

PUTTING PUBLIC CONFIDENCE FIRST: DOCTORS, PRECAUTIONARY SUSPENSION, AND THE GENERAL MEDICAL COUNCIL

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I. INTRODUCTION

Over the past ten years, many professions in the UK have acquired far-reaching interim powers to suspend their members from practice before any complaints against them have been proved.¹ In the case of the medical profession, the modern incarnation of these powers can be traced to the wave of reactive regulation triggered by Dr Harold Shipman's convictions for the murder of fifteen of his patients.² Although these powers are attended by significant procedural safeguards, their statutory parameters are incredibly broad,³ undefined, and vulnerable to draconian application. Given that interim orders are designed to be used in advance of the complaints against the doctor being proved, they are inevitably cloaked in secrecy, making them a challenging subject for study.

Precautionary suspension is a potent regulatory tool in the General Medical Council's (GMC) enforcement of its fitness to practise framework. In an effort to develop some insight into the use of this power in regulating doctors, notwithstanding this secrecy, this study takes a

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¹ The panel imposing the order is not charged with determining whether the allegations are in fact true: *R on the application of Ali v General Medical Council* [2008] EWHC 1630 (Admin).

² *Fifth Shipman Report: Safeguarding Patients: Lessons from the Past - Proposals for the Future*. (2004) at 18.42. The first Shipman report concluded that Harold Shipman had probably killed more than 200 other patients, additionally to those that the jury had convicted him of murdering: *First Shipman Report: Death Disguised* (2002). The Shipman reports are available at <<http://www.the-shipman-inquiry.org.uk/reports.asp>>.

³ S 41A of the Medical Act 1983 currently provides that an interim order is available 'for the protection of the public' or 'otherwise in the public interest' and may be issued for up to eighteen months, being thereafter renewable indefinitely provided court approval is first obtained.

two-pronged approach. The first part of the study takes a sample of interim orders hearings involving doctors over a three-month period and examines the outcomes in these cases some sixteen months later. A paradox appears to emerge from this analysis; namely that in a substantial number of cases, the gravity of the interim 'sanction' imposed by the GMC exceeds that of the final sanction imposed on the doctor concerned. The second part of this paper uses the case law arising from applications to challenge or extend interim suspension orders that has accumulated over the past ten years as a lens through which to observe how these precautionary powers have been applied. This second analysis identifies two oppositional narratives as to the function of the power to suspend doctors on an interim basis, one of which envisages interim orders as a tool to be used in the general assault upon perceived crises of confidence in the medical profession. The paper concludes with some critical reflections on the implications of this particular narrative.

Before launching into this two-pronged analysis, this paper first outlines the particular legal and political context in which these powers emerged in an effort to explain some of the problems and ambiguities associated with their use.

II. PUBLIC CONFIDENCE IN THE MEDICAL PROFESSION AND THE POST-SHIPMAN MODEL OF INTERIM ORDERS

A. *The 'Shipman Effect': Mobilising the Law to Increase Public Confidence*

The GMC is the regulatory body responsible for enforcing the 'fitness to practise' framework for doctors as set out in the Medical Act 1983. From the year 2000 to date, the GMC has survived a formidable programme of regulatory reforms, triggered or galvanised by the findings of the *Smith Inquiry* into events surrounding Dr Harold Shipman's homicidal proclivities.⁴ These reforms, without exception, aimed at least in part to redress the shortfall of public confidence in regulation of the medical profession and, in particular, to deal with a perceived lack of independence of regulator from regulated. The following inventory offers an indication of the extent and breadth of this programme of reform:

⁴ Above at n 2. Some of these reforms had already been triggered by the earlier scandal of the high level of mortality rates for children's heart surgery at Bristol Royal Infirmary: *Bristol Royal Infirmary Inquiry* (2001).

- in an effort to counter allegations that the GMC was inclined to protect doctors, its main statutory objective became 'to protect, promote and maintain the health and safety of the public'⁵;
- the 'Office of Healthcare Professions Adjudicator' was created with a view to it taking over the GMC's role of adjudicating fitness to practise cases⁶ (although this was a strongly worded recommendation of the Shipman Inquiry, the plan has been jettisoned by the Coalition Government⁷);
- the composition of the GMC's Council was changed to include more lay members⁸;
- arrangements were put in place to enhance the independence of Council members by removing the system of their election by registrants and moving to appointment by the Privy Council;⁹
- fitness to practise procedures were streamlined, including an apparent widening of the net by focussing on whether in the light of a doctor's 'conduct' fitness to practise had been 'impaired', rather than whether 'serious professional misconduct' or 'seriously deficient performance' had been committed¹⁰;
- the burden of proof in fitness to practise cases was lowered from the criminal standard requiring 'proof beyond reasonable doubt' to proof of the allegations 'on the balance of probabilities'¹¹;
- the 'über-regulator', the 'Council for Health Care Regulatory Excellence', was created with the power to launch a 'public interest' appeal against a GMC decision which it regarded as 'too lenient';¹²
- the GMC became subject to a statutory duty to report to Parliament annually on its performance in fitness to practise procedures;¹³

⁵ S 1A Medical Act 1983.

⁶ S 98 of the Health and Social Care Act 2008.

⁷ See Ministerial Statement of 2nd December 2010: accessible at <<http://ohpa.org.uk>>.

⁸ Based on a model of self-regulation, in 2000 membership of the 'Council' comprised a 75:25 split of professional members and lay members. In 2002, this was amended to a 60:40 split and in 2008 became a 50:50 split (*General Medical Council (Constitution) Order 2008* (2008/2554)).

⁹ Schedule 1, Part 1A of the Medical Act 1983. S 60(1) Health Act 2006 authorises the Privy Council to hand over these functions to the Appointments Commission.

¹⁰ *Reform of the Medical Act 1983 - The General Medical Council (Fitness to Practise) Rules* Order of Council 2004 No 2608 and the new s 35(C)(2) of the Medical Act 1983. Misconduct must nevertheless be 'serious' before it will be regarded as sufficient for fitness to practise to be impaired: *Nandi v GMC* [2004] EWHC 2317 (Admin) *per* Collins J.

¹¹ S 112 of the Health and Social Care Act 2008 amending s 60 of the Health Act 1999.

¹² A power awarded to the Council for Regulatory Healthcare Excellence by s 29 National Health Service Reform and Health Care Professions Act 2002.

¹³ S 52A Medical Act 1983.

- a licensing system was introduced, to be governed by the GMC, for anyone practising medicine in the UK.¹⁴ This was a first step towards setting up the troubled system of regular revalidation of doctors.¹⁵

In the course of the *Fifth Shipman Report*, Dame Janet Smith examined a number of reforms to the governance of the medical profession which had been instigated or, more often, expedited as a result of the Shipman affair.¹⁶ In the case of the arrangements for clinical governance (as they then stood), she concluded that they would ‘never be the method of choice for detecting deliberate malpractice. Those who deliberately do wrong usually take steps to cover their tracks’.¹⁷ Proposals for revalidation of doctors were met with similar concerns: ‘Harold Shipman would have been revalidated without difficulty under the proposals.’¹⁸ Finally, reforms to the GMC’s fitness to practise procedures would have been unlikely to have prevented ‘another Shipman’ or to have provided the means for detecting Shipman’s dysfunctional practice earlier.¹⁹ This is seemingly one of the legacies of the Shipman affair and might be called ‘the Shipman effect’. The discovery of Harold Shipman’s atrocities has been used as a vehicle to expedite sweeping reforms of medical regulation accompanied by great expense.²⁰ These reforms will often be of little assistance in, for example, preventing a ‘Shipman #2’, but are utilised in the general assault upon perceived crises of public confidence in the medical profession.

The enlarged power to suspend doctors in advance of their fitness to practise hearing was one of the first of the post-Shipman measures designed to abate public concern about the GMC’s regulatory efficacy.

¹⁴ *The General Medical Council (Licence to Practise) Regulations Order of Council 2009* inserts a new s 29 into the Medical Act 1983 on this.

¹⁵ Although the original proposals are now ten years old, plans for this contentious scheme are far from finalised: *Revalidation: a Statement of Intent* (GMC, 2010).

¹⁶ Many were initiated as a response to investigations into the events at Bristol Royal Infirmary, with such efforts being galvanised by the Shipman case.

¹⁷ See 12.142–12.143 of the *Fifth Report*, n 2 above.

¹⁸ See the conclusions to ch 26 of the *Fifth Report* (ibid). Detection of homicidal General Practitioners was not, however, the purpose of revalidation proposals: see the heated responses to ‘Have we heeded the lessons to be learned from Shipman?’ (2010) BMJ 341.

¹⁹ See ch 16 of the *Fifth Report* (ibid). See also, however, suggestions that the very idea that reforming medical regulation could prevent another Shipman was seriously flawed given the very exceptional and deliberative nature of his crimes: R Fiskin, ‘Premise is Wrongheaded’ (2010) BMJ Lett 341.

²⁰ The costs of the Shipman Inquiry alone are understood to be around £21 million: *Public Inquiries Seminar – ‘Shipman: Was it Worth It?’*, delivered by Lady Justice Smith, 24th September 2010 at Gresham College.

The following section takes a closer look at the 'post-Shipman' version of this power and compares it to the 'pre-Shipman' model.

