

Part VIII

International Contributions

Chapter 75

Physician Licensing and Disciplining in England and Europe

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Europe is a vast and diverse continent that contains more than 50 independent countries or states. In 2002, only 15 of these were in the European Union (EU), but this has now increased to 25 (from January 1, 2007, to 27). Each European state has its own legal regime, and these are as different from one another as chalk is from cheese, even within the EU.

Similarly, the law relating to the practice of medicine is just as diverse across Europe. It is therefore impossible to give a simple unified view of the registration, regulation, and disciplining of medical practice across the geographical continent of Europe.

Even within the EU, the rubrics of medical regulation are not uniform. For example, Luxembourg has only one body that awards a registrable medical qualification. Austria, Denmark, and Ireland each have three. Germany has 37. Within the EU, around 180 bodies are empowered to award registrable medical degrees, under laws that differ considerably across its principal jurisdictions, and across a multiplicity of smaller jurisdictions therein. In the United Kingdom (UK) only one regulatory authority, i.e.,

Disclaimer: The UK’s General Medical Council is referenced extensively in this chapter. The author is a coopted member of the GMC’s Fitness to Practice Committees, and he has sat on its Registration Committee, Preliminary Proceedings Committee, Professional Performance Committee, and Professional Conduct Committee. On occasion, he has chaired the Professional Conduct Committee in its hearing of disciplinary matters. But he has no authority to speak publicly for the GMC, and the views expressed here are his own. Information given here is in the public domain, and no confidential matters are disclosed.

the General Medical Council (GMC), serves as the licensing and disciplinary body, and it operates only under English law (even when it sits in Scotland,¹ which has its own system of law that dates back for centuries). By contrast, Germany has 16 *Länder* (i.e., states) to license and regulate its doctors, and in each a different version of state law applies.

The rubrics also vary greatly in regard to specialist medicine. For example, Belgium recognizes only 15 different medical specialties, but Italy recognizes more than 150.

So the task of bringing together such a diversity in a short chapter is daunting.

SCOPE OF THIS CHAPTER

This chapter will consider licensing (presently we call it “registration”²) of medical doctors within the UK and the EU, and various forms of disciplinary action that may be taken against them by the GMC, or by similar bodies within the EU.

Lack of space prevents consideration of important matters that are litigated through the civil or criminal courts in Europe, such as medical negligence or criminal activity. Nor will this chapter consider complaints against a doctor that are resolved locally.

The chapter attempts to compress a vast area of medical law into just a few pages. The price for this is that complex areas of law may be oversimplified, and corners of legal detail may be cut. Important exceptions to the general law may be omitted. This chapter should therefore be read as an introductory overview, and not as a definitive statement

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of the law applicable to medical regulation across all of Europe.

THE LEGAL BACKGROUND

The relevant pieces of legislation that apply to this chapter are as follows:

- Statute of Proclamation 1539
- Medical Act 1858
- European Convention on Human Rights 1950
- Medical Act 1983
- European Directive 93/16/EEC (Mutual Recognition of Medical Qualifications)
- Medical (Professional Performance) Act 1995
- European Specialist Medical Qualifications Order 1995
- European Primary Medical Qualifications Regulations 1996 (SI 1996/1591)
- Human Rights Act 1998
- Professional Conduct Committee (Procedure) Rules 1998 (SI 1998/2255)
- Health Act 1999
- Medical Act 1983 (Amendment) Order 2000 (SI 2000/2052)
- European Directive 2001/19/EC (Mutual Recognition of Professional Qualifications)
- National Health Service Reform Act 2002
- Medical Act 1983 (Amendment) Order 2002 (SI 2002/1803)

In the UK the medical profession was first brought together as a single profession when Parliament enacted the Medical Act of 1858. That Act established what is now called the General Medical Council, and its principal function was to maintain a Medical Register of qualified practitioners so that “persons requiring medical aid should be enabled to distinguish qualified from unqualified practitioners.”

To this day, the GMC remains the UK’s supreme professional body that regulates the qualifications of practitioners in medicine and surgery, registers them to practice, and governs them in their professional practice.

Since 1858, there have been many amendments to, but few major reenactments of, the Medical Act. The Medical Act 1983 is currently in force, as amended by the Medical (Professional Performance) Act 1995, and also by the Medical Act 1983 (Amendment) Order 2002, which was promulgated as recently as December 17, 2002.

In this chapter I can comment only briefly on the complexity of European medical law that refers to licensing and disciplining of physicians. European medical law derives from three distinct sources.

National Law

Each of the EU member states has its own national law, but there may also be subjurisdictions therein, with their own local variant of national law. Only two member states (i.e., the UK and Ireland) follow a common law system, similar to that of the United States. The remainder follow systems of civil law derived from the Napoleonic Code.

It is important to recognize that sometimes the law across the various EU states may be at complete variance with the most fundamental concepts of common law as understood in the United States, in the UK, and in Ireland. For example, in France the doctrine of binding precedent does not usually apply. In Germany the burden of proof may be reversed in medical negligence actions, and so rest on the defendant.

In the UK, medical law may come into force by (1) Act of Parliament, (2) Statutory Instrument, (3) Order in Council, or (4) case law with the force of binding precedent. In England, medical negligence cases are usually heard in the High Court. Appeals are firstly to the Court of Appeal, and finally to the House of Lords. The General Medical Council hears disciplinary cases, and at present appeals are heard by the Privy Council. There may be a further appeal to one of two European courts.

