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Fitness-to-Practise: How UK Healthcare Regulators Cause Practitioner Deaths

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Submitted: 11 May 2021, accepted: 21 February 2023, published: 28 April 2023

Abstract: Cases of practitioner ill-health and suicide have been attributed to disciplinary proceedings carried out by healthcare regulators. The methods operated by regulatory bodies when investigating claims of practitioner wrongdoing exhibit judicial irregularities and raise significant ethical concerns. Revealing how and where regulators fail to execute their fitness-to-practise responsibilities constructively creates a starting point from which fairer and safer systems of regulatory interventions can be considered. This paper is an analysis of how the regulatory establishment administers fitness-to-practise procedures, and endeavours to identify how existing approaches cause harm and undermine the integrity of regulatory oversight.

Keywords: Fitness-to-practise; judicial irregularity; ethics; regulation; suicide

How to cite: Macqueen, D. Fitness-to-Practise: How UK Healthcare Regulators Cause Practitioner Deaths. *Journal of Controversial Ideas* **2023**, 3(1), 7; doi:[10.35995/jci03010007](https://doi.org/10.35995/jci03010007).

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Introduction

A fundamental purpose of regulating healthcare services is to eliminate bad practice and uphold mandates for *protecting the public*. To achieve this, UK healthcare regulators ensure that complaints lodged against practitioners are exhaustively addressed and any allegations of misconduct are vigorously pursued. However, the impact regulators have upon healthcare professionals has been found to cause serious ill health, including cases of suicide. In 2011, a 38-year-old nurse hanged herself as a result of having the details of a sexual relationship she had entered into with an A&E patient particularised before a Nursing and Midwifery Council (NMC) fitness-to-practise (FtP) panel.¹ In 2013, a 42-year-old dentist killed himself after an NHS authority threatened to report him to the

¹ *Daily Mail* (2012). 'Hospital nurse found hanged after she faced being struck off over claims of affair with patient'. 26 September 2012. [link to this article](#).

General Dental Council (GDC) for issues relating to record keeping.² A 34-year-old GP hanged himself in 2015 fearing a General Medical Council (GMC) suspension concerning an alcohol restriction order.³ And, in 2018, a 50-year-old anaesthetist drowned himself after being haphazardly referred to the GMC due to an allegation of sexual impropriety.⁴ Circumstances such as these highlight the distressing effect healthcare regulators can have upon practitioners and raise serious questions about the processes and conduct regulatory bodies adopt when handling FtP matters.

Ambiguity within Healthcare Regulation

Regulation is an exceptionally important part of any professional service. It has been described as a means by which to reduce corruption and transaction costs, increase the legitimacy and legality of professional services, and improve policy quality through enhanced intelligence and learning.⁵ Regulatory bodies that oversee services involving specialists and practitioners typically maintain registers of approved professionals, and may also provide industry information, guidance on standards and policies, and training and qualifications. Within healthcare in the UK there are numerous regulatory bodies that oversee the various practitioner disciplines; some have judicial powers, many do not. Underpinning broad administrative functions, the primary objective of these health regulators is to safeguard the public. In seeking to accomplish this crucial undertaking procedures have been put in place which aim to ensure healthcare practitioners can be held accountable should issues of misconduct or wrongdoing arise. Accordingly, a number of official regulators have statutory powers assigned to them by Parliament, which not only steer their responsibilities and functions but grants them the legal authority to permit or prohibit a health professional from practising. Furthermore, owing to their constitutionally given statuses, these statutory regulators afford their members protected titles, which means an individual cannot legally practice as a social worker or a pharmacist, for example, without being registered with the relevant regulatory body. At present in the UK there are 10 statutory regulators, such as, the GMC, the NMC, and the Health and Care Professions Council (HCPC); these are themselves overseen and regulated by the Professional Standards Authority (PSA) for Health and Social Care, which is directly accountable to the UK Parliament.

There are also a number of non-statutory practitioner organisations, and although some attempt to replicate the statutory regulators, these are voluntary organisations that hold no legal authority empowering them to permit or prohibit an individual from practising. Many of these non-statutory or *quasi*-regulators align themselves with the statutory regulators by, amongst other things, joining the *accredited register* scheme of the PSA and duplicating legalistic FtP procedures. There are currently 28 quasi-regulators that are paid-up members of the PSA's accredited scheme, ranging from play therapists and psychotherapists to chaplains and aromatherapists. Importantly, unlike the statutory

² Harding, E. (2013). 'Worked to death: NHS dentist takes his own life after health bosses threatened to strike him off because he couldn't keep up with paperwork for 10,000 patients'. 12 August 2013. [link to this article](#).

³ *The Times* (2015). 'Young GP hanged himself over fear of alcohol test'. 25 November 2015. [link to this article](#).

⁴ British Medical Association (2020). 'For want of support'. 14 May 2020. [link to this article](#).

⁵ Hood, C. & Rothstein, H. (2001). 'Risk regulation under pressure: Problem solving or blame shifting?' London: LSE Research Articles Online. [link to this article](#).

regulators, these quasi-regulators do not have the legal authority to offer their members protected titles; anyone—with or without formal qualifications—can carry out the work that these voluntary bodies purport to regulate. This ambiguity within healthcare regulation was brought to the attention of the House of Lords in 2020, where it was highlighted that “The terms ‘counsellor’ and ‘therapist’ are not protected. All of us could call ourselves such.”⁶ Therefore, encouraging audit and oversight of quasi-regulators via an organisation like the PSA certainly adds a sensible layer of scrutiny, and is both practical and convenient. However, the pitfall of bringing voluntary organisations like quasi-health-regulators into the PSA’s ambit creates a false assumption—to both the public and other professionals—that their standards and powers are equivalent to the 10 healthcare regulators that have been granted statutory powers by Parliament.

The discrepancies that exist between quasi and statutory regulatory bodies are further revealed in the differing requirements needed to gain registration. Individuals wishing to belong to a PSA-*accredited* quasi-regulator can gain practitioner statuses by undertaking shorter part-time trainings than compared with practitioners belonging to the statutory regulators of the PSA. For example, an individual can join a quasi-regulator by completing a 10-month part-time course,⁷ or by being awarded a Practitioner Level Diploma after undertaking eight one- or two-day courses, eight online courses, and three weeks of intensive training,⁸ or by passing an online assessment that states they have the “skills, knowledge and abilities required to be a professional counsellor or psychotherapist”.⁹ In stark contrast, these economical routes to practitioner statuses and registrations are not available to practitioners working in statutory regulated occupations; usually, requirements of three or more years, often with preceding stints of clinical work-experience, are needed for registration with one of the PSA’s 10 statutory regulatory bodies.

Undoubtedly, there are significant inconsistencies within the UK’s healthcare regulatory system. Although not directly addressing regulation of individual practitioners, the Department of Health and Social Care specifically acknowledged, in a 2021 White Paper,¹⁰ the need for greater integration within the NHS, recommending the introduction of a statutory integrated care system (ICS) and an independent statutory body to oversee safety investigations. Evidently, there is a general sense of confusion within healthcare administration, and this can only be exacerbated by a regulatory system that integrates organisations with differing powers of constraint and with arbitrary conditions and standards.

Prevalence of Double Standards

Accompanying the misapprehensions surrounding regulator powers and what classifies as a qualified practitioner, concerns about how regulatory bodies specifically handle FtP matters are not uncommon, with, on occasion, both quasi and statutory regulators being formally criticised by various UK courts for poor judgement and irregular or unfair

⁶ House of Lords (2020). ‘Mental health: Unregulated treatment’. 2 March 2020. [link to this article](#).

⁷ Brighton Holistic (2021). ‘Aromatherapy Level 3 Qualification Training Course’. [link to this article](#). February 2021.

⁸ Human Givens Institute (2020). ‘Your diploma journey’. [link to this article](#). November 2020.

⁹ BACP (2021). ‘BACP Register Certificate of Proficiency’. [link to this article](#). February 2021.

