IN THE COURT OF APPEAL **C1/2018/0356**

CIVIL DIVISION

ON APPEAL FROM THE DIVISIONAL COURT (GROSS LJ AND OUSELEY J)

BETWEEN

DR HADIZA BAWA-GARBA

Appellant

and

GENERAL MEDICAL COUNCIL

Respondent

and

BRITISH MEDICAL ASSOCIATION

PROFESSIONAL STANDARDS AUTHORITY FOR HEALTH AND SOCIAL CARE

Interveners

SKELETON ARGUMENT ON BEHALF OF THE BRITISH MEDICAL ASSOCIATION FOR HEARING ON 25-26 JULY 2018

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1. The British Medical Association ("the BMA") is the trade union and professional association for doctors and medical students in the UK. At the beginning of 2018 it had approximately 156,000 members.

2. The BMA has been granted permission to intervene by Lord Justice Singh in recognition of the fact that the appeal *"raises issues of wider importance, both for the medical profession and more generally"* [CB/149]. It is right to note that the Divisional Court's decision in the present case caused widespread consternation within the medical profession. The BMA's intervention has been prompted in particular by its concern that the Divisional Court's judgment could restrict the ability of a Medical Practitioners Tribunal ("Tribunal") to form its own view of the facts and of public confidence considerations in cases involving a criminal conviction.

3. These submissions address the following issues: what is meant by the promotion and maintenance of public confidence in the medical profession (paragraphs 4 to 11 below); the importance of the

Court respecting the role and judgment of the Tribunal (paragraphs 12-14 below); the respective roles and remit of the jury and the Tribunal (paragraphs 15-21 below). The BMA does not intend to make submissions on the specific facts of Dr Bawa-Garba's case, save by way of illustration of its broader arguments.

Public confidence in the medical profession

4. As the Court will be aware, there are three limbs to the statutory over-arching objective of public protection in section 1(1A) of the Medical Act 1983: to protect, promote and maintain the health, safety and well-being of the public; to promote and maintain public confidence in the medical profession; and to promote and maintain proper professional standards and conduct for members of that profession (see section 1(1B)). The Tribunal in the present case concluded that suspending Dr Bawa-Garba's registration was a sanction which *would* be sufficient to promote and maintain public confidence in the medical profession [CB/85, para. 30] and that public confidence in the profession *would not* be undermined by a lesser sanction than erasure [CB/85, para. 32]. The Divisional Court formed an opposing view, concluding that *"the Tribunal … was simply wrong to conclude that, in all the circumstances, public confidence in the profession and in its professional standards could be maintained by any sanction short of the erasure indicated by the Sanction Guidance"* [CB/70, para 53].

5. The BMA is seriously concerned about the use of the public confidence criterion in fitness to practise cases that involve clinical error, especially where there is evidence of remediation. The BMA's response to the recent rapid policy review of gross negligence manslaughter[1] explained that it had *"previously expressed concern that the public confidence criterion could lead to 'trial by media' and called for guidance that properly relates 'public confidence' to the GMC's overarching objective of public protection. One particular problem with the criterion is the subjectivity of public confidence considerations, which can lead to the same act being treated differently in different cases depending on the extent to which the patient is harmed. We would like to see research into the question of what members of the public would really expect in cases involving clinical error."*

[1] The Secretary of State for Health and Social Care commissioned a review into gross negligence manslaughter in healthcare settings in the wake of the Divisional Court's judgment. The review, led by Professor Sir Norman Williams, published its report in June 2018 (*"Gross negligence manslaughter in healthcare – The report of a rapid policy review"*).

6. The BMA submits that the contrasting views reached by the Tribunal and by the Divisional Court as to what sanction was necessary, in the present case, to promote and maintain public confidence in the medical profession illustrate its concern about *"the subjectivity of public confidence considerations"*[2].

