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Abstract

Little is known about the work of medical tribunals and the role of medical guidelines from a comparative perspective. Fifty decisions taken by Dutch Medical Tribunals and by the Fitness to Practice Tribunals of the Health and Care Professions Council where analysed to establish the way in which (para) medical competence was socially constructed. Thematic analysis showed that insight and the establishing of the professional standard where shared elements of focus for these tribunals but differences in institutional structure meant that the way in which this was done differed significantly. Where Dutch tribunals where focused on complaint resolving and enhancing the quality of care, the English tribunal performed competency assessments of (para) medical professionals and stressed protection of the public. Medical guidelines where shown to have some relevance to the construction of competence for Dutch tribunals but the English tribunal in contrast favoured internal rules over those constructed by the profession.

Fitness to Practice Tribunals in the UK and The Netherlands: the construction of (para) medical competence and the use of evidence-based guidelines[1]

Introduction

The governance of healthcare has become increasingly complex. Medical professionals are regulated through a variety of mechanisms: well-known rules of private law like the tort of negligence, or through penal sanctions. In addition to these traditional legal mechanisms, over the last thirty years a web of mandated self-regulation has been developed. Mandated self-regulation is exemplified in both the UK and the Netherlands through a measure of control over the evidence-based guidelines for providing care while at the same time being regulated by external bodies. These bodies such as independent Fitness to Practice

[1] With thanks to Malwina Maduzia for invaluable research assistance and help with data collection. As well as the anonymous reviewers and Jo Samantha for very helpful comments that much improved this work. The usual disclaimer applies.

Tribunals upholds standards of conduct and can impose a range of sanctions when those standards are breached.

In this work a particular focus is placed on understanding two aspects of the work of Fitness to Practice Tribunals: their construction of (mis)conduct and their use of evidence-based guidelines. To this end two contrasting Fitness to Practice Tribunals are chosen: the Fitness to practice tribunal of the Health and Care Professions Council (HCPC) and the regional and national Medical Tribunals in the Netherlands. This chapter proposes in this way to make three distinct contributions to the literature in the field.

This study add to the existing literature by choosing a comparative design, looking at medical tribunals in the Netherlands and the UK. Given the fact that the literature in the UK has focused mainly on the General Medical Council (GMC) with the exception of Leigh et al[2], the decision was taken to focus on the role of the independent Fitness to Practice tribunal of the Health and Care Professions Council (HCPC) as well as medical tribunals in the Netherlands. This comparison is especially pertinent given the fact that the HCPC's Fitness to Practice Tribunal (hereafter FTP) is a relatively new tribunal that is responsible for para-medical professionals this contrast with the Dutch Medical Tribunals (hereafter MT) who are only responsible for medical professionals and have performed this work for over a century.[3] These contrasting cases allows for the testing of several hypothesis regarding the construction of competence of a (para) medical professional in the Netherlands and the UK.

First off an assumption is that the competence requirement for medical professionals will be more stringent than those for para-medical professionals, coupled with the fact the medical tribunals in the Netherlands have been established for longer the assumption is that the requirement have had time to fully develop. Comparatively analysing the role of medical guidelines in medical tribunal decision-making aims to complement existing literature on the nature of professional medical regulation in the Netherlands and the UK. A concern raised in this literature in both the Netherlands and the UK is the overly punitive decisions of medical tribunals[4], while by the same token some argue that patients are not being protected sufficiently and medical professionals get off too lightly.[5] A detailed qualitative analysis of a comparative sample of decisions by medical tribunals in the UK and the Netherlands can inform our understanding of the drivers behind the construction of what a tribunal consider to be a competent (para)medical professional. In that way moving away from binary assessments that describe these decisions as either too punitive or too lenient,

[2] 'An Analysis of HCPC Fitness to Practise Hearings: Fit to Practise or Fit for Purpose?' (2017) 11 Ethics and Social Welfare 382.

[3] For details of the history compare:FAG Hout, 'The Dutch Disciplinary System for Health Care: An Empirical Study' (Institute for Research in Extramural Medicine (EMGO institute) at the dept of Public and Occupational Health VU University Medical Center (VUMC) 2006).

[4] Lise M Verhoef and others, 'The Disciplined Healthcare Professional: A Qualitative Interview Study on the Impact of the Disciplinary Process and Imposed Measures in the Netherlands' (2015) 5 BMJ Open e009275; John Martyn Chamberlain, 'Malpractice, Criminality, and Medical Regulation: Reforming the Role of the GMC in Fitness to Practise Panels' (2017) 25 Medical Law Review 1.

[5] Gerry Mcgivern and Michael Fischer, 'Medical Regulation, Spectacular Transparency and the Blame Business' (2010) 24 Journal of health organization and management 597; Clare Dyer, 'Half of Doctors Investigated over Mid Staffs Have Faced No Action, Says GMC' (2013) 346 BMJ (Clinical research ed.) f872.

instead trying to formulate a more holistic comparative 'yardstick' to assess the nature of professional regulation by these tribunals.

Which brings us to institutional structure and position, to the best of my knowledge, this has not received much attention in the analysis of the work of these tribunals. By comparing the extent to which these tribunals legitimize there decisions with reference to their 'output' which is conceptualised here as the goals of the regulation as defined in legislation or whether they legitimize their decision in relation to their input, which would be the 'claimants' that bring cases before them. It will be shown how subtle differences in institutional positioning and structure of these tribunals explains differences in the construction of competence.

Thirdly, the role of (para) medical guidelines (hereafter guidelines) in the decisions of medical tribunals will be analysed. Here it will be interesting to contrast tribunals in the Netherlands who are assumed to use guidelines frequently, and the HCPC which given the ongoing professionalization of those it regulates is less likely to refer to para-medical guidelines. This is not done as a normative comparison, but rather to understand the potential role of medical guidelines in informing the construction of competence for health professionals and to explore differences and similarities between the two systems.

These medical guidelines are produced by medical professionals, through organisation such as NICE or independent scientific associations of medical professionals. They purport to provide advice based on medical studies on the optimal treatment of a medical condition.[6] The history of these guidelines is detailed elsewhere and will not be further explored here.[7] While the influence of medical guidelines on the practice of healthcare is the topic of many studies[8], understandably, these focus more on the delivery and quality of care and not on the wider position of these guidelines in the governance of healthcare.

The role of medical guidelines has grown to be more than just advice that can be easily ignored or dismissed. They play a role in auditing of care[9], influence remuneration of

[6] Marilyn J Field and others, *Clinical Practice Guidelines Directions for a New Program* (National Academy Press 1990).

[7] JJE van Everdingen, *Consensusontwikkeling in de geneeskunde* (Bohn, Scheltema en Holkema 1988); N Klazinga, 'Quality management of medical specialist care in the Netherlands. An explorative study of its nature and development' (Erasmus Universiteit Rotterdam 1996); David L Sackett and others, 'Evidence Based Medicine: What It Is and What It Isn't' (1996) 312 BMJ 71.

[8] Peter Dodek, Naomi E Cahill and Daren K Heyland, 'The Relationship Between Organizational Culture and Implementation of Clinical Practice Guidelines A Narrative Review' (2010) 34 Journal of Parenteral and Enteral Nutrition 669; ibid; Martin P Eccles and others, 'Developing Clinical Practice Guidelines: Target Audiences, Identifying Topics for Guidelines, Guideline Group Composition and Functioning and Conflicts of Interest' (2012) 7 Implementation Science 60; Michel Wensing, Roland Bal and Roland Friele, 'Knowledge Implementation in Healthcare Practice: A View from The Netherlands' (2012) 21 BMJ Quality & Safety 439.

[9] Ruud van Herk, Rita Schepers and Anton F Casparie, 'Huisartsen en zelfregulering. De ontwikkeling van intercollegiale toesting en standaarden voor huisartsen tussen 1970 en 1990' (1994) <https://lirias.kuleuven.be/handle/123456789/161090> accessed 12 June 2014.

medical professionals[10], are used in enforcement by healthcare regulators[11], influence legal cases[12] and are used by medical practice tribunals. It is the relationship between medical guidelines and the decisions of these tribunals that is underexplored in the current literature. While there is research on medical tribunals in the Netherlands [13] and the UK[14] this research is fragmented and focuses on a quantitative overview of decisions.[15] In addition the normative effects of medical guidelines have received some attention[16] but the role of guidelines within medical tribunals has received very limited attention and remains poorly understood. In this research guidelines are examined as potential contributors to the construction of what (para)medical competence is in front of a tribunal.

Medical professional regulation in both the UK and the Netherlands serves two distinct functions: improving the quality of medical practice and the protection of the public by the removal of those medical practitioners that endanger them. The practices in the two countries can be compared to assess which of these two goals are given more weight in the decision-making. This will allow for a cautious determination of specific cultural differences and similarities in addressing medical professional regulation. These considerations lead to the following central question: how do tribunals construct (para) medical competence and what is the role (if any) of evidence-based guidelines and the institutional structure and position of the tribunal in this process?

