ARDL

ASSOCIATION OF REGULATORY & DISCIPLINARY LAWYERS

QUARTERLY BULLETIN – SUMMER 2016

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Introduction

Although we are in the midst of the summer holiday season, this quarter's ARDL Bulletin still has plenty of regulatory activity to report with several interesting new decisions reported in Kenneth Hamer's Legal Update, and a consideration of the boundaries of regulatory appeals. The committee continues to be busy planning the forthcoming seminars and there is news about the next Annual Dinner. We keep the ARDL website updated with all our news and activity – it can be visited on http://www.ardl.org.uk/.

Annual Dinner – moving to new venue - save the date

The annual dinner is moving to a new venue to allow us to increase the numbers who can attend this hugely popular event. The ARDL Annual Dinner 2017 will be held in the magnificent surroundings of London's Guildhall:

https://www.uniquevenuesoflondon.co.uk/venue/guildhall. The dinner will be held on Friday 30th June 2017. Ticket booking information will be released shortly. Please note that anyone wanting to reserve tickets for the event must be a fully paid up member of ARDL. The committee has chosen the Guildhall as the venue for the next dinner in response to the membership survey feedback which told us that more people wanted to be able to attend the dinner but, at the same time, did not want to lose the atmosphere of the event. The new venue allows us to increase the numbers attending by approximately 120.

Financial Services Seminar – 3rd October 2016

The next in the ARDL 2016 Seminar Series is on Financial Services and is being held at the London offices of CMS

Cameron McKenna. The speakers will be Simon Morris, CMS Cameron McKenna; Robert Dedman, Prudential Regulation Authority; Vikram Sachdeva QC and the seminar will be chaired by Mr Justice Leggatt. Registration for members of ARDL is through the Eventbrite invitation which will be sent by email or through visiting the ARDL website: http://www.ardl.org.uk/.

Catriona Watt, Chair

Sidney Sussex College, Cambridge

The John Thornely Lecture 2016

The Boundaries of Professional Misconduct in the Legal and Health Care Professions

By Kenneth Hamer[1], Henderson Chambers

Sir Alan[2], ladies and gentlemen, it is a great honour as well as a personal pleasure for me to give the John Thornely Lecture 2016. These lectures began in 2005 when you, Sir Alan, gave the inaugural lecture on the European constitution – a subject on which I will say nothing tonight. I was privileged to come to Sidney in 1969 for a year as an Evan Lewis-Thomas Law Student, and John Thornely was always the kindest man possible towards me and I remember him, as many of you do tonight, with the greatest affection.

The title of my lecture is *The Boundaries of Professional Misconduct in the Legal and Health Care Professions*. I shall attempt to trace the historical development of professional misconduct and how it has evolved and what demarcates the boundaries between misconduct and deficient professional performance. The boundaries of professional misconduct have developed over time with changes in the Medical Acts and other legislation, the role of the judiciary and the ever increasing number of cases being heard in the Administrative Court. Regulators have also set standards of conduct and behaviour expected to be followed by the individual doctor, lawyer or other professional in order to ensure that public confidence in the professions is maintained.

Additionally there have been a series of inquiry reports, including Dame Janet Smith's Fifth Shipman Inquiry Report, which have greatly influenced our approach to professional misconduct. More recently the Law Commission, the Scottish Law Commission and the Northern Ireland Law Commission (which I will refer to collectively as the Law Commission) have reported on the Regulation of Health Care Professionals and the Regulation of Social Care Professionals in England. In its 2014 report, the Law Commission noted that many consultees contended that the interpretation of "misconduct" had become too wide and all-embracing and failed to assist with any strict legal analysis of cases. What amounts to deficient professional performance, and how it differs conceptually from misconduct, the Law Commission agreed can appear obscure. The Law Commission has proposed that misconduct as a ground on which to determine whether a person's fitness to practise is impaired should be reclassified as "disgraceful misconduct", whilst at the same time proposing greater emphasis should be placed on the concept of deficient professional performance as a ground for regulatory intervention, arguing that it should be given greater prominence in a new legal framework. The Law Commission's draft Bill, entitled The Regulation of Health and Social Care Professions Etc Bill, heralds a single statute for the regulation of the nine regulatory bodies that oversee some 32 health care professions in the United Kingdom.

In the solicitors' profession too there has been much change recently. The debate as to what constitutes "conduct unbefitting a solicitor" has now largely disappeared and been replaced by the Code of Conduct 2011 which sets out a series of broad principles to be followed and mandatory outcomes to be achieved

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rather than compliance with detailed rules. Likewise, the 9th Edition of the Bar's Code of Conduct, effective from 6th January 2014, contains 10 core duties and is outcomes focused. The Legal Services Act 2007 established the Office for Legal Complaints and stipulated that it must operate an ombudsman scheme. The Legal Ombudsman's role is to investigate complaints of poor service in the legal profession.

It is therefore time to take stock and examine where the boundaries of professional misconduct lie today and how they may develop in the future and with what consequence. In expressing my views in this talk, let me straightaway say that they are my personal views, and should not be taken as necessarily those of any regulator or other body.