7. The BMA notes that research has been undertaken, by the Professional Standards Authority ("the PSA"), into the public perception of dishonest behaviour: see *Dishonest Behaviour by health and care professionals: Exploring the views of the general public and professionals*. This report helpfully illustrates the ability of members of the public to take a nuanced view in relation to cases involving dishonesty: see p. 5 [AB Tab 26]:

   - *"There was a minority who saw issues in black and white and who judged any incidence of dishonesty as grounds for immediate expulsion from the profession. The great majority of both public and professionals took a more nuanced view with judgments more finely balanced around aggravating and mitigating factors.*
   - *There was a consensus that premeditated, systematic or longstanding abuse of professional trust or dishonesty in the context of financial gain or sexual exploitation should be grounds for – rapid – deregistration.*
   - *The majority however, with the exception of the most egregious cases, took a pragmatic and tolerant view on the appropriate disposals for dishonesty in FtP cases. The tendency was towards an emphasis on behaviour change and learning and rehabilitative and constructive outcomes, which allowed registrants to continue in the profession. This was particularly the case where individuals showed insight and remorse and seemed willing and capable of changing their behaviour".*

   The report further noted *"the desire expressed by both public and professionals for a greater focus on rehabilitation, learning and behaviour change"* and *"a potential use for a set of principles underpinning risks to public confidence"* [p. 8].

8. The BMA would welcome similar research into the question of what members of the public would really expect in cases involving clinical error[3] so as to inform the judgments which have to be made

[2] The BMA notes also that the Professional Standards Authority chose not to join the GMC's appeal *"because we did not find the MPT decision to be insufficient to protect the public despite our having the same statutory threshold as the GMC"* (PSA's Response to Professor Sir Norman Williams' review, at para. 1.5).

[3] The BMA acknowledges that there may be some types of case –e.g. sexual misconduct involving a breach of a fundamental rule of the professional relationship between the doctor and the patient - where the requirements of public confidence may be more readily identifiable: see, e.g., *Yeong v General Medical Council* [2010] 1 WLR 548 at paras. 48 and 50, where the court observed that the public's confidence in engaging with medical practitioners may be undermined if there is a sense that such misconduct may be engaged in with impunity and noted that where the misconduct consists of violating a fundamental rule of the professional relationship between medical practitioner and patient *"thereby undermining public confidence in the medical profession"*, *"the efforts made by the medical*

by the Tribunal and so as to reduce the risk of inconsistent, subjective and/or unfair judgments being made (whether by the Tribunal or by the Court). Indeed, the BMA submits that, as the GMC increasingly relies upon the need to maintain public confidence in the medical profession to argue for the erasure of a doctor, such research or further work ought to be undertaken (whether by the PSA, or the GMC, or both) as a matter of priority.

9. The BMA's concerns are shared by others, as is clear from the report of the rapid policy review by Professor Sir Norman Williams:

> *"12.5 The panel heard particular concerns about the regulators' roles in taking fitness to practise action on the grounds of securing public confidence in the healthcare professions. It heard there was little understanding about the type of behaviours and failings that might lead to the public losing confidence in the profession and which therefore constitute grounds for regulatory action. This needs to be better understood in order for the professional regulators to give proper consideration to their duty to protect the public."*

The PSA itself told the review that *"There is little understanding about what sorts of behaviours and failings constitute a genuine threat to public confidence, which is relevant in GNM cases where the registrant is found not to pose a risk to the public"* and identified a need for research which could inform the development of guideline cases[4].

10. The BMA notes further the observation of the Privy Council in *Royal College of Veterinary Surgeons v Samuel* [2014] UKPC at para. 31, where, in response to a submission about the *"instinctive response of ordinary members of the public on being told that [the appellant] had been convicted of offences of theft, assault and using threatening words or behaviour"*, Lord Toulson stated that:

> *"Criminologists who have conducted research into public attitudes to crime have often shown that the views expressed by the public in answer to very broad questions about different types of offending and the appropriate sentences may be very different from the views of the same people when given detailed factual information about particular offences and offenders".*

In other words, generalised assumptions about the response of members of the public to a conviction may be misplaced and inaccurate.

11. In the absence of such research, the BMA makes the following submissions:

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

[4] PSA's Response to Professor Sir Norman Williams' review at paras. 2.2, 3.10 and 3.11.

a. The BMA accepts that the question of what sanction is sufficient to promote and maintain public confidence in the medical profession is a question of judgment. Nonetheless, it is a judgment which can and ought to be reached on an informed basis and by reference to all available evidence.

b. There is no reason why a practitioner may not adduce evidence, which has already been considered by a jury, pursuant to rule 17(2)(m) of the General Medical Council (Fitness to Practise) Rules 2004, relevant to the question of maintaining public confidence in the profession. The question of what weight is to be given to evidence adduced under rule 17(2)(m) is pre-eminently a matter for the Tribunal on the facts of the individual case.

