FITNESS TO PRACTISE

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MISCONDUCT

1. Misconduct is, and remains, the basic concept for disciplinary proceedings being commenced against a member by his or her professional regulatory body. Misconduct is said to be the oldest and perhaps still the most widely used form of allegation. Misconduct leaves it to the disciplinary tribunal to decide its ambit in any particular case, as opposed to individual offences of narrow scope: ***Disciplinary and Regulatory Proceedings, Fifth Edition (2009)*** by Brian Harris OBE QC and Andrew Carnes at para 4.02. The earlier terms "infamous and disgraceful" conduct or "serious professional misconduct" have largely given way to the use of the word "misconduct" or the words "professional misconduct".

2. In ***Roylance v. General Medical Council (No 2)*** [2000] 1 AC 311, at p330, the Privy Council said:

> "The expression "serious professional misconduct" is not defined in the legislation and it is inappropriate to attempt any exhaustive definition. It is the successor of the earlier phrase used in the Medical Act 1858 "infamous conduct in a professional respect", but it was not suggested that any real difference of meaning is intended by the change of words. This is not an area in which an absolute precision can be looked for. The booklet which the General Medical Council have prepared, "Professional Conduct and Discipline: Fitness to Practise" (December 1993), indeed recognises the impossibility in changing circumstances and new eventualities of prescribing a complete catalogue of the forms of professional misconduct which may lead to disciplinary action. Counsel for the doctor argued that there must be some certainty in the definition so that it can be known in advance what conduct will and what will not quality as serious professional misconduct. But while many examples can be given the list cannot be regarded as exhaustive. Moreover the Professional Conduct Committee are well placed in the light of their own experience, whether lay or professional, to decide where precisely the line falls to be drawn in the circumstances of particular cases and their skill and knowledge requires to be respected."

3. However, the Privy Council went on to identify "the essential elements of the concept" of misconduct, and said:

> "Serious professional misconduct is presented as a distinct matter from a conviction in the British Islands of a criminal offence, which is dealt with as a separate basis for a direction by the committee in section 36(1) of the Medical Act 1983. Analysis of what is essentially a single concept requires to be undertaken with caution, but it may be useful at least to recognise the elements

> which the respective words contribute to it. Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances. The misconduct is qualified in two respects. First, it is qualified by the word "professional" which links the misconduct to the profession of medicine. Secondly, the misconduct is qualified by the word "serious". It is not any professional misconduct which would qualify. The professional misconduct must be serious."

4. In ***Meadow v. General Medical Council*** [2007] 1 All ER 1, the Court of Appeal made clear that "misconduct" should not be viewed as anything less than "serious professional misconduct". Auld LJ at [198] said:

> "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 1983 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 1983 Act - should signify a lower threshold for disciplinary intervention by the GMC".

5. Auld LJ went on to emphasise that the conduct in any given case must be serious before being branded as "misconduct" in a professional context. At [200], Auld LJ said:

> "As Lord Clyde noted in *Roylance v. General Medical Council (No 2)* [2000] 1 AC 311 at 330-332, "serious professional misconduct" is not statutorily defined and is not capable of precise description or delimitation. It may include not only misconduct by a doctor in his clinical practice, but misconduct in the exercise, or professed exercise, of his medical calling in other contexts, such as that here in the giving of expert medical evidence before a court. As Lord Clyde might have encapsulated his discussion of the matter in *Roylance v. General Medical Council,* it must be linked to the practice of medicine or conduct that otherwise brings the profession into disrepute, and it must be serious. As to seriousness, Collins J. in *Nandi v. General Medical Council* [2004] EWHC 2317 (Admin), rightly emphasised at [31] the need to give it proper weight, observing that in other contexts it has been referred to as "conduct which would be regarded as deplorable by fellow practitioners"."

6. It is clear that "misconduct" may be quite removed from the professional practice of the registrant. For example, in ***A County Council v. W (Disclosure)*** [1997] 1 FLR 574, a question arose whether the alleged sexual abuse by a father of his daughter, the father being

a medical practitioner, could constitute serious professional misconduct. It was argued that any sexual abuse was too remote from the father's occupation as a doctor since it was outwith any medical treatment of the child. But Cazalet J held, at p 581, that:

> "it seems to me that this doctor can be said, if he had sexually abused his daughter, to have demonstrated conduct disgraceful to him as reflecting on his profession and/or indeed conduct disgraceful to him as a practising doctor."

7. In ***Marten v. Royal College of Veterinary Surgeons Disciplinary Committee*** [1966] 1 QB 1, a farmer who was also a veterinary surgeon was found to have failed to give adequate care for animals on his farm. Lord Parker CJ observed, at p9:

> "But if the conduct, though reprehensible in anyone is in the case of the professional man so much more reprehensible as to be defined as disgraceful, it may, depending on the circumstances, amount to conduct disgraceful of him in a professional respect in the sense that it tends to bring disgrace on the profession which he practises. It seems to me, although I do not put this forward in any sense as a definition, that the conception of conduct which is disgraceful to a man in his professional capacity is conduct disgraceful to him as reflecting on his profession, or, in the present case, conduct disgraceful to him as a practising veterinary surgeon."

8. It is now well established that misconduct may also include incompetence or negligence <u>of a high degree</u>. In ***Preiss v. General Dental Council*** [2001] 1 WLR 1926 at [28] the Privy Council said:

> "It is settled that serious professional misconduct does not require moral turpitude. Gross professional negligence can fall within it. Something more is required than a degree of negligence enough to give rise to civil liability but not calling for the opprobrium that inevitably attaches to the disciplinary offence. Having formed their own view of the evidence, their Lordships do not hold that any of the findings of the PCC on the detailed allegations were wrong, but they consider that in the context of the treatment of this particular patient the specific shortcomings established against the appellant vary in gravity. The core and most serious shortcoming was summarised by the PCC as failure to ensure that the state of the patient's oral health was appropriate in view of the ambitious treatment plan. That is covered specifically by charge (a) as to the period after December 1994 and charge (b)(i). It was an elementary and grievous failure warranting the description of serious professional misconduct. The Board does not consider that in this case the other charges that have been established come within that description, either individually or collectively. Some or all of them may well have constituted simple professional negligence, and they are part of the setting in which the seriousness of the appellant's conduct has to be judged; but the findings directly related to oral health are dominant."

