurped the functions of the PCC.

Dr JO 05

20.217 The case of Dr JO 05 was quite similar although, in this case, the doctor was convicted of forging another doctor's signature on a prescription in an attempt to obtain a supply of dihydrocodeine, to which she was addicted. The case was reported to the GMC and referred to the PPC. There was psychiatric evidence that the doctor had been addicted to the drug for many years. The medical evidence was that the doctor was fit to practise with the proviso that she could not prescribe. The PPC adjourned the case *sine die* to enable it to be dealt with under the voluntary health procedures. The minute of its decision does not make reference to the question of whether the conduct might amount to SPM. The determinative factor was that there was evidence of a health problem.

20.218 The approach in these last two cases seems to have been that, although the facts clearly amounted to SPM and there were no evidential problems, in the PPC's view there was a better way of dealing with them. This approach may have seemed sensible and humane. I do not doubt that the PPC thought that it was taking proper account of patient safety. But, the PPC was using an unofficial procedure not sanctioned by the Rules. Also, before taking its decisions, the PPC had no evidence about whether, and if so to what extent, the doctors' conduct had affected their clinical practice or had had any impact on their patients.

Cases Concerning Clinical Errors

20.219 I propose to discuss only two cases under this heading, both of which involved errors in the prescribing or administration of drugs. These cases are of interest to the Inquiry because of the possibility that Shipman might have been reported to the GMC in the mid-1990s with an allegation that he had administered to Mrs Overton a wholly inappropriate dose of morphine which had resulted in her suffering brain damage and remaining in a persistent vegetative state until her death 14 months later.

Dr JK 07

20.220 Dr JK 07, a locum consultant surgeon, administered an excessive dose of 2% lignocaine to a patient as a local anaesthetic prior to an operation. The patient died. The post-mortem examination did not include any toxicological tests. The death was attributed to the deceased's longstanding condition of muscular dystrophy. The hospital trust was concerned about the death and undertook an internal investigation. It became apparent that there was a serious discrepancy between the amount of the drug that the nurses said had been given (13.5ml) and that which the doctor had recorded in the notes (5ml). The appropriate dose would have depended on the patient's body weight. Yet it was clear that the doctor had made no attempt to have the patient weighed. Informally, the hospital trust sought expert advice. When available, this suggested that the dosage administered was excessive and might have caused the death. The local Coroner appeared reluctant to open an inquest so the trust reported the case to the GMC.

20.221 The GMC obtained an expert opinion from an eminent professor of paediatric anaesthesia, who was also a member of the GMC. He agreed with the conclusions of the

experts consulted by the trust. He said that, if 13.5ml had been administered, that would be a gross overdose bearing in mind the deceased's weight (which, it appears from the file, had been estimated by the parents at 4.5 stone, i.e. about 28kg). The expert expressed surprise at the doctor's failure to weigh the patient, whose muscular dystrophy had resulted in reduced muscle mass. If only 5ml lignocaine had been administered, that would have been just above the maximum recommended dose for a person of the deceased's weight. If 13.5ml had been given, that would have been wholly excessive and would have amounted to SPM.

20.222 The doctor was warned that the case was to be referred to the PPC. Three allegations were to be considered: the failure to weigh the patient; the administration of 13.5ml, which was excessive, and the making of a false entry in the clinical records to the effect that only 5ml had been given. Solicitors for Dr JK 07 replied to the GMC on their client's behalf, saying that the doctor had made a genuine error in recording that he had given only 5ml; in fact he had given 10ml. He admitted that more than 10ml had been expended from the syringe but some had been wasted. I interpose to say that the nurses said that the doctor had been handed a syringe containing 10ml and had injected it all. They said that, a while later, he had asked for more; he had been given another 10ml and, when he had finished injecting, there was 6.5ml left. The doctor's account was different. He claimed that, based on his estimate of the patient's weight, he believed he could safely use up to 10ml of 2% lignocaine. He took a syringe containing 10ml and injected 5ml. During this procedure, some lignocaine was spilled; only 3.5ml was left. After a pause while the drug took effect, the operation began. It was obvious that the patient was in pain and the doctor then injected the remaining 3.5ml. The patient then appeared to be free of pain and the operation began again. Part way through the procedure, the patient again complained of pain and the doctor asked for more lignocaine. He was handed a syringe containing 10ml. On this occasion, the doctor was able to inject only about 0.5ml successfully and lost about 1.5ml through spillage. The operation recommenced. Once again, the patient complained and the doctor administered a further 1ml with further spillage of 0.5ml. The overall effect of the doctor's account was that the patient had received 10ml and 3.5ml had been spilled.

