



Drafting allegations for Fitness to Practise proceedings in the GMC Selva Ramasamy, QEB Hollis Whiteman

Please Note: it is understood that the GMC is currently reviewing its approach to this topic and is likely to issue guidance in the near future. This paper sets out some of the current thinking of the author in relation to the drafting of allegations, and seeks to identify some problems that have arisen.

A) Basic principles

The allegation is one of impairment by reason of one or more of the statutory bases (see s.35C (2) Medical Act 1983, as amended):

- misconduct,
- deficient professional performance,
- conviction or caution,
- adverse health,
- determination by a regulatory body

Impairment is to be judged on the basis of any facts found proved (2004 Rules, r.17(2)(j))

Therefore, prosecutors ought to spell out the facts which they say demonstrate impairment. This will assist:

- the doctor who needs to understand the case that he has to meet, so as to fulfil the requirements of natural justice and Article 6 ECHR;
- the panel as to the case they have to consider - well structured allegations help the panel to set out their reasons for their determination on impairment and sanction

The Courts have been supportive of the GMC approach to particularising facts since:

'... the structured determination of the Committee dealing with the various heads of charge will in itself reveal much about its decisions for reaching its decision...'
such that there is no breach of the Article 6 requirement of a reasoned decision¹.

1 *Gupta v General Medical Council* [2002] 1 W.L.R. 1691

QEB Hollis Whiteman Barristers

Queen Elizabeth Building, Temple, London EC4Y 9BS

DX LDE 482 Telephone 020 7583 5766 Fax 020 7353 0339

barristers@qebholliswhiteman.co.uk www.qebholliswhiteman.co.uk

B) Global approach to allegations

In some instances there has been a tendency to draw up allegations that read like a case summary, with every step of the journey particularised as an allegation, whether the individual allegation might be a basis for impairment or not. In general this tends to be unhelpful as it burdens the panel with needless fact finding.

Consider: what can you prove?

What evidence is admissible?

Remember the increased use of hearsay evidence in the criminal courts, and over and above that, the panel's duty to make due inquiry under rule 34(2).

Use of admissions made by the defendant doctor

Try to make use of any admissions already made in correspondence, such as any response to the rule 7 letter (this of course depends on whether the rule 7 letter covers matters you wish to allege...).

What does your expert say?

If at all possible involve your expert in the drafting and ensure that he feels able to support the criticisms made in your final draft.

Consider: what are the facts that you say indicate impairment?

Aim to spell those facts out so the defendant doctor knows the case he has to answer.

Pitching the allegations at the right level

r.17(3) permits amendments of allegations provided they can be made 'without injustice'. In general it is better to aim high in that panels are more inclined to allow amendment 'down' rather than 'up' the scale of seriousness.

NB if you only allege the most serious form of facts, and subsequently the case turns out rather differently (as often happens with late disclosure of the defence case) there is a risk that the defence will be able to claim injustice on the basis that they would have presented their case differently if they knew they were having to defend lower level allegations as well.

Therefore using the example of the specimen charge (see C below - based on a real case where the patient in fact died) you might wish to allege that the doctor's conduct contributed to the patient's death BUT you should also allege from the outset that the conduct was inappropriate, not in the patient's best interests, irresponsible/ had the potential to put the patient at risk etc, so the defence know they have to meet these allegations from the outset.

Set matters out in chronological order

Style – each regulatory body develops its own has own house style but generally:

Aim to use a single numbered head for a group of allegations that are related in time.

Within that numbered head, set out the relevant detail of what happened etc, with indented subdivisions indicated by letters (a), b), c) etc), and any further subdivisions indicated by Roman numerals (i), ii), iii) etc)

Dates – use 'on or around' if there is any uncertainty as to when an event took place

Use of quotations/ direct speech:

This is generally unwise as a witness may depart from the precise quotation in evidence: use indirect speech such as 'You told her that she should...'. (i.e. not holding this out as a direct quotation) or, if you have no option but to use a quotation, use 'or words to this effect'.

C) Specimen approach to drafting

I) Identify the doctor and his area of specialty

1. In August 2007 [try to avoid 'at all material times'] you were a General Practitioner practising at 1 Acacia Avenue, Hammersmith, London.'

II) Set out the key facts – the important events relevant to impairment such as:

the date of the particular event (using 'on or around' if not sure of the precise date)

the identity of the patient

the nature of the complaint and any history if relevant (it often is)

2. a) On or around 3 Feb 2002 Ms A consulted you
[or use the patient's real name 'Susan Smith']

b) At that consultation Ms A complained of:

- i) breathlessness;
- ii) chest pains.

c) You knew or ought to have known that Ms A was being treated for heart disease

III) Add what you say the doctor did/ did not do:

- d) You did not:
 - i) conduct any, or any adequate examination;
 - ii) take any, or any adequate history.
- e) You told her she no longer needed to take the medication prescribed for her heart condition.
- f) You did not communicate with her treating consultant as to the advice you gave.

IV) Spell out your criticisms

- g) Your conduct as set out, in particular, in points 2 d), e) and f) above was:
 - i) inappropriate
 - ii) not in the best interests of your patient
 - iii) irresponsible/ had potential to put your patient at risk

NB see comments on use of adjectives, at D) I) below

NB allegations are sometimes drafted so as to leave the all the criticisms to the very end of all the chronological numbered paragraphs e.g.

7. Your conduct at particulars 2, 3, 4, 5, and 6 was:

- a) inappropriate;
- b) not in the best interests of your patient;
- c) irresponsible.

