made light work of the complex decisions that boards of this nature often have to make, while never failing to apply the most rigorous professional standards.

The *Journal* has been previously blessed with a series of exceptional chairs –Dame Hazel Genn, Godfrey Cole and Kenny Mullan – who have been served by a series of equally exceptional editors in Andrea Dowsett, Mark Dibben, Samantha Livsey and Orla Kilgannon-Avant. But, in my view, the *Journal* has never been stronger or richer than it is now in both the range and the quality of its contributions, and is an exemplar of the high quality of the work that the Judicial College manages to produce at every level of its operation. I look forward to reading future editions of the *Journal*, as it no doubt will continue to go from strength to strength.

Jeremy Cooper, Chairman of the Editorial Board
e-mail: *jcpublications@judiciary.gsi.gov.uk*

A unique regulatory model for doctors

THE MPTS By **David Pearl**

The history of the Medical Practitioners Tribunal Service (MPTS) goes back to recommendations contained in the fifth report of the Shipman Inquiry[1] which was published in December 2004. Dame Janet Smith's recommendation number 51 states that the adjudication of allegations concerning a registered doctor's fitness to practise should be undertaken by a body independent of the General Medical Council (GMC), the statutory regulator for registered doctors. The government of the day took forward Dame Janet's recommendations, and indeed went further, and established the Office of the Health Professions Adjudicator (Health and Social Care Act 2008).

The Office was set up to take over, initially, fitness to practise hearings from the GMC as from April 2011. The coalition government at that time, however, decided that the costs of setting up OHPA were disproportionate to the benefits, and, in consequence, the Office was abolished by the Health and Social Care Act 2012. The government at that time, however, sought proposals from the GMC as to how it would ensure independent adjudication of allegations relating to the fitness to practise of its registrants, and the separation of investigation from adjudication. The response from the GMC was the creation of the MPTS. I was appointed in February 2012 as its first Chair.

The MPTS existed initially as a 'shadow' committee, but, by an amendment to the Medical Act 1983, on 31 December 2015, the MPTS has now become a statutory committee with detailed governance procedures set out in the Order.[2]

The model which has been created for the adjudication of fitness to practise is a unique one in the regulation of healthcare professionals both in the UK and abroad. Although the MPTS is still part of the wider family of the GMC, the management and operational arrangements ensure that there is a very real 'Chinese wall' between the investigation of complaints, and presenting the results of the investigation before a tribunal (a matter for the GMC) and the adjudication decisions, involving findings of fact, decisions on whether there has or has not been impairment on the part of the doctor both in the past and at the time of the hearing, and, if necessary, the appropriate sanction.

The Law Commissions, in their consultation paper on health regulation,[3] had argued strongly that there are substantial benefits to be gained from the separation of investigation and adjudication, not least of which is enhancing public and professional confidence. The Commissions, in their report,[4] stated their view that:

'. . . the establishment of the MPTS is a major step towards achieving separation. Although the service is not fully separate from the GMC, we consider that this reform has introduced a high degree of independence into fitness to practise adjudication.'

The MPTS today

The MPTS has a dedicated hearing centre in central Manchester, with 16 hearing rooms. It heard 208 new fitness to practise cases in 2012, 229 cases in 2013, 237 cases in 2014, and 239 cases in 2015. It also considers interim orders, where, pending the conclusion of the investigation by the GMC, the GMC believes that the risk to public safety of the doctor continuing in unrestricted practice is too great and accordingly it is necessary to restrict the doctor's registration in some way. The Interim Orders Tribunals heard 784 new interim applications in 2012. The number of interim order applications has fallen over the last few years, and, in 2015, the tribunals heard 522 new applications. The drop in such interim applications is almost certainly because of the approach of the High Court that the test for granting the interim order is a high one. In addition to new cases, the tribunals review most of the interim and the substantive orders prior to their expiry.

