

MEDICAL PROTECTION SOCIETY

Evidence to the Professor Sir Norman Williams Review

Gross Negligence manslaughter in healthcare

Dr Robert A. Hendry
Medical Director

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contributors

Dr Pallavi Bradshaw
Dr Lucy Hanington
Thomas Reynolds (researcher)

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Dear Sir Norman,

The review you have been tasked with leading is of the utmost importance for the medical profession, patients and for all of us who have a stake in our NHS. The review is also timely, as is clear to see from the strength of feeling that has followed the GMC's successful appeal against Dr Hadiza Bawa-Garba at the High Court.¹

The Medical Protection Society (MPS) remains deeply disappointed by the High Court's ruling in January, and the decision to erase Dr Bawa-Garba from the medical register. As her medical defence organisation (MDO), we supported Dr Bawa-Garba for seven years, from the initial trial all the way to the High Court's latest ruling.

We have an unparalleled wealth of experience in supporting doctors faced with Gross Negligence manslaughter (GNM) charges. These cases are always a tragedy, as at the centre of each is a family mourning the loss of a loved one. However, the effect such investigations and charges have on the healthcare professionals involved cannot be over emphasised, and nor can the wider ramifications for the health service.

While the case of Dr Bawa-Garba raises specific issues – and specific questions – it also brings into sharp focus many of MPS's long held concerns about the application of the law on Gross Negligence manslaughter in a healthcare setting. It also highlights the worrying evolution of the GMC's powers under the Medical Act 1983.²

Cases such as Dr Bawa-Garba's also raise concerns about the continuing presence of a blame culture in our NHS. It highlights a system where the emphasis is too often on punishment and even criminalisation, while neglecting to nurture a system where mistakes – sadly sometimes catastrophic - can be learned from and avoided in the future. Patient safety suffers when healthcare professionals are not supported to learn from mistakes.

We believe the time has come for a multi-dimensional approach to tackle what is a growing concern – the criminalisation of doctors and the threat posed to an open, learning culture in healthcare.

In our submission to your review, we set out:

- ***Proposals to reform the law on Gross Negligence manslaughter in a healthcare setting, and move English law towards the Scottish position on culpable homicide***
- ***Proposals to reform the investigatory approach to healthcare professionals accused of Gross Negligence manslaughter***
- ***Measures to support a more open, transparent and learning environment in healthcare***
- ***Steps that should be taken to address the widespread concerns about the GMCs handling of such cases.***

¹ General Medical Council v Bawa-Garba [2018] EWHC 76 (Admin) (25 January 2018)

² Medical Act 1938. Part V. Section 40A (Appeals by the General Medical Council)

Our submissions to this review are wide-ranging. Some are focused on steps that can be taken in the short term, and others represent a more long term reform agenda. While some of our recommendations are bold, all of them are achievable with a collective will from those involved.

MPS is at your disposal throughout this review process, and we stand ready to provide any assistance you may require.

We all have a stake in getting this right. I encourage you to be bold in your recommendations to Government. I look forward to exploring the contents of the MPS submission with you in the person, in the near future.

With best wishes,

Yours sincerely,

A handwritten signature in blue ink, appearing to read 'Rob Hendry', with a stylized flourish at the end.

Dr Rob Hendry
Medical Director

SUMMARY: MPS RECOMMENDATIONS

SECTION ONE: Setting a more appropriate bar for criminal proceedings

[R1]

A requirement should be placed on the Director of Public Prosecution to personally authorise all prosecutions involving a healthcare professional accused of GNM. They should also be under a requirement to issue a public statement on why the public interest is being served by that prosecution.

[R2]

We strongly advocate that the English law on Gross Negligence manslaughter should be reformed, and moved towards the Scottish position and the legal test for culpable homicide. The UK Government should establish a judge led inquiry, co-chaired by a senior member of the English & Welsh judiciary and the Scottish judiciary; the inquiry should be tasked with assessing how a comparable offence of culpable homicide could replace GNM in England & Wales.

SECTION TWO: Improving investigations

[R3]

As a matter of policy, national guidelines should be created for investigating healthcare professionals suspected of GNM, and all such investigations should be carried out by a designated 'lead' police force. A specialist unit should be established within that 'lead' force, with an overarching objective to conduct investigations in a consistent and timely manner.

SECTION THREE: Protecting a learning culture

[R4]

Written reflections with the sole purpose of education and training should be given special, legally privileged status. This should include reflections in all education and training documents, such as e-portfolios and all annual appraisals, training forms and the Annual Review of Competence Progression - whether completed by a doctor or a consultant/supervisor.