Let me begin with the medical profession. The Medical Act 1858 was passed to regulate the qualifications of practitioners in medicine and surgery. It brought together the disciplinary processes of the Royal College of Physicians that was chartered in 1518, the College of Surgeons established in 1745, and other medical bodies, including the Society of Apothecaries. It provided for the establishment of the General Council of Medical Education and Registration of the United Kingdom referred to as the General Council, later to be called the General Medical Council. The 1858 Act provided also for the appointment of a Registrar whose duty was and remains today to maintain the Register and keep up to date records of those registered to practise medicine. The GMC following a determination made by the Medical Practitioners Tribunal Service remains the only body that can erase, suspend or impose conditions on a doctor's right to practise medicine. The Pharmaceutical Society of Great Britain was founded in 1841, and the General Pharmaceutical Council likewise plays the key role of deciding who can practise as a pharmacist and who cannot.

Section 29 of the Act of 1858 stated that if any registered medical practitioner shall be convicted in England or Ireland of any felony or misdemeanour, or in Scotland of any crime or offence, or "shall after due inquiry be judged by the General Council to have been guilty of infamous conduct in any professional respect", the General Council may, if they see fit, direct the Registrar to erase the name of such medical practitioner from the Register. The words "guilty of infamous conduct" even in Victorian times would have sent a shiver down the spine of any doctor.

The legal profession started earlier. Since the time of Edward 1, in 1272, the power to suspend or prohibit attorneys and lawyers had been entrusted by the Crown to the judges. The Statute of Westminster 1275 introduced an elementary form of disciplinary control over serjeants and pleaders and provided that in the event of deceit or collusion in the King's Court, the punishment would be a term of imprisonment and disqualification for life from "pleading in that Court for any man". This procedure, which was known as silencing, was not finally repealed until 1948. However, I can think of one or two members of the Bar today who it might be difficult to "silence", whether under the Statute of Westminster or any other provision!

In May 1892, the General Council of Medical Education held an inquiry into the conduct of Thomas Allinson, a medical practitioner who was on the register. Mr Allinson had placed various advertisements in newspapers, in which he criticized fellow practitioners and their methods of treating patients with drugs. He described his fellow practitioners as "professional poisoners" and "drug doctors", who dosed their patients with poisonous drugs which lessen their chance of recovery, and lengthen the duration of their illness. He concluded with his name and address and said: "Send a postal order for five shillings, with a stamped directed envelope, and I will send you private postal advice that will benefit you." The Council judged that Mr Allinson was guilty of infamous conduct, and directed that his name be erased from the register. His appeal to the High Court to prevent erasure was dismissed and in February 1894 he appealed to the Court of Appeal, presided over by Lord Esher MR sitting with Lords Justices Lopes and Davey; *Allinson v. General Council of Medical Education and Regulation* [1894]1 QB 750. In an oft quoted passage, Lord Justice Lopes said:

> "It is important to consider what is meant by "infamous conduct in a professional respect."

> The Master of the Rolls has adopted a definition which, with his assistance and that of my brother Davey, I prepared. I will read it again: "If it is shown that a medical man, in the pursuit of his profession, has done something with regard to it which would be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competency," then it is open to the General Medical Council to say that he has been guilty of "infamous conduct in a professional respect" within the meaning of section 29. I do not propound it as an exhaustive definition."

The Court of Appeal construed the words "infamous conduct" in the 1858 Act as meaning "disgraceful or dishonourable" conduct. The word "disgraceful" used in *Allinson* to define infamous misconduct in a professional respect is the same adjective as that proposed by the Law Commission in the 2014 draft Bill to describe misconduct. Clause 120 of the Bill provides that a person's fitness to practise a regulated profession may be regarded as impaired by reason of "disgraceful misconduct (whether in the person's practice of that profession or otherwise)". It may be worthy of comment that we appear to have come full circle: from "infamous conduct" in the 1858 Act as meaning disgraceful or dishonourable conduct; to "serious professional misconduct", the expression introduced by the Medical Act 1969; to "misconduct" *simpliciter* in section 35C of the Medical Act 1983 as amended; and now finally back to "disgraceful misconduct" as the test proposed by the Law Commission to define the worst type of behaviour. Some have argued that these various expressions bear the same meaning and are no more than different ways of emphasizing that the conduct must be serious before it carries the label of misconduct. However, I cannot believe they can all have the same meaning and should be construed in precisely the same way.