[10] NHS Employers, BMA, NHS England, 'General Medical Services (GMS) Contract Quality and Outcomes Framework' (2018) 08157 <https://www.nhsemployers.org/-/media/Employers/Documents/Primary-care-contracts/QOF/2018-19/2018-19-QOF-guidance-for-stakeholders.PDF?la=en&hash=6A53571FC0F7A63FA7354951C733B9E6011EC2CD> accessed 30 November 2018.

[11] Medisch Contact, 'Inspectie richt zich op veldnormen' (18 February 2009) <https://www.medischcontact.nl/nieuws/laatste-nieuws/artikel/inspectie-richt-zich-op-veldnormen.htm> accessed 9 October 2019.

[12] Hester Uhlenbroek and Maurice Mooibroek, 'De invloed van tuchtrecht op aansprakelijkheid' (2013) 21 Medisch contact 1119.

[13] Vivienne Schelfhout, 'De Onzichtbare Kracht van Het Tuchtrecht' (*KNMG*, 18 February 2013) <http://knmg.artsennet.nl/Dossiers-9/Columns/Column/128265/De-onzichtbare-kracht-van-het-tuchtrecht.htm> accessed 19 May 2014; Marieke Anita Kleiboer, Nicolaas Jacob Herman Huls and KE Beerlage, *Tuchtrecht Op de Terugtocht?: Wettelijk Niet-Hiërarchisch Tuchtrecht: Een Vergelijkende Analyse* (LEMMA 2001); FAG Hout, 'Tuchtrechtspraak niet verbeterd sinds de invoering van de Wet op de Beroepen in de Individuele Gezondheidszorg (Wet BIG)' [2004] Ned Tijdschr Geneeskd 5; Hout (n 3); ERIK Hout, RD Friele and JOHAN Legemaate, 'De Burger Als Klager in Het Tuchtrecht Voor de Gezondheidszorg: Weinig Klachten, Mogelijk Door Geringe Kennis van Tuchtrechtsysteem' (2009) 153 Nederlands Tijdschrift voor Geneeskunde 548; J Legemaate and others, *Thematische wetsevaluatie: bestuursrechtelijk toezicht op de kwaliteit van zorg* (ZonMw 2013).

[14] I Allen, 'Handling of Complaints by the GMC a Study of Decision-Making and Outcomes' (Policy Studies Institute 2000) <http://www.psi.org.uk/site/publication_detail/960> accessed 9 October 2019; Cathal T Gallagher and Carmel L Foster, 'Impairment and Sanction in Medical Practitioners Tribunal Service Fitness to Practise Proceedings' (2015) 83 Medico-Legal Journal 15; Chamberlain (n 4).

[15] Hout (n 3).

[16] Marc Berg, Ruud ter Meulen and Masja Van den Burg, 'Guidelines for Appropriate Care: The Importance of Empirical Normative Analysis' (2001) 9 Health Care Analysis 77; Antoine Boivin, France Légaré and Pascale Lehoux, 'Decision Technologies as Normative Instruments: Exposing the Values Within' (2008) 73 Patient Education and Counseling 426.

This chapter starts with a short description of the methods chosen and the data collection undertaken. Then the regulatory environment in the Netherlands will be discussed as well as the procedure before the medical tribunal. A quantitative and qualitative analysis of decisions made by medical tribunals in the Netherlands is then presented, in addition the role of medical guidelines in these decisions will be scrutinised followed by an analysis of the institutional structure and position of the tribunal. The description of the situation in England focuses on the HCPC, and the procedure used in front of this tribunal. An analysis of the decisions taken by this tribunal is then presented along the same lines as was done in the Dutch case. A comparison is presented drawing on these collective findings presenting the most striking differences between the two systems and the implication this has for the construction of competence in front of these tribunals. A short conclusion presents an answer to the central question.

Method and data collection

A sample of decisions was drawn to allow for snapshot of the decisions taken by a tribunal while at the same time allowing for detailed qualitative analysis. As part of the qualitative analysis it was important to allow for a dataset that was large enough to enable patterns to emerge but not so large as to make detailed content analysis of these decisions too cumbersome. To satisfy these twin aims a sample of fifty decisions per country was chosen. It was thought to achieve a snapshot of decision-making decisions taken it was best to choose decisions taken at the same time in both countries. June 2019 was chosen as the month to take the snapshot, within this time period *all* final determinations by tribunals were selected. This was done systematically by working backwards from June until the number of 50 was reached. This of course meant that the time periods were not completely identical as the tribunals in the Netherlands took more decisions in this time than the HCPC did.

Fifty decisions from the Health and Care Professions Tribunal Service (hereafter: HCPTS) are collected and analysed, of the 294 decisions taken in the period 1st of October 2018 – 1st of October 2019. Fifty decisions decided between March and June 2019 have been included in the dataset. Only Final Hearings were included in the dataset as only those decisions contain final determination of sanctions. Fifty decisions from Tuchtrecht.nl are collected and analysed, of the 1067 taken in the period 1st of October 2018 – 1st of October 2019. The period of 15th of April -1st of June 2019 was chosen as the sample period, this sample period is slightly shorter as more decisions were taken by the Dutch tribunals. Tuchtrecht.nl is an official government website on which all medical tribunals in the Netherlands publish their decisions, only final determinations are published so no further restriction of the sample took place.[17]

The preliminary qualitative analysis of these decisions is conducted using a basic coding system in which the type of medical professional, the alleged wrongdoing, any references to guidelines, and the outcomes of the cases are described. In addition, a second qualitative

[17] All Dutch cases that are discussed are cited using their ECLI (European Case Law Identifier) as is customary in the Netherlands. These cases can be found by entering the identifier on the tuchtrecht.nl website.

analysis of the decisions takes place to discover themes across the dataset. This thematic analysis followed Braun and Clarke[18] with a focus on coding and theming the data through a thorough reading and examination of the decisions. This was done by breaking them down using the structure present in the decisions and going over themes and codes iteratively using aspects such as recurrence, pattern and relationship to decide on final themes.

The Netherlands

In the Netherlands most medical professionals are regulated through *Tuchtrecht*[19] based on the Wet op de Beroepen in de Individuele Gezondheidszorg[20] (hereafter: IHCP). This system regulates their behaviour as medical professionals and allows for sanctions if the professionals breach the duty of care.[21] This is a legal duty that is bound up, with ideas by the profession on the duty of care, but unlike in England it cannot be equated solely with professional ethics. Medical practitioners can be brought before medical tribunals formed for this purpose through complaints brought by patients. The health care inspectorate also has the general right to bring a complaint about all practitioners but does so sparingly (15 cases in 2018).[22] In addition, fellow healthcare practitioners can complain about colleagues, the number of these complaints is not exactly known but is likely low. As those that complain have to have an interest in the medical conduct that is the subject of the complaint there is no general right for the public or employers to complain to the tribunal. They could invite the healthcare inspectorate to bring a complaint, but as stated, this happens infrequently. There are five regional tribunals and one appeal tribunal. The regional tribunal consists of two lawyers[23] and three medical professionals normally of the same specialism as the accused professional. The appeals tribunal has three lawyers and two medical professionals.

This regimented system of medical tribunals on the one hand closely resembles specialised courts such as the military court of first instance, which feature among their members a senior military officer[24] or the specialised Corporate Chamber of the Court of Appeal (*Ondernemingskamer*) that sits together with business professionals.[25] On the other hand, these medical tribunals are similar in structure to those for lawyers, accountants, and public notaries.[26] These so called *vrije beroepen* ('free' professions) historically have been, and still are, in a privileged position, in that their professional conduct is judged partly by their peers.

[18] 'Using Thematic Analysis in Psychology' (2006) 3 Qualitative Research in Psychology 77.
[19] A literal translation would be disciplinary law. In practice this refers to professional regulation.
[20] Individual Health Care Professions Act
[21] Article 47 and 48 IHCP
[22] https://www.igj.nl/over-ons/igj-in-cijfers/cijfers-over-maatregelen/aantal-tuchtklachten
[23] Normally judges or those eligible for judicial office.
[24] https://www.rechtspraak.nl/Organisatie-en-contact/Organisatie/Rechtbanken/Rechtbank-Gelderland/Over-de-rechtbank/Organisatie/Paginas/Militaire-kamer.aspx
[25] For the profile of these 'raden' (experts) see: https://www.rechtspraak.nl/Organisatie-en-contact/Organisatie/Gerechtshoven/Gerechtshof-Amsterdam/Over-het-gerechtshof/Organisatie/Ondernemingskamer/Paginas/Profiel-Raad-in-Ondernemingskamer.aspx
[26] For all three professions there is a tribunal staffed by their peers with appeal in final instance to the general courts. These tribunals are not further explored here for more detail see: Rianne Leonie Herregodts, 'Gemeenschappelijke normen voor vertrouwensberoepen: Tuchtrechtelijke uitspraken over de tuchtnormen voor accountants, advocaten en artsen' (Rijksuniversiteit Groningen 2019); Kleiboer, Huls and Beerlage (n 13).

