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Article (Accepted Version)

Davies, Mark (2014) The future of medical self-regulation in the United Kingdom – renegotiating the state–profession bargain? *Medical Law International*, 14 (4). pp. 236-265. ISSN 0968-5332

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Pre-publication version – some errors may remain

THE FUTURE OF MEDICAL SELF- REGULATION IN THE UNITED KINGDOM – RENEGOTIATING THE STATE-PROFESSION BARGAIN?

Mark Davies¹

I. INTRODUCTION

The Law Commission recently published its report, *Regulation of Health Care Professionals Regulation of Social Care Professionals in England*.² This provides a timely reminder that medical regulation remains potentially problematic and contentious. In this article I consider the prospective future of medical regulation through the lens of its starting point – a notional state-profession bargain – and whether the Law Commission report implicitly proposes a significant renegotiation of that bargain over a century and a half after its inception.

A number of sociological considerations of the nature of professions have identified a hypothetical bargain, a notional contract, between the state and newly emerging professions such as medicine and law. The mid-nineteenth century was a particularly active time in this respect. These emerging professions attained significant elements of monopoly power in return for agreeing, inter alia, to ensure that practitioners were appropriately trained and

regulated.³ As Giaimo observes, the state granted functional associations a significant degree of autonomy to pursue their collective self-interest and attain public status, in return for serving the broader interests of public policy.⁴

The nineteenth century state therefore saw the important social function of providing medical services brought under what was intended to be a clearly defined and robust regulatory regime, whilst the medical practitioners received opportunities to earn a good living and achieve high social status in a monopoly environment.

It has been recognised that the state-profession bargain should be adapted to changing social circumstances.⁵ The state retains the power to monitor professions, underpinned by the threat of intervention if professional bodies fail to rise appropriately to the challenges of effective professional control. In principle, the threat of intervention should ensure that professional bodies retain sufficiently tight control over their members.⁶ However, the history of medical regulation has conspicuously failed to live up to this expectation in a number of respects. As Irvine observed, even though the privileges delegated by the state have always notionally been subject to medical practitioners keeping to their side of the bargain, some have treated 'self-regulation as a right to do pretty much as they please, especially in clinical practice.'⁷ In the post-1948 environment of near monopoly National Health Service (NHS) provision the implications of this attitude took on greater significance. Since the creation of the NHS, most medical practitioners have worked in environments free from genuine market competition. Therefore, any threat by the state to withdraw monopoly status from medical practitioners lacks credibility unless accompanied by proposals to reform the NHS in a manner which removes doctors from their dominant position at its heart.⁸

In the first part of this article I set the scene by considering briefly the history of the state-medical profession bargain. This is a topic widely written about in sociological academic literature, but may be less familiar to some lawyer readers. I then consider the core elements of my arguments – whether revalidation represents a significant renegotiation of the state-profession bargain and whether the Law Commission proposals, if adopted, would move the balance of the bargain even further away from the medical profession.

II. BACKGROUND TO THE CREATION OF THE STATE-MEDICAL PROFESSION BARGAIN

Whilst some organization of medical occupations existed prior to the creation of the General Medical Council(GMC) in the mid-nineteenth century,⁹ Irvine identifies the pre-GMC environment as consisting of an oversupply of ‘all kinds of “healers”...[competing] vigorously for patients, status and legitimacy.’¹⁰ ‘Unqualified’ and ‘fringe’ providers of medical services in the eighteenth and nineteenth centuries posed an economic threat to those who considered themselves to be more orthodox practitioners, and this played an important part in the professionalization debate.¹¹ Writing about Georgian England,¹² Porter identifies the London medical scene as categorized by a ‘three-tiered hierarchy’ consisting of the College of Physicians, the Incorporation of Surgeons and the Apothecaries’ Company. Beneath these tiers lay ‘an enormous range of other groups’ providing medical services – ‘wise-women, midwives, nurses, Lady Bountifuls, horse-doctors, chemists, grocers, itinerant pedlars – a list constituting a perennial penumbra of respectable and tolerated irregular.’¹³

It has been argued that the more scientifically focused amongst these competing groupings led the drive for a more controlled practice environment, to better guarantee a return on their

educational investment.¹⁴ This corresponded with the development of an eighteenth and nineteenth century environment which Porter describes as ‘an age of golden opportunity for cultivating the business side of medicine.’¹⁵ A consumer society had emerged in this period and brand identity begun to develop.¹⁶ In this regard, the moves which led to the formal professionalization of medicine and the creation of the GMC may be seen in part as a money driven branding exercise. This state and societal establishment position corresponds with the history as described by Moran, who categorizes medicine as an ancient profession which traditionally focused on the social rather than technical aspects of service provision. Unlike some other emergent nineteenth century professions, which were genuinely novel responses to the needs of a newly industrialised economy, medicine utilized the market opportunities which industrialisation offered. The Medical Act 1858, discussed below, therefore facilitated the move towards ‘new markets in medical consumption, and the new technologies of medical care, created by industrialism.’¹⁷

The outcome of the motivating factors discussed above – whether a cynical branding exercise or a more benign move intended to bring order to the relative occupational chaos, or elements of both – was the Medical Act 1858, which created the ‘General Council of Medical Education and Registration’.¹⁸ The result was the distinguishing of qualified from unqualified practitioners by controlling who was permitted to be included in the newly created ‘medical register’.¹⁹ In terms of the order in which developments occurred, the 1858 Act is often credited with creating the modern medical profession. However, it has also been argued that that the medical profession was a cause, not a result, of the Act – the profession having largely created itself and then persuaded the state to recognize this construction. Whatever the actual cause-and-effect position, the legislation cemented the relationship between the medical profession and the state.²⁰

Whilst there may have been an intended self-serving element to the 1858 Act, its immediate practical effect did not meet the expectations of at least some members of the emergent profession. Weatherall, for example, cites some contemporary observers as describing the legislation as an 'utterly futile and unremunerative' failure.²¹ The Act had not outlawed the provision of medical services by unregistered practitioners - alternative approaches such as 'homoeopathy, mesmerism, spiritualism or botanic medicine' remained lawful. Furthermore, the first medical register of 1860 included, in the view of some practitioners, examples of those they considered to be 'quacks' – damaging the profitability of orthodox practitioners and causing resentment that they had paid for membership of the newly created profession yet were not enjoying the expected financial returns.²² This insecurity, it is further suggested, accounted for the importance subsequently placed on maintaining supportive relationships and 'quiescence' within the orthodox profession,²³ and collegial governance favoured over a hierarchical approach.²⁴ The President of the GMC in 1889 is quoted as expressing concerns that the Council should not be overanxious to identify and make public the shortcomings of 'our honourable profession'.²⁵ Echoes of this approach remained over a century later, when Stacey observed that the GMC retained the image of a 'gentlemen's club', more interested in maintain good relations between members than with protecting the public.²⁶

Notwithstanding the shaky start, it has been argued that the 1858 Act was the beginning of a century long run during which time the medical profession 'reached the zenith of its independent power and public standing.'²⁷ The position as it developed, particularly in the period after the creation of the NHS in the late 1940s, has been described as an 'implicit concordat' between the state and the medical profession which permitted the latter to treat patients in the manner they chose, as long as budgetary restraint determined by the state we

adhered to. The price of this clinical autonomy was rationing by the medical profession of limited state resources, disguising this reality from the public behind the curtain of clinical decision making.²⁸ Even from within the medical profession it was acknowledged that the profession was complicit in rationing healthcare provision behind the cloak of clinical need. At least in the early days of the NHS, this weakened the hand of government.²⁹ Overall, this approach saw the state ‘cede enormous powers’ to the medical profession, in particular to hospital consultants, who have been described as running their departments ‘like fiefdoms’.³⁰

In such an environment the profession’s interpretation of acceptable behaviour and the associated regulatory approach held significant sway. The state largely adopted a hands-off approach, with no meaningful consideration of intervening in the medical regulatory system until the Merrison Committee in 1972.³¹ Even that led to little effective change. As Irvine put it:

‘The stark reality is that from the beginning in 1858 right up to the early 1990s statutory self-regulation as operated by the GMC failed the public and conscientious doctors. [The overall effect of which was] an alarming lack of a sense of collective responsibility at the level of institutional leadership in the profession to make self-regulation work properly for patients.’³²

Arguably, the GMC spent too much of its history seeking to maintain the confidence of the profession, at some expense of protecting the public.³³ On the few occasions in its history when the GMC has risen to the challenge of fearlessly regulating in the public interest, a notable example being the response, albeit rather late, to the events at the Bristol Royal Infirmary, it has been argued that this has been precipitated by expediency, not principle.³⁴

Whilst the discussion above tends to amalgamate the GMC and medical profession as a collective whole, there is some evidence that failures cannot always be attributed to the GMC – rather, the profession itself has lacked commitment to supporting the GMC in its role within the state-profession bargain.³⁵ For example, in 1975 the British Medical Association and the Royal Colleges instituted an Enquiry into doctors' continuing competence to practice.³⁶ It is of note that these senior representative professional bodies appear not to have invited the GMC to participate, a notable omission given the GMC's statutory duty to protect the public.³⁷ Whether due to the GMC's absence or otherwise, the Enquiry failed to reach a clear conclusion. In light of this, Irvine argues that self-interest proved more tempting to representatives of the profession than did any desire to maximise the chances of increasing the effectiveness of medical self-regulation.³⁸

III. ARGUMENTS FAVOURING A NEW STATE-MEDICAL PROFESSION BARGAIN

As discussed above, the medical profession has far from showered itself with glory with its operation of self-regulatory mechanisms since the creation of the General Council of Medical Education and Registration in 1858. When faced with external challenges the medical profession has proven adept at temporarily setting aside internal rivalries and differences to fend these off.³⁹ This history may be used to argue for the removal of the regulatory privileges entirely from the profession and returning these to the state, either directly or through the empowerment of a meta-regulator. This would correspond with the rise in recent years of meta-regulatory agencies in other professional spheres, accompanied by a 'thickening at the centre' with the role of the executive in monitoring and directing the

activities of professional and other regulation increasing.⁴⁰ However, one of the key motivators for the granting of self-regulatory responsibilities to professions – that they are best placed to engage with the complexity of professional knowledge and environments - remains pertinent.⁴¹ Perhaps even more pertinent than the position a century and a half ago when the GMC was first created. Today, the overall societal legal framework is far more complex and the scientific and technical complexity of medical practice far greater. The task faced by the state to regulate medical practitioners directly would be more challenging than ever.