Allinson was followed by a series of cases involving other health care professionals including dentists, veterinary surgeons and opticians. In *Felix v. General Dental Council* [1960] AC 704, the appellant, a dentist registered under the Dentists Act 1957 appealed against a determination of the Disciplinary Committee of the General Dental Council that he had been guilty of infamous or disgraceful conduct in a professional respect in overcharging for, and wrongful certification of, treatment of certain National Health Service patients. While admitting the overcharging, he denied that it was done with any fraudulent or dishonest intent or with a view to obtaining remuneration to which he was not entitled. He attributed the mistakes admittedly made to carelessness on his part or on that of his receptionist, to whom he had entrusted the keeping of his records of treatment without adequate supervision or checking. In allowing Dr Felix's appeal, Lord Jenkins, giving the judgment of the Privy Council, noted the meanings assigned to the words "infamous" and "disgraceful" in the Oxford English Dictionary. The word "disgraceful" was hardly less extreme than the word "infamous" and was described as having the meaning "shameful, dishonourable, disreputable." Lord Jenkins said that to make good a charge of "infamous or disgraceful conduct" it was not enough to show that some mistake had been made through carelessness or inadvertence. To make such a charge good there must (generally speaking) be some element of moral turpitude or fraud or dishonesty in the conduct complained of, or such persistent and reckless disregard of the dentist's duty as can be said to amount to dishonesty for this purpose. The question was, in their Lordships' opinion, to some extent one of degree, but here the overcharging concerned fell short of the degree of culpability required.

Felix is perhaps the highest the bar has been set before infamous or disgraceful conduct can be established. It was quickly distinguished in a number of cases including *Marten v. Royal College of Veterinary Surgeons' Disciplinary Committee* [1966] 1 QB 1, where it was said that conduct that was disgraceful in a professional respect was not limited to unethical conduct involving moral turpitude. In *Doughty v. General Dental Council* [1988] 1 WLR 164, by which time "serious professional misconduct" had become the test under section 27 of the Dentists Act 1984, Lord Mackay of Clashfern said that it was no longer right to apply the criteria which Lord Jenkins derived from the dictionary definitions he quoted in *Felix*. In *Doughty*, the practitioner failed to

retain radiographs of patients for a reasonable period after completion of treatment, and failed to exercise a proper degree of skill and attention when treating patients or satisfactorily to complete the treatment required by his patients. In dismissing the appeal against removal, the head note in the Law Reports boldly states:

> "Serious professional misconduct in section 27(1)(b) of the Dentists Act 1984 was not to be construed so that it had the same meaning as the repealed charge of infamous or disgraceful conduct in a professional respect within section 25(1)(b) of the Dentists Act 1957; that serious professional misconduct was a wide expression that was not restricted to dishonesty or moral turpitude but included all professional conduct, whether by acts or omission or commission, by which a dentist had seriously failed to attain the standards of conduct which members of the dental professional expected."

In *McCandless v. General Medical Council* [1996] 1 WLR 169, the Privy Council went further. There the doctor was charged with serious professional misconduct in relation to errors he had made in the diagnosis of three of his patients and a failure to refer them to hospital. Lord Hoffmann, delivering the judgment of the Board, said that serious professional misconduct could include seriously negligent treatment measured by objective professional standards, adding that since *Felix v. General Dental Council*, "much has changed" and that the public now had higher expectations of doctors and members of other self-governing professions. He added that the authorities on the old wording "are of little assistance in the interpretation of the new"; and that in their Lordships' view it should be unnecessary in the future to revisit *Felix v. General Dental Council*, or any of the other earlier authorities. The reason for this, said Lord Hoffmann, was that the words "infamous conduct in a professional respect" had been replaced by "serious professional misconduct", and that the possible penalties now available to the professional conduct committee, which used to be confined to the ultimate sanction of erasure, had been extended to include suspension and the imposition of conditions upon practise, which suggested that serious professional misconduct was intended to include serious cases of negligence.

For myself, I find it difficult to understand how widening the range of sanctions available to the tribunal or professional conduct committee can affect or alter the interpretation or meaning of the words used by Parliament to describe misconduct or the test to be applied by the committee before it can find serious professional misconduct established. Moreover, the expectations of the public, important though they are, ought not to govern the interpretation of the words used in the legislation.

To me, and I think many, the boundaries of misconduct have continued to grow apace so much so that its limits are uncertain, or, as the Law Commission noted, the concept of misconduct has become too nebulous. On the present state of the authorities, it is clear that misconduct is not capable of precise description or delimitation, only that it must be serious and conduct which would be regarded as deplorable by fellow practitioners. In *Roylance v. General Medical Council (No 2)* [2000] 1 AC 311, the Privy Council rejected the doctor's argument that there must be some certainty in the definition of misconduct so that it can be known in advance what conduct will and will not qualify as serious professional misconduct. Lord Clyde delivering the judgment of the Board said that misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances, and that the misconduct and such falling short in question must be serious. In the Scottish case of *Mallon v. General Medical Council* 2007 SC 426, the Court of Session said that in view of the infinite varieties of professional misconduct, and the infinite range of circumstances in which it can occur, it is better not to pursue "definitional chimera."