[R5]

The recent amendment to Section 35 1A of the Medical Act 1983, which would enable the GMC to compel registrants to disclose information that could incriminate them (including personal reflection), should be repealed.

[R6]

To build a much needed 'safe space' for reporting and learning, the Government should accelerate the process of giving the Healthcare Safety Investigation Branch (HSIB) a statutory underpinning. The HSIB should give legal protection to individuals (and their comments) engaging with an investigation. This protection should prevent any of their disclosure from being passed to a third party – including the regulator, employers or the police.

[R7]

Medical schools should provide greater resource to educating students on reflection and anonymisation – to ensure they understand the purpose, logical thought processes and are armed with the tools they need for modern day clinical practice, which calls for reflection.

SECTION FOUR: Improving the approach of the General Medical Council

[R8]

Section 40A of the Medical Act 1983 should be repealed, and the GMC should lose its right to appeal decisions of the MPTS. This power should rest solely with the Professional Standards Authority (PSA).

[R9]

The GMC should not be granted presumption of erasure powers, to remove a registrant from the medical register following a criminal conviction. It should be for the MPTS to determine what sanction is appropriate. The Department of Health should confirm publically, as soon as possible, that the GMC will not be granted this power.

[R10]

The governments of the UK should review how the role and powers of the MPTS can be better defined in legislation. The question of how the MPTS can be given further operational independence from the GMC should also be explored as part of this process.

SECTION ONE: Setting a more appropriate bar for criminal proceedings

1. While 'medical manslaughter' is often cited in high profile cases, the term is legally no different to the offence of Gross Negligence manslaughter (GNM). The CPS defines medical manslaughter, parallel to GNM, as 'medically qualified individuals who are performing acts within the terms of their duty of care, when the act or omission occurs'³. When discussing charges of GNM in this submission – unless otherwise stated – we are referring to a case where the definition of 'medical manslaughter' would apply.

The law in England

2. In England, the legal position is that, where it is proved that a death occurs as a result of a grossly negligent (through an otherwise lawful) act, or omission, on the part of the defendant - the defendant is guilty of GNM.
3. The lead case law in respect of GNM is known as the Adomako Test⁴. The test is one of four stages, and was set out in the House of Lords judgment. The stages are:
 - a) *the existence of a duty of care to the deceased;*
 - b) *a breach of that duty of care which;*
 - c) *causes (or significantly contributes) to the death of the victim; and*
 - d) *the breach should be characterised as gross negligence, and therefore a crime.*
4. In the Adomako judgement, Lord Mackay makes reference to 'all the circumstances' as part of the legal test for GNM.⁵ Many legal commentators, and indeed legal counsel sought by MPS, suggest that this has introduced a fifth feature to the test; criminality or badness – which is almost an entirely subjective element.
5. A further crucial piece of case law in respect of healthcare professionals charged with GNM is *Misra*⁶. In the case of *Misra*, the court held that the conduct of the defendant in the course of performing professional obligations to their patient was 'truly exceptionally bad', and showed a high degree of indifference to an obvious and serious risk to the patient's life.⁷
6. In taking into account the Adomako Test and *Misra* – for a GNM conviction– the ordinary principles of the law of negligence apply. Namely; whether there has been a breach of a

³ CPS Legal Guidance; Homicide [Manslaughter]

Accessed here: <https://www.cps.gov.uk/legal-guidance/homicide-murder-and-manslaughter>

⁴ R v Adomako [1994] UKHL 6 (30 June 1994)

⁵ Ibid

⁶ R v Misra [2005]

⁷ Ibid

duty of care towards the victim; whether the breach caused the death; and the subjective test of whether the breach amounts to gross negligence.

7. A striking feature of the current legal position on GNM in England, is that neither 'disregard' nor 'recklessness' are required for a conviction. Over the past two decades, there have been cases of medical professionals and patient mortalities involving momentary – yet major – errors, with no evidence of either recklessness or disregard on the part of the doctor, but still resulting in conviction. A notable case was that of a Norwich doctor in August 1998, who attended an out-of-hours call at a patient's home; the patient was complaining of severe lower back pain, which the doctor diagnosed as renal colic from a kidney stone. The doctor then prescribed a miscalculated dose of diamorphine, along with a dose of an anti-inflammatory drug. He administered both to the patient, and within one and half hours, the patient had died. The doctor was subsequently tried, found guilty, and convicted of GNM.⁸

MPS position

8. We believe that the current legal bar for convicting healthcare professionals of manslaughter is too low. This is resulting in good doctors being charged and criminalised for momentary errors. Everyone loses in such cases. A family has lost a loved one; a doctor risks losing their career and liberty; our NHS, already under considerable pressure, potentially loses a valuable doctor as well as suffering the untold damage to an open, learning culture.

