

***Citation for the published version:***

Gallagher, C. T., Hussain, K., White, J. D. P., & Chaar, B. (2019). The Legal Underpinnings of Medical Discipline in Common Law Jurisdictions. *The Journal of Legal Medicine*, 39(1), 15-34. DOI: 10.1080/01947648.2019.1586602

***Link to the final published version available at the publisher:***

This is an Accepted Manuscript of an article published by Taylor & Francis Group in *The Journal of legal medicine*. Published on 10/11/2017, available online:

<https://doi.org/10.1080/01947648.2019.1586602>

© 2019 Informa UK Limited, trading as Taylor & Francis Group

***General rights***

Copyright© and Moral Rights for the publications made accessible on this site are retained by the individual authors and/or other copyright owners.

Please check the manuscript for details of any other licences that may have been applied and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights. You may not engage in further distribution of the material for any profitmaking activities or any commercial gain. You may freely distribute both the url (<http://uhra.herts.ac.uk/>) and the content of this paper for research or private study, educational, or not-for-profit purposes without prior permission or charge.

***Take down policy***

If you believe that this document breaches copyright please contact us providing details, any such items will be temporarily removed from the repository pending investigation.

***Enquiries***

Please contact University of Hertfordshire Research & Scholarly Communications for any enquiries at [rsc@herts.ac.uk](mailto:rsc@herts.ac.uk)

# **THE LEGAL UNDERPINNINGS OF MEDICAL DISCIPLINE IN COMMON LAW JURISDICTIONS**

Short title: Medical discipline in common law jurisdictions

Cathal T. Gallagher,<sup>1</sup> Kasim Hussain,<sup>1</sup> Jessica D.P. White,<sup>1</sup> and Betty Char.<sup>2</sup>

<sup>1</sup> Department of Clinical and Pharmaceutical Sciences, University of Hertfordshire, Hatfield, UK

<sup>2</sup> School of Pharmacy, University of Sydney, Sydney, Australia.

Corresponding author: Dr C.T. Gallagher, Department of Clinical and Pharmaceutical Sciences, University of Hertfordshire, Hatfield, Herts, AL10 9AB, UK.

[c.t.gallagher@herts.ac.uk](mailto:c.t.gallagher@herts.ac.uk)

The authors declare that there is no conflict of interest.

# THE LEGAL UNDERPINNINGS OF MEDICAL DISCIPLINE IN COMMON LAW JURISDICTIONS

## KEYWORDS

Medical discipline; statutory law; international; fitness to practise.

## ABSTRACT

Medical regulators have a responsibility to protect, promote and maintain the health and safety of patients. Here, we compare and contrast the processes for addressing concerns about doctors in four countries with legal systems based on English common law, namely: the UK, Australia, the USA, and Canada. The legal provisions underpinning each jurisdiction's disciplinary processes depict distinctive outlooks from the different authorities, as each works towards the same goal. The initial stages of the investigation process are broadly similar in all the jurisdiction examined: however, each process has subtle differences over its comparators. Factors including: how matters of discipline are framed; the constitution of disciplinary panels; and the perceived independence of these panels all philosophically affect the public safety remit of each regulator. This work constitutes the first comparison of international regulatory frameworks for the profession of medicine.

## OVERVIEW

Medical regulators have a remit to protect, promote and maintain the health and safety of people who seek medical treatment. Where there is a potential risk to patient safety, or where the public's confidence in the medical profession could be adversely affected by the actions of a doctor, they have a statutory duty to investigate concerns.<sup>1</sup> Here, we compare and contrast the processes in place in four English-speaking countries with legal systems based on English common law, namely: the UK, Australia, the USA, and Canada. In both North American countries, the regulation of healthcare professionals is dealt with on a state – rather than

---

<sup>1</sup> Medical Act 1983 (as amended). Chapter 54. London: HMSO; 1983. (s.1A); Health Practitioner Regulation National Law (Queensland) Act 2009. No. 45. Brisbane: Office of the Queensland Parliamentary Counsel; 2009. (s.35(1)(a)); Education. Title 8. Article 131. New York: New York State Legislative Bill Drafting Commission. (s.6520); Medical Act 1981. Chapter 87. Fredericton: Service New Brunswick; 1981. (s.5(3)(a)).

federal – basis. The states of New York and New Brunswick were chosen as the entirety of their respective legal statutes affecting the regulation of the medical profession are available on-line in a consolidated form, and at no cost.

In each of the four jurisdictions, processes are in place which allow complaints against registrants to be investigated and – where appropriate – for adjudicatory tribunal proceedings to be instigated. Regulators control entry into the profession of medicine, and may restrict the practice of registrants or apply other sanctions where it is necessary in the best interest of patients, the public, or the profession. As one might expect, the disciplinary processes of each regulator are macroscopically very similar: however, there are manifold differences at each stage of investigation and adjudication that philosophically change the nature of these proceedings and what they seek to achieve (**Fig. 1**). We seek here to assess which aspects of each jurisdiction's respective medical discipline processes best protect patient and societal interests.

The General Medical Council (GMC) is the independent regulator for physicians in the UK. It has a responsibility to promote and maintain the health, safety and wellbeing of patients and the public. This includes a remit to set standards that medical professionals must meet. Where there are concerns that a doctor has failed to maintain the required standards, the GMC must carry out an investigation of complaints. Where there is evidence of misconduct which may impair the doctor's ability to practise medicine, the Medical Practitioners' Tribunal Service (MPTS) must adjudicate in hearings arising from GMC investigations.

Complaints made against Australian doctors are investigated by the Medical Board of Australia (MBA) with administrative support from the Australian Health Practitioner Regulatory Authority (AHPRA), while adjudication is a separate function carried out by each state or territory's judicial system.

Unlike the other jurisdictions discussed here, which each have a separate regulator for the medical profession, New York State has a single regulator for all professions requiring licensure. The University of the State of New York (USNY) is a governmental umbrella organization responsible for the general supervision of all educational activities within the state. It is a licensing and accreditation body that

sets standards for education from pre-kindergarten through professional and graduate school, as well as for the practice of more than fifty professional groups, including social workers, veterinarians, and the health professions. Licensure in any of these professions is regulated by the New York State Education Department's Office of the Professions (NYOP). The disciplinary processes for most professions are also regulated by the NYOP under education law. The single exception is the medical profession, whose disciplinary process is regulated under New York State Public Health law.<sup>2</sup> The Office of Professional Medical Conduct (OMPC) both investigates complaints about licensees and adjudicates hearings through its Committee on Professional Conduct (CPC).

