DIFFERENCES BETWEEN VARIOUS PROFESSIONAL REGULATORY SCHEMES IN THE HEALTH SECTOR AND UK PROPOSALS FOR REFORM

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Introduction

Health professionals in Ireland are regulated by one of the following statutory bodies:

Statutory Body	Legislation	Professionals regulated
Medical Council (MC)	Medical Practitioners Act 2007	Medical Practitioners
Nursing and Midwifery Board (NMBI)	Nurses and Midwives Act 2011	Nurses and Midwives
Pharmaceutical Society (PSI)	Pharmacy Act 2007	Pharmacists and Pharmacies
Dental Council (DC)	Dentists Act 1985	Dentists
Health and Social Care Professionals Council (Coru)	Health and Social Care Professionals Act 2005	Social workers, clinical biochemists, dieticians, dispensing opticians, medical scientists, occupational therapists, optometrists, orthoptists, physiotherapists, podiatrists, psychologists, radiographers, radiation therapists, social care workers, speech and language therapists.[1]

Each of the regulators has a range of regulatory functions including the registration of professionals, setting standards for the profession, education and fitness to practise or disciplinary regimes. This paper is concerned with the fitness to practise provisions.

The purposes of any system for the regulation of healthcare practitioners is:

(a) Protection of the public.
(b) Preservation of public confidence in healthcare practitioners.
(c) Declaring and upholding professional standards[2].

[1] The Minister for Health may designate further health or social care professionals in circumstances set out in section 2 of the Act.

[2] Building a Culture of Patient Safety - Report of the Commission on Patient Safety Commission and Quality Assurance - July 2008.

Noting the obligation to assist the practitioner with as much leniency as possible Finlay P in Medical Council v Murphy[3] set out the considerations relevant when deciding on sanction following an adverse fitness to practise finding:

> (a) To make clear to the practitioner the serious view taken of the extent and nature of the misconduct so as to deter him from being likely on resuming practise to be guilty of like or similar conduct.
>
> (b) To point out to other members of the profession the gravity of the offence of professional misconduct.
>
> (c) Protection of the public.

The broad framework for the consideration of complaints against healthcare practitioners is similar across the different regulators. Very generally the process, as in other common law jurisdictions, operates as follows: complaints received by the regulator are screened and those that pass a certain threshold proceed for inquiry. At the conclusion of the inquiry where a complaint has been substantiated one or more sanctions are imposed. The more severe sanctions (imposition of conditions, suspension of registration and cancellation of registration) are subject to approval by the High Court before they can take effect. The registrant also has a right of appeal to the High Court in relation to these more serious sanctions.

However, as is the case in other jurisdictions, there are a number of significant differences in the legislative provisions underpinning the work of the different regulators. This is undesirable for a variety of reasons, particularly as the same event may be the subject of a complaint made to more than one regulator. It can lead to uncertainty in relation to the application of legal precedent and inconsistent decision making with consequent loss of public confidence in regulation.

The system of regulation of health care professionals has been subject to criticism. For example, The Patient Safety Commission, in its report Building a Culture of Patient Safety, stated that Ireland does not have:

> *'… sufficient regulation in place to ensure as far as possible that patients receive the highest possible quality of care throughout their journey through the health system'.*[4]

It was of the view that reform of the regulation of health professionals was an important aspect of the policy response to patient safety and quality assurance.

Following a series of regulatory failures in the UK criticisms were made of comparable disciplinary regimes governing healthcare practitioners.[5]

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[3] Unreported High Court 29 June 1984

[4] Page 1

The Department of Health in the UK asked the Law Commissions[6] (referred to hereafter as the Law Commission) to review the legal framework for health and social care professional regulation in the UK. Following an extensive consultation process it produced a report in April 2014 setting out its recommendations for a simple, consistent, transparent and modern legal framework.[7]

The Law Commission noted[8]:

> *"Given the importance of health and social care professionals regulation, it is a matter of some concern that its UK legal framework is fragmented, inconsistent and poorly understood… [The] framework is neither systematic nor coherent and contains a wide range of inconsistencies and idiosyncrasies".*

The report made 125 recommendations for reform across the range of functions exercised by the regulators including in relation to fitness to practise proceedings. In January 2015 the UK Government issued a response to these recommendations.[9] This paper references those recommendations in relation to fitness to practise proceedings that are most relevant to the inconsistencies in the regulatory regimes operating in this jurisdiction.

