Doctoring with conviction: criminal records and the medical profession

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The General Medical Council decides if, when they are convicted of a crime, a doctor in the United Kingdom should be allowed to continue in their employment. This article is the first to detail these decisions for the period 2005 to 2015. No doctor was barred from practising medicine for serious violent and sex offences; including, rape, possession of images of child sexual abuse, manslaughter and domestic violence. These findings are placed in the context of contemporary developments in criminal record reform and criminological analysis of the relationship between employment and desistance. It is concluded that the high degree of devolved discretion allowed to elite professional occupations must be subjected to further critical scrutiny and policy reform.

Keywords: Criminal record, desistance, employment, ex-offenders, medical profession, re-entry

Introduction

It has been argued that much of contemporary 'crime talk' is dominated by highly punitive and frequently short sighted populist crime discourses, which prioritise economic prosperity and security over human rights and social equality (Carlen 2010). A preoccupation with public protection has certainly become a ubiquitous feature of the modern governmental crime control project (for example, see Frost 2006, Simon 2007, Wacquant 2009, Barry et al 2013, and Farrall et al 2016). Two key penological trends are bound up with this state of affairs (Simon 2007, Garland 2012, 2013). First, is the emergence of systems of punishment within western neoliberal nation-states which rely heavily on mass penal incarceration and increased community-based sentencing, arguably without adequate consideration of the negative consequences for long-term social cohesion and equality of opportunity (Maruna 2011, Wacquant 2011, Jacobs 2015).

Second, is the proactive promotion by law enforcement agencies of risk identification and management technologies and strategies, targeted at identifying and managing possible future threats to public safety (Barry et al 2013, Mythen 2014). This, in turn, has led to a growing emphasis on maximising crime detection and prevention data resources, including the development of CCTV and surveillance technologies, 'Big Data', artificial intelligence and predictive policing techniques (McCulloch and Wilson 2015, Chan and Moses 2016, Williams et al 2016). Within this context, politicians and criminal justice service leaders, particularly the police, have argued that electronic criminal record databases, including DNA databases, are important crime prevention measures for ensuring the security of all and the personal safety of the most vulnerable (Brame et al 2015, Uggen 2016).

Focusing on the second of these international trends, this article critically examines for the first time data pertaining to doctors in the UK who possess a criminal record. In doing so, it contributes to contemporary criminological debate surrounding the role of criminal records in promoting public safety. There are an estimated 10 and a half million people who possess a criminal record in the UK, which is 16% of the current 64 million population (Unlock 2015). One government study for England and Wales revealed that 33% of males born in 1953 had a conviction for at least one offence by the age of fifty-three, that in 50% of cases they had offended just once, as well as that in 85% of cases the offence had occurred before they were thirty years old (Home Office 2010). It has been argued, as a result, that it is not only a matter of public safety to ensure that ex-offenders have job

opportunities, it is also critical to a successful economy and the promotion of civil society (Hubbard 2014). However, in common with many other countries, ex-offenders in the UK find it difficult to find paid employment or access to training and educational opportunities.

A key reason why this is the case, is that under the criminal records system relatively minor offences, such as theft, frequently engender the same social stigma and civic bars as their more serious counterparts (Rukus et al 2016). Disbarring candidates from entry into certain workplaces or education and training, regardless of their age, the time expired since an offence, or the offence type, has been increasingly subject to academic and public scrutiny in the UK over the last two decades, and furthermore, has been subject to successful legal challenge under the Human Rights Act 1998. On the 22nd January 2016 the UK Court of Appeal ruled that it was contrary to article eight of the Human Rights Act 1998 for a person to be required by law to disclose multiple minor convictions regardless of the time elapsed or the personal circumstances within which an offence occurred (Rose 2016).This followed an earlier 2013 Court of Appeal ruling, which led to a number of minor convictions being deemed 'protected' from disclosure after eleven years for adult offenders, and five and a half years for youth offenders (Liberty 2013).

Although regarded by some as being progressive reforms to the UK criminal record system (for example, see Jackson 2014, Rose 2016), human rights advocates and penal reform activists have argued that they do not go far enough to ameliorate the long-term collateral damage to ex-offenders lives caused by officially sanctioned sentences imposed by courts, particularly if an offence occurs early in a person's life (for example, see Sands 2016, Unlock 2016). Nonetheless, this article contends that the UK High Court rulings underscore the need for action to be taken to ensure adequate security-based checks and balances are in place which prioritise public safety, particularly in relation to the degree of devolved discretion permitted to some types of employers.

Focusing on the medical profession as a case study to investigate how this discretion is currently applied in practice, this article contributes to the evidenced-based promotion of a more nuanced rights-based view of criminal record reform. In doing so, it seeks to develop a broader criminological conception of the relationship between work and desistance from offending behaviour, through exploring more fully the diversity of the stratified forms of employment sought by ex-offenders (Hunter 2015). Moreover, its arguments are germane to international jurisdictions, such as the US, Canada and Australia, all of whom are currently debating similar progressive reforms to their criminal records systems (Fox 2016).