9. In *Meadow*, Auld LJ said that it may also be professional misconduct where, as in that case, a medical practitioner, purporting to act or speak in an expert capacity, goes outside his expertise. Whether it can properly be regarded as "serious" professional misconduct, however, must depend on the circumstances, including with what intention and/or knowledge and understanding he strayed from his expertise, how he came to do so, to what possible, foreseeable effect, and what, if any, indication or warning he gave to those concerned at the time that he was doing so.

10. Traditionally, allegations of conduct unbefitting a solicitor have been of two kinds – either of specific breaches of rules, such as the Solicitors' Account Rules 1988, or conduct unbefitting a solicitor in specified circumstances, which can vary infinitely: see *The Solicitors' Handbook 2009* by Andrew Hopper QC and Gregory Treverton-Jones QC at para 15.9. There is no all-embracing definition of conduct unbefitting a solicitor. Professional misconduct is simply conduct which is regarded as such from time to time by the Solicitors' Disciplinary Tribunal and the court: see *Cordery on Solicitors, Vol 1, at J [2208] – [2209].*

11. There is no need to prove intentional recklessness; conduct may be conduct unbefitting even though the solicitor attempted to conform to the highest professional standards. Negligent conduct may amount to conduct unbefitting a solicitor: ***Re a Solicitor*** [1972] 2 All ER 811 and ***Connolly v. Law Society*** [2007] EWHC 1175 (Admin) at [62].

12. The Solicitors' Handbook 2009 says that it is likely that conduct unbefitting a solicitor as a concept will fade away in relation to any act or failing after 1st July 2007, which will be covered by the Solicitors' Code of Conduct 2007 as the Code is intended to be an all-embracing scheme of regulation. Similarly, the Code of Conduct of the Bar of England and Wales, 8th Edition (2004) contains fundamental principles applicable to all barristers and detailed requirements for self-employed barristers, employed barristers, acceptance and return of instructions, conduct of work etc. Part IX provides that any failure by a barrister to comply with provisions in the Code other than certain exempted paragraphs shall constitute professional misconduct.

13. Some regulatory bodies provide that a member must comply with identified fundamental principles, a breach of which will constitute misconduct.

14. CIMA's Code of Ethics for Professional Accountants states that a professional accountant is required to comply with the following fundamental principles:

(a) *Integrity*. A professional accountant should be straightforward and honest in all professional and business relationships.

(b) *Objectivity*. A professional accountant should not allow bias, conflict of interest or undue influence of others to override professional or business judgments.

(c) *Professional Competence and Due Care*. A professional accountant has a continuing duty to maintain professional knowledge and skill at the level required to ensure that a client or employer receives competent professional service based on current developments in practice, legislation and technique. A professional accountant should act diligently and in accordance with applicable technical and standards when providing professional services.

(d) *Confidentiality*. A professional accountant should respect the confidentiality of information acquired as the result of professional and business relationships and should not disclose any such information to third parties without proper and specific authority unless there is a legal or professional right or duty to disclose. Confidential information acquired as a result of professional and business relationships should not be used for the personal advantage of the professional accountant or third parties.

(e) *Professional Behaviour*. A professional accountant should comply with relevant laws and regulations and should avoid any action that discredits the profession.

DEFICIENT PERFORMANCE/COMPETENCE AND ASSESSMENT REPORTS

15. Deficient performance/competence is recognised as a separate category of impairment of fitness to practise:

- Section 35C of the Medical Act 1983 provides that a person's fitness to practise may be regarded as impaired by reason of "deficient professional performance";
- Article 22 of the Nursing and Midwifery Order 2001 provides that a registrant's fitness to practise may be impaired by reason of "lack of competence"; and
- Article 48 of the Pharmacist and Pharmacy Technician Order 2007 states that a person's fitness to practise may be impaired by reason of "deficient professional performance (which includes competence)".

16. The Code of Conduct of the Bar of England and Wales, 8th Edition, defines "inadequate professional service" as meaning such conduct towards a lay client or performance of professional services for that client which falls significantly short of that which is to be reasonably expected of a barrister in all the circumstances.

17. The relationship between bad work as misconduct and bad work as unacceptable professional conduct was considered in ***Vranicki v. Architects Registration Board*** [2007] EWHC 1644 (Admin) where Collins J observed:

> "The (Architects Act 1997) distinguishes between serious professional incompetence and unacceptable professional conduct. However, as must be obvious, there is a considerable overlap between the two and particular acts or omissions could be charged under either head. But in my view the standard applicable should not differ and unless what has been done or not done in an individual case could be regarded as a serious lapse it would not be appropriate to impose a disciplinary sanction."

18. In ***R (on the application of Calhaem) v. General Medical Council*** [2007] EWHC 2606 (Admin), Jackson said:

> "(1) Mere negligence does not constitute "misconduct" within the meaning of section 35C(2)(a) of the Medical Act 1983. Nevertheless, and depending upon the circumstances, negligent acts or omissions which are particularly serious may amount to "misconduct".

(2) A single negligent act or omission is less likely to cross the threshold of "misconduct" than multiple acts or omissions. Nevertheless, and depending upon the circumstances, a single act or omission, if particularly grave, could be characterised as "misconduct".
(3) "Deficient professional performance" within the meaning of section 35C(2)(b) is conceptually separate from negligence and from misconduct. It 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.
(4) A single instance of negligent treatment, unless very serious indeed, would be unlikely to constitute "deficient professional performance".
(5) It is neither necessary nor appropriate to extend the interpretation of "deficient professional performance" in order to encompass matters which constitute "misconduct"".

19. In that case a finding by the GMC's Fitness to Practise Panel of deficient professional performance by an anaesthetist was quashed because the panel failed to take into account the fact that exceptional circumstances are required before a single episode of treatment can found a determination of impairment through deficient professional performance.

20. The bye-laws of the Institute of Chartered Accountants in England and Wales provide that disciplinary proceedings may be brought against a member who has performed his professional work or the duties of his employment or conducted his practice inefficiently or incompetently to such an extent or on such a number of occasions as to bring discredit to himself, the Institute or the profession of accountancy.

21. In ***Holton v. General Medical Council*** [2006] EWHC 2960 (Admin), an assessment panel had found that Dr Holton's performance had not been seriously deficient. They assessed him as a consultant paediatrician, which was the field in which he had been trained, rather than the role in which he was employed. The Fitness to Practise Panel disagreed with this approach and assessed Dr Holton on the basis of the job he was actually doing i.e. what he was employed to do rather than the field in which he had been trained. The FPP's approach was endorsed by Stanley Burnton on appeal who said:

> "70. It would clearly be unfair and inappropriate to judge the performance of a registrar by reference to that of a consultant: a registrar's work will not be deficient because his standard is not that of a Consultant. Conversely, it would be inappropriate, and inconsistent with the object of public protection, for the professional standard of a consultant to be assessed by reference to that of a registrar. However, *the difference of view between the*

Assessors and the Panel was more subtle. It concerned the standard to be applied to someone who indubitably was a consultant but who had not been trained for the composition of work he undertook. The Assessors took the view, broadly, that the appropriate standard was that for which Dr Holton had been trained. The Panel took the view that the appropriate standard was that applicable to the post to which he was appointed and the work he was carrying out.