In *Preiss v. General Dental Council* [2001] 1 WLR 1926, the Privy Council held that negligence or incompetence to a high degree may be enough to amount to serious professional misconduct. *Meadow v. General Medical Council* [2007] QB 462 established that giving flawed expert evidence in court can in appropriate

circumstances also amount to misconduct. And as recently as last year the Court of Appeal in *Schodlok v. General Medical Council* [2015] EWCA Civ 769, was asked to consider the theoretical possibility whether a series of non-serious misconduct findings could, taken together, be regarded as serious misconduct. The majority, Lord Justices Moore-Bick and Vos, felt that such a possibility would be unusual but should not be ruled out. Lord Justice Beatson was less sceptical and considered that, provided it was clear from the charge or the way the case was presented, it should in principle be open to a fitness to practise panel to find that, cumulatively, a pattern of non-serious findings could be regarded as serious misconduct capable of impairing a doctor's fitness to practise.

In her Fifth Shipman Report, Dame Janet Smith described the difficulties that have been experienced over the years in defining and recognising the concept of professional misconduct and noted that the problem had become more acute over the years. As Dame Janet said in her report, until the early 1990s the GMC was mainly concerned with cases of misconduct involving dishonesty, drug abuse, indecency, improper relationships with patients and breach of confidence. In effect, the GMC was concerned with cases involving wilful, deliberate or reckless misconduct, and did not generally concern itself with wider allegations such as negligent treatment or the many and varied complaints of professional misconduct received today by the GMC and other health care regulators. Dame Janet has argued that if the boundaries are widened there is an even greater need for standards, criteria and thresholds to be set for deciding where misconduct lies.

In their book *Medical Law*, Professor Sir Ian Kennedy QC and Andrew Grubb say that at the heart of the problem has been whether the GMC should concern itself only with misconduct which is "serious" or whether it should cast its net more widely. Some have argued that a doctor who was ordinarily competent should not be exposed to a procedure which could result in him or her being prevented from practising medicine. On the other hand, to leave an aggrieved patient only with an action in negligence may not be sufficient to meet their needs or protect the public interest, both in holding the doctor to account and in seeking to ensure that mistakes are not made again.

In 2005 the Department of Health, in agreement the British Medical Association and the British Dental Association, promulgated guidance on how best to deal with concerns about doctors and dentists working in the National Health Service. The guidance, called Maintaining High Professional Standards in the Modern NHS, is a framework for local Trusts and employers when dealing with conduct matters or issues of capability or health at a local level. Whilst recognizing that misconduct can cover a wide range of behaviour and can be classified in a number of ways, the guidance says that misconduct cases will generally fall into one of four distinct categories:

- a refusal to comply with reasonable requirements of the employer;
- an infringement of the employer's disciplinary rules;
- the commission of a criminal offence; and fourthly, and perhaps most significant,
- wilful, careless, inappropriate or unethical behaviour likely to compromise standards of care or patient safety, or create serious dysfunction to the effective running of a service.

Examples of concerns about capability are:

- out of date clinical practice;
- lack of knowledge or skills that puts patients at risk;
- incompetent clinical practice;
- inability to communicate effectively;
- inappropriate delegation of clinical responsibility; and
- ineffective clinical team working skills.

The guidance states that concerns about the capability of a doctor or dentist may arise from a single incident or a series of events, reports or poor clinical outcomes. It is inevitable that some cases will cover conduct and capability issues. The guidance suggests that if a case covers more than one category of problem, it should usually be combined under a capability hearing although there may be occasions where it is necessary to pursue a conduct issue separately.

The same difficulty, namely that of defining the limits of professional misconduct, has arisen in the legal profession in much the same way as in the health care professions. In the Law Society's Gazette of April 2010, Gregory Treverton-Jones QC and Andrew Hopper QC wrote an article aptly entitled "*Rules breaches and professional misconduct – where to draw the line*?" They said:

> "Time was, not very long ago, when a visitor to the Solicitors Disciplinary Tribunal would be presented with a diet of thefts from client account, Serious Accounts Rules breaches, or solicitors who for one reason or another could no longer run their practices. Today, the same visitor might well see decent, bewildered, and sometimes angry solicitors being hauled before the SDT. For generations of solicitors, the answer to ethical dilemmas was straightforward – if it felt wrong, it probably was wrong. Always put your clients' best interests first. Never take unfair advantage. Don't put yourself in a position where your interests conflict with those of your clients. Never knowingly mislead anyone. And, above all, never, ever, dip into client account to smooth out your practice's cashflow problems."

Recognising that that instinctive knowledge stills holds well, the authors lamented that it was now accompanied by a detailed and highly prescriptive set of rules. The concept of outcomes–focused regulation enshrined in the Solicitors Regulation Authority Code of Conduct 2011 means that many solicitors may find themselves facing disciplinary action. Mr Treverton-Jones' answer, which has great merit, is that the SDT should be required to deal with only the most serious examples of professional misconduct committed by solicitors. The less serious matters should be dealt with in-house by the SRA, by way of letters of advice, reprimands and the imposition of modest fines. Likewise many investigations by the General Medical Council and other health care regulators are sensibly concluded by undertakings, warnings or advice, rather than referral to a panel.