The law in Scotland

9. The law underpinning GNM in England has evolved very differently to the nearest comparable offence under Scottish law: culpable homicide. Manslaughter is not a term that features in Scottish law.
10. Under Scottish law, culpable homicide is the killing of a person in circumstances which are neither accidental nor justified, but where the wicked intent to kill or wicked recklessness (required for murder) is absent. The tests for distinguishing both murder and culpable homicide are objective.
11. The offence of culpable homicide is the killing of a human being in all circumstances – short of murder. This is where the criminal law attaches a relevant measure of blame to the person who commits the killing. Simply put; *person A* can commit the offence if there has been a death (a homicide) and *person A* is to blame (they are culpable). Hence the offence of culpable homicide, whereby someone's death has been caused by an unlawful act which is culpable or blameworthy.

⁸ R v. Becker (2000) WL 877688

12. Culpable homicide is the killing of an individual where the accused did not have the 'wicked' intention to kill, and did not act with such a wicked recklessness as to make the culprit guilty of murder.
13. A crucial feature of the offence of culpable homicide is that the unlawful act must be intentional, or at least reckless and/or grossly careless.
14. In Scottish law, recklessness or gross carelessness are defined as taking action in the face of obvious risks which either were, or should have been, appreciated and guarded against. The definition also extends to the aforementioned, whereby the accused acted in such a way as to show a complete disregard for any of the potential dangers that may arise. Whether or not death was foreseeable is immaterial.
15. In summary, for the prosecution to prove a charge of culpable homicide, the following points must be satisfied:
 - a) *the accused committed an unlawful act;*
 - b) *the act must have been intentional, or reckless, or grossly careless;*
 - c) *the death was a direct result of the unlawful act (the causal chain must not be interrupted by an intervening act that resulted in death).*
16. A salient point from the legal approach in Scotland is that the Procurator Fiscal must act in the public interest when making a decision to prosecute a charge of culpable homicide. Crucially, the prosecution of any medical practitioner for culpable homicide must be authorised by the Lord Advocate personally before they can proceed.

MPS position

17. There is considerable public interest in the maintenance of a safety culture in medicine. We believe it is not in the public interest to discourage doctors from discharging the myriad of duties they have in respect of patient care, in the fear of prosecution. The entire workforce involved in patient care must not be afraid of being candid about errors. This is vital for patient safety.
18. Legal counsel in Scotland informs us that the Crown have actively considered culpable homicide cases involving doctors and patient mortalities, however they have only proceeded to prosecute one single case – and this resulted in acquittal. This is striking when compared to the experience in England.
19. We consider both the law and its application in Scotland, to be more robust and better suited to determining the culpability of doctors in the event of patient death, than the law and its application in England.

20. The public, and the profession itself, would always expect that the most reckless and severe cases be prosecuted. We fully endorse this position.

MPS Recommendations

21. We are calling on the Government to explore bold options for law reform in respect of GNM in a healthcare setting.

22. Recent opportunities to reform the law surrounding ‘medical manslaughter’ in England have not been seized. The Coroners and Justice Act 2009 - the most recent review of the law – left the law on GNM unchanged.⁹ In 2006, the Law Commission of England and Wales reported on their review programme of the law on homicide.¹⁰ This followed a public consultation a year earlier on updating the Homicide Act 1957.¹¹ This review recommended no changes to the law on GNM.

[R1]

A requirement should be placed on the Director of Public Prosecution to personally authorise all prosecutions involving a healthcare professional accused of GNM. They should also be under a requirement to issue a public statement on why the public interest is being served by that prosecution.

[R2]

We strongly advocate that the English law on Gross Negligence manslaughter should be reformed, and moved towards the Scottish position and the legal test for culpable homicide. The UK Government should establish a judge led inquiry, co-chaired by a senior member of the English & Welsh judiciary and the Scottish judiciary; the inquiry should be tasked with assessing how a comparable offence of culpable homicide could replace GNM in England & Wales.

