

Promoting public confidence in the medical profession: Learning from the case of Dr. Bawa-Garba

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Abstract

In a 2015 prosecution which divided public opinion, Dr Bawa-Garba was convicted of gross negligence manslaughter and sentenced to 2-years' imprisonment, suspended for 2 years. The post-conviction litigation which sought to determine whether and when Dr Bawa-Garba could return to clinical practice threatened to destabilise the already fragile relationship between the medical profession and its regulator, the General Medical Council. At the heart of this litigation lay the regulator's quest to maintain and promote public confidence in the profession, in a case where the doctor concerned was not regarded as posing a future risk to patient safety. Using the *Bawa-Garba* litigation, this commentary examines the position and use of the nebulous concept of 'public confidence' within the fitness to practise framework for doctors. Although the authors' observations arise specifically from a case decided in the UK, 'public confidence' is a touchstone concept in professional regulation regimes around the world and so these observations have relevance beyond this jurisdiction. The authors argue that, for too long, use of the rhetoric of public confidence in the regulation of the medical profession has been characterised by an unsatisfactory lack of transparency, excessive deference by the courts to regulatory tribunals and that research is increasingly signalling that instinctual 'expert' judgements on the issue of 'what the public think' may be unreliable.

Keywords

Fitness to practise, General Medical Council, professional regulation, public confidence

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Introduction

There is growing interest¹ in the concept of ‘maintaining public confidence’ as it is applied in the regulation of the healthcare professions. The term is frequently a central feature of fitness to practise frameworks, usually conceptualised as a component part of a broader duty to protect patients or the public.² In the UK, the term is acknowledged as being relevant to all stages of fitness to practise determinations in tribunals, which assess a doctor’s fitness to practise,³ despite no settled test for assessing public confidence being enshrined in either statute or case law. This lack of concretisation explains, in part, why the use of the language of ‘public confidence’ in decision-making has steadily become more controversial: its relationship with the regulator’s overriding statutory aim of protecting the public’s lacks transparency;⁴ maintaining public confidence *in the profession* can be construed as a throwback to self-(serving) regulation rather than patient-centred governance; the public confidence narrative is frequently relied upon to justify judicial deference to professional regulators,⁵ and it has been key in the use of draconian regulatory powers where the individual healthcare practitioner concerned is not currently regarded as posing a risk to patient safety.⁶

This unease surrounding the positioning of ‘public confidence’ in professional regulation spiked during the progress of Dr Hadiwa Bawa-Garba’s case through the appeal courts, a case which illustrates the sometimes difficult relationship between doctors and their regulator, the General Medical Council (GMC), and which intensified concerns that the regulator was pursuing public confidence for its own sake.⁷ After first setting out key

1. N. Williams, *Gross Negligence Manslaughter in Healthcare: The Report of A Rapid Policy Review* (June 2018) (‘the Williams Review’). Available at: <https://www.gov.uk/government/publications/williams-review-into-gross-negligence-manslaughter-in-healthcare> (accessed 24 January 2020).
2. See s.1(1A) Medical Act 1983 set out below, but similar provisions exist in Australia (see, e.g. *Craig v The Medical Board of South Australia* [2001] SASC 169) and Canada (see, e.g. *College of Physicians and Surgeons of Ontario v Minnes* [2016] ONSC 1186), although note a different articulation of the objective as to ‘maintain public confidence *in the system of self-regulation* of the medical profession’. At [18] (emphasis added).
3. *How is public confidence maintained when fitness to practise decisions are made?* (Advice to the Secretary of State – Professional Standards Authority, 2019), 4.13, relying on *GMC v Cohen* [2008] EWHC 581. Available at: <https://www.professionalstandards.org.uk/publications/detail/how-is-public-confidence-maintained-when-fitness-to-practise-decisions-are-made> (accessed 24 January 2020).
4. BMA Response to Williams Review (August 2018). Available at: <https://www.gponline.com/gmc-public-confidence-duty-risks-trial-media-doctors/article/1490583> (accessed 31 January 2020).
5. *Ahmed v GMC* [2019] EWHC 2173 at [9]; relying on *Fatnani & Raschid v General Medical Council* [2007] EWCA Civ 46 at [19].
6. P. Case, ‘Putting Public Confidence First: Doctors, Precautionary Suspension and the General Medical Council’, *Medical Law Review* 19(3) (2011), p. 339, and reference to MPTS Sanctions Guidance on ‘erasure’ in *Bawa-Garba v GMC* [2018] EWCA Civ 1879 at [29].
7. S. Lintern, ‘Jeremy Hunt to Strip General Medical Council of Powers’ (*Health Service Journal*, 11 June 2018). Available at: <https://www.hsj.co.uk/policy-and-regulation/jeremy-hunt-to-strip-general-medical-council-of-powers/7022626.article> (accessed 24 January 2020).

aspects of the post-conviction litigation in the *Bawa-Garba* case, the authors use these judgments as a springboard to discuss some of the controversies surrounding ‘public confidence’ reasoning and identify some unanswered questions about how public confidence in the medical profession is to be assessed.