European Union law

EU law applies somewhat uniformly across the member states. Often this derives from Directives of the European Council, which have the force of law. Usually the terms of a Directive are implemented into the law of each member state by specific legislation. But if a state fails actively to adopt the Directive within a specified time after promulgation, the Directive will come into force by default. Under EU law, the final court of appeal is the European Court of Justice (ECJ) in Luxembourg. Appellate decisions made by the ECJ have the force of binding precedent in the UK, whether or not the court of first instance was in the UK.

European Human Rights Law

European human rights law derives from the European Convention on Human Rights, to which more than 30 independent European countries are signatories. (This group of signatories is distinct from, but it includes, the group of EU states.) The Convention was enshrined into English law as the Human Rights Act 1998, and it requires that all UK legislation must be compatible with the European Convention on Human Rights. The final court of appeal is the European Court of Human Rights (ECHR) in Strasbourg. Decisions made by the ECHR have the force of binding precedent in the UK, whether or not the court of first instance was within the UK.

All three systems of law in the UK—national law, EU law, and human rights law—have a considerable impact on its medical jurisprudence, both in theory and in practice. Moreover, the fields of English and European medical law are evolving very rapidly at present, as evidenced by the recent legislation and recent cases cited in this chapter.

REGISTRATION

General Registration

British and EU Doctors

Article 2 of European Directive 93/16/EEC relates to primary medical qualifications, and it mandates their mutual

recognition across the EU, irrespective of whether the doctor speaks the language of the host country in which he is practicing his medicine. This Directive was implemented into English law by the European Primary Medical Qualifications Regulations 1996 (SI 1996/1591).

As a consequence of this, under the Medical Act 1983 (as amended), anyone who holds a primary medical qualification awarded by a recognized body in the UK, or an EU citizen who holds a primary medical qualification from the EU, is entitled to progress to full registration as a medical practitioner in the UK. Depending on the medical school, general medical training will have taken 4 to 6 years. A list of registrable medical qualifications awarded in the EU, and their awarding bodies, is found in the General Medical Council's publication *A Guide to the Registers 2002*.³

Non-EU Doctors

Until the end of 2002, the GMC had a two-tier system of registration for non-EU qualified doctors. Those qualified at some (but not all) medical schools in Australia, Hong Kong, Malaysia, New Zealand, Singapore, South Africa, and the West Indies had the right to apply for provisional or full registration in the UK. Doctors qualified from other medical schools (e.g., in the United States) could only apply for limited registration, but they could apply for provisional or full registration after working in the UK for a period of time under limited registration. The latter scheme has not changed.

But under the Medical Act 1983 (as amended in 2002), there will now be a single UK system for registering non-EU doctors. In future, the GMC must take into account a doctor's medical qualifications (as before), whether he is of good character, his knowledge or experience, whether this was acquired in Europe or elsewhere, and the acceptance of his medical qualification (if that is the case) by another EU state as qualifying him to practice there. Fast-track provisions to full registration will apply for eligible non-EU specialists and general practitioners. All non-EU medical graduates must show sufficient knowledge of the English language. (But see below for an important exception to this general rule regarding linguistic ability.)

Specialist Registration

British Doctors

In the UK, the European Specialist Medical Qualifications Order 1995 requires the GMC to keep and publish a register of medical specialists, but not of family general practitioners, who comprise the majority of the profession. For entry onto the specialist register, doctors must first be specialty trained at recognized centres over a specified number of years (minimum 5). In the *early* part of this training (typically after 2 years) they must pass a higher examination, such as that for the Membership of the Royal College of Obstetricians and Gynaecologists. When training has been completed satisfactorily, they will be awarded a Certificate of Completion of Specialist Training (CCST) by the Specialist Training Authority (STA) of the Medical Royal Colleges, and their names will be entered onto the

GMC's Specialist Register. Only then may they apply for consultant posts in the National Health Service, and may set up in independent private practice. This stage is approximately equivalent to the American Specialist Boards.

Other EU Doctors

By virtue of the European Medical Directive 93/16/EEC, and the European Specialist Medical Qualifications Order 1995, doctors trained in another EU state, and who hold a specialist qualification from that state, would be recognized by the GMC for entry onto the GMC's Specialist Register.

Non-EU Doctors

Specialists trained outside the EU may be recognized if the STA deems their qualification to be equivalent to the CCST.

DISCIPLINARY MATTERS UNDER THE "OLD REGIME"

Historical Role of the GMC: Conduct and Health

Historically, the GMC had always restricted its disciplinary concerns to issues of serious professional misconduct, the commission of criminal offenses, and matters relating to the health of medical practitioners. Further, it has always had the legal authority to advise the medical profession on standards of professional conduct or professional performance, and on medical ethics.

Disgruntled patients often make complaints to the GMC, and these have increased 15-fold (*sic*) between 1990 and 2002. Routinely, the courts will report all criminal convictions of doctors to the GMC. In addition, health concerns about doctors may be notified to the GMC by patients, colleagues, employers, legal authorities, or the press. It is only in response to complaints that the GMC can start disciplinary action.

The law relating to the GMC is currently in process of major change, and the new regime will be explained below. Here I shall outline only briefly the present disciplinary regime, so that the future regime (described below) will be understood more easily.

