DISCIPLINARY PROCEEDINGS AND HEALTH
PROFESSIONALS – THE POSITION AFTER CORBALLY

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Professional Misconduct and Poor Professional Performance

1. Introduction – Current Regime – Medical Practitioners Act 2007

1.01 In recent years the most fertile area for professional disciplinary proceedings has been the medical area, in relation to doctors and nurses, pharmacists etc. As regards doctors, the current disciplinary regime is set out in Parts 7, 8 and 9 of the Medical Practitioners Act, 2007. Section 57 of the 2007 Act provides that any person may make a complaint the Preliminary Proceedings Committee (“PPC”) concerning a registered medical practitioner on various grounds, including his/her alleged professional misconduct or poor professional performance. The normal procedure is that the PPC considers the complaint and forms an opinion whether there is a prima facie case for holding an inquiry, and if so the Fitness to Practice Committee (“FPC”) proceeds to hold the inquiry, which is quite a formal and legalistic hearing on oral evidence. In 2013 there were 400 complaints made, involving 503 doctors, resulting in 39 Inquiries. In 2014, 308 complaints made, involving 366 doctors, resulting in only 19 Inquiries (re Corbally).

1.02 The C.E.O. of the Medical Council acts as the prosecutor, and both the C.E.O. and the doctor are normally represented by Solicitor and Counsel. Following the report of the FPC the Medical Council can impose a wide range of sanctions including cancellation of registration (“strike off”), imposition of conditions, suspension, censure etc.. In cases of the more serious sanctions the doctor has a right of appeal to the High Court.

1.03 Some of the key issues in this area relate to the standards of professional misconduct, poor professional performance, and the standard of proof.
The Medical Practitioners Act, 1978 Act had a standard of “professional misconduct”, which was not defined in the Act. Traditionally, however, professional misconduct was regarded as encompassing only misconduct which was morally reprehensible in some way, for example a sexual assault on a patient, or committing fraud on a hospital by deliberately claiming money which one was not entitled to, or something of that nature. Such conduct was described as infamous or disgraceful conduct which was further defined as conduct involving some degree of moral turpitude, fraud or dishonesty, and this became known as the “moral turpitude” test.

The problem for the modern State in the early 1990s was that the “moral turpitude” test did not cover professional incompetence where no moral turpitude, fraud or dishonesty was involved. The best way to deal with this lacuna in the regulatory regime would have been legislation, where the legislative branch of government decides (after consultation) the applicable standards which may lead to complaints and findings and sanctions against professional practitioners. In the absence of fully considered legislation there is always a danger that hard cases can make bad law.

O’Laoire and Filling the Gap

In the absence of any new legislation the courts stepped into the gap with a piece of classic judicial law – making in the case of O’Laoire v Medical Council, unreported, Keane J., 27th January 1995. In this case Keane J. broadened the scope of professional misconduct to encompass gross negligence or incompetence, relying upon the recent decision of the Privy Council in Doughty v General Medical Council [1987] 3 All ER 843. Keane J. set out five principles comprising the test for professional misconduct, and the fifth principle was as follows:
“Conduct which could not properly be characterised as “infamous” or “disgraceful” and which does not involve any degree of moral turpitude, fraud or dishonesty may still constitute “professional misconduct” if it is conduct connected with his professional in which the medical practitioner concerned has seriously fallen short, by omission or commission, of the standards of conduct expected among medical practitioners”.

2.02 While the fifth principle known as the “expected standards” test appears a reasonable test in broad terms, there were certain problems associated with this test. The fundamental problem was that it equated the incompetent doctor with the dishonest doctor, in labelling both as guilty of professional misconduct. The trade off by Keane J. in O’Laoire was to require satisfaction of the “expected standards” test beyond a reasonable doubt, as was previously required in relation to acts of fraud or dishonesty, which were clearly quasi-criminal concepts. The result was that professional misconduct became very difficult to prove in many cases, as some Inquiry Committees were very reluctant to make a finding of professional misconduct because of the traditional stigma attached to any such finding.

3. **Arrival of Poor Professional Performance**

3.01 Against the above backdrop arrived the concept of “poor professional performance” in the 2007 Act. While it is always a hazardous exercise to try to ascertain the intention of the Oireachtas, the intention may have been (at least in part) to provide an alternative to the “expected standards” limb of professional misconduct which would carry less stigma and which would be easier to establish in practice.
3.02 There were, however, problems with the new standard of “poor professional performance” as laid down in the 2007 Act. The statutory definition in s. 2 of the Act involved another “expected standards” test, albeit with a variation from a “serious” failure to “a” failure and involving standards of “competence” rather than “conduct”. The fact that there was no statutory definition of “professional misconduct” provided in the 2007 Act was of course very unhelpful, as it then became very unclear where the boundaries were between expected standards of competence/conduct. Does conduct not involve underlying competence or lack of same? Does competence not display itself in conduct?