Criminal histories, desistance and employment

Criminal record databases are used in many countries worldwide; including, Australia, Canada, Hong Kong, New Zealand, the UK and across the European Union, as well as the USA (Soloman 2012, European Commission 2016). What is included in a criminal record, who can access all or part of it, and for what purpose, varies across international jurisdictions (Fox 2016). However, regardless of the nature of their content, or the circumstances under which this is either partially or fully disclosed, criminal record databases internationally share the same underpinning common-sense assumption: past offending is the best predictor for future offending behaviour (Jacobs 2015).

This assumption has been subject to critique on two key grounds by civics-focused, inclusive and reintegrative models of punishment and offender re-entry into society, as advocated by theorists such as Braithwaite (2007), Simon (2007), Wacquant (2009), Maruna (2011), Zizek (2011), Garland (2012) and Farrall et al (2016), amongst others. First, scholars have contended that this assumption fails to acknowledge that there are factors other than personal character and individual intent which

act to shape human behaviour, including behaviour deemed morally or criminally reprehensible, and so worthy of punishment (Loader and Walker 2007).

Empirical studies have repeatedly shown that several factors other than past criminal behaviour influence an individual's ability to desist or not from such behaviour in the future. These include, addiction and substance abuse issues; lack of paid employment; poor access to training and education; a lack of family support; types of friends; and age (Markson et al 2015, Chui 2016). Furthermore, the poorest members of society, alongside those who belong to racial and ethnic minority groups, are disproportionately represented within western criminal justice systems, and the underpinning self-justifying logic of the criminal record database perpetuates, for many of these individuals, their lived biography of social marginalisation and exclusion: it confirms that they will always belong at the edges of society (Pager 2008, Henley 2014, Fox 2016).

Second, the focus of the logic of the criminal record system on past behaviour has also been criticised for implicitly engendering collateral consequences which are ethically, if not legally, problematic, because they amplify punishment beyond the sanctions imposed by the criminal justice system (Uggen and Inderbitzen 2010, Uggen 2016). Chin (2012:1798) refers to the possession of a criminal conviction as a 'civil death', as it brings into play wide-ranging forms of discrimination, public shaming and civic rejection; including, difficulties in obtaining a visa for overseas travel and in some instances the threat of deportation; the inability to hold public office or undertake jury service; and being viewed by the insurance and banking sectors as an unsound fiscal investment (Uggen et al 2006, Jacobs 2015).

Following from this critical scholarship, criminologists concerned with promoting offender desistance from offending, such as Maruna (2001, 2011), McNeill et al (2012), Fox (2016) and Uggen (2016), advocate reforms to criminal record systems as part of a wider critique of popular punitive approaches to crime and punishment. A growing body of desistance research emerged from the mid-1990s onwards which emphasised that employers, the economy and civil society, similar to offenders themselves, are disadvantaged by the current employment and civic-participation restrictions placed on individuals who possess criminal records, particularly if a significant period of time had elapsed since their conviction (for example, see Visher et al 2004, Rodriguez and Emsellem 2011, Davis et al 2013, Hlavka et al 2015).

Yet research internationally has found that the security fears of employers and local communities leads to many ex-offenders struggling to find work, no matter how assiduous they may be, as they are often viewed as untrustworthy, unpredictable and 'dangerous to know' (Ramakers et al 2015, The Sentencing Project 2015). In addition to these negative social tropes, job searches can be hampered further by fractured family and living circumstances, poor support networks, literacy and numeracy problems, and low levels of education and training, particularly if a criminal career began at a young age (Donoghue 2013). Furthermore, the post-recession competitive marketplace in the UK and other countries, has seen the growth of insecure employment and the rise of the 'zero-hour' contract, with the result that re-entry into society via paid employment has become even more problematic for many ex-offenders (McNeill et al 2012).

Identifying a gap in the literature: professionals who commit crime

It has become axiomatic within criminology that the requirement to disclose a criminal record history, whether in part or in full, when seeking to enter employment, remains a significant barrier to promoting desistance and reducing recidivism (Bath and Edgar 2010, Liberty 2013, Unlock 2015). This goes some way to explain why rights-based arguments for reform to the criminal records

system in the UK have found some support for their position within the academic criminological literature (Stands 2016). Nonetheless, this article suggests that current debate and theorising from desistance researchers has perhaps omitted to take as fully into account as it should the high-level of devolved discretion possessed by some agencies which operate outside of the direct jurisdiction of criminal justice agencies – such as higher education institutions and professional regulators, for example - when it comes to dealing with individuals who possesses a criminal record.

To date the published desistance research with ex-offenders has tended to focus on low-paid, low-skill forms of employment, paying very little empirical and conceptual attention to ex-offenders seeking work in highly-skilled public-sector and professional occupations, such as accountancy, nursing, dentistry, social work, medicine and law (for example, see Maruna 2001, Uggen and Manza 2002, Manza and Uggen 2006, Uggen and Inderbitzen 2010, Rodriguez and Emsellem 2011, Uggen 2016). This is because these occupations often involve working in positions of significant responsibility with vulnerable adults and children, and they therefore have restrictions placed upon entry, which makes it difficult, and in some instances impossible, for people with a conviction to become an actuary, a social worker, a lawyer or a nurse, for example (Unlock 2015). Yet a key outcome of the progressive reforms to the criminal record system in the UK noted at the beginning of this article is that it has led to an increase in the level of discretion public-sector and professional occupations can (and are willing to) exercise when they receive applications from individuals who possess a criminal record (Stands 2016). Especially for minor convictions for offences committed while relatively young (Jacobs 2015).