Serious Professional Misconduct

For issues of professional misconduct, including criminal offenses, hearings take place before the GMC's best-known and most powerful committee, the Professional Conduct Committee. Precise rules of procedure are set out in Professional Conduct Committee (Procedure) Rules 1998 (SI 1998/2255). The key question for this committee is whether the doctor has been guilty of "serious professional misconduct." Its hearings are in public, and the press are allowed to be present. The doctor is legally represented, unless he declines. If serious professional misconduct is found proved, the following sanctions are available: reprimand,

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conditions on practice, suspension from the Medical Register, or erasure from the Medical Register.

One Negligent Mistake Does Not Amount to Serious Professional Misconduct If a doctor has had a single negligent incident in an otherwise unblemished career, this would not necessarily amount to serious professional misconduct. So ruled the Privy Council in the appealed case of *Rao v. GMC*.⁴

Scope of Serious Professional Misconduct A doctor need not commit an action against a specific person, nor commit a criminal offense, and yet he may still be found guilty of serious professional misconduct. It is likely that this would also apply to the new concept of “impaired fitness to practice” (see below). In the case of *Idenburg v. GMC* (2000),⁵ the Privy Council upheld the Professional Conduct Committee’s decision that a junior doctor who had left her job without notice or explanation was guilty of serious professional misconduct. She was suspended from the Medical Register for 12 months.

Admissibility of Evidence Obtained Illegally In *Idenburg*, the Privy Council also held that it made no difference whether the GMC had relied on evidence obtained unlawfully (i.e., confidential medical records disclosed without consent), and it directed that this evidence could be admitted.

Importance of Not Commenting on Nondisciplinary Matters Early in 2003, the GMC’s Professional Conduct Committee (PCC) heard the case of Dr. Langdon,⁶ a general practitioner. She usually practiced conventional medicine, but occasionally she used homeopathy, and also divining with a swinging crystal in order to confirm her choice of specific homeopathic remedies. Two of her patients (one of them a sick baby brought by her mother) had not expected such unconventional techniques to be used during their consultations, and so they complained to the GMC. The Professional Conduct Committee found Dr. Langdon guilty of failure to obtain the informed consent of her patients before she used homeopathy and divining in their management. She was suspended from the Medical Register for 3 months.

In this case the Professional Conduct Committee said that it had been careful not to give an opinion on whether homeopathy and divining were valid techniques for use in a medical context, as this was not within its remit as a professional disciplinary body. To make an authoritative scientific pronouncement on the validity of homeopathy or divining would have required more extensive evidence and time, and more extensive expertise and legal authority, than was available to them. No doubt, any attempt to have done so would have been overturned by the Privy Council on appeal.

Health Issues

For issues relating to doctors’ health (e.g., mental illness, alcohol or drug abuse), hearings take place in private before

the GMC’s Health Committee. The doctor is legally represented, unless he so declines. The key question is whether the doctor’s health is such that there is serious impairment of his fitness to practice medicine. If this is found proved, the following sanctions are available: reprimand, conditions on practice, general conditions (see below), or suspension from the Medical Register. Erasure is not available as a sanction for health issues.

Conditions on Lifestyle

The conditions imposed on a doctor’s registration need not be restricted to his medical practice, but can also relate to his general conduct and lifestyle. In 2001 the GMC’s Health Committee determined that Dr. Whitefield’s fitness to practice was seriously impaired by depressive illness and alcoholism. It imposed 14 conditions on his registration, including requirements that he abstain from alcohol, submit to random tests of blood and urine, and attend Alcoholics Anonymous. He appealed to the Privy Council, arguing that these conditions would deprive him of enjoyment of social drinking on family occasions or in public, and that they constituted interference with his private life contrary to Article 8 of the European Convention on Human Rights scheduled to the Human Rights Act 1998. The Privy Council dismissed his appeal.⁷

Problems with the “Old Regime” of Disciplinary Procedures

There are four principal problems with the “old regime” of disciplinary procedures.

Circular Definition

There is no legal definition of the term “serious professional misconduct.” In practice, it has come to mean professional misconduct of such a degree that the Professional Conduct Committee considers it to be serious. Although this is clearly a circular definition, the use of the term “serious professional misconduct” has nevertheless stood the test of time unexpectedly well.

Standard of Proof

The Professional Conduct Committee will acquit a doctor if the evidence available is not sufficient to reach the criminal standard of proof (i.e., beyond reasonable doubt), even though it might have been sufficient to reach or exceed the civil standard of proof (i.e., on the balance of probability). Then the doctor would legally be free to resume practice, as before, no matter how poor his clinical performance had been. Under such circumstances, his clinical practice could only be challenged through a civil action in negligence, a venture that is lengthy, expensive, and uncertain. This problem has now been resolved, under new performance procedures (see below).

Appeals

Appeal from the decisions and sanctions of the GMC’s disciplinary committees—Registration, Health, Conduct, and

Performance (discussed below)—are not legally straightforward. The decisions of these committees are neither subject to judicial review nor can they be appealed through the usual court system. Instead, any appeal would leapfrog the High Court, the Court of Appeal, and the House of Lords. Instead, it would be heard by the judicial committee of the Privy Council. But this has the disadvantage of requiring the UK's most senior court to spend time hearing appeals that could often be handled perfectly well by a less senior judge sitting alone. On rare occasions, Privy Council decisions may be appealed to the European Court of Justice in Luxembourg, or to the European Court of Human Rights in Strasbourg.

