Regulation of the medical profession: fantasy, reality and legality

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J R Soc Med 2004;**97**:211–218

The past decade witnessed a series of high-profile inquiries that cast a noxious miasma over the medical profession and provoked demands for strict regulation. Somehow, a balance must be struck whereby the public can be confident that doctors practise competently, with due regard to ethical and technical standards, yet the regulations are not so overwhelming as to represent a sword of Damocles permanently hanging over doctors' heads. This article explores the current regulatory framework, exclusion from the workplace, serious professional misconduct and seriously deficient performance. The General Medical Council deals with a large number of regulatory cases each year, of which a small proportion are appealed. As well as providing valuable insight into judicial thought, case law in this area is helpful in understanding the balance between social policy and medical regulation.

THE REGULATORY FRAMEWORK

The notion that doctors have complete professional freedom has long been a fantasy. However, the standards have been set largely by the profession itself. This self-regulation, which allows wide latitude in dealing with problems within the profession, has been roundly condemned in the wake of recent imbroglios.[1–3]

Statutory regulation has been repeatedly endorsed as an apposite regulatory mechanism since it carries the force of law[4] and also provides a proper foundation for the contract of the medical profession with society.[5] The Medical Act 1858 established the General Council of Medical Education & Registration of the United Kingdom, now known as the GMC. The Medical Act 1978, which followed the Merrison Report,[5] made the GMC more accountable, extended its functions particularly in relation to medical education, and separated the disciplinary processes from those that deal with doctors whose performance is impaired by ill-health. The provisions of the 1978 Act were consolidated into the Medical Act 1983 (as amended by statutory instrument), which sets out the modern structure of the Council.

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The ambit of statutory control has been considerably widened through recent legislation. Section 18 of the Health Act 1999 provides for a 'duty of quality' imposed upon health authorities and NHS trusts. Section 60 allows for modification of existing statutory regulation by means of an order in Council as opposed to primary legislation, thereby in theory allowing for more rapid and responsive future legislation. However, there exists a concern that the provisions under section 60 may augur greater governmental control not only over doctors but over other healthcare professionals as well.[6]

Statutory regulation has directly encroached into the area of clinical practice. The Medical (Professional Performance) Act 1995 empowers the GMC to regulate underperforming doctors (this being separate from issues of conduct). The National Institute for Clinical Excellence (NICE) has authority to produce and disseminate clinical guidelines aimed at promoting best practice, and these are likely to become indicative of the legal standard of care.[7] Section 19 of the Health Act 1999 established the Commission for Health Improvement (now incorporated in the Healthcare Commission), with the remit to monitor the implementation of NICE guidelines as well as local clinical governance arrangements, connoting a harder edged inspectorate role.[8] It is anticipated that this will have wide-ranging legal implications for trusts.[9]

The term 'stakeholder regulation' has gained increasing currency and bespeaks professional governance as the task and responsibility of other interest groups besides doctors. The NHS Reform and Healthcare Professions Act 2002 has established the Council for the Regulation of Healthcare Professions. The Council has statutory powers enabling intervention in cases where it considers that the public interest is not being served, or if a regulatory body imposes a sanction that is regarded as too lenient.[7] Sanctions regarded as 'too moderate' can be appealed by the Council to the High Court. Since April 2003, the Council has reviewed all GMC verdicts where the practitioner has been acquitted as well as those where the ultimate sanction available has not been imposed. The implications of these new powers are yet to be seen.