20.223 It was said on the doctor's behalf that, when making his note, the doctor had totalled the various small amounts injected but had forgotten about the first 5ml he had injected. He had recorded 5ml as the total amount injected when he should have put 10ml. When asked to write a report on the incident a few days later (for the purposes of the internal investigation), he had had his note before him and he had perpetuated his mistake. There had been no intention to mislead.

20.224 The case was considered by the PPC before the time when a minute was routinely made of the reasons for its decisions. Incredibly, as it seems to me, the PPC decided not to refer the case to the PCC, but to close it with a warning. The deceased's family was outraged at the decision and asked for full reasons. The GMC's reply explained that the caseworker had spoken to the Chairman of the PPC who had explained the decision on the basis that the PPC did not think the doctor's errors were such as to justify the GMC in restricting or stopping his medical practice.

20.225 Dr Steel, who was Chairman of the PPC at the time of this decision, explained in a witness statement to the Inquiry that, in his view, this was a borderline case. He considered that the doctor had provided a satisfactory reason for having made an error in the medical notes. He had **'admitted'** that he had given 10ml and that 13.5ml had been expended from the syringe (as the nurses claimed). The doctor had also acknowledged that he should have weighed the patient but he had made a **'genuine assessment'** that the patient's weight had been between 40 and 50kg. Dr Steel said that, in the circumstances, the PPC would have concluded that it was doubtful if the administration of 10ml was irresponsible.

20.226 Dr Joan Trowell, Chairman of the Fitness to Practise Committee, commented on this case in her written evidence to the Inquiry. She accepted that the case should have gone to the PCC for full investigation. She said that 10ml lignocaine would have been an excessive dose. However, she did not think that there was any real conflict of evidence between the doctor and the nurses; it was quite possible, she said, to lose as much as one third of the liquid during injection. I must observe that that may well be so, but it was not for members of the PPC to reach a judgement on that kind of issue without hearing the evidence. If, having heard the nurses and the doctor, the PCC had been unsure about the evidence of spillage, it would have been quite appropriate for it to take into account its knowledge of what could happen; but it was not appropriate for it to do so when there had been no examination of the evidence.

20.227 Sir Donald Irvine, President of the GMC from 1995 until 2002, also commented on this case and said that it was clear to him that the case should have been referred to the PCC. It seems to me a pity that the family did not take proceedings for judicial review. Had they done so, the application must, I think, have succeeded. The PPC had clearly gone beyond its function of considering whether the conduct complained of, if proved, might amount to SPM. On the basis of his so-called 'admission', the doctor had administered 10ml, which, according to the expert instructed by the GMC, would still have been double the maximum recommended dose. The expert had not been asked for his view on how serious an error the administration of 10ml would have been. It seems to me that the case clearly raised a question of SPM and that evidence was available to support the allegation that 13.5ml had been given, although it conflicted with what was being advanced on the doctor's behalf. In any event, it was not for the PPC, but for the PCC, to decide whether the doctor's 'admission' was in fact true. There was evidence from the nurses that he had administered 13.5ml and no one had investigated what the nurses would say about the claim that 3.5ml had been spilled and that the drug had been administered in several small amounts. Further, it was for the PCC, not the PPC, to decide whether to accept that the entry in the notes had been a genuine mistake or a deliberately false entry. Some might suggest that the doctor's claim that he had forgotten about the first 5ml ampoule sounds rather implausible. After all, it must be a fairly unusual experience in the professional life of an individual surgeon that a patient dies on the operating table; the doctor must have had plenty of time to think over his actions, in the aftermath of the death. Yet he did not advance his explanation until he was facing the possibility of proceedings at the GMC. It is not for me to make a judgement about whether the entry in the notes was a genuine error. However, nor was it for the PPC to do so.