Categorization

Concerns about a doctor cannot always be categorized simply as issues of *either* conduct *or* health. Often there is an overlap, in that health issues may contribute to problems of conduct. But the Health Committee has had no power to erase a doctor's name from the Medical Register. When there is such an overlap, the Privy Council has held⁸ that concerns on conduct may “trump” concerns on health, and so a hybrid case may be heard as a conduct case, with erasure available as a sanction.

Professional Performance

During the 1970s there arose increasing concerns about the professional performance of a small minority of doctors. This led Parliament to enact the Medical (Professional Performance) Act 1995. It gave the GMC new powers to investigate and adjudicate on a doctor's professional performance (in addition to his conduct and health), and to impose sanctions if sanctions were considered to be appropriate.

Assessors of clinical performance carry out an on-site assessment of the doctor, interview various people, review his management of patients (from their medical notes, and also using real patients or actors), conduct an assessment of his practical skills, and conduct a verbal and written examination of his knowledge. They would then write a report as to whether they consider that his performance has been so seriously deficient that action should be taken against his registration. If so, they would make appropriate recommendations. For example, they might advise him to stop operative surgery but allow him to continue in office practice, or they might recommend a more serious sanction. The doctor would be invited to accept the recommendations in the assessors' report. If he refused to accept them, the GMC's Committee on Professional Performance would then conduct a formal hearing of his case. If they found his performance to be seriously deficient, they may impose sanctions as follows: reprimand, conditions on practice, suspension from the Medical Register, or erasure from the Medical Register.

The new powers to assess clinical performance came into force on July 1, 1997. For poor clinical performance before that date, the GMC was (and remains) without legal authority to take action against, or impose any sanction on, the doctor.

In the 2000 case of *Krippendorf*,⁹ the Privy Council considered the GMC's new legal authority conferred by the Medical (Professional Performance) Act 1995. It held that, even though the GMC now had legal authority to take disciplinary action regarding the *performance* of a doctor, it had no such authority to take action regarding his *competence*. Thus, the GMC's Committee on Professional Performance had erred in law when it judged Dr. Krippendorf incompetent in the practice of medicine, and it had acted *ultra vires* when it erased her name from the Medical Register. Her name was therefore restored. Further, the Privy Council directed that the GMC's performance assessment procedures should focus its attention on the doctor's track record and assess her past performance in the medical work that she had actually been doing. It should not treat the assessment procedure as a theoretical test of the doctor's competence at work that she had never been called upon to perform.

The Privy Council's narrow interpretation of the term “performance” in *Krippendorf* led to the uncomfortable result that a doctor who had been found to be incompetent by the GMC's assessors of clinical performance was nevertheless allowed to carry on practicing medicine. Note that the effect of this Privy Council decision has now been reversed by provisions of the Medical Act 1983 (Amendment) Order 2002 (see below).

RECENT CHANGES IN THE LAW ON THE UK'S GENERAL MEDICAL COUNCIL

At the time of writing this chapter, a number of important and far-reaching reforms to the structure and functions of the GMC are in progress. These major changes were approved by Order in Council on December 17, 2002.

Order in Council

Compared with previous governance (i.e., governance under the Medical Act 1983 as originally enacted by Parliament), a curious legal anomaly now exists in regard to governance of the UK's medical profession. Parliament has enacted this anomaly deliberately, in that the Health Act 1999 (viz., Sections 60 and 62) now gives to the Secretary of State for Health the legal authority directly to amend primary legislation, i.e., the Medical Act 1983, at his discretion, by means of an Order in Council.

Previously, powers to amend the Medical Act, as to amend most other Acts of Parliament, had always been reserved to Parliament. Not surprisingly, the medical profession at first opposed this new extension to the already wide powers of the Secretary of State, but to no avail. Section 60 of the Health Act 1999 was nicknamed “the Henry VIII clause,” because such a device was first used in the Statute of Proclamation 1539, to give King Henry VIII the power to legislate by proclamation.

Nevertheless, as we shall see below, there are advantages in having available a mechanism to change the relevant legislation speedily, if the need arises.

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THE GENERAL MEDICAL COUNCIL OF THE FUTURE

The Medical Act 1983 (Amendment) Order 2002 (SI No. 1803) reforms the GMC's registration and disciplinary committees. It also states that in future the GMC's main aim will be: "to protect, promote and maintain the health and safety of the public."

The Council of the "new" GMC will have only 35 members. Of these, 16 will be laypersons, appointed by the Privy Council after rigorous interviews. Of the 19 medical members, 17 will be elected on a constituency basis by doctors nationwide. The remaining two medical members will be appointed: one by the Medical Royal Colleges and Faculties, and one by the Council of Heads of Medical Schools.

Most of the GMC's statutory committees that were previously important, and so were mentioned frequently in case law, are now to be abolished. These include: the Registration Committee, the Interim Orders Committee, the Preliminary Proceedings Committee, the Assessment Referral Committee, the Committee on Professional Performance, the Health Committee, and the Professional Conduct Committee. Instead, new committees and panels will be established: an Education Committee, an Investigation Committee, and one or more Registration Decisions Panels, Registration Appeal Panels, Interim Orders Panels, and Fitness to Practice Panels.