71. *I have no doubt that the Panel were correct.* In the present case, there is not the complication that might arise if a practitioner who was appointed to a particular post found himself carrying out work appropriate to a different post. Here, Dr Holton was appointed to a post that was described as that of a Consultant Paediatrician with special interest in Neurology; and during the period considered by the Panel, his professional work was consistent with that description, in view of the considerable proportion of professional time spent on epilepsy cases, estimated by Dr Holton to be 70 per cent. Deficiency is to be judged against the standard of his professional work that is reasonably to be expected of the practitioner. Just as the public is entitled to expect a consultant in any area of medical practice to have a higher standard of work than a practitioner of a lower grade, so the public is entitled to expect that the work of a doctor who occupies a post in any speciality is the standard applicable to that post in that speciality. I add that in my view a practitioner who works outside his speciality is liable to be judged by the standard applicable to the level and the speciality in which he works. As the Board said in ***Krippendorf v. GMC*** [2001] 1 WLR 1054 at [4]:

> The opening words of section 36A(1) make it clear that it is the standard of the <u>past professional performance</u> of the practitioner in the work which he has actually been doing to which the CPP must direct its attention.
>
> The emphasis is in the original.

72. There was no complaint relating to Dr Holton's professional performance in general Paediatrics. The question therefore arises, and was posed by Miss O'Rourke, whether deficiency in part only of a doctor's work can lead to a finding of seriously deficient professional performance. I have no doubt that it can. It is certainly sufficient that that performance is in a significant part of a doctor's work. In the present case, the alleged seriously deficient professional performance was on any basis in a very substantial part of Dr Holton's work."

22. In ***Uruakph v. General Medical Council*** [2010], May 2010, Saunders J held that it was for the GMC to decide what was the appropriate test for medical competence and not the High Court. And it was not for a doctor to refuse to take an assessment because he did not like its structure. Where a doctor had continually refused to complete an assessment to

ascertain his professional performance, the GMC's fitness to practise panel had been entitled to have found his fitness to practise impaired and to have imposed the sanction of suspending his name from the medical register, given its obligation to ensure the safety of the public.

23. The appellant doctor appealed against a decision of the panel suspending his name from the medical register for 12 months. He had qualified as a doctor in Nigeria and Australia, came to the United Kingdom and was granted full registration by the GMC in 2003. He practised in the field of obstetrics and gynaecology and worked in a number hospitals. In 2005, his work was referred to the GMC in respect of the issues concerning the conduct of operations, performance on call, poor communication with patients and missed diagnoses. The GMC's fitness to practise panel made an interim order restricting his practice. Before the final hearing of the issue of fitness to practise, the GMC asked the appellant to undergo assessment of his professional performance. Despite having twice agreed to do so, he ultimately declined to undertake any assessment having criticised the structure of the proposed tests. The panel found that his fitness to practise was impaired and imposed the suspension.

24. Saunders J held that where a charge against a doctor concerned clinical work, an appellate court had to accord deference to the decision of a panel of doctors, following ***Meadow v. General Medical Council*** [2007] QB 462. Further, it was for the GMC to decide what was the appropriate test for medical competence and not the High Court, and it was not for a doctor to refuse to take an assessment because he did not like its structure. In the instant case, the panel had been concerned about the appellant's failure to undertake an assessment, and because of the length of time since he had practised it was not possible to decide the extent of his deficiencies. Proper assessment was needed to ascertain his skills, and given his refusal to complete the assessment process, and in the light of the panel's obligation to ensure the safety of the public, the sanction imposed was the correct one.

ADVERSE PHYSICAL OR MENTAL HEALTH AND SPECIALIST ADVISERS

25. In ***Sarkodie-Gyan v. Nursing & Midwifery Council*** [2009] EWHC 2131 (Admin) the respondent's Health Committee found the appellant's fitness to practise was impaired by reason of her physical or mental health and imposed conditions of practice order for 12 months.

26. His Honour Judge Grenfell, sitting as a deputy High Court Judge, held that once it was accepted that the procedure at the hearing was required to follow the clearly defined 3 stage process of finding the facts, impairment, and sanction, the Committee's task at stage 1 was to make its findings on the facts as to whether the registrant was suffering or had in the past suffered from physical or mental health. The learned Judge said that the Committee was in the clear position to have found that the registrant's mental state in terms of her depression was stable and improved to the extent that she was at the time of the hearing fit to resume practice. Had the Committee reached that position at the conclusion of the first stage, it would then have gone on to consider the impact of those findings on the issue of impairment to practice.

27. Both the GMC's and the NMC's Fitness to Practise Rules provide that when determining whether a practitioner's fitness to practise is impaired by reason of adverse physical or mental health, the Committee may take into account that:

    (a) the practitioner's current physical or mental condition;

    (b) any continuing or episodic condition suffered by the practitioner; and

    (c) a condition suffered by the practitioner which, although currently in remission, may be expected to cause a recurrence of impairment of the practitioner's fitness to practise.

28. At any stage in the proceedings, before making a determination that a practitioner's fitness to practise is impaired, the panel or committee may, having regard to the nature of the allegation under consideration, adjourn and direct that a specialist health adviser or specialist performance adviser be appointed to assist the panel, or that an assessment of the practitioner's performance or health be carried out.

29. Rule 31 of the NMC's Fitness to Practise Rules 2004 provides that in determining whether a registrant's fitness to practise is impaired by reason of physical or mental health, the Health Committee may also take into account, amongst other matters, any refusal by the registrant to submit to a medical examination. Similarly, rule 31 provides that in determining whether a registrant's fitness to practise is impaired by reason of lack of competence, the Conduct and Competence Committee may take into account any refusal by the registrant to submit to an assessment.

30. The case of ***Watson v. General Medical Council*** [2005] EWHC 1896 (Admin) raised issues of principle as to the role and participation of medical assessors in the procedure and decisions of the GMC's fitness to practise panel. Dr Watson contended that the assessors exceeded their proper function, with the result that the hearing was unfair, and that the manner in which the assessors' advice was communicated to the parties also rendered the hearing unfair. Stanley Burnton J agreed and the appeal was allowed.

