

PART 7

FITNESS TO PRACTICE: IMPAIRMENT

Question 7-1: Should the statute: (1) retain the existing two-stage approach for determining impaired fitness to practise; or (2) implement the recommendations of the Shipman report; or (3) remove the current statutory grounds which form the basis of an impairment and introduce a new test of impaired fitness to practise based on whether the registrant poses a risk to the public (and that confidence in the profession has been or will be undermined)?

- 7.1 A small majority supported the removal of the existing statutory grounds and the introduction of a new test of impaired fitness to practise based on whether the registrant poses a risk to the public (and that confidence in the profession has been or will be undermined) – option three.¹

Option one: consolidation of the current framework

- 7.2 Many of those who supported option one felt that there was no need to change the existing system. For example, the British Chiropractic Association argued that the “current listed grounds for a finding of impaired practice are clear and unambiguous”. The Optical Confederation thought that the existing scheme protected registrants, whereas the alternatives did not “strike the appropriate balance of fairness between the registrant and the public”.
- 7.3 The Association of Regulatory and Disciplinary Lawyers argued that “the current position regarding the categories of impairment and their meaning has been clear for some years” and added:

There is no such thing as a new test that beds in with no further need for interpretation or judicial guidance on its application. For that reason we think that there must be an appreciably good reason to change the process, given the certainty that exists now about the definition and scope of the current categories or grounds of impairment. We have not identified such a reason in the discussion in the consultation paper.

- 7.4 The General Dental Council argued that “any change would be disruptive and there would be many legal challenges before the system could once again work smoothly and predictably”.
- 7.5 The General Optical Council agreed with retaining the current system but accepted there are difficulties that should be addressed. It noted that:

The current definitions are rigid, and perhaps do not place public safety/protection at the heart of the decision. We would support exploration of a more modern and flexible set of grounds of

¹ Of the 192 submissions which were received, 62 expressed a view on this question: 19 supported option one, 8 supported option two, 33 supported option three, whilst 2 held equivocal positions.

impairment, which might include issues of trust and confidence in the profession.

7.6 The Nursing and Midwifery Council argued that “the more immediate issue needing to be addressed is the current separation of processes and committees for these different statutory grounds”. It continued, “once a single Fitness to Practise Panel is introduced, as is proposed, this will remove many of the remaining concerns [regarding efficiency and effectiveness]”. The Council also preferred a term such as “deficient performance” or “poor performance”, rather than “lack of competence”, since the latter is a “narrower concept which has not been regarded as very flexible in its application to performance cases”.

7.7 The Professional Standards Authority also felt that the current system works best where the regulator has a unitary Fitness to Practise Panel “that can deal with all impairment issues holistically” and supported:

a move to require all the regulators to conduct their fitness to practise final hearings in front of such unitary committees, and to abandon the distinction between conduct, performance and health allegations, thus enabling them to consider “mixed” allegations in the round at the same hearing in the way that the General Medical Council already does. The benefit of this would be that, for example, fitness to practise cases involving matters relating to both the professional’s health and conduct, could be considered as one, rather than separately.

7.8 The Authority also queried whether our proposal for the statutory grounds would actually apply to barring decisions, given that such determinations do not include findings to the effect that a person’s fitness to practise is impaired.

7.9 However, a number of consultees were opposed to option one. The Health and Care Professions Council felt that the existing system is “difficult to understand for complainants and the public”, and leads to “the practical difficulty that health cases must be dealt with by a separate committee”.

7.10 The Royal College of Nursing argued that the current system:

causes problems for members of the public and registrants alike. In our opinion, the definition of misconduct is now so wide and diluted that a large category of activity is caught by it. It also does not help in the strict legal analysis of cases either.

7.11 The Equality and Human Rights Commission opposed this option unless it was amended to remove the references to good health and character.

Option two: Shipman recommendations

7.12 This option was supported by Rescare which argued it would provide for “objective standards in the investigation”, and “at adjudication there will be a requirement to examine both past and future and the process is consistent with the judicial process”.

7.13 Newcastle City Council argued that this option protects the public by enabling practitioners to be suspended while an investigation takes place and therefore alleviates the responsibility on employers to take such action.