¹⁰ Department of Health & Social Care (2021). [link to this article](#). February 2021.

practices.^{11–16} However, although harsh criticisms have been levied against numerous health regulators they remain comparatively impervious to strict or decisive penalties when found to have failed in their duties. A case in point notes the PSA's 2019–2020 review of the Health and Care Professions Council (HCPC) which concluded that four of the five requisite standards within their FtP procedures had not been met.¹⁷ While this extensive failure would ordinarily warrant some form of organisational cessation or suspension, the HCPC was free to continue operating. This flawed measure of immunity lies in the fact that, if a statutory regulator were to be suspended or expelled, its registered practitioners would then, in theory, be unable to continue offering their services to the general public; a suspension of crucial healthcare services, such as, the disciplines of nursing or dentistry, would simply be untenable for society. Nonetheless, questions naturally arise about the suitability of any regulator that has failed to perform to agreed or requisite standards, being able to adequately oversee a healthcare discipline and address such matters as a practitioner's FtP. In other words, should a regulator that has been found to fail in *its* duties still be permitted to continue sanctioning and suspending practitioners who are accused of failing in *their* duties?

The condoning of double standards by the regulatory establishment points to a discriminatory culture in which regulatory bodies are afforded crude freedoms that empower them to operate dogmatically and adversarially—for instance, when dealing with practitioner complaint matters—while benefiting from relative impunity when their own behaviours are found to be flawed or unacceptable. This double standard exposes an hypocrisy and undermines the constructs of *good regulation*, which holds, “regulators should act in a way which is proportionate, consistent, targeted, transparent, accountable and agile”.¹⁸ Inconsistent or poor regulation can never be a justification for overlooking or allowing unacceptable practitioner conduct, yet statutory regulators, and the quasi-regulators that mimic them, should not be exempted from censure when their own conduct falls short of trustworthy practices.

Suspending or ceasing a statutory regulator would, in reality, create extensive disruption to the healthcare services and put the public at risk. The most recent discontinuation of a healthcare regulator occurred in 2012 when the PSA's predecessor, the Council for Healthcare and Regulatory Excellence, initiated the abolition of the General Social Care Council and transferred the regulation of social work to the HCPC. (Of note, Social Work England parted from the HCPC in 2019 and now acts as the exclusive regulator of social work practitioners.) Relevantly, the current PSA has never halted or

¹¹ Dyer, C. (2017). ‘GMC is criticised for failing to properly investigate case against cosmetic surgeon’, *British Medical Journal* (Clinical research ed.), No 359, BMJ, j5002. [link to this article](#).

¹² Administrative Court Judgement—Case No: EWHC 2140 (Admin), 2013. *Johnson & Anor v Nursing and Midwifery Council*.

¹³ Dyer, C. (2014). ‘Judge condemns GMC for “unacceptable delays”, and inactivity’, *British Medical Journal*, No 348, 2014. [link to this article](#).

¹⁴ High Court Judgement—Case No: CO/3036/2016 *The Queen on the application of Vesna Mandic-Bozic and British Association for Counselling and Psychotherapy and United Kingdom for Counselling and Psychotherapy*.

¹⁵ Administrative Court Judgement—Case No: EWHC 1561 (Admin), 2019. *Beard v General Osteopathic Council*.

¹⁶ *R (on the application of Johnson & Maggs) v MNC* (2013) EWHC 2140 (Admin).

¹⁷ Professional Standards Authority (2019). ‘Performance review 2019/20—Health and Care Professions Council’. [link to this article](#)

¹⁸ Professional Standards Authority (2021). ‘The standards of good regulation’. [link to this article](#).

suspended a statutory regulator; however, it has suspended some of its quasi-regulators: the UK Council for Psychotherapy¹⁹ was suspended in 2015 and the Society of Homeopaths²⁰ in 2021. Crucially, while suspension of these quasi-regulators highlighted and exposed irregularities and failings by those organisations, the suspensions had no legal bearing on the working rights of their registered practitioner members or on the quasi-regulatory bodies themselves. This ability to suspend a quasi-regulator, albeit vainly, but not a statutory regulator further demonstrates the incongruous standards that currently exist within UK healthcare regulation.

Another issue that epitomises double standards and uncovers grave failings in matters relating to trust and transparency is, again, found amid the disparities between quasi and statutory regulators. In contrast to the statutory regulators that are bound by constitutional rules, quasi-regulators are able to misuse freedoms that have been inopportunistically given them due to their limited statuses. For example, contrary to the legal obligations statutory regulators hold toward the public, the British Association for Counselling and Psychotherapy (BACP)—a PSA accredited quasi-regulator—was seen to exploit its non-statutory status by asserting, in 2020, that, “BACP is not a public authority and is therefore not subject to Freedom of Information requests” [Freedom of Information Request]. This obstructive mentality clearly deviates from the standards and mandates that statutory regulators are required to uphold.¹⁸ Any organisation that claims to be a regulatory body, which actively ill-uses loopholes to by-pass conventional civic policies, devalues the integrity of a system that advocates transparency and accountability.

The significance of the idiosyncratic standards that exist within UK healthcare regulation points towards ill-considered and confused governance, and reveals shortcomings in regulatory practices that ultimately inform the FtP initiatives that have led to unreasonable and harmful outcomes. Even the GMC, whose own regulatory and FtP track record has been heavily criticised,^{13,21} has argued that the legislation and framework which has underpinned professional regulation has failed to keep up to date with changing healthcare systems and society, stating this has resulted in hampering “efforts to protect the public and support those we regulate to deliver great care”.²²

Impact of Fitness-to-Practise Issues on Practitioners

As emphasised, there are numerous regulatory healthcare organisations with varying standards and vastly diverging *grades* of practitioner statuses. However, one feature that unites many of these organisations involves how they engage with practitioner complaints and FtP issues. Regardless of the legal authority a regulatory body might hold over a practitioner, studies have consistently revealed that the ways by which regulators pursue practitioners accused of wrongdoing create serious and far-reaching problems as a result.

A 2014 review commissioned by the GMC into the impact of complaints procedures and FtP hearings identified that, between 2005 and 2013, 114 doctors died while under a GMC investigation, with 24 cases classified as suicide and a further 4 deaths as

¹⁹ Kingsley Napley (2016). ‘The full story behind the UKCP accreditation suspension by the PSA: confessions of a Regulator’. [link to this article](#).

²⁰ Professional Standards Authority (2021). [link to this article](#).

²¹ British Medical Association (2022). ‘Arora ruling reinforces need for an independent evaluation of the GMC’s fitness-to-practise decision-making procedures’. [link to this article](#).

²² General Medical Council (2021). ‘Regulatory reform’. [link to this article](#).

suspected suicides.²³ In 2015, Dental Protection reported that 78% of dentists' mental or physical health had been negatively affected by a GDC investigation, with 34% of dentists considering leaving the profession as a consequence.²⁴ In a 2016 article published by Imperial College London, which examined experiences of receiving complaints, doctors were quoted saying, "my life was ruined", "you feel worthless even when you know you've done the best you can", and "the patient is presumed to be right, and the doctor is presumed to be wrong, unless you can prove otherwise".²⁵ A 2015 report that considered the impact of the GMC's lowest sanction, i.e., a warning, cited doctors saying, "I will never accept it, it's like breaking my dignity and honourability", and "Your self-confidence, your belief in yourself, the emotional impact, massive. And I ended up with clinical depression."²⁶ In 2017, the British Journal of Social Work published a qualitative study into how FtP cases affected social workers; it found that five of the eight participants had considered or attempted suicide during the investigations.²⁷ In 2018, the *Nursing Standard* published a finding that specified, "36% of nurses receiving counselling who are facing fitness-to-practise proceedings by the NMC have thought of ending their lives."²⁸

Adding to the considerable levels of distress FtP investigations evidently cause practitioners, how healthcare authorities address claims of practitioner wrongdoing has also been found to have a detrimental effect on the treatment of patients. A 2015 review involving 7926 doctors, published in the *British Medical Journal*, revealed that, of doctors who had received a complaint, 84% developed a defensive or avoidant approach to their work, leading to increased referring onto other practitioners, overprescribing, and not accepting high-risk patients. The study also found that 23% of doctors who underwent a complaints process reported that they were subsequently recommending invasive medical procedures against their professional judgement.²⁹ In another 2015 research report, which investigated experiences of warnings issued by the GMC, a doctor stated, "I think I've gone beyond the level of normal patient safety, I think probably defensive beyond patient safety."²⁶

Commitments to protect the public and promote good healthcare lose validity when the processes for fulfilling those tasks are capable of causing harm to both the people who provide the services and to those receiving them. Any bureaucratic system, such as healthcare regulation, that can cause ill-health and lead to suicide, or compel professionals to act excessively out of fear, ultimately fails the people it is intended to safeguard.

