Impairment of fitness to practise: has the pendulum swung?

Martin Forde QC

Abstract
Practitioners and their legal advisers have struggled to interpret the nebulous concept of impairment of fitness to practise since its introduction in November 2004. Impairment of fitness to practise is not defined in the legislation or in the General Medical Council (Fitness to Practise) Rules 2004. This has led to competing arguments being raised before Fitness to Practise Panels regarding both the meaning of impairment of fitness to practise and the nature and quality of the evidence that can be relied upon as evidencing a lack of impairment of fitness to practise. A recent trilogy of High Court decisions appears to have provided the clarity so sadly lacking in the legislation. The cases of Cohen, Zygmunt and Azzam, all decided in 2008 in the High Court, may have provided greater protection to doctors.

Introduction
Following the Ledward, Ayling, Neale and Bristol Inquiries and the Shipman trial and Inquiry, the General Medical Council (GMC) came under enormous media and political pressure to reform its regulation of doctors.

Prior to the recent reforms, a doctor facing an inquiry by the GMC could expect to be dealt with either by reason of misconduct, a criminal conviction or a health concern. From July 1997, a doctor could also be accused of seriously deficient performance.

The fact that those four potential avenues were seen as separate and distinct, followed different procedures and that the allegations were considered by different committees, under different rules, was perceived by reformers as a serious disadvantage.

The perceived advantage of the Fitness to Practise Panel was that such a panel would deal with all aspects of an inquiry whether encompassing health, conduct, deficient performance, conviction or hybrid allegations (e.g. allegations encompassing health and performance or health and misconduct), adopting a single set of rules and sanctions guidance.

Initially, the GMC allowed evidence to be adduced, prior to a finding of impairment, relating to whether or not the facts found proved at the end of Stage 1 were typical of the doctor's usual practice or represented a lapse from the doctor's usual standards. Furthermore, evidence could be adduced as to whether or not the doctor had attempted through further training to remediate his or her practice since the events in question.

From early 2006, a harder line was adopted. No evidence of remediation or an insightful response to the matters proved was necessarily allowed to be adduced before a finding of impairment, such evidence being regarded by the GMC as only being relevant to mitigation.

How was it that such a situation occurred? The answer is that prior to guidance from the Courts the correct interpretation of the statute and the rules appeared to some ambiguous.

The statutory framework
A doctor's fitness to practise can be impaired pursuant to section 35(C) (2) of the Medical Act 1983 (as amended) in the following circumstances:

(2) A person's fitness to practise shall be regarded as "impaired" for the purposes of this Act by reason only of:

(a) misconduct;
(b) deficient professional performance;
(c) a conviction or caution in the British Islands for a criminal offence, or a conviction elsewhere for an offence which, if committed in England and Wales, would constitute a criminal offence;
(d) adverse physical or mental health; or
(e) a determination by a body in the United Kingdom responsible under any enactment for the regulation of a health or social care profession to the effect that his fitness to practise as a member of that profession is impaired, or a determination by a regulatory body elsewhere to the same effect.

Matters become further complicated by rules 17(2) (f–l) of the GMC (Fitness to Practise) Rules 2004 (Box 1).
The current regime therefore provides for a three-stage process. Establishment of the facts, consideration of impairment and, if necessary, sanction.

**The GMC’s restrictive interpretation of impairment**

A restrictive interpretation of rule 17(2)(j) precluded the doctor from adducing evidence of his or her current fitness to practise (i.e. at the time of the hearing), because it was argued by the GMC that current fitness to practise evidence did not relate to the facts found proved at the time of the hearing.

Confusion appears to have arisen regarding the change of phraseology from serious professional misconduct to impairment of fitness to practise. The old regime required the Professional Conduct Committee of the GMC to consider whether to impose a sanction when they adjudged a practitioner ‘to have been guilty of professional misconduct’ whereas the new regime uses the present tense, i.e. whether the practitioner is impaired at the time of the hearing.

The difficulty with the concept of impairment of fitness to practise was foreshadowed by Dame Janet Smith in the *Fifth Shipman Enquiry Report*: ‘it is capable of embracing any or all of the types of problem that the GMC habitually encounters … the disadvantage of the concept is that it is not at all clear what it means’.