B. Precautionary Powers of the GMC's Interim Orders Panel

The power to suspend doctors pending investigation of complaints made against them is a vital precautionary tool in the protection of patients and in protecting the integrity of the profession. NHS Trusts and their predecessors have long enjoyed wide ranging powers to suspend staff pending an investigation.²¹ By contrast, the GMC appeared to regard itself as having very limited interim powers. Although alerted to the police investigations in August 1998, the GMC had taken the view that it had no powers to qualify Shipman's registration until conviction. On 31st January 2000, Harold Shipman was convicted of murdering fifteen of his patients. A day later, notwithstanding his convictions and the decision to investigate his involvement in the deaths of more than 100 other patients, Dr Shipman remained on the GMC's register of medical practitioners. Amidst a media stimulated furore, the GMC was urged to take immediate action to remove Shipman from its register and develop more robust interim sanctions.²² By July, new interim orders provisions in the form of section 41A had been inserted into the Medical Act 1983,²³ bearing 'the hallmarks of rushed draftsmanship'.²⁴

Although these interim orders have been the subject of surprisingly little academic discussion, it is hard to over-state the impact that the Shipman affair had on the framing and use of these powers. The post-Shipman provisions represented a significant 'enlargement' of this precautionary power from its earlier form in section 42 of the Medical Act 1983, in terms of both the duration of these orders and the grounds for imposing them.

1. Duration

Previously, interim orders could only be ordered for a maximum of two months and there was no provision for renewal of the order.²⁵ The new section 41A enabled an Interim Orders Committee (later to become the Interim Orders Panel²⁶) or Fitness to Practise Panel to impose conditions

²¹ Although this power is now referred to as 'exclusion' rather than 'suspension' to distinguish it from suspension by the regulatory bodies. NHS Trust policies on exclusion must incorporate the *Directions on disciplinary procedures* (DoH, 2005).

²² HC Deb 01 February 2000 vol 343 cc907-19.

²³ Art 10 of the Medical Act 1983 (Amendment) Order (S.I. 2000/1803).

²⁴ *R (on the application of Steven James Walker) v GMC* [2003] EWHC 2308 (Admin) at [2] and echoed in *Sheill v GMC* [2006] EWHC 3025 (Admin) at [22].

²⁵ S 42(6) of the Medical Act 1983 as originally enacted.

²⁶ Above at n 23, Art 4.

on registration or suspend a doctor before the case against them had been proved. Such orders could be imposed for up to eighteen months without the involvement of the courts,²⁷ although section 41A facilitates seemingly indefinite extensions beyond this, provided court approval is first obtained.²⁸ The extension of the time limit to eighteen months was itself the subject of 'intensive negotiation' during consultation.²⁹ While eighteen months were agreed upon as the appropriate time limit, this was to accommodate those cases where the case was outside the GMC's control (i.e. generally, where it was the subject of a criminal prosecution) and it was anticipated that in other cases a shorter period would be used.³⁰ This prediction has proved to be inaccurate; all interim orders are made in the first instance for eighteen months and a great many cases take this long or longer to reach a fitness to practise hearing.

2. Grounds

The earlier form of the power to suspend doctors in advance of their case being heard by the then 'Professional Conduct Committee' had only been available '*if necessary for the protection of members of the public*'.³¹ The enlarged version set out in section 41A(1) applied where the panel was satisfied:

- i) that it is necessary for the protection of members of the public; or
- ii) is otherwise in the public interest; or
- iii) is in the interests of a fully registered person, for the registration of that person to be suspended or to be made subject to conditions.

The intention behind adding the 'public interest' ground was clear: to make the power as close to all-encompassing as possible and to vest the panel with a discretion as broad as the courts would permit. GMC guidance avoids attempting to define any of the grounds set out in section 41A, but does suggest that the 'public interest' ground

²⁷ S 41A(2) also states that these orders must be reviewed at least every six months and may also be reviewed where new evidence comes to light. The eighteen-month term is significant when compared with earlier versions of the power. Prior to 1997 orders could only be made for two months, although amended to six months by s 3 of the Medical (Professional Performance) Act 1995.

²⁸ S 41A(6) & (7). Whilst the court may express dissatisfaction about the time being taken to resolve the fitness to practise allegations, it is unlikely to refuse an application for extension but expresses its dissatisfaction by granting a shorter extension than that requested: *Sheill v GMC* [2006] EWHC 3025 (Admin); *GMC v George* [2009] EWHC 1460 (Admin).

²⁹ *Council Minutes: Meeting to consider Order in Council and Changes to Fitness to Practise Rules, 11–12 July 2000* (GMC, 2000).

³⁰ *Ibid.*

³¹ S 42(3)(b) of the Medical Act 1983 as originally enacted.

includes 'preserving public trust in the profession and maintaining good standards of conduct and performance'.³²

The enlarged power to impose interim orders has been accompanied by a dramatic increase in usage with only four interim orders being made between 1980 and 1996,³³ when compared with figures for 2009 which show that 455 new interim orders were made in that year alone.³⁴ In common with Dame Janet Smith's observations set out above regarding clinical governance and revalidation, had these enlarged powers to make interim orders been in place earlier, they would not have prevented Shipman from murdering any of his patients. As the GMC was not informed of the concerns about Shipman's practice until the second police investigation in August 1998, any action taken at this stage would not have been instrumental in preventing any further deaths.³⁵

III. AN OUTCOMES ANALYSIS OF INTERIM ORDERS: THE PROCESS IS THE PUNISHMENT?

At the outset of this study, it was possible to access limited details of interim orders throughout the current year. Details were recorded of nearly 300 interim orders hearings from 1st July 2009 to 30th September 2009 and an attempt was made to track the outcomes of these cases some sixteen months later.³⁶ It was resolved to compare the gravity of interim sanctions against the final sanction imposed upon the doctor in individual cases. It soon became apparent that this analysis would give rise to conclusions which were reminiscent of the eponymous theme of Malcolm Feeley's 1979 monograph, *The Process is the Punishment*.³⁷

³² <http://www.gmc-uk.org/concerns/hearings_and_decisions/interim_order_panel_referrals.asp>.

³³ *Fifth Shipman Report*, n 2, above, at ch 20.

³⁴ Figure kindly provided by the GMC's annual statistics team. This figure does not include all the review hearings in which existing interim orders are renewed.

³⁵ The first Shipman report documents the last death attributable to Harold Shipman (Kathleen Grundy) as being in June 1998: See *Death Disguised* above at n 2.

³⁶ It would no longer be possible to replicate this process using the GMC website as the *General Medical Council (Form and Content of the Registers) Regulations 2010* (as amended) provide that where a case against a doctor is subsequently closed without any fitness to practise finding, the interim order should cease to be published. As a consequence of the review leading to this change in policy, the GMC ceased its practice of publishing all interim orders decisions in the current year and publishes only those in the current month.

³⁷ M Feeley, *The Process is the Punishment: Handling Cases in a Lower Criminal Court* (Russell Sage Foundation 1979).

A. Outcomes Analysis: 1st July to 30th September 2009

A total of 294 IOP hearings were recorded for the months of July, August, and September of 2009. When the outcomes in these 294 cases were tracked using the GMC's online List of Registered Medical Practitioners ('LRMP') in January 2011, a significant number (80) had not yet been resolved and interim orders were still in place.³⁸ The fact that 27% of these cases remained unresolved 15 months after an interim order is imposed (or renewed) may serve to underline concerns about the length of time taken to complete fitness to practise processes, although it is not the aim of this article to explore these issues. Only 98 of the 294 cases appeared to have been determined by a fitness to practise panel. Of these cases, 23 had resulted in a lesser 'post-trial' sanction than the interim sanction (e.g. with long-term interim suspension being replaced by a short period of suspension, conditions, a warning or no action at all). Examining the minutes of the fitness to practise panels in these cases, it is clear that in some cases the severity of the *interim* sanction was taken into account in fixing the *final* sanction (as is the general rule in the context of sentencing by the criminal courts).³⁹ This was by no means evident in all the 23 cases, and there was no clear policy discernible as to when the interim sanction could be used to commute the sanction applied to the doctor concerned. Given that there is such a strong expectation in criminal procedure that pre-trial sanctions should be used to reduce the final sentence, it is not difficult to envisage a doctor being successful in an appeal against a fitness to practise panel decision which fails to provide reasons for not taking lengthy interim suspension into account when determining the final sanction.⁴⁰

A substantial number of the 294 cases had been concluded without resort to a fitness to practise hearing as follows:

- In 29 cases, the doctors concerned had 'relinquished registration' (meaning they had successfully applied for voluntary erasure from the LRMP).
- In 28 cases, the interim order had been revoked and no further action had been taken.

³⁸ The follow up searches were completed on 6th January 2011 and can only be regarded as accurate at that point in time.

³⁹ See s 67 of the Criminal Justice Act 1967 and s 240 of the Criminal Justice Act 2003, the latter imposing a duty on the sentencing judge to make an order that time spent on remand should be deducted from the sentence to be served (as applied in *R v Gordon* [2007] EWCA Crim 165; [2007] 2 All ER 768).

⁴⁰ See text accompanying notes 107–109 for further discussion of this issue.

- In 44 cases, no hearing had taken place, but the GMC had resolved to accept undertakings from the doctor which would appear on the LRMP.

Month	No of IOP cases	No. of cases where outcome known ⁴¹	Case concluded with voluntary undertakings	Interim orders revoked and removed from record	Cases resolved by Fitness to Practise Panel ('ftpp')	Interim sanction exceeds sanction imposed by ftpp
July 2009	102	84	10	11	48	11
August 2009	98	68	15	8	32	7
September 2009	94	62	20	9	18	5
Total	294	214	44	28	98	23

If some of these figures are put together, namely:

- (1) cases where orders were revoked and no further action was taken;
- (2) cases where the order of conditions or suspension was removed and the case was resolved by accepting undertakings from the doctor concerned; and
- (3) cases where a final fitness to practise hearing was reached, but the sanction imposed was less severe than the interim sanction,

the combined total suggest that for these three months, the *interim* sanction outweighed the *final* sanction in approximately 95 (32.3%) of the cases where interim orders had been imposed.⁴² If the cases in which the outcome is not yet known are excluded from this calculation, then it is possible to say that, for this sample, 44.4% of the cases were characterised by an interim sanction which exceeded the final sanction.