Professions with a strong civic orientation, such as medicine, possess a significant degree of occupational autonomy over who is allowed to enter as well as the processes by which expulsion occurs, including when criminal convictions come to light (Chamberlain, 2015). Consequently, they represent an ideal problem space for examining how much discretionary power non-state agencies should possess when dealing with individuals who possess a criminal record (Brazier and Ost 2013). Nonetheless, this article does not propose to examine the impact of criminal record reform in the UK on ex-offender entry into professional occupations. Rather, it is concerned with what happens when an individual is convicted of an offence when they already have gained entry into a highly-skilled professional occupation which possesses a strong civic-minded duty to others, and which involves them working with vulnerable adults or young people. This focus enables us to examine how professional elites apply their discretion in practice, and in doing so, identify how they currently balance the need to protect the public from harm with the duty to promote the public interest through ensuring the continued provision of essential public services.

Case study: medical practitioner conviction data 2005 - 2015

The foregoing section outlined the substantive focus of this article on the degree of discretion allowed to non-criminal justice agencies when defining the future employment opportunities of members convicted of a crime. In the UK, professional regulatory bodies oversee professional occupations, controlling entry into and exit from, these occupations (Brazier and Ost 2013). This system allows them a necessary degree of autonomy and discretion over their activities, due to the highly specialised and esoteric nature of their expertise, as well as the prolonged apprenticeship period required of new members (Chamberlain 2015). For example, the health and social care professions are overseen by nine such regulators: the General Chiropractic Council; the General Dental Council; the General Medical Council; the General Optical Council; the General Osteopathic Council; the Health and Care Professions Council; the Nursing and Midwifery Council; Pharmaceutical Society of Northern Ireland; and the General Pharmaceutical Council. Each of these regulators oversees training and professional standards, and maintains a register of practitioners.

Most importantly, only these bodies can act to remove a practitioner from their respective registers, and furthermore, they must follow a strict regulatory process, which will only occur once the outcome of a magistrate or crown court hearing is known.

How the General Medical Council administers conviction cases

Similar to other professional regulators in the UK, the management of cases when a doctor receives a conviction is divided into two stages: investigation and adjudication (Chamberlain 2016). Two case examiners, who collect and review the available evidence, conduct investigations. Investigations will always result in a decision being made on the doctor's fitness to practise. There are several categories of decision. First, an investigation can be closed with no further action, or with some form of advice being issued. Second, the doctor is asked to accept a warning. This is action on registration, because a warning is made available to employers and the public for five years. This occurs when the doctor has committed acts or omissions which are serious deficiencies in practice or conduct which, if repeated, would require further action, but on this occasion there is a migrating factor impacting on the judgment which means it does not progress further. For example, it might be a first offence, which furthermore is classified as a relatively minor summary offence such as drink driving (Ashworth and Zedner 2014). Third, the doctor may be asked to accept voluntary undertakings to restrict or improve their practice; for example, re-train or work under supervision. Fourth, a doctor may be referred to a tribunal for further consideration and adjudication.

The adjudication stage involves holding a tribunal hearing. This occurs when the case examiners judge that a doctor's actions warrant suspension or erasure from the medical register (GMC 2014b). However, not all cases considered by a tribunal result in a finding against the doctor, or erasure from the medical register. Hearings are composed of a mixture of medical and non-medical lay members. The format is adversarial, with the General Medical Councils's (GMC's) legal representative presenting evidence and argument in the public interest, and a practitioner's legal representative similarly presenting their own argument and evidence (GMC 2014a). There are several possible tribunal outcomes: the case may be closed without sanction; a warning may be issued; restrictions may be placed on a doctor's practice; or they may be suspended or erased from the medical register, and therefore be unable to practice medicine in the UK (GMC 2014b).

Conviction type and case outcomes

Contact was made with the GMC to obtain under the Freedom of Information Act (2000) the information they hold pertaining to the number of qualified doctors in the UK convicted of criminal offences, and how they administer these cases. In response, the GMC provided descriptive statistical outcome data for the period 2005 to 2015, for the investigatory and adjudication stages of its fitness to practise procedures. Table one details the data obtained. In total, 1317 doctors were convicted of 1359 offences during this period. This is less than one percent (0.50%) of doctors on the register in 2015 (n 273,761) (Chamberlain 2016).

Insert table one here

The outcome data obtained from the GMC provided at a broad level a description of the nature of the offence committed by a doctor: Dangerous Driving; Motoring Offences; Sex offences; Child Pornography; Violence; Manslaughter/Murder; Fraud & Forgery; Theft & Handling Stolen Goods; Drug Offences; Criminal Damage; Disorder Offences; Overseas Determination; Other Offences. Due to a combination of practical and cost-related factors, it was not possible to drill down further into the dataset for each case and identify the exact offence classifications, as used in UK court proceedings, including the nature of the penalty tariff applied by the court (1). Nonetheless, the

conviction category data does bring to the foreground several pertinent trends in relation to the types of offences committed and how the GMC responds to them.