⁹ Coroners and Justice Act 2009

¹⁰ The Law Commission (LAW COM No 304). Murder, Manslaughter and Infanticide. *Project 6 of the Ninth Programme of Law Reform: Homicide.* (Order by the House of Commons to be printed – 26th November 2006)

¹¹ The Law Commission of England & Wales. A New Homicide Act for England and Wales? *Consultation Paper No 177.* (2005)

SECTION TWO: Improving investigations

Investigations by the police

23. We have an unparalleled wealth of experience in supporting doctors faced with an investigation into suspected GNM. The exact number of police investigations in this area is unknown, and we can only comment on the basis of the investigations in which MPS has had an involvement.
24. From those investigations, we can confidently say that there is an alarming lack of awareness of the specialist issues at play when investigating a death in a medical setting. There is also a glaring lack of consistency across the country in how such investigations are pursued and managed.
25. We make no criticism of police forces – either individually or collectively - as this lack of expertise and experience in ‘medical manslaughter’ is entirely understandable. When compared to the vast majority of crimes, GNM is comparatively rare and a unique occurrence for investigation by many police forces. Of the 43 police forces across England and Wales, each may only deal with a single GNM investigation every few years. Yet looking at it from a different perspective, this hypothesis would still suggest almost two dozen doctors could expect to face investigation every year.
26. We cannot overstate how much of an impact being under investigation for GNM can have on a doctor. The threat of a lost career, and lost liberty, can hang over a person for years. From our own cases, we have seen doctors be on bail for over two years from the time of their first police interview, to a charging decision being made. Such timescales are not untypical. They can be devastating for the doctor and their family.

MPS Recommendations

27. In our meetings with various police bodies, there has been a ready recognition on their part that individual forces’ to do not possess the requisite experience and expertise of ‘medical manslaughter’ to achieve a consistent, specialist investigation. We believe there would be a broad consensus around centralising these investigations into a single body.

[R3]

As a matter of policy, national guidelines should be created for investigating healthcare professionals suspected of GNM, and all such investigations should be carried out by a designated ‘lead’ police force. A specialist unit should be established within that ‘lead’ force, with an overarching objective to conduct investigations in a consistent and timely manner.

SECTION THREE: Protecting a learning culture

Reflections

28. Learning from mistakes and recognising how to do things better is human nature and occurs both in our personal and professional lives. In its widest sense doctors are constantly reflecting through audits, de-briefs, teaching and evidence driven practice. Without it medicine could not advance and improvements in patient safety would be hindered. It is the formalisation of this process in modern healthcare which is now under scrutiny.
29. When errors – sometimes fatal errors – are made in the NHS, Significant Event Analyses and inquisitorial processes facilitate learning and improvement across the healthcare landscape. The effectiveness of these processes rely absolutely on the healthcare professionals' trusting that they can be open with the process, especially when something has gone seriously wrong in the provision of patient care.
30. Many factors weigh upon the doctor when engaging with these processes. As well as the personal and professional desire to identify learnings, there are regulatory, legal, contractual, professional and ethical considerations– many of which interconnect, but many of which have a tension between them and the human instincts of self-preservation.
31. For instance, in England, healthcare organisations are under a statutory duty of candour, and all doctors are under a professional duty.¹² The GMC also recently acquired a power that would enable them to compel doctors to disclose information that could incriminate them, including written reflections¹³. While it is welcome that the GMC has stressed that it does not demand to see personal reflections as part of Fitness to Practise (FtP) cases, the fact remains they have power to do so. The GMC's policy could change at any point.
32. There is an understandable sense of fear on the part of many in the profession, that by fulfilling their obligations and professional desire to be reflective following adverse events, they can incriminate themselves to such a degree as to leave themselves open to potential suspension or erasure from the medical register – or even criminal prosecution.
33. It is vital that doctors reflect during all stages of their career; from medical school and beyond. However, for this to have meaning and for the NHS to truly have a culture of openness, where lessons are learned and patient safety constantly improved, a 'safe space' is needed to discuss errors openly.

¹² 'Duty of candour.' Health and Social Care Act 2008 (Regulated Activities). Regulations 2014: *Regulation 20*

¹³ Medical Act 1983. Part V. Section 40A (General Council's power to require disclosure of information)

34. While affording legal privilege to all processes requiring reflection would undermine its fundamental purpose – as all doctors are accountable for their actions - there are certain situations where providing a truly confidential environment is in the public interest.
35. The recently created Healthcare Safety Investigation Branch (HSIB) began its first investigations in April 2017. Its stated focus is on learning and improvement – sharing information across the healthcare system to the benefit of patients and doctors.