Some tentative corroboration of this rather surprising finding can be offered by looking at the rate of interim suspensions ordered by the IOP compared with the rate of suspensions⁴³ imposed after a fitness to practise hearing. Daniel Freed observed what he called an 'imbalance ratio' which he summarised as follows: '[O]f the many paradoxes which

⁴¹ As of 6th January 2011.

⁴² Cases of relinquished registration are left out of this particular equation as although technically it can be said that as the GMC has not imposed a final sanction, the interim sanction has exceeded the final sanction, it can equally be argued that the registrant has imposed upon themselves the ultimate sanction of erasure.

⁴³ Including erasure as what might be regarded as suspension lasting at least five years, after which time the doctor is entitled to apply for re-registration.

beset the criminal justice system, few surpass the picture of judges and jailers imprisoning more accused offenders before their trials than after conviction.⁴⁴ A similar trend appears to be at work here with more than fifteen new interim suspensions being ordered each month,⁴⁵ whereas for 2009 the equivalent of twelve suspensions a month were being ordered at the conclusion of a fitness to practise case.⁴⁶

The finding that 44.4% of the cases sampled were characterised by an interim sanction which exceeded the final sanction can be contrasted with a counter perspective which looks at the number of cases in which a doctor's fitness to practise is found to be impaired, but where no interim order had been ordered. Using again a timeframe of three months, it is possible to say, for example, that from 1st November 2010 to 31st January 2011 (inclusive), the GMC's fitness to practise panels made 66 findings of 'impairment'. In 29% of these cases, no interim order was in place. It might be argued that among these cases, particularly the five where erasure from the register was considered necessary, interim powers were under-utilised and patients had not been adequately protected. While there is certainly room for comment and further exploration of such findings, reversing the pattern of enquiry in this way does not detract from the surprising conclusion that pre-trial sanction so frequently exceeds final sanction. Most of the 44% of cases where pre-trial sanction exceeded final sanction involved cases where no formal finding of 'impairment' was ever made because the case was not disposed of by a fitness to practise panel. It is the use of interim orders in these cases which make the conclusion most striking.

B. The Process is the Punishment?

To the extent that this analysis suggested that in a substantial number of cases the weight and gravity of 'pre-trial' sanctions exceeded the final sanction imposed, it echoed findings made in Malcolm Feeley's study, *The Process is the Punishment*, first published in 1979. Feeley's empirical study of law in action in the lower criminal courts of New Haven, Connecticut rapidly became a classic of American socio-legal research.⁴⁷ Feeley's study generated a number of conclusions which

⁴⁴ D Freed, 'The Imbalance Ratio' (1973) 1 *Beyond Time* 25, referred to in Feeley, above at n 37, 235.

⁴⁵ Drawing from the statistics available from July to September 2009 and assuming that these months are broadly representative of the year.

⁴⁶ Using the *Fitness to Practise Statistics 2009* (GMC, 2010) which reported 68 suspensions and 77 erasures ordered by the fttp in 2009.

⁴⁷ J Earl, 'The Process is the Punishment: Thirty Years Later' (2008) 33(3) *Law and Social Inquiry* 737.

brought into question the quality of justice meted out in the lower courts and challenged a number of precepts upon which contemporary ideals of criminal justice were based. He suggested that, paradoxically, for smaller scale crimes, the pre-trial process often served the function of punishing the defendant, and in many cases, pre-trial punishment (e.g. detention and the costs associated with retaining counsel and attending continuances) exceeded post-trial sanction in the form of the sentence imposed by the judge.⁴⁸ This conclusion was particularly contentious, implying as it did that those other than the judiciary (such as prosecutors and bail bondsmen) had significant and sometimes substantial roles in meting out sanctions and were actively inverting the 'adjudicative ideal' which required sanctions to be administered after a fair trial had concluded with a finding of guilt. These conclusions implied, controversially, a subversion of the 'due process' model which had supposedly recently transformed the American criminal justice system. Feeley's study is read by some as suggesting further that substantial pre-trial costs often incentivised the defendant to 'give up,' plead guilty, and accede to the system.⁴⁹ This was another bombshell for the due process movement, as it implied that procedural safeguards directed towards preserving the right to trial by jury were being undermined.⁵⁰

The implications of Feeley's findings hinged upon the very notion of proper 'punishment': it was instinctively repugnant that the formal sentencing function of the judge appeared to be being usurped by more informal mechanisms not provided for by statute. It was this instinctive repugnance which demanded further inquiry and explanation and which produced much excitement among scholars of criminal justice. While both the courts and the GMC doggedly avoid characterising disciplinary sanctions as 'punishments',⁵¹ it is clear that the rationales for sanctions and punishments share much common ground.⁵² Both interim

⁴⁸ There was far more to Feeley's study than simply the observation that the process was in some cases the punishment, although this became a central theme of the book and the theme which has most often been adopted in later research.

⁴⁹ Earl above at n 47, p 744.

⁵⁰ Feeley himself was not altogether perturbed by these particular aspects of his study, asserting that procedural justice did not have a unique claim to just outcomes and that the various personnel worked hard to achieve a form of substantive justice. Feeley above at n 37.

⁵¹ *Raschid and Fatnani v The General Medical Council* [2007] 1 WLR 1460 at [18]; *Meadow v GMC* [2006] EWCA Civ 1390; [2007] 1 QB 462 per Sir Anthony Clarke MR at [32] (the purpose of the sanction is not to punish but to protect the public).

⁵² See F Zacharias, 'The Purposes of Lawyer Discipline.' (2003-4) 45(2) William and Mary Law Review 675 arguing more generally that professional discipline has a great deal to learn from criminal law theory.

orders and final sanctions have as their stated objectives the 'maintenance of public confidence' and 'upholding of standards'.⁵³ These objectives would appear to be very close to the 'expressive functions' of punishment which seek to communicate to society the unacceptability of the given conduct and which are regarded by many as the hallmark of 'punishments' as opposed to other administrative penalties.⁵⁴

C. *Explaining the 'Process is the Punishment' Paradox*

Viewed in the abstract, the fact that the gravity of the GMC's interim sanction often exceeds that of the final sanction imposed on the doctor concerned is reminiscent of the Queen of Hearts' anarchic style of courtroom justice and her conviction that there should be 'sentence first, verdict afterwards'.⁵⁵ Certainly, the frequency with which interim orders are used is likely to be a contributory factor to reports that doctors subject to fitness to practise procedures are treated as presumed guilty until proven innocent.⁵⁶ Is this a sign that interim orders are used excessively, disproportionately, or inappropriately? Such a conclusion would need a great deal more evidence as to the precise grounds upon which interim orders were made and the impact of the order in individual cases. So what, if anything, is to be made of the conclusion that for a substantial number of cases (44% in the sample studied), the gravity of the GMC's interim sanction exceeded the final sanction imposed on the doctor?

To begin to answer this question, it is necessary to view the mechanism of interim orders in the context of the broader landscape of fitness to practise decision making by the GMC. The use of interim orders serves a number of functions not apparent from the face of the statute. These functions include: protecting public confidence in the regulator by providing an answer (albeit an expensive procedural one) to frequent criticisms that the GMC's disciplinary procedures take too long to reach a conclusion; the functionalising of delay in the fitness to practise process and facilitation of redemption; and enhancement of the regulator's stealth and efficiency.

⁵³ See n 32 above for interim sanctions, and for final sanctions see the judgment of *Meadow v GMC* [2006] EWCA Civ 1390; [2007] 2 WLR 286 at [189].

⁵⁴ E.g. J Feinberg, 'The Expressive Function of Punishment.' (1965) 49 *The Monist* 397.

⁵⁵ L Carroll, *Alice's Adventures in Wonderland* (Macmillan Press 1865) ch 12.

⁵⁶ G McGovern and others, 'Medical Regulation, Spectacular Transparency and the Blame Business' (2010) 24(6) *Journal of Health Organisation and Management* 597.

1. Maintaining public confidence in the regulation of doctors

Where a doctor is identified as a potential risk to patients but it takes three years or more to resolve the issue of whether fitness to practise is 'impaired' and to impose a sanction, this will be assumed by many to point to an obvious failing in the regulator's performance of its duty to protect patients and the public.⁵⁷ Such delays, if made known to the public, could potentially resurrect the GMC's reputation for protecting its members. The use of interim suspension can pre-empt these criticisms, affording the regulator more time to scrutinise the evidence on the practitioner's potential impairment. The order appears on the register which is readily accessible to the public and therefore communicates the regulator's commitment to pursuing the case.

2. Functionalising delay and facilitating redemption

Interim orders are a small cog in a complex regulatory framework, and they would appear to perform a vital function in what I have referred to elsewhere as the 'redemption model of fitness to practise'.⁵⁸ The final decision as to whether doctors should be the subject of formal sanction is informed by an assessment as to whether their fitness to practise is 'impaired'. The degree of their 'impairment' is assessed at the time of their hearing⁵⁹ (if there is one) and the system operates so as to incentivise the development of insight, contrition, and remediation in the time between the incident giving rise to the complaint and the final hearing. The use of interim orders, not only serves to protect patients (where necessary), but also gives the doctor the opportunity to reflect and develop these desired values of insight and remorse, and time to prove that since the incident(s) in question they are professionally redeemed and therefore fit to return to practice. The interim order also bridges the gap between the allegations and final determination of the case which often spans a number of years. In this way, it helps to counter the allegation that final sanction is devalued because of the passage of time between the incidents triggering the complaint and final sanction. The idea that interim suspension is used as part of a 'sanctions package' so as to complement and facilitate the broader regulatory aim of optimising the redemption of doctors accused of misconduct is not apparent on the face of the statute. It is, however, a conclusion which is hard to resist having studied fitness to practise in its broader context, and

⁵⁷ As *per* s 1A Medical Act 1983 referred to above at n.5.