²³ Horsfall, S. (2014). 'Doctors who commit suicide while under GMC fitness to practise investigation'. [link to this article](#).

²⁴ Dental Protection (2019). 'Voluntary removal from the register', [link to this article](#).

²⁵ Wighton, K. (2016). 'Patient complaint procedures leave doctors emotionally distressed'. [link to this article](#).

²⁶ Community Research (2015). 'The effects of having restrictions on practice or warnings - Research Report for the GMC'. [link to this article](#).

²⁷ Worsley, A., McLaughlin, K. & Leigh, J. (2017). 'A subject of concern: The experiences of social workers referred to the Health and Care Professions Council', *The British Journal of Social Work* 47(8): 2421–37.

²⁸ Jones-Berry, S. (2018) 'How fitness to practise fears raise suicide risk for troubled nurses'. [link to this article](#).

²⁹ Bourne, T. et al. (2015). 'The impact of complaints procedures on the welfare, health and clinical practice of 7926 doctors in the UK: a cross-sectional survey', *BMJ Open* 5(1). [link to this article](#).

Fitness-to-Practise: A Legalistic Process

The term *fitness-to-practise* is what healthcare regulators typically refer to when seeking to determine whether a practitioner can remain a practicing member of their membership body. If an FtP matter arises involving a statutory regulator and results in an adverse outcome for a practitioner, legislation exists which can be called upon to prevent the practitioner carrying out their healthcare occupation. In contrast, owing to being voluntary membership bodies, quasi-regulators do not have the legal authority to prohibit a practitioner from practising should it decide a contravention has occurred. The experiential impact of this imbalance points to a significant inequality between practitioner occupations. Those who are statutorily regulated labour under the continual threat that any wrongdoing or errors they might make could lawfully lead to the enforced loss of their livelihood, while practitioners who belong to one of the PSA's quasi-regulators, do not suffer the same risk of a legally enforced discontinuation of their healthcare work.

Although this legislative disparity demonstrates ongoing inconsistencies and confusion within the regulatory system, statutory regulators, and many of the quasi-regulators, nonetheless, incorporate legalistic practices to satisfy legislative mandates particularly when pursuing healthcare professionals accused of wrongdoing. Subsequently, any practitioner who is alleged to have failed in their healthcare duties or is deemed to have brought their occupation into disrepute can face FtP procedures that share legal traditions which operate within the mainstream UK judicial system.

When a complaint against a practitioner is received by a regulator information is gathered and, usually, some form of a *threshold test* is carried out. This test aims to help a regulator determine whether there is a case to be made against a practitioner based on the issue or complaint lodged. Once a regulator has sought the necessary information and completed preliminary investigations, it will decide whether the complaint is valid, whether it can be successfully argued, and whether the matter should be brought before a tribunal or disciplinary (i.e., FtP) panel. If the regulator determines that the complaint is cogent and worthwhile bringing before an FtP panel, it will set about building a case against the practitioner. Following a decision to pursue the complaint, the regulator works with the primary complainant (i.e., a patient or organisation) to build a case that conveys and substantiates the practitioner's alleged transgressions. Typically, from this point forward, it is the regulatory body that assumes the complaint on behalf of the complainant and officially makes the case against the practitioner.

Once a regulator has completed preparing its case, in which evidence and allegations of wrongdoing are gathered and listed, the regulator sends their case material to the accused practitioner (customarily via the practitioner's legal representation). In response, the practitioner is given the opportunity to produce a rebuttal or defence against the regulator's case and allegations. As with civil or criminal judicial matters, the practitioner's material will eventually be gathered together with the regulator's material and submitted, in advance of a hearing, to the chosen FtP panel. In some cases, where a practitioner admits fault, and depending on the nature of the allegations, a full hearing may not necessarily be held, but sanctions or conditions against the practitioner may still be imposed by the regulator. Where a practitioner chooses to dispute a complaint and corresponding allegations, an FtP hearing will be scheduled, with the regulator instructing a panel (routinely made up of three individuals) to hear and rule on the applicable case. Occasionally, to clarify any supplemental issues of dispute or ambiguity, a preliminary hearing might be held ahead of the principal hearing.

Resembling judicial traditions, FtP hearings afford regulators (the official complainant) and practitioners (the accused respondent/registrant)—often with the aid of legal representation—the opportunity to present their versions of events and arguments to the regulator’s appointed FtP panel. Having heard both parties and, if required, asked its own questions, the FtP panel makes findings on whether the regulator’s case of alleged wrongdoing against the practitioner has been established and, if so, how serious the wrongdoing is deemed to have been. If a panel finds in favour of the regulator’s case, the panel might ask the regulator to submit recommendations regarding sanctioning the practitioner; the practitioner will also be given the opportunity to respond to the regulator’s sanctioning recommendations. To conserve public protection obligations, regulators will also pursue practitioners who choose not to engage in FtP procedures or have discontinued their membership with their regulatory organisation. In these cases, FtP hearings are held without a practitioner being present or represented, with judgements formed and published in their absence. Importantly, statutory regulators are required to give practitioners the automatic right to seek permission from the High Court to lodge an appeal against any adverse rulings, and the High Court has the power to dismiss an appeal request, overturn a panel’s decision, or recommend a reconsideration of the case.

With legislation promoting a legalistic approach to investigating and pursuing practitioners, it is of *harmful* significance that FtP matters can persist for years and at great financial costs. The 2022 upturned case of a doctor, censured over a request for a laptop,³⁰ took 15 months, with the legal and tribunal costs for the GMC being in excess of £40,000 [Freedom of Information Request]; these figures do not include the costs incurred by the salaried staff of the GMC who produced and brought the case, nor the legal costs incurred by the doctor. This particular case is an especially disconcerting indictment on regulatory practices in the UK, highlighting the hostile and profligate lengths a regulator will go when fulfilling its FtP duties.

Regulator Digressions from Legal Principles

Although the FtP procedures operated by healthcare regulators appear to observe conventional legal processes, there are, in fact, significant deviations. These departures from established legal traditions are contributory factors that lead to the alarming and traumatising consequences many practitioners suffer when facing accusations of wrongdoing.

In civil and criminal hearings in the UK, cases are heard and determined by judges and juries that are not affiliated with the disputing parties. FtP hearings, on the other hand, are heard and determined by panels that are selected, prepared, and employed by the same regulatory body that produces the allegations they are instructed to preside over. This liaison between the complaining parties (i.e., the regulators) and those that determine FtP hearings’ outcomes highlights how cases are dispensed in a manner that do not faithfully observe the *principles of natural justice* which are central to all judicial proceedings in the UK. An employment tribunal, for instance—a civil case, which is managed by His Majesty’s Courts and Tribunal Service—is usually heard by a judge and two wing members who are all entirely unconnected to the parties in dispute; they play

³⁰ Medical Practitioners Tribunal Service (2022). ‘Record of Determinations. Public Record’. [link to this article](#).

no role in initiating or generating a claimant's (complainer) or respondent's (defendant) case. Likewise, in criminal matters, cases are determined by independent magistrates, judges and juries who have no known association with the claimants or defendants. This fundamental condition of objectivity and impartiality grants the various contentious parties a greater prospect of being heard fairly and ensures that the outcomes of the disputes are determined by individuals who are appropriately independent.