MPS Position

36. Steps must be taken to support and reassure doctors who are feeling vulnerable in the present climate. The level of concern in the profession should not be underestimated. We recognise the concern, and we are calling upon government, employers and regulators to play their part in addressing it.
37. The law must be compatible with the environment in which doctors' practise. For organisations like the HSIB to be effective, clear legal protections are needed to create a 'safe space'.

MPS Recommendations

38. Action is needed to further support openness and learning, and give doctors confidence in the process. Some of these actions can be taken relatively swiftly; others will require change over a longer period of time.

[R4]

Written reflections with the sole purpose of education and training should be given special, legally privileged status. This should include reflections in all education and training documents, such as e-portfolios and all annual appraisals, training forms and the Annual Review of Competence Progression - whether completed by a doctor or a consultant/supervisor.

[R5]

The recent amendment to Section 35 1A of the Medical Act 1983, which would enable the GMC to compel registrants to disclose information that could incriminate them (including personal reflection), should be repealed.

[R6]

To build a much needed 'safe space' for reporting and learning, the Government should accelerate the process of giving the Healthcare Safety Investigation Branch (HSIB) a statutory underpinning. The HSIB should give legal protection to individuals (and their comments) engaging with an investigation. This protection should prevent any of their disclosure from being passed to a third party – including the regulator, employers or the police.

[R7]

Medical schools should provide greater resource to educating students on reflection and anonymisation – to ensure they understand the purpose, logical thought processes and are armed with the tools they need for modern day clinical practice, which calls for reflection.

SECTION FOUR: Improving the approach of the General Medical Council

The GMC and Dr Bawa-Garba

39. On 13 June 2017, a tribunal of the Medical Practitioners Tribunal Service (MPTS) determined that Dr Hadiza Bawa-Garba should be suspended from medical practice for a period of 12 months.¹⁴ In its determination, the tribunal stated that it was of the view that *“a fully informed member of the public would view suspension as an appropriate sanction, given all the circumstances of your case.”*¹⁵ It went on to say that it was *“satisfied that the goal of maintaining public confidence in the profession would be satisfied by the suspension of your registration.”*¹⁶

40. This review is largely the result of the action the GMC then took.

41. On the 7 December 2017, the GMC used its power to bring an appeal before the High Court, seeking to overturn the tribunal's decision not to erase Dr Bawa-Garba from the medical register.¹⁷ It argued that the tribunal had gone behind Dr Bawa-Garba's conviction for Gross Negligence manslaughter when it took the decision not to erase her from the medical register, due to concerns over her perceived failings in the care of Jack Adcock. The GMC argued that her erasure was necessary to maintain public confidence in the medical profession.

¹⁴ MPTS determination – Dr Bawa-Garba [GMC Ref No. 6080659]. (13 June 2017)

¹⁵ Ibid p.31

¹⁶ Ibid p.31

¹⁷ Medical Act 1983. Part V 40A . (Appeals by the General Medical Council)

42. In the judgment of the court, Mr Justice Ouseley, with whom Lord Justice Gross agreed, the tribunal had gone behind Dr Bawa-Garba's conviction when it made its determination.¹⁸ The court ruled in favour of the GMC, and ordered that Dr Bawa-Garba be struck off the medical register. The judgement cited an earlier court judgement of Sir Thomas Bingham in the case of *Bolton v Law Society*; there it was held:

*"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."*¹⁹

MPS Position

43. We vehemently disagreed with the GMC's decision to appeal the tribunal's determination in Dr Bawa-Garba's case. We instructed eminent legal counsel, including Queens Counsel, and stood by Dr Bawa-Garba's side throughout the GMC's appeal to the High Court – as we had throughout this tragic case.

44. The unprecedented level of debate around this case demonstrates how widespread the concern is about the GMC's actions. There is also justifiable concern about the evolving body of case law, and the growing sense that the deck is being stacked against the doctor in favour of a regulator that is attaining ever greater power.

The GMC's decision to appeal

45. The GMC has said that it had no choice but to make this appeal. The Professional Standards Authority (PSA), which oversees the performance of the GMC and also has its own right of appeal against MPTS decisions, takes a different view.