There remains the isolated incident or single issue case, and whether a single act or omission, or series of incidents relating to a single patient, should properly be categorised as misconduct. The doctor practitioner concerned will often have an otherwise unblemished long and distinguished career, yet in relation to a single incident may have fallen below the standards expected of a reasonable and competent practitioner, and which the doctor himself or herself would fully expect to follow. Should the isolated incident attract the label of professional misconduct? The case of Dr Aga is in point: *Aga v. General Medical Council* [2012] EWHC 782 (Admin). Dr Rakesh Aga was an experienced consultant gastroenterologist at the Medway NHS Trust. In 2012 he challenged the decision of the General Medical Council to the effect that his failure to recognise hypoglycaemia in a 54 year-old patient should be categorised as misconduct. The fitness to practise panel had nonetheless decided that his fitness to practise was not impaired and that it was not appropriate to give a warning. On an application for judicial review against the finding of misconduct, Mr Justice Eady held that, in the light of all the evidence, while it may be possible to criticise Dr Aga, no act or omission had been established which in any way adversely affected the patient. It was one isolated episode. It was not a case of multiple acts or omissions. In some respects Dr Aga may have saved the patient's life. Insofar as there was an act or omission at all, the Court found that it could not be categorised as particularly grave, so as to attract the label of misconduct.

The converse is the notorious case of Alfie Winn. In 1982, Alfie Winn, a child aged eight years, became ill with vomiting and a high temperature. His general practitioner was called and attended upon Alfie, who was asked to open his mouth. The boy seemed comatose and the doctor said that if Alfie could not be bothered to open his mouth, he would not examine him. He prescribed an antibiotic. Two hours later, the family called an ambulance and Alfie was taken to hospital. He died four days later of meningitis. The professional conduct committee of the GMC found the facts proved and held that the doctor's behaviour did fall below acceptable standards. Nonetheless, it

considered it did not cross the threshold for a finding of serious professional misconduct. The case attracted wide publicity with questions in Parliament and the GMC's guidance *Professional Conduct and Discipline: Fitness to Practise*, known as the Blue Book, was amended to emphasise that the public are entitled to expect that a registered medical practitioner will afford and maintain a good standard of medical care.

In part as a result of the Alfie Winn case, the concept of deficient professional performance was introduced by the Medical (Professional Performance) Act 1995. Serious deficient performance as it was originally called enabled the GMC to take action in relation to a practitioner's registration if the doctor's performance was found to have been seriously deficient. Today it is focused on whether the practitioner's fitness to practise is currently impaired by reason of deficient professional performance which may include professional competence. Governed by the General Medical Council (Fitness to Practise) Rules 2004 as amended the procedure involves a somewhat cumbersome process of assessment and monitoring whereby the practitioner agrees to submit to an examination by an assessment team of his or her performance or track record in the work the practitioner is doing. It is a moot point whether a single incident can give rise to a finding of deficient professional performance. In *Calhaem v. General Medical Council* [2007] EWHC 2606 (Admin), Mr Justice Jackson said that deficient professional performance connotes a standard of professional performance which is unacceptably low and which (save in exceptional circumstances) has been demonstrated by reference to a fair sample of the doctor's work, and that a single instance of negligent treatment, unless very serious indeed, would be unlikely to constitute deficient professional performance. Earlier, Lord Walker of Gestingthorpe in *Sadler v. General Medical Council* [2003] 1 WLR 2259 said that it would plainly be contrary to the public interest if a sub-standard surgeon could not be dealt with as a case of deficient professional performance unless and until he had repeatedly made the same error in the course of similar operations. Mr Justice Ouseley in a case *called R (Vali) v. General Optical Council* [2011] EWHC 310 (Admin) recognized that deficient professional performance may arise from a single event although adding that, normally one would expect to find a pattern of conduct underlying an allegation of deficient professional performance.

In her Fifth Shipman Report, Dame Janet Smith observed that there is no specific place in the legislation for the isolated or nearly isolated serious error, committed not deliberately or recklessly, but negligently. She proposed that a further category should be added to the means by which impairment may be proved, namely deficient clinical practice, which could relate to a single issue case of one or more than one instance. Referring to the categories of allegations by means of which impairment of fitness to practise may be demonstrated, Dame Janet said:

> "25.70 [I]n my view, there is a *lacuna* in the categories. There is a category of allegation which does not fall easily within the range of 'deficient professional performance' or of 'misconduct'. Misconduct generally connotes behaviour which has been undertaken deliberately or recklessly. In order to give the GMC jurisdiction to deal with cases of serious negligence which puts patients at risk, the bounds of [serious professional misconduct] were extended to embrace negligent acts of omission, usually arising in a clinical context, provided that they were sufficiently serious. However, to describe some of these cases as 'misconduct' required some 'stretching' of the use of the language…. With the advent of the performance procedures came the concept of [serious deficient performance]. This was usually characterised by a pattern of unacceptable clinical practice, although it could relate to organisational or behavioural problems…. So, there were then two concepts, [serious professional performance] and [serious deficient performance], neither of which comfortably accommodated a