Similarly, the College of Physicians and Surgeons of New Brunswick (CPSNB) fulfils the roles of standard-setter, investigator and adjudicator in the eastern Canadian maritime province of New Brunswick.

## **INVESTIGATION**

### *Initial assessment of complaints*

#### **UK**

In the UK, the GMC is responsible for investigating concerns about those who wish to be registered as doctors.<sup>3</sup> Such concerns typically take the form of a complaint from a member of the public. Any allegations made are usually subject to a review by the Registrar to determine if it is appropriate to proceed with an investigation.<sup>4</sup>

#### **Australia**

Similarly, upon receipt of a notification (complaint) against an Australian practitioner, the AHPRA must conduct a preliminary assessment.<sup>5</sup> The AHPRA may then further investigate a doctor if the MBA decides it is necessary or appropriate.<sup>6</sup>

---

<sup>2</sup> Public Health. Article 2. Title 2-A. New York: New York State Legislative Bill Drafting Commission.

<sup>3</sup> Medical Act 1983. Chapter 54. London: HMSO; 1983. (s.1B(c))

<sup>4</sup> General Medical Council (Fitness to Practise) Rules Order of Council 2004/2608. London: HMSO; 2004. (rule 4(4))

<sup>5</sup> Health Practitioner Regulation National Law (Queensland) Act 2009. No. 45. Brisbane: Office of the Queensland Parliamentary Counsel; 2009. (s.149(1))

<sup>6</sup> Id. (s.160)

## **New York**

The OPMC investigates all complaints and suspected professional misconduct in New York. The OPMC must investigate all complaints received.<sup>7</sup> The OPMC Director must conduct a preliminary report to determine if any conduct needs further investigation.<sup>8</sup>

## **New Brunswick**

Complaints against physicians in New Brunswick must be made to the CPSNB. Again, the Registrar must undertake an initial investigation to ascertain the nature of the complaint, and to obtain any other information relevant to the case. If, following an initial investigation, the Registrar believes that a physician may be unfit to practice, or that an act of professional misconduct has taken place, he may appoint an investigator to assist in the investigation.<sup>9</sup>

### *Investigation of complaints*

## **UK**

An investigation, carried out under rule 7 of the GMC's Fitness to Practise Rules 2004, involves obtaining further information from the complainant or from the organisation that has referred the matter. Investigations must be carried out by the Registrar,<sup>10</sup> or by an investigation team acting under the supervision of the Registrar. Where a need is identified to establish if there is any risk to patients or to public confidence in the profession, or where explicit consent has been obtained from the complainant, the doctor may also be consulted. The GMC must endeavour to disclose the complaint to the doctor at an early stage, in order to provide an early opportunity for comment.<sup>11</sup> There is no legal requirement for the Registrar to produce a written report of the investigation's findings: although, in cases where the allegation must be referred, such a report would appear to be necessary. The GMC does have limited powers to reprimand a registrant where an investigation exposes minor deviations from expected standards, or if the investigation has failed to reveal any of

---

<sup>7</sup> Public Health. Article 2. Title 2-A. New York: New York State Legislative Bill Drafting Commission. (s.230, para.10(a)(i)(A))

<sup>8</sup> Id. (s.230, para.10(a)(i)(B))

<sup>9</sup> Medical Act 1981. Chapter 87. Fredericton: Service New Brunswick; 1981. (s.55.2(1))

<sup>10</sup> General Medical Council (Fitness to Practise) Rules Order of Council 2004/2608. London: HMSO; 2004. (rule 7(2))

<sup>11</sup> Id. (rule 7(1)(c))

the behaviours described in s.35c(2) of the Medical Act 1983 as causing the doctor's fitness to practise to be impaired.

## **Australia**

The investigators in Australian cases may be contracted by the AHPRA, but are usually members of their staff.<sup>12</sup> As soon as practicable after completing an investigation, the investigator must give a written report to the MBA, which must include the findings of the investigation and the investigator's recommendations about any action to be taken.<sup>13</sup> At this point, the MBA can reprimand a registrant in cases involving minor deviations from expected standards.<sup>14</sup> If, it reasonably believes that the doctor's professional conduct or performance may be merely unsatisfactory, it may establish a Performance and Professional Standards Panel.<sup>15</sup> Cases involving seriously deficient conduct or performance must be referred to tribunal for adjudication

## **New York**

In New York, if there is evidence of misconduct, the licensee will be invited to an interview before the OMPC as part of the investigation,<sup>16</sup> at which they are given the opportunity to explain the conduct being investigated prior to it being referred. The licensee may be both represented by counsel and accompanied by a stenographer. The licensee must pay the cost for the stenographic transcription and the record should be given to the department within 30 days of the interview.<sup>17</sup> If the director decides to close an investigation after an interview, the Director must notify the licensee in writing.<sup>18</sup> Alternatively, the case may be referred to the Investigation Committee by the Director.<sup>19</sup>

---

<sup>12</sup> Health Practitioner Regulation National Law (Queensland) Act 2009. No. 45. Brisbane: Office of the Queensland Parliamentary Counsel; 2009. (s.163)

<sup>13</sup> Id. (s.166)

<sup>14</sup> Id. (s.178)

<sup>15</sup> Id. (s.182(1))

<sup>16</sup> Public Health. Article 2. Title 2-A. New York: New York State Legislative Bill Drafting Commission. (s.230, para.10(a)(iii))

<sup>17</sup> Id. (s.230, para.10(a)(iii)(A))

<sup>18</sup> Id. (s.230, para.10(a)(iii)(D))

<sup>19</sup> Id. (s.230, para.10(a)(iii)(C))

## New Brunswick

In New Brunswick, the Investigator must inform the Registrar of their findings in writing, and the Registrar must present these findings to the Complaints and Registration Committee.<sup>20</sup> Unlike in the other jurisdictions discussed here, the Registrar cannot dispose of the case at this stage.