Vehicle-related offences

The most prevalent convictions are vehicle-related offences, which encompass both dangerous driving and motoring offences (n 769, 57% of all 1359 cases). Motoring offences include convictions for driving without insurance or road tax, failing to stop, and driving without due care and attention. Dangerous driving includes speeding offences, causing injury to others, and driving under the influence of alcohol and/or drugs. 90% of vehicle related offences (n 693) are dealt with at the investigatory stage, and result in either a warning (n 331), advice (n 180), or no further action (n 107). 10% (n 76) were referred to a tribunal hearing by the case examiners. In these cases, doctors are more likely to be subject to high impact decisions which will directly affect their paid employment, with most (n 54) either being suspended for a period of time (n 38), and/or having conditions placed upon their professional practice (n 16); for example, they may be required to attend a drug and/or alcohol treatment programme before they are able to operate on patients again. Finally, one doctor voluntarily self-erased themselves from the medical register at the investigatory stage as a result of receiving a conviction for dangerous driving.

Violent and sex crime

After vehicle-related offences, the most common type of convictions are violent and sex offences (n 240, 18% of all 1359 cases). This category includes violent crimes such as domestic violence and grievous bodily harm (n 200), murder and manslaughter (n 4), sex offences such as rape, voyeurism and public exposure (n 30), and the possession of images of child sexual abuse (n 6). In 85% of these cases, examiners issued a warning (n 127), gave advice (n 34), or concluded their investigation with no further action (n 33). In only 15% of cases (n 35) was a doctor convicted of a violent or sex crime referred to a tribunal hearing. However, for those who were referred, the majority (n 28) were either suspended for a period of time (n 16), or had conditions placed on their professional practice (n 12).

Although convictions for the possession of images of child abuse or murder/manslaughter were in all but one instance immediately referred to a tribunal hearing, in half of these cases doctors had conditions placed on their practice (n 5 of 9 cases), and so were allowed to continue in their employment. One doctor had no action taken against them, in spite of possessing a conviction for murder/manslaughter. Finally, it is of note that between 2005 and 2015 no doctor was erased from the medical register, and so prevented from practicing medicine in the UK, for possession of a conviction for a violent or sex crime, including for serious sex offences such as rape and the possession of images of child sexual abuse.

'Other' offences

'Other' offences account for 6% (n 80) of all 1359 cases. This covers a range of offences which do not easily fit within the other categories, including injunctions, non-molestation orders, trade description offences, perjury, perverting the course of justice, and health and safety offences. 85% of these cases (n 68) were dealt by case examiners, with the majority being given advice (n 36), issued with a warning (n 12), or agreeing undertakings (n 4). 16 cases were concluded with no further action. Nonetheless, tribunal cases were more likely to result in the doctor being suspended (n 7) or having conditions placed on their practice (n 1).

Fraud and forgery

Similar to 'other' offences, fraud and forgery offences account for 6% (n78) of all 1359 cases. This covers a range of case types, from altering medical records, to creating and/or doctoring qualification certificates, making fraudulent health insurance claims, and falsifying legal and financial documents (for example, mortgage applications). Case examiners are more likely with these offences than any other category to issue a warning against a doctor (n 20) or to refer them to a tribunal. Indeed, 53% of cases (n 41) were referred to tribunal, and in 83% of hearings (n 34 of 41), a doctor was suspended from the medical register. Additionally, this is the only category of offence where a doctor in the UK between 2005 and 2015 was erased from the medical register by the GMC after a tribunal hearing (n 2).

Theft & handling stolen goods

Theft and handling stolen goods account for 4% (n 59) of all 1359 cases. 85% (n 50) of these cases were closed at the investigatory stage, with examiners typically issuing warnings (n 28), giving advice (n 9), agreeing undertakings (n 4), or concluding the case with no further action (n 8). However, at the tribunal stage doctors with are likely to be suspended (n 5) or have conditions placed on their future practice (n 2).

Drug offences

Drug offences, which includes convictions ranging from the possession of illegal drugs for personal use to drug trafficking, also account for 4% (n 57) of all 1359 cases. Similar to fraud and forgery cases, case examiners tended to issue a warning (n 16) or refer drugs cases to a tribunal. Indeed, 46% of these doctors (n 26 of 57) were referred to tribunal. However, instead of facing an increased likelihood of suspension, as is the case with fraud and forgery cases, in 46% of these cases (n 12 of 26) tribunal hearings placed conditions on a doctor's future professional practice. Such conditions often involve restricting their access to pharmaceuticals in the workplace as well as requiring they participate in drug counselling. Only 5 doctors were suspended from the register for drug offences. None were erased.

Criminal damage, disorder offences and oversea determinations

The three smallest categories of offences the GMC manages are criminal damage (n 35, 3% of all 1359 cases), disorder offences (n 31, 2% of all 1359 cases) and oversea determinations (n 10, <1% of all 1359 cases). This covers a number of differing case types, including anti-social behaviour orders, damage to buildings/dwellings, and instances where an offence has been committed outside of the UK. Case examiners, who typically provide advice or conclude a case with no further action, predominately manage criminal damage (n 35) and disorder offences (n 31). Indeed, of these 66 cases, only 4 criminal damage cases were referred to a tribunal. Overseas offences are responded to differently, as they can cover the full range of offence types, including violent and sex offences, with the result that 50% of these cases (n 5) were referred to a tribunal hearing for further consideration by case examiners. However, in 3 of these cases no further action was taken, with conditions being placed on a doctor's professional practice. No doctor was erased from the medical register for these three smallest offence categories.