It can be argued that simply recreating the state-profession bargain, moderately modified to bring it up to date, would hardly be worth the effort. Rather, if the process is to be worthwhile the bargain should seek to ensure a new model of doctor. Financial reward as a key motivator has the potential to undermine public faith in a remodelled bargain. For example, recent years have witnessed general practitioners collectively negotiating terms with the state which saw significant pay increases coupled with reduced working hours and, for many, an opt out from out-of-hours care. Subsequent reports suggest that some patients have experienced longer waits to see their GP and unsatisfactory out-of-hours provision.⁴² Similarly, consultants seeking to significantly reduce out of hours and weekend working have, it has been argued from some quarters, shown little of the compassion traditionally associated with the ideal model doctor. For example, it was reported in 2012 that at the British Medical Association's annual consultants' conference attendees rejected calls to ensure that sufficient numbers of senior doctors were available during evenings and at weekends, some complaining that such a move equated to them being 'rostered like their juniors'. The consultants are reported to have acknowledged the importance of consultant led care to reducing mortality rates, but rejected the motion largely on the basis that pay levels were 'not enough'. The 2003 consultant

contract had made weekend work and work after 7pm optional for hospital consultants.⁴³ Money, it seems, for some in the medical profession may have overridden concerns for patient care, despite evidence from both the UK and abroad that patients admitted to hospital at weekends were more likely to die than those admitted during the week.⁴⁴ Organisation for Economic Co-operation and Development statistics indicate that UK doctors are amongst the most highly paid in the industrialized world, a position further enhanced by the fact that within the monopoly environment of the NHS, pay for the vast majority of doctors comes from the public purse in an environment with no meaningful market risk. OECD figures also indicate comparatively lower spending on modern life saving equipment and a lower ratio of doctors per thousand of the population in the UK. Both latter factors potentially exacerbated by the proportion of the NHS budget spent on doctors' wages. The generous pay for UK doctors has not prevented the UK being one amongst developed countries with the highest rates of avoidable deaths.⁴⁵ Whilst there is no clear correlation between these various statistics, they do support the argument that doctors in the UK have manoeuvred themselves into an advantageous financial position, free of market pressures encountered by many other professional groups in the UK and some doctors in other industrialized nations, yet this has not been accompanied by a particularly impressive comparative picture in terms of the overall quality of medical care. The state-profession bargain, it seems, has been and remains significantly skewed in favour of the medical profession.

IV. REVALIDATION AS AN EXAMPLE OF RENEGOTIATING THE BARGAIN?

In the last decade or so there have been a few examples of state intervention into the medical regulatory process which could be seen as partial renegotiation of the state-profession bargain. Enforced changes to remove the power of doctors to elect members of the GMC and

constitutional changes to ensure a non-medical majority, following recommendations by the *Shipman Inquiry*, are notable examples.⁴⁶ However, the most significant has related to the debate and provisions regarding revalidation and the pressure this has placed on the extent of trust between state and profession.⁴⁷ In this section I consider whether or not renegotiation of the bargain is an accurate categorization of these developments.

Discussion of revalidation can be dated back a number of decades⁴⁸ but serious consideration arose when the GMC was empowered to introduce revalidation from 2002.⁴⁹ The core idea behind revalidation is that doctors would no longer normally be registered for life. This represents a move away from the traditional approach by the GMC - described as being to 'drum convicted sinners out of the profession, not to ensure continued professional virtue'.⁵⁰ Irvine argued that the GMC recognised that at the time politicians 'were ready to pick a fight with the medical profession' after the Bristol and other scandals and that the GMC needed to be seen to be proactive.⁵¹

The underpinning principle of revalidation is that by having to establish their fitness to practise on a periodic basis, members of the medical profession would work harder to retain the privileges of their professional status. The desired result would be an increase in the quality of medical care and better protection for the public against rogue or otherwise unfit practitioners.⁵²

From this perspective, 'revalidation should be a new beginning [which allows] the medical profession to review its culture...' ⁵³ and represented the change from 'management by exception', which had been the position since the GMC's inception, by ensuring that all practitioners would periodically be confirmed as fit to practise.⁵⁴ One early issue with this

view of revalidation is that the GMC were simultaneously facing in two potentially contradictory directions. On the one hand they sought to emphasise to government and the public that revalidation was a response to past crises, to minimise the risk of any likely repetition of the various scandals which had emerged from within medical practice. By requiring individual practitioners to account for their continued suitability, the Medical Register would once again satisfy its intended purpose – to ensure that the public can have confidence that all doctors are competent, adhere to high ethical standards and can be trusted with their patients' lives and wellbeing.⁵⁵ On the other hand, the GMC was careful to reassure doctors that revalidation would be light-touch and that individual practitioners should have nothing to fear. For this audience, the focus was on doctors being encouraged to see revalidation as a positive opportunity for them to reflect on their practice.⁵⁶ Such reassurances appear not to have been wholly persuasive – with significant opposition coming from those members of the GMC elected by the profession, from representatives on the BMA Council,⁵⁷ as well as from individual practitioners.⁵⁸ It is telling that some commentators from within the profession were critical of revalidation in principle without, apparently, acknowledging just how shocking the events at Bristol, the activities of Harold Shipman and certain other cases were and their potential effect of undermining trust in the medical profession. For example, as van Zwanenberg states:

‘In just over a decade, the NHS has moved from being an organisation based on high trust relationships to one where explicit written down standards, which are monitored, have become the norm for individuals and institutions. Revalidation is part of this increased bureaucratic control being applied to professional self regulation. It may increase apparent accountability, but may not foster a culture which increases patients' trust and doctors' professionalism.’⁵⁹

From 2000 to 2003 the first set of proposals from the GMC would have created a revalidation process which was described by the Shipman Inquiry as ‘manifestly designed to protect patients.’⁶⁰ It would have required all registered doctors to produce a detailed revalidation folder – including information about critical incidents and patient complaints.⁶¹ These folders would have formed the basis of five-yearly revalidation process by a ‘revalidation group’, reporting to the GMC.⁶² This folder based approach was not free from flaws – for example it was unclear what, if any, security mechanisms would have been put in place to ensure that doctors moving between employers did not remove unfavourable information. It was also questionable whether the resources to be made available for revalidation would have been sufficient to ensure that sufficient revalidation group members were recruited and trained to allow enough time to be spent scrutinising each folder.⁶³ Standards against which doctors were to be measured were also relatively ambiguous – an approach fostered during the bargaining process by those seeking to protect professional interests. Notwithstanding such criticisms, this initial model for revalidation remains the most comprehensive of the variants mooted. Subsequently, the GMC retreated from this model, influenced in part, it was argued, by powerful opposing medical interest groups,⁶⁴ and in so doing ‘lost sight of their aspirational proposals’.⁶⁵ The model of revalidation moved towards significant reliance on existing employment related appraisal processes, with the idea of revalidation panels being abandoned and most aspects of revalidation delegated to local procedures.⁶⁶ No retesting of knowledge or practical skills was included.⁶⁷ Appraisal, generally viewed as a formative process, was to double up as a process for determining continued fitness to practise - a supposed system of protection which offered little enhancement to pre-existing systems.⁶⁸ Following the Fifth Report of the Shipman Inquiry, which disapproved strongly of the watered down proposals, the GMC plans were suspended by the Secretary of State for Health

in 2005 and the Chief Medical Officer instructed to undertake a review of the proposals for revalidation.

It has been argued that until the criticism by the Shipman Inquiry repoliticised the issue, the development of a revalidation policy had represented a re-establishing, especially by the British Medical Association, of historic power and close ties with the government. The result of which was a move away by government from the explicitly critical approach of the 1990s, towards acceptance of the policies proposed by the profession ‘in exchange for a *quid pro quo* in the negotiation of the employment contract.’⁶⁹

The model of revalidation which was developed subsequent to 2005 retains significant elements of the weaknesses about which the Shipman Inquiry was critical. The power of the medical profession and its beneficial relationship with government may be seen to have at least partially won the day. *The General Medical Council (Licence to Practise and Revalidation) Regulations 2012* were made by the GMC and agreed by the Department of Health and Privy Council, resulting in revalidation finally being implemented on 3 December 2012, with the GMC expecting the majority of licensed doctors to have undergone revalidation for the first time by March 2016. The model of revalidation adopted is based around workplace appraisals and associated clinical governance mechanisms.⁷⁰ Revalidation will occur in five yearly cycles based around the decision whether or not to renew a doctor’s license to practise.⁷¹ The GMC explicitly state that revalidation is complementary to existing workplace systems ‘for achieving high quality care’.⁷² Employing organisations are required to appoint a senior doctor trained as a ‘responsible officer’ to oversee the systems for governance and appraisal and advising the GMC about each doctor’s fitness to practise.⁷³ As part of appraisal, doctors are expected to collect and be prepared to discuss six types of

supporting information: continuing professional development; quality improvement activity; significant events; feedback from colleagues; feedback from patients; complaints and compliments. The GMC states that these must be discussed ‘at least once in each five year cycle’.⁷⁴

This appears to be revalidation process which lacks robustness. For example, the six types of supporting information noted above equates on average to little more than one area to be covered each year. In terms of feedback from patients, colleagues and others, the GMC recommends that doctors think broadly about who might give the most useful feedback. For example, not just patients but carers and family members and even medical students. In terms of feedback content the GMC has produced standard questionnaires. However, despite this reasonably encouraging rhetoric, the GMC appears to have no clear and compulsory mechanism to ensure that negative responses are not disposed of or that doctors follow the GMC’s recommendations to seek to use feedback opportunities creatively. The GMC states that it would ‘expect’ that any questionnaire will be administered independently of the doctor and the appraiser’. However, ‘expect’ is not the most compelling term which could have been chosen and there appears to an absence of a clear statement of consequences, if any, if this expectation is not met. In terms of frequency and sample size, the GMC states at least once every five years but does not prescribe a minimum sample size. Once every five years and what could be a very small response sample risks accusations that this approach lacks robustness in light of the GMC stating that ‘patient feedback should be at the heart of doctors’ professional development.’⁷⁵ As Thomas argued in 2005, Harold Shipman could have satisfied revalidation requirements unless the process required someone to be ‘unafraid to ask “why do so many of your patients die?” ... Revalidation must lead to an environment where supportive asking of uncomfortable questions becomes the norm.’⁷⁶ The latter appears not to have been achieved by the model finally adopted by the GMC. It has been observed

that mechanisms within clinical governance processes for addressing poor individual performance lack clarity and that responsibility for poor performance could involve complex interactions between different clinicians and also managers. It has also been argued that organisational responses to clinical governance policies may ultimately come to rely upon traditional medical hierarchies and their technical medical expertise.⁷⁷ So, the revalidation process is built upon foundations which may themselves be unfit for this purpose and which default to hierarchical self-regulatory processes which have failed in a number of key instances. Early stage research into the perception various stakeholders have about revalidation indicates that it is viewed as a ‘depersonalised’, ‘complex’ and ‘abstracted’ process.⁷⁸ As such, it may continue to be viewed as alien and unwelcome by members of the profession, whilst simultaneously failing to represent a particularly positive change to the state-profession bargain for the public.