⁵⁸ See P Case, 'The Good, the Bad and the Dishonest Doctor: the General Medical Council and the Redemption Model of Fitness to Practise' (2011) 31 Leg Stud (awaiting publication).

⁵⁹ *Per* Mitting J in *Zygmunt v GMC* [2008] EWHC 2643 (Admin) adopting the construction of s 35(D) of the Medical Act 1983 suggested by Dame Janet Smith in the *Fifth Shipman Report* above at n 2, para 25.48.

also taking into account the conclusions of the case law study set out below.

3. Enhancing regulator stealth and efficiency

The possession of such wide-ranging powers available at an interim stage of fitness to practise proceedings enables the GMC to adopt the role of the 'benign big gun', having a wealth of sanctions available and securing the co-operation of doctors through the threat, express, or implied, of their use.⁶⁰ The existence of formidable powers of interim suspension and the stigma they attract may be invaluable in negotiations with doctors who are the subject of complaint, making it clear that sanctions can be imposed at any time if the doctor does not demonstrate the desired level of co-operation. It is perhaps the persuasive value of interim orders that we see at work in the number of cases where an interim order is in place and the doctor applies to relinquish registration. This consensual solution of voluntary erasure saves the cost of lengthy fitness to practise proceedings and avoids the added attention which a finding of impairment can bring. Relinquishing registration is always a possible outcome of a complaint against a doctor, but the impact of interim orders provides added incentives to practitioners to step out of the regulator's gaze.

As is clear from the above, the tentative findings that there is an 'imbalance ratio' between pre-verdict and post-verdict suspensions and that pre-verdict sanctions very often exceed the final sanction do not necessarily imply any criticism of the GMC's use of their precautionary powers. What they at least hint at is that the functions served by interim orders are not apparent from the face of the statute. As we shall see, this lack of definition has understandably given rise to confusion and conflict in the case law. What the conclusions set out here also indicate is that research into this 'interim' component of ensuring doctors' 'fitness to practise' has been hitherto neglected, and its importance understated, yet in many cases the interim sanction imposed is of at least as much significance as the final sanction imposed on the doctor after any final substantive hearing. These findings should be taken as a signal that judicial vigilance in the approach taken to legal challenges of interim orders is crucial.

IV. OBSERVATION OF INTERIM ORDERS THROUGH CASE LAW

This section of the paper moves from focusing on the outcomes of cases where an interim order has been made to interim orders which have

⁶⁰ I Ayres and J Braithwaite, *Responsive Regulation: Transcending the Deregulation Debate* (OUP 1992), particularly ch 2.

been the subject of an appeal. Mirror images of the 'GMC model' of interim orders have been rolled out to a number of other professional disciplinary regimes in the UK.⁶¹ Consequently, the case law emerging from the use of these copycat provisions is utilised in the course of this paper.

The now significant body of case law which has emerged from practitioner appeals against interim suspension orders ('ISOs') offers divergent constructions of the function of this regulatory power:⁶²

The patient protection narrative—a 'narrow construction' which tends to reserve the power of interim suspension for extreme 'emergency' cases where intervention is required to protect patients from a real risk of harm and where the courts are more willing to scrutinise the grounds of their use; and

The public confidence narrative—a 'broad construction' which envisages freer use of ISOs for reasons of preserving public confidence in doctors and affords more autonomy to the regulator in the use of these powers. Instances of this broader narrative are particularly interesting for the questions they raise about the legitimacy and the efficacy of using pre-hearing sanctions to preserve public confidence (or professional reputation).

The case law analysis that follows sets out to identify and explore these competing narratives as to the functions of precautionary suspensions.

V. DIVERGENT CONSTRUCTIONS OF THE POST-SHIPMAN MODEL OF INTERIM ORDERS

A. *The 'Patient Protection Narrative': Precautionary Suspension as an 'Emergency' Power of Last Resort*

This narrow construction of precautionary suspension combines: (i) a high threshold for interim suspension to qualify as being in the public interest, holding the exercise of the power to be justified only in rare cases; and (ii) a conservative view as to the permissible grounds of interim suspension and a reluctance to accept that a precautionary

⁶¹ For example, nurses and midwives (Art 31 of the *Nursing and Midwifery Order 2001* (SI 2001/253)); pharmacists (Art 54 of the *Pharmacists and Pharmacy Technicians Order 2007* and Rule 39(2) of the *Royal Pharmaceutical Society of Great Britain (Fitness to Practise and Disqualification etc. Rules) Order 2007*); health professionals (Art 31 of the *Health Professions Order 2001* (SI 2002/254)); social care workers (*General Social Care Council (Conduct) Rules 2003*, Rule 5(1)(b)); dental practitioners (s 32 *Dentists Act 1984* as amended), and opticians (s 13L *Opticians Act 1989* as amended).

⁶² Here the focus is exclusively on ISOs as opposed to interim orders to the effect that conditions should be imposed on the doctor's registration—this is simply because the latter have produced hardly any case law.

suspension is justified in the absence of a clear risk of harm to the public from allowing the practitioner to continue in his or her profession. Where the narrow construction of precautionary suspension has been identified in court judgments, these judgments also tend to feature a less deferential approach to the grounds for challenging an IOP's decision.

1. High threshold for interim suspension

The three-strand test for interim orders in section 41A of the Medical Act 1983 itself leaves ample room for conflicting interpretations. While the first justification for imposing an interim order (protection of the public) is qualified by a requirement of 'necessity', the second ground (suspension which is 'otherwise in the public interest') is not expressly subject to the same proviso.⁶³ This raises the question of why the second ground is apparently so much broader? If the second ground is intended to apply where there is no 'necessity', it would surely cover all those cases where it was necessary to protect the public, making the first ground, in effect, redundant.

Considering the wording of the three strand test, Davis J in *R (on the application of Shiekh) v General Dental Council* stated that the bar was set high, that suspension would only be justified as in the public interest 'in a relatively rare case', and that although statute did not explicitly apply a necessity test to the 'public interest' ground, necessity was an appropriate 'yardstick'.⁶⁴ Similarly, in an appeal by a social worker, Robertson J regarded the power as available wherever there was 'the need for speedy and urgent action to protect the public' and commented that it was 'an emergency procedure not an administrative one'.⁶⁵ Referring to the power as 'draconian', he went on to decide that he could envisage cases of 'violence, serious breach of trust, mental health issues' where its use would be merited, but that it was not indicated in a case where a social worker was accused of inadequacies in her supervision of an Assessment Team.⁶⁶

⁶³ See s 41A Medical Act 1983 set out above in the text accompanying notes 26–31. In the case of dentists, the wording of the test is almost identical: s 32 Dentists Act 1984 as amended.

⁶⁴ [2007] EWHC 2972 (Admin) at [16]. Cf the contrasting approach in *Sandler* discussed below. The General Optical Council's guidance on interim orders seems to assume that 'necessity' is a precondition to the exercise of this power: *FTP Guidance to Panel Members* (General Optical Council) 14 (available at <<http://www.optical.org>>).

⁶⁵ *Bradshaw v General Social Care Council* [2010] UKFTT 3 (HESC) at [8].

⁶⁶ It was also not indicated in a case where an employer had concerns about a social worker's performance but no specific risk to the public had been identified: *Sonia West v GSCC* [2009] 1614. SW-SUS.

2. Restricted grounds for interim suspension 'in the public interest': Yeong, Shiekh, and Sosanya

The narrow construction regards the imposition of an interim order in the absence of a clear risk to the public as only rarely justified, and is generally hostile to the suggestion that protecting public confidence in the profession is a sufficient stand alone reason for interim suspension. Even where the allegations against the doctor disclose that patients were put at risk, this construction holds that it would be unusual for an incident in relation to a single patient to meet the threshold level of risk to the public to trigger interim suspension as opposed to an order for conditions.⁶⁷

The GMC's own referral criteria used by its Interim Orders Panels ('IOPs') appear to embrace this narrow interpretation, reserving the consideration of interim orders for extreme cases,⁶⁸ and only rarely on the grounds of public interest alone.⁶⁹ In particular, where the allegations do not concern clinical performance, the guidance states that referral to an IOP may be appropriate, *notwithstanding the absence of a direct risk to patients* (my emphasis). This is, however, in cases where:

the doctor faces allegations of a nature so serious that it would not be in the public interest for the doctor to hold unrestricted registration whilst the allegations are resolved. The question would be whether public confidence in the profession would be seriously damaged by the doctor concerned holding unrestricted registration whilst the allegations against him are resolved.⁷⁰

The guidance subsequently gives examples of allegations meeting the level of gravity referred to as rape, attempted rape, murder, and sexual abuse of children.⁷¹ As will be seen below, in practice, the post-Shipman precautionary powers have been utilised in a broader range of cases than seems to be envisaged by this guidance.

⁶⁷ Supported by case law from appeals against ISOs by social workers which suggest that ISOs may be difficult to justify where the complaints relate to an isolated instance or a single case where the professional has enjoyed an otherwise unblemished career: *Rickerby v General Social Care Council* [2010] 1724.SW-SUS-ISO terminated as the complaints related to management of one family.