c. Given the absence of any such research, the somewhat nebulous nature of the public confidence criterion, and the risks of subjectivity, extra care and caution should be exercised by the Court before it overturns a decision of the Tribunal as to what public confidence requires.

d. The BMA submits that the correct approach should mirror that explained by Holgate J in *R (Wallace) v Secretary of State for Education* [2017] EWHC 109 (Admin), at para. 96(v): *"Public concern about the misconduct in this case and maintaining public confidence in the teaching profession should be assessed by reference to the established standard of the 'ordinary intelligent citizen'. Such a citizen should be assumed to be reasonably well-informed about the issues raised by the case. 'Public confidence in the profession' should not be assessed by taking into account the perceptions of someone who is ill-informed or uninformed"* [AB, Tab 20].

e. The BMA notes that Sanctions Guidance provides relatively little guidance on this specific issue[5].

f. It would be wrong for Tribunals or Courts to make the assumption (whether directly, by applying a presumption, or indirectly) that, in a GNM case, maintaining public confidence requires the imposition of an order for erasure.

g. In assessing what sanction may be sufficient to maintain and promote public confidence, the Tribunal must be able to take into account a wide range of matters, including mitigating factors such as insight and remediation. It can readily be understood that public confidence in the profession may be undermined by allowing doctors to continue to practise who continue to pose a significant risk to patients, have shown no insight and have made no

[5] Paragraph 17, for example, merely states, under this heading, that doctors must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession, and that the reputation of the profession as a whole is more important than the interests of any individual doctor.

efforts at remediation; conversely, however, it must be relevant to any assessment of what is required in order to maintain public confidence in the profession (or at least capable of being relevant, depending on the facts of the individual case), that a doctor poses no continuing risk, has made substantial efforts at remediation and has good insight.

h. Reliance upon the public confidence limb of the overarching objective may, if it results in outcomes that are too severe, have counter-productive consequences which are contrary to the public interest – such as encouraging defensive practice, discouraging remediation, candour and openness as the best means of protecting and promoting patient safety, and deterring new entrants to the profession.

i. The public confidence criterion permits the Tribunal to take into account the public interest in an otherwise good and competent doctor being permitted to continue to practise. See:

   i. <u>*Bijl v General Medical Council*</u> [2001] UKPC 42 Privy Council at para 13 [AB, Tab 7]: *"The committee was rightly concerned with public confidence in the profession and its procedures for dealing with doctors who lapse from professional standards. But this should not be carried to the extent of feeling it necessary to sacrifice the career of an otherwise competent and useful doctor who presents no danger to the public in order to satisfy a demand for blame and punishment."*

   ii. <u>*Giele v General Medical Council*</u> [2006] 1 WLR 942 at para. 29 [AB, Tab 12]: *"that confidence will surely be maintained by imposing such sanctions as is in all the circumstances appropriate. Thus in considering the maintenance of confidence, the existence of a public interest in not ending the career of a competent doctor will play a part."*

   iii. <u>*R (Wallace) v Secretary of State for Education*</u> [2017] EWHC 169 (Admin) at para. 84 [AB, Tab 17]: *"the public interest in retaining a person who is able to make a valuable contribution to a profession, can be a factor carrying substantial weight against prohibiting him or her from working in that profession"*.

These authorities remain, in the BMA's submission, good law. The BMA agrees with the Appellant that the Divisional Court was wrong to conclude otherwise in relation to <u>***Bijl***</u> (Appellant's skeleton paragraph 24). It submits that <u>***Bijl***</u> usefully reinforces the point that "public confidence" is not a factor that automatically outweighs other relevant factors including the doctor's current competence and the current level of risk, if any, to patients.

<u>Respect for the role and remit of the Tribunal</u>

12. The BMA submits that the Divisional Court's judgment risks undermining the unique role and remit of the Tribunal to determine questions of sanction. Panel members have training and expertise

appropriate to their role; the Tribunal comprises Panel members who are lay persons and doctors advised by a legally qualified legal assessor; the Tribunal has the facility to consider a much broader range of evidence than the Court and to take full account of all the circumstances relating to impairment and fitness to practise. Panel members will typically have experience of significantly more fitness to practise cases than a Judge will. Unlike a Court, the Tribunal is not limited to a reaching a single determination, as a Tribunal can order a review hearing to consider at a later stage whether a doctor's fitness to practice remains impaired and what further action needs to be taken.