In my experience while this (slightly) shortens the form of the allegations on paper, it can upset panellists as they find it complicates matters to have to link the allegations up in their determination (ie 'particular 7 a) is found proved in relation to particular 2 b), 3 c) 4 a) to e) etc')

D) Some issues as to the content of allegations

I) The use of adjectives in allegations

NB this may be one of the matters under review by the GMC

1 Allegations of dishonesty, indecency/sexual motivation

These can properly be described as facts, as they are to do with the mental element of the conduct in question. They must be set out in the allegations - indeed to fail to plead these matters would amount to a serious procedural error. (*Singleton v Law Society* [2005] EWHC 2915 (Admin.) paras. 11-13; R (on the application of the *Council for the Regulation of Healthcare Professionals v (1) NMC (2) Michelle Kingdom* [2007] EWHC 1806 (Admin.))

It is sometimes suggested that the Council should simply allege dishonesty ALONE if that is their case. This may make sense from a criminal lawyer's approach, but bear in mind the regulatory system not quite the same as the criminal process. Prosecutors in the criminal courts have the advantage of far greater knowledge of the defence case, via police interviews, defence case statements and effective case management procedures where expert evidence is disclosed well in advance of the hearing.

In the GMC, the problem we face is that often we do not get disclosure of the defence case until very late in the day.

This sometimes creates a need for an application to amend where the test the panel must apply is whether the amendment can be made 'without injustice', and as observed above, the defence may be able to claim that they would have dealt with the witnesses differently if they knew the allegation was made at lower levels as well.

It may be that a sensible approach in dishonesty cases is to allege that the conduct was:

- a) misleading
- b) intended to mislead (to cover the 'white lie')
- c) dishonest.

2 Allegations that conduct was inappropriate, unprofessional, not in the patient's best interests etc

It may be said that this sort of allegation, relied on by the GMC over the years, involves objective assessments or judgements, based on the facts. As such it may be said that they are perhaps better considered as part of the judgement on impairment rather than as part of the decision at the facts stage.

However, with the move to the civil standard of proof it may be thought that the use of these terms at the facts stage provides a useful marker as to the seriousness of the allegations as the GMC puts them, and thus a useful marker as to cogency of evidence required to discharge the burden of proof (ie the more serious allegations will be particularised as 'irresponsible etc').

If we are to continue to use these adjectives, many of the terms currently used blur so that there is no sensible distinction between them (eg improper, inappropriate, unprofessional, below the standard to be expected of a doctor)

It may be best to assess whether three clear steps, in ascending order of seriousness, will suffice (eg, inappropriate, not in best interests, irresponsible)

II) Use of the phrase 'failed to'

This implies that the doctor should have done something (and did not)

It can be a helpful way to approach cases provided you are confident that your expert will support the fact that there was a duty to take the step suggested.

III) Performance and Health cases

Given that fitness to practise cases involve a 3 stage process, in performance and health cases we need to set out the facts which are to be proven, which in turn (if proven) will form the basis for the finding of impairment

In relation to Performance and Health cases there are usually two possible scenarios:

- either an assessment has been completed
- or
- an assessment has not been completed (because the doctor has failed to submit or comply with the assessment)

In the second scenario, you have little option but to aim to plead some of the foundation matters (in addition perhaps alleging a failure to submit or comply with an assessment (if the case has been referred under r.7(6)), and/or possibly making use of the r.17(8) adverse inference provision)

In the first scenario, we ought to be able to deal with matters more simply. The assessors will have completed their report, and it will have been served. The report sets out the conclusions of the assessors including (as required by sched. 1 para. 4 or sched. 2 para. 4 to the 2004 Rules):

- a) an opinion as to whether the practitioner is fit to practise either generally or on a limited basis; and

- b) any recommendations as to the management of the case

Any assessment (health or performance) is necessarily a statement of opinion, and not a fact BUT if you particularise the conclusion of the assessment team

i.e.

- a. 'On [dates] you underwent an assessment of your professional performance comprising [insert elements]'
- b. the formal opinion of the assessment team was [insert]

the fact that that was their opinion becomes the factual finding of the panel. The panel then goes on to consider what that means when they come to judge impairment. The defendant doctor, if he wishes to challenge that opinion, may do so at the impairment stage by calling other evidence which may undermine the assessors' opinion when the panel consider the question of impairment.

From the defence perspective, the problem with this approach is that if the fact that is pleaded is that the GMC assessors formed an opinion, then that fact cannot sensibly be challenged at stage 1 – any evidence the defence may have would be irrelevant to the issue of whether the assessors had formed that opinion in the past. The effect is to deny the defence the ability to challenge the case at stage 1 where there is a burden and standard of proof, instead forcing them to make their points at the impairment stage where the decision involves the exercise of judgement rather than any issue of burden and standard of proof.

If this is thought to be objectionable, a solution may be to allege (in addition to setting out the conclusion of the assessors) 'and their conclusion was correct/ well founded' – if that is done, the defence can then admit the opinion, but if they wish, deny that it was well founded, and call evidence on that issue.

Health cases

Aim to particularise the specific condition using schedule on a separate sheet
eg 'On x date you were diagnosed as suffering from the condition set out in schedule 1'
schedule 1 : tuberculosis

Multi-factorial cases

Remember: stage 1 involves the proving of facts, stage 2 involves a judgment of impairment on the basis of the proven facts. Cases often change their shape as the defence evidence emerges. You should NOT draft your allegations so as to tie specific facts to specific bases of impairment as the approach of the GMC is to take matters on a holistic basis.