A rehabilitative case management pattern

How the GMC manages cases follows a distinctive pattern, as illustrated by table two, which details the processing outcomes for all offence categories. At the investigatory stage, in 85% of cases, examiners operating without independent oversight (legal or otherwise), exercised a high degree of discretion, with the result that a doctor convicted of an offence did not need to attend a tribunal hearing and can continue in their employment. In the 15% of cases where further investigation and a tribunal hearing is deemed necessary, there is a significantly increased likelihood that a doctor will be temporarily suspended for a period of time (55% of all tribunal cases), or at the very least subject to oversight and monitoring (25% of all tribunal cases). Nonetheless, there is a systemtic reluctance to permanently prevent a doctor from practicing medicine in the UK for the possession of a criminal record, with <1% (n 2) of doctors being struck off the medical register as a result of a tribunal hearing.

Insert table two here

This is indicative of a system of punishment that is mindful of the need to enact a penalty proportionately, based on the nature of the crime committed, and which seeks to promote offender reintegration and rehabilitation, as appropriate. For example, 90% of vehicle-related crimes are dealt with at the investigatory stage, while more serious offences, that are perhaps more likely to be directly or indirectly linked to the workplace, notably fraud and forgery (53% of cases) and drug related offences (46% of cases), are more likely to be forwarded to a tribunal hearing. However, while the fraud and forgery offences are more likely to lead to a doctor being suspended from their employment for a period of time, drug related offences are more likely to result in a doctor having conditions placed on their professional practice. This arrangement enables them to continue to work under supervision while attending a rehabilitative counselling and support programme (GMC 2014a).

This case management pattern could be dependent on the nature of the cases the GMC deals with. In 97% of cases, the GMC is dealing with one-off offending behaviour, the majority of which is for vehicle-related offences such as speeding (57% of all offences), which unlike fraud, forgery and drug offences for example, arguably possesses little direct bearing to the workplace and matters of professional probity and ethics. Nonetheless, the analysis of outcome data by the offence categories supplied by the GMC does highlight notable trends in the management of cases, which require further reflection and critical consideration.

Discussion

The GMC administers a regulatory process whereby possession of a criminal conviction does not automatically disbar a doctor from keeping their paid employment. Indeed, the data detailed in this article suggests that the highly valued skill-set possessed by doctors, rather than the nature of the offence that they have been convicted of, is actively influencing the discretionary manner by which their criminal record is dealt with by their regulatory body. Such pragmatic utilitarianism is necessary when seeking to balance the public interest with the need to ensure public protection, particularly in the context of service-oriented occupations such as medicine which provide an essential public service. Furthermore, it follows good practice guidance in relation to criminal records and employment found within the respective contemporary legislative and academic literatures (see Rose 2016, Sands 2016, The Sentencing Project 2015, Unlock 2016). It seeks to balance the need to ensure the public are protected from possible harm with the recognition that ex-offenders can (and do) contribute to the social good, and furthermore, that maintaining paid employment significantly aides their rehabilitation and reintegration into society (Uggen 2016).

Nonetheless, while the value of this approach is clear, particularly when dealing with highly skilled professionals which perform an essential public service, it is equally important given the nature of the work doctors do, to remain mindful of the need to protect the public interest first and foremost. Two key aspects of how the GMC manages convictions are important in this regard. Firstly, only two doctors were erased by the GMC from the medical register for the perod 2005 to 2015, both of which were for fraud and forgery offences (a further third doctor self-erased themselves for the possession of a dangerous driving office). Secondly, 85% of violent and sex crime cases were actioned by case examiners, rather than being subject to a formal tribunal hearing, and no doctor was erased from the medical register for a range of convictions which raise serious public protection concerns; including, rape, the possession of images of child sexual abuse, grievous bodily harm, domestic violence and murder/manslaughter.

These findings run contrary to the statutory provisions set out in the General Medical Council (Fitness to Practise) Rules 2004. These place a duty on the GMC use its discretionary powers to secure the public interest when there is a significant potential risk to members of the public of serious harm occasioned by the commission of a specified offence, and furthermore, that this discretionary action be informed by the Disclosure and Barring Service list of autobar offences; Schedule 15 Offences, Parts I & II of the Criminal Justice Act 2003; the Misuse of Drugs Act 1971, and Theft Act 1968 (GMC 2014a, 2014b). Indeed, according to these rules, the GMC should have sought to permanently erase doctors from the medical register for convictions for images of child sexual abuse, rape, serious sexual assault, murder/manslaughter and grievious bodily harm, for example.

This raises pertinent and far reaching questions concerning the degree of unaccountable devolved discretion it currently possesses. Not least of all because a series of high profile medical negligence and malpractice scandals over the past two decades in the UK have repeatedly highlighted serious institutional failings in the management of complaints against doctors, with the GMC being heavily criticised for appearing to be biased toward protecting the interests of medical practitioners (Chamberlain 2015). Consequently, the next section of this article contends that these findings possesses implications for the regulation of doctors and high status professional occupations more generally in the UK.