The existence of extensive legislation, augmented in recent years, provides the statutory basis for comprehensive external regulation of doctors. However, the regulatory

process may develop further by increasing in complexity and the degree of control. Modern medical practice is perceived as being radically different from that of just a few years ago. Scientific and technological developments along with heightened patient expectations have brought about the recognition that benefit and risk go together, and that medicine is no longer 'simple and safe'.[10] Change has been catalysed by the huge number of adverse healthcare events that occur each year[11] as well as by the revelation of a culture wherein medical staff have encouraged silence and failed to deal with poor practice.[12] The National Patient Safety Agency collects data on adverse events from institutions, patients and carers, and the reporting of unsafe practice is underpinned by extensive statutory protection for whistleblowers by means of the provisions of the Public Interest Disclosure Act 1998. There is an acute awareness by the public of their rights and entitlements, generated by a greater knowledge and access to medical information. A shift in practice towards a patient-centred approach, together with an enhanced expectation of the legal standard of care,[13] is likely to drive up regulatory standards through litigation.

EXCLUSION FROM THE WORKPLACE

It is commonplace for a doctor, at the slightest hint of a problem, to be excluded immediately from the workplace.[14] For a suspended doctor, the endeavour to vindicate oneself can be arduous, time-consuming and costly and may have to be relentlessly appealed in court, even to the House of Lords.[15] Many doctors fail to exonerate themselves because they have neither the resources nor the energy for a prolonged legal battle.

Whereas thirty years ago one or two doctors were suspended each month, nowadays one or two are suspended each week.[16] Whistle blowing, professional jealousies, disputes over private practice and interpersonal friction with colleagues or managers are the principal reasons.[17] The National Audit Office Study[18] has revealed that, between April 2001 and July 2002, over 1000 clinical staff were excluded from trusts. The average suspension for doctors was 47 weeks compared with 19 weeks for other clinical staff, and the cost to the NHS was £40 000 000 a year (doctors accounting for three-quarters of this sum). This report has confirmed the impression that the process of suspension has been costly, haphazard and badly handled in many NHS organizations.[19]

There has been a longstanding recognition that doctors' disciplinary issues are complex[19] and that the NHS has experienced intractable difficulties in addressing underperformance, albeit involving only a small minority of the medical workforce.[20] The National Clinical Assessment Authority (NCAA) was launched in England in April 2001, with the principal remit of providing a support service for trusts that have concerns over the performance of individual doctors. The service now extends to Northern Ireland and Wales. The Department of Health has taken an important step forward by agreeing a novel approach about how concerns regarding doctors should be handled,[21] and has provided valuable guidance.[22] Early identification of problems should be built upon the processes of appraisal and revalidation; trusts should consult with the Assessment Authority before suspension unless there is a threat to patient safety, and should act to facilitate rapid objective assessment of the doctor's performance by the Authority; suspension should be for a period of no longer than two weeks with further exclusions limited to periods of four weeks and extended only after formalization with the Assessment Authority, rather than continuing in perpetuity; the NCAA should automatically review all cases of doctors suspended for longer than six months, and the practice of informal 'gardening leave' should be prohibited.

The Assessment Authority stresses its non-inquisitorial function and refers to its caseload as 'performance referrals' rather than 'investigations'. Straightforward cases (the majority) are resolved by telephone advice; more complex cases progress to a full NCAA assessment.[23] From its inception (April 2001) to June 2003, the NCAA received 206 general practitioner performance referrals and 397 hospital and community referrals.[24] In an analysis of cases over six months (April–September 2003)[25] the NCAA deemed that in 85% suspension was inappropriate and urged resolution by alternative local action. The role of the Assessment Authority 'is to ensure that the decision to suspend a doctor is taken only where it is necessary and will facilitate a resolution, and to avert unnecessary or inappropriate suspension'.[25] The NCAA is said to have acknowledged that the fault for a doctor's poor performance often lies jointly with a 'dysfunctional clinical team' as well as trust management.[26] The Authority has recommended that trusts should have a performance advisory panel to deal with concerns raised, and that a named senior officer within each trust should act as an NCAA contact. Trust managers should explore all options with local human resources teams before suspending a doctor. The Medical Defence Union views the NCAA as having a positive influence on the relationship between doctors and their employing trusts.[24]