7.14 The Professional Forum of the Pharmaceutical Society of Northern Ireland also supported this option on the basis that:

The inclusion of a clear definition of impaired fitness to practise ensures objectivity and clarity. There is also the ability for the Fitness to Practise Panel to consider the effect of the registrant's conduct on the reputation of the profession, which the Forum supports. The use of the final test, realistic prospect of a prosecution, is also supported as this should reduce the number of minor or irrelevant cases. The Professional Standards Authority supported implementing the Shipman report with some minor amendments to "make it clear that, absent a risk of future repetition, a past failure is not sufficient to amount to current impairment of fitness to practise".

7.15 The United Chiropractic Association also felt that option two had the potential to ensure that only appropriate cases were pursued. It considered that a large number of cases brought under the current system could be considered to be "unnecessary and costly".

7.16 However, several consultees opposed option two. The General Pharmaceutical Council argued that it "appears very legalistic, it requires different tests at different stages and in our view is likely to lead to delays and additional costs". The Medical Defence Union felt that some aspects would be "very difficult to put into practice", for example, it would be difficult "to establish satisfactorily how someone is liable to act in the future".

7.17 The Association of Regulatory and Disciplinary Lawyers felt that the Shipman recommendations were not "sufficiently flexible" since they suggest that if any of the criteria are found then impairment follows. This was described as "overly prescriptive" and inconsistent with "modern case law on the role of personal mitigation". Furthermore, this option would permit a finding that a registrant's fitness to practise "is impaired (present tense) on the basis of future risk alone". It argued that "any finding of impairment must be based on past misconduct" and "an assessment of future risk flowing from it, not future risk alone".

7.18 Similarly, the General Dental Council argued that the Shipman recommendations were flawed because "at adjudication all past misdeeds would need to be investigated and a surmise made about future conduct" which would be "disproportionate and unhelpful".

Option three: removal of the statutory grounds

7.19 The Patients Association said this option was "clearer, has the potential to be more efficient and we particularly welcome the inclusion of a 'reasonable person' test". An individual consultee (Lucy Reid) preferred this option because:

Given that the overriding objective for the regulators is to protect the public and for the practitioner it is to act in the best interests of their

patient, introducing a new test based upon whether a risk is posed would be most logical.

7.20 The British Society of Hearing Aid Audiologists felt that option three “relates most closely to the basic regulatory function of protecting the public from the risks resulting from the practice of a registrant whose fitness to practise is impaired”. The Society and College of Radiographers and the Wales National Joint Professional Advisory Committee both agreed that option three was properly concerned with risk to the public and confidence in the professions.

7.21 The General Medical Council supported “the removal of the statutory grounds and the introduction of a new simpler test that would be more easily understood by the public”. However, it suggested that the test should be “based on whether the registrant poses a risk to the public or that confidence in the profession has been or will be undermined”.²

7.22 The Health and Care Professions Council argued that option three “is clearer, much more straightforward and aligns with what is suggested to be the paramount duty of professional regulation”. The Council felt that while this option could reduce the threshold for allegations and lead to an increase in the number of investigations, this danger could be addressed by a “standard of acceptance for allegations” which makes it clear:

what the regulator considers to be a fitness to practise issue and ensures that consideration is given to whether the allegation meets the realistic prospect test before referral to formal fitness to practise proceedings.

7.23 The British Association for Counselling and Psychotherapy felt that “the removal of grounds and categories enhances the regulators’ option to consider a much wider field of potential cases/complaints” and therefore will “enhance public confidence”. It also felt that the risk of a larger number of referrals “needs to be managed at the initial investigation stage”.

7.24 The Patients Association disagreed “that the increase in the number of fitness to practise cases should be a concern” since:

This is not a lowering of the threshold but a widening of the scope of what fitness to practise means which fits much more with public perception and is entirely consistent with the regulators’ duties to uphold the paramount duties.

² Emphasis in the original.