All of these statistics must be seen against a total of some 270,000 registrants in the UK, and an average number of complaints over the last four years as approximately 10,000 a year. The average length of the hearings has been reduced in the last four years, although it still remains at around 7.9 days for a new substantive hearing. Most doctors are represented by counsel, although the number of self-represented doctors remains high, running at 15% in 2015 in the case of the substantive hearings, and 10% in 2015 for interim applications. The outcomes of the hearings remain fairly constant, as illustrated by the tables below.

Outcome of medical practitioner tribunals in 2011–15*

	2011	2012	2013	2014	2015
Erasure	65	55	55	71	72 (30%)
Suspension	93	64	86	86	95 (39%)
Conditions	24	20	32	22	24 (10%)
Undertakings	1	1	0	3	1 (0.5%)
Warning	23	12	13	10	6 (2.5%)
Impairment – no further action	2	6	1	4	2 (1%)
No impairment	33	48	38	37	38 (16%)
Voluntary erasure	1	2	4	4	1 (0.5%)
Total	**242**	**208**	**229**	**237**	**239**

Outcome of interim orders tribunals in 2011–15*

	2011	2012	2013	2014	2015
Suspension	158	207	125	102	49 (9%)
Conditions	236	336	375	350	359 (69%)
No order made	95	241	134	119	114 (22%)
Total	**489**	**784**	**634**	**571**	**522**

* MPTS took over running of hearings from 11 June 2012

The tribunals sit as a panel of three, at least one of whom must be a medical practitioner with a licence to practise, and one must be a lay member. Traditionally, the tribunals have been assisted by legal assessors who provide advice to the tribunal, but one of the important amendments to the Medical Act 1983 introduced in December 2015 is that the mandatory requirement for legal assessors to be appointed for every hearing has now disappeared. The MPTS has now acquired a 'mixed model'. By paragraph 7(1B) Schedule 4, Medical Act 1983, the MPTS must appoint a person as an assessor to an MPT or an IOT for the purpose of advising the tribunal on questions of law arising in proceedings before them a) if the chair of the tribunal is not a legally qualified person, or b) in any other case where they consider it appropriate to do so.

The MPTS is at present trialling the use of legally qualified chairs, using them for interim orders tribunals, and for substantive review hearings, in particular for reviews on the papers. The MPTS at the present time has a pool of 218 members who sit on the substantive medical practitioner tribunals and 61 members who sit on interim orders tribunals. This is made up of 146 medical members, 113 lay members and 20 legally qualified chairs. In addition, there are some 69 legal assessors who are appointed, under paragraph 7(2) of Schedule 4, Medical Act 1983, for particular proceedings.

Important changes

Two other changes to the procedures introduced by the 2015 amendments are of substantial importance. First, case management has been given a statutory presence which it had not previously enjoyed, and it is hoped that robust proactive case management will reduce further the length of hearings. Case management decisions will be binding on the parties and indeed, barring changes in the circumstances, binding on the tribunals as well. There is a new power in certain circumstances to make a costs award against a party, either the doctor or the GMC, who has behaved unreasonably in the conduct of the proceedings and, in particular, against a party who has failed to comply with case management directions or failed to comply with the fitness to practise rules.

Now, as a result of the 2015 reforms, the GMC also has a power to appeal to the High Court . . . if it considers that the decision is not sufficient . . . for the protection of the public.

Decisions made by a tribunal can be appealed to the High Court by the doctor. Now, as a result of the 2015 reforms, the GMC also has a power to appeal to the High Court under s40A Medical Act 1983 if it considers that the decision is not sufficient (whether as to a finding or a sanction or both) for the protection of the public. The GMC can consider an appeal if it is of the view that the decision of a tribunal has failed to comply with the over-arching objectives in s1B Medical Act 1983, namely a) to protect, promote and maintain the health, safety and well-being of the public; b) to promote and maintain public confidence in the medical profession, and c) to promote and maintain proper professional standards and conduct for members of that profession. Providing the GMC with a right of appeal underlines, of course, the separation of the adjudicatory process from the investigation of any concern about fitness to practise, and emphasises the autonomous status of the MPTS.