The systems of regulation in the UK are similar to those operating in this jurisdiction. In the recent Supreme Court decision of Corbally v Medical Council[10] Hardiman J noted the desirability of having similar systems of regulation in the UK and Ireland given the mobility of professionals between these jurisdictions:

> *"…It seems very desirable that these processes, which are based on mutual knowledge and mutual respect in relation to medical training and conditions of practice, should not be complicated or made strange to persons from the other jurisdiction, without good reason.*
>
> *Despite this, of course, the Irish legislature is perfectly free, if it so wishes, to institute an entirely different system for the regulation of the Irish medical profession. But, having regard to the long historical continuity of relations between the medical communities, and the well established practise of citing relevant English (and other Common Law) authorities in our courts, I would not lightly conclude, in the absence of express language, that the legislature*

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[5] See for example, Learning from Bristol: the Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995, Final Report (2001) Cm5207; the Shipman Inquiry Fifth Report: Safeguarding Patients, Lessons from the Past – Proposals for the Future (2004) Cm6394.

[6] Law Commissions of England and Wales, Scotland and Northern Ireland

[7] Law Commission, Scottish Law Commission, Northern Ireland Law Commission - Regulation of Healthcare Professionals, Regulation of Social Care Professionals in England, April 2014.

[8] Para 1.2

[9] Government's response to Law Commission Report 345Scottish Law Commission report 237 Northern Ireland Law Commission report 18 (2014) Cm 8839 SG/2014/26

[10] [2015] IESC 9

had in fact decided to differentiate sharply between the respective systems of medical regulation."

Grounds for Making a Complaint

Various types of conduct can render a healthcare practitioner liable to disciplinary action. For example the conduct may be such as to raise concerns in relation to clinical ability, may amount to a breach of a Code of Conduct or may be conduct that could bring the profession in question into disrepute. The different enactments are inconsistent as regards what conduct may render a practitioner liable to disciplinary action.

The legislative grounds for a complaint have evolved over the past 35 years with some of the more recent legislative provisions introducing detailed definitions. The grounds for making a complaint are similar to those that may render a healthcare professional in the UK liable to disciplinary action. The terminology can be complex and difficult to understand. Similar criticisms have been made of the legislative grounds for inquiry in the UK. [11]

The following are the grounds that currently render a health professional liable to disciplinary action before one or more of the regulators in this jurisdiction:

1. Professional Misconduct

This is a ground for complaint available to each of the regulators. However, the term is defined in some enactments but not in others. It is not defined in the Medical Practitioners Act, the Nurses and Midwives Act or the Dentists Act. These regulators rely on the definition provided by Keane J in O'Laoire v Medical Council, which states:

(1) *Conduct which is "infamous" or "disgraceful" in a professional respect is "professional misconduct"...*
(2) *Conduct which would not be "infamous" or "disgraceful" in any other person, if done by a medical practitioner in relation to his profession, that is, with regard either to his patients or to his colleagues, may be considered as "infamous" or "disgraceful" conduct in a professional respect.*
(3) *"infamous" or "disgraceful" conduct is conduct involving some degree of moral turpitude, fraud or dishonesty*
(4) *The fact that a person wrongly but honestly forms a particular opinion cannot of itself amount to "infamous" or "disgraceful" conduct in a professional sense.*
(5) *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*

[11] Shipman Inquiry - 5th report, Dame Janet Smith, November 2004

misconduct" if it is conduct connected with his profession in which the medical practitioner concerned has seriously fallen short, by omission or commission, of the standards of conduct expected among medical practitioners."[12]

The Pharmacy Act defines professional misconduct in similar terms save that it excludes the 5th element of the O'Laoire test, namely the serious falling short of expected standards and includes a breach of the Code of Conduct. It also includes a breach of the Code of Conduct for Pharmacists as professional misconduct. Under the Health and Social Care Professionals Act professional misconduct is defined as a breach of the Code of Professional Conduct and Ethics adopted by the Registration Board of that profession and includes a corresponding breach in another jurisdiction.

2. Poor professional performance

This is a relatively new concept that was introduced in the series of legislation commencing with the Health and Social Care Professionals Act 2005[13]. The term is defined in each of the Acts although not consistently. The definition in the Medical Practitioners Act and Nurses and Midwives Act is:

> *"… **a** failure by the practitioner to meet the standards of competence (whether in knowledge and skill or the application of knowledge and skill or both) that can reasonably be expected of medical practitioners practicing medicine of the kind practiced by the practitioner."*

The definition in the Pharmacy Act and Health and Social Care Professionals Act is:

> *"… **any** failure of the [registrant] to meet the standards of competence that can reasonably be expected of [registrants]."*

It is not clear what significance, if any, attaches to this difference.