Positioning ‘public confidence’ in the regulatory framework

First, however, it is necessary to look at exactly where the directive to maintain public confidence in the profession sits within the regulatory framework. The language of public confidence in the profession has a long history in the case law of professional regulation,⁸ including the regulation of doctors, but has only recently been expressed in statute. The GMC’s functions, as set out in the Medical Act 1983, include coordinating medical education, maintaining the medical register and investigating fitness to practise concerns. Section 1(1A) of the 1983 Act was amended in 2015 to provide that the GMC’s overarching objective in exercising its functions is to ‘protect the public’, and s.1(1B) further provides that this objective includes a tripartite bundle of aims: (i) to protect, promote and maintain the health, safety and well-being of the public, (ii) to promote and maintain public confidence in the profession and (iii) to promote and maintain proper professional standards and conduct for members of that profession.⁹ Distinct from earlier case law, parliamentary debate and the language of the statute itself confirm that maintaining public confidence was not intended to have application outside the context of the parent objective of ‘protecting the public’.¹⁰

Bawa-Garba v the GMC: Twists and turns in fitness to practise decision-making

In 2015 Dr Bawa-Garba, a paediatrician, was convicted of gross negligence manslaughter (GNM) in respect of one of her patients at Leicester Royal Infirmary Hospital. During a night shift featuring IT meltdowns and communication failures that many clinicians will be familiar with, and having worked a double shift of 12–13 h, Dr Bawa-Garba’s actions and omissions were (according to a jury) a material contributory cause of the

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8. References to the need to promote public confidence in the profession are common in the application of professional sanctions against healthcare professions generally, but also other professions, to include teachers, social workers, opticians, dentists and lawyers.
 9. These amendments were introduced by the *General Medical Council (Fitness to Practise and Over-arching Objective) and the Professional Standards Authority for Health and Social Care (References to Court) Order 2015* (2015/794).
 10. This Act was amended in 2015 with the intention, described by Earl Howe, then health minister, to strengthen the powers of the General Medical Council. In the House of Lords debate of these reforms, the need to promote and maintain public confidence was stressed, although ‘maintaining public confidence’ was considered only to be relevant in so far as it was in pursuit of ‘the protection of the public’: Hansard HL vol 760, cols 257–59 (17 March 2015), at 258.

death of 6-year-old Jack Adcock.¹¹ Notwithstanding these system failures, the jury found that the defendant's performance had been 'truly exceptionally bad'¹² and by a majority verdict, found Dr Bawa-Garba guilty of GNM. Justice Nicol sentenced her to 2 years imprisonment, suspended for 2 years and the Court of Appeal unanimously rejected her appeal against conviction.¹³

The prosecution and conviction of Dr Bawa-Garba divided public opinion. The tests for liability in GNM are notoriously vague, marred by circularity¹⁴ and 'potentially unfair to those prosecuted'.¹⁵ Some queried the public interest in prosecuting this case at all (particularly given the use of National Health Service [NHS] resources inevitably involved in defending it),¹⁶ and further questions were raised regarding the appropriateness of asking juries to make decisions turning on intricacies of professional competence,¹⁷ the foregrounding of the defendant's failures against the backdrop of substantial system failures and failings by other staff¹⁸ and the role of expert witnesses in securing her conviction.¹⁹ These issues are not explored further in this commentary, the focus of this article being the litigation connected with the question of whether Dr Bawa-Garba's GNM conviction meant that she should be excluded from medical practice.

From suspension to erasure and back again

In an interim order hearing, Mr Justice Knowles considered that Dr Bawa-Garba did not need to be suspended from practice on public confidence grounds once she had been charged with GNM and pending the outcome of the criminal trial.²⁰ This was because a decision based on maintaining public confidence was one of balance, and even a conviction of an offence as serious as manslaughter should not automatically lead to erasure from the medical register.²¹

11. *Bawa-Garba v GMC* [2018] EWCA Civ 1879.

12. A commonly used formulation of the threshold required for liability in gross negligence manslaughter.

13. *Bawa-Garba v The Queen* [2016] EWCA Crim 1841.

14. M. Brazier and A. Alghrani, 'Fatal Medical Malpractice and Criminal Liability', *Journal of Professional Negligence* 25(2) (2009), pp. 51-67 at 67.

15. O. Quick, *Regulating Patient Safety: The End of Professional Dominance* (Cambridge: CUP, 2017) at 112.

16. R. Foster, 'The Case of *Dr Bawa-Garba* and the Tension between Fitness to Practise, the Criminal Law and the Supervisory Jurisdiction of the Court', *Judicial Review* 23(4) (2018), pp. 259-269.

17. Available at: <https://thesecretbarrister.com/2018/01/31/some-thoughts-on-dr-bawa-garba-and-our-faith-in-the-jury-system/> (accessed 24 January 2020).

18. See E. Gasper, 'Promoting Honesty and Truthfulness When Things Go Wrong During Care Delivery for Sick Children', *Comprehensive Child and Adolescent Nursing* 41(2) (2018), pp. 83-88 at 85.

19. *Williams Review*, *supra* note 1.