It has the appearance of a corporatist bargain between the state wanting oversight over the disciplinary process of these professionals but at the same time allowing them so freedom to control how they were judged through the inclusion of their peers.

In comparison with the UK the institutional embedding of these tribunals is more closely tied to the state. In the UK, at least on paper, the regulator such as the HCPC or General Medical Council are placed on some distance from the state and they then operate independent fitness to practice tribunals.[27] How relevant these differences are will be explored below.

The system of professional medical regulation in the Netherlands

The stated aims of the disciplinary jurisdiction over medical professionals in the Netherlands is to protect the quality of care and protect patients against incompetence and carelessness of medical professionals.[28] It is predominantly aimed at improving the practice of medicine, as well as excluding those that cause harm or a seriously malfunctioning in their profession. The explanatory memorandum to the most recent change in the regulation of medical professionals expresses this clearly as: 'improving the capacity for learning of the [medical] sector.'[29] This is presented as the primary aim of the system, with protecting patients seen as a secondary aim.[30]

This idea of professional regulation as aimed at improving the quality of care would suggest Dutch medical tribunals would use cases to draw out general rules of correct medical conduct, to *educate* rank and file medical professionals. Medical guidelines could play a role in these types of cases, given the fact that they can be seen to embody the normative standards that medical professionals need to adhere to. On the other hand, there might also be cases where the focus is placed on the dysfunctional behaviour of the medical professional where protecting patients (and the profession) is the primary focus. Medical guidelines that focus on clinical decision-making would be less prominent in these cases. These assumptions will be tested in the qualitative and quantitative analysis of the decisions taken.

The Tribunal Procedure

After a patient or the Healthcare Inspectorate has lodged a complaint about a healthcare professional[31] with a regional tribunal first there is the possibility to be heard in a pre-

[27] The procedure of these tribunals will be outlined in greater detail below.

28 Most recently reconfirmed in the change of the ICHP Act to improve the functioning of disciplinary tribunals Kamerstuk 34629 Wijziging van de Wet op de beroepen in de individuele gezondheidszorg in verband met de verbeteringen die worden doorgevoerd in het tuchtrecht alsmede verbeteringen ten aanzien van het functioneren van de wet nr 3. Available at: https://zoek.officielebekendmakingen.nl/kst-34629-3.html MvT

[29] Ibid par. 2.3.

[30] Ibid.

[31] The healthcare professionals that are regulated under this system are: doctors, dentists, pharmacists, phycologists, psychiatrists, physiotherapists, midwives, nurses and physician assistants, educational psychologist, clinical technologist. Art 47 under 2 IHCP. All mention of medical practitioners is intended to only relate to these regulated professions.

hearing.[32] This hearing can be used to clarify facts and to explore whether the patient might wish to withdraw the complaint for example because the medical professional apologises or because the reasons for the medical decisions taken have now become clear. After this hearing the complaint is referred to a full hearing before the tribunal unless the complaint is manifestly unfounded in which case it is disposed of without a hearing.[33] The procedure before the tribunal is inquisitorial, both parties are permitted, but not required, to be assisted by (legal) council. The tribunal has to assess whether the medical professional has violated one of the two open professional standards: 1) any conduct or omission that violates the care a medical professional should show to a patient in his care, or someone who is in distress needing medical attention, or the direct relations of those persons.[34] 2) Any other conduct or omission than that identified under 1 that violates the conduct of a reasonable medical practitioner.[35] The difference between standard one and two is that for standard one to apply the patient needs to be in the care of the medical professional, there needs to be a medical treatment contract (express or implied).[36] For standard two this condition does not have to be met, so this standard could cover such situations as providing advice to other medical professionals about the patient, or other situations in which no treatment contract with the patient is present.

The appeals tribunals has developed a standard description of these two standards that is widely copied: 'The disciplinary review of professional conduct is not aimed at assessing whether that conduct could have been better, but whether the medical practitioner during the professional conduct has stayed within the boundaries of a reasonably competent exercise of the profession, taking onto account the progress of science at the time of the conduct complained of and what was accepted as the norm or the standard within the profession at that time.'[37]

If at the conclusion to the case the tribunal finds that one or more complaints made are well-founded sanctions can be imposed ranging from no sanction, to warning, fine, reprimand, suspension, and erasure.[38] In contrast to England the tribunal does not have the power to impose conditions but it does sometimes impose a conditional suspension and formulates conditions that need to be met for the suspension not to take effect. As stated if

[32] Art 66 IHCP. This does not take place if one of the parties does not want to be heard at the pre-hearing.
[33] Art 67a IHCP.
[34] Art 47 under 1 (translation from Dutch by author).
[35] Art 47 under 2 (translation from Dutch by author).
[36] Law on the medical treatment contract (Wet geneeskundige behandelovereenkomst).
[37] Dutch: 'Vooropgesteld wordt dat het bij tuchtrechtelijke toetsing van professioneel handelen het er niet om gaat of dat handelen beter had gekund, maar om het geven van een antwoord op de vraag of de beroepsoefenaar bij het beroepsmatig handelen is gebleven binnen de grenzen van een redelijk bekwame beroepsuitoefening, rekening houdend met de stand van de wetenschap ten tijde van het klachtwaardig geachte handelen en met hetgeen toen in de beroepsgroep ter zake als norm of stand was aanvaard.' (translation from Dutch by author).
[38] Art 48 IHCP.

a patient or the healthcare inspectorate is not satisfied with the decision an appeal can be lodged with the appeals tribunal, no further appeal is possible.[39]

Decisions by Medical Tribunals in the Netherlands: a quantitative analysis

Of the sample of decisions taken thirty-six (72%) were a decision in first instance, fourteen (28%) decisions were made on appeal. Forty-seven decisions were taken about doctors (94%), the remainder were a decision on a dentist, a nurse and a midwife.[40] That the largest group that is complained about is doctors is linked to the fact that in the Netherlands GP, specialists in hospitals and doctors in allied medicine (such as those advising on insurance or benefit claims) all are classed as doctor[41]regardless of specialisation.

The types of complaints made were classified by using the system provided on tuchtrecht.nl.[42] Twenty-three (46%) complaints were about incorrect treatment or diagnosis. Sixteen (32%) were concerned with insufficient or no care being provided. Three (6%) were concerned with unprofessional communication by a medical practitioner. Five (10%) complaints were focused on a medical professional providing an incorrect report or incorrect statement. One (2%) concerned the breaching of the duty of (medical) secrecy. Finally, two (4%) cases concerned informed consent, and the provision of insufficient information to allow patients to make informed choices about their care. It has to be remembered that the nature of the complaints is driven by the patients that complain about their care, as will become apparent this is an important difference with the more 'regulator focused' approach the HCPC takes.

This categorisation is helpful to show that the majority of complaints concern clinical matters, and a minority concern aspect that relate to the communication of decisions. However, this neat classification, on more detailed inspection, conceals the fact that in some cases it appears that patients complain about the care they received because the communication about their care has been insufficient or has broken down, so the distinction between complaints about clinical decisions and those about communication cannot be so neatly drawn.

Looking at the outcome of the cases in forty-one (82%) of cases the complaint was declared to be unfounded. In nine cases (18%) the complaint was partly or fully well-founded.[43] The sanctions imposed were: one case no sanction (11%), four cases (44%) a warning and four

[39] The only exception is an appeal in the interests of the law to the Supreme Court. This is an extraordinary procedure that does not affect the rights of the parties but is only instigated to clarify (difficult) points of law. Only the procurator-general at the Supreme Court can start such a procedure. Art 75 ICHP.
[40] This shows doctors are overrepresented in this sample is 67% of complaints in 2018 were directed against doctors. Jaarverslag Tuchtcolleges available at: https://magazines.tuchtcollege-gezondheidszorg.nl/jaarverslagen/2018/01/jaarcijfers-over-2018
[41] Dutch: arts.
[42] These classifications were checked by accuracy through detailed reading of the complaints and revisions were made when classifications were deemed to be incorrect by the researcher.
[43] This slightly higher than the average if compared with all cases decided in 2018 which stands at 13%. Jaarverslag Tuchtcolleges available at: https://magazines.tuchtcollege-gezondheidszorg.nl/jaarverslagen/2018/01/jaarcijfers-over-2018

cases (44%) a reprimand. The more serious sanctions such as suspension and erasure were not present in this sample.