31. It was not in dispute that the appellant's fitness to practise was seriously impaired by virtue of a depressive disorder, alcohol dependence (currently abstinent) and opioid dependence (currently abstinent). Conditions had previously been imposed on her registration. In preparation for a resumed hearing the appellant had been examined by medical examiners who had submitted reports to the panel. At the hearing before the panel there were two medical assessors, both psychiatrists.

32. In his judgment, Stanley Burnton J reviewed the domestic and European jurisprudence in circumstances where advice was given to tribunals. Assessors had been used in the administration of justice for a considerable period. The classic statement of the role of assessors is in the speech of Viscount Simon LC in ***Richardson v. Redpath Brown & Co Limited*** [1944] AC 62 at pages 770-71 where Viscount Simon said of a medical assessor appointed under the Workmen's Compensation Acts:

> "But to treat a medical assessor, or indeed any assessor, as though he were an unsworn witness in the special confidence of the judge, whose testimony cannot be challenged by cross-examination and perhaps cannot even be fully appreciated by the parties until judgment is given, is to misunderstand what the true functions of an assessor are. He is an expert available for the judge to consult if the judge requires assistance in understanding the effect and meaning of technical evidence. He may, in proper cases, suggest to the judge questions which the judge himself might put to an expert witness with a view to testing the witness's view or to making plain his meaning. The judge may consult him in case of need as to the

> proper technical inferences to be drawn from proved facts, or as to the extent of the difference between apparently contradictory conclusions in the expert field….but I cannot agree that [giving evidence] is within the scope of an assessor's legitimate contribution."

33. In a series of cases, the European Court of Human Rights has held that a Government commissioner in France, and a *procureur général* in Belgium, who advise tribunals on the issues in cases, must not retire with the tribunal when it considers its verdict if the rights of the individual under article 6 of the European Convention on Human Rights are not to be infringed. Neither a Government commissioner nor a *procureur général* is formally a party to the proceedings, and they advise the tribunal independently of the parties and objectively: the ***Borgers v. Belgium (Application 12005/86)*** (1991) 15 EHRR 92; ***Vermeulen v. Belgium*** (1996) January 26, Application No. 19075/91; ***Kress v. France*** (Application No 39594/98); and ***Van Orshoven v. Belgium (Application No. 20122/92)*** 1997 26 EHRR 55.

34. Stanley Burnton J considered the role of a clerk to justices and a legal assessor, both of which have been the subject of judicial consideration: ***Mort v. UK, Application No. 44564/98; Nwabueze v. General Medical Council*** [2000] 1 WLR 1760; ***Procurator Fiscal v. Kelly*** [2003] UKPC D1; and ***Practice Direction (Criminal Proceedings: Consolidation)*** [2002] 1 WLR 1870 at para 55.7.

35. From this review of the authorities the learned judge said:

> "[55] It follows that, as in the case of legal assessors to disciplinary tribunals, the requirements of a fair trial are not necessarily infringed if the legal adviser retires with the justices; but the parties must be given an opportunity to make representations on the advice that has been or is given.
>
> [56] The role of a medical assessor is not the same as that of a legal assessor to a tribunal (in which I include a Health Panel) or a legal adviser to justices. In the first place, as the European Court of Human Rights pointed out, legal advisers do not in general give their personal views on the facts or the outcome of a case. In the present case, the assessors did not in terms give their personal views on the outcome of the case: they did not state in terms that it was necessary for conditions on the Appellant's registration to be continued, or what those conditions should be. But their opinions, if accepted by the Panel, made it inevitable that at the very least conditions would be imposed, and for that purpose they would have to find that her fitness to practise remained seriously impaired under r 24(2).

> [57] There is a further difference between the role of a legal adviser or assessor and that of a medical assessor. A legal adviser to justices advises only on questions of law, and the decisions of the justices may be appealed on issues of law. A medical examiner advises on factual issues, and there is no appeal against a Health Panel's decision on issues of fact. In my judgment, this makes it more important that advice on issues of fact, such as the medical significance of the information before the Panel, should be given openly and that the parties should be able to respond to that advice before the Panel makes its determination.
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> [60] In my judgment, the authorities to which I have referred above establish that those who advise a tribunal on issues of fact, whether as its experts or as assessors, should do so openly, in the presence of the parties, and in circumstances in which the parties have an opportunity to make submissions on that advice before the tribunal makes its decision. This is, in general, what fairness requires. If the advice is controversial, there may be circumstances in which the tribunal may have to consider whether to permit the parties to put before the tribunal their own experts' responses to that advice
>
> [61] The medical assessors' special relationship with a tribunal makes it the more important that all of their advice is given in the presence of the parties. The assessors are not parties to the case before the Panel. Nor are they members of the Panel. Where their advice may be adverse to the practitioner's case, it is particularly important that it is given in the presence of the parties, before the Panel deliberates on its determination, and in circumstances in which the parties have an opportunity to address that advice. Otherwise, the suspicion may be created that the advice given in private was not precisely the same, or was not given in the same manner, as that announced in public, or that the assessors have exercised influence on the decision of the tribunal. A perception of unfairness, and of bias on the part of the tribunal, is liable to be created."

CONVICTION CASES

36. How far can a defendant in disciplinary proceedings challenge a conviction against him obtained in criminal proceedings?

37. In ***Shepherd v. The Law Society*** [1996] EWCA Civ 977 Mr Shepherd was accused before the Solicitors' Disciplinary Tribunal of conduct unbefitting a solicitor in that he had been convicted of 15 offences of dishonesty and sentenced to 3 years imprisonment in respect thereof. He sought an adjournment in order to bring evidence before the Tribunal to establish that he had been wrongly convicted. His application was refused and he was struck off the roll. His appeal was dismissed, the Court of Appeal holding that "*in the*

absence of some significant fresh evidence of other exceptional circumstances" it should not be possible to challenge a criminal conviction in disciplinary proceedings. The court noted that Mr Shepherd did not appeal against his conviction preferring instead to establish before the Solicitors' Disciplinary Tribunal that he had been wrongly convicted and perhaps to use this as a lever to seek leave to appeal out of time against his conviction.

38. Regulation 13 of the Bar's Disciplinary Tribunals Regulations 2005 provides that the fact that a barrister defendant has been convicted of a criminal offence may be proved by producing a certified copy of the certificate of conviction relating to the offence, and proof of a conviction shall constitute *prima facie* evidence that the barrister defendant was guilty of the offence the subject thereof.