⁶⁸ *Interim Orders Committee: Referral Guidance* (GMC, 2008) (revised 7th August 2009).

⁶⁹ See *Yeong v GMC* [2009] EWHC 1923 (Admin) at [27] and the discussion of the fitness to practise panel on the difference between IOPs and fitness to practise panels.

⁷⁰ Para 8 of the referrals guidance.

⁷¹ Para 9.

The judgments in *R (on the application of Shiekh) v General Dental Council*⁷² and *R (on the application of Sosanya) v GMC*⁷³ concerned successful applications to terminate ISOs. Both demonstrate a reluctance to countenance the use of interim suspension in the absence of a direct risk of harm to patients. Unproven allegations of money laundering in *Sosanya* were considered by the court not to merit suspension ‘in the public interest’ and the interim order was terminated. Noting that no specific risk to the public had been identified, the judge stated: ‘I repeat, the charges she faces have nothing to do with her abilities as a doctor. There is no suggestion that if she were to continue in practice she would be given access to moneys or might then become tempted into activities of the kind with which she is charged.’⁷⁴ *R (on the application of Shiekh) v General Dental Council* also concerned a practitioner not regarded as posing a direct risk to the safety of the public.⁷⁵ *Shiekh* was convicted of conspiracy to defraud in relation to his handling of his associates’ travel expenses claims. The Crown Court judge concluded: there was sustained dishonesty and there was a conspiracy to defraud, ‘but I consider it unlikely that you would indulge in making dishonest claims in the future.’ Mr Shiekh was subsequently referred to the General Dental Council’s Interim Hearings Panel.⁷⁶ Balancing Mr Shiekh’s interests against the ‘damage done to the reputation and public confidence in the profession’, the Panel considered it proportionate to impose an eighteen month suspension order in advance of the fitness to practise hearing. On appeal to the High Court, the fraud allegations were not considered to give rise to a case for suspension in the public interest.⁷⁷

More recently in *Yeong v General Medical Council*,⁷⁸ the High Court distinguished the powers of the IOP from those of the Fitness to Practise Panel (responsible for hearing the case in full against the doctor and determining whether a sanction is appropriate) stating that: ‘It will not typically be appropriate for the Interim Orders Panel at the interim stage... to impose sanctions on grounds based simply on the importance in the public interest of maintaining clear standards of behaviour, as distinct from dealing with an immediate risk

⁷² [2007] EWHC 2972 (Admin).

⁷³ [2009] EWHC 2814 (Admin).

⁷⁴ [2009] EWHC 2814 (Admin) at [25]. No finding of impairment has been made against Dr Sosanya since the quashing of this ISO.

⁷⁵ [2007] EWHC 2972 Admin.

⁷⁶ S 32(4) Dentists Act 1984 which allows interim orders on similar terms as s 41A of the Medical Act 1983.

⁷⁷ Although note that later on the General Dental Council took the decision to erase Mr Shiekh from the register given the scale of his fraudulent activities: *Shiekh v General Dental Council* [2009] EWHC 186.

⁷⁸ *Yeong v GMC* [2009] EWHC 1923 (Admin) at [61].

posed by a practitioner in relation to his treatment of patients.’ Again, this judgment portrays the ISO as an emergency provision, not suited to general deployment in the assault on perceived crises of confidence.⁷⁹

Yeong, Shiekh, and Sosanya all chime with a reluctance to endorse interim suspension on public interest grounds where there is no clear risk to the public associated with allowing the practitioner to continue in practice. The power is constructed as an emergency provision and not as a regulatory tool to be used liberally in the pursuit of maintaining public confidence in the profession.

B. The ‘Public Confidence Narrative’: Precautionary Suspension as a Tool for Protecting Patients and Public Confidence

The broad construction of interim suspension powers combines: (i) a lower threshold for interim suspension; and (ii) an open-ended approach to the permissible grounds for interim suspension manifested by a greater readiness to accept that ISOs are justified in the absence of a risk of harm to patients. These cases also tend to demonstrate greater autonomy afforded to the regulatory body in the form of a markedly deferential approach to the grounds for challenging the imposition of an interim order.

1. Lower threshold for interim suspension

Three recent cases⁸⁰ tend to suggest that a lower threshold for interim suspension is being deployed than that envisaged in *Yeong, Shiekh, and Sosanya*. All three instances involved allegations relating to the treatment of a single patient and were referred to the GMC against a backdrop of intense media interest. The facts of each case meant that it was hard to see why suspension would be regarded as ‘necessary’ for protecting patients and, by inference, the decision to suspend was likely to have involved a substantial element of acting to protect public confidence.

Two of these cases arose out of the tragic case of *Baby P*.⁸¹ Dr Sabah Al-Zayyat had examined *Baby P* at St Anns Hospital two days before his death from injuries inflicted by child abuse. She was accused of knowing

⁷⁹ This sentiment is echoed in a judgment of the First Tier Tribunal in *Roach v General Social Council* which disapproved interim suspension where the only purpose appears to have been protecting the reputation of the profession of social workers [2010] UKFTT 15 (HESC)—the practitioner presented no clear risk to service users as he had removed himself from the profession.

⁸⁰ These ‘cases’ have not been subject to appeal and therefore a court judgment, but have proceeded through the GMC’s fitness to practise procedures, minutes of which are available on the GMC’s website.

⁸¹ The pseudonym given to Peter Connelly, the toddler aged 17 months whose death resulted in a public inquiry: *Laming Inquiry*, 2009.

that *Baby P*'s name was on the child protection register and failing to conduct an adequate physical examination of him. Dr Al-Zayyat was suspended for almost eighteen months before her case came up for a substantive hearing.⁸² Dr Ikwueke, *Baby P*'s General Practitioner, was also subject to a lengthy interim suspension of seventeen months. When his case reached a hearing it was concluded that he had demonstrated significant remorse and had made extensive attempts at remediation of deficiencies, had a previously unblemished record, and his failure to appreciate the child protection role of a GP was an isolated case. Both cases feature a lengthy interim suspension under the watchful eye of the media. Both raised concerns about the doctors' response to the case of a single patient with no suggestions of dishonesty, criminal offences, or of posing a risk to patients which could not be addressed by imposing conditions on their registration.

The case of the 'bloodgate doctor', Wendy Chapman, reveals a similar pattern to that observed in the *Baby P* cases. Dr Chapman was accused of assisting a rugby player to fake an injury (using a 'stitch cutter' to make an incision in his lip). She subsequently admitted concealing the fakery before a disciplinary committee hearing of the European Rugby Cup. Dr Chapman was subject to an ISO for twelve months prior to her fitness to practise hearing. This hearing concluded with a warning.⁸³ Although it was concluded that her conduct was not acceptable, her fitness to practise was not 'impaired' taking into account that she had been suffering from a major depressive disorder. Again, her case appeared to fall outside the GMC's guidance on interim orders in that it was not suggested that Dr Chapman posed a real, imminent risk to patients. Rather this was a single patient incident which could, ostensibly, have been addressed by conditions. Worldwide media coverage, likely to excite public confidence concerns, was probably a factor in the interim suspension of Dr Chapman.

2. Use of interim suspension to protect public confidence: Sandler, Bradshaw, and TR

The consultation paper which presaged the arrival of the post-Shipman interim provisions envisaged a power which was 'as wide ranging as possible' in order that the GMC could act quickly so as to avert risks to patients or damage to public confidence in the profession.⁸⁴ This document emphasised the need for a tool to deal with the unpredictable,

⁸² In February 2011, Dr Al-Zayyat's request for voluntary erasure from the register was granted.

⁸³ September 2010.

⁸⁴ *Modernising Medical Regulation: Interim Strengthening of the GMC's Fitness to Practise Procedures*. NHS Executive Consultation paper, May 2000 at 1.6.

having the necessary flexibility to respond to novel, unforeseeable cases. This was, of course, a key feature of the Shipman case: who could have imagined that a member of the register for medical practitioners would earn the epithet of Britain's most prolific serial killer?⁸⁵ This broader conception of the utility of ISOs is consistent with a number of court judgments which reject the emergency power construction of interim orders. Specifically, the cases of *Sandler*, *Bradshaw*, and *TR* not only endorse a broader conception of the power, but also explicitly approve of its use as a tool for managing public confidence.⁸⁶

The case of *TR v GSCC*, although concerned with a social worker, illustrates the courts' willingness to sanction interim suspension of a professional in the absence of identified imminent risk. *TR* became the subject of an ISO because of her cohabitation with a man who had served a prison sentence for sexual assault of children in a children's home.⁸⁷ Her partner had been consistent in maintaining his innocence and *TR* believed that he was innocent of all charges. The First Tier Tribunal accepted that an ISO was appropriate and proportionate on the grounds of protecting 'public confidence', making no reference to any potential risk of harm (e.g. a risk that children might come into contact with *TR*'s partner by virtue of her work). It might be tempting to regard the result in this case as a product of the fact that consensus on the malignance of child abuse means that its mere suggestion can attract hyperbolic responses and a tendency to bypass rational risk assessment. This would not, however, explain the case of *Sandler v GMC*.⁸⁸

In *Sandler*, the allegations against the doctor concerned fraud, although such fraud was distinguishable from the cases of *Shiekh* and *Sosanya* in that the fraud arose in the context of his 'clinical duties' in completing cremation certificates. The interim order had been imposed just as Dr Sandler was about to face prosecution under the Cremation Act 1902, not because of a risk to the public, but because suspension was considered to be 'otherwise in the public interest', having regard to the adverse effect of Sandler's case on the reputation of the profession.⁸⁹ The fact that its use was only considered once a decision had been taken to charge Dr Sandler twelve months after the GMC

⁸⁵ In terms of known murder victims, Shipman is now widely regarded as the worst serial killer in the world: 'Inquiry reveals psyche of Britain's worst serial killer' *The Independent* (20 July 2002).