In stark contrast to civil and criminal cases, healthcare regulators seek to determine practitioner wrongdoing by employing their own panels to make findings on the cases and allegations they themselves have generated. Regulators, such as, the General Osteopathic Council (GOsC) or the NMC, including some quasi-regulators that hold FtP hearings, directly employ and instruct a selection of individuals (panel members) to hear and determine their FtP cases. In GMC hearings, the GMC presents its case against a doctor before its Medical Practitioners Tribunal Service (MPTS), which "is a statutory committee of the GMC and is accountable to the GMC".³¹ Similarly, the HCPC builds cases against its practitioners and presents those cases before its Health and Care Professions Tribunal Service (HCPTS) unit, which "is the fitness-to-practise adjudication service of the Health and Care Professions Council".³² Under these conditions, the principle of impartiality, a basic component of judicial remedying, is effectively suspended when bringing and hearing cases against healthcare practitioners.

This formula, in which healthcare regulators and their FtP panels are concomitant, creates a predisposed alliance that produces a situation whereby any allegations brought against a practitioner cannot be evaluated with the same degree of impartiality and fairness as is mandatorily afforded cases presented in front of a criminal or civil court. For this reason, in circumstances that have legally significant consequences, where an association exists between the complaining party (i.e., a regulator) and the judges (i.e., a regulator's FtP panel), it is misleading and improper to claim—to both the public and to health practitioners—"that hearings are conducted and managed by independent Panels."³² To all intents and purposes, practitioners who are required to attend FtP hearings are essentially forced to forgo the established legal tenet of an individual's *right to a fair hearing*; allegations against practitioners are effectively determined by people the *allegers* (i.e., the regulators) have employed. Therefore, with regulatory bodies using their own *personnel* to hear and determine their own cases against their practitioner-members, healthcare FtP procedures diverge radically from reputable legal principles, and typify a draconian and biased system that ensures practitioners are marginalised and more easily discredited. The only point at which a practitioner accused of wrongdoing can seek intervention from a legitimately independent party is if they lodge an appeal with the High Court challenging a decision or sanction they have received. Although only available to statutorily regulated practitioners, the High Court offers a distinguishable measure of impartiality not otherwise available in FtP cases. Under these circumstances, the High Court can consider an FtP panel's findings against a practitioner and determine whether it has erred in forming its ruling.

However, further weakening the integrity and fairness of FtP undertakings, the PSA's quasi-regulators have an even greater latitude when administering their FtP procedures. Not being bound by constitutional directives—and in addition to selecting their own FtP

³¹ Medical Practitioners Tribunal Service (2021) 'Our role'. February 2021. [link to this article](#).

³² Health and Care Professions Tribunal Service (2022). 'Role of the Tribunal Service'. September 2022. [link to this article](#).

panel members—they can effectively decide for themselves, by appointing their own associates, if a practitioner can appeal an adverse judgement. Akin to a kangaroo court, which is an “unofficial court set up by a group of people . . . to deal with a disagreement or with a member of the group who is considered to have broken the rules”,³³ quasi-regulators are free to assert and implement their own FtP prerogatives. While their procedures and judgements do not have a legal impact upon a practitioner’s right to continue practising, the fact that a quasi-regulator can act unilaterally, i.e., effectively deciding for itself if a practitioner can appeal a judgement, betrays the PSA’s principles of good regulation.¹⁸ This unfair paradigm, which the PSA and the regulatory establishment ostensibly defends, maintains the considerable obscurity and mistrust that surrounds healthcare regulation and reinforces a scepticism about the efficacy of FtP methods.

Bias within Fitness-to-Practise Hearings

In addition to regulators utilising their own panels to hear their FtP cases, the composition of those panels highlights another layer of irregularity concerning bias. Unlike judges and juries in normal judicial proceedings, the hearing panels instructed to determine regulators’ FtP cases do not stand independently from the influences of the regulator that has instructed and employed them. For instance, the HCPC’s Tribunal Service—which hears cases against HCPC registered practitioners—stated that its Tribunal Advisory Committee “reports directly” to the HCPC, advising it “on the recruitment, training and assessment of Tribunal panellists, panel chairs and legal assessors”.³⁴ While this recruitment and training connection does not necessarily attest to collusion existing between the HCPC’s complainant and prosecuting branch and the HCPC’s hearing panels (the HCPTS), it does identify a close and questionable link between the *prosecuting* regulator and the FtP *judging* panels. As highlighted, collaborative dynamics such as these expose impartiality shortcomings, and fuel a potential for unfavourable determinations to be made against practitioners. Individuals who are employed and trained by a regulator to make judgements on that regulator’s cases can never be incontrovertibly impartial.

Although the link between regulators and their FtP panels is standard within healthcare, it appears to counter clear governmental recommendations, which state:

The independence and impartiality of those who pass judgement on health professionals in fitness to practise proceedings is central to public and professional confidence in their findings and the sanctions that they impose. In the future, there must be no room for doubt that adjudication panels are compromised by partiality to the profession over which they pass judgement or that they are swayed by hostile media scrutiny.³⁵

Is it, therefore, the regulators who have acted solitarily and produced frameworks which positions FtP panels more in their favour, or is it a failing of the Government to promote or devise protocols that unambiguously enforce FtP panels’ impartiality?

³³ Cambridge Dictionary (2023). ‘Kangaroo court’. Cambridge University Press. [link to this article](#).

³⁴ Health and Care Professions Tribunal Service (2021). ‘The Tribunal Advisory Committee’. February 2021. [link to this article](#).

³⁵ Secretary of State for Health (2007). ‘Trust, assurance and safety—The regulation of health professionals in the 21st century’. [link to this article](#).

This jaundiced approach to administering FtP cases places regulators, and any organisations that observe similar procedures, in the position of being both the complainant and the judge. Determining practitioner wrongdoing, whereby regulatory bodies prepare, pay, and instruct their own panels to make findings on their own cases, self-evidently risks partiality and raises the prospect of bias interfering with outcomes. Theories explicating cognitive biases, which are recognised psychological factors known to impact how decision-makers consider issues and form resultant opinions or verdicts, accent the likelihood of prejudice occurring when healthcare regulators commission their own panels to hear their cases. FtP panels that are employed and trained by a regulator will naturally have their views influenced and shaped beyond that of any case material the regulator or practitioner may present to them in hearings. In 2015, the quasi-regulator, UK Council for Psychotherapy, published a statement from the Chair of their Professional Conduct Committee claiming that its complaints team spends much of its time dealing with “members using any legal argument they can to attempt to circumvent UKCP investigating the allegations.”³⁶ This statement, which implies that legal process is exploited by practitioners with the intention of “avoiding a difficulty or a rule”,³⁷ exposes significant bias towards practitioners, and an hypocrisy when mindful of the fact that the copious number of allegations commonly listed against practitioners are generated by professional regulatory complaints teams and their lawyers.

A cynical mentality held by a head of a regulatory body’s complaints committee, that clearly conveys a poor view of practitioners, potentiates a *confirmation bias*,³⁸ which would assert that FtP panels will be inclined to make findings that would favour the hostile views and allegations of their regulator employers. Although appropriate investigatory processes and sound triaging of complaints would likely result in adverse findings against practitioners who have transgressed, the propensity for bias within FtP hearings is borne out by 2019–2020 statistics, which report, for example, that in only 1% of cases heard by NMC FtP panels were facts against nurses found to be unproven,³⁹ 81% of GMC [Freedom of Information Request] cases resulted in sanctions or warnings, and only 8% of FtP cases heard by the General Optical Council (GOC) [Freedom of Information Request] were dismissed. Contrasting these figures with the criminal justice system—which utilises independent magistrates and juries to make determinations—statistics for 2020–2021 showed conviction rates of 70% for magistrate hearings and 60% for jury hearings.⁴⁰ It is difficult to imagine any regulatory organisation—which engages adversarially with matters of alleged practitioner wrongdoing—being able to avoid imparting its own predispositions upon the individuals it selects and trains to preside over its FtP cases. With there being this inherent conflict of interest, it is highly implausible that any panel member could *hear* a case, that is presented adversarially against a practitioner, from a position that reliably regards the practitioner to be innocent until proven otherwise.

Making it easier for adverse findings to be determined, it is worth highlighting that the *civil standard of proof* employed in mainstream civil cases, which requires determinations to be based on the probability that fault had occurred rather than not, is also utilised within healthcare regulator FtP cases. With the *criminal standard of proof* (which regulators like

³⁶ *The Psychotherapist* (2015). ‘Professional Conduct Committee: An update’, Issue 61: 35.