In twenty of the fifty cases reference was made to either the law or to medical guidelines. These references were very varied. This ranged from references to the law on patient confidentiality[44], specific medical guidelines developed by professional associations on gallstones and prostate carcinoma[45] to a practice direction on how to deal with conflicts in the workplace for physicians that work for companies.[46] The reference to guidelines is observed in all types of cases across different types of complaints. References to guidelines are made in cases of complaints that are well founded as well as those that are declared unfounded. It is important to note here that unlike England there is no NICE in the Netherlands with a central responsibility for producing guidelines, rather these guidelines are produced by (combinations of) professional associations of medical professionals.[47]

Looking at this sample a few preliminary observations can be made. A large amount of the claims that are made are declared unfounded. A reason for this could be that all patients can complain in a free[48] procedure, so that it is likely that some complaints are not serious enough to fulfil the criteria of the law. Support for this observation can be found if one compares complaints made by patients with those made by the healthcare inspectorate. As Hout et al. shows complaints by the inspectorate are few but these are far more frequently successful and account for a large degree of the serious sanctions such as erasure and suspensions. [49] A further interesting element is the range of medical guidelines referred to, not only those that deal with specific medical diseases, made by professional associations are referenced but a much wider range of documents of varying provenance is used to support the decision-making process. More detail and examples will be provided below.

A qualitative overview of 50 decisions by Medical Tribunals in the Netherlands

A qualitative analysis of the sample of the decisions has uncovered three recurring themes: communication, the professional standard and insight. These three themes align with the different stages a complaint goes through before a decision is made by the medical tribunal. In the first stage of the formulation of the complaint and the establishing of facts *communication* forms a central theme. In the second phase where the tribunal needs to decide on the merit of the complaint and judge whether a medical professional has acted in accordance with accepted norms the central theme is *professional standard*. Finally, when

[44] ECLI:NL:TGZRAMS:2019:103
[45] ECLI:NL:TGZCTG:2019:143 and ECLI:NL:TGZCTG:2019:141
[46] ECLI:NL:TGZREIN:2019:31
[47] For more detail on the history and institutional structure of the development of medical guidelines compare: Friso Johannes Jansen, *Professional Regulation and Medical Guidelines: The Real Forces behind the Development of Evidence-Based Guidelines* (2020) ch 3.
[48] From the 1st of April 2020 a €50,- fee is levied.
[49] 'Tuchtklachten van de Inspectie voor de Gezondheidszorg effectief voor aangeklaagden en beroepsgenoten' (2011) 89 Tijdschrift voor gezondheidswetenschappen 58.

deciding on the appropriate sanction the reasoning of the tribunal is directed towards *insight*. These three themes are further discussed below.

Communication

The preliminary quantitative classification of the decisions by medical tribunals point to the fact that the majority of the decisions concern the clinical decision-making of medical professionals. An analysis of the sample of decisions shows that indeed the complaint about the clinical decision-making in the majority of cases is the primary complaint. But the range of complaints discerned by the tribunal in the formulation of the grounds of complaints frequently also list complaints about communication. The impression this material generates is that the perceive inadequacy of the communication of the health care professional is the main motivation of the complaint.

In one decision, as an example, the patient complained about decisions of a psychiatrist to end his care in a forensic clinic because he was deemed to have violated the (house)rules of the clinic.[50] One of the complaints made was that incorrect amounts of medication had been prescribed. In this sense this was a complaint about incorrect care being provided and this is also how the case is categorised in the sample. The gist of the complaint, however, was that the fact that the psychiatrist was alleged to have communicated to the parents that their son would not be removed from the clinic. After being removed from the clinic the son had, again, committed crimes. The fact that one of the parents was also the person representing this patient in their complaint gives credence to this reading. The medical tribunal, after dismissing the complaints about both the clinical actions and the communication directly address the parent of the patient and voice sympathy with the worries the parents will have had about their son, but explains that despite this the care provided was more than adequate.[51]

This decision is an illustration the way in which complaints in this procedure are processed. While the patient and the parents in this case were motivated to complain because of the *result* of the perceived lack of communication and care, the reoffending the tribunal only looked at the *behaviour* of the medical professional at the time. The medical tribunal procedure is in this sense a narrow one, it does not concern itself with all behaviour of medical professionals but only that *medical* action or inaction for which they are personally responsible. Here the tribunal observed that the legal rules on consent were followed and the communication was adequate. It is possible there is a local protocol within the clinic on communication with patients but these were not mentioned in the decision.

The Professional Standard

A second theme emerging from the decisions is that of the professional standard. If the conduct complained of is medical decision-making that falls within the scope of the procedure, how is this conduct to be judged? In the sample there are four different ways in which the panel approaches the formulation of this professional standard. The medical

[50] ECLI:NL:TGZCTG:2019:147
[51] ECLI:NL:TGZCTG:2019:147 at 4.4.

professional has to stay within the boundaries of what a reasonably competent medical professional would have done in the given circumstances, given the state of science at the time and what is considered the norm in the profession at the time. This is a very flexible and open definition of what professional conduct is and the tribunal is given great discretion in further filling this in. Four different approaches by the tribunal can be identified: the medical professional has to comply with the law, with medical guidelines, with rules set by the tribunal itself, or is subject to a process of peer review.

Decisions by the tribunal on the issue of patient confidentiality where decided with reference to the legal norms that regulate professional conduct.[52] An illustration is a case in which a father wanted to be informed about the care delivered to his 13-year old daughter, the GP refused to provide this information as the daughter objected, and the GP followed the legal norms in this regard.[53] The tribunal considers in detail whether the medical professional has applied the legal standards correctly and concluding this is the case rejects the complaint as unfounded.[54] In this case the professional standard equals the correct application of the legal rules. Only a small minority of cases, however, touch upon areas of law where such clear rules exist, all the examples in the dataset concern either medical secrecy or informed consent.

A second group of cases are those in which the tribunal finds the professional norm in the following of medical guidelines. In some cases, following the guideline in itself is sufficient to declare the complaint unfounded.[55] Other cases show that breaching a guideline without justification leads to a sanction.[56] While there is one case in the sample in which breaching a guideline is seen as justified, but the medical professional gets sanctioned for a different complaint.[57] The influence of medical guidelines on the decision-making is clear, following a medical guideline closely is seen as prima facie evidence that the medical practitioner stayed within the boundaries of reasonable practice. Medical practitioners can deviate from these guidelines but that would require detailed argumentation and record-keeping to ensure the tribunal would be convinced by its appropriateness. The treatment of these medical treatment guidelines produced by professional associations has the appearance of a double-edged sword. On the one hand, there are those cases where medical practitioners cannot be asked to do more than a guideline requires, even if more optimal care could be given. On the other hand, guidelines do clearly restrict the availability of other approaches to care, because medical practitioners are forced to carefully justify why they have deviated from a guideline and do not always succeed in doing so.

[52] There are also a number of guidelines on this issue, for example the guideline 'dealing with medical information' written by the Dutch Healthcare Federation, but these do no more than explain the practical implementation of the legal framework (https://www.knmg.nl/advies-richtlijnen/knmg-publicaties/omgaan-met-medische-gegevens.htm). The fact that the tribunal partly consists of lawyers perhaps explains why they feel comfortable applying the legal rules without reference to any guidelines.
[53] ECLI:NL:TGZRAMS:2019:103
[54] ECLI:NL:TGZRAMS:2019:103 at 5.3
[55] ECLI:NL:TGZRSGR:2019:73; ECLI:NL:TGZRAMS:2019:79; ECLI:NL:TGZRSGR:2019:72
[56] ECLI:NL:TGZCTG:2019:143
[57] ECLI:NL:TGZCTG:2019:141

Guidelines or laws are not the only sources the medical tribunal uses to judge whether a medical practitioner has acted in accordance with the professional standard. When a complaint was made about a report written by a medical professional, for use to decide on benefits or for use in a court procedure for example, the tribunal referred to rules it had laid down in earlier decisions as the standard.[58] The report needs to stay within the area of competence of the professional, needs to contain the facts, a suitable method, lists its sources and the conclusion should reasonably follow from the analysis of the facts.[59] This is an example of an area where the tribunal is explicit about an aspect of the professional standard, writing of reports and statements by medical professionals, and evaluates whether medical professionals satisfy this standard. From the sample we can see that 10% of the complaints concern reports, which is a high number given the small number of reports written in relation to 'regular' medical consultations that are delivered. A reason why reports are often complained about seems to be that they are often used in contentious court procedures (such as divorce or custody procedures). Complaining about the medical professional that wrote the report to the tribunal is aimed at showing the court the (often negative) report is off no value and it should not be used to decide on benefits or custody over children.