### *“Investigating Committees”*

## UK

At the end of the investigation, the case is considered by two case examiners (one medical and one non-medical) employed by the GMC. At this stage, they can: conclude the case with no further action; issue a warning; agree undertakings with the doctor; or refer the case for adjudication to the MPTS. No case can be concluded or referred for adjudication without the agreement of both a medical and non-medical case examiner. If they do not agree, the matter must be referred considered by the Investigation Committee, which has the same powers as the case examiners. The doctor may also request that the case be referred to the Investigation committee if, for example, they do not wish to accept a warning proposed by the case examiners.<sup>21</sup> A quorate Investigation Committee must have at least a chairperson, one medical panellist, and one lay panellist.<sup>22</sup> A list of people eligible to undertake these roles is maintained by the GMC,<sup>23</sup> from which the Registrar selects panellists.<sup>24</sup> Investigation Committees sit in public,<sup>25</sup> unless the Committee decide that it would be in the best interest of the practitioner or the public to sit in private.<sup>26</sup>

When deciding whether to refer a case to the MPTS, the GMC must be mindful of their own *Sanctions guidance*.<sup>27</sup> The main reason for the existence of this process is to protect the public, which includes:

1. protection of health, safety and wellbeing;

---

<sup>20</sup> Medical Act 1981. Chapter 87. Fredericton: Service New Brunswick; 1981. (s.55.5)

<sup>21</sup> General Medical Council (Constitution of Panels Tribunals and Investigation Committee) Rules Order of Council 2015 (2015/1965). (rule 11(3))

<sup>22</sup> Id. (rule 7)

<sup>23</sup> Id. (rules 3(1) & 6(1)(b))

<sup>24</sup> Id. (rule 5(2))

<sup>25</sup> Id. (rule 41(1))

<sup>26</sup> Id. (rule 46(1))

<sup>27</sup> Sanctions guidance for members of medical practitioners tribunals and for the General Medical Council's decision makers. Manchester: General Medical Council; 2016.

2. maintenance of public confidence in the medical profession; and
3. maintenance of proper professional standards of conduct.<sup>28</sup>

Both the GMC and MPTS are required to impose the least restrictive sanction that satisfies this threefold remit.<sup>29</sup> The purpose of any sanction imposed is not to punish or discipline the doctor.<sup>30</sup> Where the GMC can achieve this without recourse to the MPTS, they are required to do so.

## Australia

The MBA's Performance and Professional Standards Panel is analogous to the GMC's Investigation committee. A panel must consist of at least three members.<sup>31</sup> At least half, but no more than two-thirds, of the panel must doctors chosen from a list approved by the MBA under s.183 of the National Law.<sup>32</sup> Hearings before a panel are not open to the public.<sup>33</sup> Professional Standards Panels are free to decide their own procedures,<sup>34</sup> but are required to observe the principles of natural justice.<sup>35</sup> Where a practitioner has behaved in a way that constitutes unsatisfactory professional performance or unprofessional conduct, panels may direct that no further action be taken; impose conditions on the doctors practise; issue a caution; or reprimand the doctor.<sup>36</sup> Where threshold criteria are reached, it must refer the case for tribunal.<sup>37</sup>

## New York

The Investigation Committee of the OPMC is composed of 2 physicians and 1 lay member.<sup>38</sup> After a decision by a majority of the Investigation Committee, the Director of the OPMC may decide that a hearing is needed: however, violations involving professional misconduct of minor or technical nature, or where the substandard

---

<sup>28</sup> Medical Act 1983. Chapter 54. London: HMSO; 1983. (s.1A)

<sup>29</sup> Sanctions guidance for members of medical practitioners tribunals and for the General Medical Council's decision makers. Manchester: General Medical Council; 2016. (para. 20)

<sup>30</sup> Id. (para.16)

<sup>31</sup> Health Practitioner Regulation National Law (Queensland) Act 2009. No. 45. Brisbane: Office of the Queensland Parliamentary Counsel; 2009. (s.182(2))

<sup>32</sup> Id. (s.182(4))

<sup>33</sup> Id. (s.189)

<sup>34</sup> Id. (s.185(1))

<sup>35</sup> Id. (s.185(2))

<sup>36</sup> Id. (s.191(3))

<sup>37</sup> Id. (s.193)

<sup>38</sup> Public Health. Article 2. Title 2-A. New York: New York State Legislative Bill Drafting Commission. (s.230, para.6)

practise did not amount to misconduct, may be dealt with at this stage by administrative warning.<sup>39</sup> To apply these expedited procedures, the Director must gain the concurrence of the Committee on Professional Conduct. Administrative warnings are confidential, do not assume guilt, and cannot be used as evidence of misconduct. If there is a subsequent allegation of similar misconduct, the matter may be reopened and there may be proceedings.<sup>40</sup>

Although **New York's OMPC** also has a remit to “protect the public by investigating professional discipline issues involving physicians”, its language is much more disciplinarian in nature to that of the GMC or MBA. Like the CPSNB, it employs the language of criminal courts: a doctor’s “guilt” or “innocence” is tested, and “penalties” are imposed.

### **New Brunswick**

Unlike the others, New Brunswick’s Complaints and Registration Committee has a quorum of five members. This must include: two medical professionals; two lay members; and a chairperson, who must be a member of the CPSNB Council.<sup>41</sup> The Committee may require the physician to comply with a variety of assessments, including; a physical or mental examination; an inspection or audit; and any other investigations the Committee may deem appropriate.<sup>42</sup> If a physician fails to comply with the assessment(s) required by the Committee, they may restrict a physician’s registration or suspend the physician from the register.<sup>43</sup> Upon consideration of the complaint, written representation(s) and assessment results, the Committee may: recommend that no further action be taken; provide counselling, caution, or censure; or refer the complaint to a Board of Inquiry.<sup>44</sup> Counselling is advice as to how to improve the physician’s conduct or practice; a caution is intended to forewarn the physician that if the conduct recurs, more serious disciplinary action may be considered; and a censure is the expression of strong disapproval or harsh criticism. To apply either of these three reprimands, the Registrar must gain the concurrence of the Council of the College. The findings of the Committee are reported to the

---

<sup>39</sup> Id. (s.230, para.10(m)(i))

<sup>40</sup> Id. (s.230, para.10(m)(ii))

<sup>41</sup> Medical Act 1981. Chapter 87. Fredericton: Service New Brunswick; 1981. (s.57(2))

<sup>42</sup> Id. (s.57(7))

<sup>43</sup> Id. (s.57(7.1))

<sup>44</sup> Id. (s.57(8))

council, in conjunction with any recommendations. The Registrar must then notify both the physician and complainant, in writing, of the findings, recommendations and decision(s) of the Committee.<sup>45</sup>

### *Comparison*

The initial stages of any investigation are broadly similar, regardless of the jurisdiction involved: a complaint is received and parsed for spuriousness; substantive complaints are then subject to further investigation, the outcome of which is reported to an “investigating committee.”