7.25 The Royal College of Nursing supported an amended version of option three whereby the risk ground is “worded in the present tense (‘is a risk’)” and therefore the concept of “making a judgment at the date of hearing (and thus taking into account remedial steps, remorse, reflection, etc) is maintained”. The Royal College of Nursing suggested further amendment in order to ensure that the registrant must pose a “significant risk” to the public “in the course of their professional activities”, thus reducing the ability of fitness to practise panels to intervene in matters of private morality. On this basis, it was argued that the additional threshold of impaired fitness to practise would be “unnecessary” and could be removed since if a registrant posed a significant risk it would be obvious that fitness to practise is impaired.

7.26 The General Pharmaceutical Council supported a hybrid approach whereby option three is supplemented by “a duty on the regulators to identify impairment criteria for use in practical decision-making”. It was felt this would provide “predictability and specificity which is helpful in fairness terms, without the stultifying effect of having the criteria defined in detail in the statute”.

7.27 However, several consultees opposed option three. The General Optical Council stated:

We are not yet convinced that this change would have benefits that would justify the risks of introducing an entirely new system, and believe that under such a system there is a possibility that we may end up having similar legal arguments under another name.

7.28 The British Chiropractic Association felt that:

to not limit evidence to any predetermined categories runs the risk of an apparent “scattergun” approach to evidence that is likely to result in registrants facing a disparate range of allegations thereby making it increasingly difficult for a registrant to understand properly the case he/she is facing.

7.29 The Professional Standards Authority argued that option three omits “an important element of the purpose of fitness to practise proceedings – the declaring and upholding of professional standards”. It said that this option will not achieve consistency in the ways in which the regulators undertake fitness to practise cases. Furthermore, the Authority stated:

We have not been able to envisage any scenarios involving conduct which do not fall within the legal definition of either misconduct or one of the other statutory grounds of impairment, in relation to which a regulator would wish to bring fitness to practise proceedings.

7.30 The Association of Regulatory and Disciplinary Lawyers queried whether this option “adds anything to the current position” since a risk to the public has been “central to a finding of impairment since the introduction of the current scheme in 2004”. It added that:

The requirement to characterise the facts found proved as misconduct, deficient performance etc defines the issues and provides the decision-maker with a rigor of approach to the facts and

a route-map to the decision on impairment, and indeed sanction, which should not be abandoned in favour of a focus on the *consequences alone* of what he has done (future risk to the public, undermining public confidence); we predict that if there is no codified requirement to categorise the essence of the complaint by reason of which it is said the practitioner's fitness to practise is impaired, competent panels will continue to do so anyway, (demonstrating the need to codify the requirement for all panels).³

7.31 The Nursing and Midwifery Council was concerned that:

Considerable legal costs would undoubtedly be incurred on all sides in implementing the new provisions and in building up a new body of case law to assist in the interpretation of the new risk-based definition. We would also suggest that, even if the statutory grounds are removed, some non-exclusive reference to them, as part of the definition of impairment, may still be helpful. This would illustrate the varying ways in which a risk to the public may be established, for example, misconduct, poor performance, ill-health. This would enable reliance to still be placed on the helpful body of case law that has built up in this field.

7.32 RadcliffesLeBrasseur argued that option three would lead to “uncertainty” and produce:

a three stage test; establishing the facts, establishing risk to those whom the registrant treats from those facts and then establishing impairment. There would be the prospect that the third stage would be meaningless and/or otiose ... It is hard to see a Fitness to Practise Panel concluding that the doctor was a risk to patients but that he was unimpaired. There is a fear that risk is being proposed to make it easier to impose sanctions/restrictions.

7.33 It was also argued by RadcliffesLeBrasseur that the adoption of a risk threshold would have the following consequences:

One strand of fitness to practise decision making is that panels hand down sanctions in order to mark disapproval of past conduct in order to set standards for the profession. They may do so based on a finding of impairment despite accepting evidence of remediation, in other words even where they find no risk. The adoption of a risk threshold for the imposition of sanctions would remove that option.

7.34 The Equality and Human Rights Commission expressed concern that option three might allow a wider range of relevant evidence to be gathered and could result in “inappropriate evidence being incorrectly perceived as relevant” in relation to assumptions “about people, for instance in relation to their physical or mental health”. A consultee at an event organised by a law firm argued that this option might have an impact on sanctions, given that the practice of some regulators is to limit certain sanctions to different categories of case.

