On 23 September 2013, Niall Dickson, Chief Executive of the General Medical Council (GMC) released a press statement in which he stated: “Following a thorough investigation, we have taken the decision to close four cases involving doctors who held management positions at Stafford Hospital. We took this decision – as the prosecutor of cases against doctors – following advice from Tom Kark QC, the leading counsel to the Francis Inquiry. He advises us in the strongest terms that these cases cannot proceed to a hearing.”

This decision provides a useful opportunity to consider the GMC guidance for doctors in management which was available at the time of the Mid Staffordshire Inquiry and also the more recent guidance published by the GMC in 2012.

The decision to close the four cases involving doctors was made following Tom Kark QC’s advice in which he confirmed that although the evidence was capable of establishing serious failings in respect of the provision of care, safety of patients and clinical governance this was not sufficient to establish either misconduct or impairment against any individual doctor.

Evidence of a failing

Although many were no doubt surprised by this decision given the many criticisms made following the Francis Inquiry, it reiterates the very clear remit of the GMC which is that in order to achieve a successful fitness to practise prosecution it is necessary to establish the specific responsibility of that individual doctor. In addition, the GMC must be able to prove that the doctor’s failing was so serious to amount to serious misconduct or deficient professional performance to impair their current fitness to practise. In short, failings must be directly linked to the specific actions of an individual doctor. Establishing this link is much more difficult where the failings are seen to be as a result of systemic failings which took place over a number of years and concerned a wide range of individuals with a variety of responsibilities.

Mr Kark states in his letter of advice to the GMC: “To mount a successful Fitness to Practise prosecution it would therefore be necessary to call evidence establishing the specific responsibility of the doctor in questions for the area in which the Trust had failed and to go on to prove that the doctor acted or failed to act in such a culpable way so as to have caused or contributed to the deficiency; moreover it would be necessary to prove that the doctor’s failing in the period prior to 2009 was so serious as to amount to serious

By Lisa Jones, Healthcare Associate, Berrymans Lace Mawer LLP
misconduct or deficient performance such as to impair their current fitness to practise at the time of the hearing in 2014.”

The GMC, clearly concerned about the likely criticism of its procedures as a result of this decision, reacted with the following press statement: “However, there is a separate and wider issue within the current legal arrangements under which we operate, and we are currently working with the Department of Health to see what more can be done to increased appropriate accountability when things go wrong.”

Historically, there have been few examples of successful disciplinary proceedings of doctors in managerial roles at the GMC and this is demonstrated in some relevant case law.

In the case of Roylance v General Medical Council [2000] it was said by the Privy Council that there was a need for there to be a sufficiently close link with the profession of medicine in order for a doctor who held a managerial role to be held to account.

More recently in the case of R (on the application of Remedy UK Ltd) v the General Medical Council [2010] the High Court confirmed that conduct involving managerial or administrative functions could be described as being linked to medical practice but these must be part of the day to day practice of a professional doctor. The making and implementation of government health policy was not considered to be a medical function.

New guidance

At the time of the failings at Stafford Hospital the GMC guidance applicable was entitled ‘Management for Doctors’. Although this guidance set out many duties and responsibilities of doctors who are in management roles, the new guidance published in 2012 entitled ‘Leadership and Management for all doctors’ is clearer on precisely what a doctors duties are in these areas.

In Tom Kark’s letter of 10 September 2013 he accepts that the GMC’s guidance on duties of doctors in management positions during the relevant period could have been considerably clearer.

In the press release Niall Dickson goes onto state: “………We want to be able to hold doctors to account where they have harmed patients or put them at risk, even if they have subsequently shown insight and can claim they are no longer a risk to patients. We also want to have a right of appeal against panel decisions by the Medical Practitioners Tribunal Service – this would allow us to act when we believe the panel has been too lenient. We hope these changes will form part of the Law Commission’s current wide ranging review of the law governing the regulation of healthcare professionals.”

If a detailed inquiry happened again, could the outcome be different because of the new guidance?