Balancing the public interest with public protection

A key limitation of the data obtained from the GMC for this article is that it is not possible to know why a case was managed as it was. The high-level descriptive category format in which the GMC was prepared to release its data means that it is not possible to know why, for example, examiners referred one drug offence case to a tribunal hearing and another was dealt with by them through issuing a warning. It is, therefore, impossible to identify to what degree there is consistency or otherwise in case examiner decision-making when dealing with similar offence categories. Furthermore, only a significant amount of financial outlay would enable access to the original case file data held by the GMC, and even then, pertinent information used to inform examiner decision-making (but deemed personal to the doctor and which therefore might serve to identify them) would be redacted; for example, court hearing details, interviews with their colleagues, and information exchanges with their employer [1].

The GMC and other health and social care professional regulators in the UK which adopt a similar approach, compare highly unfavourably with regards to the availability of case information for public scrutiny, to the open justice approach adopted by Magistrate and Crown courts in England and Wales, as well as the Supreme Court (Chamberlain 2015). All of whom since 2011 have operated

under an open justice policy whereby case files, decisions and judgements, are all freely available and accessible online to the public (Roberts and Ashworth 2016).

Significant and far-reaching questions exist in regards to the appropriateness of the lack of external scrutiny of, and the poor availability of public access to, GMC case examiner decisions. If public regulatory bodies are to engender public confidence in their decisions then they have to be transparent, publicly available and accessible (Brazier and Ost 2013). The current manner in which the GMC case examiners are able to exercise discretion without independent day-to-day scrutiny of their decisions, alongside the high costs associated with obtaining a modicum of access to the evidence on which these judgements have been made, serves to obfuscate its decision-making procedures from public view.

It is arguable, therefore, that the public must have the right to greater access to the information on which courses of action have been agreed between doctors, employers and their regulatory body, particularly when they more often than not have been allowed to continue in their employment in spite of possessing a criminal record. It might be the case that it is in the public interest to take a proportionate and measured approach so a doctor is not automatically barred from practicing medicine when they commit a criminal offence, but this does not obviate the need for regulatory processes and case examiner decisions to be more readily accessible and open to public scrutiny.

The medical profession has historically enjoyed a considerable degree of public trust, but a series of high profile medical malpractice scandals over the last three decades, including at Alder Hay Children's Hospital, Bristol Royal Infirmary, Mid-Staffordshire NHS Trust and Morecombe Bay NHS Foundation Trust, have cast a long shadow over the GMC, and how it handles complaints against doctors (see Williams et al 2014, Chamberlain 2015).The GMC has been repeatedly accused of acting to first and foremost protect doctors, rather than the public it serves. Some patient-rights campaigners and regulatory policy analysts have called for the GMC to be abolished and replaced by a more independent regulator (see McCartney 2014). However, successive UK governments have concluded that the public interest is best served by subjecting the GMC to a process of incremental reform designed to make it more publically accountable for its decisions (Chamberlain 2016).

This incremental reforming approach is congruent with white collar crime literature pertaining to the 'economics of punishment' (Geis 2006, Whyte 2009, Ruggiero 2016). This stresses that, when it comes to highly skilled occupations which contribute significantly to the national economy and provide essential public services, there is a reluctance on behalf of political and social elites to enact punishment when infractions occur in all but the most severe cases, as the financial consequences of doing so are felt to be too high (Simpson 2013). For example, Case (2011) found in her research into clinical negligence cases that, due to the severe financial ramifications associated with stopping a trained doctor from practising medicine, in the vast majority of cases a 'redemptive model' of punishment is advocated by employers, medical regulatory elites and the courts. This required a practitioner subject themselves to an enhanced level of colligate and work-based supervision, as well as complete a rehabilitative skill training programme designed to address any practice-based issues raised. More punitive and therefore more costly measures, such as dismissal and in some cases imprisonment, are reserved for the most publicly sensitive cases, which often draw significant media coverage, such as is in the case of Harold Shipman for example, and in doing so they serve as a symbolic reminder that justice has been done and the public protected from further harm (Quirk 2013).

It is undoubtedly difficult to strike the right balance between the privacy and employment rights of a doctor, with the need to hold the behaviour of individuals who provide essential public services to a

high degree of scrutiny and sanction (Henley 2014).The esoteric and often highly technical nature of modern forms of professional expertise might support the conclusion that it is in the public interest for these occupations to possess a high degree of devolved autonomy and discretion in matters concerned with the acquisition and application of professional technique, including the rehabilitative (or not) disciplining of group members when problems arise (Chamberlain 2015). However, this is not necessarily the case in regards to matters of professional probity and ethics, including when a practitioner commits a criminal offence (Whyte 2009). Indeed, the findings outlined in this article serve to illustrate that it very much is in the public interest for matters of professional probity and ethics to be subject to greater independent non-medical scrutiny and oversight.

At the very least, there is a need to look again at the high level of discretion possessed by high status professions, such as medicine, when it comes to disciplinary matters such assessing the appropriateness of continuing the employment of someone who obtains a criminal record. In particular, clarification is needed pertaining to how (and if) the thresholds for action employed by the GMC when dealing with similar cases differ depending on the kind of employment a person is looking for. The current restrictions on public access to case files and case examiner decisions make it is impossible to ascertain if the actions of the GMC are appropriate and proportionate. Indeed, at the moment it is questionable whether it, as a self-funding professional body with limited financial resources, is best placed in all cases to independently risk-assess whether a doctor meets the threshold for re-employment when they have committed serious criminal offences.