⁸⁶ As does *R (on the application of Steven James Walker) v GMC* [2003] EWHC 2308 Admin. Although mentioned in passing, maintaining public confidence was a factor which the IOP was entitled or even bound to take account of (at [30]).

⁸⁷ *TR v General Social Care Council* [2010] UKFTT 75 (HESC).

⁸⁸ *Sandler v General Medical Council* [2010] EWHC 1029 (Admin).

⁸⁹ *Ibid* at [23].

became aware of the doctor's 'misconduct' further underlines the fact that it was being used here to address concerns related to public confidence and professional reputation.

Sandler's admission of some of the charges and the imminent passage of his case through the criminal courts in the full gaze of the media make the *Sandler* case somewhat exceptional and not necessarily a marker of general approval of imposing interim suspension under the rubric of protecting confidence in the medical profession. Connections might have been made between *Sandler* and the Shipman affair in the public's mind. The Shipman Inquiry had criticised the rubber stamping of cremation certificates and had recommended reforms to prevent another 'Shipman' being able to evade detection for so long.⁹⁰ As Dr Sandler was allegedly fraudulent in his role of corroborating the cause of death, his case therefore had the potential to reignite media interest in Shipman type scenarios, a factor which may have figured in the IOP's decision.

More worrying than what might be regarded as the 'exceptional' case of *Sandler* is the high watermark of the broad construction of interim powers demonstrated in *Bradshaw v GMC*.⁹¹ Here the court endorsed the use of interim suspension in a case not clearly indicated by the GMC's guidance, but did so by adopting a broad construction of what was required to protect the public in tandem with concerns about public confidence. Dr Bradshaw faced allegations that in the course of disciplinary investigations by his employer (in response to his complaints of harassment by a colleague), he had acted in a way which demonstrated a lack of probity and honesty. Interim suspension was regarded by the IOP as being 'necessary for the protection of members of the public' and also as being 'in the public interest'. His Honour Judge Kaye recognised that this was not one of those cases indicated in the GMC's guidance (being neither an allegation of rape, murder, or sexual assault of children), but regarded it as a case particularly likely to undermine public confidence. Appearing to distinguish the money laundering allegations in *Sosanya*, Mr Justice Davis regarded the complaints against Dr Bradshaw as having direct implications for the doctor:patient relationship:

Although these allegations involved a colleague (which was serious enough) and did not involve a patient, a right thinking member of the public might well ask himself (or herself) "What if a complaint by a patient were made"? Would the doctor seek to cover that up or

⁹⁰ *The Shipman Inquiry: Third Report – Death Certification and the Investigation of Deaths by Coroners* (Cm 5854, 2003).

⁹¹ [2010] EWHC 1296 (Admin).

lie or make false accusations to defend himself? These factors, submitted Ms White, are likely to undermine public confidence in the honesty and integrity of the doctor and are much closer to the doctor/patient relationship than, say, money-laundering or false travel claims (even though these too might be said to smack of lack of probity).

The judgment in *Bradshaw* has little resonance with the thinking in the earlier cases of *Shiekh* and *Sosanya*. The lack of probity (albeit denied by Dr Bradshaw) in a context which could be extrapolated into a doctor: patient relationship sufficed for an interim suspension to be ‘in the public interest’. *Bradshaw* therefore has extraordinary implications for the application of interim suspension, for the same extrapolation could be made in any case where there are allegations of dishonesty. It might be argued that interim suspension is indeed sensible in all cases where the allegations suggest dishonesty (although this was clearly not subscribed to by *Shiekh* or *Sosanya*) on the basis that imposing conditions upon a dishonest doctor’s registration is futile, as it relies upon the already questionable integrity of the practitioner in complying with those conditions. The conclusions suggested by *Bradshaw* are unsatisfactory, at the very least for leaving an unresolved tension between practice and GMC guidance on interim orders, as the latter is a long way from identifying cases involving lack of probity allegations as being ripe for interim suspension.

VI. INTERIM ORDERS AS A WEAPON IN THE GENERAL ASSAULT ON THREATS TO PUBLIC CONFIDENCE?

The conflict between the *patient protection* and *public confidence* narratives of interim suspension remains unresolved by the case law and we are left to wait for a Court of Appeal decision on the matter. While it is possible to defend a narrower, *patient protection* construction of ISO powers, it can more easily be argued that in the context of the reactionary political milieu of the early 2000s, it is the broader model of ISOs which was intended. The use of ISOs to foster public confidence in the professions looms large in the appealed cases of *TR*, *Bradshaw*, and *Sandler*, raising unanswerable questions about just how common this particular application of the public interest is.⁹²

⁹² Further support for this construction is to be found in the extremely brief judgments in *Gerrard v NMC* [2010] EWHC 710 (Admin) at [9] and *Sedgewick v The Care Council for Wales* [2010] UKFTT 129 (HESC) at [6]. Both these cases, however, concerned clear risks to the public. See also *R (on the application of Vuuren) v GMC* [2007] EWHC 553 (Admin) at [15]–[16]—

The end of preserving public confidence in the medical profession (to include its regulator) is firmly embedded in the philosophy and processes of professional regulation. This objective has a long history, although its terminology has in recent years been updated and sanitised: what was once articulated as preserving the profession's reputation, 'the profession's most valuable asset',⁹³ is now frequently referred to as 'preservation of public confidence' in the profession. While the tone of the former defines the objective as self-interested protection of a benefit enjoyed by the profession's members, the latter implies a utilitarian aim, confidence being necessary for patients to submit to the beneficial services of professionals.⁹⁴ This utilitarian version of the objective enables its absorption into the calculation of what is 'in the public interest'. The 'embedded' nature of this end is demonstrated by the fact that no explicit mention is made of the necessity of preserving public confidence in the profession in the Medical Act 1983 or in associated legislation.

Neither the interim orders provisions themselves nor the overarching statutory purpose of the GMC⁹⁵ refer to the need to preserve the reputation of the profession or preserve public confidence. Despite this absence of 'public confidence' rhetoric on the face of the statutory provisions, GMC guidance and what might be called the 'Bolton principles' in the case law⁹⁶ make persistent reference to preserving confidence in the profession as a dominant objective. As has now been seen, this objective also features significantly in the use of precautionary suspension against doctors. So what are the implications of embracing the *public confidence* narrative for interim orders?

support for interim suspension of a doctor accused of violence towards his wife and daughters and dishonest concealment of it.

⁹³ *Bolton v Law Society* [1994] 1 WLR 512 at 518–9 (referring to professions generally, although in the context of a case against a solicitor).

⁹⁴ See *Makki v General Medical Council* [2009] EWHC 3180 (Admin)—one of the few judgments where the public benefits of trust in the medical profession are spelled out.

⁹⁵ In the case of the GMC's statutory purpose, s 1A of the Medical Act states that 'The main objective of the General Council in exercising their functions is to protect, promote and maintain the health and safety of the public.' The protection of public confidence in the profession may be viewed as part and parcel of this objective or as a subsidiary function and not its 'main' objective.

⁹⁶ Generally referring to the case of lawyers' discipline: *Bolton v Law Society* [1994] 1 WLR 512. This case elevated the importance of preservation of public confidence in the professions so that they may be 'trusted to the ends of the earth': *Bolton* at 518–9, cited with approval in many GMC cases (e.g. *Gupta v GMC* [2002] 1 WLR 1681 at 1702: 'It is true that in that case misconduct by a solicitor was at stake. But the approach there outlined applies to all professional men. There can be no lower standard applied to doctors', *per* Lord Rodger at [21]).

A. *Dysfunctional Aspects of the Public Confidence Narrative for Interim Orders*

Alongside the gains to be had from this broad construction of interim powers (summarised in section II of this paper), there are consequences which would seem to have a poor fit with the public interest, namely: the costs of interim orders for the doctor concerned and for the healthcare system; the doubtful legitimacy of using interim powers to protect professional reputation and concerns arising out of use of regulatory power to promote confidence in the regulator rather than in the profession.

1. Costs for the doctor and for the health care system

A construction of interim suspension powers which envisage their use as a tool for protecting public confidence has serious implications for the doctor concerned. In *NMC v Finnegan*, Justice Lloyd Jones vowed that the courts would ‘always be vigilant to ensure that there are proper grounds for an extension of an interim suspension, that being a matter which necessarily has a huge impact on the registrant’.⁹⁷ The impact will, of course, vary from case to case depending on the support network available to the doctor, their finances, and their health, but there is little doubt that the consequence of exclusion from the profession can be devastating. An interim order leaves its mark on the List of Registered Medical Practitioners (LRMP) with no accompanying explanation as to the charges faced by the doctor (although most onlookers would no doubt assume that a doctor who is the subject of an interim order from the GMC faces fairly serious charges). As Lord Justice Sedley in *Mezey v South West London and St George’s Mental Health NHS Trust* concluded, suspension is not a ‘neutral act’ as it casts a shadow over the employee’s competence.⁹⁸ A lengthy suspension is likely to be demoralising for the good doctor and can in some cases trigger a crisis in the doctor’s mental health.⁹⁹

In 2003, the National Audit Office (‘NAO’) reported on what it saw as over-use of suspension of doctors by NHS Trusts.¹⁰⁰ The report voiced general disapproval of cases in which a doctor had been excluded where there was no risk to patients,¹⁰¹ the failure to reserve suspension

⁹⁷ [2010] EWHC 1518 (Admin).