20.228 For the sake of completeness, I shall recount the further history of this case. In the light of the PPC's decision, the family put further pressure on the Coroner to hold an inquest. The

Coroner asked to see the GMC's papers. Solicitors acting for the GMC suggested that the Deputy Coroner should obtain the relevant papers from the hospital trust. The solicitors disclosed the existence of Dr JK 07's response and said that the GMC would seek the doctor's consent to its disclosure. The GMC did not disclose the existence of the expert report but mentioned that it had been assisted by advice from its members. This was inappropriate, as the Deputy Coroner had made it clear that she was not minded at that time to accept the family's assertion that the GMC had had evidence before it of clinical incompetence. In the event, the Coroner was persuaded to hold an inquest and the verdict was misadventure. The police investigated and, in due course, Dr JK 07 was charged with manslaughter. His defence was that, although he had been negligent, he had not been grossly so. He was acquitted of manslaughter but the trial Judge refused an order for costs, a decision which implies that the Judge's view was that the defendant had brought the prosecution upon himself.

Dr JK 09

20.229 The complaint in the case of Dr JK 09 comprised an allegation that the doctor, a consultant urologist, had prescribed an excessive dose of an alpha-blocker, terazosin (Hytrin), as a result of which the patient died. The patient was admitted to hospital in the mid-1990s with a three-week history of breathlessness and problems with micturition. He subsequently developed an unproductive cough and breathlessness. A diagnosis was made of hypertensive heart failure for which he was prescribed medication. Six days later, his blood pressure and heart failure were better controlled but he was still complaining of difficulty in voiding urine. His medication was adjusted and he was referred to Dr JK 09. Nine days after the patient's admission to hospital, Dr JK 09 reviewed him and prescribed 5mg Hytrin. The manufacturers recommend that the initial dose of this drug should not exceed 1mg and that the drug should be taken **'before bedtime'**. When the pharmacist saw the prescription, she telephoned the ward to say that this was rather a high dose and that close monitoring of the patient's blood pressure would be required following administration. The drug was not available until the next day. At 11am the following day, the patient was found collapsed. He had not been given any Hytrin and was not due to take it until 'bedtime'. His heart rate was fast and irregular. Blood pressure was stable at 130/80. Treatment was commenced with digoxin. The patient appeared to recover. At 10.05pm, Hytrin was administered in accordance with the instructions of Dr JK 09. Within a short time, the patient's blood pressure had fallen to dangerously low levels. He died a week later and the cause of death was found to be hypoxic organ damage due to drug induced hypotension. The coroner's inquest recorded a verdict of misadventure and that the death was a consequence of the deceased having been prescribed a dose of Hytrin in excess of the recommended dose.

20.230 The deceased's daughter made a complaint to the GMC and submitted the British National Formulary data sheet for Hytrin. Dr JK 09 was asked for his explanation and submitted a sworn affidavit in which he agreed that he had prescribed a dose in excess of the recommended dose but said that he had done so on the basis of a discussion he had had with the local representative of a drug company which supplied or manufactured it. He said he had been advised that this larger dose was being prescribed by doctors and

that 'serious side effects were rare'. He said that he could not substantiate this conversation but he would never have gone against the data sheet advice without having received guidance. He claimed that he had treated other patients with a 5mg dose without adverse effect. He also said that, subsequently, he had attended a conference of urologists, where a paper had been presented which reported on a study of 30 elderly men who had been treated with 5mg Hytrin daily. Two had experienced dizziness but, otherwise, there were no severe side effects. He had tried to contact the urologists who had presented the paper without success. Nor had he been able to obtain a copy of their paper. He produced an abstract of the paper from a British journal, but this did not mention the dosage used in the trial. Dr JK 09 also added that he had not been told about the collapse during the morning of the day it occurred. Had he been told, he would have said that the Hytrin should not be given, as it was only for the relief of urinary tract symptoms. He was also critical of the way in which the emergency following the administration of the drug had been handled. He was of the view that the patient should have been admitted to intensive care, whereas he had been treated by junior staff on the ward.