20. For further detail on interim orders, see s.41A Medical Act 1983 and Case *supra* note 6.

21. *Dr. Bawa-Garba v General Medical Council* [2015] EWHC 1277 (QB) [92].

Following Dr Bawa-Garba's GNM conviction in 2017, the Medical Practitioners Tribunal Service (MPTS) examined her case and concluded that a finding of 'impaired fitness to practise' was necessary to maintain public confidence.²² A finding of 'impairment' is the gateway to 'sanctions' which qualify a doctor's registration with the GMC and therefore eligibility to practise, including suspension or erasure.²³ The tribunal found that a 1-year suspension was sufficient to maintain public confidence in this case, given that her failings were not deliberate or reckless, they took place in the context of wider systemic failings and she did not present a continuing risk to patients.²⁴

Following the tribunal's decision, the GMC exercised its then relatively new powers of appeal²⁵ against MPTS outcomes,²⁶ arguing that a 1-year suspension from practice was insufficient to 'protect the public'.²⁷ In a judgment which appeared to conflate the level of sanction required to maintain public confidence, with the verdict of the jury, the High Court agreed with the GMC, quashing the suspension and replacing it with the sanction of erasure.²⁸ The tribunal's decision and its emphasis on systemic failures which the jury had been aware of demonstrated, according to Justice Ouseley, that its approach:

did not respect the true force of the jury's verdict nor did it give it the weight required when considering the need to maintain public confidence in the profession and proper standards.²⁹

The GMC's appeal was upheld on the basis that given the verdict of the jury in the criminal case, nothing short of erasure would uphold public confidence in the profession.³⁰

22. Minutes of fitness to practise hearing – July 2017 available through the General Medical Council register. Available at: gmc-uk.org (accessed 31 January 2020).

23. Sanctions are listed at s.35C Medical Act 1983. Note that a warning can be given in the absence of a finding of 'impairment'.

24. Medical Practitioners Tribunal Service decision, June 2017 [32].

25. S.40A Medical Act 1983. The General Medical Council's (GMC) relationship with the Medical Practitioners Tribunal Service (MPTS) is an anomaly, explicable only by reference to growing concern that the GMC's role in investigating and adjudicating in fitness to practise cases had involved it acting as 'judge and jury', hence the decision was taken to establish the MPTS as a separate arm of the GMC, although existing within the GMC: J. Chamberlain, 'Malpractice, Criminality and Medical Regulation', *Medical Law Review* 25(1) (2017), pp. 1-22 at 19.

26. S.40A Medical Act 1983.

27. [2018] EWHC 76.

28. [2018] EWHC 76.

29. [2018] EWHC 76 at [38].

30. [2018] EWHC 76 at [53] and see E. Stuart-Cole, 'Medical Manslaughter: The Effect of Lay Findings of (Criminal) Gross Negligence on Professional Tribunals: *General Medical Council v Dr Bawa-Garba* [2018] EWHC 76' *The Journal of Criminal Law* 82 (2018), pp. 197-200.

The Court of Appeal overturned this ruling, restoring the original suspension order³¹ and finding that Justice Ouseley had adopted an ‘impermissible approach’ by applying a presumption of erasure where a jury had found a doctor guilty of GNM.³² Justice Ouseley’s approach had also been contrary to his own expressed view that a *presumption* in favour of erasure in convictions for GNM was inappropriate and that sanctions should depend on the individual facts and circumstances. Subsequently, after a total of 18 months’ suspension, Dr Bawa-Garba was finally cleared by the MPTS to return to practice, subject to conditions, it not being in the public interest to ‘deprive the public of an otherwise competent and dedicated practitioner’.³³

The case rang alarm bells amongst the medical profession for a number of reasons. While some of the profession’s concern was directed at the use of the criminal law, there was also ‘consternation and outrage’ at the regulator’s handling of the case.³⁴ Firstly, many clinicians believed that this post-conviction litigation was an example of the GMC ‘going after doctors’ in appealing the MPTS decision and seeking erasure of a competent doctor who was not considered to pose a risk of harming her patients.³⁵ This is consistent with the reported belief among some doctors that in recent times, the GMC has been ‘adopting a more punitive approach’³⁶ to the management of fitness to practise cases³⁷ and that the regulator adopts an approach of ‘guilty until proven innocent’.³⁸ Secondly, clinicians working in a challenged NHS³⁹ empathised with Dr Bawa-Garba during the night of Jack’s death, observing ‘[that] could have been any of us’,⁴⁰ and widespread support was expressed for the convicted paediatrician by using the ‘IAmHadiza’ hashtag on twitter. The GMC’s pursuit of erasure prompted a vote of ‘no confidence’⁴¹ and led to a recommendation to remove the regulator’s power

31. [2018] EWCA Civ 1879.

32. [2018] EWCA Civ 1879 at [88] and [89].

33. Minutes of Medical Practitioners Tribunal Service decision, 9 April 2019 (Available at: <https://www.mpts-uk.org/-/media/mpts-rod-files/dr-hadiza-bawa-garba-09-april-2019.pdf>), applying *Bijl v GMC* [2001] UKPC 41 (accessed 31 January 2020).