No single jurisdiction has an investigating process that is clearly superior to the others. Each have subtle differences that afford some level of advantage or disadvantage over their comparators. In cases that meet specified threshold criteria, the GMC and MBA may refer the matter for adjudication, effectively bypassing their respective investigating committees. All complaints investigated in New York and New Brunswick must be considered by their corresponding committees before they can be referred. These committees serve to parse cases by deciding which issues can be dealt with a minor censure or warning, and which must be referred for adjudication. The analogous GMC and MBA investigating committees are only parsing committees in cases where the threshold criteria for direct referral to tribunal are not met. Furthermore, in the case of the GMC, the Investigation Committee can be bypassed where two case examiners agree on the necessity for referral.

While the requirement of both North American regulators for all doctors to be subjected to the same stepwise process can be seen to promote fairness, it can also be resource-intensive, especially in cases where it is obvious from an early stage that the case will end up in front of a full disciplinary panel. Conversely, the GMC’s process allows for the Investigation Committee to be bypassed where threshold criteria are met, or where the case examiners believe it is otherwise in the public interest to proceed immediately to tribunal. The MBA may similarly refer direct to tribunal, but in this case without the need for case examiners. The MBA need only establish Performance and Professional Standards Panel where it believe the

---

<sup>45</sup> Id. (s.57(10))

misconduct to be minor: in cases of seriously deficient conduct or performance, a case may be directly referred for adjudication.

### *Health concerns*

As part of the investigation process in each of the UK,<sup>46</sup> Australia,<sup>47</sup> New York,<sup>48</sup> and New Brunswick,<sup>49</sup> a practitioner may be compelled to undertake a medical assessment to determine if their ability to practise is adversely affected by virtue of poor mental or physical health. The form and extent of these examinations differs greatly between jurisdictions. Even the terminology used reflects the ethos of the respective regulators: in New Brunswick an “incapacitated member” is one with an adverse physical or mental health condition, while in Australia, such a person is said to be “impaired.” The New York State legislation makes reference to “physical or mental disability.”

Where a doctor may be unfit to practise due to adverse health, all of the processes downstream of this – from basis of any ruling to the powers of the adjudicator – are affected. The procedures in such cases are sufficiently different to warrant a separate comparison, which we do not propose to include here: rather, we will limit this discussion to instances where the complaint is related to professional misconduct or deficient performance.

### *Interim measures*

Under s.1 of the Medical Act 1983, the GMC must maintain a standing Committee known as an Interim Orders Tribunal. The purpose of a tribunal is to determine whether a doctor’s registration should be immediately restricted. This happens when the allegations are serious enough that, if proven, they would mean the doctor poses a threat to patients or the public. The panel does not aim to find facts in relation to the case, but merely makes a decision based on the nature of the allegation whilst the investigation proceeds. The tribunal has the authority to impose conditions on, or

---

<sup>46</sup> General Medical Council (Fitness to Practise) Rules Order of Council 2004/2608. London: HMSO; 2004. (rule 17(7))

<sup>47</sup> Health Practitioner Regulation National Law (Queensland) Act 2009. No. 45. Brisbane: Office of the Queensland Parliamentary Counsel; 2009. (s.156)

<sup>48</sup> Public Health. Article 2. Title 2-A. New York: New York State Legislative Bill Drafting Commission. (s.230, para. 7)

<sup>49</sup> Medical Act 1981. Chapter 87. Fredericton: Service New Brunswick; 1981. (s.57(7))

suspend, a doctor's registration for up to 18 months.<sup>50</sup> The MPTS and GMC have published a joint guidance for tribunals on *Imposing Interim Conditions on a Doctor's Registration*.<sup>51</sup>

An interim order must be reviewed within 6 months, and every 6 months thereafter, unless new evidence has become apparent, in which case an earlier review may be requested by the doctor, at any time.<sup>52</sup> Upon review, the tribunal may decide to revoke the order, vary the existing conditions, or replace an existing conditions order with a suspension order (or vice versa), which will take effect for the remaining period of up to 18 months.<sup>53</sup> Alternatively, the High Court may decide to revoke an interim order that has lasted its maximum period, if they consider the imposition or further extension of an order will not be beneficial in the interests of *both* the public and doctor. Where the court has made such a decision, it is final.<sup>54</sup>

The Medical Board of Australia has the power to take immediate action in relation to a doctor's registration at any time, if it believes this is necessary to protect the public.<sup>55</sup> This is an interim step that Boards can take while more information is gathered or while other processes are put in place. The action has immediate effect, and continues to have effect until either: the decision is set aside on appeal; or the suspension is revoked, or the conditions are removed, by the Medical Board.<sup>56</sup>

If the OPMC has received information alleging that a licensee is engaging in behaviour that could cause the transmission of a communicable disease, and it would not be in the public interest to wait for a hearing; or where a licensee is believed to be engaging in activities that could cause imminent danger to public health, the State Commissioner of Health may take immediate action to restrict their practise.<sup>57</sup> If a licensee has been found guilty of a felony, or has been found to be an imminent danger to patient's health or been disciplined for an action by a hearing in

---

<sup>50</sup> Medical Act 1983. Chapter 54. London: HMSO; 1983. (s.41A(1))

<sup>51</sup> Medical Practitioners Tribunal Bank (Imposing conditions on a doctor's registration). Manchester: General Medical Council; 2016.