Whilst rhetoric suggests that suspension is a 'neutral act' (and not a dismissal for the purposes of employment law), in reality an exclusion often has serious human implications. A study of 105 suspended doctors showed that one-third required treatment for medical problems directly attributable to the suspension, one-third had sought psychiatric help and about half declared that a family member, usually the spouse, had suffered ill health as a consequence.[27]

Exclusion from the workplace is perceived as being unfair because doctors are suspended pending an inquiry, before proof of culpability or even before being allowed an opportunity to respond to any allegations. The new guidelines stipulate that the practitioner should be informed of the nature of the allegation and be given an opportunity to put his or her case before a decision on formal exclusion.

Doctors deserve a transparent investigation within a reasonable timeframe as well as a fair appeals procedure. Suspension, as well as informal 'gardening leave', has a negative impact on a doctor's career and harms a professional reputation[24] even when the practitioner is subsequently cleared of wrongdoing. For a clinician, exclusion can result in reduced self-esteem and disturbing emotions: 'The loss of my job was like a bereavement. Powerful, confusing and shifting emotions swept over me—disbelief (can this really be happening?), sadness, guilt, self-doubt and anger'.[28] Long after the end of a period of suspension and subsequent exoneration, a doctor may be left with a career in shreds and no way of picking up the threads or getting financial compensation.[29] New Department of Health guidelines, as well as the growing reputation of the NCAA for using suspension as a last resort, are welcome developments.

SERIOUS PROFESSIONAL MISCONDUCT

The GMC has the power to investigate or take action against a doctor in circumstances of alleged serious professional misconduct. An investigation triggered by a complaint to the GMC passes through three stages—screening, the Preliminary Proceedings Committee (PPC), and the full public hearing at the Professional Conduct Committee (PCC). At any stage during the proceedings, referral to the Health Committee can be made if there are grounds for considering that the doctor's ability to practise is impaired for reasons of health (Medical Act 1983, Section 37), except where erasure might be contemplated as the sanction.

At the first stage, a medical screener considers the case and directs either that it proceeds no further or that it is referred for investigation. At the second stage, it is the duty of the PPC to consider cases referred by the screener and to determine whether there should be a full hearing by the PCC. The PPC has the power (Medical Act 1983, Section 41a) to refer the case to the Interim Orders Committee if the circumstances are such that they wish to make an interim order for suspension of a practitioner's registration or to impose conditions. The screener and PPC sit in private and, although there is no statutory requirement to give reasons for their decision, in practice reasons must be given to avoid a successful challenge by judicial review. The third stage is a full public hearing before the PCC. It is for the GMC to prove its case on the criminal standard of 'beyond reasonable doubt', and represents a higher burden of proof than the civil standard, decided on a balance of probabilities (i.e. more probable than not). The PCC must feel 'sure' about the culpability of the doctor.

After the evidence has been heard, the PCC makes a finding of fact (for which it does not have to provide detailed reasons). If some, or all, of the facts are found proved, then the PCC needs to consider whether this could amount to serious professional misconduct, and if so, the sanction to be imposed. Reasons must be given for its decision, as well as the penalty. A finding of serious professional misconduct may result in a reprimand, the imposition of conditions, suspension or erasure from the Register (Medical Act 1983, Section 36). Until April 2003, an appeal by the doctor lay to the judicial committee of the Privy Council (Medical Act 1983, Section 40), but now lies to the High Court.