20.231 The case came before the PPC, which decided not to refer it to the PCC. The letter of explanation sent to the complainant explained the decision on the basis that the doctor **'had acted in good faith in what he thought at the time would be** (*the patient's*) **best interests, however,** (*the doctor*) **has been warned that the Committee would take a serious view if further complaints of a similar nature were to be received'**.

20.232 In his statement to the Inquiry, Dr Steel said that this was a **'borderline decision'**. He said that, after careful consideration, the PPC would have decided, on balance, that this isolated example of clinical misjudgement, for which the doctor had expressed regret, was not an appropriate case for referral to the PCC. The PPC would have used the clinical expertise of its own members when arriving at the decision.

20.233 Dr Trowell was of the view that the case should have been referred onwards. The GMC solicitors would then have had the opportunity to investigate further the various claims made by the doctor in his response. She expressed the view that, had this case come to the PPC after the case of Toth, rather than before, it would have been handled differently. She was also confident that, under the new FTP procedures, a case such as this would be fully investigated at an early stage before any decisions were taken.

20.234 It is clear, as Dr Trowell recognised, that, in this case, the PPC again exceeded its powers. It should have referred this case on so that the doctor's various claims could be investigated. As it was, the PPC accepted them all as true and then formed a judgement about how the case should be dealt with. It should have considered whether the prescribing of a dose five times that which was recommended might amount to SPM. If it might (and, plainly, it could), the case should have been referred. The basic facts were admitted. It was for the PCC, not the PPC, to decide upon the truth of the doctor's explanation and whether the doctor's conduct did in fact amount to SPM.

Conclusions

20.235 The two cases of judicial review (Holmes and Richards), to which I have referred, demonstrate clearly that, in those cases, the PPC exceeded its powers by reaching a

concluded judgement on whether the matters alleged might amount to SPM and that, in the case of Holmes, it also misdirected itself as to the meaning of SPM. In the case of Holmes, the GMC plainly accepted the criticisms of the Court; indeed it actively sought them. However, in the evidence of its witnesses and its submission to the Inquiry, its stance was that the cases of judicial review were not representative of the general standard of PPC decisions. In any event, it was said that, after the *aide memoire* was produced for the guidance of PPC members, any problems there might have been had been resolved. I can see that it should not be said that the PPC habitually misdirected itself just because it was found to have done so in two cases of judicial review. But the problems in those cases were very fundamental. Three separate decisions were involved. In the nature of things, very few cases go to judicial review; the remedy was not used at all against the GMC until the late 1990s. It seems to me likely that the errors disclosed in the judicial review cases were typical of the PPC's approach.

20.236 However, the cases of judicial review are not the only evidence available as to the quality of PPC decisions. Professor Allen and her team observed the operation of the PPC in a large number of cases and expressed their concern that members of the PPC did not appear to understand their role or the test they were to apply. The cases examined by the Inquiry also throw light on the operation of the PPC. PPC panels sat in private and there was no means of monitoring or auditing their outcomes. The judicial reviews and the few cases the Inquiry has looked at are the only glimpses afforded to the public of what happened there. The observations of the PSI team, the cases of judicial review and the Inquiry's own evidence all present a similar picture. Together, these different sources of evidence lead me to the conclusion that, in making decisions, the PPC often exceeded its powers and applied the wrong legal test. Of course, I am not saying that the PPC was always wrong when it declined to refer a case on to the PCC. However, I am driven to the conclusion that it was wrong in a significant number of cases and that those cases give rise to a real cause for concern that the PPC has been far too much influenced by its desire to be 'fair to doctors' and far too little concerned about the protection of patients and the public.