Previously only members of the General Medical Council sat on the disciplinary committees, but they will no longer do so. In future, such panels will be populated by coopted medical and lay members. This will mark a clear separation between those committees taking general policy decisions (e.g., the Registration Committee) and those taking disciplinary decisions on individual cases (e.g., a Registration Decision Panel).

License to Practice, and Revalidation

The Medical Act 1983 (as amended in 2002) will introduce a new license to practice for all doctors who wish to practice medicine. It will also introduce a requirement for a regular revalidation of practice.

Doctors with a license to practice will undergo periodic revalidation to retain it, and so revalidation will demonstrate that a doctor remains up to date and fit to practice. Doctors who do not wish to revalidate will not hold a license to practice medicine, and they will not be allowed to prescribe drugs or exercise the other rights and privileges currently provided by registration. Revalidation will probably come into force in 2005.

The New Fitness to Practice Procedures

Until now, the GMC's various disciplinary committees had considered charges that were variously framed as "serious professional misconduct," "criminal conviction," "seriously deficient performance," or "serious impairment of fitness

to practice by reason of a physical or mental condition." But the definition of these terms has been vague, and far from satisfactory, and this has led to many difficulties.

Under the Medical Act 1983 (as amended in 2002) there will now be the single concept of "impaired fitness to practice" by reason of misconduct, deficient professional performance, a criminal conviction, adverse physical or mental health, or a determination of another regulatory body.

The fitness to practice procedures have been reformed. Progress of a case through the new disciplinary process will now be divided into two main stages.

First, an Investigation Committee will investigate allegations suggesting that a doctor's fitness to practice may be impaired. In its investigations, it may legally override the Data Protection Act by requiring confidential documents to be disclosed.

For minor matters, if the Investigation Committee determines that the matter need not be considered further, it has the legal authority to conclude the case by giving a warning regarding the doctor's future conduct or performance. For serious matters, if the Investigation Committee finds that there is a *prima facie* case to answer, then a Fitness to Practice Panel will be appointed to adjudicate.

Whilst a serious case is awaiting formal hearing, the Investigation Panel may refer it to an Interim Orders Panel. This may make an order, to take immediate effect, that a doctor's registration be made conditional or even suspended, pending formal hearing. Such an order is likely to be made if it is necessary for the protection of members of the public, or otherwise in the public interest, or in the interests of the doctor.

In certain circumstances, the GMC may disclose information about a doctor to his actual or potential employers, or to organizations to whom he is providing services. It may also disclose information if it determines that this is in the public interest.

Next, a Fitness to Practice Panel will decide on whether the doctor's fitness to practice is impaired. Its hearings will be adversarial in nature, as with the Professional Conduct Committee now. The panel will usually consist of five members (three is a quorum), at least one of whom must be on the Medical Register, and at least one of whom is a layperson. The panel will have a Legal Assessor, who is usually a senior Queen's Counsel or a retired judge. He advises on matters of law, and any advice that he gives *in camera* must be repeated in public. In the case of *Walker v. GMC* (2002),¹⁰ the Privy Council held, on appeal, that the Legal Assessor should not express an opinion regarding an appropriate sanction, as this might be taken to constitute legal advice.

Procedure and rules of evidence are similar to a criminal trial. Charges are read. Witnesses (both factual and expert) give evidence under oath, and they are cross-examined. If evidence is not in dispute, a statement may be admitted without oral evidence being heard. (Note: depositions are not used in the English legal system.) A criminal standard of proof is required, in that any charge must be proved

beyond reasonable doubt. If the panel finds one or more charges proved, any previous disciplinary findings by the GMC will be disclosed, and evidence in mitigation heard. Typically this will be documentary evidence in the form of supporting testimonials, and verbal evidence from witnesses, as to the character of the defendant doctor.

In private session, the Fitness to Practice Panel will then determine whether the doctor has been guilty of "impaired fitness to practice." If it finds against him, it may issue a warning regarding his future conduct or performance, or it may make a direction regarding conditional registration or suspension, or even erase his name from the Medical Register. Erasure or suspension will automatically revoke his license to practice. Even if it finds that a doctor's fitness to practice is not impaired, it has authority to give a warning regarding his future conduct or performance.

Sanctions usually come into force 28 days after the hearing, to allow time to appeal. But a Fitness to Practice Panel has authority to put a sanction into immediate effect, and it is likely to do so when it is satisfied that this is necessary for the protection of the public, or is otherwise in the public interest, or in the best interests of the doctor.

Before 2000, disciplinary sanctions could not be put into immediate effect. But this changed when the Interim Orders Committee was established, with legal authority to impose immediate sanctions (see below). Before this, all stages of the disciplinary mechanism had to be followed through, including allowing 28 days for appeal, before sanctions could become effective.

Whenever a Fitness to Practice Panel makes its determination on a case, brief reasons for the basis of its decisions regarding serious professional misconduct, and for the imposition of any sanction, must be set out, in compliance with the Privy Council's ruling in the appealed cases of *Stefan v. GMC* (1999)¹¹ and *Selvanathan v. GMC* (2000).¹² However, in the case of *Gupta v. GMC* (2001)¹³ the Privy Council later held that there was no similar duty to give reasons for decisions on matters of fact.