The attitude of those acting for the GMC was that no evidence of the doctor’s usual practice or remediation since the misconduct or deficient performance alleged was admissible at stage 2 as set out above. The practitioner’s fitness to practise could be irredeemably impaired by reason of past matters sufficient to undermine public confidence in the profession; this regardless of any context or insightful steps taken by the practitioner to undergo remediation. Consequently, the profession perceived that an increasing number of cases where an isolated lapse from otherwise high professional standards might result in a finding of current impairment.

**The contrary view**

Obviously those of us acting for practitioners were anxious to adduce evidence, short of pure mitigation, of context and remediation. Plainly, we sought to argue there can also be instances of negligent misconduct that fall short of impairment when in seen in context. The Courts have been keen to emphasize that impairment still denotes ‘serious misconduct’ and not mere negligence.

This was made clear by the Court of Appeal in *Meadow*: Auld LJ emphasized that the use of the word ‘misconduct’ in section 35(C) of the Medical Act did not connote a lower threshold for a finding of impairment compared with the previous statutory regime which spoke in terms of serious professional misconduct:

As to what constitutes ‘serious professional misconduct’, there is no need for any elaborate rehearsal by this Court of what, on existing jurisprudence, was capable of justifying such condemnation of a registered medical practitioner under the 1983 Act before its 2003 amendment. And, given the retention in the Act in its present form of section 1(1A), setting out the main objective of the GMC ‘to protect, promote and maintain the health and safety of the public’, it is inconceivable that ‘misconduct’ – now one of the categories of impairment of fitness to practise provided by section 35C of the Act – should signify a lower threshold for disciplinary intervention by the GMC.

That a practitioner can be guilty of misconduct or deficient performance insufficient to amount to impairment of fitness to practise was emphasized by Mr Justice Silber in the case of *Cohen*:

I must stress that the fact that stage 2 is separate from stage 1 shows that it was not intended that every case of misconduct found at stage 1 must automatically mean that the practitioner’s fitness to practise is impaired.

There must always be situations in which a Panel can properly conclude that the act of misconduct was an isolated error on the part of a medical practitioner and that the chance of it being repeated in the future is so remote that his or her fitness to practise has not been impaired. Indeed the Rules have been drafted on the basis that the once the

---

**Box 1 Rules 17(2) (H-I)**

(i) where facts remain in dispute, the Presenting Officer shall open the case for the General Council and may adduce evidence and call witness in support of it;

(g) the practitioner may make submissions regarding whether sufficient evidence has been adduced to find the facts proved or to support a finding of impairment, and the FTP Panel shall consider and announce its decision as to whether any such submissions should be upheld;

(h) the practitioner may open his case and may adduce evidence and call witnesses to support it;

(i) the FTP Panel shall consider and announce its findings of fact;

[j] the FTP Panel shall receive further evidence and hear any further submissions from the parties as to whether, on the basis of any facts found proved, the practitioner’s fitness to practise is impaired;

(k) the FTP Panel shall consider and announce its findings on the question of whether the fitness to practise of the practitioner is impaired, and shall give its reasons for that decision;

[l] the FTP Panel may receive further evidence and hear any further submissions from the parties as to the appropriate sanction, if any, to be imposed or, where the practitioner’s fitness to practise is not found to be impaired, the question of whether a warning should be imposed;

[This is the end of Stage 1 and the start of Stage 2]

[j] the FTP Panel shall receive further evidence and hear any further submissions from the parties as to whether, on the basis of any facts found proved, the practitioner’s fitness to practise is impaired;

[k] the FTP Panel shall consider and announce its findings on the question of whether the fitness to practise of the practitioner is impaired, and shall give its reasons for that decision;

[This is the end of Stage 2 and the start of Stage 3]

[l] the FTP Panel may receive further evidence and hear any further submissions from the parties as to the appropriate sanction, if any, to be imposed or, where the practitioner’s fitness to practise is not found to be impaired, the question of whether a warning should be imposed;

[This is the end of Stage 3]
Panel has found misconduct, it has to consider as a separate and discreet exercise whether the practitioner's fitness to practise has been impaired. Indeed section 35D(3) of the Act states that where the Panel finds that the practitioner's fitness to practise is not impaired, 'they may nevertheless give him a warning regarding his future conduct or performance'.

Both those passages were quoted with approval by Mr Justice Mitting in Zygmunt and, in the author's view, must support the proposition that some evidence must have to be adduced as to whether or not the misconduct alleged was an isolated error, unlikely to be repeated or not.