39. In ***Stannard v. General Council of the Bar*** January 24th 2006, Hart J said that there was no significant difference between the solicitors' disciplinary rules which had a statutory origin and the Bar's disciplinary regulations which did not. In his view precisely the same considerations of policy apply to the approach to be taken by a disciplinary tribunal of the Bar as were held by the Court of Appeal in ***Shepherd*** to apply in the case of the solicitors' disciplinary tribunal. Accordingly, as a matter of law the tribunal was entitled to refuse to hear evidence which sought to go behind the conviction unless there were exceptional circumstances. Such was the course adopted by the Privy Council in the case of ***Jerayetnam v. Law Society of Singapore*** [1989] 2 All ER 193.

40. Rule 34(3) of the General Medical Council (Fitness to Practise) Rules 2004 provides that production of a certified copy of a conviction shall be "*conclusive evidence*" of the offence committed, and by Rule 34(5) the only evidence which may be called by the practitioner in rebuttal of a conviction so certified is evidence for the purposes of proving that he is not the person referred to in the certificate or extract. Likewise, Rule 31(3) of the Nursing & Midwifery Fitness to Practise Rules 2004 provides that the only evidence which may be adduced by the registrant in rebuttal is evidence of proving that he or she is not the person referred to in the certificate or extract.

41. A police caution may also be a category of impairment of fitness to practise. Section 35C(2)(c) of the Medical Act 1983 provides that a person's fitness to practise shall be regarded as impaired by reason of "A conviction of caution in the British Islands for a

criminal offence". Similarly, Article 22 of the Nursing & Midwifery Order 2001 and Article 48 of the Pharmacist and Pharmacy Technicians Order 2007 provide that a police caution in the British Islands is a reason why a person's fitness to practise shall be regarded as impaired.

42. Regard should be had to the Home Office Circular 16/2008 which provides guidance to the police and prosecutors on the use of cautions. A simple caution, known as a formal caution before Home Office Circular 30/2005, was renamed to distinguish it from a conditional caution.

43. Circular 16/2008 provides:

> "18. An admission of guilt is required before a person can be invited to accept a caution: an admission must not be sought as part of the cautioning process. The method of obtaining and recording the admission must be PACE compliant.
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> …
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> 24. Has the offender been made aware of the significance of a simple caution? If a simple caution is being considered, then the full implications must be explained (and provided in writing) to the offender. Under no circumstances should suspects be pressed, or induced in any way to admit offences in order to receive a simple caution as an alternative to being charged.
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> …
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> 33. The significance of the admission of guilt in agreeing to accept a simple caution must be fully and clearly explained to the offender before they are cautioned. The pro forma attached to this Circular can be used to do this.
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> 34. A simple caution is not a form of sentence (which only a court can impose), nor is it a criminal conviction. It is, however, an admission of guilt and forms part of an offender's criminal record. It may influence how they are dealt with, should they come to the notice of the police again and may also be cited in court in any subsequent proceedings.
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> 35. A simple caution will appear on a subject access request made by the offender under the Data Protection Act 1998. It may also be disclosed for employment vetting purposes, licensing purposes or to inform judicial appointments."

44. Paragraph 37 of the Circular identifies "notifiable occupations" and provides that where a simple caution is issued to someone employed in a notifiable occupation, this should be

disclosed by the police to their employer in accordance with the guidelines set out in the Circular. A list of notifiable occupations is available in every police station.

45. It would appear to be permissible for a regulator to serve an allegation that relies upon a criminal conviction as evidence of impairment in circumstances where the practitioner was absolutely or conditionally discharged by the criminal court for the offence in question. In ***R v. Patel (Application under Section 58 Criminal Justice Act 2003)*** [2006] EWCA Crim 2689, Hughes LJ said that whilst section 14 of the Powers of Criminal Courts (Sentencing) Act 2000 prevents the court appearance from ranking as a conviction, "*it does not enable any person to assert that they have never committed the offence or for that matter that they have never been found guilty of it. For the ability to contend that the offence has never been committed, the rehabilitated person has to look to the provisions of the Rehabilitation of Offenders Act, in particular section 4(2).*" The Rehabilitation of Offenders Act 1974 does not apply to proceedings in respect of a person's admission to, or disciplinary proceedings against, a member of any of the professions specified in Part 1 of Schedule 1 to the Order.

46. Thus whilst it is not open to a regulator to proceed in the case of a criminal conviction where the practitioner has been absolutely or conditionally discharged on the footing that the practitioner has been convicted (see ***Simpson v. General Medical Council*** (1955) The Times, 9th November; and ***R v. Statutory Committee of Pharmaceutical Society of Great Britain ex parte Pharmaceutical Society of Great Britain*** [1981] 2 All ER 805) it is nevertheless permissible to rely upon the conviction as evidence of impairment by reason of misconduct and the practitioner cannot assert that he or she has never committed the offence or for that matter was not found guilty of it. Had Parliament intended that in the case of an absolute or conditional discharge not only the conviction, but the facts underlying the conviction should be disregarded in any future disciplinary proceedings, then the Powers of Criminal Courts (Sentencing) Act 2000 would have said so.

47. In ***R (Jenkinson) v. Nursing & Midwifery Council*** [2009] EWHC 1111 (Admin), following her conviction for causing grievous bodily harm with intent, the claimant had been found guilty of misconduct by an earlier committee of the NMC and struck off the nursing register. Her conviction was subsequently quashed by the Court of Appeal, Criminal Division, when it became clear that the expert evidence founding the conviction, namely, how the ventilator of a patient in her charge operated, was erroneous. Thereafter

the claimant sought to have the committee's decision to strike her off the nursing register set aside. The subsequent committee accepted the advice of its legal assessor that it had no jurisdiction to set its original decision aside, and declined to do so.

48. The NMC ultimately supported the claimant's judicial review application, and sought guidance as to how it should deal with situations such as this. Cranston J, in granting the application and quashing the original decision to strike the claimant off the nursing register, said that it was unwise for the court to provide specific guidelines. However, it was plain from ***Akewushola v. Secretary of State for the Home Department*** [2000] 1 WLR 2295 CA and ***Wade and Forsyth on Administrative Law***, 9th Edition (2004) at page 262, that the powers of the NMC were not stillborn and that in cases of accidental slips, mistakes, flaws or miscarriage of justice, it had the power to act and rectify a mistake. It was clear on the facts of the instant case that the original decision that the claimant was guilty of misconduct, so that it was appropriate to strike her off the nursing register, was based on a mistake, namely that she was guilty of a criminal offence. Once that conviction was quashed, the subsequent finding of misconduct and sanction fell away. Accordingly, the original decision amounted to a miscarriage of justice based upon a mistake.