Perhaps with issues such as these in mind, in 2014 the GMC tendered for a three year ‘wide-scale evaluation’ of revalidation. There is a risk that consideration of revalidation will revert to a cycle of re-evaluation, possible more robust mechanisms being proposed and parts, at least, of the medical profession seeking to weaken such proposals on grounds such as unworkability, and detraction from the time clinicians have to devote to patients and other aspects of service delivery. Devising a robust and effective model for revalidation also faces the perennial challenge that modern medical practice and the organisation of the NHS encompasses a mass of different specialisms, and some clinicians also working in managerial or educational roles.

In terms of alternative models for revalidation, some lessons may be learned from the education world. One model which has the potential to be more extensive and robust could

involve close, independent inspection of professional practice and associated documentation – perhaps modelled on Ofsted⁷⁹ lines but adapted to focus on individual practitioners. Patient and other interested party survey input could be modelled on a variation of the National Student Survey, again adapted to focus on individual practitioners. Such changes could be coupled with the periodic retesting of knowledge.

Such an approach, adopted as part of a renegotiated profession-state bargain, would be more expensive than the current model of revalidation but would also be more intrusive for individual members of the profession than the current compromise model. Evidence of professional resistance to less robust models of revalidation indicates that many medical practitioners and their representative organisations would not accept such changes willingly.

V. IS A SIGNIFICANTLY RENEWED STATE-PROFESSION BARGAIN A PRACTICAL PROPOSITION? LESSONS FROM THE LAW COMMISSION REPORT

If revalidation in its current form is viewed as largely a failed attempt by the state to rebalance the state-profession bargain, the question arises whether such rebalancing can ever be a practical proposition. A timely starting point with regard to future prospects is the 2014 Law Commission report, *Regulation of Health Care Professionals Regulation of Social Care Professionals in England*. This followed on from the 2011 Department of Health commissioned policy paper, *Enabling Excellence: Autonomy and Accountability for Health and Social Care Staff*,⁸⁰ in which the government had asked the Law Commission to undertake a simplification review of the existing legislative framework and to develop a draft Bill for consultation.⁸¹

The Law Commission recognised the points discussed in the introductory observations above, that much has changed since the creation of the GMC and that there now existed a complicated landscape governing complaints about health and social care professionals:

‘As well as regulators’ fitness to practise procedures, there are locally managed systems such as employment disciplinary processes, the NHS and social care complaints procedures, and the Performers List system. National regulators such as the Care Quality Commission and Health Service Ombudsman handle individual complaints, as well as publishing reports and good practice guides...’⁸²

The Law Commission’s overarching recommendation is that there should be a single statute providing a framework for all healthcare regulatory bodies. This would be aimed at consolidating and simplifying the position, provide the opportunity to enhance regulator powers, enhance regulatory efficiency and introduce co-working between regulators.⁸³ This represents a potentially radical departure from the position in 1858 when the medical profession which came to be regulated by the GMC was the only one in meaningful terms and, as other healthcare occupations emerged, for the subsequent century and a half it remained at the top of a hierarchical pyramid. The Law Commission’s proposed new legal framework would aim to impose consistency across all medical regulators to the extent needed to guarantee ‘the same core functions, minimum procedural requirements and certain key public interest provisions.’⁸⁴

In terms of what it meant by all medical regulators, the Law Commission identified almost 1.5 million health and social care professionals, spanning 32 professional and occupational

groups variously governed by nine regulatory bodies.⁸⁵ Overseeing and supervising the nine separate regulators is the Professional Standards Authority.⁸⁶ As well as its oversight function, the Professional Standards Authority is also tasked with sharing good practice and advising the governments of the constituent parts of the UK.⁸⁷

Across the nine regulators, the focus of regulation remains on individual practitioners, rather than being institutional or systems based, and the intended overarching aim is to ensure public safety by setting appropriate entry standards and by controlling in practice or, where necessary, removing from practice those deemed no longer to be fit to practise.⁸⁸ The reality identified by the Law Commission, however, is that of a fragmented, inconsistent and poorly understood legal framework, having grown in a piecemeal manner, through various statutes, Orders in Council⁸⁹ and other regulatory mechanisms, since the initial creation of the GMC. The result is a wide range of legal provisions which are ‘neither systematic nor coherent’ and include ‘a wide range of inconsistencies and idiosyncrasies.’⁹⁰ This is unsurprising given the century and a half of political engagement with healthcare, including the creation of the National Health Service. The focus of this article on the renegotiation of the state-professional bargain through the lens of the Law Commission proposals presents an opportunity to address the inconsistencies in an attempt to reformulate the bargain to meet early 21st century needs and beyond.

As previously noted, the Law Commission’s proposed new legislative framework is intended to impose consistency across regulators with regard to core functions, key public interest provisions and minimum procedural requirements. Operational matters would remain under the control of each individual regulator, with flexibility in how they set standards for members of their profession.⁹¹ Constitutional matters would be subject to Government

oversight, with the power to impose a single constitution on more than one regulator, if this would better achieve consistency. The Law Commission specifically recommended a statutory provision that members of the regulated profession could not constitute a majority membership of their regulatory body – a position already in place with the GMC, but not with all other healthcare regulators.⁹²

The Law Commission also considered streamlining the rule making powers of regulators by removing the need for Parliamentary or Privy Council approval, although such a move should be considered in light of the loss of opportunities for expert input from Government lawyers and specialists at the Department of Health. The Commission ultimately recommended that ‘regulators should be given powers to make legal rules which are not subject to approval by Government or any Parliamentary procedure’ but with oversight by the Professional Standards Authority.⁹³ The Government should also be directly empowered to intervene in the event of a regulator failing to meet its obligations, subject to the requirement to consult the Professional Standards Authority.⁹⁴

To ensure compliance with the Equality Act 2010 and other rights provisions, the Law Commission considered that there should no longer be general requirements of good health and good character on the part of registered practitioners. Continued registration should be dependent only on fitness to practise and so any health or character requirements must only relate to such fitness.⁹⁵ This provision is not as clearly explained as it might have been. Adopting the Law Commission’s reference to rights provisions, there is scope for continuing debate about whether a license to practise medicine is, or should be, a ‘privilege’ which can be withheld or withdrawn in light of any information which suggests that an individual might not be a suitable person in which a hypothetical member of the public would feel comfortable

putting trust over their bodily integrity and physical, mental and emotional well-being, or whether it is a 'right' possessed by a doctor and which has to be removed rather than withdrawn. In many, perhaps most, instances the practical distinction between the two approaches may be indistinguishable, but in some it may not. For example, in *R v Misra and another*⁹⁶ the defendants, Amit Misra and Rajeev Srivastava were senior house officers convicted of manslaughter of a patient. Each was sentenced to 18 months imprisonment, suspended for two years. When the GMC considered the behaviour of doctors Misra and Srivastava, it concluded that in neither case was the behaviour of such magnitude that erasure of their names from the medical register was warranted. Following one possible interpretation of the Law Commission's position, if a conviction for manslaughter is insufficient to result in a doctor's permanent removal from practice, how should this be applied to, for example, applicants for admission? Will all forms of manslaughter fall into the same category, or is leniency specific to gross negligence manslaughter? Clearly such examples will be unusual and are unlikely to be central to the Law Commission focus – presumably this focus is that any generalised or stereotypical attitudes regarding disability or character should not thoughtlessly be applied to questions of whether someone should remain in their healthcare profession. However, the fact that examples of the type discussed can relatively readily be found⁹⁷ does reinforce the need for greater explanation on the part of the Law Commission as to what exactly its recommendation means. Similarly, greater clarity would be helpful in terms of the interaction of the above recommendation and the Commission's later point that certain criminal convictions should result in automatic removal of a registrant from practice.⁹⁸

The Law Commission also recommended that all medical regulators should have the power to set standards for continuing training and professional developments. Subject to ensuring

compatibility with EU requirements, regulators would also be empowered to remove from their registers registrants who fail to demonstrate compliance. With regard to revalidation as, inter alia, a mechanism for monitoring standards some respondents to the Law Commission consultation exercise expressed concerns that revalidation was disproportionately burdensome, expensive and lacking cost-benefit analysis evidence sufficient to support it as being necessary. The Commission, however, concluded that the introduction or authorisation of systems of revalidation should be considered across the range of health regulatory professions.⁹⁹

In terms of other future developments for addressing impaired fitness to practise, the Law Commission identified three main options for reform. The first two would see the existing legal framework retained, with consolidation and rationalisation across the different medical regulators. The second of these would draw more from the recommendations of the *Shipman Inquiry* in terms of the detail of investigation and adjudication.¹⁰⁰ Some respondents to the Law Commission consultation expressed concerns that the Shipman Inquiry proposal may be complex, unduly legalistic and inflexible, with associated risks of delay and added expense. Other concerns focussed upon the fact that impairment might be founded on the basis of future risk alone, rather than on past misconduct. Also, personal mitigation would become irrelevant. These and other considerations led to the Commission discounting this option.¹⁰¹ The final option is more radical, departing from the current approach and replacing it with a simplified test of impaired fitness to practise focussed on public protection. Any evidence which had relevance to public safety could be considered, without a panel having to be satisfied that an allegation fitted a pre-defined statutory ground. Some respondents to the Law Commission consultation argued that this latter option gave the impression of a ‘scattergun approach’ which might draw more registrants into the disciplinary arena. It may also result in

opaqueness of decision making if regulatory panels continued to adopt grounds similar to the former statutory ones, but informally and without this being clearly articulated,¹⁰² although the latter could make the regulatory panel vulnerable to judicial review.

Taking into consideration the range of consultation responses, and the reasoning that the current system is long established and well supported by a body of case law, the Law Commission concluded that there would need to be a compelling case for significant change. Retention of the current approach was therefore favoured.¹⁰³ It is a pity that the Law Commission adopted a rather conservative conclusion with regard to the future of determining impaired fitness to practise. Whilst the body of case law reasoning cannot be disputed, English common law provides numerous examples of previously well established bodies of precedent being departed from, if societal and legal process necessitates this. In particular, the carefully reasoned approach from the Shipman Inquiry is rather quickly dismissed by the Law Commission. The test proposed, which included, inter alia, consideration of whether the practitioner is a risk to patients; has brought the profession into disrepute; has breached one of the fundamental tenets of the profession, or; that his or her integrity cannot be relied upon are potentially draconian but the nature of the misconduct investigated by the Shipman and certain other inquiries had demonstrated that a more forgiving approach could be extremely harmful to patients. The future risk element was also potentially harsh but also important – the magnitude of the behaviour investigated by the Shipman Inquiry left no room for compromise in terms of acceptability of simply waiting to see what might happen. The proposed test of whether a ‘reasonable and well-informed person would consider, in the light of what is known about the allegation and about the doctor’s past and present circumstances, that there is a real risk’ that he or she might act in a particular way was necessary to address future risk. Concerns by consultation respondents may, therefore, have been pertinent but not necessarily well-founded in terms of public protection.