34. L. Hamilton, *Independent Review of Gross Negligence Manslaughter and Culpable Homicide* (London: General Medical Council, 2019), p. 3.

35. D. Cohen, ‘The Bawa-Garba Case, the GMC, and a “Tragic Circle”’, (*The BMJ Opinion*, 13 December 2017). Available at: <https://blogs.bmj.com/bmj/2017/12/13/deborah-cohen-the-bawa-garba-case-the-gmc-and-a-tragic-circle/> (accessed 1 June 2019).

36. It is frequently said that punishment is not a function of the fitness to practise regime, albeit that sanctions may sometimes be experienced as punitive: e.g., *Sadler v GMC* [2003] UKPC 59 at 17.

37. Chamberlain, *supra* note 25.

38. G. McGivern and M. Fisher, ‘Medical Regulation: Spectacular Transparency and the Blame Business’, Special Issue. *Journal of Health Organisation and Management* 24(6) (2010), p. 597.

39. Characterised by austerity, staff shortages, bed shortages and rising demand.

40. P. Krishan, ‘Dr Bawa-Garba Could Have Been Any One of Us’ (*PULSE*, 29 January 2018). Available at: <http://www.pulsetoday.co.uk/news/gp-topics/legal/dr-bawa-garba-could-have-been-any-one-of-us/20036066.article> (accessed 24 January 2020).

41. ‘BMA Declares It Has No Confidence in the GMC’, *Pulse*, 27 June 2018.

to appeal MPTS decisions.⁴² Thirdly, clinicians raised eyebrows at the argument of ‘upholding public confidence’ used by the GMC to justify its stance that erasure was the only appropriate sanction.⁴³ It is the last point that this article will now explore in more detail. One of the many significant aspects of the *Bawa-Garba* case is that it involved a fitness to practise case sheared of issues of patient safety, laying bare the workings of the public confidence objective. The Court of Appeal judgment is therefore of particular significance to regulatory jurisprudence, but what can it tell us about the role of ‘maintaining and promoting public confidence’ in the application of professional sanctions?

How are risks to public confidence to be assessed?

At the heart of reservations about public confidence justifications for the use of regulatory powers are questions about how assessments of what is needed to maintain public confidence are reached. Law and practice in this area has treated such decisions as instinctual judgements, trusted to the expertise of the specialist tribunal and court judgments frequently remind us that judges should be ‘slow to interfere’ with the tribunal’s assessment.⁴⁴ Given the long-standing policy of deference here, it is difficult to see why the tribunal’s decision was so readily discarded by the High Court in *Bawa-Garba*’s case. Both the GMC’s argument and the judgment of Justice Ouseley regarded the tribunal decision as discounting the jury’s verdict – the verdict being, in effect, clear evidence that public confidence could not tolerate such a doctor returning to medical practice. But, as the Court of Appeal made clear, that stance ignored the fact that the decisions of the jury and of the tribunal are taken ‘by different bodies, with different functions, addressing different questions and at different times’.⁴⁵ Certainly, the jury had not been asked its opinion about whether Dr Bawa-Garba should ever return to practice, and neither had the jury been given a detailed report into the systemic failures at the hospital that night.⁴⁶ The jury’s verdict was therefore an extremely crude proxy for determining what was needed to ‘maintain public confidence’.

Although the Court of Appeal in *Bawa-Garba v GMC* went on to reference ‘public confidence’ no less than 32 times, it offered little further guidance on its meaning or

42. N. Williams, *Gross Negligence Manslaughter in Healthcare: The Report of a Rapid Policy Review* (London: Department of Health, June 2018), p. 50/Recommendation 6. The power to launch public interest appeals is in any event a duplicate of that which is vested in the Professional Standards Authority: S.29(4) of the NHS Reform and Health Care Professions Act 2002.

43. N. Hodson, ‘Convicting a Doctor of Gross Negligence Manslaughter Without Striking Them off Damages Public Confidence in the Profession’ (*Blog, Journal of Medical Ethics*, 13 January 2019). Available at: <https://blogs.bmj.com/medical-ethics/2019/01/13/convicting-a-doctor-of-gross-negligence-manslaughter-without-striking-them-off-damages-public-confidence-in-the-profession/> (accessed 25 May 2019).

44. See, for example, *Hasan v GMC* [2003] UKPC 5 at [10], but repeated in countless cases.

45. [2018] EWCA Civ 1879 at [76].

46. S. Ost, ‘Drs Bramhall and Bawa-Garba and the Rightful Domain of the Criminal Law’, *Journal of Medical Ethics* 45(1) (2019), pp. 151-155 at 153.

application, but rather consigned it to the expertise of the profession's tribunal. The decision as to the appropriate sanction was an 'evaluative', 'multifactorial' decision, a 'kind of jury question' upon which reasonable people might reasonably disagree.⁴⁷ This categorisation of the expert tribunal's decision as ordinarily beyond the reach of judicial interference has echoes of the much maligned *Bolam* test⁴⁸ and underscored once again, in thick black pen, the court's stance of deference to the decision maker. As the regulator is often identified as part of the profession, this can be viewed as yet another variant of 'medical exceptionalism', the idea that medics have 'unique insight' into these issues.⁴⁹ Having consigned the issue of appropriate sanction to expert regulators, the Court of Appeal went on to affirm pre-existing statements on how public confidence demands were to be gauged, relying upon an 'ordinary person' type standard. For example, public confidence decision-making should 'reflect the views of an informed and reasonable member of the public'⁵⁰ and, in a similar vein:

public confidence in the profession must be assessed by reference to the standard of "the ordinary intelligent citizen" who appreciates the seriousness of the proposed sanction, as well as the other issues involved in the case.⁵¹