Rejection by the Courts of the restrictive view of impairment

The recent trilogy of cases, Cohen, Zygmunt and Azzam have, in the author's view, resulted in a resounding rejection of the restrictive view, not only indicating that contextual evidence of the misconduct or deficient performance should be admitted at stage 2 (i.e. how representative the error or errors may be of the doctor's usual practice), but also what attempts the practitioner has made to remediate him or herself.

Cohen

Dr Cohen, a consultant anaesthetist, was criticized for his treatment of a single patient during the course of a 2.5-hour operation as well as an inadequate pre- and post-operative assessment. The Fitness to Practise Panel found those criticisms justified assisted by expert evidence given to them by an independent consultant anaesthetist, concluded that Dr Cohen’s fitness to practise was impaired despite the fact that the expert who gave evidence on behalf of the GMC in respect of the errors made by Dr Cohen in the following terms:

‘However I do not consider that these were so serious as to amount to misconduct, such that his registration might be called into question.’

The lack of a proper definition of impairment has already been commented upon. The phraseology used by the expert was no doubt influenced by the only attempt the GMC have made to define impairment of fitness to practise. This is set out in paragraph 11 of its Indicative Sanctions Guidance, commented upon dismissively by Mr Justice Mitting in Zygmunt in trenchant terms:

Current GMC guidance, given following criticism by Smith LJ of an earlier version, is given in section 1, paragraph 11 of the Indicative Sanctions Guidance for Fitness to Practise Panels of April 2005:

‘Neither the Act nor the Rules define what is meant by impaired fitness to practise but for the reasons explained below, it is clear that the GMC’s role in relation to fitness to practise is to consider concerns which are so serious as to raise the question whether the doctor concerned should continue to practise either with restrictions on registration or at all.’

This is unhelpful. To advise a decision-making Panel as to the test which it must apply that ‘the GMC’s role in relation to fitness to practise is to consider concerns which are so serious as to raise the question whether the doctor concerned should continue to practice…’ (my emphasis) does not define a test at all. It identifies and begs the question without providing any guidance as to how it is to be answered.

The panel found that Dr Cohen’s actions were inappropriate, unprofessional and of a standard below that to be expected of a registered medical practitioner. However they gave no reason why they rejected the evidence of the expert witness called by the GMC that Dr Cohen’s errors and misconduct were ‘easily remediable’.

Counsel for the GMC submitted, in keeping with the restrictive view of impairment of fitness to practise, that the remediable nature of the practitioner’s failings was not relevant to the issue of impairment but only sanction. The judge recorded her submissions as follows:

She submits that the Panel were not entitled to address the remediable nature of the appellant’s failings at this stage and that this matter did not have any bearing on his fitness to practise. Her case is that the requirements of the public interest – the protection of patients, maintenance of public confidence in the profession, and declaring and upholding standards of conduct and behaviour of doctors – are properly to be considered at the sanctions stage and she relies on paragraphs 13 to 15 of Indicative Sanctions Guidance. So she says that the impact of the public interest of the appellant taking steps to remedy his errors were properly addressed at the sanctions stage and not, as the appellant considers to be the position, at the fitness to practise stage, namely at the second stage.

The judge roundly rejected this approach in the following terms:

Any approach to the issue of whether a doctor’s fitness to practice should be regarded as ‘impaired’ must take account of ‘the need to protect the individual patient, and the collective need to maintain confidence in the profession as well as declaring and upholding proper standards of conduct and behaviour. In my view, at stage 2 when fitness to practise is being considered, the task of the Panel is to take account of the misconduct of the practitioner and then to consider it in the light of all the other relevant factors known to them in answering whether by reason of the doctor’s misconduct, his or her fitness to practise has been impaired. It must not be forgotten that a finding in respect of fitness to practise determines whether sanctions can be imposed: section 35D of the Act.

Indeed I am in respectful disagreement with the decision of the Panel which apparently concluded that it was not relevant at stage 2 to take into account the fact that the errors of the appellant were ‘easily remediable’. I concluded that they did not consider it relevant at stage because they did not mention it in their findings at stage 2 but they did mention it at stage 3. That fact was only considered as significant by the Panel at a later stage when it was dealing with sanctions. It must be highly relevant in determining if a doctor’s fitness to practise is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated. These
Impairment of fitness to practise: has the pendulum swung?

are matters which the Panel should have considered at stage 2 but it apparently did not do so.

