

MEDICAL PROFESSIONAL DISCIPLINE

Has the pendulum swung too far?

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A profession can generally be thought of as a group of people following a particular calling whose actions are governed by high standards of both ethics and practice. The latter however, do not fall out of the sky; standards have to be both established and maintained on mutually agreed lines by professionals themselves. This paper is particularly concerned with the second aspect, that of the maintenance of standards. There are many ways of maintaining standards. Probably the best is the feeling by individual professionals that they are ethically obliged to deliver services of the highest quality both out of respect for their clients and their fellow professionals. Failure by an individual brings the whole profession into disrepute.

Origins of Medical Discipline

However, another aspect of standards-maintenance is through the exercise of discipline against those professionals who do fall short of the standards required both by mutual consent and very often by law. In this respect, a leading Australian sociologist Daniel makes the very important point that "Public perceptions of a profession will be governed the way discipline *is seen to be* applied and enforced in the profession" (Daniel, 1995) [author's emphases].

That statement has strong echoes of the old saying: "Justice must be seen to be done." In this light it can be asserted that the application of discipline is one of the most crucial aspects of professionalism.

If that was always true, it became even more true during the second half of the twentieth century when ideas about consumer rights and provider responsibility and duty of care moved to the forefront of public consciousness. Accountability became one of the great watchwords and catchcries of public life.

Surprisingly this development tended to catch the medical profession offside because, as the emergence of the Hippocratic Oath around the fifth century BCE testifies, physicians from the earliest times had a consciousness of their professional responsibilities. *Primum non nocere* ("above all, do no harm") was their watchword.

When an early medical professional association, the College of Physicians, was established in 1518 in London, its articles of association included a disciplinary clause which allowed physicians who were considered to have fallen short of its

standards, to be expelled, or more euphemistically, to have their names struck off the medical register.

A difficulty for early starters in any field however, is that the world changes and all too often they fail to change rapidly enough to meet changing circumstances. This was true of the medical profession. While early associations of physicians were aware of the necessity of disciplinary measures, the grounds on which discipline was to be exercised were very different to those which emerged later, since what the early associations were concerned with was that their members were upright and honourable members of society and respected its morals and mores. Those who failed to do so were, in the words of the statutes of the Royal College of Physicians (it became "Royal" when granted a charter by King Charles II) were adjudged to be guilty of "infamous conduct in ... professional respect" and therefore liable to being deregistered. In the words of Freckleton (1996):

[T]he criterion for continuing professional practice has widely been regarded as being whether the practitioner has slipped from being of good *fame* and character bespeaks a concern on the part of the professions with the reputation of the practitioner and public face of the profession (p139).

For more than three centuries a practitioner's "fame" if not his¹ reputation was seen to depend on his good character, not on his practice standards. As pointed out by Berlant (1975), infamous conduct did not include "mistakes or incompetence short of gross malpractice and gross incompetence" (p161).

That that situation persisted well into the twentieth century is evident for instance in a publication commemorating the centenary of the British General Medical Council, which was published in 1958. Its then registrar Pyke-Lees reported that among the 200 doctors who had been deregistered in the 50-odd years since 1900, "77 have been erased for adultery or improper conduct with a patient, 53 for procuring or attempting to procure abortion or miscarriage, 45 offences connected with drink or drugs" (1958 p27). Absent from that list of miscreancies is anything connected to practice standards.

Pyke-Lees's book was published at the cusp of medical disciplinary eras. Paradoxically it was as medical treatment became more efficacious as a result of the rise of scientific medicine in the late nineteenth and early twentieth centuries that public expectations of the professions became much more exacting. Before this time, it was generally accepted that the ability of medical practitioners to mitigate the effects of disease and ageing was limited, while early death was accepted with fatalistic resignation.