Historically, the investigatory capacity of the GMC and its willingness to investigate has been woefully inadequate, resulting in a failure to detect in a timely manner, if at all, very serious misconduct.¹⁰⁴ The Law Commission identified failings in the legislative structure regarding what may or may not constitute an investigable allegation and reinforced earlier findings that the regulatory approach has essentially been and largely remains ‘a passive and reactive one’. The Commission proposed statutory provisions which would enable the regulators to more effectively classify information which comes to their attention as a potential allegation to be investigated. This, the Commission said, would better allow regulators to deal with anonymous reports or information which arises from media investigations. The Commission recorded some respondents to their consultation exercise as noting that some health regulators already acted in this manner, whilst some other consultees expressed concern, albeit not supported with evidence, that regulators may be ‘overzealous’ and ‘disproportionate’ when digging into matters which come to their attention if investigatory provisions were broadened.¹⁰⁵ In this latter regard, the Law Commission proposals remain modest. For example, a number previous instances of serious misconduct, which were committed over lengthy periods, went undetected by the GMC not because the Council was taking an unduly prescriptive stance when considering the types of allegation it was permitted to investigate but, more fundamentally, it lacked any meaningful policing and investigatory capacity and many of its resources ‘on the ground’, i.e. all other doctors who should have been fulfilling their role as participants in ‘self’-regulation, failed conspicuously because of an unwillingness to report colleagues.¹⁰⁶

In terms of screening matters for potential onward referral, the Law Commission favoured significant regulator discretion.¹⁰⁷ As noted above, certain criminal matters would result in

automatic removal of a registrant.¹⁰⁸ The Professional Standards Authority would retain the power to refer fitness to practise decisions to the higher courts if public protection requirements have not been met. The Commission also recommended that this referral power should be extended to include matters which had been disposed of by consent.¹⁰⁹ The latter should address an issue which has dogged the regulation of doctors, permitting some who have misbehaved to escape public scrutiny by being permitted to have their names voluntarily erased from the medical register.¹¹⁰ The Law Commission also recommended that the Authority's powers should be extended to oversee the economic and business performance of the regulators, with government ensuring that sufficient resources are available for the Authority's extended role as well as existing roles.¹¹¹

Separating investigation and adjudication

Historically, medical regulators such as the GMC have undertaken both the investigation and adjudication stages of regulation – an approach which has been subject to criticism.¹¹² In the late 2000s the Labour government legislated to separate these functions, with the creation of the Office of the Health Professions Adjudicator.¹¹³ This followed a 2007 Government White Paper, *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*.¹¹⁴ As part of the subsequent coalition government's cost-saving measures, the Office of the Health Professions Adjudicator was abolished in favour of what was perceived to be the more cost-effective approach of regulators retaining the adjudicatory function, but building in further safeguards.¹¹⁵ In response, the GMC established the Medical Practitioners Tribunal Service (MPTS), which remained connected to and funded by the GMC, but operationally separate, with a requirement to report annually to Parliament. Parliament approved the establishment of the MPTS in 2011 and it was launched in June 2012. The Law

Commission supported the idea of separate adjudication as a means of underpinning confidence in the regulatory process, with the favoured option being the transfer of the function to HM Courts and Tribunals Service. The option was not, however, thought to be politically palatable, at least in the short-to-medium term, and so the Commission declined to include any specific mechanism in the draft Bill, leaving it to Parliament to decide whether or not to consider the matter further. Pending this, the Commission recommended that the Professional Standards Authority oversee moves by regulators towards further separating investigation and adjudication along the lines of the GMC's Medical Practitioners Tribunal Service.¹¹⁶ Time will tell how effective the MPTS will be compared with its predecessors, but in the transition from the previous GMC fitness to practice panel model a number of the former panel members are now with the MPTS. At the time of writing in August 2014, 108 panel members were identified by the MPTS as having been appointed in 2010 or earlier, with a number of these significantly earlier than this. This number represents over a third of total panel members. Many of these members will have gained significant experience under the previous adjudicatory model. With areas of complex adjudication, such as that relating to medical regulation, the desire for an element of continuity of expertise and experience is perhaps inevitable, but such continuity may also significantly slow any attempts to change cultural attitudes within the organisation.

Unlike some other professions, for example barristers and solicitors, the regulation of healthcare professionals has generally not included a consumer complaints element. Complaints which don't raise fitness to practise issues have remained within the remit of a healthcare professional's employer.¹¹⁷ The conclusion of the Law Commission was that healthcare regulators having the power to run their own complaints services was undesirable, as it might result in conflicts of interest between regulation and complaints handling, as well

as diverting or watering down the use of available resources. This latter point was, however, not decisive and the regulators should be empowered to fund a consumer complaints service, to be run independently. Such power would only be useable with the approval of the Professional Standards Authority – which would be required to confirm that funding such a service would enhance ‘the main duty to protect and promote the health, safety and well-being of the public and maintain public confidence in the profession’.¹¹⁸ This cautious approach on the part of the Law Commission creates potential tensions with other influential commentary - such as the Francis Report into the failings at the Mid Staffordshire NHS Foundation Trust. The Francis Report identifies complaints and how they are handled as providing valuable insights into effectiveness of maintaining standards, and therefore as a source of accountability.¹¹⁹ With regard to this point, lessons may be learned from the complaints system operated by, and ultimately imposed upon, lawyers in England and Wales over the past two to three decades.¹²⁰ After significant and sustained criticism of the systems operated by the professions themselves, especially the solicitors’ profession, the process was removed from their control by means of the Legal Services Act 2007 and placed in the hands of the Legal Services Board and, from there, the Legal Ombudsman and the Office for Legal Complaints. Complainants about legal services now have a one-stop shop, irrespective of the type of lawyer being complained about.¹²¹ By insisting upon independence of healthcare consumer complaints services the Law Commission may have had a similar model in mind, but the discretionary nature of whether and, to some extent, how each professional regulator approaches the issue of future complaints resolution poses the risk that many of the problems encountered with complaints handling by the legal professions are at risk of being repeated.

VI. CONCLUSIONS

The original state-medical profession bargain in the mid-nineteenth century arose at a time when scientific medicine was in its infancy and before the creation of organised state provision of medical care. In this environment there was little for either side to lose, but potentially much to gain from the bargain. Over a century and a half later, scientific high-technology medicine, largely provided free at the point of use by the state under the auspices of the NHS, is now the norm in the UK. In this environment doctors are integrated and have a power base within this model. As a result, attempts to govern the state-medical profession relationship have lacked teeth, in large part because the dependence by the state on the medical profession in the attempt to meet the healthcare needs of the population result in weak bargaining powers on the part of the state.¹²² The nature of health provision in the UK inevitably means that smaller (although not necessarily small in absolute terms) scale bargaining with segments of the medical profession is a relatively regular feature. For example, in the early 2000s consultants in England and Wales rejected a proposed contract which would have transferred significant powers to managers, at the expense of clinical autonomy. The eventual agreement with the state did not include the power transfer and included an improved pay package for consultants.¹²³ What occurs far less frequently is the wholesale reconsideration of the position profession wide. As discussed, revalidation is the only significant example of this in recent years. Whilst the need for a robust revalidation process for doctors has been advocated from a variety of quarters and the state has acknowledged its importance, the reality remains that a significant failure rate amongst doctors seeking revalidation, or a widespread refusal to cooperate if doctors viewed the process as being unduly onerous, would quickly bring the NHS to a point of crisis. When such non-cooperation by doctors was in prospect in different circumstances over 40 years ago - when the GMC sought more money from each doctor by way of an annual fee for retention of their name on the medical register, removal from the register being the penalty for non-

compliance - the government stepped in before any significant crisis could ensue.¹²⁴ In essence, the profession demonstrated that if doctors and their representatives objected strongly enough to a particular proposal or development they could wield very significant power. Reflecting such previous encounters, the medical profession was able to fend-off all but a significantly watered down revalidation process, which involves little more than pre-existing employment based appraisal mechanisms.

The prospective bargaining parties are also now numerous and complex. As well as the GMC as regulator and the British Medical Association, as trades union, the Medical Royal Colleges have responsibilities for various specialities and other specialist associations have also developed. The various organisations speaking on behalf of all or elements of the medical profession are first and foremost premised on notions of professional autonomy.¹²⁵ As has been seen with the collective efforts to shape models of revalidation, forceful voices emerge from within these professional organisations.

Viewed from the perspective of significant renegotiation of the state-medical profession bargain, the lengthy review, consultation exercise and proposals by the Law Commission offered a rare opportunity. At first sight, the Law Commission proposals appear to offer little more than a tidying up and rationalisation exercise. However, when considered in greater detail the proposals do potentially contain more radical depths. The first of these is the central premise that the regulation of doctors should be further subsumed within a larger regulatory framework which encompasses all other major healthcare occupations and professions and, presumably, would also encompass additional professional groupings which emerge in the future. A number, perhaps all, other healthcare occupations would, historically, have been

viewed as of significantly lower status than doctors. Whilst the Commission proposals stop short of full integration and leave each profession with its own regulator, the proposals do point in the direction of further future integration. Of all of the healthcare professions brought under the Law Commission's proposed regulatory umbrella, doctors potentially have the most to lose from these moves if they threaten the distinct, powerful status they have so far enjoyed. Such developments in the training and regulatory framework also present the prospect of the merging of healthcare roles such that work traditionally restricted to doctors is shared with, or even overridden by, other healthcare professions. The development, for example, of physician associates as healthcare professionals who may be viewed as sitting somewhere between nurses and fully qualified doctors represents a further muddying of the waters. Instructive comparisons can be made with the relationship between solicitors and legal executives. Originally Solicitor's Clerks in the 19th century, developing into Solicitors Managing Clerks, with their own Association by the late 1920s, and by the 1960s being reinvented as the Institute of Legal Executives. Legal executives largely remained as assistants to solicitors until relatively recently, but have since acquired extended rights of audience in the courts, are permitted to apply for judicial appointment, have the capacity to practice independently of solicitors or to acquire partnership equivalent status in solicitors firms. In 2012 the Institute of Legal Executives was granted a Royal Charter, bringing it more clearly in line with the Law Society and the Bar Council as a fully fledged branch of the legal profession. Physician associates may currently be categorized as assistants to doctors,¹²⁶ but career development and lobbying on their part may see them developing into a threat to traditional medical hierarchies.

Further comparisons can be drawn with lawyers. The shake-up of the legal services market by the Legal Services Act 2007 presents the prospect of the traditional high status

professional roles of barrister and solicitor being overridden by new models of lawyer and legal services provider, more narrowly trained but potentially cheaper than their traditional counterparts. As Susskind has argued, in the future, whilst some work will remain for what he calls ‘the expert trusted adviser’ undertaking complex, high value tasks in a personalized manner and underpinned by strict principles of confidentiality and other elements of legal ethics, other legal tasks may be automated, commoditized and undertaken or overseen by workers with far lower levels of legal training than is commonly associated with practising lawyers today.¹²⁷ Such a model could see the end of differentiated professional training leading to different designated roles, to be replaced by a single training model which would allow students to step off at a point sufficient to meet their career aspirations (and to step back on at a later date if further progression along the professional qualification spectrum is desired). The 2007 Act also weakened the regulatory bodies of existing legal professions by removing from them control over complaints handling and placing their remaining regulatory functions under the jurisdiction of a meta-regulator, the Legal Services Board.

