



# Healthy competition

Recent decisions on appeal from the General Medical Council perilously undermine the healthcare regulatory system, argues Nicholas Peacock

**HEALTHCARE REGULATORY TRIBUNALS ARE** on the cusp of non-compatibility with Article 6 of the European Convention on Human Rights, in particular the requirement for an independent and impartial tribunal.

The precariousness of their position is not helped by the recent judgments of the Court of Appeal in *GMC v Meadow* [2006] EWCA Civ 1390 and *GMC v Fatnani and Raschid* [2007] EWCA Civ 46.

### Panels heard by Privy Council

Until 1 April 2003 appeals from the General Medical Council's (GMC) disciplinary panels were heard by the Privy Council. The Privy Council had to consider the impact of the Human Rights Act 1998 on the appellate jurisdiction which it exercised. Article 6(1) of the European Convention on Human Rights guarantees that: "In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law."

In *Tehrani v UK Central Council for Nursing, Midwifery and Health Visiting* [2001] SLT 879, Court of Session, Lord Mackay of Drumadoon held that a right of appeal to a court of full jurisdiction prevented a breach of Article 6(1). However, the right of appeal had to be unrestricted, permitting a complete rehearing of the case.

The Privy Council soon had to deal with whether the GMC, which both prosecuted and adjudicated upon doctors, was Article 6 compliant. In *Ghosh v GMC* [2001] 1 WLR

1915, PC, Lord Millett stated: "The appeal is by way of rehearing in which the Board is fully entitled to substitute its own decision for that of the Committee. The fact that the appeal is on paper and that witnesses are not recalled makes it incumbent upon the appellant to demonstrate that some error has occurred in the proceedings before the Committee or in its decision, but this is true of most appellate processes."

Lord Millett also stated that the Board's powers: "Are not as limited as may be suggested by some of the observations which have been made in the past... For these reasons the Board will accord an appropriate measure of respect to the judgment of the Committee whether the practitioner's failings amount to serious professional misconduct and on the measures necessary to maintain professional standards and provide adequate protection to the public. But the Board will not defer to the Committee's judgment more than is warranted by the circumstance (emphasis added)." See also *Gupta v GMC* [2002] 1 WLR 1691, where the Privy Council had expressly set down at least a change of emphasis in its approach.

### Jurisdiction passed to High Court

Under section 40 the Medical Act 1983 as amended, jurisdiction passed to the High Court on 1 April 2003. Initial judicial consideration was given to the circumstances in which the High Court should intervene, in particular whether it had to be shown that the decision being appealed was "wrong" or "clearly wrong".

The Court of Appeal has now been given two opportunities to shed light on the High Court's approach. In *GMC v Meadow* [2006] EWCA Civ 1390 Auld LJ (with whom both other judges agreed on this point) analysed the section 40 jurisdiction at paragraphs 117 to 128. After (i) repeating that the courts will give due deference to the views of the tribunal below and (ii) clarifying that the correct test was simply whether the tribunal below was "wrong", without the need for any adverbial emphasis, Auld LJ tackled the wider nature of the jurisdiction and whether the appeal was a rehearing or a review.

### Lacking in clarity

The answer is disappointingly lacking in clarity. Auld LJ stated that the appeal is a rehearing. As we have seen above, it always was. However, Auld LJ then stated at paragraph 127 that for practical purposes there was little difference between a rehearing and a review anyway. His conclusion was: "It all depends on the nature of the disciplinary tribunal, the issues determined by it under challenge and the evidence upon which it relied in doing so, how the High Court should approach its task of deciding whether the decision of the tribunal was, as provided by Civil Procedure Rules (CPR) 52.3(a) "wrong", and, whether on the way to reaching such a conclusion, it draws, pursuant to CPR 52.4 "any inference of fact which it considers justified on the evidence".

The Court of Appeal's second examination of the appellate jurisdiction was in *GMC v Fatnani and Raschid* [2007] EWCA Civ 46.

Worryingly for those who represent doctors, this decision appears to be an attempt (and will no doubt be relied upon as such by those who represent the GMC in the higher courts on appeal) to give undue deference to the views of the original tribunal.

Laws LJ extracted two strands from the existing jurisprudence. The first was stated to be “the reputation or standing of the profession rather than the punishment of the doctor” (para 18). This will come as news to the GMC, which regards itself first and foremost as being concerned with the protection of members of the public and patients. Moreover, in selecting a passage in support which drew heavily on the observations of Sir Thomas Bingham MR in *Bolton v Law Society* [1994] 2 All ER 486, a case concerned with the regulation of solicitors, Laws LJ did not cite (if they were indeed mentioned to him in argument at all) the important observations of Collins J about the differences between doctors and lawyers in *CHRE v GMC & Southall* [2005] EWHC 579 (Admin) and *Giele v GMC* [2005] EWHC 2143 (Admin).