The rise of microbiology and the concomitant rise in knowledge of the aetiology and control of disease, the increasing success of surgical techniques and interventions, the most of all the discovery of antibiotics, all helped create the idea that "the

illnesses to which human flesh is heir" had been conquered and that all individuals could anticipate living a long and healthy life. In this new climate of thinking attitudes towards the medical profession changed. While on the one hand doctors were seen to be heroic miracle workers, on the other hand their practice failures were regarded with the vengeful savagery of those whose high expectations had been betrayed. That provoked a new emphasis on medical discipline not so much in the profession itself, as among the public, as Pyke-Lees himself observed with some surprise when he stated "[T]o the general public, and to the Press ... the [General Medical] Council is concerned above all with discipline" (p25).

Ever attentive to their electoral interests, governments also began to take much more interest in questions of medical discipline and thus to become much more critical of medical regulatory bodies which seemed to be failing to exercise such discipline.

All too often those regulatory bodies responded too slowly to the new climate and demands for professional accountability. To illustrate that point I am going to focus on the particular jurisdiction in which I live and work, the State of New South Wales in Australia.

New South Wales

This State it should be said, is by no means an inconsequential entity. It has a population of over six million, which twice the size of that of Ireland for instance, and also many of several countries which recently joined the European Union such as Latvia, Estonia and Lithuania. There are 25,000 registered doctors in New South Wales, which as part of the federal system in Australia, is governed by a parliament exercising sovereign power over medical regulation and therefore over medical discipline.

Developments in this sphere in New South Wales have mostly mirrored those of other jurisdictions around the world, although over the last ten years New South Wales has diverged from world practice in one crucial sphere, that of medical discipline. In a unique development, New South Wales applied a system known as collaborative regulation, or the co-regulation of medical discipline, in terms of which a "lay" body, the Health Care Complaints Commission, shared the exercise of medical discipline together with the local Medical Board.

Now however, as a result of the political fallout from a hospital crisis in 2002/2003, the system of co-regulation has been much attenuated and the formerly shared decisions about medical discipline have been placed entirely in the hands of the Health Care Complaints Commission.

This paper argues that that situation has been created to serve the political interests of the governing party in the New South Wales parliament and that the squeezing of the medical profession to the margins in this way, means that the pendulum of power with regard to discipline, has swung too far.

Up to 1994, medical discipline in New South Wales has been wholly under the control of its Medical Board, a body which traces its origins back to 1838, although it only began exercising real regulatory power from 1901. This Medical Board was a typical regulatory body, which followed the pattern established in Britain in 1858 with the formation of the General Medical Council (referred to from this point as the GMC).

Both of these bodies and others established around the world in the late 19th and early 20th centuries to regulate medical practice, operated in terms of "peer review", that is on the principle that only doctors were able to judge the actions of fellow doctors when it came to the exercise of medical discipline.

This principle had been enshrined in law by the *Allinson* case of 1894² in which a medical practitioner had appealed to the High Court in Britain against being deregistered by the GMC for "infamous conduct". In that case Justice J Lopes laid down that British courts would not overturn disciplinary decisions of the GMC since these had been taken by the "professional brethren of good repute and competency" of the accused doctor. That precedent was followed around the world and also in New South Wales, where in 1917 Mr Justice Pring rejected an appeal by a Dr Cline against his deregistration by the Medical Board on the grounds that "this court is very loath to disturb the finding of a board of professional men whose knowledge of what may be termed professional misconduct must be very much greater than the court can possess."³.

Secure behind this legal precedent, the Medical Board over the next sixty years applied disciplinary action against doctors mainly on the grounds of financial fraud and addiction to drugs or alcohol, while ignoring issues of negligent or incompetent practice (Thomas, 2002).

The most glaring example of this related to the case of the Chelmsford Private Hospital, in which over nearly two decades between 1960 and 1980, an unproven procedure known as "deep sleep therapy" was applied to hundreds of patients, 25 of whom died as a result while many more suffered various degrees of mental trauma and damage. When the media discovered the story, it made headline news for years on end. Despite a growing public furore, no action was ever taken against the doctors responsible for administering the treatment.

The failure of the Medical Board to act on the Chelmsford affair forms a typical example of what was referred to above, namely the failure of medical professional bodies to adapt quickly enough to the changing temper of the times. Chelmsford demonstrated that for most of the 20th century, the power pendulum with regard to medical discipline had been pushed too far in favour of the medical profession.