⁹⁸ [2007] EWCA Civ 106; [2007] IRLR 244 at [12].

⁹⁹ There is a growing number of cases where employees have successfully sued their employers for mismanaging their suspension in a way that caused them psychiatric harm: e.g. *Gogay v Hertfordshire CC* [2000] EWCA Civ 228; [2001] 1 FLR 280. See also the assertion in Sir Liam Donaldson’s report that fitness to practise procedures were often unnecessarily distressing for doctors: *Good Doctors, Safer Patients* (DoH, 2006) ch 4.

¹⁰⁰ *The Management of Suspension of Clinical Staff in NHS Hospital and Ambulance Trusts in England* (NAO, 2003).

¹⁰¹ E.g. where the case had resulted from a breakdown in teamworking or personality clashes—at 14.

as an option of last resort, and the failure to conduct investigations quickly enough while the suspension was in force. The report pointed to the unnecessary consumption of resources caused by inappropriate suspensions, including the cost of employing replacement cover, and the cost of paying the suspended doctors' salary. While the report was directed at the NHS as an employer of doctors and not the GMC, the concerns raised would seem to be equally applicable to interim suspensions by the GMC.

Even if the doctor's own interests do not count for much in the calculation of what is in the public interest, the NAO report underscores the fact that the removal of a doctor from his or her post for a significant period of time has serious cost implications for the health care system which must organise replacement personnel. Extensive use of interim suspension powers can inflate the transaction costs of regulation in other ways. For example, there is the fact that while the suspension endures, there is a costly de-skilling effect which needs to be addressed before the doctor returns to practise. Perhaps more importantly, there is the risk that excessively precautionary regulation can have a negative impact on professionalism with indirect implications for patient safety. Reactive regulation which subjects professionals to interventionist styles of regulation may reduce doctors' inclinations to act with beneficence towards patients or contribute to incentives to cover up mistakes rather than face the professional consequences.¹⁰² Finally, the cost to the GMC of the interim orders process itself is significant and is rising substantially year on year. To some extent, this is to be expected given that, alongside 'new' referrals, the IOP hears 'review' cases at a frequency of at least every six months.¹⁰³ This does not, however, explain the year on year rise in 'new' IOP referrals from 259 in 2006 to 455 in 2009.¹⁰⁴

2. The legitimacy of using the 'Bolton principles' at the interim stage is questionable and should be qualified

Accepting the *public confidence* narrative for interim suspension involves an assumption that it is appropriate to take action against the doctor's registration in order to protect public confidence in the profession at the interim stage of disciplinary proceedings. Even if protecting the reputation of the profession and that of its regulator are not to be viewed as separate goals (as to which see below), there

¹⁰² K Checkland and others, 'Re-thinking Accountability: Trust versus Confidence in Medical Practice' (2004) 13 *Quality and Safety in Health Care* 130.

¹⁰³ S 41A(2) *Medical Act* 1983.

¹⁰⁴ See the GMC's *Fitness to Practise Annual Statistics* publications from 2007 to 2008 at 2.6.1 of each report (the figures for 2009 were kindly provided by the GMC's annual statistics team).

is something instinctively problematic about applying an *interim* sanction on the grounds of protecting the profession's reputation. First, consider the lack of congruence between the roles of the IOP and FTTP. The judgment in *Yeong v GMC* regarded the functions of these panels as discrete, and this is reinforced by decisions which reject the possibility of taking a lengthy interim suspension into account when determining the final sanction.¹⁰⁵ But if the broader construction is embraced and it is legitimate to use interim powers to protect the profession's/regulator's reputation, there would appear to be an overlap in functions, for this is also a stated aim of the final sanction.¹⁰⁶ Is it really appropriate to have the protection of public confidence as an objective for both pre-trial and post-trial sanctions? There are broadly two possibilities arising from this overlap, but no clear guidance as to which approach is to be followed. First, so as to avoid the final sanction being disproportionate, the sanction necessary to protect reputation can be apportioned between the interim sanction and the final sanction. There are signs that this can indeed happen as, for example, in the case brought against Dr Aturu¹⁰⁷ where the twenty-one-month interim suspension seems to have been taken into account when fixing the sanction as a four-week suspension, noting that usually it would be for twelve months for an incident of dishonesty. It could be argued that such a practice (although broadly consistent with what happens in criminal sentencing)¹⁰⁸ severely compromises the expressive function of disciplinary sanctions with implications for public confidence in the profession.

Alternatively, if 'apportionment' of the sanction is resisted,¹⁰⁹ then the use of both interim and final sanction to achieve the same purpose appears to be very close to creating a risk of 'double jeopardy' (the doctor may not be being 'punished' twice over for the same misconduct but may be sanctioned twice over in the name of protecting the profession's reputation). While there have been numerous attempts to challenge disciplinary proceedings on the ground that they infringe the rule against 'double jeopardy', they have

¹⁰⁵ E.g. the case of Dr Darley heard by the fttp in May 2010—considerable weight could not be placed on a lengthy interim suspension when determining sanction as, relying on *Yeong* [2009] EWHC 1923 (Admin), the functions of the interim order and final sanction were different. Cf the case of Dr Aturu below.

¹⁰⁶ The aims of final sanction are protection of the public, maintaining public confidence, and upholding professional standards: *Meadow v GMC* [2006] EWCA Civ 1390; [2007] 2 WLR 286 at [189].

¹⁰⁷ March 2010.

¹⁰⁸ See above at n 39.

¹⁰⁹ As it was in *Yeong*, above at n 105.

generally failed because the court has maintained that disciplinary sanctions serve different objectives to a criminal sentence,¹¹⁰ and similarly that interim sanctions have separate functions from final sanctions.¹¹¹ In the context of disciplinary proceedings, it is far from clear that interim suspension and final sanction perform distinct functions.

3. 'Self-interested' regulation

Despite the litany of scandals which typically precedes the assertion that trust in the medical profession is in crisis,¹¹² the assertion that public confidence in the medical profession is 'damaged' should not be accepted uncritically. Thus, the extent to which regulatory action to protect public confidence is justified is questionable. There is more than anecdotal evidence that the Shipman scandal has not in fact rocked patients' trust in the doctors who treat them.¹¹³ For example, studies of newspaper coverage show an increase in the number of stories concerning doctors between 1980 and 2000, but no difference in the ratio between positive and negative stories in the same period.¹¹⁴ Mori Poll research suggests that doctors still occupy first place among 'trusted professions' and, that this trust is gaining rather than declining.¹¹⁵ This counterintuitive poll result is perhaps explicable on the grounds that antiquated visions of doctors as 'paragons of virtue'

¹¹⁰ *Dey v General Medical Council* (Privy Council Appeal No 19 of 2001) [2001] UKPC 44.

¹¹¹ *Sarfaraz Alam Awan v Law Society* [2003] EWCA Civ 1969 at [25] finding that the power of the Office for the Supervision of Solicitors to intervene in a solicitor's practice under s 35 of the Solicitors Act 1974 fulfilled a different function from the Solicitors Disciplinary Tribunal in exercising its power to strike off after the case had been heard.

¹¹² The Bristol/Alder Hey 'retained organs' scandal (see the Redfern Inquiry: <<http://www.rlcinqury.org.uk>>); the Bristol Royal Infirmary cardiac surgery scandal <<http://www.bristol-inquiry.org.uk>>; Shipman; Richard Neale and Rodney Ledward (both gynaecological surgeons accused of intimidating and threatening behaviour towards patients and shoddy surgery: see the Ritchie Inquiry at <doh.gov.uk> and, more recently, the case of 'Baby P'; the 'routine neglect' and unusually high mortality rates discovered at Mid-Staffordshire NHS Foundation Trust <www.midstaffpublicinquiry.com>; and the report *Care and Compassion?* a damning report of care of the elderly in the NHS (Health Service Ombudsman, February 2011).

¹¹³ See e.g. public consultations discussed in: A Chisholm et al at 5.6; *Views on Erasure and Restoration of Doctors* (Mori, 2000); 'BMA Starts Healthcare Funding Review' (2000) 320 *BMJ* 653 citing a Mori Poll in the immediate aftermath of Shipman which suggested no loss of public confidence in doctors; and B Hurwitz and others, *The Intimate Massacre: The Harold Shipman Case* (Crime Narratives in Context 2003).

¹¹⁴ N Ali and others, 'Bad Press for Doctors' (2001) 323 *BMJ* 782.

¹¹⁵ *Trust in Doctors: Annual Survey of Public Trust in Professions* (Mori Poll, 2009).

are being deposed for more realistic images of doctors.¹¹⁶ In light of the above, it is questionable whether such broad sweeping powers of suspension in advance of a full hearing are really necessary to safeguard elusive notions of public confidence in doctors.

While public opinion research does not identify a crisis of public trust in the medical profession, confidence in the medical profession's regulator has been compromised for some time. Almost twenty years ago Margaret Stacey concluded that the GMC existed as much to protect professional interests as those of patients.¹¹⁷ Ten years ago, when the Shipman affair was still very much in the media, there remained a strongly held view that the GMC protected its own and that self-regulation was a byword for leniency and an 'overly sympathetic approach' to disciplining doctors.¹¹⁸ It should be noted, however, that members of the public expressing this opinion were often not terribly well informed on the powers or workings of the GMC.¹¹⁹

The research cited above would tend to suggest that public confidence in members of the medical profession and confidence in the system for regulating the medical profession are distinct phenomena, albeit that their inter-connectedness is undeniable. For example, self regulation of professions has traditionally been justified when members of the profession can be 'trusted' to regulate themselves.¹²⁰ The courts do, however, tend to conflate the two, for example with Sales J in *Yeong v GMC* concluding that regulatory inaction against misconduct could result in the public not having confidence in the doctor concerned.¹²¹ The danger which accompanies the assumption that confidence in the profession and in its regulator are co-extensive, is that self-preservation strategies of the regulator can masquerade as attempts to build confidence in the profession.