The Case of Dr. Harold Shipman

The problems with the former leisurely approach to disciplinary matters were well illustrated by the case of Dr. Harold Shipman. He was a family doctor, but also Britain's most prolific serial killer. The police arrested him on September 7, 1998, and he was charged with murder. Following a lengthy period in custody, on January 31, 2000, the criminal courts found him guilty of murdering 15 of his patients, usually in their homes. Most had been fairly healthy. He was sentenced to life imprisonment.

The GMC organized an almost immediate hearing before its Professional Conduct Committee. Dr. Shipman was found guilty of serious professional misconduct on February 11, 2000, and suspended from the Medical Register with immediate effect. However, his name could not be erased from the Medical Register until 28 days later, on March 11, 2000, to allow for appeal. (He did not in fact appeal from the GMC's decision.) Thus, the GMC was

powerless but to allow his name to remain on the Medical Register for more than 18 months after he was first charged with multiple murder and for more than 5 weeks after he had been convicted of multiple murder in the criminal courts. During most of this time (i.e., until his suspension on February 11, 2000) he was legally entitled to practice medicine in prison (including the prescription of drugs), and indeed he did so. Other prisoners consulted with him.

When all criminal and disciplinary hearings were concluded, the Chief Medical Officer commissioned a clinical audit¹⁴ into Dr. Shipman's clinical practice between 1974 and 1988. This conducted a review of the clinical records and cremation forms that were still available, and it concluded that there were in fact 236 deaths about which there was concern. However, the Crown Prosecution Service took the view that the public interest would not be served by investigating the matter any further.

Interim Orders Committee

The Shipman case highlighted the fact that the GMC should be empowered to act swiftly and effectively when a doctor's fitness to practice is called into question, particularly in very serious cases. However, the GMC had been advised by its lawyers that, as the law stood in early 2000, it was unable to suspend a doctor charged with a criminal offense, even in the most serious cases, until the doctor is convicted. During 2000 the government therefore used its powers granted under Section 60 of the Health Act 1999 to promulgate an Order in Council¹⁵ amending the Medical Act 1983. This established an Intermediate Orders Committee, which had the power, *inter alia*, to suspend a doctor, with immediate effect, at any stage of the fitness to practice procedures, if this is in the public interest or the doctor's interest.

If it is to act effectively in this regard, the GMC is clearly dependent on early notification of concerns. But in a small number of police investigation cases, the police may ask the GMC to delay a decision to ask a doctor to appear before the Interim Orders Committee, if it believes that early action could compromise an ongoing police investigation.

Appeals

Before 2002, appeals against decisions of the Professional Conduct Committee were to the Privy Council. However, the National Health Service Reform Act 2002 has now charged the High Court with responsibility to hear these. This is an important change in the appeals procedure, and it is likely that it will greatly increase the frequency of appeals against the GMC's disciplinary decisions. At the time of writing there have been no appeals under this new procedure. Nevertheless, the present and extensive case law on appeals to the Privy Council from decisions of the Professional Conduct Committee will apply with binding authority on the new panels. For this reason, such Privy Council cases are referenced in this chapter.

INTERNATIONAL CONSIDERATIONS ON IMPAIRED DOCTORS

There have been notorious cases where doctors were erased from the medical register in another jurisdiction, yet allowed to remain on the UK Medical Register, and so could practice medicine legally in the UK. Dr. Richard Neale is an example.

The Case of Dr. Richard Neale

Dr. Neale graduated in medicine in England in 1970. In 1977 he emigrated to Canada, where he worked as an obstetrician and gynecologist. In 1978 he was banned from surgery in British Columbia after he had operated on a patient against his chief's advice, and she died. He then moved to Toronto but, after the deaths of two further patients, he was erased from the Canadian Medical Register in 1985. He then returned to the UK where he obtained a consultant post.

A former colleague in Canada telephoned the GMC in London to alert them to the events in Canada. He was told that the GMC had no jurisdiction to take action regarding the events in Canada. But now that Dr. Neale was working in England, further serious problems arose from his clinical practice, particularly his surgery. In 2000, he was called before the GMC's Professional Conduct Committee to answer 37 charges relating to poor standards of treatment, treatment without consent, and false claims about qualifications and experience. He was found guilty of serious professional misconduct, and his name was erased from the UK Medical Register, 15 years after he had first been erased in Canada for similar offenses.

Only when Dr. Neale was found guilty of serious professional misconduct in the UK could his name be erased from the UK Medical Register. Neither in 1985, nor in 2000, did the GMC have any legal authority to take into account, let alone to base any sanctions upon, adverse professional findings that had been made earlier in another jurisdiction. The legal situation in this regard has now changed (see below).

Registration and Disciplinary Authorities in the EU

Since 1959 the Standing Committee of European Doctors (at www.cpme.be) has led the way in standardizing the recognition of medical degrees within the EU. The competent registration and disciplinary authorities in the EU member states (as of 2002) that are equivalent to the UK's General Medical Council are given in Appendix 75-1.

Future Restrictions in the UK

In future, by virtue of the Medical Act 1983 (as amended in 2002), any doctor who has been disqualified in an EU member state, for reasons of professional misconduct,

health, or criminal conviction, will be ineligible for registration in the UK. Further, any doctor found guilty of a criminal offense, or subject to an adverse determination by a health care regulator, in any other jurisdiction throughout the world, may be refused registration, or refused continuing registration, in the UK.