³ Emphasis in the original.

- 7.35 The Department of Health felt that the existing framework should be maintained as “there is a large body of case law to support it” and the case to radically depart from it had not been made. The Scottish Government considered that the current arrangements are “appropriate, familiar to the regulators, work well and are supported by established case law”.

Other comments

- 7.36 The British Association for Music Therapy asked the Law Commission to consider the definition of fitness to practise in relation to “registrants working as educators of students in training, rather than as practitioners working with patients”. It was argued that “different standards may be appropriate for each context, and that clarification is needed” and furthermore, “some educators may not be registered ... and so would not be subject to the same standards (and possible sanctions) as their registered colleagues”. This had been prompted by a recent fitness to practise case where students brought allegations of deficient professional performance against a registrant in her role as their tutor.

- 7.37 The Association of Clinical Biochemistry felt that the statute must clarify “what sort of physical or mental health ‘problems’ may constitute a risk to the public”. It gave the example of:

where a practitioner contracts a sexually transmitted disease which is treatable and may have been acquired faultlessly from a spouse or civil partner; or be suffering from stress and depression caused by excessive demands at work. It is also possible that in some situations carrying out an investigation could contravene the Equalities Act 2010 if a healthy individual would not be investigated in the same circumstances.

- 7.38 The Patients Association felt that the key stumbling block is the order in which cases are being considered, in that facts are first established and then it is considered whether the professional’s fitness to practise is impaired. It suggested the following reordering of the process:

- (1) whether, if the alleged acts took place, there would be a risk to the public or to public confidence;
- (2) if there would be a risk to the public or to public confidence, would a professional’s fitness to practise be impaired;
- (3) whether there is evidence that those acts took place; and
- (4) if they then can be proven, what sanctions should be brought.

- 7.39 Several consultees acknowledged that this was a difficult area, and stressed that whichever option was adopted, “the main focus ... should be consistency across all professions” (Coventry and Warwickshire Partnership Trust). An individual consultee (Jane C Hern) agreed that a clear framework was required:

as it will not be conducive to maintaining the confidence of either the profession, or the public, if regulators are perceived to be able to do

whatever they like in the name of patient protection and according to a fuzzy definition of impairment.

Question 7-2: If a list of statutory grounds of impaired fitness to practise is retained, should it refer to a broader range of non-conviction disposals?

7.40 A majority disagreed that the statutory grounds should include a broader range of non-conviction disposals.⁴ For example, the Department of Health felt that the statutory grounds should not include a broader range of non-conviction disposals.

7.41 The Health and Care Professions Council felt that it was “already able to handle effectively a range of non-conviction disposals”. It will “investigate the circumstances which led to that action being taken, in order to determine whether an allegation of misconduct should be made”.

7.42 The Medical Defence Union argued that:

In the interests of a fair procedure, it should not be assumed that a non-conviction disposal amounts to impaired fitness to practise. The registrant may have agreed to such a disposal for all sorts of reasons and the matter has not been tested by the courts. Further, its relevance to fitness to practise will be dependent on the facts of the specific case. The regulator will need to investigate the matter in the usual way and, if the allegations seem to raise questions of impaired fitness to practise, apply the realistic prospect test.

7.43 The Association of Regulatory and Disciplinary Lawyers stated:

Our concerns about “other disposals” arise principally because the other potential disposals will almost certainly result from procedures that are inappropriate to found a disciplinary sanction that could permanently terminate a professional person’s ability to work in his or her chosen profession.

7.44 Similarly, the Medical Protection Society argued that non-conviction disposals should not be included because they “concern suspected and unproven offences and they also concern a lesser category of offence”. It referred to *R v Hamer* in which the Court of Appeal held that a fixed penalty notice:

constituted neither an admission of guilt nor any proof that a crime had been committed. It was not to be regarded as a conviction and it was not to be admissible in evidence as an admission of an offence as payment of any penalty does not create a criminal record. However, we recognise a regulator’s right to investigate what appears to be a pattern of behaviour.⁵

7.45 UNISON argued that:

⁴ Of the 192 submissions which were received, 27 expressed a view on this question: 9 said the list should include non-conviction disposals, whilst 18 disagreed.