The role of the screener has been circumscribed following *Toth*.[30] The complainants were the parents of a boy with glycogen storage disease. The child was unwell and the parents alerted the attending general practitioner (GP) to the underlying condition as well as the need to administer intravenous glucose. Despite notification, adequate intervention did not occur. The child became severely hypoglycaemic and died. The subsequent complaint to the GMC was screened out at the preliminary stage because of a conflict of evidence between the complainants' and the GP's version of events regarding disclosure of the need for glucose. The screener felt that it was not 'beyond reasonable doubt' that the relevant medical history had been provided by the boy's parents. The complaint was pursued and came before the same screener a second time, and was rejected again on the same grounds. The complainants applied for judicial review of the decision. In giving judgment Lightman J identified three key principles for triggering a full investigation—namely, that the public has an interest in the maintenance of standards and the investigation of complaints of serious professional misconduct; that complainants have a legitimate expectation that such complaints (in the absence of some special and sufficient reason) will be publicly investigated by the PCC; and that in such cases justice should be seen to be done.

Several consequences flow from these principles. First, the screener has a narrow role in deciding whether or not a complaint need proceed further. Lightman J offered the following list of circumstances where there might be no need for further action. 'There may be . . . nothing which in law amounts to a complaint; because . . . verification is lacking; because the matters complained of . . . cannot amount to serious professional misconduct; because the complainant withdraws the complaint; or because a practitioner has already ceased to be registered'. Second,

it is not for the PPC or screener to resolve conflicts of evidence. Utmost caution needs to be exercised when deciding not to refer because only limited evidence is available to the screener and the PPC compared with the much greater amount that will be available at a full hearing. Furthermore, whilst a practitioner is afforded access to the complaint and is able to respond to it, the complainant has no right of access to this response and cannot make an informed reply. *Toth*, therefore, introduces the presumption that complaints should proceed subject to limited exceptions.

In making a finding of serious professional misconduct, Lord Mackay proposed a two-stage test:[31] did the doctor's conduct, either by an act or by an omission, fall short of the standard of conduct expected amongst doctors, and if so was this falling short 'serious'? In determining what amounts to serious, case law consistently indicates that the court expects a high standard of behaviour from doctors. In 1894, in *Allinson*,[32] Lord Esher said 'The question is not merely whether what a medical man has done would be an infamous thing for anyone else to do, but whether it is infamous for a [doctor] to do it'. This sentiment was reiterated by Lord Hoffman in *McCandless*,[33] as recently as 1995: 'The public has high expectations of doctors and members of other self-governing professions', and behaviour that brings disgrace on the profession is viewed in a dim light. It is clear that matters relating to moral turpitude would inevitably fall within the category of serious misconduct, and the court's view in this regard has been unyielding. In *Dr Mohinder Singh*,[34] the appellant's registration was suspended for twelve months following a conviction on ten counts of dishonesty and a suspended sentence of two years' imprisonment. Despite the advancement of impressive personal mitigation, the Privy Council took the view that there is 'no room for dishonest doctors'. However, in matters pertaining to professional practice, with no element of immorality, should the same degree of stringency be applied? A finding of serious professional misconduct and its consequences can negatively impact on a doctor's life and career, as well as the society he serves. Even if a doctor is allowed to continue in unrestricted practice, a stigma still attaches. In the words of Lord Cooke in *Preiss*[35] 'Something more is required than a degree of negligence . . . for the opprobrium that inevitably attaches to the disciplinary offence'. It is suggested that Lord Cooke may have been alluding to a level of 'recklessness' or 'intent' that should be required before a verdict of serious professional misconduct can be returned.

An analysis of recent appeals to the Privy Council casts light on modern jurisprudence relating to medical regulation, as well as the position taken by the court to secure fairness for the defendant doctor while preserving the public interest. With regard to appeals concerning matters of fact, the Privy Council has been reluctant to disturb a finding of fact made by the PCC.[36] As a tribunal at first instance the PCC is in the best position to judge the credibility and reliability of the evidence given by witnesses. This advantage is considered significant and the PCC is more likely to be correct in such a decision than any other court or body where these factors cannot be deployed. This position has been recently reaffirmed in *Selvanathan*.[37]

There has been no hesitation by the Privy Council to interfere where unnecessary or irrelevant factual matters have been raised against the defendant doctor. In *Misra*,[38] the appellant was found to be guilty of serious professional misconduct in relation to the management of a patient and an appeal was lodged but only in relation to the sanction of erasure. It was found as a matter of fact that allegations of dishonesty as well as the appellant's drinking habits (which were not relevant to the charges against him) were used to discredit him. The PCC's finding of serious professional misconduct was set aside because considerations outside the charges were taken into account in reaching a decision.