<sup>52</sup> Medical Act 1983. Chapter 54. London: HMSO; 1983. (s.41A(2))

<sup>53</sup> Id. (s.41A(3))

<sup>54</sup> Id. (s.41A(10))

<sup>55</sup> Health Practitioner Regulation National Law (Queensland) Act 2009. No. 45. Brisbane: Office of the Queensland Parliamentary Counsel; 2009. (s.156)

<sup>56</sup> Id. (s.159)

<sup>57</sup> Public Health. Article 2. Title 2-A. New York: New York State Legislative Bill Drafting Commission. (s.230, p.12(a))

a different jurisdiction, the commissioner may order the licensee to stop practicing medicine immediately. The suspension will remain in place until the hearing of the Committee on Professional Misconduct is completed. Such hearings must start within 90 days of the commissioner's order and end within 90 days of this start date. Where a licensee is being investigated in a different jurisdiction, and the order is based on this, the hearing will start within 30 days of the disciplinary proceedings in that jurisdiction finishing.<sup>58</sup>

An interim order may be imposed on the physician by the Registrar, without a formal hearing, if the council of the CPSNB deem such action necessary in the best interest of patients and members of the public.<sup>59</sup> The order may impose conditions or a period of suspension on the physician's licence, which the Registrar must inform them of as soon as practicable.<sup>60</sup> Furthermore, serious allegations may be disclosed to the Regional Health Authority, the Minister of Health and any other official the Registrar considers appropriate to inform. Interim orders take effect immediately. When appealing such an order, the physician must establish a *prima facie* case demonstrating that the revoking or varying the order will be beneficial to patients.<sup>61</sup>

Interim suspensions can be applied on public safety grounds in all four jurisdictions. A doctor may see his or her employment – and with it his or her livelihood – brought to a sudden halt by reason of an allegation against them which may subsequently prove groundless. The GMC compounds this power – which is tantamount to a presumption of guilt – by requiring its registrants to “cooperate with formal inquiries and complaints procedures” and “offer all relevant information”,<sup>62</sup> effectively removing the right to remain silent that would be enjoyed during a criminal investigation in the UK, or – indeed – any of the territories under discussion here.

## ADJUDICATION

### *Membership*

---

<sup>58</sup> Id. (s.230, p.12(b))

<sup>59</sup> Medical Act 1981. Chapter 87. Fredericton: Service New Brunswick; 1981. (s.56.1(1))

<sup>60</sup> Id. (s.56.1(2)(a))

<sup>61</sup> Id. (s.56.1(4))

<sup>62</sup> Good Medical Practice. London: General Medical Council; 2013. (para. 73)

## UK

An MPTS panel has a quorum of three members, appointed from a pool of around 280 members. Each panel must consist a chairperson, one medical, and one lay panellist.<sup>63</sup> A member or officer of the GMC, or a committee of the GMC, cannot serve on the tribunal.<sup>64</sup> The chairperson may be legally-qualified. In hearings with a legally-qualified chair (LQC), the tribunal will comprise of the chair and at least two other tribunal members. The legally-qualified chair and the tribunal members make decisions together. In hearings without an LQC, the tribunal will comprise of at least three tribunal members who will make decisions. A legal assessor may provide advice to such tribunal, but takes no part in the decision-making process. There may be a majority of either medically-qualified members or lay members on any given panel, but in no circumstances is either group absent.

## Australia

The membership of an Australian tribunal panel is dependent on the state or territory in which the misconduct is alleged to have occurred: for example, in South Australia, a typical panel will be made up of a president or deputy president (who is a magistrate), two medically-qualified members and one lay member;<sup>65</sup> while in New South Wales, a senior member, who is legally qualified, is assisted by two doctors and one lay member.<sup>66</sup> In no case is there ever a majority of non-medically-qualified members on a panel.

## New York

Hearings in New York are heard by a Committee on Professional Conduct. As with an Investigation Committee, it is composed of two physicians and one lay member, all drawn from the State Board. An administrative officer, licensed to practise law in New York State, is assigned by the commissioner. The administrative officer can rule on all motions, including those related to disclosing information or material that is protected due to privilege or confidentiality, procedures, and other legal obligations.

---

<sup>63</sup> General Medical Council (Constitution of Panels Tribunals and Investigation Committee) Rules Order of Council 2015 (2015/1965). (rule 7)

<sup>64</sup> Id. (rule 4(3))

<sup>65</sup> Health Practitioner Regulation National Law Act 2010 (SA). Adelaide: Office of the Parliamentary Counsel; 2010. (s.15)

<sup>66</sup> Civil and Administrative Tribunal Act 2013. No 2. Sydney: New South Wales Parliamentary Counsel's Office; 2013. (s.27)

They may also rule on objections to questions posed by the parties or committee members, and draft the conclusions of the hearing committee: however, they have no voting privilege.<sup>67</sup>

### **New Brunswick**

Quorum for New Brunswick's Board of Inquiry is three, including two medically-qualified members.<sup>68</sup>

### **Comparison**

There may be a majority of either medically-qualified members or lay members on any given MPTS panel. Hearings are chaired by an LQC, unless the doctor has no legal representation and exceptional circumstances are identified that indicate the hearing would benefit from a separate legal assessor. This could include where the particular vulnerability of a doctor would be best served by the chair and legal advisor to the tribunal being distinct. Where the case is complex, or likely to last more than 20 days, a legal advisor may also be mandated. In the vast majority of cases, this means that the panel will have two lay members and one medically-qualified member. (Although it is possible for the LQC to also hold a medical qualification, there have been no dual-qualified tribunal members to date.)

In most circumstances, then, an MPTS panel maintains a two thirds majority of lay members over registrant members. Quorum for New Brunswick's Board of Inquiry is three, including two medically-qualified members. In New York, the CPC comprises two physicians and one lay member, all drawn from the State Board. For Australian tribunals, the membership is more fluid: however, in no case is there ever a majority of lay members on a panel. Given that the remit of these committees is to protect the public, and not to represent the interests of doctors, ensuring that disciplinary cases are presided over by a majority of lay people would appear to be the logical approach.