49. It is well settled that in the case of prior civil proceedings, and where the rules of the regulator provide that findings of any court shall be prima facie evidence of the facts so found, the practitioner is entitled in disciplinary proceedings to challenge the correctness of the conclusion reached by the judge or tribunal, and is to be given a full chance of exculpation and he is entitled to the opportunity of controverting or refuting the prima facie case made from the earlier civil proceedings; see ***General Medical Council v. Spackman*** [1943] AC 627, per Viscount Simon LC at p635-636 and Lord Atkin at p637-638. Lord Wright at p645 said that the practitioner was entitled to a full and fair opportunity of stating his case before the council. No doubt in the absence of some explanation the regulator would be entitled to rely on the judgment as evidence of the findings of fact made against the practitioner in the earlier proceedings, and it is not required to reprove the whole case by endeavouring to get the previous witnesses or documents that were before the judge.

50. In ***General Medical Council v. Spackman*** [1943] AC 627, Viscount Simon LC at pp634-635 drew a distinction between a case in which a practitioner had been convicted of a

criminal offence, and a case in which the allegation of misconduct arose from adverse conclusions reached in a civil court of law. In the former case, the practitioner cannot go behind the conviction and endeavour to show that he was innocent of the charge and should have been acquitted. In the latter case, whilst an adverse conclusion reached in a court of law might lead to a charge of professional misconduct the conclusion reached in the courts would be prima facie proof of the matter alleged.

51. Viscount Simon at pp635-636 said:

> "There is no question of estoppel or of *res judicata*. In such cases the decision of the courts may provide the council with adequate material for its own conclusion if the facts are not challenged before it, but if they are, the council should hear the challenge and give such weight to it as the council thinks fit. The same view must, I think, be taken if the practitioner challenges the correctness of a finding of adultery by the Divorce Court. The decree provides a strong prima facie case which throws a heavy burden on him who seeks to deny the charge, but the charge is not irrebuttable...What matters is that the accused should not be condemned without being first given a fair chance of exculpation. This does not mean that the council has to rehear the whole case by endeavouring to get the previous witnesses to appear before it, though in special circumstances the recalling of a particular witness, in the light of what the accused or his witnesses assert, may, if feasible, be desirable. The council will primarily rely on the sworn evidence already given at the trial. It is not required to conduct itself as a court."

IMPAIRMENT

52. Most health care regulatory bodies provide for disciplinary allegations to be determined by reference to a person's fitness to practise being impaired. For example:

- Section 35C of the Medical Act 1983 as amended
- Article 22 of the Nursing and Midwifery Order 2001
- Article 48 of the Pharmacist and Pharmacy Technicians Order 2007
- Article 51 of the Pharmacy Order 2010

53. The Nursing and Midwifery Council has defined "fitness to practise" as meaning a registrant's suitability to remain on the register without restrictions.

54. There are two factors which any fitness to practise panel considering impairment should have clearly in mind. First, it should examine the question of whether the practitioner's fitness to practise is impaired as a separate exercise from the fact finding stage. Second, the issue whether the practitioner's fitness to practise is impaired is a matter of judgment for the panel rather than a matter of proof.

55. The word "impaired", although not defined in the statutory provisions, involves some lowering in quality of reduction or deterioration of the practitioner's fitness to practise his or her profession. As to the question of considering the practitioner's position today with matters at the time of the events, Sir Anthony Clarke, Master of the Rolls, in ***Meadow v. General Medical Council*** [2007] 462 at [32] said:

> "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 FPP thus looks forward not back. However, in order to form a view as to the fitness of a person to practise today, it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past."

56. In ***Cohen v. General Medical Council*** [2008] EWHC 581 (Admin), Dr Cohen, a Consultant Anaesthetist, appealed against the decision of the GMC's fitness to practise panel that his fitness to practise was impaired and to impose conditions on his registration. The complaint which led to the practitioner's appearance before the panel was made by Mr B who underwent surgery for suspected cancer of the colon. Apart from Mr B's case, the practitioner was of good character who had been a Consultant Anaesthetist since 1980 with no previous adverse findings made against him and with many references extolling his skills and expertise. Significantly, the GMC called an expert Consultant Anaesthetist who, whilst critical of the way in which the practitioner had treated Mr B in relation to his pre- and post-operative care and assessment, and his note-taking, nevertheless did not consider that these matters were so serious as to amount to misconduct, such that the practitioner's registration might be called into question; and said that the core anaesthetic treatment of Mr B was carried out to a standard entirely in keeping with what might be expected of a Consultant Anaesthetist.

57. Silber J, in allowing the appeal and setting aside the conditions, held that whether the practitioner's fitness to practise was impaired was a relevant factor at stage 2, rather than at

stage 3, the sanctions stage. On the facts, the errors of the practitioner were easily remediable and the panel should have concluded that his fitness to practise was not impaired.

58. In ***Zygmunt v. General Medical Council*** [2008] EWHC 2643 (Admin), the appellant, a neurosurgeon, challenged the panel's finding that his fitness to practise was impaired by reason of misconduct and the imposition of a two-month suspension. The allegation arose out of a wrong diagnosis made by Professor Zygmunt that the patient suffered from a tumour and not an infected abscess.

59. The court (Mitting J) noted that even if a panel properly finds that a practitioner has been guilty of misconduct, it may nonetheless conclude that his or her fitness to practise is not impaired. In many, perhaps the great majority of cases, the issue will not be live, but in cases in which it is, it must be separately and appropriately addressed by the panel. As to the meaning of fitness to practise, Mitting J adopted the summary of potential causes of impairment offered by Dame Janet Smith in the Fifth Shipman Inquiry Report (2004, paragraph 25.50). Dame Janet Smith considered that impairment would arise where a doctor (a) presents a risk to patients; (b) has brought the profession into disrepute; (c) has breached one of the fundamental tenets of the profession; or (d) has acted in such a way that his integrity can no longer be relied upon. Mitting J noted that Dame Janet Smith recognised that present impairment of fitness to practise can be founded on past matters. A doctor's current fitness to practise must be gauged partly by his/her past conduct of performance. It must also be judged by reference to how he/she is likely to behave or perform in the future.

60. At [31] Mitting J said:

> "In a misconduct or deficient performance case, the task of the panel is to determine whether the fitness to practise is impaired by reason of misconduct or deficient performance. It may well be, especially in circumstances in which the practitioner does acknowledge his deficiencies and takes prompt and sufficient steps to remedy them, that there will be cases in which a practitioner is no longer any less fit to practise than colleagues with an unblemished record."