The Panel must, for example, contrary to Miss Callaghan’s submissions be entitled, if not obliged, to consider whether the misconduct is easily remediable in the case of the doctor concerned. If this is not so, the Panel would be precluded from considering that it was not because the doctor has psychiatric or psychological problems which mean that he will be unable to remedy the misconduct and is likely to repeat it.

(iv) Conclusions

I have concluded that the decision of the Panel that the fitness to practise of the appellant was impaired was wrong even after taking account of the need to give substantial weight to the public interest including the protection of patients, the maintenance of public confidence in the profession and upholding proper standards of conduct and behaviour.

The judge considered that fitness to practise should not be found without consideration of other factors, such as whether the misconduct was easily remediable. To disregard that fact was a serious error. He accepted that for instance in the presence of psychiatric difficulties misconduct might be incapable of being easily remediable but concluded: ‘... the ease with which misconduct can be remedied is relevant to the issue of whether a doctor’s fitness to practise has been impaired’.

He reinforced the point by stating:

‘...if the misconduct is easily remediable, this must be very relevant and merit very serious consideration by the Panel. This point is fortified by the evidence in this case, which was that these matters had been remedied by the appellant by the time of the hearing.’

The Appeal against the finding of impairment was upheld.

Zygmunt

The case of Zygmunt adopted the approach in Cohen and emphasized the fact that when considering whether a medical practitioner’s serious professional misconduct or deficient performance meant his fitness to practise is impaired, it was necessary to determine whether any impairment was still current. The Panel’s determination upon sanction read so far as relevant as follows:

Apart from this one episode in 2001 when you failed to act in accordance with the requirements of ‘Good Medical Practice’ in the areas identified, the Panel has received no evidence that suggests you pose a risk to your patients. To the contrary, the evidence of senior professional colleagues, given without reservation, was that you are a safe doctor.

The period of suspension which the Panel has imposed in order to mark its disapproval of your misconduct should not result in a deterioration of your surgical skills. The Panel has not identified any areas of your practice which require remedial training.

The judge considered that evidence highly relevant to stage 2 of the Inquiry had not been given until stage 3 – the sanctions stage. He stated:

The evidence which led to this favourable conclusion (i.e. the previously quoted passage), a conclusion which on any common sense view relates to Professor Zygmunt’s current fitness to practise, should have been put before the Panel at the second stage. Had it been, the Panel would have had material upon which it could have concluded that Professor Zygmunt’s fitness to practise was not impaired.

The matter was therefore remitted back to the Fitness to Practise panel for further consideration of the question of impairment of fitness to practise.

Azzam

Perhaps the high watermark of judicial clarification of the issue of impairment of fitness to practise thus far is the case of Dr Azzam.

Dr Azzam was at the relevant time a specialist registrar working in obstetrics and gynaecology. The case raised a number of issues but in essence involved the misreading of a CTG trace as suspicious rather than pathological. The child died as a result of birth asphyxia, and it was common ground that had an error not been made in reading the trace the child would have been delivered 35 minutes earlier and the tragedy would have been averted.

Since the incident, however, Dr Azzam had undergone considerable remediation and had continued his training, being described in exemplary terms by his peers. Once again the GMC allowed evidence of remediation to be taken into account fully after the finding of impairment. Evidence was allowed in relation to character and Dr Azzam’s propensity to act in the manner alleged. At the time of considering the issue of impairment the Panel specifically stated they had attached ‘little weight’ to his otherwise exemplary career, training testimonials and reme-diation. Mr Justice McCombe was not impressed by this approach.

He quoted the Master of the Rolls in the Meadow case as follows:

In Meadow v GMC [2007] QB 462, 481H Sir Anthony Clarke MR said this, “In short the purpose of FTP proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. The FTP first looks forward not back. However, in order to form a view as to the fitness of a person to practise today it is evidence that it will have to take into account of the way in which the person concerned has acted or failed to act in the past.”

He then quoted Mr Justice Silber in the Cohen case:

It must be highly relevant in determining if a doctor’s fitness to practise is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated.

Counsel for the GMC persisted in the argument that the Fitness to Practise Panel were only entitled to determine at the impairment stage (Stage 2) whether the facts that they found proved at stage 1 raise the question whether the doctor concerned should continue to practice without
restrictions on his or her registration – in other words the restrictive view.