But this was in fact, dangerous for the profession. Not only were there the rising expectations of Medicine among the public discussed earlier, but it was precisely at the time of Chelmsford that the consumerist movement, with its demands for public accountability and transparency, was demonstrating increasing political strength.

Governments responded by establishing Departments of Consumer Affairs and also new "counter-bureaucratic" offices such as those the Ombudsperson. Almost fatally against its own interests, the Medical Board of the time took no cognisance of these developments or of the efforts of the New South Wales government to galvanise it into action not only on the Chelmsford issue, but also in response to a rising tide of consumer complaints against both individual medical practitioners and medical institutions.

Thus in 1984 the government, as embodied by its Minister for Health, moved towards taking responsibility for medical discipline by establishing a "Complaints Unit" within the Department for Health, this being probably the first body of its kind in the world dedicated to receiving and investigating consumer complaints about failures of medical treatment. It is important to note that this Unit was staffed by non-medical personnel, its first two directors having worked for consumer advocacy agencies before they joined the Unit's staff. It was partly through the highly activist efforts of these figures that the Medical Practitioners' Act of 1987 was passed.

This Act constituted a historical legislative watershed, which swept away the old "infamous conduct" grounds for medical discipline and instituted new regulations which defined professional misconduct as a lack of adequate knowledge, experience, skill, judgement or care. Smith, a legal commentator, complained that the new definition was "far wider than that deriving from common law" and that the new Act exceeded "the justifiable limits of disciplinary control of the medical profession" (1994 p47). It can only be remarked in response that the pendulums of history seldom swing in moderate arcs.

The Act also reformed the Medical Board, bringing in many more lay and legal members as well as representatives of the consumerist movement. While doctors remained in the majority, the control of the Board by their professional body, the Australian Medical Association, was broken. None the less, it is not surprising that the members of the Medical Board reacted to the creation and activities of the Complaints Unit with some suspicion, especially because the Unit had been given much wider and stronger powers by the Act. Despite that however, the exclusive right of the Medical Board to exercise discipline remained unchanged and any action against a practitioner or against an institution had to be referred to the Board by the Complaints Unit.

It was a situation which could have resulted in confrontation and deadlock. That however, was avoided by the political skills of its director, Ms Merilyn Walton who made it her business to establish both official and unofficial contacts with officials of the Board. She was able to convince them that the Complaints Unit could actually help the Board to improve its disciplinary performance since the Complaints Unit had developed investigatory capacities which the Board lacked and was willing to put these capacities at the disposal of the Board. Her offer was accepted and an informal and mutually complementary working relationship was established. That relationship

in fact, formed the foundation of the collaborative regulatory system which developed later. The informal collaboration proved to be so fruitful and effective that it was formalised by the 1987 Act, which required the Unit and the Board to inform each other of the complaints each body received.

Once again this relationship proved to be very successful and in the early 1990s the New South Wales government took it further, passing legislation which required the two bodies not merely to inform each other of complaints, but together to consider the complaints which came before them and to decide together on what action should be taken in response to those complaints.

This was also a watershed move, because for the first time in close on a hundred years in New South Wales and indeed in the whole world, the system of medical peer review had in effect been abolished in this particular jurisdiction. In terms of this unique development a government had recognised the right of a lay body not only to participate in the review of medical complaints, but also more importantly how they should be handled and what kind of discipline should be applied when it was decided that that was necessary. As has been demonstrated, up to that time, medical discipline had been the sole and exclusive province of the Medical Board and indeed this remains the case both in the other States of Australia and in the world outside.

The new system of collaborative regulation came into effect in 1994 when a law was passed which transformed the status of the Complaints Unit from a mere subsection of the Department for Health to that of a fully-fledged statutory authority, the Health Care Complaints Commission (HCCC). Perhaps the actual mechanics of the co-regulatory system are not so important at this point, but what can be said is that it has worked well. In 2001, Dr Alison Reid, medical director of the Medical Board, stated:

The New South Wales system provides a rigorous and consistent approach to the assessment and subsequent management of complaints and notifications received by the Medical Board or the Health Care Complaints Commission. Central to the success of the approach is the collaborative relationship between both bodies (2001).