An interesting jurisprudence has been established by the High Court and the Court of Appeal on how disciplinary tribunals such as the MPTS should go about their task. The burden of proof remains on the GMC to prove its case on a balance of probabilities. In misconduct and performance cases, the tribunal, having made findings on the facts, must decide whether the misconduct or failure in performance, is sufficiently serious to warrant a finding that this constitutes, at the time of the event in question, impairment on his or her practise. If the answer is in the affirmative, the tribunal must then go on to consider whether the doctor remains impaired at the time of the hearing. The tribunal will have to consider whether the doctor has or has not developed sufficient insight into the issues that brought him or her before the tribunal, and whether he or she has engaged in any remediation, such as undergoing further courses and so on. But if there is a finding of continued impairment, the tribunal then has to consider what sanction to impose.

The MPTS, together with the fitness to practise directorate of the GMC, has produced a Sanctions Guidance (March 2016 edition) which outlines the purpose of sanctions and the factors to be considered. The document provides, in effect, a crucial link between the two key regulatory roles of the GMC: setting standards for the medical profession, and taking action when a doctor's fitness to practise is called into question because he or she has not met those standards.

The fully reasoned decisions taken by the tribunal are communicated to the parties at the conclusion of each stage of the proceedings; namely after the deliberation on the facts, on whether there is impairment, and on the appropriate sanction. Copies of the tribunals' decisions held in public are also available on the MPTS website for 12 months after the end of the hearing. All hearings are in public unless there are health issues or other exceptional reasons for the tribunal to hear evidence in private. All restrictions or requirements placed on doctors (except those relating solely to a doctor's health) are published online on the medical register (see here).

The future

I anticipate that there is little appetite on the part of the Government to introduce any major reforms in the field of regulation in the health sector during the course of the present Parliament. The Law Commissions' draft Bill[5] which provides the health care regulators with the power to make their own rules, is not likely to be introduced. Any suggestion that the adjudication of fitness to practise be assimilated into the First-tier Tribunal, once mooted by some, is remote speculation. Likewise, appeals are almost certain to remain to the respective High Courts of England and Wales, Scotland and Northern Ireland, and not be transferred to the Upper Tribunal.

Any suggestion that the adjudication of fitness to practise be assimilated into the First-tier Tribunal, once mooted by some, is remote speculation.

Much work will continue to be done to reduce the time it takes for a case to be heard (both prior to the hearing and the hearing time itself), through robust case management in particular. Legal assessors will continue to be used, but perhaps primarily in the category of case where they add value, in particular where the doctor is self-represented in lengthy and complex hearings. In many of these hearings, the tribunal needs to adopt a more inquisitorial approach in order to test the evidence produced both by the doctor and the GMC. The presence of an appropriately trained Legal assessor may ensure that these hearings are conducted fairly and justly.

The categories of sanctions may be increased to add warnings (as recommended by Dame Janet in her report) which at present can only be made by a tribunal when it concludes that the doctor's fitness to practise is not impaired. And work must be done, as in all courts and tribunals, on finding ways to reduce the burdens and pressures on self-represented doctors. There will be major work on developing more use of technology, through VDU evidence, and less reliance on paper documentation.

The MPTS will be seeking applicants during 2016 for medical members, legally qualified chairs and legal assessors, and anyone interested in applying is encouraged to visit the website (*www.mpts-uk.org*) for further information.

David Pearl is National Chair of the Medical Practitioners Tribunal Service *Back to contents*

[1] 'Safeguarding Patients: Lessons from the past – proposals for the future' (Dame Janet Smith) (2004) Cm 6394.

[2] General Medical Council (Constitution of the Medical Practitioners Tribunal Service) Rules Order of Council 2015 (2015 No 1967).

[3] Joint consultation paper LCCP 202 / SLCDP 153 / NILC 12 (2012).

[4] Law Com 245 / Scot Law Com No 237 / NILC 18 (2014).

[5] Law Com No 345 / Scot Law Com 237 / NILC 18 (2014).