Opportunities for further criminological research

The data outlined in this article suggests that ex-offenders in highly-skilled occupations are seeking to either maintain their current job or re-enter the job marketplace via similar high status employment, and furthermore, are being supported to do so by their professional regulators. It appears, therefore, that employment opportunities for ex-offenders are stratified by different occupational types, and furthermore, that the relationship between work and desistance is more complex than perhaps has previously been envisaged. The desistance literature and rights-based discourses which critique the negative effects of the requirement to disclose criminal histories, have to date operated with a restricted conception of the types of occupational opportunities sought by ex-offenders (King 2013, Roe 2016). There has been a tendency to focus on low-paid, low-skill forms of employment, paying little empirical and conceptual attention to ex-offenders seeking work in highly skilled public sector and professional settings (Davis et al 2013, Markson et al 2015, Farrall et al 2016). As a result, there is an important opportunity here to broaden current criminological understanding internationally of the diversity of ex-offenders experiences of seeking and maintaining paid employment, as well as in managing the social stigma and 'civil death' associated with the possession of a criminal record (Chin 2012).

The biographical profile of a doctor convicted of a criminal offence might at first sight appear to contrast sharply with that of persistent youth or adult offenders. For example, there is a range of inhibiting factors that can influence desistance; including, addiction and substance abuse issues, a lack of a persistent employment history, poor access to training and education, as well as poor family and support networks (McNeill et al 2012, Uggen 2016). Yet the data outlined in this article revealed that some doctors are affected by key desistance factors, such as drug and alcohol abuse, for example. Furthermore, although the GMC is predominately dealing with one-off instances of criminal behaviour, 15% of doctors with a conviction (n 195 of 1317 doctors) did have a further fitness to practise case opened against them at some point between 2005 and 2015 for reasons other than obtaining a criminal conviction, but which nonetheless could be associated with previous offending behaviour; including, addiction and substance misuse, personal and family problems, and

mental health issues. Finally, similar to other offenders, doctors can and do suffer from the same public shaming and civic rejection associated with the possession of a criminal history, perhaps more so given the high social regard the medical profession is held in by society (Unlock 2016).

Given these considerations, this article contends that researchers would find significant value in comparatively exploring several key thematic desistance concerns with doctors in relation to other low and high-skill occupational groupings; including, firstly, their lifecourse, lifestyle and pattern of offending behaviour *before* they were convicted of an offence; secondly, how they negotiate the social stigma attached to the possession of a criminal history *after* they have been punished for committing an offence, both in the workplace and civil society; thirdly, what is similar/dissimilar about the cognitive and affective impact of their experience of possessing a criminal identity when compared to other types of offender; and fourthly, public perceptions of 'appropriate punitiveness' towards offenders and how these might be shaped by the nature of their occupation. Exploring these areas would serve to expand current criminological understanding of the complex and non-linear but nonetheless frequently cyclical relationships, which research has shown exist between crime, employment and reoffending behaviour (Jackson 2014).

Finally, exploration of these thematic desistence concerns should remain mindful of the 'economics of punishment' literature discussed earlier in this article, to help further criminological understanding of the differing forms of 'white coat' crime commited by doctors, and how these compare and contrast with the types of offence committed by members of other occupational groups, both inside and outside of the workplace (Quirk 2013). Hunter (2015) notes that the respective desistence and white collar and corporate crime literatures are often treated as if they are distinctive from one another. However, opportunities do exist to explore linkages between these literatures, particularly in relation to the regulatory handling of instances where members of different occupations have, or are in danger of obtaining, a criminal record. For example, at present little is known about the comparative impact of temporary suspensions from the workplace (which increasingly occur while regulatory and criminal investigations are being completed) on individuals who work in the banking and business sectors, the police, or the health and social care professions (Case 2011, Chamberlain 2016). Yet their growing use by private and public sector regulatory bodies, who are increasingly acting to suspend employees as a result of finding themselves under intensive (often media-led) pressure to act to protect the public from the *possibility* of future harm, highlights an important new avenue for future interdisciplinary research.

Conclusion

In the UK, professional occupations possess considerable autonomy and control over the admission, training and disciplining of members (Chamberlain 2015). This article has focused on the high degree of discretion possessed by the medical profession when deciding if a group member should continue in their employment when they have been convicted of a criminal office. It has done so against the background of a growing international concern with the deleterious effects of the 'civil death' associated with possession of a criminal record (Rukus et al 2016). Similar to other countries worldwide, the 2008 global banking crisis led to the emergence in the UK of an austerity agenda and large-scale public-sector reform (Sands 2016). Reducing the costs associated with the court, policing, prison and probation systems, has been a particular area of concern over the last decade for successive liberal-conservative and conservative governments (Farrall et al 2016).

The re-emergence of contemporary debates surrounding how the criminal records system should be reformed to the benefit of ex-offenders, civil society and the economy, undoubtedly is bound up with these broader changing socio-political circumstances (Hubbard 2014). Nonetheless, although

rights-based arguments for reform to the criminal records system in the UK have also found significant support for their position within the academic desistance literature, as this article has discussed, criminological research and thinking surrounding criminal record reform has arguably until now been restricted in its analytical scope because it has (perhaps understandably) emphasised examining ex-offender entry into relatively low-status, low-skill, forms of employment and training (Markson et al 2015, Ramakers et al 2015).