³⁷ *Oxford Learners Dictionaries* (2021). ‘Circumvent’. Oxford University Press. [link to this article](#).

³⁸ Nickerson, R.S. (1998). ‘Confirmation bias: A ubiquitous phenomenon in many guises’, *Review of General Psychology* 2(2).

³⁹ Nursing and Midwifery Council (2020) ‘Annual Fitness to Practise Report 2019–2020’. [link to this article](#).

⁴⁰ Crown Prosecution Service (2022). ‘Annual Report and Accounts 2020–2021’. [link to this article](#).

the GMC and NMC once exercised) requiring determinations of wrongdoing to be based on a “beyond reasonable doubt” threshold, the civil standard was introduced to make bringing cases against practitioners fundamentally more appealing. In support of this, the UK’s Secretary of State for Health stated, “The perception that it is not worth taking action due to difficulties in proving allegations to the required standard of proof potentially weakens public confidence in health regulators and threatens public health and safety.”³⁵ Naturally, the impact of adopting the civil standard means that a regulator’s FtP panel need only to be persuaded—by the regulator’s litigators—that wrongdoing *probably* happened for adverse rulings to be made against practitioners. This judicial mechanism used within FtP matters points to an intrinsic malignancy within UK healthcare regulation, and seems somewhat disproportionate when considering it has far-reaching consequences and the potential to end a practitioner’s ability to earn a living or continue their career.

Besides conflicts of interest and regulator-imparted cognitive biases, the appointing of FtP panels also reveal features of *actual* or *apparent* judicial bias. These legal concepts specifically emphasise that judicial failings occur when “a judge is a party to the litigation or has a financial or other interest in the outcome of the litigation” or “there is something in the judge’s conduct or behaviour, their interests, affiliations or their allegiances, that gives rise to a suspicion that they have not decided the case in an impartial manner”⁴¹ Accordingly, with there being an unassailable affiliation between healthcare regulators and their FtP panels, which risks engendering collusion and prejudice, the vitally important assumption that a practitioner should be presumed innocent until proven guilty is jeopardised. There is a considerable likelihood for panel members who are prepared by the complaining party (the regulator) to view, from the outset, the accused practitioner as being at fault. Hence, while it is claimed that the burden of proof lies with the regulator,⁴² due to propensities for bias, it is the accused practitioner who, in actuality, has the overwhelming task of having to convince a regulator’s FtP panel that the regulator’s allegations are inaccurate or false.

In comparison to how civil and criminal cases are administered and impartially heard, the evidence of partisanship within regulator FtP hearings is considerable. The current approach used by regulators to establish fault and censure practitioners is beset with conflicts of interest that pollute legal customs needed to fairly address claims of practitioner wrongdoing. With partiality and features of bias being distinct components of how regulatory bodies pursue practitioners, the resolute and long-established tenet, “the mere appearance of bias is sufficient to overturn a judicial decision”,⁴³ draws stark attention to how regulators disregard judicial probity and subvert the legal rights of practitioners facing FtP procedures.

Procedural Hostility

In addition to the professional alienation a practitioner can suffer when being investigated by a regulator, the degradation practitioners experience as a result of regulatory bodies being permitted to act without restraint is demonstrated by the extensive number of collaborators regulators utilise to assist them in their efforts to substantiate the allegations they bring against practitioners. Once a regulator has decided to pursue a practitioner for claims of wrongdoing, the targeted practitioner is subjected to the collective hostilities of:

⁴¹ Enyo Law (2019). ‘Without prejudice? Judicial bias and unfair conduct’. [link to this article](#).

⁴² Health and Care Professions Tribunal Service (2021). ‘Giving evidence’. February 2021. [link to this article](#).

⁴³ R v Sussex Justices, ex parte McCarthy, 1924. 1 KB 256, 259 (‘R v Sussex Justices’).

(1) the complainer and their associates (e.g., family members or professional colleagues); (2) the regulator's case manager, complaints team, and Registrar; (3) the regulator's legal representation (e.g., paralegals, solicitors, and barristers); (4) the regulator's witnesses; and (5) the regulator's nominated FtP hearing panel. These groups are consolidated for the singular purpose of helping the regulator expose the alleged failings of the accused practitioner and secure an adverse judgement.

Obtaining evidence to determine if a contravention occurred is absolutely necessary. However, the structured system operated by healthcare regulators—which functions adversarially and sees regulators unite numerous parties hostile to the practitioner—epitomises bullying, which has been defined as “an imbalance of power which is used to either defame, harass, intimidate or upset another person”.⁴⁴ With bullying and intimidation being found to increase anxiety, depression, burn-out, and suicide in health professionals,⁴⁵ the current FtP procedures implemented by healthcare regulators, which obligate practitioners to participate in overtly hostile and partisan hearings, routinely places practitioners directly in harm's way. Added to the stress and harm caused by exposure to numerous condemnatory groups, practitioners who have to contend with such hostile regulator practices are likely to become distressed and defensive, and less likely to be able to respond in an appropriately reflective or collaborative way. Research has found that harsh and unsympathetic criticism significantly deteriorates the way in which a recipient responds to the antagonist and the particular issue in question.^{46,47}

As well as the various parties utilised to achieve adverse outcomes for practitioners accused of wrongdoing, regulators have also adopted the judicial practice of adversarial litigation which is standard in UK civil and criminal cases. This form of litigation is a ruthless accusatorial practice that effectively allows for callous rhetoric to be used to smear and discredit an opposing side's case, sometimes with devastating outcomes; suicides have been attributed to how court witnesses have been treated on the stand by litigating lawyers.^{48,49} While adversarial litigation is common practice within the UK's legal system, it is executed with equal vigour within healthcare FtP domains; aside from regulator tribunal panels not being entirely separate from the regulator, both regulator (prosecuting) and practitioner (defending) parties are free to engage adversarially to argue their respective cases. A 2019 GMC case demonstrated the level of maliciousness that can occur within FtP hearings, where exchanges saw witnesses being called “serial liar”, “doper”, and “spineless”,⁵⁰ and included a lawyer being accused of bullying.⁵¹ A regulatory

⁴⁴ BBC (2015). ‘The definition of bullying’. April 2015. [link to this article](#).

⁴⁵ Hernandez, R. et al. (2018). ‘The intimidation factor: Workplace intimidation and its effects on wellness, morale, and patient care’, *Academic Pediatrics* 18(5).

⁴⁶ Baron, R.A. (1998). ‘Negative effects of destructive criticism: Impact on conflict, self-efficacy, and task performance’, *Journal of Applied Psychology* 73(2).

⁴⁷ Raver, J.L. et al. (2012). ‘Destructive criticism revisited: Appraisals, task outcomes, and the moderating role of competitiveness’, *Applied Psychology* 61(2).

⁴⁸ Scott, K. (2002). ‘She couldn't take it anymore’. *The Guardian*, 2 August 2002.

⁴⁹ Pidd, H., Ibbotson, P., & Batty, D. (2013). ‘Sexual abuse victim's suicide sparks call for review of court procedures’. *The Guardian*, 9 February 2013.

⁵⁰ Cary, T. (2019). ‘Shane Sutton branded “a serial liar” and “a doper, with a doping history” at Richard Freeman tribunal’. 12 November 2019. [link to this article](#).

⁵¹ *Cycling News* (2019). ‘Freeman absent from medical tribunal after ‘upsetting’ media reports’. 9 December 2019. [link to this article](#).

system that facilitates such behaviour raises questions as to its capacity for protecting the public and the professions of healthcare.