Linda Haller, writing in the analogous field of regulation of the legal profession, concluded that a regulator which pursued the 'private

¹¹⁶ See P de Prez, 'Self-regulation and Paragons of Virtue: The Case of "fitness to practise"' [2002] 10 Med L Rev 28.

¹¹⁷ '... all were agreed on the importance of regulation for the help it would be to them in controlling who would practise, thereby reducing competition. Contrary to the beliefs of many, the interests of the public were a secondary, not a primary consideration.' M Stacey, *Regulating British Medicine: The General Medical Council* (Wiley & Sons, Chichester 1992) 20.

¹¹⁸ *Trust Assurance and Safety* particularly ch 1; A Davies, 'Mixed Signals: Using Educational and Punitive Approaches to Regulate the Medical Profession' [2002] PL 703 at 718: 'The GMC has long been characterised as a body which protects, rather than regulates, doctors.'

¹¹⁹ See also *Views on Erasure and Restoration of Doctors* (Mori, 2000) at 10–12.

¹²⁰ E Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (Harper & Row 1970).

¹²¹ At [50].

interest' of protecting the profession's reputation where there was no outstanding need to protect the public might be regarded as misusing public funds.¹²² In the medical domain, connections have frequently been asserted (although rarely substantiated) between confidence in the profession and the welfare of patients generally;¹²³ therefore protection of public confidence in doctors might be regarded as falling easily within 'the public interest'. What is more questionable is whether the 'public interest' should include bolstering the reputation of *the regulator* at significant expense. As detailed above, interim orders hearings are a significant and rapidly increasing expense for the GMC in terms of personnel (counsel, Legal Assessor, and panellists), although it might be questioned whether this expense involves 'public money'. Haller makes the point, however, that even when a regulator is funded by registrants rather than by the taxpayer (as the GMC is), inappropriate regulatory goals may still be regarded as a waste of public money in terms of the investment made in educating and training registrants to current professional standards.¹²⁴

4. The dangers of judicial complacency in reviewing interim orders

Appeals against professional sanction have traditionally been characterised by a markedly deferential approach to the decision of the regulatory body. There is consensus that respect for the decision of the professional tribunal is the starting point.¹²⁵ This is apparently because while appeals are invariably on the basis of written submissions and evidence, the Panel will likely have had the benefit of hearing and seeing witnesses give evidence in person.¹²⁶ The regulatory body's instinct as to how public confidence is to be managed was also an area which required deference when deciding appeals against professional sanction.¹²⁷ These precepts have been applied not only to determination of final sanctions but also in cases where an interim order has been challenged under section 41A(10) of the Medical Act 1983. In the context of interim orders, Davis J in *Shiekh* rationalised this deference as follows: 'the Panel is an expert body which is well acquainted with the requirements that a particular profession needs to uphold and with issues of public perception and public

¹²² L Haller, 'Smoke and Mirrors: When Professional Discipline May Cause Harm' (2005) 8 Legal Ethics 70 at 84.

¹²³ See e.g. *Makki v General Medical Council* [2009] EWHC 3180 (Admin).

¹²⁴ Above at note 122, 84.

¹²⁵ *Meadow v GMC* [2006] EWCA Civ 1390; [2007] 2 WLR 286.

¹²⁶ *Ibid.*

¹²⁷ The Court of Appeal in *Raschid & Fatnani v General Medical Council* regarded the principal role of the sanctions at the disposal of the FTTP as the maintenance of public confidence. This purpose gave particular force to the need for deference to the Panel's decision in any appeal.

confidence'.¹²⁸ The utility of an application to terminate an interim order under section 41A(10) has also been curtailed by the judgments in *Sandler* and *Bradshaw*. In marked contrast with the judgment in *Shiekh*, the judgments in *Sandler* and *Bradshaw* both endorse the view that the courts can only intervene if the IOP's decision is 'wrong'. In *Sandler*, Justice Nicol reached this conclusion notwithstanding that both parties had agreed that *Hiew v GMC*¹²⁹ established that the court's powers under section 41A were 'original' powers. Nicol J determined that *Hiew* was concerned with applications from the GMC to extend interim orders under section 41A(7) where the courts' powers were of a different kind.

The claim that the GMC has special expertise in what is necessary to protect professional reputation is seemingly unassailable, and yet it is questionable whether the GMC truly enjoys the expertise which it is assumed to have, whether it is indeed possible to have such expertise, and, even if it is possible, whether it is appropriate to rely upon it so heavily in cases where the practitioner concerned has not reached the final stages of the fitness to practise process. In a tribute to Feeley's *The Process is the Punishment*, the first part of this paper made observations regarding the surprising number of cases where the gravity of the interim sanction exceeded that of the final sanction. While these observations do not necessarily imply criticism of the way in which the GMC's panels are using these powers, they would surely indicate that a markedly deferential approach to challenges against interim orders is no longer appropriate.

VII. CONCLUSION

The Shipman affair is widely perceived as denting public confidence in medical regulation. The measures introduced in the aftermath work to increase confidence in the systems of regulation often without appreciably reducing the risk that a Shipman #2 could continue to operate without being detected. In a classic example of the 'Shipman effect', the interim orders provisions and their application have a 'crooked relationship' with the events which triggered their enactment. They are over-inclusive, and have been explicitly approved as a weapon in the general assault upon perceived crises of confidence in the medical profession. These enlarged powers are also notably absent from the Commonwealth jurisdictions of Australia,¹³⁰

¹²⁸ n 75, above.

¹²⁹ [2007] EWCA Civ 369; [2007] 1 WLR 2007.

¹³⁰ S 87(1) of the *Medical Practitioners Act 2008* states that interim orders of no more than thirty days are available where an 'activity of the practitioner

New Zealand,¹³¹ and Canada¹³² which have not experienced a Shipman of their own and where they continue to employ an 'emergency' model of interim orders.

As has been the case in criminal justice research, studies of pre-adjudication processes in professional discipline have been neglected.¹³³ The wording of section 41A of the Medical Act 1983 is so open-ended, and the (understandable) secrecy surrounding its application so dense, as to potentially frustrate attempts to meaningfully scrutinise the GMC's use of these powers. Nevertheless, some insight has been obtained by way of analysing the outcomes of cases where interim orders have been imposed. An outcomes analysis of interim orders imposed over a three-month period suggested that, in a significant number of cases, 'pre-verdict' sanctions exceeded the final sanction. The conceptual proximity of disciplinary sanctions with 'punishment' meant that this finding demands an explanation. This explanation involves looking at the wider context of the GMC's function of striving to ensure that the doctors on its register are fit to practise. Imposing an interim order on a doctor in advance of a full investigation of the complaint can serve a number of functions not evident on the face of section 41A of the Medical Act 1983. These functions include protecting public confidence in the GMC by providing an answer (albeit an expensive procedural one) to frequent criticisms that disciplinary cases against doctors take too long to reach a conclusion, making constructive use of delay in the fitness to practise process and facilitating the professional redemption of the doctor concerned.

The case law analysis of interim orders identified two competing perspectives as to the purposes of interim orders; a narrow version which constructs the power as an emergency provision designed to protect patients from dangerous doctors and a broader version which construes the power as available in the general assault upon perceived crises of public confidence in the medical profession. It is unsatisfactory that after ten years, and despite the proliferation of these powers across many professions, this conflict remains unresolved. The discretion afforded to the IOPs by the statutory language would appear to enable precautionary suspension where there are predicted implications

concerned presents a risk of imminent injury or harm to the physical or mental health of any person'.

¹³¹ S 104(1)(a) of the *Medical Practitioners Act 1995* provides for interim suspension where 'necessary or desirable ... having regard to the need to protect the health or safety of members of the public'.

¹³² See s 37(1) of the *Regulated Health Professions Act 1991* (authorising interim orders where the conduct of the member exposes or is likely to expose his or her patients to harm or injury).

¹³³ See Feeley's suggestion to this effect, above at n 37, 199.

of the case for public confidence in the profession, albeit that no risk to patients has been identified. The analysis of case law arising out of interim orders makes it clear that precautionary suspensions *are* deployed in some cases as a means of maintaining or protecting public confidence in the medical profession. However, as set out earlier, it seems that the public's confidence in doctors is fairly resilient and does not necessarily merit an excessively precautionary approach. Research into the public's expectations regarding the medical profession suggests that putting patients first and protecting patients are the prior concerns and lapses of judgment or condemnable conduct which does not infringe these values is not core to their values of a good doctor.¹³⁴ Further, an excessively precautionary approach can prejudice patient safety by deepening professional hostility towards the GMC and thereby increasing the risk of covering up mistakes and deficiencies and by removing good doctors from practice unnecessarily.

The case law also makes it clear that the broad construction of interim orders has been accompanied by a markedly deferential approach to appeals against interim suspensions. In light of the tentative findings made in Part II of this paper (the suggested imbalance ratio between pre-verdict suspension and post-verdict suspension/erasure and the significant number of individual cases where the interim sanction exceeded the final sanction), it is imperative that the courts exercise vigilance when given the opportunity to review interim orders in individual cases.

¹³⁴ L Gilson, 'Trust and the Development of Health Care as a Social Institution' (2003) *Social Science and Medicine* 1453; H Davies, 'Falling Public Trust in Health Services: Implications for Accountability' (1999) *Journal of Health Services Research Policy* 193.