3.03 In practice it seemed to me that most competence cases were falling under poor professional performance and not professional misconduct after the introduction of the 2007 Act, whether this was an intended result of the Act or not. However, from an early stage a problem arose with the new standard and the concept of “performance”, in terms of whether a single event or a single failure by the practitioner would ever amount to poor professional performance. This issue ultimately came to a head in the decisions of the High Court and in the Supreme Court in Corbally v the Medical Council [2013] IEHC 500.

4. The Corbally Decision

4.01 A fundamental finding in the High Court Judgement by Kearns P. in Corbally was to accept certain principles laid down by the English High Court in a case involving the interpretation of a similar standard in England i.e. “deficient professional performance”. In R. (Calhaem) v General Medical Council [2007] EWHC 2606 (Admin), Jackson J. set out five principles governing the English standard including the following third and fourth principles:
(3) ‘Deficient professional performance’ within the meaning of 35C(2)(b) is conceptually separate both 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 negligence treatment, unless very serious indeed, would be unlikely to constitute ‘deficient professional performance’.

4.02 Kearns P. held in Corbally that the above principles were the appropriate principles for construing s. 2 of the 2007 Act in this jurisdiction also. There was also a problematic reference to causation as being a relevant factor in terms of assessing whether a single event would be sufficiently serious to justify a finding of poor professional performance.

4.03 On appeal the Supreme Court upheld the decision of Kearns P. quashing the decision of the Medical Council in relation to the sanction imposed on the doctor in question, and also the decision quashing the underlying finding of the FPC of Poor Professional Performance. The judgment for the majority of the Court was delivered by Hardiman J., and in his judgment he appeared to lower the test from “very serious” to “serious”. While he states at paragraph 28 that he had derived assistance from the learned persuasive judgement of Jackson J. in Calhaen, ultimately the ratio of his judgment appears to be found at paragraphs 40 and 51. In these paragraphs he holds that there is a threshold of “seriousness” before any finding of poor professional performance can be made. At paragraph 40 he states as follows:
“40. I would apply a “seriousness” threshold to a finding of poor professional performance, as well as to professional misconduct for the precise reason stated by Mr. Justice Keane – only conduct which represents a serious falling short of the expected standards of the profession could justify a finding by the professional colleagues of a doctor of poor professional performance on his part, having regard, in particular to the gravity of the mere ventilation of such an allegation and the potential gravity of the consequences of the upholding of such an allegation. As mentioned above, there is no distinction in the sanction available for poor professional performance and for professional misconduct, respectively“.

4.04 In his judgment Hardiman J. also set out another ground which he felt might be sufficient standing alone to quash the underlying finding of the FPC, relating to the legal assessor’s advice. He held that the FPC had failed to follow the advice of the legal assessor that a once off error or single instance error must be serious in some way, and while the Committee are entitled in principle to disregard legal advice proffered by the legal assessor, they had failed to furnish any “clear and cogent reasons” for departing from that advice.

4.05 Following the Supreme Court decision in Corbally it is somewhat unclear where the dividing line, if any, between professional misconduct and poor professional performance now rests. At paragraph 17 of his judgment for the majority Hardiman J. stated that there may be some lacuna in the consideration by the drafters of the 2007 Act of what precisely is intended to be the difference between the two standards of professional misconduct and poor professional performance and whether it is intended, or not, that one be intrinsically less serious than the other. At paragraph 3 of his judgment O’Donnell J. stated that it does appear that the 2007 Act in this regard was not perhaps fully thought through, and neither entirely adopts the position in the UK nor establishes a fully coherent and independent
scheme of professional supervision and discipline. At paragraph 82 of his judgment McKechnie J. stated that it is not altogether clear what was intended by the definition of poor professional performance in the 2007 Act, and of more significance what the definition, as enacted, actually means.

5. Conclusion:

5.01 The decision of the Supreme Court in Corbally has, on the one hand clarified certain aspects of the standard of poor professional performance introduced in the 2007 Act, by holding that there is an implicit threshold of seriousness before any finding of poor professional performance can be made. On the other hand, however, the judgments have highlighted the overall lack of clarity as to the dividing line, if any, between poor professional performance and the traditional standard of professional misconduct. We may assume that into that lack of clarity will step the barristers practising in the area of professional regulatory law, and we will have to await with interest any further judgments of the Superior Courts and/or any amending legislation which might clarify some of these issues.