THE ROLE OF THE REGULATORY BODIES

1 In the last few years there have been significant changes to disciplinary regimes of the various regulatory bodies. The General Medical Council, the General Dental Council, and Nursing and Midwifery Council have embarked on comprehensive reviews of their fitness to practice procedures, and others have either followed suit or indicated an intention to follow suit. This paper considers those changes, assesses where they leave the existing public law jurisprudence and examines whether there are other avenues for challenging the decisions made by the regulatory bodies.

2 The nine regulatory bodies concerned with healthcare whose right to self-regulate is recognised by statute are:

- The General Chiropractic Council (GCC)
- The General Dental Council (GDC)
- The General Medical Council (GMC)
- The General Optical Council (GOC)
- The General Osteopathic Council (GOsC)
- The Health Professions Council (HPC)
- The Nursing and Midwifery Council (NMC)
- The Pharmaceutical Society of Northern Ireland (PSNI)
- The Royal Pharmaceutical Society of Great Britain (RPSGB)

3 There have been a number of forces behind these changes. First, a series of high-profile cases involving medical practitioners dating back to the mid 1990s have resulted in a public perception that the regulatory bodies, and specifically the GMC, were failing in their role of protecting patients. The first such case was the GMC inquiry into paediatric cardiac surgery at Bristol. The public inquiry that followed the GMC inquiry which reported in 2001 was critical of the existing system of regulation and recommended, amongst other things, the introduction of a
body to oversee the activities of all the regulatory bodies.¹ Bristol was followed by the cases of Rodney Ledward (and the public inquiry into his conduct), Clifford Ayling (who was convicted of indecently assaulting female patients over a number of years), and that of Harold Shipman. Each case in turn has increased the pressure on the regulatory bodies and on the Government to institute changes to the disciplinary schemes. Indeed, by the time that the Shipman inquiry commenced its investigations into the actions of Dr. Shipman the GMC’s reforms of its fitness to practice procedures were sufficiently advanced for the inquiry to be able to consider the likely impact of the GMC proposed changes.²

Second, there has been judicial criticism of the disciplinary procedures of the regulatory bodies. These criticisms have been reinforced and broadened with the advent of the **Human Rights Act 1998**. One of the principle issues has been the problems (and potential for unfairness) arising where a regulatory body is at the same time investigator, prosecutor and judge. This difficulty was recognised in **Preiss v GDC [2001] 1WLR 1926**. Preiss identified a number of other features of the GDC’s disciplinary procedures that were (in common with other regulators) open to criticism. Principle amongst these were the fact that the President of the GDC had sat as preliminary screener and chairman of the Conduct Committee, and that members of the PPC and Conduct Committee were also members of Council. In addition Lord Cooke suggested that there should be separation between the general policy making functions (i.e. the regulatory element) and the adjudicatory functions (i.e. the disciplinary element).

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¹ In April 2003 this recommendation was implemented when the Council for the Regulation of Healthcare Professionals (CRHP) was established pursuant to section 25 of **National Health Service Reform and Health Care Professions Act 2002**. On 15th July 2004 the CRHP changed its name to the Council for Healthcare Regulatory Excellence (CHRE)
Third, whilst the principle of the need for change was embraced before the creation of the Council for Healthcare Regulatory Excellence (CHRE), given that one of the CHRE’s core functions is to oversee and promote “good professional self-regulation” the CHRE is itself a force for change. The CHRE has, through its publications, been critical of the response of some of the regulatory bodies to the need for change, and the courts have sought to highlight the need for co-operation between the individual regulators and the CHRE; see CHRP v (1) HPC & (2) Jellett [2005] EWHC 93 [41] where Richards J observed that:

“It is worth stressing that the duty of bodies such as the HPC to co-operate with the Council is clearly stated in section 27(1) of the 2002 Act and is reflected in paragraph 81 of the Court of Appeal’s judgment in Ruscillo/Truscott.”

This drive for change has resulted in an extensive overhaul of the disciplinary procedures of the regulatory bodies. These changes have been and continue to be achieved by the extensive use of section 60 Orders which enable the Government to modify the regulation of the healthcare professions including amending their primary legislation by means of orders in Council.

One of the first significant changes made by many of the regulatory bodies was to secure an appropriate “separation of powers”. The Dentists Act (Amendment) Order 2001 (a section 60 Order) ultimately produced rules which reduced the number of Council members to 29 and which ensured that members of Council could not sit on any of the GDC’s Fitness to Practice Committees. Similarly, in July 2003 the GMC reduced the size of its General Council from 104 members to 35, and provided that members of Council could not sit on its adjudicatory committees.