It is clear that the GMC will be looking for changes within the legal framework
in which it would still be able to proceed with cases against doctors even where it cannot establish that the particular doctor is currently impaired. The Mid Staffs Inquiry focuses on the care provided between 2005-2008. Due to the passage of time it was by 2013 difficult to establish that a doctor’s fitness to practise was impaired.

The new guidance clearly sets out the obligations of all doctors in various areas of medical practice. In addition, it also sets out the responsibilities of those doctors who are considered to have ‘extra responsibilities’. Doctors with ‘extra responsibilities’ are defined as doctors with management or leadership responsibilities at a personal, team, organisation or policy level.

The previous guidance simply stated: “We recognise that doctors in an assortment of roles take on management responsibilities to varying degrees: you may be a single-handed general practitioner or lead a small clinical team; or you may be a clinical or medical director or a chief executive. We also recognise that your ability to put into effect parts of the guidance in this booklet will depend on the authority your position gives you as well as the resources made available to you.”

The new guidance is much more detailed (almost double in length) and much more definitive in setting out the obligations of those doctors within management. The guidance sets out the wider management and leadership responsibilities of doctors in the workplace, including:

1. Responsibilities relating to employment issues;
2. Teaching and training;
3. Planning, using and managing resources;
4. Raising and acting on concerns;
5. Helping to develop and improve service.

When considering the background of the Francis Inquiry and the criticisms made in the subsequent report the following paragraphs are of particular note:

20. You are accountable to the GMC for your own conduct and any medical advice you give. This includes
while you serve as a member of a decision-making body for a health or social care organisation, such as a hospital or health board.

27. You must follow the guidance in Good Medical Practice and Raising and acting on concerns about patient safety when you have reason to believe that systems, policies, procedures or colleagues are, or may be, placing patients at risk of harm.

28. If you have a management role or responsibility, you must make sure that systems are in place to give early warning of any failure, or potential failure, in the clinical performance of individuals or teams. These should include systems for conducting audits and considering patient feedback. You must make sure that any failure is dealt with quickly and effectively.

29. If you are managing or leading a team, you should make sure that systems, including auditing and benchmarking are in place to monitor, review and improve the quality of the team’s work. You must make sure that teams you manage are appropriately supported and developed and are clear about their objectives.

82. If you are responsible for managing resources, or commissioning or delivering health services, you should have a detailed knowledge of how management processes work and how they affect the delivery of patient care.

The change of wording is usefully highlighted by comparing paragraphs 24 of the old guidance and 21 of the new guidance.

Paragraph 24 of the old guidance states as follows:

Paragraph 21 of the new guidance in comparison states as follows:

If, as a member of a board or similar body, you are concerned that a decision would put patients or the health of the wider community at risk of serious harm, you must ask for your objections to be formally recorded and you should consider (my emphasis) taking further action.

Paragraph 21 of the new guidance in comparison states as follows:

If, as a member of a board or similar body, you are concerned that a decision would put patients or the health of the wider community at risk of serious harm, you must ask for your objections to be formally recorded and you should (my emphasis) take further action in line with our guidance Raising and acting on concerns about patient safety.

There is certainly more emphasis on a doctor being compelled to take action rather than just considering whether it is necessary or not.

Although it could never be said for certain, it is at least arguable that had this guidance been in place at the time of the failings at Mid Staffordshire hospital, it may have been easier to bring cases against the doctors involved. However, the new guidance does not deal with the remaining difficulty of establishing that a doctor remains impaired where a hearing takes place a significant time after the alleged incidents have occurred.

With the new guidance in place doctors who also hold managerial positions can be certain that it is not only matters of their competence as a clinician which are relevant to maintaining registration with the GMC but also their competence as a manager. The Mid Staffs Inquiry potentially highlighted ‘gaps’ in the current system of regulation for doctors and it is clear that the GMC will want to take as many steps as possible to try and fill these ‘gaps’ when looking at managerial accountability and responsibility.

Doctors who are looking to further their careers and experience new challenges in management roles should be aware of the increased scrutiny by the GMC when carrying out this role. Although, in these cases it is always going to be more difficult to establish a successful prosecution, the GMC has certainly taken an initial but important step in providing the much needed clearer and more defined guidance.