> case of serious negligence such as that I described above. Such a case could not sensibly be termed [serious professional performance]; nor, if it was a 'one-off' incident, could it possibly amount to [serious deficient performance].
>
> 25.71 Unfortunately, section 35C [of the Medical Act 1983] has perpetuated this problem. There is still no place for the isolated or nearly isolated serious error, committed not deliberately or recklessly, but negligently. Nor is there a place for a case of two or three 'lower level' incidents which do not demonstrate the 'pattern' necessary to constitute deficient performance but which may nonetheless put patients at risk. It seems to me to be obvious that such cases ought to enter the FTP procedures because they could be cases of impairment of fitness to practise. I suggest that, if the legislation is to be amended, a further category should be added to the means by which impairment may be proved, namely 'deficient clinical practice', which could relate to one or more than one incident. The aim would be to ensure that the 'routes' to impairment of fitness to practise embrace all the circumstances which might put patients at risk."

I agree with every word of that. On re-reading her report, I can well understand if the Lady Justice might feel like the Italian conductor Toscanini, who remarked, "God tells me how the music should sound, but you stand in the way!"

In my view, the Law Commission is to be applauded for proposing in clause 120 of the draft Bill that deficient professional performance may include an instance of negligence. Hopefully, this will ensure that a pattern of repeated conduct is not required to establish a case of deficient professional performance, and that the one-off or isolated instance of negligence is capable of being addressed as deficient performance rather than trying to fit it into the concept of disgraceful misconduct. I add a note of caution though. For my part, I think there is much to be said for a category of clinical deficient practice to be distinguished from disgraceful misconduct and an assessment of the practitioner's performance. Such a category – deficient clinical practice – would undoubtedly cover the isolated or nearly isolated serious error, committed not deliberately or recklessly, but negligently.

The legal profession has similarly recognised the tension between conduct unbecoming a solicitor and lesser misconduct amounting to deficient professional practice. In *Sharp v. Law Society of Scotland* 1984 SC 129, breaches of the solicitors' accounts rules were admitted but in acquitting the junior partners of professional misconduct, Lord Emslie, Lord President, said that their failings were less culpable than those of the senior partners regarding the firm's accounting system and were not so serious or so reprehensible that a reasonable tribunal, properly directed, would have stigmatised their conduct as professional misconduct, which he described as a grave charge. Paragraph 301 of the 8th edition of the Code of Conduct of the Bar in England and Wales stated that a barrister must not engage in conduct whether in pursuit of his profession or otherwise which was dishonest or otherwise discreditable to a barrister; was prejudicial to the administration of justice; or was likely to diminish public confidence in the legal profession or the administration of justice or otherwise bring the legal profession into disrepute. I do not think anyone would quarrel that a failure by a barrister to comply with such a fundamental principle should constitute professional misconduct. Minor breaches were often not deemed to amount to professional misconduct unless particularly serious. The 9th edition of the Code provides, however, that professional misconduct means any breach of the Bar Standards Boards *Handbook* which is not appropriate for disposal by the imposition of administrative sanctions.

Let me attempt to bring these strands together and offer my own thoughts for the future. We have identified that professional misconduct has arisen in the past when a practitioner is found guilty of infamous conduct or serious professional misconduct or, as now proposed, disgraceful misconduct. But such labels do not tell us how far the boundaries of professional misconduct extend, only that the conduct concerned must be serious. Nor do they help us to define the meaning of deficient performance, whether in the legal or health care professions, or tell us when deficient practice crosses the line to become professional misconduct. We should, I believe, rightly be proud of our system of independent self-regulation of the professions and that it commands the support of Parliament and the confidence of the public. But it can only continue to do so if the system is fair, just and transparent. The reluctance of the courts to define the boundaries of misconduct, coupled with the widening of its scope to include negligence, has left the individual practitioner, the complainant and the regulator in a state of uncertainty as to the extent or limits of misconduct. If, as I believe, the concept of misconduct has become too wide ranging, as the Law Commission too appears to accept, there is, I suggest, a need for a revised understanding of what constitutes professional misconduct and a better demarcation of the boundaries between professional misconduct and deficient professional performance.

Whilst it may not be possible to lay down exact lines of demarcation, the Department of Health guidance *Maintaining High Professional Standards in the NHS* points, I believe, the way towards disgraceful misconduct as involving wilful, reckless, inappropriate or unethical behaviour likely to compromise standards of care or patient safety or other immoral or disgraceful behaviour. In this way, I suggest, disgraceful misconduct should be limited and confined to those cases involving serious or potentially serious harm or conduct which brings the profession into serious disrepute, and which may be said to be fundamentally incompatible with continued registration. That would leave deficient professional performance to encompass cases of negligent or incompetent practice or where there has been a failure to deliver an adequate standard of care sufficiently serious to justify regulatory intervention. I suggest that greater prominence should be given to the concept of deficient professional performance, or deficient clinical practice, particularly in cases of a single incident or series of events. The isolated incident of negligence could, save in extreme circumstances, be better considered as deficient professional performance or deficient clinical practice. With a clearer demarcation between disgraceful misconduct and deficient performance or practice the regulator, both in the legal and health care professions, and the public will more readily be able to see where the boundaries of professional misconduct lie. Also this might be expected to lead to a saving in costs with many practitioners accepting that their professional performance or practice was on the relevant occasion deficient, and thereby avoid a lengthy hearing to determine whether their behaviour should be categorised as disgraceful misconduct.