The Law Commission proposals could represent the beginning of similar intermingling and associated weakening of traditional professional positioning within the medical field. As with Susskind’s ‘expert trusted advisers’, the most complex aspects of medical practise will continue to require very highly trained individuals, but some other areas of medicine traditionally undertaken by doctors could increasingly be undertaken by other healthcare providers, perhaps supported by accompanying enhanced use of technology.¹²⁸ Bringing more closely together the currently distinct qualification and regulatory models applied to different healthcare professions could turn out to be a first step towards significantly greater unification. The prospect of the fragmentation or significant realignment of medical hierarchies may be further exacerbated as the traditional medical profession has increasingly

become divided. Described in one study as 'networks at war', the profession may increasingly struggle to unite even though it is in its collective interest to do so.¹²⁹ Viewed from this perspective, considerations of renegotiating the state-doctor bargain may be misplaced. It may be far less a renegotiation and far more the state stealthily retrieving and redistributing previously gifted powers and privileges.

¹ Sussex Law School, University of Sussex

² Law Commission, Scottish Law Commission, Northern Ireland Law Commission, *Regulation of Health Care Professionals Regulation of Social Care Professionals In England*, Law Com No 345, Scot Law Com No 237, NILC18 (2014)

³ Meg Stacey, 'The General Medical Council and Professional Self-Regulation', in David Gladstone (ed) *Regulating Doctors*. London: Institute for the Study of Civil Society 2000; 28–39 .

⁴ Susan Giaimo, 'Health Care Reform in Britain and Germany: Recasting the Political Bargain with the Medical Profession', *Governance*, July 1995, Volume 8, Issue 3, 354–379, 354.

⁵ *Report of the Committee of Inquiry into the Regulation of the Medical Profession*, 1975, Cmnd 6018, Stationary Office, London

⁶ Susan Giaimo, 'Health Care Reform in Britain and Germany: Recasting the Political Bargain with the Medical Profession', *Governance*, July 1995, Volume 8, Issue 3, 354–379, 354, citing Streeck, Wolfgang and Philippe C. Schmitter, 1985, 'Community, Market, State - and Associations? The Prospective Contribution of Interest Governance to Social Order' *European Sociological Review* 1:119-138.

⁷ Sir Donald Irvine, 'A short history of the General Medical Council', *Medical Education*, Volume 40, Issue 3, March 2006, 202–211

⁸ For further recent discussion of this aspect from a sociological perspective, see Waring, J.; Bishop, S.(2013)., 'McDonaldization or commercial re-stratification: corporatization and the multimodal organisation of English doctors', *Social Science and Medicine*, Vol.82, 147-55.

⁹ For example, in Scotland creation of Edinburgh University's medical faculty in 1726 was followed by the establishment of medical societies. Such societies included libraries, pressure group functions, post-graduate education facilities, debating societies and professional support groups. J. Jenkinson, 'The Role of Medical Societies in the Rise of the Scottish Medical Profession 1730-1939', *Social History of Medicine* (1991) 4 (2): 253-275, citing I. Waddington, *The Medical Profession in the Industrial Revolution* (Dublin, 1984).

¹⁰ Sir Donald Irvine, 'A short history of the General Medical Council', *Medical Education*, Volume 40, Issue 3, March 2006, 202–211, citing M. Stacey, *Regulating British Medicine; the General Medical Council* (Chichester: Wiley, 1992)

¹¹ J. Jenkinson, 'The Role of Medical Societies in the Rise of the Scottish Medical Profession 1730-1939', *Social History of Medicine* (1991) 4 (2): 253-275, 262

¹² Defined by the *History Today* 'Historical Dictionary' as the period of British history that roughly equates with the time spent on the throne of the ruling dynasty of the Electorate of Hanover (1692- 1837). <http://www.historytoday.com/historical-dictionary/g/georgian-era>

¹³ Roy Porter, 'Before the Fringe: Quack Medicine in Georgian England', 1986, *History Today*, 36(11) (online edition); Roy Porter, *Quacks: fakers and charlatans in English medicine*, (2001: The History Press Ltd)

¹⁴ Sir Donald Irvine, 'A short history of the General Medical Council', *Medical Education*, Volume 40, Issue 3, March 2006, 202–211, citing Klein R. *Regulating the Medical Profession; Doctors and the Public Interest*. Health Care UK 1997/1998. London: Kings Fund 1998;152–163 .

¹⁵ Roy Porter, 'Before the Fringe: Quack Medicine in Georgian England', 1986, *History Today*, 36(11) (online edition)

¹⁶ Roy Porter, 'Before the Fringe: Quack Medicine in Georgian England', 1986, *History Today*, 36(11). See, also J. Jenkinson, 'The Role of Medical Societies in the Rise of the Scottish Medical Profession 1730-1939', *Social History of Medicine* (1991) 4 (2): 253-275, 262.

¹⁷ M. Moran, *The British Regulatory State* (Oxford: Oxford University Press, 2003), 48.

¹⁸ Abbreviated to 'General Medical Council' in 1951.

¹⁹ The Council was empowered to control admission to the register, initial medical education and the disciplining of registered practitioners. Subsequent legislation in 1886 enhanced the educational role regarding the medical disciplines in which prospective practitioners were required to pass examinations.

²⁰ J. Jenkinson, 'The Role of Medical Societies in the Rise of the Scottish Medical Profession 1730-1939', *Social History of Medicine* (1991) 4 (2): 253-275, 264

²¹ Mark W. Weatherall, 'Making Medicine Scientific: Empiricism, Rationality, and Quackery in mid-Victorian Britain', *Social History of Medicine* (1996) 9 (2): 175-194, 175-177, citing M. J. Peterson, *The Medical Profession in Mid-Victorian London* (Berkeley, 1978); I. Waddington, *The Medical Profession in the Industrial Revolution* (Dublin: Gill and Macmillan, 1984); T. N. Stokes, 'A Coleridgean against the Medical Corporations: John Simon and the Parliamentary Campaign for the Reform of the Medical Profession', *Medical History*, 33 (1989), 343-63.

²² Mark W. Weatherall, 'Making Medicine Scientific: Empiricism, Rationality, and Quackery in mid-Victorian Britain', *Social History of Medicine* (1996) 9 (2): 175-194, 175-177.

²³ Mark W. Weatherall, 'Making Medicine Scientific: Empiricism, Rationality, and Quackery in mid-Victorian Britain', *Social History of Medicine* (1996) 9 (2): 175-194, 177-179.

²⁴ M. Moran, *The British Regulatory State* (Oxford: Oxford University Press, 2003), 56-57.

²⁵ Pyke-Lees W. Centenary of the GMC 1858–1958: the History and Present Work of the Council. London: GMC 1958, cited by Sir Donald Irvine, 'A short history of the General Medical Council', *Medical Education*, Volume 40, Issue 3, March 2006, 202–211 Stacey, M., *Regulating British Medicine: the General Medical Council* (Chichester: Wiley, 1992), 23

²⁶ M. Stacey, *Regulating British Medicine: the General Medical Council*, 1992 (Chichester: Wiley, 1992), 204.

²⁷ Sir Donald Irvine, 'A short history of the General Medical Council', *Medical Education*, Volume 40, Issue 3, March 2006, 202–211, citing Freidson E. Profession of Medicine; a Study of the Sociology of Applied Knowledge (Chicago: University of Chicago Press 1970), 383–92 (no page number cited).

²⁸ Rudolf Klein, *The New Politics of the NHS: From Creation to Reinvention* (Abingdon: Radcliffe Publishing, 2006), 141. This view was also expressed in the first edition of this work, published in 1983.

²⁹ Sir Donald Irvine, 'A short history of the General Medical Council', *Medical Education*, Volume 40, Issue 3, March 2006, 202–211. Irvine held the position of GMC President between 1995 and 2001

³⁰ Christopher Pollitt, 'The politics of medical quality: auditing doctors in the UK and the USA', *Health Serv Manage Res.* 1993 Feb; 6(1):24-34.

³¹ Sir Donald Irvine, *The Doctors' Tale: Professionalism and Public Trust* (Oxford: Radcliffe Medical Press 2003); M. Moran, *The British Regulatory State* (Oxford: Oxford University Press, 2003)

³² Sir Donald Irvine, 'A short history of the General Medical Council', *Medical Education*, Volume 40, Issue 3, March 2006, 202–211

³³ See, for example, *Gupta v General Medical Council* [2002] 1 WLR 1691, 1702; *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council* [2011] EWHC 927 (Admin); *Luthra v General Medical Council* [2013] EWHC 240 (Admin). Law Commission, Scottish Law Commission, Northern Ireland Law Commission, *Regulation of Health Care Professionals Regulation of Social Care Professionals In England*, Law Com No 345, Scot Law Com No 237, NILC18 (2014) at paras 3.2, 3.14, 3.21-3.23 and Recommendation 13.

³⁴ The Shipman Inquiry, *Safeguarding Patients: Lessons from the Past, Proposals for the Future*. Chairman: Smith, Dame Janet. London: Stationery Office 2004;1023–176; Sir Donald Irvine, 'A short history of the General Medical Council', *Medical Education*, Volume 40, Issue 3, March 2006, 202–211.

³⁵ It is also acknowledged that the modern medical profession is itself not a unified entity, but rather is divided into specialities with each with their own agenda foci. For recent discussion of some aspects of this, see Waring, J.; Bishop, S.(2013)., 'McDonaldization or commercial re-stratification: corporatization and the multimodal organisation of English doctors', *Social Science and Medicine*, Vol.82, 147-55.

³⁶ Chairman: Sir Anthony Alment, *Competence to practise: The report of a Committee of Enquiry set up for the medical profession in the United Kingdom* (London: 1976).

³⁷ Donald Irvine, *The Doctors' Tale: Professionalism and Public Trust* (Oxford: Radcliffe Medical Press, 2003).

³⁸ Sir Donald Irvine, 'A short history of the General Medical Council', *Medical Education*, Volume 40, Issue 3, March 2006, 202–211

³⁹ Fenton L and Salter B, 'Competition and compromise in negotiating the new governance of medical performance: the clinical governance and revalidation policies in the UK', *Health, Economics, Policy and Law*, 2009, 4: 283-203

⁴⁰ J. Black, 'Tension in the Regulatory State', *Public Law*, 2007, 58, 64.

⁴¹ Black and other discuss the interaction of meta-regulation and localised and/or self-regulatory structures in a variety of regulatory environments. J. Black, 'Tension in the Regulatory State' (2007) *Public Law* 58-73; J.