Both attempts to capture how public confidence should be assessed are intriguing. On the one hand, both confirm that the use of regulatory powers in the name of public confidence must go beyond 'knee-jerk' reactions, appeasement of populism or reacting 'to the public mood of the moment'.⁵² But in doing so, they also appear to endorse the guesstimating of public opinion, which is then subjected to a corrective gloss should that opinion be found wanting. The test therefore becomes what an 'expert' thinks 'the public' thinks, with room for selective adjustment. Foster notes the tension between, on the one hand, reserving issues of public confidence for the expertise of the specialist tribunal, while, on the other, articulating the benchmark as 'reflecting the view of an informed and reasonable member of the public'.⁵³ These formulations also raise questions about how deferential the courts should be, given their own familiarity and experience in dealing with the 'reasonable man' and the 'officious bystander' in the ordinary business of deciding contract and tort claims. It seems incongruous to suggest that the

47. *Bawa-Garba v GMC* [2018] EWCA Civ 1879 at [61].

48. *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582. For a summary of the criticisms of the test, see R. Mulheron, 'Trumping *Bolam*: A Critical Legal Analysis of *Bolitho*', *The Cambridge Law Journal* pp. 609-638 (2010), pp. 611-612.

49. C. Foster, 'The Rebirth of Medical Paternalism: An NHS *Trust v Y*', *Journal of Medical Ethics* 45 (2019), pp. 3-7 at 3.

50. [2018] EWCA Civ 1879 at [96], citing *Giele v General Medical Council* [2005] EWHC 2143 (Admin) [2006] 1 WLR 942 at [33].

51. [2018] EWCA Civ 1879 at [96], citing *Wallace v Secretary of State for Education* [2017] EWHC 109 (Admin), [2017] PTSR 675 (at [92] and [96(v)]).

52. *Hamilton Review* at 167.

53. Foster, *Supra* note 16.

profession's tribunal is so much better placed than a court to make these assessments and it is argued that the policy of deference on these issues should be reconsidered.

While the High Court and Court of Appeal judgments in *Bawa-Garba's* case chose to contextualise the jury decision differently, the judgments still share common ground in characterising public confidence assessments as instinctual. This instinctual judgement approach is conspicuously at odds with an emerging narrative, which recommends deconstruction of public confidence assessment. The *Williams Review* (commissioned in response to concerns raised by healthcare professionals regarding convictions for GNM) recommended research to 'review how the impact on public confidence is assessed in reaching fitness to practise decisions about individual healthcare professionals' and the development of 'guidance to support consistent decision making in this area'.⁵⁴ Implicit in this recommendation is a view that more transparency is required in the use of 'public confidence' as a justification for regulatory decisions. The follow-on report from the Professional Standards Authority, *How is public confidence maintained when fitness to practise decisions are made?*, appeared to endorse this view, noting divergence in the referencing of public confidence in different regulatory frameworks and a certain 'lack of reasoning' and the use of 'standard text' in tribunal decisions to indicate that public confidence had been considered.⁵⁵ Research commissioned as part of the *Hamilton Review* of GNM and culpable homicide (commissioned by the GMC) surveyed members of the public on issues relating to criminal conviction and public confidence.⁵⁶ Specific aspects of the *Hamilton Review* research appeared to suggest that public confidence in the profession was far more nuanced than the High Court judgment in the *Bawa-Garba* case had assumed. Researchers found that only 41% of over 2,000 respondents would expect a doctor to be struck off after a GNM conviction which had resulted in a suspended sentence.⁵⁷ This finding suggests a number of possibilities and could, for example, be construed as a defence of the original MPTS decision and its expertise in assessing public confidence issues. Once again, however, the broader implications of conducting this research, and of its findings, are that instinctual judgements are no longer satisfactory and that the deployment of public confidence justifications needs further contextualisation, for example, a grounding in research on public opinion and patient perspectives.⁵⁸

54. Department of Health and Social Care, *Williams Review into Gross Negligence Manslaughter in Healthcare* (2018) [12.5] and *Recommendations*, p. 42.

55. *How Is Public Confidence Maintained When Fitness to Practise Decisions Are Made?* (Advice to the Secretary of State – Professional Standards Authority, 2019) at 7.12.

56. *Independent Review of Gross Negligence Manslaughter and Culpable Homicide* (Leslie Hamilton, 2019). Available at: https://www.gmc-uk.org/-/media/documents/independent-review-of-gross-negligence-manslaughter-and-culpable-homicide—final-report_pd-78716610.pdf (accessed 24 January 2020).