That collaborative relationship however, was destined to come to an abrupt end as a result of the Camden and Campbelltown hospital crisis of 2002-2003, arising from allegations that their errors and negligence had led to 17 seemingly avoidable deaths.

The issue was referred to the HCCC for investigation and early in 2003 it produced a large and thorough report which found that the allegations had been "sustained".

However, it laid the blame for the situation not on individual practitioners and nurses, but on the hospital system itself and the inadequately resourced conditions under which clinical staff had been working rather than the clinical staff themselves. The failure of the Complaints Commissioner to "name names" in the report led to her being unceremoniously sacked. The Commissioner's position was determined by her

belief in the "systems approach" in terms of which hospital failures are due to their inadequate systems of governance and management and not to the failures of medical staff. But that of course, does not suit the State government, because if as the Commissioner argued, it was the system and not individual doctors who were at fault, then the blame for the deaths and substandard treatment at the hospitals in question lies with the government which is responsible for the system.

The State government moved swiftly to ensure that it would not "take the rap" on this score. It therefore passed a new Health Care Complaints Act in 2004 which emasculated the system of co-regulation. While the Medical Board and the HCCC were still required to consult with each other on disciplinary proceedings arising from complaints, the final decision on which cases are to be referred to the Medical Tribunal, is now the responsibility of the "Director of Proceedings" in the HCCC.

A major result has been to transform the formerly consensual relationship between the HCCC and the Medical Board into a conflictual one because the HCCC has been refusing to refer any cases to the Medical Tribunal except those that it is sure it will win. The Medical Board believes that other cases in which the outcome is less certain, should be taken to the Medical Tribunal anyway because they need to be acted on and while winning such cases is not certain, it is also possible that they may be won.

When at the end of giving a paper on this topic the floor was opened to questions, there was only time to consider one question. This was raised by a conference participant who is on the staff of the HCCC, who justified its refusal to take the less certain cases to the Medical Tribunal on the grounds that the running of cases was costly and the HCCC did not want to waste public monies on cases that could possibly be lost. There was no time to discuss this point, although had I been able to reply I would have pointed out that that the HCCC official's explanation merely confirmed the point that that under the new system body was failing to take cases to the Tribunal because their outcome was not certain. I would argue that one reason for this is that a succession of successful prosecutions would suit the interests of the party in power in the New South Wales parliament, because it could use such cases to show that it was successfully pursuing miscreant doctors, always a popular "vote catcher".

And while the HCCC official asserted that it was an "independent body", this is not altogether true. The HCCC is a statutory authority and as such enjoys a good deal of independence - probably greater than most other statutory authorities - it is none the less responsible to and reports to the parliament of New South Wales. Like all parliaments that institution embodies lofty democratic ideals, including first and foremost, the ideal of democracy which makes government responsible and accountable to the people. In practice however, parliaments mostly do not function well unless they are controlled by the particular party that forms the government-of-the-day and such governments can and do use statutory authorities to suit their own

interests. In practice, the independence of the HCCC therefore, could be argued to exist only insofar as its actions and judgements do not harm the interests of the ruling party in New South Wales.

Summary

In summary, this paper has dealt with the way the pendulum of medical discipline in New South Wales has swung from one extreme - when Medicine wholly controlled this sphere and used it to protect the interests of the medical profession - to another extreme, in which medical discipline is now being controlled by government to suit its interests. I would argue that neither of these extremes is a healthy one; but for the moment the chances of hauling the pendulum back towards more a "golden mean", seem to be slim indeed.

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¹ The sexist terminology used here reflects the almost total dominance of the medical profession by males up to the late 19th century

² *Allinson v General Council of Medical Education & Registration* [1894] 1:QB 750

³ ((1917) 314 WN NSW 127)