I offer these thoughts, as I say, as my own and not on behalf of any regulator or body. I can only end by quoting Oscar Wilde who remarked that it is always unwise to give advice, and to give good advice is often disastrous! Thank you.

Regulatory Appeals – An Alternative Forum

Sam Thomas, 2 Bedford Row

The Court of Appeal[3] in *Michalak v General Medical Council*[4] has endorsed an alternative route of appeal to the Employment Tribunal (ET) for claims of discrimination, victimisation or harassment by a *'qualifications body'* such as the General Medical Council, General Dental Council or Nursing and Midwifery Council. This overrules a previous decision by the Employment Appeal Tribunal[5] which held that the conventional route of challenge, to the High Court by way of judicial review (JR), precluded consideration by an ET. Where the issues are limited to procedural unfairness or the lawfulness of a decision JR remains; however, arguments relating to protected

3 Moore-Bick LJ; Kitchin LJ; Ryder LJ
4 [2016] EWCA Civ 172
5 See: Jooste v General Medical Council [2012] Eq. L.R. 1048

characteristics can now be heard in an alternative forum.

A qualifications body has the power to register and, in appropriate cases, to remove, limit or suspend the registration of a qualified individual contained upon its lists (a Registrant). Under the *'fitness to practise'* jurisdiction, a qualifications body receives, scrutinises and screens initial complaints about Registrants. Where the complaints go forward to an inquiry, a qualifications body is responsible for the preparation of the evidence and the drafting of allegations. Any hearing that follows is heard by a fitness to practise committee which is part of the qualifications body but is operationally independent. A decision to erase, suspend, or to impose conditions on a Registrant is susceptible of a statutory route of appeal to the High Court, which is empowered to dismiss the appeal; allow the appeal and quash the original decision; substitute a new decision for the original decision; remit the matter for re-hearing, and in all circumstances make a costs order.

The Equality Act 2010 (the Act), s.53, prohibits a qualifications body from discriminating against a Registrant based upon a protected characteristic such as age, disability, race, religion or sex. Discrimination can include: withdrawing a Registrant's qualification; varying the terms on which an individual holds the qualification; or subjecting a Registrant to any other detriment as a result of a protected characteristic. An ET may award appropriate damages against a qualifications body which breaches this prohibition. However, prior to *Michalak v General Medical Council*, it was thought that section 120(7) of the Act removed the jurisdiction of the ET in relation to the fitness to practise jurisdiction because of the oversight of the High Court:

> ***120 Jurisdiction***
>
> *(1) An employment tribunal has, subject to section 121, jurisdiction to determine a complaint relating to—*
>
> *(a) a contravention of Part 5 (work);*
>
> *(7) Subsection (1)(a) does not apply to a contravention of section 53 in so far as the act complained of may, by virtue of an enactment, be subject to an appeal or proceedings in the nature of an appeal.*

On 23 March 2016, The Court of Appeal in *Michalak v General Medical Council*, rejected this interpretation of section 120(7). It was held that although JR is undoubtedly a remedy of last resort, it is not an appeal on the merits that provides a determination in relation to potentially relevant unlawful treatment. (See: *Michalak v General Medical Council*, per Ryder LJ, at [40]):

> *'The modern form of judicial review may well be enacted but is not related to the statutory scheme within which the unlawful treatment complained of occurred nor is any remedy that is available in judicial review a remedy on the merits of discrimination, harassment, victimisation or other unlawful treatment, let alone from a specialist forum equivalent to the ET.'*

The High Court can quash a decision of a qualifications body but cannot make an award of damages without other relief. The High Court can grant a declaration but would not ordinarily make a finding on contested evidence and cannot issue a recommendation in respect of discrimination, harassment or victimisation. The Court of Appeal held that the appropriate forum to consider whether a qualifications body had breached the prohibitions within the Act was an ET (See: *Michalak v General Medical Council*, per Ryder LJ, at [45]):

> *'The ET is better equipped to deal with disputed decisions of fact and to examine courses of conduct. It is able to call on witnesses to provide evidence. These matters are important in discrimination claims which turn, in general, on the question of why a claimant was treated in a particular way and whether that treatment points to discrimination in respect of a protected characteristic. Judicial review, on the other hand, is set up to consider procedural unfairness and the lawfulness of a decision. It naturally goes more to the question of how a*

decision was made rather than why it was made.'