57. *Promoting and Maintaining Public Confidence in the Medical Profession: Full Research Report for the GMC* (2019) at p. 7 – this was the report of the research with the public commissioned as part of the Hamilton Review.

58. Earlier research commissioned by the Professional Standards Authority into dishonesty has suggested a divergence of views as to what 'public confidence' requires between the

Public confidence beyond the realms of clinical competence

A recalibration of the approach to assessing public confidence issues, with more emphasis on research into public confidence, could lead to different outcomes and may in time address long-held concerns that regulatory action too often extends into conduct beyond the clinical sphere. Devaney and Holm, for example, have argued that professional regulation is still based on ‘the profession’s values’ and not to any ‘appreciable extent on what the public upon reflection might think about doctors’ private actions in their private lives’.⁵⁹ Woolley, writing about disciplining lawyers in Canada, also questions the regulatory legitimacy of using professional disciplinary sanctions against conduct out with professional practice. Her research uses behavioural psychology to suggest that, contrary to regulatory assumptions, dishonesty in a personal context provides no evidence that a solicitor is not fit to practise or that such conduct may spill over into the conduct of their professional affairs.⁶⁰ It seems that we know little about whether dishonesty in private affairs leaches into professional life, and far less about whether the ‘informed and reasonable member of the public’ maintains such a distinction.

A full examination of when non-clinical conduct might or should be relevant to fitness to practise is outside the scope of this commentary, but it is clear from the case law that ‘maintaining public confidence’ as a rationale for imposing professional sanctions looms large in cases involving either proven dishonesty or sexual misconduct.⁶¹ Public confidence in the profession is regarded as at risk if the regulator does not ‘mark the seriousness’ of these types of conduct by imposing a severe sanction.⁶² Accordingly, in cases of dishonesty or sexual misconduct, MPTS and judicial rhetoric suggest a virtually ‘zero tolerance’ approach on public confidence grounds. Thus, in *GMC v Chandra*, Lady Justice King recently observed that there was little more fundamental to the heart of the doctor’s role as the patient’s entitlement to be entirely confident of their doctor’s sexual probity,⁶³

profession itself and the public, with the profession and the public being more sceptical of the concept of public confidence than the regulator: *Dishonest Behaviour by Health and Care Professionals* (London: Policis, 2016) at 7.

59. S. Devaney and S. Holm, ‘The Transmutation of Deference in Medicine: An Ethico Legal Perspective’, *Medical Law Review* 26(2) (2018), pp. 202-224 at 223.
60. See A. Woolley, ‘Regulatory Legitimacy and Legal Ethics: Regulating Lawyers for Personal Misconduct’, in R. Mortenson et al., eds., *Alternative Perspectives on Lawyers and Legal Ethics* (Routledge: Abingdon, 2011) at 5–7.
61. *Pillai v GMC* [2009] EWHC 1048 at [27] ‘in cases of dishonesty the balance ordinarily can be expected to fall down on the side of maintaining public confidence by a severe sanction against the practitioner concerned. Indeed, that sanction will often and perfectly properly be the sanction of erasure, even in the case of a one-off instance of dishonesty’.
62. *Nkomo v GMC* [2019] EWHC 2625 at [14] – dishonesty by way of a conviction for fraud in avoiding child maintenance payments.
63. [2018] EWCA Civ 1898: ‘If a member of the public submits him or herself to a physical or mental examination or consultation by a doctor, he or she is ordinarily entitled to expect that that doctor is a person whose trustworthiness and sexual integrity is not and never has been, seriously in question’. At [79].

and in *Singh v GMC*, the court regarded the GMC as entitled to take the view that ‘there is no room for dishonest doctors’.⁶⁴

It is also precisely in these cases of dishonesty or sexual misconduct that the doctor’s efforts to remediate and demonstrate that they pose very little risk of repeating their misconduct are of subdued significance when it comes to deciding the appropriate sanction. In *Yeong v GMC*, for example,⁶⁵ the defendant doctor had been involved in a sexual relationship with a patient. Dr Yeong pleaded for clemency on the basis that this behaviour was unrelated to his clinical practice, bore no relation to his ability to work as a doctor, there were suggestions that the patient in this unusual case had been the ‘dominant party’⁶⁶ and he had since taken steps to minimise the risk of this ever occurring again.⁶⁷ Dr Yeong’s appeal against suspension⁶⁸ was unsuccessful; when the misconduct took the form of violating a fundamental rule of the professional relationship and thereby undermining public confidence in the profession:

the efforts made by the medical practitioner in question to address his behaviour for the future may *carry very much less weight* than in a case where the misconduct consists of clinical errors or incompetence.⁶⁹

If, as *Yeong* and other cases suggest, conduct which is deemed to impact public confidence renders mitigating factors, such as doctors’ expressions of remorse and efforts to remediate, less potent, it becomes even more important that there is transparency and fairness in the application of public confidence arguments.