The duty of the PCC to give reasons for its decisions has been incrementally advanced by case law. The previous position, as in *Libman*,[36] was that the Committee was not required to give reasons beyond a bare statement of the findings of fact. In *Selvanathan,*[37] the court disapproved of *Libman* and acknowledged that practice had moved on. The court cited *Rai*[39] with approval, where it was stated that giving reasons would promote justice by enabling the doctor to understand the PCC's finding against him, thus demonstrating the weight that is attached to ensuring fairness and justice for the medical practitioner.

The Privy Council has not been slow to overturn a decision of serious professional misconduct that has been reached through a process made defective by procedural impropriety. This has mainly occurred either because the advice given by the legal assessor was inaccurate or inappropriate or because correct procedure was not followed. The legal assessor who assists the Committee at its hearing is not a judge, but simply advises the Committee on points of law and reports his or her advice in open court.[36] In *Walker*[40] an appeal was brought on the grounds of procedural impropriety in respect of the advice given by the legal assessor. The assessor had expressed the opinion that erasure ought to be ordered, and had also commented that the imposition of the condition not to practise surgery would be tantamount to erasure of the appellant's registration. On appeal it was held that the first expression was improper and the second erroneous. Furthermore, failure to declare this advice in open session, thereby not giving all parties the opportunity to pass comment, constituted procedural impropriety. The decision was quashed and the case remitted to a fresh PCC with a different legal assessor.

In *Rao*[41] the advice given by the legal assessor was held incorrect. A finding of serious professional misconduct was made after the failure of the doctor to respond appropriately to a telephone call from an out-of-hours general practice service. Conditions were imposed regarding the assessment and supervision of his practice relating to telephone consultations. Although this was a single incident, the advice given by the legal assessor was that the charge could amount to serious professional misconduct if the incident could be divided into 'separate elements', but not if it was a single event only. The Committee's determination referred to 'defects' in the practice of the doctor and imposed the condition of supervision and assessment of his telephone consultations. This indicated that the Committee regarded these as being inadequate on more than one occasion, which went beyond the charge of a single instance of clinical failure. At no stage in the hearing was it suggested that there had been repeated failures. Material misdirection by the legal assessor invalidated the finding of serious professional misconduct, and it was held that, if properly advised, it was not inevitable that the PCC would have arrived at the same conclusion.

In arriving at a determination, the first step is for the PCC to make a finding of fact and then, as a separate issue, take all relevant circumstances into account and consider whether or not the facts proven amount to serious professional misconduct. Overlap of these two steps would not be in the interests of justice. This point was considered in *Silver*.[42] Having studied the transcript of the hearing the Privy Council raised concern about the manner in which the PCC had reached its determination. In delivering judgment, Sir Philip Otton said 'It is axiomatic that after the findings of fact, all the relevant circumstances must be considered before a finding of serious misconduct can be arrived at. The matters set out [by the PCC] immediately following the announcement of serious professional misconduct . . . were relevant to and should have been taken into consideration when arriving at the decision of serious professional misconduct, and not merely as a consideration as to the appropriate sanction and conditions the Committee were minded to impose'. In determining whether this was of sufficient significance to invalidate the result, their Lordships applied the test in *Rao*. If the proper sequence of events had been followed and the appropriate questions posed and answered, would the Committee *inevitably* have arrived at the same conclusion on the issue of seriousness? Their Lordships were not convinced that the finding of serious professional misconduct was set aside.