Exposing a culture of perniciousness within the regulatory establishment, the treatment of practitioners who face grievances is straightforwardly correlated with numerous cases of practitioner ill health and suicide.^{1,3,4,23,25–29} While it is vital that practitioner complaint matters and transgressions are properly addressed, the approaches used by regulators to fulfil this remit portray regulatory bodies as persecutory and unreasonable administrators. In a detailed account by a GP of a 10-month GMC investigation that led to no action, the doctor highlighted how the conduct of the regulator had a “dehumanising effect”, and cited experiencing “episodes of palpitations, migraines” and hair loss.⁵² Evidently, the hostility and anxiety regulators exert when pursuing practitioners places practitioners at significant psychiatric risk and, as such, can only weaken their capacity to respond in a robust and competent manner when required to defend themselves in front of a regulator’s FtP panel. With hostility playing such a central role in how healthcare regulators choose to investigate and determine practitioner errors and faults, the PSA’s assurances of *right-touch*⁵³ and *good regulation*¹⁸ lose significant credibility.

Systemic Subjugation

The original purpose of regulation was to standardise physician qualifications and to discourage harmful medical practices, such as, surgeons—in the 1800s—acting recklessly by demonstrating how quickly one could amputate a patient’s leg.⁵⁴ More recently, the notorious case of Dr Harold Shipman, found guilty of murdering 15 patients—and suspected of many more killings—punctuated severe regulator-oversight failings. This case led to the UK Government becoming more active in healthcare regulation, publishing White Papers, such as, “Trust, Assurance and Safety—The Regulation of Health Professionals in the 21st Century”, in 2007, which sought to set “out a programme of reform to the United Kingdom’s system for regulation of health professionals.”³⁵ Healthcare legislation has since evolved in a manner that explicitly aims to assure the public that maximum efforts will be made to protect society against bad practitioners and unsatisfactory practices. Subsequently, a consequence of the Government’s contributions prompted regulators to become more obsessive and aggressive in their pursuance of practitioners who are alleged to have faulted.

Underpinned by the premise of self-regulation, there is a perversity about a system that compels and, in many cases, legally requires individuals to register with and pay subscriptions to organisations that function in deliberately hostile ways, and which have been inculpated in the deaths of individuals they have sought to censure. This extraordinary convention is made all the more objectionable when it has been observed, for example, that most of the GMC staff working in its FtP division had “never worked in the health industry before joining the GMC and therefore have a limited knowledge or understanding of the day-to-day realities of frontline clinical practice”.²⁹ Importantly, although uncompromising and hostile approaches to engaging with FtP issues have not

⁵² *GP Online* (2019). ‘How I survived a bewildering 10-month investigation by the GMC’. 20 September 2019. [link to this article](#).

⁵³ Professional Standards Authority (2021). ‘Right-touch regulation’. [link to this article](#).

⁵⁴ Ann, R. (2012). ‘Saints and sinners—Robert Liston’. *The Royal College of Surgeons of England: Bulletin* 94: 64–65. [link to this article](#).

been discouraged by the UK Government, neither has legislation been introduced that either releases regulators' *duties of care* towards practitioners or dictates FtP procedures which evidently cause practitioners to develop serious medical and psychiatric conditions. Undoubtedly, this questionable upshot of reform has emerged through panic and an ill-advised relationship between the regulatory establishment and political initiatives.

The problematic relationship between legislative mandates and regulatory practice—resulting in FtP procedures that cause undue harm and distress—has fused together to guarantee any leniency towards practitioners is decisively quashed. In addition to the various unified parties that are brought together by regulators to aid in their securing of practitioner *convictions*, there is also an overseeing judicious component which brings an extra layer of accusation and condemnation. This additional category of admonishment arises when FtP panels are deemed to have failed in ratifying allegations against a practitioner or are thought to have been too lenient in their levying of sanctions. To prevent such situations, the PSA has been given the task of assessing judgements and sanctions imposed by the 10 statutory regulators upon their practitioner members. If it believes an FtP panel has wrongly found in favour of a practitioner or been unduly lenient, it will appeal to the High Court to have the particular case against the practitioner redetermined, or apply for the practitioner to be more harshly disciplined. Curiously, the PSA indicated in a 2017 FtP reform report that they would like to see a less confrontational approach to healthcare regulation, stating, “We argued in *Regulation rethought* that fitness to practise ought to move to a less adversarial framework focused on remediation and local resolution.”⁵⁵ However, as revealed by the cases they submit to the High Court,⁵⁶ this outwardly sensible intention does not correlate with their ongoing adversarial efforts to seek severer sanctions against practitioners. Relevantly, reinforcing the perception that healthcare regulation is excessively punitive, the GMC—in addition to any additional legal challenges to FtP cases the PSA might seek to exercise—has itself also been granted the constitutional right to appeal to the High Court when it disagrees with decisions its own tribunal panels have made.^{57,58} Irrespective of their rationale or pertinence, these extra tiers of adjudication are further evidence of a system that is vehemently determined to ensuring practitioner wrongdoing is established and that the heaviest sanctions are issued.

The uncompromising efforts by healthcare regulators to subjugate practitioners alleged to have transgressed, not only illustrate the imperious and unsympathetic attitude the regulatory establishment holds towards healthcare professionals, but exemplify a culture of victimisation and exhibit a misappropriation of obligations and power. Although legislation influences what functions a regulator is required to perform, it is revealing to note that the PSA does not seek to challenge findings or sanctions imposed upon practitioners that have been considered excessive or unreasonable. While this custom points to a regulatory system that neglects consideration of its healthcare workers, the fact that the PSA states, “We do not investigate individuals' complaints about regulators or registers and cannot resolve them for you”,⁵⁹ exposes a disturbing sense of complicity

⁵⁵ Professional Standards Authority (2017). ‘Right-touch reform—A new framework for assurance of professions’. November 2017. [link to this article](#).

⁵⁶ Professional Standards Authority (2023). ‘Cases appealed’. [link to this article](#).

⁵⁷ Medical Practitioners Tribunal Service (2023). ‘Appeals’. [link to this article](#).

⁵⁸ Dyer, C. (2022). ‘GMC’s appeal for GP trainee to be struck off dismissed by High Court’. *British Medical Journal* 378:o1628. [link to this article](#).

⁵⁹ Professional Standards Authority, (2023). ‘Share your experience’. [link to this article](#).

with regulators. This sweeping negation of inspective responsibility by the PSA adds to the view that healthcare regulation is anti-practitioner and inherently skewed in favour of regulator authoritarianism. With the PSA not obligated to investigate complaints about its regulatory organisations, individuals who have suffered regulator faults or irregularities have little recourse other than to initiate arduous and costly legal proceedings or attempt seeking a Parliamentary intervention, i.e., a hugely expensive and time-consuming judicial review. In effect, without a separate body that has the specific remit and authority to investigate complaints about regulator conduct, healthcare regulation can remain, for the most part, free to carry out activities that have been causally linked to practitioner harm and suicide. This one-sided bureaucratic structure starkly conveys a double standard within healthcare oversight and bears the unacceptable sign of autocracy.

Discrediting

In FtP cases claims of wrongdoing against practitioners are vociferously developed by regulator complaints and legal teams, and typically yield exhaustive lists of allegations. Promoted as a means by which to protect the public, the message that is explicitly communicated to all is that the regulator has decided that their practitioner-member is at fault and will, therefore, vigorously embark upon a course of action that intends to ensure the practitioner is thoroughly admonished. This was recently substantiated in the 15-month investigation concerning the doctor who had requested a laptop from her company's IT department. The specific area of contention related to her claiming she had been "promised" a laptop for her locum medical work. Although the GMC's FtP panel (MPTS) recorded that "it could not properly determine" whether the doctor had been dishonest in her request for a laptop, they nonetheless agreed with the GMC's position that the doctor had been dishonest. Also, the panel stated that the doctor was "a competent clinician, and there is no need to protect the public",³⁰ but nonetheless determined that she should be suspended. The panel went on to state that their sanction "would send an appropriate message to the medical profession and the wider public"⁶⁰ about the gravity of the doctor's misconduct. The sanction and exceptional display of punitiveness, however, was met with widespread condemnation of the GMC and its FtP panel. The British Medical Association, for instance, published a press release stating, "This ruling reinforces the BMA's view that there needs to be a comprehensive root and branch independent evaluation of the GMC's fitness-to-practise decision-making procedures starting from the referral process itself—something we have called for repeatedly."²¹ Subsequently, the GMC—which had generated and pursued the case and its sanctions—attempted to distance itself from its tribunal panel's ruling, stating "we believe that the dishonesty test was applied incorrectly by the tribunal".⁶⁰

The vigour given to subjugating practitioners was similarly illustrated in a 2019 FtP case concerning a physiotherapist who failed to store patient records appropriately.⁶¹ Demonstrating the efforts taken to scandalise the practitioner, the HCPC's FtP panel, the HCPTS, determined and published, "that the only appropriate and proportionate response to protect the public and the wider public interest in these circumstances is to make a 12 month suspension order." Endorsing the HCPC's assertions, the panel stated that the

⁶⁰ Tilley, C. (2022). 'GMC overturns suspension of GP after "incorrectly applied" dishonesty test'. *Pulse Today*, 22 June 2022. [link to this article](#).