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3 See National Health Service Reform and Health Care Professions Act 2002 section 25(2).
4 This reads: “Each regulatory body must in the exercise of its function co-operate with the Council”.
5 Ruscillo v (1) CRHP & (2) GMC & CRHP v (1) NMC & (2) Truscott [2004] EWCA Civ 1356.
6 Section 60 of Health Act 1999.
Complimenting these reforms has been the institution of an independent hearings panel or list of professional and lay members who are eligible to sit on Fitness to Practice Panels/Committees. In the case of the GMC The General Medical Council (Constitution of Panels and Investigation Committee) Rules Order of Council 2004\(^7\) expressly provides that a member of the General Council may sit on the Investigation Committee but may not sit on a Fitness to Practice Panel. It also provides that:

“No panellist shall act as a panellist on a [Fitness to Practice] Panel or the [Investigation] Committee … for the substantive hearing of a case that he has previously considered or adjudicated upon in any other capacity.”\(^8\)

Thus it should no longer be possible for an individual to sit on a Fitness to Practice Panel for a fitness to practice hearing if s/he has previously, for instance, considered the case as a member of an Interim Orders Panel. Whilst this might be thought to be an anathema from a public law perspective it is to be borne in mind that this is effectively what happened in Preiss and has continued to happen since.\(^9\)

In revising their disciplinary schemes the regulatory bodies have sought to introduce more transparent, efficient and effective procedures designed better to protect the public and regulate the profession. In particular the regulatory bodies have sought to distance themselves from the widely held public perception that their only reason for existence is to protect the interests of their members. The consistent themes\(^10\) running through the reforms are:

- A revision of the membership of the committees with a view to securing “separation of powers” (see above)

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\(^7\) 2004 No. 2611
\(^8\) Rule 4(3).
\(^10\) For a consideration of the detail of the changes introduced by the regulatory bodies see Fitness to Practise: Health Care Regulatory Law, Principle and Process – Joanna Glynn Q.C. & David Gomez.
• The greater involvement of the public by the appointment of more lay members to sit on the fitness to practice panels
• A revision of the role of the committees or panels so as clearly to demarcate the investigatory and adjudicatory functions
• A departure from the concept of “serious professional misconduct” and the introduction of the concept of “impairment of fitness to practice”
• A broadening of the type of complaint/allegation that can give rise to a finding of impairment

10 Of those regulatory bodies which have completed their reforms or put proposals out for consultation the approach has been to establish an investigation committee and a fitness to practice committee (variously called Fitness to Practice Panel/Committee (GMC & GOC), Professional Performance Committee (GDC), Conduct & Competence Committee (NMC & HPC). In the case of the GMC and the GDC there is no separate Health Committee as there is in the case of the NMC and HPC, health issues coming under the umbrella of the Fitness to Practice Panel or Professional Performance Committee as the case may be.

11 The type of complaint/allegation that may give rise to a finding of impairment is significantly widened in the new disciplinary schemes. Whereas the GMC historically would look only at conduct, conviction and health (with performance being added in July 1997) the categories which may give rise to a finding of impairment are now: misconduct; deficient professional performance; conviction or caution (now including an overseas conviction); adverse physical or mental health; and, a determination of impairment by another UK health or social care regulatory body or by a regulatory body elsewhere. The other regulatory bodies have adopted similar approaches save that in the case of the NMC a certificate evidencing the determination of another regulatory body only prima facie evidence of the facts
referred to in the determination and not conclusive of such facts as would be the case with the other regulatory bodies.

12 In relation to conduct cases the GMC, GDC and GOC adopted the terminology of “serious professional misconduct”. Absent a finding of serious professional misconduct no steps could be taken in relation to doctor or dentist’s registration. Prior to the change in its rules on 1st August 2004 the NMC could remove a practitioner’s name from the register or issue a caution on the basis of a finding of simple misconduct (i.e. there was no requirement for the misconduct to be “serious” or “professional” – albeit that logic dictates that any misconduct would have to be related in broad terms to the practice of nursing).

13 Under the new or proposed disciplinary schemes these concepts are replaced by the concept of impairment of fitness to practice. Unhappily this term is not defined in any of the legislation. The NMC attempted a definition in its consultation document suggesting that “fitness to practice” meant “a person’s suitability to be on the register without restrictions”, and the GMC’s Indicative Sanctions Guidance for Fitness to Practise Panels dated April 2005 includes a similar definition at paragraph 11:

“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.”

14 At present the only regulatory bodies operating new style disciplinary procedures are:

- The Health Professions Council (since 9th July 2003)
- The Nursing & Midwifery Council (since 1st August 2004)
- The General Medical Council (since 1st November 2004)
The other regulators are following suit with the GDC probably closest to completing its reforms with the others either at a consultation or pre-consultation stage.