---

<sup>67</sup> Public Health. Article 2. Title 2-A. New York: New York State Legislative Bill Drafting Commission. (s.230, para.10(e))

<sup>68</sup> Medical Act 1981. Chapter 87. Fredericton: Service New Brunswick; 1981. (s.59(1))

## *How matters of discipline are framed*

### **UK**

The terms used to define a departure from expected standards differ greatly between jurisdictions. Since the amendment of s.35 of the Medical Act in 2002, all charges levelled by the GMC at tribunal must be assessed at in terms of whether the doctor's fitness to practise is "impaired".<sup>69</sup> The introduction of the concept of impairment was designed to remove the cumbersome procedural complications that had arisen from maintaining four conceptually distinct channels of discipline, namely:

- serious professional misconduct;
- deficient performance;
- seriously deficient performance; and
- health concerns.<sup>70</sup>

### **Australia**

Although the concept of "impairment" is not defined in the statutory provisions, it involves some deterioration of the doctor's ability to practise the profession of medicine. Under Australia's new National Law, the AHPRA continues to recognise four broadly equivalent disciplinary channels, namely:

- professional misconduct;
- unprofessional conduct;
- unsatisfactory performance; and
- health concerns.<sup>71</sup>

### **New York & New Brunswick**

In contrast, both New Brunswick and New York maintain a single distinct channel of discipline, namely; professional misconduct. In the former case, expectations and obligations of doctors are all contained with the Medical Act and associated regulations: any deviation of these would constitute an act of professional

---

<sup>69</sup> Medical Act 1983 (Amendment) Order 2002/3135. London: HMSO.

<sup>70</sup> Case P. (2011) The good, the bad and the dishonest doctor: the General Medical Council and the 'redemption model' of fitness to practise. *Legal Studies* 31: 591-614.

<sup>71</sup> Health Practitioner Regulation National Law Act 2010 (SA). Adelaide: Office of the Parliamentary Counsel; 2010. (s.196(1)(b)(i-iv))

misconduct.<sup>72</sup> The New York state statute book contains a comprehensive list of definitions of professional misconduct applicable to physicians.<sup>73</sup>

### *Proceedings*

#### **UK**

Although the proceedings in all four jurisdictions described here follow the adversary process, the concept of impairment of fitness to practise constrains the format of MPTS hearings, which must follow a rigid structure comprising three stages, namely:

1. *finding on the facts*, during which the panel decides on disputed facts before moving on to stage 2;
2. *deciding whether or not fitness to practise is impaired*, during which the panel considers whether the registrant's fitness to practise is impaired based on the facts found; and
3. *imposing a sanction*, at which stage the panel may issue an appropriate sanction.

At stage 2, the panel are required to decide on whether or not a doctor's fitness to practise *is* [currently] impaired; not whether it *was* impaired at the time at which the proven facts occurred. If the panel concludes that the doctor's fitness to practise is impaired, the hearing moves to stage 3, where a sanction may be applied in accordance with the GMC's guidance. Following a successful High Court appeal of a decision by the precursor of the MPTS, aggravating and mitigating factors outlined in the GMC's Sanctions Guidance must be considered not only when determining sanction, but also when initially assessing a doctor's fitness to practise.<sup>74</sup>

---

<sup>72</sup> Medical Act 1981. Chapter 87. Fredericton: Service New Brunswick; 1981. (s.56(c))

<sup>73</sup> Education. Title 8. Article 130\*(3). New York: New York State Legislative Bill Drafting Commission. (paras. 6530-1)

<sup>74</sup> Cohen v General Medical Council [2008] EWHC 581 (Admin). In the opinion of Silber J, the panel considered that it followed automatically that Dr Cohen's fitness to practise was impaired from the factual findings of misconduct. He stressed that "it was not intended that every case of misconduct found at stage 1 must automatically mean that the practitioner's fitness to practise is impaired [at stage 2]". He disagreed with the decision of the panel that it was not relevant to take mitigating circumstances into account at stage 2. A major point of mitigation, namely that the misconduct was "easily remediable", was only considered as significant by the panel at a stage 3, when it was dealing with sanctions. It was found that Cohen's fitness to practise should not have been regarded as impaired and the sanctions imposed by the panel should be substituted for a warning.

## Australia

In contrast to the tightly structured proceedings of the MPTS, Australian tribunals are not subject to the strict controls imposed by adoption of the concept of fitness to practise. Hearings are subject only to generic rules & regulations dealing with each State or Territory's Civil and Administrative or Health Practitioners Tribunal. The South Australian Health Practitioners Tribunal, for example, is not bound by the rules of evidence and may inform itself on any matter as it sees fit. It must act according to equity, good conscience and the substantial merits of the case, without regard to technicalities and legal forms.<sup>75</sup> The tribunal rules are much less restrictive than those directing the MPTS, and any sitting tribunals "may dispense with compliance with any part of these Rules" and "do all or any acts or give any directions relating to the conduct of a proceeding as it thinks proper to dispose of that proceeding expeditiously".<sup>76</sup>

## New York

In New York, the licensee must appear at the hearing and may be represented by an attorney licensed to practice that state. An adversary procedure is followed, at which the licensee and the State Board may produce evidence and witnesses, cross-examine witnesses, and examine evidence. Either party may have subpoenas issued for him for witnesses and evidence.<sup>77</sup>

## New Brunswick

There is a statutory requirement for of any registrant whose conduct or fitness to practise is being queried to appear in front of the CPSNB Board of Inquiry.<sup>78</sup> The rules of evidence in an inquiry are pursuant to the *Rules of Court* governing civil trials in The Court of Queen's Bench of New Brunswick.<sup>79</sup> However, a Board of Inquiry may make rules under which the inquiry is to be held, and may do all things

---

<sup>75</sup> Health Practitioner Regulation National Law Act 2010 (SA). Adelaide: Office of the Parliamentary Counsel; 2010. (s.18(9))

<sup>76</sup> South Australian Health Practitioners Tribunal Rules 2011. Adelaide: Office of the Parliamentary Counsel; 2011. (rule 3(2))

<sup>77</sup> Public Health. Article 2. Title 2-A. New York: New York State Legislative Bill Drafting Commission. (s.230, para. 10(c))

<sup>78</sup> Medical Act 1981. Chapter 87. Fredericton: Service New Brunswick; 1981. (s.59(11))

<sup>79</sup> Id. (s.59(9))

necessary to provide a full and proper inquest.<sup>80</sup> Both parties have a full right to examine, cross-examine and re-examine witnesses, and to scrutinise evidence.<sup>81</sup>

## Comparison

Each of the four regulators have a fundamental duty to ensure the safety of patients and the public. Although disciplinary proceeding may also have a remit to uphold standards and to maintain confidence in the profession, its primary function is one of patient safety. The presentation of the case in Australia, New York, and New Brunswick is essentially as follows: on the basis of the facts found, did the doctor commit an act of misconduct? The UK process introduces the additional step of assessing whether the registrants fitness to practise is currently impaired as a result of that misconduct. The inclusion of this step focuses panellists on their patient safety remit, away from the punitive mindset that could be fostered.