46. Under a Freedom of Information (Fol) request by the Health Service Journal (HSJ), the PSA released its own legal assessment of the GMC's decision to appeal against Dr Bawa-Garba.²⁰

47. It must be noted that the PSA also has the power to appeal a determination of the MPTS.²¹

48. In the PSA documents released under the Fol request, the PSA concluded that the GMC's argument as to why it had to appeal the case was incorrect, and that it "appeared without merit given the established case law."²² The PSA's legal opinion went on to state

¹⁸ *General Medical Council v Bawa-Garba* [2018] EWHC 76 (Admin) (25 January 2018)

¹⁹ *Bolton v Law Society* [1994] 1 WLR 512, 517-519

²⁰ "Doubts over GMC's handling of manslaughter case revealed", *Health Service Journal* (19/02/18).

²¹ Medical Act 1983. Part V 40B. (Appeal under section 40A: Role of Professional Standards Authority for Health and Social Care)

²² Appendix 2.0

that; “it appears that the GMC is seeking to create a line of case law which establishes a distinction in how the courts approach appeals by a regulator and a registrant.”²³

MPS Position

49. We have long been concerned about both the GMC and the PSA having the same right of appeal against an MPTS determination. In our evidence submission to the PSA’s latest performance review of the GMC, we stated that:

“MPS shares the PSA’s ongoing concern about the relatively recently acquired power of the GMC to appeal against decisions of the MPTS. We have long been opposed to the GMC having this power. The PSA already has the power of appeal, and we agree with PSA’s view that this situation is adding complexity and increasing costs to proceedings. More concerning for MPS, it prolongs the uncertainty for the doctor at the centre of the case – and with that can come a whole host of health problems. The GMC should lose its power to appeal MPTS decisions during any forthcoming programme of regulatory reform.”²⁴

50. In light of recent events, we believe there is an even greater sense of urgency to review the anomaly of both the GMC and PSA having the same right of appeal. This is a situation that only applies only to registrants of the GMC, as no other healthcare professional regulator has this power.

51. Given the PSA’s own assessment of the GMC’s decision to appeal the case of Dr Bawa-Garba, there is justifiable concern about the GMC’s proposal that there should be a presumption of erasure for ‘serious crimes’. They consulted on these proposals in 2011 and recently called on the Government to give them this power in their submission to the Department of Health consultation on reforming professional regulation. The argument being that some crimes are so serious that surely any doctor convicted of them should be struck off without having to a hold hearing to reach this determination.

52. We have responded to the Department of Health consultation to say that we are firmly opposed to this proposal. The Courts serve a different purpose to the MPTS. The Courts dispense justice, including punishment. The MPTS’ role is to assess the doctor’s fitness to practise and if needed issue a sanction in order to protect the public and/or the reputation of the profession. We believe the MPTS rather than the Court is best placed to make decisions about a doctor’s fitness to practise.

²³ Ibid 39a

²⁴ Appendix 3.0

The role of the MPTS

53. The MPTS is the adjudicator of all fitness to practise proceedings brought by the GMC against a registrant. It is the body responsible for 'making independent decisions about a doctor's fitness to practise, measured against professional standards set by the General Medical Council'.²⁵
54. When carrying out its function, the MPTS has to adhere to the objectives provided to the GMC through the Medical Act 1983:
- (a) to protect, promote and maintain the health, safety and well-being of the public,*
 - (b) to promote and maintain public confidence in the medical profession, and*
 - (c) to promote and maintain proper professional standards and conduct for members of that profession.*
55. In coming to a decision on sanction, it is necessary for the Tribunal to make a judgement taking into account what is sufficient for the protection of the public. Panel members have training and expertise appropriate to their role. The Tribunal has the facility to consider a much broader range of evidence than the Court, and take full account of all the circumstances of a case. This includes information relevant to systems failures, patient safety and the capacity to remediate. This is why the Tribunal, and not the Court, is best placed to make decisions in matters relating to impairment and fitness to practise.

MPS Position

56. It is for the Criminal Courts to determine a defendant's guilt or innocence. It is for the Criminal Courts' to determine a sentence, and to punish the convicted. It is not – nor should it be – for the GMC or MPTS to punish a doctor. It is the role of the GMC and MPTS to protect the public, which it does by considering whether a doctor is fit and safe to practise and where necessary, issuing sanctions that are sufficient for the protection of the public.
57. We are concerned that the direction of travel, both in terms of the approach of the GMC and the evolving case law, suggests we are moving towards a presumption of erasure for doctors convicted of crimes such as GNM.
58. GNM convictions do not in themselves demonstrate whether systems failures and misfortune played a role or whether or not the doctor has shown they are capable of remediation.

²⁵ The Medical Practitioners Tribunal Service.
Accessed here: <https://www.mpts-uk.org/about/1595.asp>