13. The importance of respecting the judgments reached by the Tribunal, and of avoiding excessive interference by the Court (particularly on the basis of a differing view as to what is required in order to maintain public confidence), has been reiterated in case after case. In view of the approach taken by the Divisional Court the BMA sets out below the key principles and authorities. See:

    a. *Bolton v Law Society* [1994] 1 WLR 512 at p516, p518 and p520 [AB, Tab 4]:

    "it would require a very strong case to interfere with sentence in such a case, because the disciplinary committee are the best possible people for weighing the seriousness of the professional misconduct"

    "The decision whether to strike off or suspend will often involve a fine and difficult exercise of judgment, to be made by the tribunal as an informed and expert body on all the facts of the case"

    "so far as the difference between striking off and suspension are concerned, I find it difficult to think that the Divisional Court could have expected to bring more insight to bear on that question than a tribunal with a majority of practising solicitors among its members".[6]

    b. *Marinovich v General Medical Council* [2002] UKPC 36 para 28 [AB, Tab 9]:

    "… it has been said many times that the Professional Conduct Committee is the body which is best equipped to determine questions as to the sanction that should be imposed in the public interest for serious professional misconduct. This is because the assessment of the seriousness of the misconduct is essentially a matter for the Committee in the light of its experience. It is the body which is best qualified to judge what measures are required to maintain the standards and reputation of the profession."

    c. *Council for the Regulation of Healthcare Professionals v General Medical Council and Southall* [2005] EWHC 579 (Admin) para 11 [AB, Tab 11]:

    "where there is misconduct constituted by a failure to reach proper standards in treating patients, the expertise of the tribunal in deciding what is needed in the interest of the public

[6] And see further at p. 520: *"In my judgment, the Divisional Court was doing, no doubt unwittingly, exactly what authority says the court should not do, namely substitute its own view on penalty for that of the professional tribunal."*

is likely to carry greater weight" (and note the contrast drawn with dishonesty or sexual misconduct, where *"the court is likely to feel that it can assess what is needed to protect the public or to maintain the reputation of the profession more easily for itself and thus attach less weight to the expertise of the tribunal.")*

d. *Fatnani and Raschid v General Medical Council* [2007] 1 WLR 1460 at para. 19 [AB, Tab 14]: it is because:

"a principal purpose of the panel's jurisdiction in relation to sanctions is the preservation and maintenance of public confidence in the profession rather than the administration of retributive justice" that *"particular force is given to the need to accord special respect to the judgment of the professional decision-making body in the shape of the panel"*.

e. *General Medical Council v Jagjivan* [2017] EWHC 1247 (Admin), [2017] 1 WLR 4438 [AB, Tab 19], where the Court confirmed that the well-settled principles in relation to section 40 appeals can be applied to section 40A appeals. See in particular para. 40 (iv):

"In regulatory proceedings the appellate court will not have the professional expertise of the Tribunal of fact. As a consequence, the appellate court will approach Tribunal determinations about whether conduct is serious misconduct or impairs a person's fitness to practise, and what is necessary to maintain public confidence in the professions and sanctions, with diffidence."

14. These are weighty principles. For the purposes of the present appeal, the BMA emphasises that:
    a. It is important to bear in mind that these principles apply with equal force to appeals under section 40 and to appeals under section 40A of the Medical Act.
    b. The Court should be particularly slow to interfere with the decision of the Tribunal on the basis of a differing view as to the weight to be attached to a matter (cf. Divisional Court's judgment, para. 53, CB/70), or by reading into the Tribunal's decision views that the Tribunal has not expressed (cf. Divisional Court's judgment, para. 41 CB/68).
    c. It is of paramount importance that the Court does not merely pay lip service to this line of authority, but actually applies it.