Following a series of high-profile appeal cases in the UK High Court, an MPTS panel must consider facts material to the practitioner's fitness to practise looking forward.<sup>82</sup> Although fitness to practise will, by necessity, have been impaired at the time the misconduct occurred, the doctor's behaviour in the interim period, during which they are free to continue unimpeded in their practice, must be considered if a panel can claim to be looking forward when deciding the current status of fitness to practise. This is particularly relevant in cases where the doctor has made an effort to remedy any shortcomings that contributed to the misconduct, as for example where there are gaps in the practitioner's clinical knowledge.

## *Penalties and appeals*

### UK

Under section 35D(2) of the Medical Act 1983, the MPT may impose the following sanctions:

- no further action;
- warning;

---

<sup>80</sup> Id. (s.59(5))

<sup>81</sup> Id. (s.59(7))

<sup>82</sup> *Azzam v General Medical Council* [2008] EWHC 2711 (Admin), *Cohen v General Medical Council* [2008] EWHC 581 (Admin), *Zygmunt v General Medical Council* [2008] EWHC 2643 (Admin).

- undertakings;
- conditions (maximum 3 years);
- suspension (maximum 1 year); or
- erasure

Any panel decision that restricts a doctor's registration or removes the doctor from the Medical Register can be appealed in the High Court (or in the Court of Session in Scotland, or in the High Court of Justice in Northern Ireland) under s.40 of the Medical Act 1983. The statutory period to lodge an appeal is 28 days. The GMC is bound by rulings of the Administrative Court of the Queen's Bench Division of the High Court (and its equivalents in Scotland and Northern Ireland), and has had to change its guidance for deciding whether a doctor's fitness to practise is impaired based on the outcome of several significant appeals.<sup>83</sup>

### **Australia**

Where a doctor's actions have been found to constitute professional misconduct, unprofessional conduct, or unsatisfactory performance, an Australian tribunal may direct any of the following actions:

- no further action;
- the placing of conditions on registration;
- reprimand;
- suspension of registration; or
- erasure from the Medical Register.

The appeal body depends on the state or territory in which the tribunal sits. In Queensland, for example, appeals are heard by the Court of Appeal, while in South Australia, the District Court is the appellate body for Health Practitioners' Tribunals. Appeals must be made either within 28 or 30 days, depending on the court procedures rules regulating each state or territory.

---

<sup>83</sup> Dyer C. (2008) GMC changes guidance on fitness to practise after High Court ruling. *British Medical Journal* 337: a2887, Dyer C. (2009) Practice makes perfect: refining the rules that judge safe medicine. *British Medical Journal* 339: b3113.

## New York

The New York Committee on Professional Conduct has a larger range of “punishments” available to it than do the other regulators. These include fines, public service, and partial suspensions.<sup>84</sup> The CPC may order any of the following:

- reprimand;
- completion of education or training;
- limitation of license to practice;
- suspension of license (partial or complete);
- revocation/annulment of license;
- fine (up to \$10,000 for each charge); or
- 500 hours of public service.

Where their license to practise is revoked, annulled, suspended for more than 180 days, or restricted in any way, the doctor must comply with various legal requirements within 15 days.<sup>85</sup> These include notifying their patients of the cessation or limitation of practice, transferring medical records to any physician(s) who accept their former patient(s), returning unused New York state official prescription forms, and destroying all other prescription pads containing the licensee’s name. Failure to comply may lead to prosecution and additional penalties.

Determinations of the committee can be appealed to the administrative review board.<sup>86</sup> The review board consists of 5 members (3 physicians, and 2 lay members) appointed by the NY State Governor with the State Senate’s consent. Within 14 days of the committee’s decision being served, notice of the review should be served by certified mail to the review board and the other party. A notice of review stays any penalty until a new decision is reached unless that penalty is a suspension, an annulment, or a revocation of license. Reviews consist of a review of the record of the hearing and submitted briefs only: there are no appearances or testimonies. A written decision from the review board must be given within 45 days.<sup>87</sup> An order of the Administrative Review Board or a determination of a committee in which no

---

<sup>84</sup> Public Health. Article 2. Title 2-A. New York: New York State Legislative Bill Drafting Commission. (s.230-a, paras.1-9)

<sup>85</sup> Id. (s.230, p.10(h)(ii))

<sup>86</sup> Id. (s.230, p.10(i))

<sup>87</sup> Id. (s.230-C, para. 4(a))

review by the administrative review board was requested before the appellate division of the third judicial department. Such decisions shall not be stayed or enjoined except upon application and upon a showing that the petitioner has a substantial likelihood of SUCCESS.<sup>88</sup>

### **New Brunswick**

A Board of Inquiry of the CPSNB adjudicates on the allegation(s), evidence and facts, with a view to determining if physician is guilty of misconduct.<sup>89</sup> If a registrant is found to be guilty of misconduct, the Board of Inquiry will seek to determine the reasons behind why the member acted in such a manner, before imposing a sanction. The sanction imposed will vary depending on the severity of the initial allegation and the factual findings of the inquiry.