⁵ [2010] EWCA Crim 2053, [2011] 1 WLR 528.

Cautions, which are also currently accepted as a statutory ground, are less robust. Registrants often state that they were not aware of the impact on their registration of accepting a caution, and if they had realised would not have done so. Any disposal process that has an element of compromise or consent could be undermined if the impact of doing so goes beyond the issue that the disposal is addressing.

7.46 The Pharmaceutical Society of Northern Ireland was opposed to the introduction of a broader list. It thought that a “standardised definition of what constitutes misconduct” would be preferable to a “prescriptive list”.

7.47 However, some consultees argued that the statutory grounds should include a broader range of non-conviction disposals. The General Optical Council stated:

Although the presence of a criminal conviction/non-conviction disposal does not automatically lead to a finding of impairment, such matters do raise a question about a registrant’s fitness to practise. A single fixed penalty notice may not merit an investigation or concern but a string of them might.

7.48 The General Medical Council noted that a shift in police policy towards an increased use of fixed penalty notices meant that reference to a broader range of disposal would help to “future proof” the legislation. An individual consultee (James Kellock) saw the problem of increasing non-conviction disposals in different terms:

Parliament has considerably expanded the number and range of non-court disposals of allegations and the application of the various options by different police forces appears to be inconsistent.

7.49 An individual consultee (Lucy Reid) argued that:

I think that it should refer to a broader range but also should consider the conviction criteria – potentially having to consider a fitness to practise case because of a parking or speeding ticket appears over the top.

7.50 The Scottish Government argued that the list of non-conviction disposals should be expanded to cover, for example:

fixed penalty notices in contexts such as theft and public order offences (but not in relation to other contexts such as speeding or parking offences unless these have resulted in wider public order issues or offences). We would suggest that if this list was expanded to include speeding/parking fines and/or penalties, this would suggest a punitive rather than a public protection function.

Question 7-3: How adequate are the powers of the regulators to require disclosures from the Independent Safeguarding Authority and Disclosure Scotland? What practical difficulties, if any, arise as a result of differences between the protection of vulnerable groups schemes in England, Wales, Northern Ireland and Scotland?

- 7.51 A majority agreed that the regulators' powers to require disclosures from the Independent Safeguarding Authority and Disclosure Scotland were inadequate.⁶
- 7.52 Several consultees pointed out that up until recently the Independent Safeguarding Authority did not have powers to share the reasons for barring decisions with regulators. The Authority itself argued that this will be addressed by the Protection of Freedoms Act 2012. The Department of Health agreed that the new legislation will address some of the current problems. It argued there should be "broad enabling powers to apply to information sharing" between the regulators, and the relevant safeguarding bodies.
- 7.53 However, the General Medical Council argued that under current transitional arrangements the provision of reasons by the Independent Safeguarding Authority "is still extremely patchy". It also argued that the legislation is "unclear about the types of cases that should be referred and about the timing of referrals" and it had been pressing the Government for official guidance to be issued.
- 7.54 The Health and Care Professions Council reported that where the Independent Safeguarding Authority has reached a decision not to bar the individual, "there is no way for [us] to know this unless we had made the referral in the first place". The Independent Safeguarding Authority therefore "may hold information that is relevant to fitness to practise which does not reach the threshold to bar the individual, but this is not disclosed to the regulator".
- 7.55 The Nursing and Midwifery Council stated:
- We face significant hurdles in seeking relevant information and evidence from all agencies, particularly the Independent Safeguarding Authority, the Police Service of Northern Ireland, various other police forces, and Disclosure Scotland. This is despite the fact that we regularly assist these agencies and we have a memorandum of understanding with many of them. We acknowledge that there have also been deficiencies on our part in complying with the Independent Safeguarding Authority requirements and in responding to requests for disclosure. Some of the difficulties lie in the lack of clarity regarding the overlap between the powers of disclosure to and from these bodies and current data protection legislation.
- 7.56 The General Osteopathic Council stated that "the current powers are not clearly defined and there is confusion about what can be disclosed and used".