⁶¹ Health and Care Professions Tribunal Service (2019). 'Hearings and Decisions', HCPC v Stokes. 18 December 2019.

“Registrant’s insight is limited and that she has not remediated her failings”. It went onto smear the practitioner by cataloguing her errors, and reporting that she had, “not engaged in a meaningful manner with the regulatory procedures”, “failed to keep her governance training up to date”, showed “no evidence of any action . . . to remediate her misconduct”, and “there was no evidence to suggest she had undertaken any courses to update her IT skills”. Although the panel conceded that the physiotherapist “understood these were serious breaches of confidentiality”, they revealed their proclivity towards the regulator by choosing to specifically highlight one of the regulator’s witness’s opinions who had claimed that the practitioner had “not fully acknowledged the gravity of the situation”. Furthermore, the fact that the panel acknowledged “there was no evidence of patient harm and that the registrant uploaded the results of her visits properly onto the system”, and recognised the practitioner was “a good physiotherapist”, “well liked and respected by colleagues and service users”, and “dedicated to meeting the needs of her patients”, it did not prevent them from branding her as a risk to the public and ordering her to discontinue working. This case, which centred around filing-management failings, captures the excessive, punitive, and derisive approach regulators and their tribunal panels adopt when seeking to censure health professionals. In this particular case, it is difficult to see how the HCPC’s 12-month removal of “a good physiotherapist” from the health service, was proportionate or protected—rather than harmed—the public; would constructive sanctions, such as, clerical management courses, not have been more advantageous to all parties?

A highly publicised case in 2019 showed the collusive dynamics that existed between a regulator’s litigating officers and its FtP panel; the case involved a doctor accused of ordering prohibited medication for competition athletes. Although the doctor had already conceded 18 of the 22 allegations that had been listed against him, the GMC evidently felt that one of its remaining allegations was not comprehensive enough. Consequently, after approximately two years of building their case, the GMC made a request to its MPTS panel—at the start of the hearing—to have an allegation against the doctor changed from reading, “Your motive for placing the order was to obtain Testogel to administer to an athlete to improve their athletic performance”, to “You placed the order and obtained the Testogel (a) when you knew it was not clinically indicated for the non-athlete member of staff, and (b) knowing or believing it was to be administered to an athlete to improve their athletic performance.”⁶² This changing of the allegations at the commencement of the hearing, which the GMC’s MPTS panel agreed to, not only demonstrates the cooperative relationship that exists between regulators and their panels, but shows the lengths a regulator will go to discredit a practitioner.

With the disparagement of practitioners being an inherent element of present-day FtP cases, procedural customs also guarantee that a long-term disgracing of practitioners is achieved. In addition to the negative portrayal of practitioners in actual FtP hearings, which are usually open to the public, regulators ensure that the details of the cases they have won are published, sometimes for years, and retained in records indefinitely. This prolonged element of practitioner shaming is influenced by the principle of *open justice* and driven by the premise that it is in the public’s interest to broadcast and preserve the failings of reprimanded practitioners. Yet, regardless of whether a practitioner is actually found to be at fault or not, the adversarial viscidness used in FtP hearings to smear and denigrate practitioners—such as labelling them as negligent, dishonest,

⁶² Fletcher, P. (2019). ‘Blow for Freeman as GMC secures change to key Testogel allegation’. 7 November 2019. [link to this article](#).

lacking insight, unreliable, impaired, or a risk to the public, etc.—mars and disadvantages practitioners ubiquitously. Research has found that the repercussions of complaints and allegations lodged against practitioners cause significant harm, not only to their physical and psychological wellbeing, but to their careers and professional reputations also.²⁶ The professional obligation to continually report such matters to insurers, employers, or membership organisations, for instance, elongates the distress and shame practitioners can suffer.

Adding to the ruinous effect of current FtP conventions, the cynical stance regulators take towards their practitioner members is typified by the HCPC, which stores, for 20 years, lodged practitioner complaints that do *not* meet the threshold test to pursue an investigation, and retains FtP material permanently even when its case against a practitioner has not succeeded.⁶³ Similarly, although it is common practice to publish cases of *erased* practitioners for a period of five years, the GDC, for example, continues to publish FtP cases of dental practitioners they have “suspended indefinitely” dating back to 2010.⁶⁴ As these administrative practices show, it is a reality that, within the healthcare sector, complaints against practitioners, and any ensuing FtP matters, are never fully concluded or “spent”.

The interminable discrediting of practitioners by the regulatory establishment has a particular relevance in today’s climate. The FtP procedures carried out by present-day regulators demonstrate remarkable similarities to the contemporary notion of *cancel culture*, which has been defined as, “a way of behaving in a society or group, especially on social media, in which it is common to completely reject and stop supporting someone because they have said or done something that offends you.”⁶⁵ Due to developments in mass media and content retrieval, the sully of practitioners by their regulatory bodies now has an opened-ended consequence. The public vilification of practitioners in FtP hearings naturally makes for macabre and enthralling theatre and attracts various sections of the media. With privacy being a casualty of the internet age, the smearing of practitioners by regulators is amplified and protracted by press and social media publications, which adds to the trauma and humiliation practitioners suffer when encountering and dealing with claims of wrongdoing. The various activities by which the regulatory establishment seeks to propagandise contempt for practitioners greatly compounds the often distressing and challenging circumstances health professionals can regularly be required to work in. As noted by the NHS Confederation, the numbers of staff considering leaving the workforce has risen by 30% since 2021 and there is “a noticeable drop in the number of staff recommending the NHS as a place to work.”⁶⁶ In view of this, an uninhibited discrediting culture within practitioner regulation can only further disincentivise those aspiring to work in healthcare.

Humiliation and Psychiatric Illness

As reports and studies attest, practitioners pursued for claims of wrongdoing are destabilised by the concerted and hostile efforts of regulatory complaints procedures. The methods used by regulators, which merge accusatorial vernacular with the animosity of

⁶³ Health and Care Professions Council (2019). ‘Record retention and disposal policy’. [link to this article](#).

⁶⁴ General Dental Council (2023). ‘Upcoming hearings and previous decisions’. [link to this article](#).

⁶⁵ *Cambridge Dictionary* (2023). ‘Cancel culture’. Cambridge University Press. [link to this article](#).

⁶⁶ NHS Confederation (2022). ‘Fall in staff morale a real cause for concern’. [link to this article](#).

several hostile parties, has the effect of consolidating the disparagement, emasculation, and ostracising of practitioners. Under the guise of due process, the adversarial approaches employed by regulators force accused practitioners to endure criticisms which are then circulated. This programme by which regulators seek to fulfil FtP initiatives shares parallels with smear tactics that are defined and characterised as the spreading of suspicion, disseminating hyperbole, and embellishing details for the purpose of damaging another's credibility. Causing shame and humiliation can provoke in individuals profound feelings of marginalisation and rejection which can substantially elevate levels of emotional and psychological distress that can lead to suicide.⁶⁷ In 2014, as a result of a GMC investigation, during which a 71-year-old doctor took his life, the coroner wrote, "I am concerned that clinicians who are subject to such investigative processes are suffering adverse psychological effects which may be unrecognised and unsupported."⁶⁸ Accordingly, the devastating effect shame and humiliation can have on practitioners who are required to attend public and judicial settings, where they face numerous parties that have been purposefully brought together to openly condemn them, undoubtedly worsens their levels of stress and exhaustion, which are already weakened by regulator investigatory processes, and raises the risk of significant psychological distress and suicidal ideation. As revealed in many reports,^{1,3,4,23,25–29,52,68} the FtP undertakings of UK healthcare regulators have caused practitioners to develop serious psychiatric illnesses, with fatal outcomes in some instances.