The final process in use by the tribunal is what could be described as a process of *peer review*. In these types of cases, which form the majority of the sample, no explicit reference to law, guideline or explicit rule is made rather the medical members of the panel assess the conduct based on their own experience and ideas of what the appropriate conduct should be. A GP not calling or visiting the partner of a deceased patient to provide after care[60], and not giving a patient suffering from a fall the necessary checks[61] were deemed to violate the professional standard, where the evaluation of the complications of a cataract operation in contrast was done appropriately.[62] In all these cases the care delivered by the medical professional was evaluated by their peers, the medical members of the tribunal, based on their expertise and experience. In that evaluation it is not always clear, at least this cannot be gleaned from the decision, whether this evaluation implicitly follows medical guidelines on the topic, or what other basis is used for the evaluation. This does mean that the decisions by the tribunal can be unpredictable. The only case against a midwife in the sample provides a, tragic, illustration of this. In this case, a foetus died during the pregnancy and the midwife was accused of misreading the information from various ultrasounds about the growth of the baby and therefore missed the worrying fact that the growth rate of the baby had suddenly decreased.[63] The tribunal in evaluating this conduct stated that a medical guideline that was relevant for this aspect of medical practice was not yet generally implemented so not strictly speaking applicable to the conduct of the midwife, but that nonetheless the midwife could be expected to know about its content because there was a lot of attention in the profession for the issue of growth-reduction of the baby during

[58] ECLI:NL:TGZREIN:2019:31
[59] ECLI:NL:TGZCTG:2014:17
[60] ECLI:NL:TGZREIN:2019:29 at 5.
[61] ECLI:NL:TGZREIN:2019:30
[62] ECLI:NL:TGZCTG:2019:134
[63] ECLI:NL:TGZCTG:2019:136 at 3.

pregnancy. [64] Here it seems the tribunal requires the medical practitioner to have up-to-date medical knowledge independently from the availability of any official guideline or rule and in that sense is placing the bar slightly higher. If a larger sample of cases is analysed it is likely more examples will be found of this aspect of standard-setting by the tribunal. The way the tribunal applies these 'expectations' seems to be more stringent than in England. It is not sufficient for the professional to satisfy the *Bolam* standard[65] as it is not enough to point to a body of practitioners following the midwives approach but instead one has to follow what the majority of the profession, as interpreted by the tribunal, consider to be adequate conduct.

All these four different approaches to operationalising what the professional standard is for medical practitioners seem to be primarily aimed at improving the quality of care. In cases where a tribunal requires the law to be followed, or check whether a practitioners follows a medical guideline this is most explicit, but also in cases of 'softer' norms of correct behaviour, such as providing adequate aftercare for a bereaved patient, the aim is to promulgate norms that strengthen, in the eyes of the medical tribunal, the delivery of care.[66]

Insight

The third theme that emerges from these decisions is the importance of insight in determining the severity of sanctions imposed by a medical tribunal. Insight here means specifically the extent to which the medical practitioner has understood why the conduct was wrong, what steps have been taken to prevent it happening again, and where appropriate whether there has been an apology to a patient. In one case the tribunal imposed no sanction for the fact that a medical practitioner had not recorded a conversation with the patient's GP in his medical file, the reasons given were that medical practitioner had regretted this mistake, explained that he erroneously thought he could no longer access the medical file, and had taken measures to avoid repetition.[67] In another case, the tribunal was driven to impose the sanction of a reprimand, which is published in a local newspaper and recorded on a public register, rather than a warning given the fact that the medical practitioner had stated his practice was 15-years ahead of the norm.[68] The tribunal clearly found this to be arrogant, and lacking in sufficient insight and they stated that in these circumstances only a reprimand was an appropriate penalty.[69] In the remaining seven cases in this sample further references to the amount of insight, and the extent the medical practitioner was showing willingness to learn were made to support the penalty being imposed. The tribunal seems to value it favourably if the medical practitioner has taken action to prevent mistakes through training or supervision plans and weighed this in

[64] ECLI:NL:TGZCTG:2019:136 at 5.2.
[65] Bolam v Friern Hospital Management Committee [1957] 1 WLR 582
[66] An open issue, that is not further discussed her, is whether medical practitioners actually learn from these decisions and consequently whether the medical tribunals satisfy this goal of improving the standard of care. For more detail see: Hout 2011.
[67] ECLI:NL:TGZREIN:2019:32 under 5.
[68] ECLI:NL:TGZREIN:2019:29
[69] ECLI:NL:TGZREIN:2019:29 under 5.

the balance when a sanction is imposed. The tribunal does not however itself require the professional to take any remedial action. This seems to be a reflection of the particular institutional position the tribunal holds, responding to complaints from patients coupled with a lack of the penalty of 'conditions' as they are imposed by the HCPC. The sample of nine cases in which a sanction was applied by the tribunal is small, so these findings need to be interpreted with caution, further research especially of cases where suspension and erasure were imposed is warranted.

Nonetheless, there interesting parallels between the approach of Dutch medical tribunals and the GMC as the work of Case on the role of the 'redemption model of fitness to practice' [70] shows. In both instances, the fact that a member of the profession shows a willingness to take responsibility, and an openness to learn is evaluated positively. The harsher penalties, it can be cautiously suggested, are thus reserved for those that are incorrigible, who are seen as the members of the profession that are most likely to cause harm given their resistance to the norms of the profession.

Medical Tribunal Decisions in the Netherlands and the role of Medical Guidelines

The role of medical guidelines is medical tribunal decisions is a nuanced one. Medical tribunals in formulating the professional standards that medical practitioners have to comply with, use a range of sources of which medical guidelines are only one. In deciding on the appropriate professional standard for clinical decision-making guidelines play a role. We have seen that guidelines can both be used as shield by medical practitioners, where compliance with guidelines indicates the professional standard has been met, and as basis for sanction if deviation from the guidelines is not sufficiently documented and argued. There also areas of medical practice where there are no medical guidelines to refer to, such as complaints around communication of care, or areas where there is clear legal regulation such as the area of patient confidentiality.

Notwithstanding the fact that guidelines are not all pervasive they have an important role to signify the norm that is accepted in the relevant medical field at the time the disputed medical conduct took place. A guideline given the fact that members of the profession draft it, gives the tribunal certainty about what was accepted as the norm or standard in the medical field. What is interesting about this use of guidelines is that the tribunal, at least in the sample studied, does not consider whether the guideline enjoys widespread acceptance in the profession. Instead, it is either simply assumed to be the case, or otherwise not considered necessary to provide further reasons for this aspect of the decision-making. Especially the case of the midwife[71] illustrates this, as the guideline can be seen as a codification of the understanding of the profession on the preferred way of treating a condition and the panel expected the midwife to act in accordance with it as the expected norm in the profession.

[70] Paula Case, 'The Good, the Bad and the Dishonest Doctor: The General Medical Council and the "Redemption Model" of Fitness to Practise' (2011) 31 Legal Studies 591.
[71] ECLI:NL:TGZCTG:2019:136

The Institutional Structure and Position of Medical Tribunals in the Netherlands

Thinking about how we can explain these observations and the differences that will become apparent when we discuss the English case below it is tempting to say these differences are due to the fact that we are comparing a tribunal for allied health professionals with one for medical professionals. There is some force to this argument, invariably some of the differences, for example in the use of guidelines, could be explained this way. It would overlook, however, an important aspect that is likely to be more important. The fact that patients (almost) exclusively are the drivers of complaints, and the lack of a filtering mechanism, means that the tribunals dealt with complaints in a specific way, leading to a specific construction of competence. The focus lies on dealing with a specific instance of care, disclosed by the complaint of the patient, not a holistic evaluation of the competence of the professional. The sanction is legitimised in relation to the gravity of this single episode, which likely also explains why these sanctions are relatively light compared to those imposed by the fitness to practice tribunal in England. This also means that, apart from cases in which the healthcare inspectorate is directly involved, not much energy is directed towards revalidation of the professional or other activities such as training and supervision.

To make sure that the tribunal fulfils its function of improving the delivery of care by healthcare professionals it presents anonymised versions of the decisions to professional journals of medical practitioners for publication. In this way, the attempt is made to bridge dealing with individual complaints and educating the whole group of professionals.

England

In England, the professional regulation of various strands of the medical profession is divided between eight different councils: the General Medical Council, the General Dental Council, the General Optical Council, the General Osteopathic Council, the General Chiropractic Council, the General Pharmaceutical Council, the Nursing and Midwifery Council, and the Health and Care Professions Council. These councils are responsible for setting standards for training, education and practice as well as dealing with disciplinary matters. These various regulators of the medical profession in England are overseen by a meta-regulator the Professional Standards Authority[72] that oversees all aspect of their work, including fitness to practice decisions. For the purposes of this work only the Health and Care Professions Council (HCPC) will be considered in greater detail.

Professional Medical Regulation by the Health and Care Professions Council

The HCPC regulates the allied health professions.[73] The powers of the HCPC are enumerated in the Health and Social Work Professions Order 2001 (hereafter: the Order).[74] The

[72] S.25 National Health Service Reform and Health Care Professions Act 2002

[73] The full list of those regulated is: arts therapists, biomedical scientists, chiropodists, clinical scientists, dieticians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologist, prosthetists, radiographers, social workers, speech and language therapists.