⁶ Of the 192 submissions which were received, 20 submissions expressed a view on this question: 6 said the powers were adequate, 14 said they were inadequate.

7.57 Some consultees suggested specific amendments to legislation. For example, the General Optical Council argued that its power to require “relevant” information from the Independent Safeguarding Authority should be amended to ensure that:

any decision about relevance is a matter for the regulator and not the person holding the information. It is assumed that regulators have sufficient experience in the field of public protection that information will be used appropriately, shared only with those who are either a party or a decision maker, and where necessary sensitive information is dealt with in a private hearing.

7.58 RadcliffesLeBrasseur argued there should be a requirement that the regulator and the Authority “inform the professional when and the circumstances in which information is being passed from one to another about that professional”.

7.59 The General Social Care Council argued that a barring decision by the Independent Safeguarding Authority “should be treated as evidence (rather than conclusive proof) that the fitness to practise of a registrant is impaired”.

7.60 The Independent Safeguarding Authority suggested that all health and social care professional regulators should be able to use a barring decision and the reasons for the bar “as ‘findings of fact’ in their fitness to practise processes”. It suggested that this position is not consistent across all regulators. It agreed that a barring decision should be one of the statutory grounds, but said that:

it should be noted that there may be work that a health and social care registrant could legally undertake that would not be a regulated activity (work they are barred from). An example of this would be a barred medical doctor undertaking research work with no contact with children or vulnerable adults.

7.61 The General Dental Council said that:

It would be useful if the Authority and Disclosure Scotland had an obligation to disclose to the regulators when they make a decision to bar or are in the process of barring a registrant, and that reasons were given, not just the outcome.

7.62 In relation to requests for information from the regulators, the Independent Safeguarding Authority suggested that there is a lack of understanding about how its processes differ from standard fitness to practise processes. It felt that:

This means that regulators may request information that is not relevant for their purposes. Further engagement in relation to establishing memoranda of understanding ... should assist this understanding and the development of appropriate information sharing arrangements.

7.63 Some consultees provided examples of practical difficulties which arise as a result of differences between the protection of vulnerable groups schemes in England, Wales, Northern Ireland and Scotland.⁷

7.64 The General Medical Council reported that as a result of the differences between the different schemes it operates two different referral systems, which “is complex and increases the risk either that we will treat doctors differently depending on where they are living or that an individual case may get overlooked”.

7.65 The Royal College of Midwives expressed:

major concerns with differences in the manner in which the organisations in different countries operate and in the level of scrutiny and evidence that is consulted before a decision is made. In many systems the individual has only limited ability to challenge a ruling. The regulators must take these into account but should be free to challenge them, however this does not help a registrant whose livelihood has been removed on the basis of unchallenged evidence.

7.66 In relation to differences between England and Scotland, the Scottish Government stated that the policy intention is that:

Separately, and subject to the appropriate regulations being made in the future, Disclosure Scotland will provide the nine health regulators with a copy of a Protecting Vulnerable Groups Scheme Record if the applicant provides details of their registration at the time of their initial application to join the Protecting Vulnerable Groups Scheme. The power to provide that copy of the Protecting Vulnerable Groups disclosure record would be separate from the health regulatory bodies being able to request a Protecting Vulnerable Groups disclosure record for their regulatory purposes *per se*.

7.67 It pointed out that there are differences between the English and Scottish systems in relation to the sharing of “soft intelligence” in that Disclosure Scotland “share this type of information with the regulators, but leave the regulators the decision of what to do with the details”. It added:

We are also aware that there is the possibility of future changes to the scheme in England. We understand that the proposals are for only one certificate to be issued to the applicant rather than two as now; to the applicant and the registered person. The registered person will know that the application has been made as they will have countersigned the form. The change in England therefore is that the subject will be able to see and challenge a disclosure before anyone else gets to see it.

⁷ Of the 192 submissions which were received, 6 gave examples: 3 said that there was a lack of clarity around legal responsibilities, 2 said that complex systems and guidance had to be put in place, whilst 1 said that there were potential problems regarding delay.

7.68 An individual consultee (Lucy Reid) felt that “it is very easy for practitioners to become career tourists in order to elude detection of issues”.