20.237 Of particular concern to the Inquiry is the statistical evidence showing that many conviction cases (apparently of a quite serious nature) were closed by the PPC. The Inquiry has not examined these cases in detail but the figures are worrying and give rise to a fear that, in this respect also, the GMC has been failing to protect patients.

20.238 I am also concerned about the way in which some cases were referred by the PPC into the voluntary health procedures despite the fact that there was plainly evidence of conduct capable of amounting to SPM and no real evidence of ill health. I accept, of course, that referral into the voluntary health procedures may be a proper way – even the best way – of protecting patients and the public in some cases. However, in the case of Dr JO 04, that cannot be said. The truth about the doctor's allegedly dishonest and unethical conduct was never established and there was no medical evidence that he was driven to obtain drugs by dishonest means as the result of an addiction. After a while under the voluntary health procedures, that doctor will doubtless have been free to practise without restriction and yet, for all anyone knows, he might be thoroughly dishonest.

20.239 It seems to me that there were several underlying causes for the failures of the PPC. First, the Committee's statutory powers and duties were not clearly spelled out in the legislation. The PPC had to decide whether any case **'ought to be referred for inquiry'** by the PCC. The Rules provided only that, when referring a case to the PCC, it should indicate the matters which, in its opinion, **'appear to raise a question whether the practitioner has committed serious professional misconduct'**. In Chapter 17, I described the difficulty that had been experienced over a period of many years in defining and explaining SPM. It seems to me obvious that, for the purposes of ensuring consistency and fairness, the GMC, as a body, should have given careful consideration to the proper function of the PPC, when compared with the functions of the screeners and the PCC, and should have developed clear guidelines for its operation. It appears that, until 2001, when the *aide memoire* was produced, it was thought that no guidance was needed because members of the PPC were well-respected professionals and lay Council members who carried out their duties in a conscientious fashion. I do not doubt their conscientiousness but it is clear that their understanding of the nature of their function was flawed, probably because many of them acted at times as screeners, and at other times as members of the PCC, and confused their various roles. Moreover, the lack of guidance left individuals to form their own views on a wide range of topics, including, for example, the threshold for SPM and the role of hearsay evidence in GMC hearings.

20.240 Another serious underlying problem has been the absence of proper criteria for decision making. There has never been a concerted attempt to define thresholds for SPM, applicable for various forms of misconduct. At times, examples of what might or might not be regarded as SPM were given, but these were never more than a miscellaneous collection drawn from a wide variety of different types of conduct. There has never been what Professor Allen described as a 'hierarchy' of examples of misconduct from which thresholds could be established. Although the *aide memoire* no doubt assisted in directing the PPC's mind to the sorts of questions it should have been asking (and in dissuading it from taking irrelevant considerations into account), it provided no assistance at all in deciding whether a case did or did not reach the required threshold for referral to the PCC. Until this problem is tackled, there will be difficulties with any decision-making person or body within the GMC.

20.241 Very shortly, the PPC will no longer exist. It may be said that, for that reason, there has been little point in examining its operation, since its past failures are of only historical interest. I do not accept that, for three reasons. In future, the PPC's filtering functions will be performed mainly by case examiners, who will not be Council members but will be contracted to the GMC to undertake the work and will be directed and managed by Council members and staff. In theory, that seems a good idea; how it will work in practice remains to be seen. However, whenever case examiners disagree on whether a case should be referred to a FTP panel for a hearing, the IC will have to decide what should happen. To that extent, it will be the successor to the PPC. Second, until recently, members of PPC panels have always been members of the GMC. Examination of the ethos of the PPC is of relevance to my assessment of the ethos of the GMC as a whole and to my recommendations as to whether the GMC is willing to and capable of providing adequate protection for patients in the way it regulates doctors in the future. Third, in 1996, the GMC

committed itself to the development of procedures and processes that would be fair, objective and transparent. Those were fine and appropriate words. It has been important to examine the actual decisions of the PPC, to discover how they have measured up to the GMC's aspirations. The result of that examination suggests to me that there is a gulf between the aspiration and reality.