Black, 'The emergence of risk-based regulation and the new public risk management in the United Kingdom' (2005) *Public Law* 512-548

⁴² See, for example, http://cdn.yougov.com/cumulus_uploads/document/bo8lpz5s7k/YG-Archive-PHA-Media-results-290813-HealthExpress.pdf

⁴³ Helen Jaques, 'Consultants reject calls to be "rostered like their juniors" for out of hours work', *BMJ Careers*; 10 Mar 2012 (<http://careers.bmj.com/careers/advice/view-article.html?id=20006982>)

⁴⁴ See, for example, O. Mikulic, E. Callaly, K. Bennett, D. O'Riordan, B. Silke, 'The increased mortality associated with a weekend emergency admission is due to increased illness severity and altered case-mix', *Acute Medicine* 10(4) 2011: 181-186; C.M. Bell, D.A. Redelmeier, 'Mortality among patients admitted to hospitals on weekends as compared with weekdays', *N Engl J Med.* 2001 Aug 30;345(9):663-8. Not all within the medical profession share this view. For example, the Society for Acute Medicine (SAM), based in Scotland, have called for consultant-led care to be consistently delivered, twelve hours per day, seven days per week in acute medicine and associated general (internal) medicine on the grounds that 'patients deserve the same high quality consultant-led care irrespective of the day of the week on which they are admitted to hospital.' http://www.acutemedicine.org.uk/index.php?option=com_content&view=article&id=162:seven-day-working-for-consultants-in-the-acute-medical-unit&catid=72:position-statements&Itemid=30

⁴⁵ <http://www.oecd.org/health/health-systems/oecdhealthdata.htm>

⁴⁶ Health Care and Associated Professions (Miscellaneous Amendments) Order 2008, SI 2008 No 1774; Health and Social Care Act 2012, s 227. For further discussion, see Law Commission, Scottish Law Commission, Northern Ireland Law Commission, *Regulation of Health Care Professionals Regulation of Social Care Professionals In England*, Law Com No 345, Scot Law Com No 237, NILC18 (2014) at paras 4.20-4.21.

⁴⁷ Guillemin M, Archer J, Nunn S & de Bere SR, 'Revalidation: Patients or process? Analysis using visual data' *Health Policy*, 2014, 114 (2-3), 128 – 138, 129

⁴⁸ See, for example, discussion by the Merrison Committee in the 1970s: Secretary of State for Social Services. Report of the Committee of Inquiry into the Regulation of the Medical Profession. Chairman: A.W. Merrison, Cmnd. 6018. London: HMSO 1975, 129 and the GMC's own ideas in 1999, General Medical Council (1999), News, Spring, Issue 5, London: General Medical Council. See also the observations of Donald Irvine regarding behind the scenes discussions within the profession in the mid-to-late 1990s. D. Irvine (2003), *The Doctor's Tale: Professionalism and Public Trust*, Oxford: Radcliffe Medical Press, 140

⁴⁹ Medical Act (Amendment) Order 2002, which defines revalidation as 'the evaluation of a medical practitioner's fitness to practise'

⁵⁰ Klein, R., *The Politics of the National Health Service*, (London: Longman, 1983)

⁵¹ D. Irvine (2003), *The Doctor's Tale: Professionalism and Public Trust*, Oxford: Radcliffe Medical Press, 142.

⁵² This corresponds with the three central themes of revalidation: ensuring public trust in the medical profession; ensuring continuing professional development; and identifying poor performance. Department of Health, *Assuring the quality of medical practice: implementing supporting doctors protecting patients* (London: DoH, 2001), cited by Tim van Zwanenberg, 'Revalidation: the purpose needs to be clear', *BMJ*. Mar 20, 2004; 328(7441): 684–686. In some respects the focus on individual doctors runs counter to some trends in recent years to focus on systems failures rather than individual culpability. However, the latter remains important. See, for example, Shojania KG, Dixon-Woods M. 'Bad apples': time to redefine as a type of systems problem? *BMJ Quality & Safety*, doi:10.1136/bmjqs-2013-002138; Guillemin M, Archer J, Nunn S & de Bere SR (2014) 'Revalidation: Patients or process? Analysis using visual data' *Health Policy* 114 (2-3), 128 - 138

⁵³ C. du Boulay, 'Revalidation for doctors in the United Kingdom, the end or the beginning?', *BMJ*, Vol. 320, 3 June 2000

⁵⁴ The Policy Framework for Revalidation : A Position Paper – July 2004

⁵⁵ GMC, *Effective, inclusive and accountable reform of the GMC's structure, constitution and governance*, March 2001, 4 and *Developing medical regulation: a vision for the future – the GMC's response to the call for ideas by the review of clinical performance and medical regulation*, April 2005. As discussed above, there is scope for debate regarding whether the medical register ever satisfied this supposed 'intended purpose' in terms of listing only those practitioners who were genuinely fit to practice.

⁵⁶ See, for example, GMC, Report of the Revalidation Steering Group, February 1999; The Policy Framework for Revalidation : A Position Paper – July 2004, cited in Mark Davies, *Medical self-regulation, crisis and change* (Aldershot: Ashgate, 2007), chapter 17. In 1975 the Merrison Committee had rejected the idea of relicensing as being overly problematic. The BMA's Alment Committee (Chairman: Sir Anthony Alment, Competence to practise: The report of a Committee of Enquiry set up for the medical profession in the United Kingdom (London: 1976)) concluded that there was an absence of persuasive evidence that such a move was necessary. The committee considered that re-licensure moved the point of trust away from individual doctors, where it was best placed, and into the realm of systems and institutions. With hindsight, this has proved to be a curious (or possibly a self-serving) analysis – the crises which have emerged from failures in the regulatory

process have served to suggest that placing trust in individual doctors has been ineffective in terms of protecting the public.

⁵⁶ Sir Donald Irvine, *The Doctors' Tale: Professionalism and Public Trust* (Oxford: Radcliffe Medical Press 2003)

⁵⁷ Sir Donald Irvine, *The Doctors' Tale: Professionalism and Public Trust* (Oxford: Radcliffe Medical Press 2003), 152; S. Boseley and Hartley-Brewer, 'Doctors plunge into new crisis', *The Guardian*, 30 June 2000 (web edition)

⁵⁸ For example, Tim van Zwanenberg notes that consultations with the profession showed that a large proportion of general practitioners who responded, 81%, were "broadly in support" of revalidation but once the detail of responses was considered there were also numerous adverse comments. These included objections in principle and anxiety about the process. Tim van Zwanenberg, 'Revalidation: the purpose needs to be clear', *BMJ*. Mar 20, 2004; 328(7441): 684–686. van Zwanenberg himself concludes that it 'is difficult to escape the conclusion that the purpose of revalidation is as a form of professional regulatory enforcer to ensure the NHS implements appraisal in a designated manner' and, citing Pringle, that 'the most likely outcome is the worst of all worlds, where the developmental and formative nature of appraisal is lost, and where revalidation fails to identify poor performers.' M. Pringle, 'Re-evaluating revalidation and appraisal', *Br J Gen Pract* 2003, 53: 437-8.

⁵⁹ Tim van Zwanenberg, 'Revalidation: the purpose needs to be clear', *BMJ*. Mar 20, 2004; 328(7441): 684–686, citing Tim van Zwanenberg 'The system responds'. In: Harrison J, Innes R and van Zwanenberg T, eds. *Rebuilding trust in healthcare*, (Oxford: Radcliffe Medical Press, 2003).

⁶⁰ The fifth report of the Shipman inquiry, *Safeguarding Patients: Lessons from the Past—Proposals for the Future*, para 27.300 (www.the-shipman-inquiry.org.uk)

⁶¹ General Medical Council, *Revalidation: Report on the Outcome of the Consultation Exercise*, November 2000

⁶² General Medical Council, *Revalidating Doctors*, 2000, pp23-24

⁶³ M. Davies, *Medical self-regulation, crisis and change* (Aldershot: Ashgate, 2007), chapter 17

⁶⁴ Not all were supportive of the move away from a more rigorous stance. For example, Professor Mike Pringle, an elected member of the GMC, voiced opposition to the idea that a maximum of 'five appraisals and a clinical governance sign off' as being sufficient. M. Pringle, 'Making Revalidation Credible', *BMJ* 2005;330:1515 (25 June)

⁶⁵ See A. Esmail, 'GMC and the future of revalidation - Failure to act on good intentions', *BMJ* Vol. 330, May 14 2005.

⁶⁶ *Developing medical regulation: a vision for the future – the GMC's response to the call for ideas by the review of clinical performance and medical regulation*, April 2005, Appendix A, para 1.

⁶⁷ The Policy Framework for Revalidation: A Position Paper – July 2004; *BMA response to the Chief Medical Officer review on maintaining high standards of professional practice*, May 2005. Such re-testing had also been rejected as part of the GMC's earlier, otherwise more robust, proposals. It had been argued that inadequate knowledge was not commonly a problem witnessed in disciplinary cases and therefore this omission was not particularly significant. Sir Graeme Catto, 'The GMC - Revalidation - What Are We Trying to Measure?', *Medico-Legal Journal*, 71(106), 2 October 2003. In contrast, Robinson argued that some doctors displayed levels of medical knowledge and competence that was 'so low as to make one wonder how they ever got on the Register in the first place' and that re-testing was necessary for public protection, Robinson, J., *A Patient Voice at the GMC: a Lay Member's View of the GMC*, Report 1, Health Rights, London. Dame Janet Smith observed that 'If a doctor cannot bring his/her knowledge base up to standard within five years, surely s/he should not be practising.' The fifth report of the Shipman inquiry, *Safeguarding Patients: Lessons from the Past—Proposals for the Future*, para 26.197 (www.the-shipman-inquiry.org.uk). Evidence from negligence cases indicates that a majority involve some element of clinical fault, A.F. Phillips, *Medical Negligence Law: Seeking a Balance*, (Aldershot: Dartmouth, 1997), 170

⁶⁸ The fifth report of the Shipman inquiry, *Safeguarding Patients: Lessons from the Past—Proposals for the Future*, para 26.76. For further discussion, see para 26.72 (www.the-shipman-inquiry.org.uk). Tim van Zwanenberg argues that 'Formative appraisal and summative revalidation are seen as uneasy bedfellows.- Tim van Zwanenberg, 'Revalidation: the purpose needs to be clear', *BMJ*. Mar 20, 2004; 328(7441): 684–686, citing M. Pringle, 'Re-evaluating revalidation and appraisal', *Br J Gen Pract* 2003;53: 437-8 and M. Conlon, 'Appraisal: the catalyst of personal development', *BMJ* 2003;327: 389-91.

⁶⁹ Fenton L and Salter B, 'Competition and compromise in negotiating the new governance of medical performance: the clinical governance and revalidation policies in the UK', *Health, Economics, Policy and Law*, 2009, 4: 283-203

⁷⁰ Underpinned by *The Good Medical Practice Framework for appraisal and revalidation and Supporting Information for Revalidation*. Modified requirements are in place for doctors who are not conventionally employed.