[74] SI 2002/254.

overarching objective of the HCPC in exercising its functions is the protection of the public.[75] The standards set for the profession are there for the public to retain confidence in the profession and to ensure the safety and well-being of the public.[76]

Clearly, these regulations, at least on paper, place great emphasis on preventing practitioners from practicing that might harm members of the public. Another interesting feature of the nature of the regulation of the professions under this order is the focus on competency. Medical practitioners that do not have the required competencies are those whose practice could be harmful to the public. One might therefore expect evaluations of the medical tribunal to focus on the character of the medical practitioner to assess whether he/she has the required competency, or could be taught any that are found to be lacking. If this assumption is correct, the role of medical guidelines will be different. Medical guidelines are direct at prescribing specific behaviours, more so than a discussion of the competency of the person performing the required behaviour.

The Tribunal Procedure

The HCPC disciplinary process is triggered through a complaint from member of the public, other medical professional or through action by the HCPC on its own initiative. Complaints referred will first be dealt with by screeners[77] who assess whether the concern raised falls within the competence of the HCPC and whether matter is serious enough.[78] The matter if meeting the threshold is then referred to an investigation panel.[79] This panel decides whether there is a case to answer based on the paper evidence available, which means an evaluation of whether there is a realistic prospect of the allegations being proven. If this is the case, the allegations are referred to the Conduct and Competence Committee (hereafter: the medical tribunal) which makes the determination whether the fitness to practice of the relevant medical professional is impaired. The tribunal consists of a chair, who may be a lay person or a person with a medical background, a lay member and a member of the profession which corresponds to the profession of the person brought before the tribunal. The tribunal is assisted by a legal assessor, who has the role of providing legal advice to the tribunal to make sure the proceedings are conducted fairly and in accordance with the rules.

There are five different reasons for impairment: misconduct, lack of competence, a conviction or caution, physical or mental health, and a different licensing body determining that the fitness to practice is impaired.[80] If impairment is found on any of these grounds a range of sanctions is available: no action, mediation, caution, conditions on practice,

[75] S4 Health and Social Work Professions Order 2001.
[76] S4A Health and Social Work Professions Order 2001.
[77] S23 Health and Social Work Professions Order 2001.
[78] Applying the Health and Care Professions Council's (HCPC) Threshold policy for fitness to practise investigations. Available at: https://www.hcpc-uk.org/globalassets/resources/policy/threshold-policy-for-fitness-to-practise-investigations.pdf
[79] S26 Health and Social Work Professions Order 2001.
[80] S22(1)(a) Health and Social Work Professions Order 2001.

suspensions and striking off the register/erasure.[81] The medical practitioner can appeal any sanction to the High Court.[82]

The procedure used is adversarial, with the medical practitioner having the opportunity to respond during all steps of this procedure. The patient that raised the original concern is not directly involved in the procedure, it is the HCPC that brings the allegations before the medical tribunal. The general standard used, the focus on impairment of fitness to practice, also implies a focus away from specific actions of a medical practitioner towards a more general assessment of the adequacy of the competency of the person concerned.

Decisions by the HCPC tribunal: a quantitative analysis

Of the sample half of the cases were those involving social workers, in 18% of cases a paramedic was involved, 8% of cases involved a biomedical scientist, 6% a radiographer, 4% a psychologist. The remainder of professions were only involved in a single case: clinical scientist, occupational therapist, hearing aid dispenser, physiotherapist and chiropodist. The overrepresentation of social workers in the sample could be explained given they form the largest group of professionals regulated by the HCPC at the time[83] and given the nature of the work they do and the direct interaction with the public they are likely to receive a larger number of complaints than the average allied health professional.

The category of complaints to the HCPC tribunal can be divided into three broad categories which reflect the grounds of impairment: misconduct, lack of competence, and convictions. The three categories were equally represented in the sample. In the category of misconduct cases involved violent outbursts directed at patients, and other unprofessional approaches of patients or colleagues in addition dishonesty in various forms such as falsifying documents. Where lack of competence was alleged the allegation frequently focused on the inadequate recording of care/paperwork especially in cases of social workers, more general complaints about care delivery also featured. Finally, when it comes to convictions a range of offences was seen: fraud, they, driving under the influence and the indecency with a child.

Looking at the sanctions meted out by the tribunal the following picture emerges. In one case the allegation was not well founded. In the remainder of the cases a sanction was imposed. In three cases (6%) no further action was taken, 12 cases (24%) led to a caution, 5 cases (10%) led to conditions being imposed on the practice of the allied healthcare professional, 9 cases (18%) resulted in a suspension, 19 (38%) cases resulted in striking off the register, finally there was 1 case of voluntary removal from the register.

Finally looking at the role of allied healthcare guidelines in this sample of cases they were noteworthy by their complete absence. In a case of a biomedical scientist, reference was made to a legal standard the Blood Standards Quality Regulations[84], but this seems to be

[81] S29 Health and Social Work Professions Order 2001.
[82] S38(4)(c) Health and Social Work Professions Order 2001.
[83] This has since changed, but these developments are not considered here.
[84] Likely reference will have been made to the Blood Safety and Quality Regulations 2005, SI 2005/50 rather than the non-existent blood standards quality regulation.

the exception. Rather the cases references guidelines of a different kind. Virtually all cases refer to the HCPC Standards of Conduct, Performance and Ethics[85], which are complemented by standards of proficiency for all the 16 specific professions regulated by the HCPC. These general standards, which are described as an ethical framework for practice and threshold standards respectively describe in general terms the conducted that is expected of a medical practitioner. It is in reference to these standards that the potential impairment of a medical practitioner is judged.

A second source of frequent reference are a range of judgments of the High Court.[86] These mainly consider a range of procedural matters the tribunal has to take into account and the definition of professional misconduct. Examples are Cohen v GMC[87] tasks of the medical tribunal in the adjudicative process and the factors they need to take into account. Roylance[88] and Nandi[89] which define the terms professional misconduct, one of the grounds for impairment. Adeogba[90] on the rules surrounding conducting hearings when the medical practitioner is not present and Calhaem[91] which ruled that only in exceptional circumstances could a single episode of treatment lead to a declaration of impairment.[92] Looking at the sample it therefore appears that the references to guidelines and law are directed internally, to the procedurally correct running of the tribunal and the upholding of the standards set by the HCPC.

A qualitative overview of 50 decisions by the HCPC medical tribunal

A qualitative analysis of the sample of decisions uncovers three themes: *establishing of facts*, *the professional standard* and *insight*. There is therefore some overlap with the themes identified when analysing the Dutch cases, but it will become clear that the way these terms are operationalised in England is markedly different.

Establishing of Facts

A striking feature of medical tribunal proceedings is the care with which they establish the facts. In almost every procedure, witnesses are heard whose testimony is carefully scrutinised and reliability weighed, clearly mimicking the requirements of an adversarial court procedure. This focus is understandable given the fact that the HCPC has to prove the factual allegations, on the balance of probabilities.[93] It is then a matter for judgment of the medical tribunal whether these proven allegations amount to grounds for impairment.[94] The fact that the regulator the HCPC faces the medical practitioner, rather than a direct

[85] Available at: https://www.hcpc-uk.org/standards/standards-of-conduct-performance-and-ethics/
[86] A total 42 unique cases were referred to, not all of these will be discussed.
[87] Cohen v GMC [2008] EWHC 581 (Admin).
[88] Roylance v GMC (No 2) [2000] 1 AC 311.
[89] Nandi v GMC [2004] EWHC 2317.
[90] Adeogba v GMC [2016] EWCA Civ 162.
[91] Calhaem v General Medical Council [2007] EWHC 2606.
[92] All the cases referred to relate to appeals taken against the GMC but the rules given by the High Court are generally taken to apply to all medical tribunals. In fact of the 43 cases referred to in this sample only 1 was based on an appeal against the HCPC.
[93] The standard of proof in civil cases, which is lower than the standard in criminal law.
[94] Compare: CRHP v GMC and Biswas [2006] EWHC 464 (Admin).

confrontation between patient and medical practitioner contributes to this more formalised approach. It is therefore necessary for a medical practitioner to be represented at a hearing to be able to fully contest witness evidence provided, and to provide an alternative reading of the facts. Where the medical practitioner is not present those facts are likely to be readily accepted, which will feed into the discussion of the professional standard.

The Professional Standard

The decisions of the medical tribunal centre on the concept of impairment. The tribunal has to decide whether currently the medical practitioner is fit to practice his or her chosen profession. In virtually all cases in the sample, reference was made to the standards in HCPC Standards of Conduct, Performance and Ethics which contain ten general standard such as being honest, open about mistakes, respecting patient confidentiality and managing risks appropriately. Given the general ethical norms all regulated professionals have to adhere to the medical tribunal carefully examine the *character* of the medical practitioner. Especially the value of honesty is instructive in this regard, as standard 9.1 explicitly requires 'that your conduct justifies the public's trust and confidence in you and your profession.'[95] The cases analysed are very consistent in evaluating was has been called the personal component[96] i.e. the personal conduct, competence and behaviour of the medical practitioner. In particular any efforts at remediation of the mistake, work towards avoiding repetition and an insight into the failings. Because the evaluation of impairment is one directed towards the future, looking at the position at the time of the panel hearing the actions that took place after the alleged conduct are relevant.