In the former case Collins J stated: “It follows that in my view testimonials can in the case of doctors be accorded greater weight than in the case of solicitors. The requirement of absolute honesty so that there can be absolute trust in a solicitor is obviously of paramount importance. That he may be a good solicitor is obviously something to be taken into account, but the public interest in him being able to continue to practise is not so important. Thus testimonials which establish that a doctor is, in the view of eminent colleagues and of nursing staff who have worked with him, one who is not only competent but whose loss to the profession and to his potential patients would be serious indeed can, in my opinion, be accorded substantial weight.”

Laws LJ’s second strand was stated to be “the need in consequence to give special place to the judgment of the specialist tribunal.”

It is a common misconception among those who do not practise regularly in disciplinary tribunals (but who may nonetheless represent such tribunals or adjudicate upon them on appeal) that the tribunals are manned by expert professionals, even by professionals in the area of specialism of the defendant. They are not. It appears to be GMC policy to try to include on a Fitness to Practise panel one professional from the defendant’s own area of specialism.

This apparent policy is not always put into practice. Universal, however, is the require-

ment for at least one lay member to be included on each panel. In practice there will usually be two lay members on a panel of four or five. Even the chair may be a lay member (a matter which at the Shipman Inquiry concerned Dame Janet Smith, who felt that the chair should be legally qualified). Regular practitioners will have experience of cases where the panel comprises a majority lay membership. It is fundamentally inappropriate to seek to label such tribunals as specialist or professional. In fact, the court is in no worse position than the lay membership of any panel to determine the issues involved; indeed, a judge of the High Court ought to be in a significantly better position.

No-one would support the right of murderous, sexually predatory or even downright incompetent doctors to practise their profession. The issue, however, is how allegations against those doctors are determined. Thus, no one would presumably dispute the right to an accused doctor to a fair hearing before an independent and impartial tribunal.

#### Disciplinary tribunals

Disciplinary tribunals are staffed by a mixture of professionals and lay members. Lay members often have similar positions on various different tribunals. Although described as “lay”, they often have a background within a specific interest group, such as patients’ rights groups. Panel members are “trained” by the same organisation which prosecutes and adjudicates (often by trainers who also prosecute). They constitute a panel drawn from appointees or delegates of the very same body which brings the prosecution and which devises and promulgates the guidance which forms the basis of the charge. They allow “sanction bids” from the prosecutor. Although tribunals have independent legal advice, the legal assessor’s views are not binding and are not uncommonly rejected.

## ‘The recent judgments of the Court of Appeal in *Meadow* and in *Fatnani* give no cause for optimism on the part of healthcare professionals and their representatives that the High Court will be prepared to offer any but a cursory reconsideration of the issues before the original tribunal’

There are legitimate concerns about the adjudicatory function of healthcare disciplinary tribunals as constituted. The sooner the adjudicatory function is hived off, the better. Those concerns are only magnified if the High Court appears to show itself to be unwilling to entertain appeals, or to whittle down the ambit of any such appeal until it is near defunct. Whereas courts were traditionally disinclined to allow appeals from disciplinary tribunals (the modern relic of that disinclination still exists in the “due deference” argument), the passing of the Human Rights Act 1998 allowed a welcome re-examination of the appellate jurisdiction.

#### No cause for optimism

The recent judgments of the Court of Appeal in *Meadow* and in *Fatnani* give no cause for optimism on the part of healthcare professionals and their representatives that the High Court will be prepared to offer any but a cursory reconsideration of the issues before the original tribunal.

This fear is best summarised by citing Laws LJ in *Fatnani*, who stated: “The approach [these strands] commend does not emasculate the High Court’s role in section 40 appeals: the High Court will correct material errors of fact and of course of law and it will exercise a judgment, though distinctly and firmly a secondary judgment, as to the application of the principles to the facts of the case.”

If this passage is used by prosecutors and Courts to narrow the ambit of what in law should be an untrammelled right of appeal by way of rehearing (albeit without oral evidence), then it is not only healthcare professionals who will lose out; the regulatory system generally will surely be the poorer.

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Nicholas Peacock is a barrister at Hailsham Chambers, 4 Paper Buildings, Temple, London. He specialises in healthcare regulatory law and regularly represents clients in healthcare regulatory tribunals