The distinct roles of the jury and the Tribunal and the significance of Rule 34

15. Rule 34(3) of the General Medical Council (Fitness to Practise) Rules 2004 provides that *"production of a certificate purporting to be under the hand of a competence officer of a Court in the United Kingdom or overseas that a person has been convicted of a criminal offence or, in Scotland, an extract conviction, shall be conclusive evidence of the offence committed"*. The effect of Rule 34 (3) (in a case such as the present) is that that Tribunal must proceed on the basis that the

doctor was guilty of gross negligence manslaughter – in other words *"fell below the standard of a reasonably competent doctor … in a way which was gross or severe"* or was *"far below"* the standard expected of a reasonable doctor [Nicol J's summing up, SB/186]. However, *"even in cases of medical gross negligence manslaughter, where the consequence of the harm in every case is identical, that is, the death of a patient, the level of culpability of the defendant will vary considerably."*: Garg v R [2013] 2 Cr App R (S) 30 [AB, Tab 15].

16. It is important not to confuse the distinct roles of the jury and the Tribunal. The jury is considering solely the binary question of whether the particular conduct constituted gross negligence manslaughter. Its concern is with a particular point in time and it is not addressing factors such as insight, risk or remediation. The Tribunal, by contrast, is concerned with reaching a judgment as to whether the doctor is fit to practise as a doctor at the time of the Tribunal's decision. It will be the function of the Tribunal, in a conviction case, to determine whether the doctor's fitness to practise is impaired and, if so, what sanction should be imposed. These are predominantly forward looking exercises, involving assessment of *"the current position looking forward not back"* (Yeong v GMC at para. 19).

17. Whether in conviction cases or some other case in which public confidence is invoked, the Tribunal must be permitted to (indeed, it would err if it did not) have regard to all relevant circumstances. These will often include precisely the kinds of matters identified by the Tribunal in the present case as mitigating and aggravating factors such as: the doctor's character, prior record, the absence of any evidence of other concerns, the passage of time since the offence, the fact that the behaviour in question was not deliberate or reckless and evidence of remediation.

18. The Tribunal is entitled to consider the circumstances and context in which the offence was committed. Doing so does not mean that the Tribunal is breaching Rule 34 or proceeding otherwise than on the basis that the offence was committed. The environments, factual context and circumstances in which clinical failures amounting to gross negligence occurred may be relevant to the doctor's fitness to practise looking forward, to questions of proportionality and public confidence and to the Tribunal's decision as to what sanction should be imposed.

19. It involves no breach of Rule 34, or lack of respect for the jury's verdict, to consider the same mitigating (or other) evidence (including evidence of systemic pressures or remediation) that was before the jury, because the purpose of such consideration is not to conclude that the doctor's conduct

did not amount to gross negligence, but to consider what is a proportionate and appropriate fitness to practise sanction at the time of the Tribunal's decision.

20. The BMA submits that the Divisional Court's approach to the Tribunal's decision was wrong and that its conclusions, as set out in paras. 41-3 and 47 of its judgment [CB/68-69], involve (as the Appellant's skeleton puts it) *"an impermissible degree of reading between the lines as to what the MPT had concluded"*. In a conviction case, the Tribunal is not required to make its own findings as to personal culpability. It proceeds on the basis of the conviction. The Tribunal in the present case did not make its own assessment of the degree of the Appellant's personal culpability on 18 February 2011, nor did it find that her culpability was less severe than that found by the jury or conclude that it was below the level for gross negligence manslaughter. The Tribunal (as recommended by the Sanctions Guidance) identified a range of mitigating and aggravating factors for the proper purpose of deciding what the appropriate sanction was.

21. Finally, the BMA submits that there must be no presumption that a conviction of manslaughter by gross negligence should lead to erasure from the medical register save in exceptional circumstances. If the Court did in fact apply such a threshold, as the Appellant with some justification contends (see, e.g. Divisional Court's judgment at paras. 51-53, CB/70), it was wrong to do so. Nothing in the Act, the Rules, case law or the Sanctions Guidance provides support for any such presumption, and it would be contrary to the general principle that in determining sanction consideration should be given to all relevant circumstances. Indeed, the Sanctions Guidance (AB, Tab 24 at para. 20) states in terms that the Tribunal should, when deciding what, if any, sanction to impose, start with the least restrictive and should have regard to the principle of proportionality, weighing the interests of the public against those of the doctor. The decision as to sanction depends on the facts and circumstances of each case, considered individually. It follows that a suspension order *may* be an appropriate sanction in a case of gross negligence manslaughter. Whether to impose a suspension order or to erase in an individual case is a matter for the expert judgment of the Tribunal.

JENNI RICHARDS QC (39 Essex Chambers)
NADIA MOTRAGHI (Old Square Chambers)
29 June 2018