Kenneth Hamer, Henderson Chambers

The implications of this decision are potentially far reaching. A Registrant now has an alternative route of appeal, away from the High Court, in which a tribunal can consider evidence on an issue of discrimination, harassment or victimisation. Witnesses could be called to attest to whether an investigation into a Registrant's fitness to practise was a result of a protected characteristic. This would be unheard of in the High Court which would rarely, if ever, consider evidence or the merits of a claim unless it met the high bar of irrationality.

There are significant limitations to the powers of an ET, which would be unable to quash a decision in relation to a Registrant's fitness to practise. Allegations drafted by a qualifications body which were predicated on a discriminatory basis and resulted in an interim order of suspension could be considered by an ET but the registration decision could not be overturned. Theoretically however the ET could award damages for the loss of income the Registrant suffered during any period of suspension.

Qualifications bodies must be alive to potential challenge not only to their decisions, for example to refer to a fitness to practice committee, but also any process which might have a detrimental effect on a Registrant. In *Michalak v General Medical Council*, it was suggested that mere investigation of the appellant acted to her detriment. Only in very exceptional occasions would an investigation commence because of a protected characteristic such as age, gender, race or religion. However, investigations into a Registrant's fitness to practise where the consideration is disability, including mental health conditions such as stress and depression, are not uncommon. The Act, s.53(7), provides a limited exception to investigations in relation to disability. However, an investigations committee, or their delegated body, must be aware that the exemption from the ET's jurisdiction, on which they were previously able to rely, no longer exists.

***Rehman v. Bar Standards Board* [2016] EWHC 1229 (Admin)**

Dismissing R's application for an adjournment of his appeal, Hickinbottom J said that while the court should hesitate before refusing an adjournment application made for the first time by a litigant in person on medical grounds, the decision was a matter of discretion and was fact-specific. The applicant had to produce evidence from a medical practitioner identifying the condition relied upon and specifying the features preventing his participation in the trial process. The evidence was required to detail the medical practitioner's familiarity with the condition; provide a reason prognosis; and give the court confidence that what was being provided was an independent opinion formed on the basis of a proper examination. The court could then consider what weight to attach to that opinion and what arrangements might be made to accommodate the applicant's difficulties. Whether the applicant could effectively participate in the hearing depended on a number of factors, including the nature of the hearing and the merits of his case.

***Barnett v. Solicitors Regulation Authority* [2016] EWHC 1160 (Admin)**

Garnham J said that the authorities in relation to appeals under section 49 of the Solicitors Act 1974, namely *Shaw v. Logue* [2015] EWHC 5 at [33] and [62], and *Benyu v. Solicitors Regulation Authority* [2015] EWHC 4085 at [49] – [51] provide ample support for the proposition that the appeal proceeds by way of a review rather than a rehearing, the court will give appropriate weight to the fact that the tribunal is a specialist tribunal which had the advantage of hearing the evidence first hand. It will be slow to interfere with the tribunal's findings unless they were "plainly wrong", and the court may also interfere with the tribunal's decision if it finds a serious procedural or other irregularity in the tribunal proceedings.

Professional Standards Authority v. Health and Care Professions Council and Ajeneye **[2016] EWHC 1237 (Admin)**

In this case, the PSA's appeal was allowed against the HCPC's sanction of a caution order. The registrant, a senior biomedical scientist, had dishonestly provided false references for two acquaintances who were seeking to be employed as biomedical scientists. This was not a lapse in professional standards. It was two acts of dishonesty in combination with a dishonest attempt to place blame elsewhere in the course of the hearing. The damage caused to the public interest was evident in the harm caused to one patient and the manifest risk to which others were exposed. Further, the damage to public confidence caused by the fact that two wholly incompetent and dishonest individuals were employed as health professionals with the assistance and connivance of the registrant was obvious. Such conduct could not be met by a caution, even for five years.

Jerry v. Nursing and Midwifery Council **[2016] EWHC 681 (Admin)**

The appellant nurse had failed to record test results in a patient's notes and been dishonest when completing them later without an explanation. Her behaviour was fundamentally incompatible with registration. May J, in dismissing the appeal, said that a finding of dishonesty would always put a registrant at risk of erasure. There was no serious irregularity and the panel had not been wrong to arrive at the sanction of erasure.

Legal Assessors

R (British Medical Association) v. General Medical Council **[2016] 4 WLR 89**

In dismissing the BMA's application for judicial review challenging the legality of the General Medical Council (Legal Assessors and Legally Qualified Persons) Rules 2015, Hickinbottom J said that paragraph 6(b) did not require a legally qualified chair, when he has given advice to the other members of the tribunal panel in private and after their deliberations have begun, to make the parties privy to that advice and give them an opportunity to comment upon it, prior to the tribunal making a decision. It was sufficient for the advice to be incorporated into the tribunal's decision. There was an exception, where the legal chair considered it was necessary for the advice to be given to the parties to enable them to comment upon it before a decision was made. An example would be where a new material legal point arose during the panel's deliberations, upon which the parties had had no earlier opportunity to comment or challenge. The 2015 rules were not contrary to article 6 or common law fairness, nor otherwise unlawful.