While breaching boundaries with a patient clearly compromises the therapeutic relationship, the issue of public confidence in the profession also comes to the fore in cases where the issue which has brought the doctor to the regulator’s attention has no direct connection at all with their clinical practice. There are recent cases which have resulted in a significant period of suspension, specifically because of the need to protect public confidence in instances of proven dishonesty.⁷⁰ The case of junior doctor, Sharifa Scerif, for example, resulted in an 8-month suspension due to fare dodging on London transport by dishonestly using her sister’s ‘Freedom pass’.⁷¹ This reach of ‘public confidence’ into conduct unrelated to clinical performance or conduct towards patients is not new. In *Fatnani & Raschid v GMC*, a 70-year-old doctor was involved in a court case regarding

64. *Singh v GMC* [1998] UKPC 23 at [7].

65. *Yeong v GMC* [2009] EWHC 1923.

66. Having harassed the doctor and extorted significant amounts of money from him, at [6].

67. [2009] EWHC 1923 at [12].

68. [2009] EWHC 1923 at [27].

69. [2009] EWHC 1923 at [48] to [50] (emphasis added).

70. Available at: [https://www.mpts-uk.org/-/media/mpts-rod-files/dr-sharifa-scerif-01-nov-19.pdf,para \[29\]](https://www.mpts-uk.org/-/media/mpts-rod-files/dr-sharifa-scerif-01-nov-19.pdf,para [29]) (accessed 31 January 2020).

71. It is worth noting, however, that very similar ‘misconduct’ is far more likely to result in a striking off in the legal profession. See the case of Adam Kemeny (2019). Available at: <https://www.lawgazette.co.uk/news/solicitor-banned-for-evading-650-in-train-fares/5069062.article> (accessed 31 January 2020).

fraud which had been instigated by her daughter and to which the clinician denied having any knowledge.⁷² Despite having an unblemished medical career that spanned several decades, and a conviction that was not related to her career or abilities as a doctor, the regulatory body regarded erasure as necessary to maintain public confidence.⁷³ While Justice Collins disagreed, substituting erasure with a 12-month suspension,⁷⁴ the GMC successfully appealed. Lord Justice Laws found that Justice Collins had overlooked two fundamental principles of this jurisdiction: ‘the preservation of public confidence in the profession and the need *in consequence* to give special place to the judgement of the specialist tribunal’.⁷⁵ This deeper shade of deference apparently applied to issues of public confidence is problematic, first, because it suggests that the further removed the conduct is from the practice of medicine itself, the more remote the court’s power to interfere with the discretion of the medical tribunal. Secondly, this supposedly extended deference on issues of public confidence seems to be in tension with authorities which treat appeals from sanction in ‘non-clinical’ fitness to practise cases as inviting a qualified or reduced level of deference by the courts rather than a heightened one.⁷⁶ These contradictions add further weight to the case for a review of public confidence reasoning.

Loose thinking: Confidence in the profession, protecting ‘reputation’ or room for retribution?

While it is not disputed that confidence in clinicians is a vital part of medicine and without it a doctor cannot do her job,⁷⁷ the judgment in *Bawa-Garba* leaves us no clearer on what the substantive content of ‘maintaining and promoting public confidence’ is. There are questions, for example, as to whether it can be equated with protecting the ‘reputation’ of the profession. Consultation prior to the 2015 reforms provoked a prophetic warning from the British Medical Association that overemphasising public confidence could result in competent clinicians being ‘punished’ for the sake of the profession’s reputation.⁷⁸ In *Bolton v Law Society*, a case concerned with the regulation of solicitors,⁷⁹ Sir Thomas Bingham had stated that when the profession’s ‘reputation’ was at risk, an individual could justifiably be expelled from the profession and that the

72. *Fatmani, Raschid v General Medical Council* [2007] EWCA Civ 46.

73. [2007] EWCA Civ 46 at [9].

74. [2007] EWCA Civ 46 at [33].

75. [2007] EWCA Civ 46 at [26] (emphasis added); confirmation that special deference is due to the tribunal on matters of public confidence appears in *Yassin v GMC* [2015] EWHC 2955 at [32].

76. For example, see *Meadow v GMC* [2006] EWCA Civ 1390 at [280] (non-clinical performance as an expert witness); *Shamsian v GMC* [2011] EWHC 2885 and *R (on the application of Khan) v GMC* [2008] 3509 at [78] (dishonesty).

77. *Makki v General Medical Council* [2009] EWHC 3180 at [43].

78. Op. cit., col 261 and see A. Rimmer, ‘Doctors Could Face “Trial by Media” Under New GMC Sanctions, BMA Warns’, g7569 *BMJ* (2014), p. 349.

79. *Bolton v Law Society* [1994] 1 WLR 512.

‘most fundamental of all’ purposes of professional sanction was to ‘maintain the reputation of the solicitors’ profession as one in which every member, of whatever standing, may be trusted to the ends of the earth’.⁸⁰ While historically there was a lack of clarity in the case law over whether *Bolton* had application to the medical profession,⁸¹ the Court of Appeal in *Bawa-Garba*, and subsequently in *GMC v Chandra*, confirmed that the ‘*Bolton* principles’ applied ‘equally to doctors as solicitors’.⁸² No comment was made about Lord Bingham’s use of the language of ‘reputation’, which jars with the statutory language of ‘protecting the public’.⁸³ Tribunal decisions and judgments grappling with public confidence issues in fact routinely rely on Lord Bingham’s speech in *Bolton*, consequently the language of the ‘profession’s reputation’ appears in recent appeal judgments,⁸⁴ and is evident in key documents such as the *MPTS Sanctions Guidance* which inform every MPTS decision.⁸⁵ But as the Professional Standards Authority’s research has pointed out, emphasis on the profession’s ‘reputation’ in this context is outmoded⁸⁶ – a further reason to review the operation of the public confidence maxim.