The judge was not persuaded:

It seems to me that, in the light of the authorities cited, it must behove a FTP Panel to consider facts material to the practitioner’s fitness to practise looking forward and for that purpose to take into account evidence as to his present skills or lack of them and any steps taken, since the conduct criticized, to remedy any defects in skill. I accept Miss Callaghan’s submission that some elements of reputation and character may well be matters of pure mitigation, not to be taken into account at the “impairment” stage (paragraph 54 of her skeleton argument). However, the line is a fine one and it is clear to me that evidence of a doctor’s overall ability is relevant to the question of fitness to practise. Even if Miss Callaghan is correct as to the construction of rule 17(2)(j) (which I doubt, but do not have to decide) the rule clearly envisages the admission of relevant further evidence at stage 2. The panel must consider that evidence (in the same manner as any other evidence received) and weigh it up, decide whether to accept it and then to determine whether, in the light of the further evidence that it does accept and the facts found proved at stage 1, the practitioner’s fitness to practise is impaired.

This statement of the law is good authority for the proposition that overall ability and at least a degree of evidence relating to competence and character should be admissible when a panel comes to determine the question of impairment.

The judge also quoted with approval aspects of testimonial evidence of insight, competence and contrition all of which he felt should have been taken into account in determining the issue of impairment:

(Dr Azzam) informed me about the impending GMC investigation involving him shortly after commencing work here in Winchester. We have discussed the cases in detail. He has insight into the criticisms of his management, fully accepts that there were significant deficiencies but is deeply upset that this could now involve assessment of his fitness to practise. I have absolutely no concerns about his aptitude and ability to continue practising in this field. To this end I am currently supporting him in applications to obtain a Consultant post in this specialty. I do this without reservation and believe that he will excel in this role...

He quoted and was impressed by the following passage of oral evidence given to the Panel:

Dr Pitman also gave oral evidence to the Panel which included the following:

De Bono: Do you have any concerns about Dr Azzam’s ability as an obstetrician based on what you know about him or your experience of him?

Pitman: I have absolutely no concerns about his willingness, aptitude and ability to make the next step in to the consultant grade. My biggest concern, depending on the decision process of the Panel today, is if a trainee who has passed through a training programme in one of the most highly respected obstetric and gynaecological training regions in this country is found having had four years flawless training in this region to be found now by the GMC in any way as being unfit to practise, that casts a major concern in both my mind and I am sure the entire specialty’s mind as to how the GMC would respect and value structured training programmes at specialist registrar level if somebody can pass through without any difficulty and now on the basis of clinical cases that occurred over four years ago can be found to be in any way deficient in his current practice.

On the question of impairment the judge was to reach the following conclusions of importance not only in this case but in all cases where impairment of importance not only in this case but in all cases where impairment of fitness to practise is alleged:

It is difficult to see the manner in which Dr Azzam could have remedied the specific conduct for which he was criticized. Nothing that he could do or the Panel could do or this court can do can reverse the tragic effect of Dr Azzam’s error or errors. All that Dr Azzam could do with regard to ‘fitness to practise’ was to be aware of the mistake and to do all in his power to learn from it. In my judgment, the testimonial evidence and, in particular, the evidence of Dr Pitman, an expert in this field, demonstrated that he had done just that.

In my judgment, it was quite impossible for the Panel to afford only ‘little weight’ to the evidence that it heard and read at stage 2. Giving all respect to the experience of the Panel in hearing and determining medical conduct matters, the evidence of Dr Azzam’s rehabilitation was outstanding and uncontested. It required to be given substantial weight in deciding whether the doctor’s fitness to practise was truly impaired for the future. In failing to do that I consider the Panel’s decision at stage 2 was flawed.

If proper weight had been given to the evidence of Dr Azzam’s actions to remedy his deficiencies and his then current ability and skill, I consider that the Panel could not have found that his fitness to practise was still impaired as at October 2007.

**Conclusion**

Much confusion has been caused by the lack of a definition of the phrase ‘impairment of fitness to practise’. It is likely that the restrictive interpretation of the Fitness to Practise Rules has lead to findings of impairment that would not have been made had the clarification provided in the cases of Cohen, Zygmunt and Azzam informed the definition of impaired fitness to practise, from the outset. One hopes the public have not been deprived of the skills of competent practitioners as a result.

As Mr Justice McCombe was to conclude in the Azzam case:

The public, as patients, did not need protection from Dr Azzam. On the contrary, on the uncontested evidence, it needed his professional skill.