61. Mitting J went on to say that he agreed with Silber J in *Cohen* that when fitness to practise was being considered, the task of the panel is to take account of the misconduct of the practitioner and then to consider in the light of all the other relevant factors known to

them whether his or her fitness to practise is (rather than has been) impaired. Accordingly, the judge quashed the decision of the panel on the question of fitness to practise being impaired and remitted it to the panel to re-determine in the light of the guidance given in the judgment. He added that if the panel does determine that fitness to practise is not impaired, it can of course give Professor Sigmund a warning as to his future conduct or performance which will not be free of effect.

62. In ***Azzam v. General Medical Council*** [2008] EWHC 2711 (Admin), the practitioner appealed against the panel's decision to impose a one-month suspension. At the conclusion of the fact finding stage (stage 1) counsel for the practitioner applied to the panel to admit evidence on Dr Azzam's behalf in three broad categories: (1) testimonial evidence; (2) evidence as to Dr Azzam's training following the incident in the case; and (3) evidence from a Dr Pitman as to Dr Azzam's current performance. The application was opposed by the GMC, but the panel acceded to the application but went on to state that it gave it "little weight".

63. The Court (McCombe J) held that the panel erred in deciding to give little weight to Dr Azzam's testimonial evidence going to his rehabilitation since the incident because such evidence was relevant to the issue of whether his fitness to practise was impaired at the date of the hearing. McCombe J said that it must behove a fitness to practise 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 criticised, to remedy any defects in skill. He accepted that some elements of reputation and character may well be matters of pure mitigation, not to be taken into account at stage 2. The line is a fine one.

64. In ***Jalloh v. Nursing & Midwifery Council*** [2009] EWHC 1697 (Admin), Silber J. dismissed the registrant's appeal against the finding of impairment and a conditions of practice order for 18 months. The registrant was an experienced mental health worker. The overall picture was of a series of serious mistakes by the registrant, a failure to comply on a number of occasions with proper procedures and a disregard of the interests of a vulnerable patient. This was not the case of one error, but a series of errors. Even after taking account of the mitigating factors there was a great deal of evidence which showed that because of the appellant's repeated failures her fitness to practise was impaired. The

committee considered there was a risk of repetition despite the mitigating factors which included that the patient was hostile and angry, the event in question was very traumatic and was likely to cause a degree of panic, lack of practical training, the presence of a lot of equipment on the trolley which impeded resuscitation, and the registrant's unblemished record and excellent conduct both before and after the event.

65. Silber J at [36] said:

> "I agree with the committee in reaching the decision which they did, especially as there was a risk of repetition."

66. At [37], Silber J went on to say that the judgment of the committee deserved respect as the body best qualified to judge what the profession expects of its members and the measures necessary to maintain high standards of professional practice and treatment. The committee consisted of three members, two of whom were nurses, one of whom had psychiatric experience, and that would be a relevant factor.

67. In ***Saha v. General Medical Council*** [2009] EWHC 1907 (Admin), the panel held that the fitness to practise of the appellant was impaired by reason of misconduct and directed his registration to be erased. The relevant misconduct found was a failure by the appellant to co-operate fully and to provide relevant information, in breach of paragraph 30 of *Good Medical Practice*, in connection with an investigation by the GMC into the appellant's conduct. The investigation concerned the fact that the appellant was or had been a healthcare worker who was infected with hepatitis B.

68. One of the issues that fell for determination was the question of separate consideration of "misconduct" and "impairment" at stage 2 of the proceedings. Mr Stephen Morris QC sitting as a Deputy High Court Judge held that there was no requirement in all cases for there to be a formal "two-stage process" in considering the issues of misconduct and impairment and no requirement that, in all cases, the reasons for a finding of impairment had to be distinct from the reasons of a finding of misconduct. The panel was required to consider whether there had been misconduct and, further, whether that misconduct was such as to impair fitness to practise, and often a finding of impairment would follow from one of misconduct. In the instant case, the panel had considered both issues and found,

broadly, that one and the same facts gave rise to the misconduct and the impairment. That approach was not erroneous as a matter of law.

69. The learned judge said:

> "94. (Counsel for the appellant) submitted that the Panel erred in law in not applying a "two-stage process" to the issues of "misconduct" and "impairment". The decisions of this court in *Cohen, Zygmunt* and more recently, *Cheatle* [2009] EWHC 645 (Admin), impose a requirement upon an FTP panel to consider and decide separately these two issues. By contrast, in the present case (counsel for the appellant) contended that there was no such "two-stage process", that the panel never actually determined that the appellant's actions amounted to misconduct, and that the panel applied exactly the same reasoning in respect of "misconduct" and "impairment".
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> 95. This is an argument of some substance. In the present case, the panel did not expressly identify (a) findings on "misconduct" and (b) findings on "impairment"; and the delineation between the two is not easy to identify. Moreover, the panel gave almost the same reasons for its finding of misconduct and its finding of impairment, namely, breach of *Good Medical Practice*, not in the best interests of patients and undermining public confidence in the medical profession. In the case of impairment, the panel, additionally, characterised the breach as a breach of "fundamental principles".
>
> 96. In my judgment, it would certainly have been better, particularly, in the light of this Court's observations in *Zygmunt* and *Cohen*, if the Panel in the present case, had clearly indicated distinct consideration of the two issues of "misconduct" and "impairment".
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> 97. However, I accept (Counsel for the GMC's) submission that, as a matter of law, there is no requirement in *all* cases for there to be a formal "two-stage" process. The requirement under the Act is that there are two "steps"; the panel must consider whether there has been misconduct and further whether that misconduct is such as to impair fitness to practise. As pointed out by Cranston J in *Cheatle* whilst misconduct is about the past, impairment is an assessment addressed to the future, albeit made in the context of the past misconduct.
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> …
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> 99. Nor, as a matter of law, is there a requirement that, in all cases, the reasons for a finding of impairment must be distinct from the reasons for the finding of misconduct. Often a finding of impairment will follow from past misconduct, but that is not necessarily the case. As Mitting J put it in *Zygmunt* "even though the panel… finds… misconduct, it *may* conclude that fitness to practise is not impaired." After saying that in perhaps the majority of cases, the issue will not be live (i.e. in such cases, a finding of impairment will follow from the finding of misconduct), Mitting J continued, in contrast, by stating that in cases in which the issue is live, then impairment "must be separately and

> appropriately" addressed. It is thus necessary to distinguish between cases where misconduct is, of itself, likely to lead to a finding of impairment and cases where misconduct does not necessarily lead to a finding of impairment, because of other factors to be taken into account. Such factors usually comprise events between the date of misconduct and the date of the panel hearing, such as a one-off event of misconduct followed by the passage of substantial time, an(sic) otherwise unblemished record, or subsequent retraining. In each of *Zygmunt*, *Cohen* and *Cheatle*, the panel had failed to take into account what had happened in the period between a one-off incident of past clinical misconduct and the date of the assessment of fitness at the panel hearing."