The procedures of the RPSGB have been the subject of similar judicial criticism to that discussed above in relation to the GDC arising in Preiss. The regulations governing the Statutory Committee (which determines allegations against registered persons) have been criticised for their “informality”, as has the “in house” nature of the process in which the Chairman considers the allegation, then directs the holding of an inquiry which he then chairs. For an attempt at a wholesale attack on the disciplinary process see (R on the application of Heath) v The Home Office Policy & Advisory Board For Forensic Pathology [2005] EWHC 1793 Admin in which Newman J suggested that where there were deficiencies in the scheme for disciplining a home office pathologist the gaps could be filled by the tribunal so long as the process was one which could achieve justice and fairness between the parties. This is a similar approach to that of Sedley LJ in Panjawani where he said since the coming into force of the Human Rights Act it was necessary to read down the Pharmacy Act where appropriate and disregard those Regulations which did not conform with Convention standards.

Whilst some of the concepts introduced by these new disciplinary procedures are new and untested by the courts others are familiar from the old regimes. Therefore existing case law will in some cases continue to be of assistance. A good example of this is the challenge to decisions taken in investigatory process (see further below).

11 See Korsner v RPSGB [1999] EWHC Admin 154, and Panjawani v RPSGB (see above).
The preliminary or investigative stage of the disciplinary process has been subjected to scrutiny in the past and this will continue under the regimes.

Under the old GMC scheme the decisions at the investigation stage were taken by the screeners and Preliminary Proceedings Committee (PPC). Under the old scheme the role of the PPC was identified in section 42(2) of the Medical Act 1983 as:

“It shall be the duty of the [PPC] to decide whether any case referred to them for consideration in which a practitioner is alleged to be liable to have his name erased … ought to be referred for inquiry by the [PCC] …”

Section 35C of the 1983 Act as amended (i.e. the new scheme) reads:

“(4) The Investigation Committee shall investigate the allegation and decide whether it should be considered by a Fitness to Practice Panel.
(5) If the Investigation Committee decide that the allegation ought to be considered by a Fitness to Practise Panel.”

Given the striking similarity in the test (i.e. “ought to be referred” and “ought to be considered”) it is reasonable to assume that the line of authority from R v GMC ex parte Toth [2000] 1WLR 2009 to, most recently, David v GMC [2004] EWHC 2977 (Admin) is likely to continue to be of general application in terms of any challenge to the decision of an Investigation Committee to refer an allegation for a determination by a FTP. Likewise the case law which arose in relation to the “aide memoire” produced by the GMC to assist the PPC in making its decision whether or not to refer a case to PCC: in Woods v GMC [2002] EWHC 1484 (Admin) the aide memoire received judicial approval from Burton J, and in R v GMC ex parte Henshall [2004] EWHC 3246 (Admin) Pitchford J rejected an attempt to rewrite part of the aide memoire in an attempt to lower the hurdle that the complaint had to cross for it to be referred for a full hearing.12

12 NB ex parte Henshall is the subject of an appeal.
21 As the other regulatory bodies use forms of words similar to “ought to be considered” or “ought to be referred” the case law that has developed on the question of approach to be adopted at the investigatory stage and the test to be applied is likely to remain of general application.

22 A separate issue that arose in *ex parte Henshall* and which remains despite the new scheme was whether the GMC could lawfully refuse to disclose a practitioner’s response to the complainant’s complaint where the practitioner had expressly refused to disclosure. The decision of the Court of Appeal is awaited on this point, but it is of note that the GMC’s 2004 Fitness to Practice Rules give the Registrar the discretion not to pass on a practitioner’s response to the maker of the allegation.\(^\text{13}\) Such a refusal would arguably raise common law fairness issues and would be capable of challenge by way of judicial review.

23 Also at the preliminary or investigatory stage consideration needs to be given to:

- The initial decision (usually made by the Registrar) as whether or not the allegation falls into one of the categories that may give rise to a finding of impairment – see paragraph 11 above
- The discretion that may be exercised (again usually by the Registrar) to allow an allegation which is more than 5 years old to proceed\(^\text{14}\)
- The need to give reasons at each stage of the investigatory process
- What guidance (if any) is given to those undertaking the investigatory phase by the regulatory body and whether they are truly independent of that body

\(^{13}\) Rule 7(1) reads: “…the Registrar shall write to the practitioner – (d) informing him that representations received from him will be disclosed, where appropriate, to the maker of the allegation (if any) for comment.”

\(^{14}\) In the context of the GMC see r.4(5) of the 2004 Fitness to Practice Rules.
Public law challenges are less likely to arise once the adjudicatory phase has commenced. From a procedural perspective the Court of Appeal’s decision in R (on the application of Mahfouz) v GMC [2004] EWCA Civ 233 is interesting. Dr. Mahfouz sought an adjournment of his disciplinary proceedings on the second day of the hearing in order to challenge by way of judicial review the panels refusal to recuse itself after some of the panel members had read prejudicial articles concerning Dr. Mahfouz in the press. The High Court labelled the decision to refuse an adjournment as a “stern” one but took the view that it was open to the panel to refuse the application. Whilst acknowledging that it was usually preferable to allow proceedings to run their course and challenge them by way of an appeal, the Court of Appeal concluded that on the facts of Dr. Mahfouz’s case an adjournment should have been granted.