The appeal in *Silver* also illustrates the approach taken by the Privy Council with regard to the severity of the finding of serious professional misconduct. Their Lordships said: 'Having reviewed all the circumstances and having given due weight to the appellant's long, unblemished record as a single handed practitioner in a deprived area, [we] have come to the conclusion that his misconduct did not call for the opprobrium that inevitably attaches to a conviction of the disciplinary offence'. Should a single act of carelessness carry the stigma of serious professional misconduct when balanced against a long and untarnished professional career? In *Rao*,[41] the Privy Council was of the view, on the basis of *Preiss*,[35] that something more than negligence was required. It is our suggestion that in cases of lesser gravity the PCC should have the power to issue a reprimand or caution without the need to find serious professional misconduct and the obloquy that inevitably ensues.

The protection of patients and the public interest are considerations of paramount importance in determining sanctions, and cannot be compromised. However, what of the issue of public confidence in the profession? A consequentialist ideology was applied in the case of *Bolton*,[43] which concerned a lawyer suspended for misconduct, and can be summed up in the words of Sir Thomas Bingham: 'The reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is part of the price'. The same principle has been applied to the medical profession. In *Gupta*[44] Lord Rodgers said: '*Mutatis mutandis*. The same approach falls to be applied in considering the sanction of erasure imposed by the Committee in this case', and the appeal was dismissed. However, it is important to balance public confidence against the individual circumstances of the doctor. In *Bijl*,[45] an appeal against erasure, Lord Hoffman said: 'The Committee was rightly concerned with public confidence in the profession and its proceedings when dealing with doctors who lapsed from professional standards, but this should not be carried to the extent of feeling it necessary to sacrifice the career of an otherwise competent and useful doctor, who presents no danger to the public, in order to satisfy a demand for blame and punishment'. This is indeed a welcome statement.

SERIOUSLY DEFICIENT PERFORMANCE

Although an investigation regarding performance may be triggered by a single incident, this often follows a pattern of sustained poor practice that may already have been recognized within the local medical network.[46] The Medical Professional (Performance) Act 1995 has statutorily widened the GMC's powers to encompass the assessment of practitioners whose performance may be deficient. The assessment process comprises three phases.[47] Phase one is peer review performance in the workplace. Phase two assesses competence by using tests that reflect the relation between clinical competence and performance. These phases are lengthy and detailed and employ specialty-

specific assessment tools, applied by a team of assessors from the same discipline as the doctor. The evidence collected is submitted to the Committee for Professional Performance (CPP) for the final phase, and oral evidence is taken from the lead assessor, the doctor in question and other relevant parties. If seriously deficient performance is proved, then the CPP has power to suspend the doctor's registration for up to twelve months or to make registration subject to compliance with conditions.

In the interests of fairness to the doctor, it is essential that what is undertaken during a performance assessment evaluates what the doctor actually does or is expected to do in routine practice, and should not be an assessment of general medical competence. In *Krippendorf*[48] the question of underperformance was triggered when adverse side-effects were experienced by several children as a result of defective administration of the BCG vaccine. The Assessment Panel's report concluded that the doctor's professional performance had been seriously deficient and the CPP was satisfied that this report was conclusive. Accordingly, the doctor was suspended for twelve months, directed to be retrained in paediatrics, and ordered that she should limit her practice to non-clinical work. She appealed on the basis that the tests that she had been required to perform tested her general competence in a wider field than that which she actually practised. Her principal role was the administration of the vaccine in the BCG immunization programme.

The Privy Council held that the decision regarding an appellant's performance needed to be based upon the standard of her actual rather than general performance. The Privy Council stressed that it was not the function of the CPP to conduct an examination equivalent to that of student examination boards. Theoretical questions were relevant only insofar as the answers may throw light on the practitioner's professional performance in specific areas of work activity undertaken. The correct approach would have been an assessment of the work that the practitioner had been performing and not a general assessment of competence within that discipline, or failure to achieve appropriate standards in work that either the assessment panel or the CPP perceived that she should have been doing. The test for seriously deficient performance, therefore, must be based on what is actually done by the doctor during everyday routine practice.