⁷¹ The license to practise provision was introduced in November 2009 as a forerunner to revalidation. The Law Commission has observed that the model of revalidation, based around the decision to renew, or not, a doctor's licence to practise, rather than the direct renewal of registration, is necessary to ensure compliance with the EU Qualifications Directive 2005/36/EC. The Commission's argument is that loss of registration on failure to revalidate would be a disproportionate obstacle to the EU's requirements for recognition of a doctor's qualifications. Law Commission, Scottish Law Commission, Northern Ireland Law Commission, *Regulation of Health Care Professionals Regulation of Social Care Professionals In England*, Law Com No 345, Scot Law Com No 237, NILC18 (2014) at paras 4.45-4.50

⁷² <http://www.gmc-uk.org/doctors/revalidation/12385.asp>

⁷³ http://www.gmc-uk.org/GMC_revalidation_governance_handbook_51305205.pdf, p5. Responsible Officers must comply with obligations under the Medical Profession (Responsible Officer) Regulations 2010; General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012 and The Medical Profession (Responsible Officers) (Amendment) Regulations 2013

⁷⁴ <http://www.gmc-uk.org/doctors/revalidation/12385.asp>

⁷⁵ General Medical Council, *Supporting information for appraisal and revalidation*, March 2012

http://www.gmc-uk.org/static/documents/content/RT_-_Supporting_information_for_appraisal_and_revalidation_-_DC5485.pdf

[Supporting information for appraisal and revalidation - DC5485.pdf](http://www.gmc-uk.org/static/documents/content/RT_-_Supporting_information_for_appraisal_and_revalidation_-_DC5485.pdf)

⁷⁶ Paul Thomas, 'Will GP revalidation make things better or worse?' *Br J Gen Pract.* 2005;55(513):318-319.

⁷⁷ B. Salter, *The New Politics of Medicine* (Basingstoke: Palgrave, 2004); Fenton L and Salter B, 'Competition and compromise in negotiating the new governance of medical performance: the clinical governance and revalidation policies in the UK', *Health, Economics, Policy and Law*, 2009, 4: 283-203

⁷⁸ Guillemin M, Archer J, Nunn S & de Bere S.R, 'Revalidation: Patients or process? Analysis using visual data' *Health Policy*, 2014, 114 (2-3), 128 – 138, 137

⁷⁹ Ofsted is the 'Office for Standards in Education, Children's Services and Skills'. Categorized as an independent and impartial body, reporting direct to Parliament, which inspects and regulates schools and other services which care for children and young people.

⁸⁰ <https://www.gov.uk/government/publications/enabling-excellence-autonomy-and-accountability-for-health-and-social-care-staff>

⁸¹ The Law Commission methodology for the 2014 report focused upon consultation with stakeholders, the public and other interested parties. A consultation paper, consisting of 111 provisional proposals and 66 consultation questions, was published on 1 March 2012. The Commission reported receiving 192 written responses to this. The Law Commission also attended 44 events across the UK – audiences at which included patients, health and social care professionals, academics, professional bodies, the regulatory bodies, lawyers, service providers and representatives from charities and campaigning organisations.

⁸² Law Commission, Scottish Law Commission, Northern Ireland Law Commission, *Regulation of Health Care Professionals Regulation of Social Care Professionals In England*, Law Com No 345, Scot Law Com No 237, NILC18 (2014) at para 10.2.

⁸³ Law Commission, Scottish Law Commission, Northern Ireland Law Commission, *Regulation of Health Care Professionals Regulation of Social Care Professionals In England*, Law Com No 345, Scot Law Com No 237, NILC18 (2014) at 2.5. The recommendation is given effect by clause 1 and part 10 of the draft Bill for a single statute produced by the Law Commission.

⁸⁴ Law Commission, Scottish Law Commission, Northern Ireland Law Commission, *Regulation of Health Care Professionals Regulation of Social Care Professionals In England*, Law Com No 345, Scot Law Com No 237, NILC18 (2014), para 2.8

⁸⁵ General Chiropractic Council; General Dental Council; General Medical Council; General Optical Council; General Osteopathic Council; General Pharmaceutical Council; Health and Care Professions Council; Nursing and Midwifery Council; Pharmaceutical Society of Northern Ireland. Law Commission, Scottish Law Commission, Northern Ireland Law Commission, *Regulation of Health Care Professionals Regulation of Social Care Professionals In England*, Law Com No 345, Scot Law Com No 237, NILC18 (2014) at 1.1, citing with regard to numbers the Professional Standards Authority, *Annual Report and Accounts 2012-13* (2013) p 4

⁸⁶ The Professional Standards Authority describes itself as aiming to be a strong, independent voice for service users and the public in the regulation of health and care professionals throughout the UK.

<http://www.professionalstandards.org.uk/about-us/our-work>

⁸⁷ Black categorized the Professional Standards Authority as a 'meta-regulator'. J Black, "Tension in the Regulatory State" (2007) *Public Law* 58, 63. Cited by the Law Commission, Scottish Law Commission, Northern Ireland Law Commission, *Regulation of Health Care Professionals Regulation of Social Care Professionals In England*, Law Com No 345, Scot Law Com No 237, NILC18 (2014) at 12.2-12.3. The Commission also observed that the Authority does not categorize itself as having the role of managing regulators, but as an oversight and audit body with the task of improving the regulation of medical professionals.

⁸⁸ These being: (1) setting the standards of behaviour, competence and education ; (2) dealing with concerns about professionals who may be unfit to practise due to poor health, misconduct or poor performance; and (3) maintaining registers of professionals who are fit to practise and setting the requirements for periodic re-registration (and in some cases revalidation) for each profession. Certain titles such as ‘doctor of medicine’ or ‘pharmacist’ are protected, with criminal sanctions for use without appropriate registration. Similarly, certain activities are reserved to registered professionals. Law Commission, Scottish Law Commission, Northern Ireland Law Commission, *Regulation of Health Care Professionals Regulation of Social Care Professionals In England*, Law Com No 345, Scot Law Com No 237, NILC18 (2014) at paras 1.7 – 1.8

⁸⁹ Prior to the Health Act 1999, new and amended regulations needed primary legislation. Section 60 of the Act provided that changes could be achieved by Her Majesty by Order in Council. Such an order could have broad scope, including allowing new professions to be regulated. Law Commission, Scottish Law Commission, Northern Ireland Law Commission, *Regulation of Health Care Professionals Regulation of Social Care Professionals In England*, Law Com No 345, Scot Law Com No 237, NILC18 (2014) at 2.41.

⁹⁰ Law Commission, Scottish Law Commission, Northern Ireland Law Commission, *Regulation of Health Care Professionals Regulation of Social Care Professionals In England*, Law Com No 345, Scot Law Com No 237, NILC18 (2014) at 1.1 – 1.2 and 2.3

⁹¹ Law Commission, Scottish Law Commission, Northern Ireland Law Commission, *Regulation of Health Care Professionals Regulation of Social Care Professionals In England*, Law Com No 345, Scot Law Com No 237, NILC18 (2014) at 6.36.

⁹² Law Commission, Scottish Law Commission, Northern Ireland Law Commission, *Regulation of Health Care Professionals Regulation of Social Care Professionals In England*, Law Com No 345, Scot Law Com No 237, NILC18 (2014) at 2.8, 2.12 and 4.11-4.15 and Recommendations 16-17.

⁹³ Benefits of Government input included expertise to help to ensure that proposed rule changes did not conflict with Human Rights Act 1998 or other legal provisions. Law Commission, Scottish Law Commission, Northern Ireland Law Commission, *Regulation of Health Care Professionals Regulation of Social Care Professionals In England*, Law Com No 345, Scot Law Com No 237, NILC18 (2014) at 2.13-2.14, 2.21 and Recommendation 3 - given effect by clauses 23 to 24 of the Commissions draft Bill.

⁹⁴ Unless the Authority itself is subject to intervention. Law Commission, Scottish Law Commission, Northern Ireland Law Commission, *Regulation of Health Care Professionals Regulation of Social Care Professionals In England*, Law Com No 345, Scot Law Com No 237, NILC18 (2014) at paras 2.48-2.53, 2.74-2.79 and Recommendations 8, 9 and 10. These recommendations were given effect by clauses 244, 245, 251 and 252 of the draft Bill produced by the Law Commission. The Commission also strongly urged Parliament to create a specialist joint committee on health and social care professionals regulation to scrutinise the regulators and to better encourage public confidence in the process. Para 2.83 and Recommendation 11.

⁹⁵ Law Commission, Scottish Law Commission, Northern Ireland Law Commission, *Regulation of Health Care Professionals Regulation of Social Care Professionals In England*, Law Com No 345, Scot Law Com No 237, NILC18 (2014) at para 5.76.

⁹⁶ [2004] EWCA CRIM 2375, [2004] All ER (D) 107 (Oct)

⁹⁷ Other examples where doctors have been permitted to remain in practice include *R v Becker* - a manslaughter conviction after a doctor injected a patient with three times the maximum safe dose of diamorphine; *R v Sinha* - a doctor convicted of offences relating, inter alia, falsifying patient records following the death of a patient, and sentenced to six months imprisonment; *Singh v GMC*, a GP, convicted of numerous counts of dishonesty, including ones related to medical practice. For further details of these, see M. Davies, *Medical self-regulation, crisis and change* (Aldershot: Ashgate, 2007). For further discussion of medical professional encounters with the criminal law see, for example, S. Ost and H. Biggs, 'Consensual' sexual activity between doctors and patients: a matter for the criminal law?' in A. Alghrani, R. Bennet and S. Ost, (eds.) *Bioethics, Medicine and the Criminal Law Volume I: The Criminal Law and Bioethical Conflict: Walking the Tightrope* (Cambridge: Cambridge University Press, 2013), 102-117 and J. Miola, 'The Impact of the Loss of Deference Towards the Medical Profession' in S. Ost, (eds.) *Bioethics, Medicine and the Criminal Law Volume I: The Criminal Law and Bioethical Conflict: Walking the Tightrope* (Cambridge: Cambridge University Press, 2013), 220-235

⁹⁸ Recommendation 63, given effect by clauses 66 and 67 of and schedule 4 to the draft Bill.

⁹⁹ Law Commission, Scottish Law Commission, Northern Ireland Law Commission, *Regulation of Health Care Professionals Regulation of Social Care Professionals In England*, Law Com No 345, Scot Law Com No 237, NILC18 (2014) at 4.45-4.50 and Recommendations 53-54. These recommendations to be given effect by clause 107 part 4 of the draft Bill.

¹⁰⁰ *The Shipman Inquiry Fifth Report: Safeguarding Patients, Lessons from the Past – Proposals for the Future* (2004) Cm 6394 paras 25.63-25.65.