There is however a second, independent, reason why a medical practitioner might be unfit to practice the public component as outlined in Grant: 'namely the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession.'[97] Especially in cases of cautions and convictions, the medical tribunal invariably declares that to maintain the trust of the public in the profession a finding of impairment should be made. This ranges from a case in which a medical practitioner received a police caution for hitting a neighbour in a moment of anger, to indecency with a child. Here upholding the reputation of the profession is seen as a reason to consider practitioners unfit to practice, regardless of whether the conviction has any relation with their professional conduct or not. When the medical tribunal considers impairment on public grounds there seems to be very little room for insight or remediation, these simply cannot outweigh the need to uphold standards, and maintaining the confidence of the public. This marks a clear difference with how cases that solely involve lack of competence are dealt with. In those cases remediation and insight is accepted as a valid reason not to consider someone impaired.

An overview of the whole of the sample therefore show how the professional standard set by the medical tribunal is influenced to a large extent by the need to maintain the

[95] HCPC, 'Standards of Conduct Performance and Ethics'.
[96] Cohen v GMC [2008] EWHC 581 (Admin).
[97] Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council & Paula Grant [2011] EWHC 927 (Admin) par 71.

confidence of the public in the profession. This means that all conduct of medical practitioners is liable to being scrutinised, whether it is private or public, if it relates to their *character*, as flaws in character such as dishonesty can disqualifies a professional from a position of trust and has the potential to harm (a member of) the public.

The underlying logic of this decision-making could be summarised succinctly as the need for an allied healthcare professional to have the attributes of competence necessary to deliver care of the required standard. Any absence of these attributes in their character or conduct or likely to have the potential of causing harm. The evaluation of the professional competence of the professional in specific circumstances is therefore more incidental to proceedings, and references to guidelines are not seen, because the proceedings are often mainly directed towards public interest goals that do not require a medical evaluation.

Insight

Analysis of the sanctions imposed by the panel show the importance of the sanctions policy[98] that the HCPC has developed. In all cases, the panel refers to this policy when imposing a sanction. This policy details a range of mitigating and aggravating factors that can be taken into account by the medical tribunal. The findings over the whole sample closely mirror those of Leigh et al[99] in that the presence of the registrant is the most important factor in determining the severity of the sanction and therefore the severity of the sanction does not always mirror the severity of the conduct found proven. Important mitigating factors recognised in the sanctions policy are insight, remediation and an apology. From the sample, it is clear that the only way for the medical tribunal to be convinced about the seriousness and genuine nature of insight into the failings and/or efforts towards remediation is through the presence of the medical practitioners. Little weight is attached to written statements. An example is formed by the sub-set of cases in which dishonesty was proven; these are according to the sanctions policy serious cases that would warrant the more serious sanction of striking-off or a suspension. Nonetheless, the sample shows a case in which only a caution was given for a dishonesty offence because the registrant had shown extensive remorse and insight into the wrongfulness of the actions, could point to a heavy workload and poor support, leading the panel significantly mitigate the sanction. Cases in which the medical practitioner was not present and dishonesty was proved almost without exception led to a striking-off order, even, as Leigh et al [100] also note, the conduct alleged sometimes seemed less serious. This sample also aligns with the findings of Case[101] who highlights a redemption model of practice that allows medical practitioners to regain access to the profession if appropriate remorse, insight and remediation is shown.

The Institutional Structure and Position of the HCPC Fitness to Practice Tribunal

[98] HCPC, 'Sanctions Policy'.
[99] Leigh, Worsley and McLaughlin (n 2).
[100] ibid.
[101] (n 70).

In contrast to the Dutch case, the HCPC tribunal is driven by cases brought by the HCPC as regulator. This means that in all cases in the sample the practitioner was faced by a range of allegations stemming from multiple events, all things being equal this would explain the comparatively harsh sanctions imposed. Another important element was the explicit framework of professional ethics, this allows for a holistic assessment of character and conduct as expressed through (the lack of) competence a much wider lens that that employed in front of Dutch tribunals. The hypothesis formulated that the Dutch medical professionals would be held to a higher standard is therefore not born out within this research. The fact that the cases selected to appear before the tribunal are more severe points to a clearer filtering mechanisms as employed by the HCPC, which is absent in the Netherlands.

Medical Tribunals in The Netherlands and England: a comparative perspective

The analysis of a sample of Dutch and English medical tribunal decisions have highlighted important differences in the approaches taken within the systems of medical professional regulation. Consequently, the role of medical guidelines in these decisions has also varied. Rather than a complete discussion of all these differences, the focus will be placed on three aspects: the goals of professional regulation, the institutional structure and position of the tribunals and the role of medical guidelines. These themes will be used to explain the various ways in which medical guidelines are used in these contexts.

The goals of professional regulation

The analysis of the decisions taken by medical tribunals in the Netherlands and in England show in interesting divergence in the conceptualisation of the (primary) goals of professional regulation. Where in the Dutch cases a direct interaction takes place between a patient with a specific complaint about the medical actions of a medical practitioner in the English case the interaction is one between a regulator and the regulated medical practitioner. These specific institutional features also colour the weight that is attached to the goals of the professional regulation at issue.

The Dutch medical tribunal functions as a ‘complaint-resolving mechanism.’ Patients get the chance to explain why they feel the care they received was deficient in some way, and the tribunal performs a detailed assessment of that care. This assessment can take place use legal norms, standards formulated by guidelines, or be based on peer review. The results of the assessment are then used to retrospectively evaluate the performance of the medical practitioner so that their conduct can be corrected and other medical practitioners can learn about the correct conduct. It is clear from the sample that in the majority of cases improving the quality of healthcare is the dominant theme, and removing negligent professionals a secondary consideration.

The HCPC medical tribunal functions as a ‘competency-assessment mechanism.’ Here the regulator gets the opportunity to convince the tribunal that the medical practitioner should no longer practice medicine, at least not without conditions being imposed. The focus is therefore shifted to look more at misconduct, and if the issue if competence is raised to only look at a range of behaviours not an isolated case. Removing those professionals that do not

live up to the expectations of the profession and the public is the main goal. There are elements of a punitive approach, especially in those cases where maintaining the confidence of the public is given as a ground for impairment, where one can be disciplined even if the individual competence to practice medicine is not in question. Protecting the public, by removing professionals that are likely to cause harm, is therefore the overarching focus of the process.

The institutional position and structure of the tribunals

A striking difference is between the number of decisions that lead to an imposition of a sanction: where in England this is in the large majority of cases, the Dutch case is the polar opposite. This might, give on first sight the impression that the English system is far more punitive, but this overlooks the filtering that takes place before decisions are placed before a medical tribunal in England. Where in the Dutch case a patient has direct access to the tribunal, in England complaints that are likely to be unfounded are filtered out in the earlier parts of the procedure. So the final word on which system is the more punitive cannot be given, there is simply too much of a gap in the type of cases that appear before them.

Finally, the positioning of the medical tribunals within the wider regulatory environment is an important factor to consider. The structure in England is one where the profession is responsible for hosting the medical tribunal and where there is a meta-regulator (Professional Standards Authority) with an oversight function as well as the High Court that exercises supervisory jurisdiction. Within this structure, the tribunal which consist a lay people and medical practitioners is focused, mainly through the advice of the legal assessor, to consider very carefully the fairness of the procedure involved. This leads to a formal, cumbersome, adversarial process to assure the formal legitimacy of the imposition of sanctions on a professional. The Dutch medical tribunal is established by law, and is hosted and financed directly by the State. Medical professionals as well as (former) judges staff the panel. There is no external review of the decisions, given the internal appeal mechanism to the Central Medical Tribunal. The involvement of more lawyers in the Dutch procedure paradoxically allows for a far more informal inquisitorial process, because the requirements of due process are considered to be met through the presence of these judges, and the focus is on evaluating medical conduct.

The role of medical guidelines

What is the role of medical guidelines in medical tribunals in the Netherlands and England? We have seen that the focus on professional ethics means that the HCPC tribunal makes no mention of any (para)medical guidelines. The focus of the tribunal on the continuing fitness to practice of medical professionals explain this, the tribunal is focused on establishing the character of the medical practitioner, and does not rely solely on a medical evaluation of the conduct of the professional. Given this perspective, individual historical instances of medical malpractice carry weight insofar as they support the lack of competency and character of the medical practitioner and are used in this way.

The Dutch medical tribunal does use guidelines in a range of cases, although this is still in a minority of the cases sampled, given their focus on resolving complaints. An evaluation of

the specific individual medical conduct is warranted, as only this medical conduct is amenable to review by the tribunal and medical guidelines play a role in this evaluation. The impact of these guidelines on the assessment of the tribunal is mixed. On the one hand, there is a group of decisions where guidelines are shields for doctors, following guidelines equals care of the appropriate standard and therefore complaints are dismissed. On the other hand, there is a group of cases in which doctors are confronted by the need to explain, and therefore carefully document in medical records, any deviations from a guideline. It is often the lack of documentation of the deviation of a guideline that leads to a successful complaint, rather than the deviation as such, because the tribunal can require doctors to fulfil their legal duty to have adequate patient records. Nevertheless, even in the Dutch case, guidelines are not as prominent as might be expected, in the majority of cases the conduct complained about was not covered by a medical guideline or the members of the tribunal did not explicitly use them in their evaluations. Within the confines of the data of the study, it therefore appears that guidelines only had a moderate impact on decision-making by medical tribunals in the Netherlands.