If the doctor's performance is such as to impose a danger to patients, then suspension must follow. Otherwise conditions are usually imposed. Typical conditions require a doctor to obtain further supervised training, to have mentor assistance, and to take steps for overall improvement by postgraduate education under the supervision of a postgraduate dean. Conditions are meant to impose safeguards on the doctor's practice in order to protect patients and also to provide an overall rehabilitative package for the practitioner. The doctor must inform his or her employer (and any prospective employer) of the conditions, which need to be in place before any future work can be undertaken, to obtain reports from the mentor and supervisor, and to provide evidence at a resumed hearing that the conditions have been met. Failure to meet the conditions could result in further sanctions being applied.

Conditions, however, may often be extremely difficult to fulfil. The principal difficulty is that intensive supervision of the type required is dependent upon adequate manpower and resources. Whilst the CPP has power to impose conditions, implementation is frequently difficult, particularly within the constraints of local arrangements. Doctors working within a managed environment may find sufficient support facilities for the fulfilment of conditions. However, those working in isolation or in small practices may find conditions unworkable. If conditional registration is to be effective in meeting its objectives, then there is a need to develop a robust infrastructure for the remediation of underperforming doctors.

A sound mechanism is essential for the early detection of underperformance.[47] This is to be facilitated by the GMC with proposed changes for the continued registration of doctors. As of 2005, a new system based upon a licence to practise will move into effect. This will be augmented by the need for periodic revalidation that will depend upon evidence of adequate continuing professional development. Evidence will be required under seven headings—namely, good clinical care; maintenance of good medical practice; teaching and training; relationships with patients; working with colleagues; probity; and health. Evidence will be collected either through appraisal or by direct submission and it is anticipated that this model, supported by appropriate documentation, will be a valuable tool in the 'early diagnosis' of underperformance.

CONCLUSION

Recent legislation has widened statutory powers, has provided for greater governmental control, and has infiltrated areas that were previously considered exclusively clinical domains. Stakeholder regulation has shifted the balance of power away from control by medical professionals and the GMC is now overseen by the Council for the Regulation of Healthcare Professionals. Statutory regulation forms one tier of professional regulation that is tied into a wider quality framework.

The GMC, as the principal regulatory body for the medical profession, plays a key role in defining and maintaining standards. It has a particular duty in relation to protecting patients and the public interest, and there exists

a fine balance between maintaining this and placing draconian restraints upon doctors. The GMC has modernized its outlook by abolishing arcane structures in order to streamline and speed up processes. Under the new reforms there will be a single investigation stage bringing together with three historically separate procedures (conduct, performance, health) and a separate adjudicative stage. Continued registration with the GMC will require a 'licence to practise' which will be dependent upon regular revalidation through evidence of maintaining good medical practice.

Workplace disciplinary procedures against doctors have often been summary, resulting in immediate exclusion. A report from the National Audit Office has confirmed the long-held perception that doctors have been suspended for inordinate lengths of time, resulting in loss of a precious medical resource. New guidance from the Department of Health aims at reducing unnecessary suspensions and provides a framework requiring employers to refer cases to the NCAA. Exclusion should be a last resort.

Public confidence in doctors is contingent upon a dependable and reliable system of professional regulation. In modern practice, doctors work in partnership with other professionals. If the effects of regulation are to be of real value to patients and the public, rather than mere aspiration, regulation of the 'medical' profession must not focus just on doctors. It must also be in tune with the wider influence of the interaction between doctors, other healthcare providers, managers, and the government in order to be responsive and relevant to contemporary society. Unless this is done regulation of the medical profession will remain limited in achieving and maintaining consistent and high standards of healthcare.

Competing interests AS is an Associate Member of the General Medical Council and sits on Fitness to Practise Panels.

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