70. In ***Yeong v. General Medical Council*** [2009] EWHC 1923 (Admin), Dr Yeong's registration with the GMC was suspended for 12 months by reason of misconduct following a sexual relationship with a former patient. Dr Yeong obtained an expert report from an experienced psychiatrist who assessed that he did not have a psychological disposition to engage in sexual relationships with patients, the likelihood of recurrence was extremely low, and that Dr Yeong did not pose a risk to patients in his capacity practising as an obstetrician and gynaecologist. On appeal Dr Yeong contended (amongst other grounds) that the panel applied an incorrect test of impairment of fitness to practise.

71. Sales J, in his judgment at [31], said that the panel in its impairment decision, plainly considered that Dr Yeong did present a heightened risk of improper conduct in relation to his patients in future, and that was treated by the panel as a relevant consideration weighing in favour of the decision which it took on impairment. Sales J went on to state at [38] that:

> "The question of the possibility of a recurrence of such misconduct by Dr Yeong was a matter of the ordinary assessment of likely human behaviour, in relation to which a psychiatrist's expertise confers no special privileged insight. The assessment of risk of any particular form of future behaviour is the sort of task which courts and tribunals regularly perform without needing to refer to expert psychiatric evidence."

72. In dismissing Dr Yeong's appeal, Sales J said that "importantly the panel's view was that the general public interest in clearly marking proper standards of behaviour for doctors in respect of relationships with their patients so as to uphold public confidence in the medical profession was by far the weightiest factor pointing in favour of the finding of impairment of fitness to practise and the sanction which was imposed."

73. As to whether Dr Yeong's current fitness to practise was impaired, Sales J considered that *Cohen, Meadow* and *Azzam* fall to be distinguished from the present case on the basis that each of *Cohen, Meadow* and *Azzam* was concerned with misconduct by a doctor in the form of clinical errors and incompetence. Sales J accepted the submission of counsel for the GMC that:

> "Where a FTPP considers that the case is one where the misconduct consists of violating such a fundamental rule of the professional relationship between medical practitioner and patient and thereby undermining public confidence in the medical profession, a finding of impairment of fitness to practise may be justified on the grounds that it is necessary to reaffirm clear standards of professional conduct so as to maintain public confidence in the practitioner and in the profession. In such a case, the efforts made by the medical practitioner in question to address his behaviour for the future may carry very much less weight than in a case where the misconduct consists of clinical errors or incompetence."

74. In relation to such types of misconduct, the question of remedial action taken by the doctor to address his areas of weakness may be highly relevant to the question of whether his fitness to practise is currently (i.e. the date of consideration by the panel) impaired. But the position in relation to Dr Yeong's case, that is, improperly crossing the patient/doctor boundary by entering into a sexual relationship with a patient was different. As Sales J made clear, in the latter type of case the efforts made by the medical practitioner in question to address his behaviour for the future may carry very much less weight.

75. Sales J referred to the overarching function of the GMC as set out in section 1(1A) of the Medical Act 1983 to have regard to the public interest in the form of maintaining public confidence in the medical professional generally and in the individual medical practitioner when determining whether particular misconduct on the part of that medical practitioner qualifies as misconduct which currently impairs the fitness to practise of that practitioner. The public's confidence in engaging with him and with other medical practitioners may be undermined if there is a sense that misconduct which violates a fundamental rule governing the doctor/patient relationship may be engaged in with impunity. Secondly, a firm declaration of professional standards so as to promote public confidence may be required, and efforts made by the practitioner to reduce the risk of recurrence may be of less significance than in other cases, such as those involving clinical errors or incompetence.

76. In ***Nicholas-Pillai v. General Medical Council*** [2009] EWHC 1048 (Admin), the panel found that the practitioner was guilty of dishonesty in relation to note-taking and had given misleading instructions to his solicitors. Mitting J considered the extent to which the practitioner's misleading instructions to his solicitors were relevant to impairment, and said:

> "[16]…[T]he panel are, in my view, clearly entitled to take into account, at the stage at which they determine whether fitness to practise is impaired, material other than the allegations which they have considered which suggest that it either is not impaired or that it is impaired.
>
> [17] To take an instance not far removed from this case, this was an isolated act of professional dishonesty. If Dr Nicholas-Pillai had acknowledged that he had made up the notes after the event, or had inserted a date that he had no reason to believe was right after the event, and had accepted that, in so doing, he intended to mislead the patient's solicitors, then hard though it may have been to make those admissions, they would have stood to his credit, and might have tended to suggest that his fitness to practise was not as impaired as otherwise it would ordinarily be found to have been. But he did not do that.
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> [18] In the view of the panel, which is not disputed, he contested the critical allegations of dishonesty and intention to mislead. That was a fact which the panel were entitled to take into account in determining whether or not his fitness to practise was impaired, even though it did not form a separate allegation against him. Indeed, it is hard to see how it could have done. Once can envisage circumstances in which lying to a disciplinary panel may itself amount to professional misconduct such as to lead to a finding that fitness to practise is impaired and a severe sanction. In a case, for example, of alleged clinical error, where a doctor had given false evidence to the panel about it, the panel would not be entitled to treat that as a freestanding ground of impairment of fitness to practise leading to a sanction. If it found that the original clinical error which founded the allegation did not impair his fitness to practise and it was only the lies told to the panel, then that would have to be pursued in separate proceedings, with the charge made the subject of a separate allegation. But that set of circumstances is likely to be highly unusual.
>
> [19] In the ordinary case such as this, the attitude of the practitioner to the events which would give rise to the specific allegations against him is, in principle, something which can be taken into account either in his favour or against him by the panel, both at the stage when it considers whether his fitness to practise is impaired, and at the stage of determining what sanction should be imposed upon him."

77. In refusing permission to appeal to the Court of Appeal, [2009] EWCA Civ 1516, Lord Justice Hooper said that the fact the practitioner had given dishonest evidence must compound the original dishonesty and be a factor which a panel is entitled to take into account.

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