It may happen that an EU doctor, who is theoretically entitled to UK registration, but who is not in fact so registered, may render medical services reprehensively, perhaps in an emergency, whilst visiting the UK. In such a case the GMC, if it thinks fit, may impose a prohibition on him practicing medicine in the UK at any time in the future.

Future Dangers in the Cross-Border Practice of Medicine in Europe

A new European Directive on the Mutual Recognition of Professional Qualifications (2001/19/EC) was promulgated on July 31, 2001 (Section 2.7 relates to doctors). Its principal aim is to liberalize the law relating to the provision of services, including medical services, across all member states of the EU.

This Directive imposes on each EU member state a mandatory obligation to take into consideration the recognition by another member state of non-EU qualifications, irrespective of where those qualifications were obtained. It also puts an obligation on the relevant authorities to determine applications for mutual recognition within a maximum of 4 months. This short time scale will make it difficult when authorities are asked to recognize medical qualifications obtained in remote parts of the world.

Most importantly, the Directive would allow a doctor established in any one of the EU's member states to practice medicine in another EU state for up to 16 weeks a year, without being subject to registration requirements in the host state. There is no requirement that he should understand the host state's language. Thus, he could practice medicine legally in England without the GMC being aware of his presence, let alone authorizing him. If found guilty of medical malpractice, the GMC could not erase him from the Medical Register, as his name would not be there.

Clearly there will be dangers to patients if this Directive comes into force as presently drafted. In response, the GMC has linked with other regulatory bodies, in the UK and the EU, in the hope that the draft Directive will be considerably amended, in the direction of safety, before it comes into force in the medical arena. The Alliance of UK Health Regulators on Europe (AURE) has its own website at: www.aure.org.uk.

However, not everyone sees the European Directive on the Mutual Recognition of Professional Qualifications in a negative light. Stephen Whale, who is a leading English human rights lawyer, has written that:

Vested interests in the British medical establishment have to appreciate that the legitimate need to maintain standards cannot be used as a convenient cover for frustrating the legal rights of European doctors.¹⁶

Issues Arising from the European Convention on Human Rights

Severity of Sanctions

Some have argued that the GMC's Professional Conduct Committee has, on occasion, been too severe in the sanctions that it imposes on doctors who are found guilty of serious professional misconduct. In the appealed cases of *Bijl v. GMC*¹⁷ and of *Hossain v. GMC*,¹⁸ the Privy Council addressed this point. Dr Bijl had removed a kidney stone laparoscopically but he encountered massive hemorrhage. He then left the hospital too soon, when his patient's bleeding was not yet under full control, and the patient died. As for Dr. Hossain, a general practitioner, one Law Lord hearing the case said that he was probably "overworking, overstretched and overtired" when he failed to make adequate assessments or adequate records on four patients he visited at home. The Professional Conduct Committee found both doctors guilty of serious professional misconduct, and erased their names from the Medical Register.

On appeal, the Privy Council reversed both of these decisions. Dr. Bijl was given a year's suspension, and Dr. Hossain was referred back for reconsideration as to whether conditions on clinical practice should be imposed.

In *Bijl*, the Privy Council held that when a surgeon was found guilty of serious professional misconduct involving an error of judgment, rather than any allegation against his practical skills, and it was unlikely that he would repeat the error, it was not appropriate that the maximum sentence available (i.e., erasure) be imposed. The desire to maintain public confidence in the medical profession should not result in sacrificing the careers of otherwise competent and useful doctors who presented no danger to the public, in order to satisfy a demand for blame and punishment.

It may be argued that a sanction too severe may breach Article 3 of the European Convention on Human Rights, which proscribes "degrading treatment or punishment."

Right to a Fair Trial (in England)

In disciplinary hearings before its Professional Conduct Committee, the GMC acts both as prosecuting body and adjudicating body. Furthermore, cases have taken very many years before they come to a hearing. It has been argued that this breaches the fair trial requirements of Article 6.1 of the European Convention, which requires "a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law." The Privy Council considered this point in *Ghosh v. GMC* (2001).¹⁹ But it dismissed it, on the grounds that the processes of the Professional Conduct Committee were subject to control by an appellate body that had full jurisdiction to reverse the initial decision if it saw fit.

"Chinese walls" operate to keep separate the GMC's various functions. In the case of *Nicolaidis*, the High Court accepted this arrangement, and it explained it as follows:

... the functions of the Professional Conduct Committee as a panel are separate from those of the GMC as a whole;

*investigation/presentation and adjudication functions are kept entirely separate and are performed by different people.*²⁰

Right to a Fair Trial (in Ireland)

In 2000 the GMC's Professional Conduct Committee found that Dr. Borges, an Irish gynecologist who worked in England, was guilty of serious professional misconduct for sexually inappropriate behavior with two patients. It erased his name from the Medical Register with immediate effect. An appeal to the Privy Council failed.²¹

He then faced similar disciplinary action before the Irish Medical Council, but the GMC's principal witness in London, England, refused to testify in Dublin, Ireland. The Irish Medical Council then proposed to erase his name from the Irish Medical Register without a full hearing. But his lawyers applied to the Irish High Court for judicial review, arguing that it would contravene his human rights if they erased him, without him being able to cross-examine before the Irish Medical Council those witnesses who had given evidence against him in London. The judicial review in Ireland is still in progress.²² Furthermore, the European Court of Human Rights in Strasbourg has agreed to hear the case later on appeal, if needs be.