Where a member is guilty of professional misconduct, the Board of Inquiry may administer the following sanctions:

- admonition;
- conditions;
- suspension for a fixed or indefinite period;
- removal from the relevant register;
- fine (up to \$10,000); or
- payment of costs.<sup>90</sup>

As the CPSNB maintain both the register of physicians and the specialist registers, the sanctions of suspension and removal may apply to either. Sanctions imposed take effect immediately, and can only be removed by the Court of Appeal of New Brunswick.<sup>91</sup> A party to the proceedings who is affected by an order of the Discipline and Fitness to Practise Committee may appeal to the Court of Appeal of New Brunswick on a question of law or fact within 30 days of the service of the order.<sup>92</sup>

---

<sup>88</sup> Id. (s.230-C, para. 5)

<sup>89</sup> Medical Act 1981. Chapter 87. Fredericton: Service New Brunswick; 1981. (s.59(14))

<sup>90</sup> Id. (s.59(14)(d))

<sup>91</sup> Id. (s.59(16))

<sup>92</sup> Id. (s.61(1))

## SEPARATION OF FUNCTIONS

In UK law, most healthcare regulators are responsible for both the investigation and adjudication of allegations of concerns raised about their registrants. This has led to criticism that as the standard-setters, prosecutors and adjudicators, the regulators' adjudicatory independence is open to question. In 2004, the *Fifth Report of the Shipman Inquiry* recommended the clear separation of adjudication from the General Medical Council's other functions through the establishment of an independent judicial body in the eventual form of the MPTS).<sup>93</sup> The further separation of investigation and adjudication by transferring the adjudicative function from the MPTS to the First-tier Tribunal (Health, Education and Social Care Chamber) was considered by the Law Commission's 2014 review of healthcare regulation: however, it ultimately decided that the MPTS – though not fully separate from the GMC – did have a high degree of independence, and recommended that other healthcare regulators move towards such a system.<sup>94</sup> In Australia, the formation of the AHPRA in 2010 saw the complete devolvement of all adjudicatory functions to completely independent Civil and Administrative or Healthcare Tribunals. In both New Brunswick and New York, sub-committees of the medical regulators – the CPSNB and the OMPC, respectively – are responsible for both investigation of complaints and adjudication of allegations.

Although the investigation processes on each jurisdiction closely mirror one another, there are marked difference between each jurisdiction. Neither the OPMC, nor the CPSNB may refer a case to their respective adjudicatory panels until all stages of their investigatory processes have been followed in full. In contrast, the GMC and MBA may refer a case directly to a tribunal at any stage where they believe that it is in the interests of the doctor, patients or the public to do so.

Uniquely, the GMC's process includes a resource-saving step at the end of the preliminary investigation, at which each case is considered by two "case examiners".<sup>95</sup> This allows straightforward or "clear-cut" cases to be disposed of

---

<sup>93</sup> (2004) *The Fifth Report of the Shipman Inquiry*, Cm 6394. London: HMSO. (paras. 27.204-210)

<sup>94</sup> Great Britain Law Commission, Scotland Scottish Law Commission and Northern Ireland Law Commission. (2014) *Regulation of health care professionals; regulation of social care professionals in England*, Law Com No 345, Scot Law Com No 237, NILC 18. London: HMSO.

<sup>95</sup> General Medical Council (Fitness to Practise) Rules Order of Council 2004/2608. London: HMSO; 2004.

without the need to convene a meeting of the Investigation Committee. Cases can be concluded with the agreement of both examiners. If they do not agree, the matter is considered by the Investigation Committee, which has the same powers as the case examiners.

The GMC and OPMC's respective Investigation Committees and the New Brunswick Complaints and Registration Committee consider only written evidence in the form of the results of an investigation. Where a case is referred to an investigation committee, the OPMC does require that the licensee be interviewed in order to provide an explanation of the issues under investigation. Although the MBA's Performance and Standards Panel does not preside over full adversarial hearing, it may interview the practitioner, the complainant or other witnesses; and give the practitioner the opportunity to make submissions the opportunity to discuss the allegations with the panel.

## **CONCLUSIONS**

This work constitutes the first comparison of the technical aspects of four procedurally-different **systems** seeking to attain the same goal, namely: to enforce standards set by their respective regulatory frameworks with a view to protecting patients and the public from medical misconduct.

While no one system may be considered perfect, each contains processes that could potentially benefit the others. For each step in the process, one or other jurisdiction takes a position to act in the interests of either the public or of the respondent doctor, or to occupy some middle ground. With regard to hearings, for example, only Australia has an independent adjudicator: in both the American and Canadian jurisdictions, the regulator sets standards, investigates complaints, brings charges, and adjudicates upon them, leaving them open to accusations of acting from self-interest. In the UK, the medical regulator occupies a middle ground by using a semi-independent adjudicator.

The ease with which a doctor's license to practise can be suspended is, in general, too easy. In the UK, one could easily imagine a physician losing their job, defaulting on their mortgage, and having their life spiral downwards during the six-month period between reviews, on the basis of an accusation that later proves to be utterly

groundless. New Brunswick's requirement that, when appealing an order, a physician must demonstrate that a revocation will provide patient benefit presents a significantly higher barrier than that required to effect a suspension in the first instance. New York's precondition that, where a physician is suspended, their hearing must be expedited does anything to compensate for the ease with which a physician's livelihood can be snatched away.

Of the four jurisdictions examined, the UK most clearly acts in the interest of the public and the medical profession – rather than the accused doctor – at every step of its process. The framing of misconduct in terms of impairment of fitness to practise ensures that protection of the public and maintenance of public confidence in the profession are to the fore of panel members' minds when deciding how to dispose of a case. Additionally, the GMC is the only regulator for which lay panel members outnumber **registrants** in almost all cases.

While sanctions handed down by the GMC may seem punitive to the **physicians** receiving them, their function is clearly not to punish. Conversely, the penalties issued in New York and New Brunswick include a fine, which can have little function other than a punitive one: it does not protect the public, nor does it do much to uphold public confidence in the profession.

Having examined the processes involved in dealing with misconduct in these four jurisdictions, the next step will be to compare outcomes. To this end, we are currently seeking funding to examine how each regulator interprets similar behaviour when assessing a doctor's misconduct and deciding on the appropriate sanction to apply. This will involve subjecting hearing transcripts from each jurisdiction to directed content analysis. Answering the question of whether similar behaviour leads to similar outcomes across these jurisdictions will allow us to better understand whether the procedural differences highlighted have any meaningful difference on the work of the respective regulators.

## **FIGURE LEGEND**

***Fig. 1: The disciplinary processes activated by the receipt from a member of the public of a complaint against a doctor in: (a) the United Kingdom; (b) Australia; (c) New York; and (d) New Brunswick.***