¹⁰¹ Law Commission, Scottish Law Commission, Northern Ireland Law Commission, *Regulation of Health Care Professionals Regulation of Social Care Professionals In England*, Law Com No 345, Scot Law Com No 237, NILC18 (2014) at paras 7.9-7.11

¹⁰² Law Commission, Scottish Law Commission, Northern Ireland Law Commission, *Regulation of Health Care Professionals Regulation of Social Care Professionals In England*, Law Com No 345, Scot Law Com No 237, NILC18 (2014) at 7.10

¹⁰³ Law Commission, Scottish Law Commission, Northern Ireland Law Commission, *Regulation of Health Care Professionals Regulation of Social Care Professionals In England*, Law Com No 345, Scot Law Com No 237, NILC18 (2014) at 7.1-7.17. In addition to deficient professional performance and disgraceful misconduct the Commission thought it desirable to add an additional statutory ground of 'impaired fitness to practise based on insufficient knowledge of the English language.' After consideration of the Equality Act 2010 and the United Nations Convention on the Rights of Persons with Disabilities, the Commission concluded that action on the grounds of ill-health should continue to be available to regulators, but emphasised that a decision of a panel relates to impaired fitness to practise, rather than diagnosis alone. So it would not be appropriate to determine that a practitioner is impaired without any evidence of behaviour that calls into question their ability to practise safely. Similarly, the continuance of the health route should not be used to restrict a practitioner's right to practise based on assumptions about the impact of disability or ill health generally. The Law Commission gives full effect to these proposals in recommendation 55 and clause 120 of its draft Bill: A person's fitness to practise a regulated profession should be regarded as impaired by reason only of:

- (1) deficient professional performance;
- (2) disgraceful misconduct;
- (3) the inclusion of the person in a barred list;
- (4) a determination by a relevant body to the effect that the person's fitness to practise is impaired;
- (5) adverse physical or mental health;
- (6) insufficient knowledge of the English language;
- (7) a conviction or caution in the British Islands for a criminal offence, or a conviction elsewhere for an offence which, if committed in England and Wales, would constitute a criminal offence;
- (8) the person having accepted or been dismissed with an admonition under section 302 of the Criminal Procedure (Scotland) Act 1995, been discharged under section 246(2) or (3) of that Act, accepted a conditional offer under section 302 of that Act, or accepted a compensation offer under section 302A of that Act;
- (9) the person having agreed to pay a penalty under section 115A of the Social Security Administration Act 1992; or
- (10) the person having been bound over to keep the peace by a magistrates' court in England or Wales.

¹⁰⁴ M. Davies, *Medical self-regulation, crisis and change* (Aldershot: Ashgate, 2007)

¹⁰⁵ Law Commission, Scottish Law Commission, Northern Ireland Law Commission, *Regulation of Health Care Professionals Regulation of Social Care Professionals In England*, Law Com No 345, Scot Law Com No 237, NILC18 (2014) at para 8.3-8.9 and Recommendation 56. This recommendation to be given effect by clause 121.

¹⁰⁶ See, for example, J. Robinson, 'Though shalt not disparage another doctor', *Health Matters*, reproduced in the *Bulletin of Medical Ethics*, June/July 1998; Burrows, J., Telling Tales and Saving Lives: Whistleblowing – The Role of Professional Colleagues in Protecting Patients from Dangerous Doctors, *Medical Law Review*, 9, Summer 2001, 110-129; A. Samuels, 'Can A Doctor "Blow The Whistle" Or "Grass" On A Colleague?', *MLJ* 70(135), 5 September 2002; M. Davies, *Medical self-regulation, crisis and change* (Aldershot: Ashgate, 2007), chapter 12

¹⁰⁷ However, matters should not be referred for investigation if they appeared to be vexatious, were made anonymously or the complainant is unwilling to participate, and the allegation could not otherwise be verified. Law Commission, Scottish Law Commission, Northern Ireland Law Commission, *Regulation of Health Care Professionals Regulation of Social Care Professionals In England*, Law Com No 345, Scot Law Com No 237, NILC18 (2014) at 8.14 and Recommendations 57 and 59. These recommendations would be given effect by clause 121-123 of the draft Bill.

¹⁰⁸ Notably conviction for murder, trafficking people for exploitation, blackmail resulting in a custodial sentence, rape and sexual assault resulting in a custodial sentence and certain offences against children. This would be subject to the right to make representations to the regulator and a right to appeal to the higher courts on the grounds of an error in law or finding of fact. Recommendation 63, given effect by clauses 66 and 67 of and schedule 4 to the draft Bill.

¹⁰⁹ Recommendation 68, given effect by clause 167(6) and (7) of the draft Bill. Prior to this stage being reached, regulators should also have powers to review decisions: (1) not to refer an allegation for an investigation; (2) not to refer a case to a fitness to practise panel; and (3) to dispose of a case by means of advice, a warning, agreeing undertakings, voluntary erasure, or referral for mediation. Recommendations 70 and 109, given effect by clauses 134 and 167 of the draft Bill.

¹¹⁰ For example, Michael Haslam, a former consultant psychiatrist, was granted voluntary erasure from the medical register in 1999. He was subsequently convicted of indecent assault against ‘vulnerable female psychiatric patients’ who were in his care. Haslam’s misconduct had been ongoing for many years and the option of voluntary erasure had been made by the GMC after it had begun to investigate him. *The Kerr/Haslam Inquiry Report*, July 2005, Cm 6640-1, pp399-401

¹¹¹ Law Commission, Scottish Law Commission, Northern Ireland Law Commission, *Regulation of Health Care Professionals Regulation of Social Care Professionals In England*, Law Com No 345, Scot Law Com No 237, NILC18 (2014) at paras 12.11-12.13 and Recommendations 102-104, 106 and 108, given effect by clauses 219, 222, 227, 230, 234 and 238 of the draft Bill.

¹¹² M. Davies, *Medical self-regulation, crisis and change* (Aldershot: Ashgate, 2007); Law Commission, Scottish Law Commission, Northern Ireland Law Commission, *Regulation of Health Care Professionals Regulation of Social Care Professionals In England*, Law Com No 345, Scot Law Com No 237, NILC18 (2014) at para 9.7, citing *The Shipman Inquiry Fifth Report: Safeguarding Patients, Lessons from the Past – Proposals for the Future* (2004) Cm 6394, paras 27.204 to 27.210.

¹¹³ The Health and Social Care Act 2008

¹¹⁴ February 2007, Cm 7013

¹¹⁵ Health and Social Care Act 2012

¹¹⁶ Law Commission, Scottish Law Commission, Northern Ireland Law Commission, *Regulation of Health Care Professionals Regulation of Social Care Professionals In England*, Law Com No 345, Scot Law Com No 237, NILC18 (2014) at paras 9.8-9.19, Recommendation 72, given effect by clause 168(4) of the draft Bill and Recommendation 73, given effect by clauses 29 and 168 of the draft Bill. At Recommendations 74 and 75 the Commission proposed that fitness to practise hearings should be conducted by a panel of a minimum three members, at least one of whom is a lay member. Membership would not be open to members of the regulatory body, nor members of other regulators, nor to members of the Professional Standards Authority board. Investigatory and adjudicatory body membership would be separate. Suggestions that panel chairs should be legally qualified were considered, but the arguments not felt to be sufficiently compelling for this to be a requirement. It would, however, remain at the discretion of individual regulators to choose to make use of legal chairs. These recommendations were given effect by clauses 28, 137-138 of the draft Bill.

¹¹⁷ This approach is likely to give rise to inconsistency and varying challenges – for example sole or small medical or dental practices may have may give rise to problems of ‘who to complain to?’, whilst in large hospitals complainants may have to overcome bureaucratic hurdles. It is also curious that formalised complaints processes have been established for many years in relation to solicitors and barristers, even though these professions operate in a market environment offering the sanction of the client being able to take their business elsewhere (subject to the usual caveats associated with professional services often being categorized as credence goods), whilst users of NHS services will usually lack such market power.

¹¹⁸ Law Commission, Scottish Law Commission, Northern Ireland Law Commission, *Regulation of Health Care Professionals Regulation of Social Care Professionals In England*, Law Com No 345, Scot Law Com No 237, NILC18 (2014) at paras 11.26 – 11.30, Recommendation 100, given effect by clause 27 of the draft Bill.

¹¹⁹ Robert Francis QC, *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry -Executive summary*, February 2013, HC 947, paras 1.152-1.157

¹²⁰ See, for example, R. Abel, *English Lawyers Between Market and State* (Oxford: Oxford University Press, 2003); Sir David Clementi, *Review of the Regulatory Framework for Legal Services in England and Wales – Final Report*, December 2004; M. Davies, ‘Solicitors – The Last Twenty Years of Self-regulation?’, (2005), *Journal of Professional Negligence* 21(1), 3–26; Rt Hon Lord Hunt, *The Hunt Review of the Regulation of Legal Services*, October 2009

¹²¹ Barristers; Law costs draftsmen; Legal executives; Licensed conveyancers; Notaries; Patent attorneys; Probate practitioners; Registered European lawyers; Solicitors and Trademark attorneys are all covered.

¹²² Fenton L and Salter B (2009) ‘Competition and compromise in negotiating the new governance of medical performance: the clinical governance and revalidation policies in the UK’, *Health, Economics, Policy and Law*. 4: 283-203, citing R. Klein (1989), *The Politics of the NHS*, London: Longman; R. Klein (1990), ‘Competition and compromise in negotiating the new governance of medical performance: the clinical governance and revalidation policies in the UK’, *British Medical Journal*, 301: 700-702.

¹²³ Fenton L and Salter B (2009) ‘Competition and compromise in negotiating the new governance of medical performance: the clinical governance and revalidation policies in the UK’, *Health, Economics, Policy and Law*. 4: 283-203

¹²⁴ The government appointed the Merrison Committee of Inquiry to make recommendations regarding doctor input into the operation of the GMC in return for their collective role in funding it. Secretary of State for Social Services. Report of the Committee of Inquiry into the Regulation of the Medical Profession .Chairman: A.W. Merrison, Cmnd. 6018. London: HMSO 1975.

¹²⁵ Fenton L and Salter B, 'Competition and compromise in negotiating the new governance of medical performance: the clinical governance and revalidation policies in the UK', *Health, Economics, Policy and Law*, 2009, 4: 283-203

¹²⁶ <http://www.nhscareers.nhs.uk/explore-by-career/doctors/careers-in-medicine/physician-associate/>

¹²⁷ Richard Susskind, *The End of Lawyers?* (Oxford University Press, 2008); Richard Susskind, *Tomorrow's Lawyers: An Introduction to Your Future* (Oxford University Press, 2013)

¹²⁸ Moves in this direction have already been identified within the traditional medical model. Harrison, for example, describes what he calls 'scientific-bureaucratic medicine', with a tendency for managerialism to override professionalism and increasing reliance on algorithmic based medicine. Trustworthiness and other traditional professional characteristics associated with individual practitioners begin to take second place to trust placed in systems. S. Harrison S. 'New Labour, Modernisation and the medical labour process', *J Soc Policy* 2002, 31(3):465–485. It does not take much of a leap of imagination for doctors to find themselves further edged out of this process, to be replaced by other types of healthcare provider.

¹²⁹ Fenton L and Salter B, 'Competition and compromise in negotiating the new governance of medical performance: the clinical governance and revalidation policies in the UK', *Health, Economics, Policy and Law*. 2009, 4: 283-203