While the regulatory establishment enjoys legislative protections, the overtly hostile procedures used by regulators situate them disconcertingly close to unlawful behaviour, whereby "a person is guilty of an offence if, with intent to cause a person harassment, alarm or distress, he uses threatening, abusive or insulting words or behaviour, or disorderly behaviour, thereby causing that or another person harassment, alarm or distress".⁶⁹ In the aforementioned coroner's report, it stated, in remarks directed to regulators, that "Consideration should be given to the language and tone of written communication . . . and the assessment and identification of suicidal or other self harming behaviour by the relevant body".⁶⁸ It is certainly a criticism of the regulatory establishment that healthcare regulators, who have been repeatedly challenged about their FtP activities, show no regard for the fact that their conduct can be aligned with lawfully prohibited activities. Moreover, the Corporate Manslaughter and Corporate Homicide Act 2007 recognises an organisation is "guilty of an offence if the way in which its activities are managed or organised—(a) causes a person's death, and (b) amounts to a gross breach of relevant duty of care owed by the organisation to the deceased."⁷⁰ Although suggestions of manslaughter might appear far-fetched, being vociferous and proactive participants in the undermining of practitioners who face accusations of wrongdoing, and subsequently take their lives, places healthcare regulators ominously close to such indictments. Comparisons with coercive control, which has been defined as, "an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse

⁶⁷ *Times of India* (2012). 'Royal hoax call nurse's brother says she died of shame'. [link to this article](#).

⁶⁸ Wilcox, F. (2014). 'Regulation 28: Report to prevent further deaths'. Courts and Tribunals Judiciary. [link to this article](#).

⁶⁹ Criminal Justice and Public Order Act 1994, section 154. [link to this article](#).

⁷⁰ Crown Prosecution Service (2018). 'Corporate manslaughter', [link to this article](#).

that is used to harm, punish, or frighten their victim”,^{71,72} are not indistinguishable. Irrespective of culpability, constraining practitioners to belong to organisations that have been implicated in the deaths of practitioners is arguably a failing of governmental oversight and administration.

Although the public denouncing of practitioners has become an acceptable standard within FtP matters, ethical and judicial concerns arise when compelling individuals—who have been debilitated by the intimidatory and adversarial methods of their regulator—to attend FtP hearings made up of affiliated parties overtly hostile to the practitioner. Under such conditions, being required to enter a tribunal environment having been made psychiatrically vulnerable raises significant ethical questions.

Conclusion

Every industry can suffer instances of criminal and malevolent activity from its members. Yet, in contrast to how FtP matters are addressed within healthcare, judicial principles safeguard the rights of individuals accused of civil or criminal offences better than of health practitioners accused of misconduct. The procedures of today’s healthcare regulators, which markedly depart from precepts underpinning judicial fairness and have led to the deaths of practitioners, neglect morality and abandon core legal values. Any bureaucratic process that has evolved in such a way that it can reduce an individual to taking their own life exposes a catastrophic fragmenting of probity. Being authorised by Parliament to investigate and discipline practitioners should not exempt healthcare regulators from acting morally. Defending upstanding intentions—i.e., protecting the public—by employing obdurate tactics, which ensure the inordinate stigmatising of practitioners, negates principles that underpin human rights, such as, dignity, fairness, equality, and respect.⁷³ Ultimately, regulatory organisations that observe investigative systems and disciplinary procedures that have the capability of causing health professionals psychiatric illnesses and suicide harm the healthcare industry and society as a whole.

While investigating complaints and concerns is an essential responsibility and necessity, it is debateable, however, if the methods presently used by regulators suitably safeguard the wellbeing of the public or the various branches of healthcare. The current practices adopted by regulators in FtP disputes reveal unfair processes and excessive punitiveness. With stress-related illnesses amongst the healthcare workforce ever-increasing,^{66,74–79} ensuring practitioners are treated reasonably and fairly when infringements are alleged to have occurred is especially important. The prevailing adversarial and partisan customs applied by healthcare regulators in FtP matters—which have had the capacity to render individuals suicidal—show a lack of prudence and

⁷¹ Graham-Kevan, N., Powney, D., & Mankind Initiative (2021). ‘Male victims of coercive control experiences and impact’. Research England—University of Central Lancashire. [link to this article](#).

⁷² Women’s Aid (2022). ‘Coercive control’. [link to this article](#).

⁷³ Equality and Human Rights Commission. (2019). ‘What are human rights?’ [link to this article](#).

⁷⁴ Gerada, C. (2018). ‘Doctors, suicide and mental illness’. *British Journal of Psychiatry Bulletin* 42(4): 165–68. [link to this article](#).

⁷⁵ Kumar, S. (2016). ‘Burnout and doctors: Prevalence, prevention and intervention’. [link to this article](#).

⁷⁶ Randstad (2021). ‘The impact of meant health and stress on nurses’. [link to this article](#).

⁷⁷ *British Dental Journal* (2019). ‘More than half of dentists say stress is affecting their practice’. *British Dental Journal* 226(1): 7.

⁷⁸ Royal College of Psychiatrists (2017). ‘Looking after yourself’. [link to this article](#).

⁷⁹ BASW (2018). ‘UK social workers: Working conditions and wellbeing’. [link to this article](#).

foresight, and corrode the integrity of reliable and ethical regulatory oversight. The *British Medical Journal* published a study in 2018 that explicitly mentioned how doctors felt they worked in a “dangerous and toxic environment with a blame culture which jeopardises patient safety and discourages learning and reflection”.⁸⁰

Regulatory *duty of care* mandates should not only exist to protect the public but should equally extend to the treatment of practitioners. Fulfilling public safeguarding obligations are vitally important undertakings, yet they should not placate or absolve irregular administrative practices. The existing measures operated by regulators to address issues relating to practitioner conduct arguably fail to uphold “natural justice”, specifically the *rule against bias* and *the right to a fair hearing*. Given the impact an FtP hearing can have upon an individual’s life, consideration should therefore be given to employing separate judicial entities—made up of panels that are indisputably independent—to hear and determine FtP cases. Applying a legitimately impartial jury or panel-led approach to determining cases would, as a minimum, afford members of the public and members of the healthcare professions a clearer, safer, and more just system for ascertaining whether claims of error or wrongdoing are valid. Regulator-selected and financed FtP panels cannot confidently offer undistorted objectivity or assurances of neutrality. Given it is the public who are the intended beneficiaries of FtP undertakings, should their input not have a much greater bearing? Furthermore, replacing the adversarial system with more collaborative or inquisitorial legal conventions would lessen the harmful effects caused by hostile exchanges, and generate greater levels of understanding and awareness where contentions and matters of wrongdoing have arisen.

Healthcare regulators were never established to act as autocratic purveyors of vitriol. Procedures normalised by repetition or ill-informed duress should not go unchallenged simply because they are dispensed by authorities with (and without) legislated powers. At present, the processes implemented by regulatory bodies when pursuing claims of practitioner wrongdoing exhibit prejudicial components and show a reckless contempt for health professionals. A system of oversight that can cause ill-health, extreme distress, and practitioner suicides, not only destabilises and discourages the general healthcare workforce, but reveals serious flaws which undermine the rationale and integrity of regulation. Introducing a governmental watchdog, tasked with monitoring the regulatory establishment and calling into question irregular or unethical proceedings, may go some way towards ameliorating unsafe FtP practices and preventing aberrant and harmful outcomes. With the benefits of effective regulation—such as, insight, understanding, development, rehabilitation, and support—having been displaced by acrimonious and pejorative intentions, a substantial review into the wisdom and mechanics of how healthcare regulators currently conduct FtP affairs is urgently needed.

⁸⁰ Wise, J. (2018). ‘Survey of UK doctors highlights blame culture within the NHS’. *British Medical Journal* 362: k4001. [link to this article](#).