Two further issues which will require consideration by the Administrative Court need some consideration: the requirement to give reasons and the correct definition of “impairment” and “fitness to practice”.

To date challenges to failures to give reasons at both stages (i.e. fact finding and serious professional misconduct/sanction) of the disciplinary process have failed. The new regimes envisage a 3 stage process: facts; impairment to fitness to practice; and, sanction. It is difficult to suggest that the adoption of a 3 stage process is of itself grounds for giving reasons at the fact finding stage, but there is the practical argument that where the tribunals’ findings of fact will have a significant impact on the determination of impairment and sanction it would be helpful to have reasons at the fact finding stage. In practice tribunals are alive to this point and will provide clarification where it is needed, but the absence of reasons in such circumstances is unlikely to provide grounds for challenge: the criminal courts confront this difficulty every day.
Notwithstanding the above the absence of coherent reasons at any stage of the disciplinary process remains a legitimate ground of challenge and the approach of the courts generally is to seek to ensure that the decisions of disciplinary tribunals are properly reasoned. Newman J considered the need to give reasons in the context of the NMC and concluded that basic principles of fairness required reasons to be given. Two particular points he made were:

“That a general explanation of the basis for the determination on the questions of serious professional misconduct and of penalty will normally be sufficient. (Selvanathan v GMC [2001] Lloyds’ Rep Med 1)

…

That reasons need not elaborate nor be lengthy but should be such as to tell the parties in broad terms why the decision was reached.”\(^{15}\)

In R (on the application of Campbell) v GMC [2004] EWHC 1288 the court considered the issue of the adequacy of reasons from a different perspective. The Claimant sought to challenge the GMC’s decision to find the practitioner not guilty of serious professional misconduct. The court concluded that reasons given by the tribunal should not be construed in a “pedantic and nit-picking spirit”. There is therefore a balance to be struck in determining whether the reasons given are adequate: the propositions set out in paragraph 11 of Newman J’s judgment in Needham probably now accurately summarise the state of the law.

As discussed above the terms “impairment” and “fitness to practice” are not defined in the legislation, and the guidance issued, for instance by the GMC in its Indicative Sanctions document, provides little more help than the House of Lords did when seeking to define serious professional misconduct in Doughty v GDC [1988] A.C. 164, 173.

The difference between the old scheme and “impairment of fitness to practice” is the loss of the words “serious” and “professional”. As discussed above these

words were also missing in the NMC’s old disciplinary scheme. Whether the absence of these words in the NMC scheme made any difference is debatable: there was an implicit requirement that the conduct complained of had some relationship with the practice of nursing (i.e. a nurse was unlikely to be disciplined for conduct which had nothing to do with the practice of nursing). Further, in practice the fact that “misconduct” was not qualified by “serious” did not result in trivial complaints being brought before a disciplinary tribunal. There remained an implied requirement to determine whether the misconduct was so serious as to warrant interfering with the practitioner’s registration; particularly so given that under the old NMC scheme the only sanctions available were a caution and erasure.

31 For my part I am not sure that dropping the reference to “professional” will result in any significant difference. The regulatory bodies have always interpreted this fairly freely, and have been prepared to intervene where a practitioner’s conduct is not directly related to his profession but tends to bring the profession into disrepute. Further, it is to be seen whether in practice concepts of “seriousness” will be read back into the new schemes as in the case of allegations of conduct it will be necessary to make an assessment as to whether the practitioner’s conduct is sufficiently impaired to warrant imposing a sanction. When considering the concept of “misconduct” in the pharmaceutical legislation the courts have been prepared to read in the concept of seriousness.

32 Although the circumstances in which a true public law challenge to a finding of impairment of fitness to practice are likely to be limited the court was prepared to entertain such a challenge in Campbell (see above) where the Claimant (complainant at the GMC) contended that the finding that the practitioner was not guilty of serious professional misconduct was poorly reasoned and perverse. The High Court concluded that the decision of PCC could not be impugned. The Claimant succeeded in the Court of Appeal, albeit not by means of the perversity
challenge but by an attack (with the help of the observations of Dame Janet Smith in the Fifth Shipman Report) on the Privy Council’s decision in Silver v GMC [2003] UKPC 33.

There are therefore a number of aspects of the disciplinary schemes open to challenge. Whilst the new schemes introduce some new concepts and seek to address criticisms of the old schemes, many of the challenges and much of the jurisprudence that developed under the old schemes continue to be relevant.