In examining a previously unexplored high-status, highly-skilled, occupational type for the first time, this article has contributed to criminological understanding of criminal record reform and offender reintegration into society. At first sight, a degree of practical congruence might be said to exist between the model of ex-offender case management used by the medical profession and the civics-focused, inclusive and reintegrative models of punishment and offender re-entry into society advocated by theorists such as Braithwaite (2007), Wacquant (2009), Maruna (2011) McNeill et al (2012) and Farrall et al (2016). Yet closer inspection of the data which underpins this regulatory model highlighted serious concerns surrounding a lack of necessary checks and balances needed to ensure public interest and safety needs are prioritised when professional groups exercise their discretionary privileges. Once again, the medical profession in the UK appears to be guilty of closing its ranks to protect the privileges of its members at the expense of its public responsibities (Chamberlain 2016).

In addition to these UK-specific public safety concerns, there is a broader social justice issue present in the data, which possesses significant international relevance for contemporary criminological debates surrounding employment and the disclosure of criminal histories. Indeed, a key contribution of this article is that it provides empirical evidence in support of the conclusion that employment opportunities for ex-offenders are socially stratified, and members of higher status groups appear to have greater access to them. This is a pertinient finding, as it is a common theme in the desistence and white collar criminological literature internationally that ex-offenders from socially marginalised and excluded groups, such as racial and ethnic minorities for example, tend to be overrepresented in low-status, low-skilled, and casual forms of employment (see Pager 2008, Hunter 2015, Delebarre 2016). The pragmatic utilitarianism which lies at the centre of recent calls for criminal record reform and the promotion of reintegrative models of offender re-entry and rehabilitation, must emphasise equality of opportunity for all social groups and all forms of employment, if it is to act as an antidote to the exclusory and discriminatory excesses of contemporary 'popular punitive' approaches to crime and justice. We must be mindful of this as we seek to expand our criminological imagination through exploring with ex-offenders how they manage to doctor with conviction.

FOOTNOTE

1) Under the Freedom of Information Act used to acquire the conviction data from the GMC, there is an exemption for requests where it would cost the public authority more than £450 to process. This is equivalent to two and half day's work, and it would cost significantly more than this to obtain further information for all 1359 cases for the period 2005 to 2015. The author was also informed that certain key personally identifying information would be redacted. The GMC charge £2.25 per page for a copy of the case transcripts it holds, and these files can easily be forty pages in length. The estimated minimum cost of obtaining paper copies of all case transcripts - £141,030 – was, therefore, prohibitive.

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Table one: 2005 -2015 outcome data for investigatory and adjudicatory stages by offence category

Investigatory stage outcome	**Dangerous Driving**	**Motoring Offences**	**Sex Offences**	**Child Sex Abuse Images**	**Violence**	**Manslaughter & Murder**	**Fraud & Forgery**	**Theft & Handling Stolen Goods**	**Drug Offenc**
Issue warning	269	62	20	0	107	0	20	28	16
Give advice	113	67	0	0	34	0	4	9	4
Refer to tribunal	63	13	4	5	22	4	41	9	26
Conclude with no action	47	60	6	0	27	0	5	8	5
Agree undertakings	68	1	0	1	10	0	8	5	6
Restored to register after suspension	4	1	0	0	0	0	0	0	0
Voluntary erasure	1	0	0	0	0	0	0	0	0
Total	**565**	**204**	**30**	**6**	**200**	**4**	**78**	**59**	**57**
Adjudication stage outcome									
Suspension	38	8	3	1	11	1	34	5	5
Conditions on practice	16	2	1	4	5	2	3	2	12
No impairment, but receive warning	4	2	0	0	1	0	0	2	5
Agree undertakings	0	0	0	0	1	0	0	0	2
Impairment, but no action	5	0	0	0	1	0	0	0	1
No impairment & no action	0	0	0	0	3	1	2	0	1
Erased from medical register	0	0	0	0	0	0	2	0	0
Grant restoration to register	0	1	0	0	0	0	0	0	0
Total	**63**	**13**	**4**	**5**	**22**	**4**	**41**	**9**	**26**

Table two: 2005 -2015 investigatory and adjudicatory stages by outcome categories

Investigatory stage outcome	**Total**	**%**	**Adjudication stage outcome**	**Total**	**%**
Issue warning	550	41%	Suspension from register	114	55%
Give advice	293	22%	Place conditions on practice	52	25%
Refer to tribunal for adjudication	208	15%	No impairment - but issue warning	16	8%
Conclude with no action	192	14%	Agree undertakings	4	2%
Agree undertakings	110	8%	Impairment- but no action	10	5%
Restored following previous suspension from register	5	0.4%	No impairment - no action	9	4%
Voluntary erasure from register	1	0.1%	Erasure from medical register	2	1%
Total number of cases *nb total is over 100% due to rounding up*	1359	101%	Grant restoration to register	1	0.50%
			Total number of cases nb total is over 100% due to rounding up	208	101%