International Collaboration in the Future

Given that there is a significant international traffic in doctors, it is becoming increasingly important that regulatory authorities should exchange between themselves information concerning deficient doctors who ply their trade internationally. The International Association of Medical Regulatory Authorities (IAMRA) has been set up as a forum to develop new concepts and approaches in medical regulation, and to support regulatory authorities in protecting the public. IAMRA aims to promote international cooperation and collaboration among regulatory authorities, and to facilitate exchange of medical regulatory information. Its website is to be found at membersonly.fsmb.org/IAMRA/IAMRA_text.htm.²³

Endnotes

1. This point was debated in the case of *McAllister v. GMC*. The Privy Council ruled that English law would apply for GMC hearings held in Scotland. [1993] 1 All E.R. 982.
2. Legislation recently passed will soon introduce a "license to practice medicine" in the UK.
3. *A Guide to the Registers 2002* is available from the General Medical Council, 178 Great Portland Street, London W1W 5JE, England (www.gmc-uk.org.uk).
4. *Rao v. GMC*, Privy Council (Appeal 21/2002), judgment given on December 9, 2002. All Privy Council judgments may be freely downloaded from www.Privy-Council.org.uk.
5. *Idenburg v. GMC*, Privy Council (Appeal 62/1999), judgment given on March 23, 2000.
6. *Langdon v. GMC*, PCC determination on January 15, 2003. Copies of determinations of the GMC's disciplinary committees

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- may be obtained by post from the GMC's address above. They are not yet available on the GMC's website.
7. *Whitefield v. GMC*, Privy Council (Appeal 90/2001), judgment on November 14, 2002.
 8. *Crabbie v. GMC*, Privy Council (Appeal 7/2002), judgment given on September 23, 2002.
 9. *Krippendorf v. GMC*, Privy Council (Appeal 43/1999), judgment on November 24, 2000.
 10. *Walker v. GMC*, Privy Council (Appeal 94/2001), judgment given on November 5, 2002.
 11. *Stefan v. GMC*, Privy Council (Appeal 16/1998), judgment given on March 8, 1999.
 12. *Selvanathan v. GMC*, Privy Council (Appeal 21/2000), judgment given on October 11, 2000.
 13. *Gupta v. GMC*, Privy Council (Appeal 44/2001), judgment given on December 21, 2001. The lawyer for Dr. Gupta who led in this case was Cherie Blair, Q.C., the wife of Tony Blair, who was Prime Minister at the time.
 14. "Harold Shipman's Clinical Practice: a Clinical Audit Commissioned by the Chief Medical Officer," Department of Health, London (Dec. 2000). This may be downloaded free of charge from www.doh.gov.uk/hshipmanpractice/shipman.pdf.
 15. Medical Act 1983 (Amendment) Order 2000 (SI 2000/2052).
 16. S. Whale, *Developments in the European Legal Orders: Implications for the Medical Profession*, 70 *Medico-Legal Journal* 80–86 (2002).
 17. *Bijl v. GMC*, Privy Council (Appeal 78/2000), judgment given on October 2, 2001.
 18. *Hossain v. GMC*, Privy Council (Appeal 74/2002), judgment given on January 22, 2003.
 19. *Ghosh v. GMC*, Privy Council (Appeal 69/2000), judgment given on June 18, 2001.
 20. *R. v. General Medical Council, exp. Nicolaidis* [2001] *Lloyds L.R. Med.* 525 s24.
 21. *Borges v. GMC*, Privy Council (Appeal 71/2000), judgment given on September 10, 2001.
 22. *Borges v. Irish Medical Council*, listed in the High Court of Ireland on December 12, 2002.
 23. Tip: do not put 'www' in the address, or you will be connected to the homepage of the Illinois Alaskan Malamute Rescue Association!

APPENDIX 75-1: REGISTRATION AND DISCIPLINARY AUTHORITIES IN THE EU (2002)

Austria	Vienna	Österreichische Ärztekammer www.aek.or.at
Belgium	Brussels	Ordre des Médecins Ministère de la Santé Publique et de l'Environnement www.health.fgov.be and www.socialsecurity.fgov.be
Denmark	Copenhagen	Danish Board of Health www.sst.dk and www.sum.dk
Finland	Helsinki	National Board of Medico-Legal Affairs www.fimnet.fi
France	Paris	Conseil National de l'Ordre des Médecins www.conseil-national.medicin.fr
Germany	Cologne	Bundesärztekammer www.bundesaerztekammer.de
Greece	Athens	Ministry of Health, Welfare, and Social Security www.yypyp.gr
Ireland	Dublin	Medical Council of Ireland www.rcsi.ie
Italy	Rome	Ministero della Sanità www.sanita.it
Luxembourg	Luxembourg	Ministère de la Santé www.santel.lu
Netherlands	Rijswijk	Ministry of Health www.minvws.nl
Norway	Oslo	Norwegian Board of Health www.legeforeningen.no
Portugal	Lisbon	Ministério de Saude www.ordemosmedicos.pt
Spain	Madrid	Consejo General de Colegios de Médicos de España www.msc.es
Sweden	Stockholm	Socialstyrelsen www.slf.se
UK	London	General Medical Council www.gmc-uk.org.uk