Conclusion

This comparative analysis of a sample of decisions taken by medical tribunals in the Netherlands and England has presented a varied insight into the decision-making by these tribunals. An analyses of the decisions yielded comparable themes such as concerns around the definition of the professional standards and the importance of insight in deciding on the appropriate sanction for a medical practitioner. Despite these superficial similarities, the way these terms were given meaning differed substantially. Where the professional standard in England was decided with reference to the character of the medical practitioner in the Dutch case the specific medical behaviour came to the fore. The reasons for these differences lies partly in the differences in weight the various goals of professional regulation had in the respective countries. In England, protecting the public from harm by removing negligent professionals was the primary aim, where in the Dutch case the general improvement of the practice of medicine was more prominent. These contrasting aims in turn can be linked to institutional position and structure of the tribunals, and differences in history and choices made in this respect. In England, the tribunal has to deal with allied health professionals that have committed offences where in the Netherlands this is left to the criminal justice system.

The presence of guidelines in the reasoning of medical tribunals in the Netherlands does not necessarily equate to impact on the final decision-making of the tribunals. The use of guidelines in this respect is not straightforward. In some cases, following the guideline assures the medical practitioner that the professional standard is met, but by the same token deviations from the guidelines without adequate supporting rationale in the medical records will lead to a sanction. In the majority of cases however, the conduct is evaluated without any explicit reference to medical guidelines, so even in the case of the Dutch medical tribunals the important of medical guidelines in regulating medical conduct should not be overstated.

The result of these various differences is that guidelines somewhat more prominent in the Netherlands than they are in England. Where in the Netherlands these are used in a range of cases to help define the professional standard of medical professionals. In England the evaluation of the character of medical professionals and their competency is the route to establishing medical competence. We are thus left with two contrasting models of constructing competence: a model of judging individual behaviour, sometimes through the use of guidelines, but also using legal norms or forms of peer review to assess competence in the Netherlands. A holistic character evaluation of conduct, private or public, to establish attributes of competence for the avoidance of harm to the public in England. Juxtaposition of these varies traits can hopefully lead to a strengthening of both towards the common goals of protecting the public and improving the delivery of care.

Bibliography

Allen I, 'Handling of Complaints by the GMC a Study of Decision-Making and Outcomes' (Policy Studies Institute 2000) <http://www.psi.org.uk/site/publication_detail/960> accessed 9 October 2019

Berg M, ter Meulen R and Van den Burg M, 'Guidelines for Appropriate Care: The Importance of Empirical Normative Analysis' (2001) 9 Health Care Analysis 77

Boivin A, Légaré F and Lehoux P, 'Decision Technologies as Normative Instruments: Exposing the Values Within' (2008) 73 Patient Education and Counseling 426

Braun V and Clarke V, 'Using Thematic Analysis in Psychology' (2006) 3 Qualitative Research in Psychology 77

Case P, 'The Good, the Bad and the Dishonest Doctor: The General Medical Council and the "Redemption Model" of Fitness to Practise' (2011) 31 Legal Studies 591

Chamberlain JM, 'Malpractice, Criminality, and Medical Regulation: Reforming the Role of the GMC in Fitness to Practise Panels' (2017) 25 Medical Law Review 1

Dodek P, Cahill NE and Heyland DK, 'The Relationship Between Organizational Culture and Implementation of Clinical Practice Guidelines A Narrative Review' (2010) 34 Journal of Parenteral and Enteral Nutrition 669

Dyer C, 'Half of Doctors Investigated over Mid Staffs Have Faced No Action, Says GMC' (2013) 346 BMJ (Clinical research ed.) f872

Eccles MP and others, 'Developing Clinical Practice Guidelines: Target Audiences, Identifying Topics for Guidelines, Guideline Group Composition and Functioning and Conflicts of Interest' (2012) 7 Implementation Science 60

Everdingen JJE van, *Consensusontwikkeling in de geneeskunde* (Bohn, Scheltema en Holkema 1988)

Field MJ and others, *Clinical Practice Guidelines Directions for a New Program* (National Academy Press 1990)

Gallagher CT and Foster CL, 'Impairment and Sanction in Medical Practitioners Tribunal Service Fitness to Practise Proceedings' (2015) 83 Medico-Legal Journal 15

HCPC, 'Standards of Conduct Performance and Ethics'

——, 'Sanctions Policy'

Herregodts RL, 'Gemeenschappelijke normen voor vertrouwensberoepen: Tuchtrechtelijke uitspraken over de tuchtnormen voor accountants, advocaten en artsen' (Rijksuniversiteit Groningen 2019)

Hout E, Friele RD and Legemaate J, 'De Burger Als Klager in Het Tuchtrecht Voor de Gezondheidszorg: Weinig Klachten, Mogelijk Door Geringe Kennis van Tuchtrechtsysteem' (2009) 153 Nederlands Tijdschrift voor Geneeskunde 548

Hout FAG, 'Tuchtrechtspraak niet verbeterd sinds de invoering van de Wet op de Beroepen in de Individuele Gezondheidszorg (Wet BIG)' [2004] Ned Tijdschr Geneeskd 5

Hout FAG, 'The Dutch Disciplinary System for Health Care: An Empirical Study' (Institute for Research in Extramural Medicine (EMGO institute) at the dept of Public and Occupational Health VU University Medical Center (VUMC) 2006)

Hout FAG and others, 'Tuchtklachten van de Inspectie voor de Gezondheidszorg effectief voor aangeklaagden en beroepsgenoten' (2011) 89 Tijdschrift voor gezondheidswetenschappen 58

Jansen FJ, *Professional Regulation and Medical Guidelines: The Real Forces behind the Development of Evidence-Based Guidelines* (2020)

Klazinga N, 'Quality management of medical specialist care in the Netherlands. An explorative study of its nature and development' (Erasmus Universiteit Rotterdam 1996)

Kleiboer MA, Huls NJH and Beerlage KE, *Tuchtrecht Op de Terugtocht?: Wettelijk Niet-Hiërarchisch Tuchtrecht: Een Vergelijkende Analyse* (LEMMA 2001)

Legemaate J and others, *Thematische wetsevaluatie: bestuursrechtelijk toezicht op de kwaliteit van zorg* (ZonMw 2013)

Leigh J, Worsley A and McLaughlin K, 'An Analysis of HCPC Fitness to Practise Hearings: Fit to Practise or Fit for Purpose?' (2017) 11 Ethics and Social Welfare 382

Mcgivern G and Fischer M, 'Medical Regulation, Spectacular Transparency and the Blame Business' (2010) 24 Journal of health organization and management 597

Medisch Contact, 'Inspectie richt zich op veldnormen' (18 February 2009) <https://www.medischcontact.nl/nieuws/laatste-nieuws/artikel/inspectie-richt-zich-op-veldnormen.htm> accessed 9 October 2019

NHS Employers, BMA, NHS England, 'General Medical Services (GMS) Contract Quality and Outcomes Framework' (2018) 08157 <https://www.nhsemployers.org/-/media/Employers/Documents/Primary-care-contracts/QOF/2018-19/2018-19-QOF-guidance-for-stakeholders.PDF?la=en&hash=6A53571FC0F7A63FA7354951C733B9E6011EC2CD> accessed 30 November 2018

Sackett DL and others, 'Evidence Based Medicine: What It Is and What It Isn't' (1996) 312 BMJ 71

Schelfhout V, 'De Onzichtbare Kracht van Het Tuchtrecht' (*KNMG*, 18 February 2013) <http://knmg.artsennet.nl/Dossiers-9/Columns/Column/128265/De-onzichtbare-kracht-van-het-tuchtrecht.htm> accessed 19 May 2014

Uhlenbroek H and Mooibroek M, 'De invloed van tuchtrecht op aansprakelijkheid' (2013) 21 Medisch contact 1119

van Herk R, Schepers R and Casparie AF, 'Huisartsen en zelfregulering. De ontwikkeling van intercollegiale toesting en standaarden voor huisartsen tussen 1970 en 1990' (1994) <https://lirias.kuleuven.be/handle/123456789/161090> accessed 12 June 2014

Verhoef LM and others, 'The Disciplined Healthcare Professional: A Qualitative Interview Study on the Impact of the Disciplinary Process and Imposed Measures in the Netherlands' (2015) 5 BMJ Open e009275

Wensing M, Bal R and Friele R, 'Knowledge Implementation in Healthcare Practice: A View from The Netherlands' (2012) 21 BMJ Quality & Safety 439

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