There are also questions regarding the extent to which decision-making on the basis of public confidence feeds a perceived public need for retribution and therefore helps to sustain blame culture in the world of professional regulation. The link with blame culture is made in an earlier case of *Bijl v GMC*,⁸⁷ a case which was foregrounded in the *Bawa-Garba* judgment. *Bijl* resembles the case of *Bawa-Garba* in a number of respects, including the failings relating to one patient, the patient dying, the doctor acknowledging their mistakes and not being regarded as a continuing risk to patients and having an otherwise unblemished career. The clinician had been charged with continuing surgery for too long on a patient and then leaving the hospital while her condition was still serious. There were concerns around public confidence in the context of a clinician departing from professional standards, although the Board regarded *Bijl* as a doctor who had committed an error of judgement and who was ‘clearly determined never to make that mistake again’.⁸⁸ Lord Hoffman took his remorse into account, saying:

80. *Bolton v Law Society* [1994] 1 WLR 512at 518.

81. P. Case, ‘Doctoring Confidence and Soliciting Trust: Models of Professional Discipline in Law and Medicine’, *Journal of Professional Negligence* 29 (2013), pp. 87-107.

82. [2018] EWCA Civ 1879 at [84] and *GMC v Chandra* [2018] EWCA Civ 1898 at [59].

83. See S.1(1A) and S.1(1B) of the Medical Act 1983.

84. For example, in the *Bawa-Garba* case itself: [2018] EWCA Civ 1879 at [84].

85. Appearing three times in the *Sanctions Guidance* (updated November 2019), for example, para 17. Available at: https://www.mpts-uk.org/-/media/mpts-documents/dc4198-sanctions-guidance-november-2019_pdf-80152538.pdf (accessed 24 January 2020).

86. *How Is Public Confidence Maintained When Fitness to Practise Decisions Are Made?* (Advice to the Secretary of State; Professional Standards Authority, 2019).

87. [2001] UKPC 41.

88. *Bijl v General Medical Council* [2001] UKPC 41.

public confidence in the profession . . . 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.⁸⁹

Lord Hoffmann went on to highlight a contemporary report which urged a rejection of blame culture and a plea that honest failures should not result in retribution and blame,⁹⁰ themes which are even more pressing today.⁹¹ It is therefore crucial to guard against public confidence rhetoric being used to satisfy perceived public appetite for retribution (particularly in cases where retributive criminal law sanctions have already been imposed),

Conclusion

It is not disputed that trust and confidence in our doctors are important. Clinicians who have put patients at risk and who are not open to learning from their mistakes should not remain in practice, but the precise relationship between the use of regulatory powers to maintain confidence and the statutory ‘public protection’ objective remains indistinct. Despite comments in the judgments about public confidence issues requiring ‘a fair impartial system’ and decision-making according to ‘settled legal principle’,⁹² it seems that at present, these assessments are currently made on an instinctual and largely unprincipled basis. The *Bawa-Garba* judgment did not break new ground by deferring to regulatory authority on matters of public confidence. Case law is saturated with statements affirming the general deference which courts should afford to MPTS decisions because of the expertise of panel members.⁹³ But in the authors’ view, the *Bawa-Garba* litigation has exposed a number of fundamental problems with public confidence rhetoric in professional regulation; a time-honoured lack of transparency twinned with reliance on instinctual judgement, concerns that without the benefit of research neither the courts nor the professional tribunal can credibly claim to have expertise in what the public thinks, and the fact that the basis and justifications for the courts’ heightened deference on these particular issues remains unclear. All of these factors signal that a

89. *Bijl v General Medical Council* [2001] UKPC 41at [13].

90. *A Commitment to Quality: A Quest for Excellence – Statement on Behalf of the Government, the Medical Profession and the NHS* (London: Department of Health, 2001).

91. J. Wise, ‘Survey of UK Doctors Highlights Blame Culture within the NHS’, k4001 *BMJ* (2018), p. 362 (referencing the *Caring Supporting Collaborative* (2018) report commissioned by the British Medical Association (BMA) and more recently, the widely acclaimed report commissioned by the General Medical Council by M. West and D. Coia, *Caring for Doctors, Caring for Patients* (London: General Medical Council, 2019), which emphasises throughout the need to shift the focus from blame to learning).

92. Both in *Bawa-Garba* [2018] EWHC 76 at [33].

93. For example, see *Council for the Regulation of Healthcare Professionals v General Medical Council and Southall* [2005] EWHC 579 (Admin) at [11], and *Khan v General Pharmaceutical Council* [2017] 1 WLR 169 at [36].

review of the mechanics of public confidence decision-making on the part of regulators is long overdue.

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