The Supreme Court in Corbally v. Medical Council considered the nature of the distinction between professional misconduct and poor professional performance. Hardiman J, delivering the majority judgment, stated:

> *"A significant aspect of the foregoing statutory scheme is that the "sanctions" which are available in the case of a finding of poor professional performance are exactly those available in the case of a finding of professional misconduct. These include "cancellation of a practitioner's registration" i.e. striking off the medical register. There is, therefore, no sense in which the offence of "poor professional performance" is intrinsically less serious than "professional misconduct". Indeed, it appears to me from a consideration of the relevant Sections of the Act of 2007, there may be some lacuna in the consideration by the drafters of the measure of what precisely is intended to be the difference*

[12] Unrep, Supreme Court 25 July 1997
[13] It is not a ground for inquiry under the Dentists Act

> *between the two delicts and whether it is intended, or not, that one be intrinsically less serious than the other."*[14]

As regards what conduct is captured by the term poor professional performance Hardiman J concluded:

> *"…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."*

It would appear therefore that for doctors and nurses and midwives there is no distinction between the expected standards test for professional misconduct as defined by Keane J in O'Laoire v the Medical Council and poor professional performance as defined by Hardiman J and the same incident or conduct can amount to either professional misconduct or poor professional performance. It can also be assumed that for conduct to amount to a breach of a Code of Conduct only a serious breach will permit an adverse finding.

The Law Commission also considered the nature of the distinction between professional misconduct and poor professional performance. It considered how greater clarity might be introduced in this area and, in particular, to demarcate the boundaries between misconduct and deficient professional performance. It noted from the applicable caselaw misconduct was of two types: serious misconduct in the exercise of professional practice and conduct of a morally culpable or otherwise disgraceful kind. It suggested that most of the conduct that was currently held to amount to misconduct be removed from that category on basis that such conduct was covered adequately by definition of deficient professional performance.

However it was of the opinion that there would be classes of serious professional misconduct which would not fall within the definition of deficient professional performance. For example a single incident of negligent treatment would be unlikely to constitute deficient professional performance. The Law Commission suggested that disgraceful misconduct be retained to deal with conduct which may or may not be related to the exercise of professional skills but which brings disgrace upon the practitioner and thereby prejudices the reputation of the profession. The Government however, in its response to the Commission Report did not agree and indicated that the current definitions be retained given the large body of precedent.

3. Inability to practice due to physical or mental disability/impairment[15]

[14] Para 17

[15] The Pharmacy Act uniquely includes an emotional disturbance within this ground

This ground for taking disciplinary action is available to all the Regulators. The manner in which health complaints are dealt with is addressed in a separate section of this paper.

4. Conviction for indictable offence

Each of the Acts, other than the Pharmacy Act, provides that where a complaint is made on the grounds of a criminal conviction the matter must be referred to the Council for consideration. In the case of the Medical Council and the Nursing and Midwifery Board, where the Council is of the opinion that:

> *"the nature of the offence that is the subject matter of the complaint or the circumstances in which the offence was committed render the [practitioner] permanently unfit to continue to practise …and it is in the public interest that the Council take action immediately.."*

it shall cancel registration. The opinion required of the Health and Social Care Professionals Council in these circumstances is more straightforward:

> "*the nature of the offence or the circumstances in which it was committed ought to disqualify the registrant from practicing…"*[16]

The Dentists Act merely provides that the person's name may be erased from the register[17].

Where the Council is not so satisfied the complaint processed in the usual way.

Under Pharmacy Act, however, regardless of the circumstances giving rise to the conviction, the complaint must go through the usual process from initial screening, through inquiry and on to sanction, assuming a finding on the part of the Professional Conduct Committee.

The issue of convictions was considered by the Law Commission which recommended[18] that registration be cancelled for any registrant convicted of murder, trafficking people for exploitation, blackmail (where a custodial sentence is imposed), and certain offences against children, subject to the right to make representations and appeal. The Government agreed with this recommendation and is considering what serious offences should result in automatic cancellation of registration.

[16] Section 53(1A)
[17] Section 42
[18] Recommendation 63

5. Breach of Code of Conduct

Whereas each of the regulators has a function to issue Codes of Conduct or Ethical Guides, in some cases a breach of such a Code is a specific ground for complaint.

Under the Pharmacy Act the definition of professional misconduct includes breach of the Code of Conduct. Under the Health and Social Care Professional Council Act misconduct is defined as being a breach of such the Code of Professional Conduct and Ethics.[19] Under the Nurses and Midwives Act breach of the Code is a ground in its own right. Breach of a code is not included as a ground for complaint under the Medical Practitioners Act. As noted above, following the Corbally decision it seems clear that only a serious breach could result in an adverse finding on this ground.

6. Failure to comply with a condition of registration

7. Failure to comply with an undertaking or to take any action specified in a consent requested by committee of inquiry

8. Contravention of relevant Act

   In some cases this is explicitly stated to include breaches of rules, regulations or bye-laws made under the relevant Act.

9. Any irregularity in relation to the custody prescription or supply of a controlled drug. This is contained in the Nurses and Midwives Act only.

10. Failure to comply with relevant provisions of the Health (Pricing and Supply of Medical Goods) Act, 2013

    This ground was introduced for all of the regulators other than the Health and Social Care Professionals Council.

11. Health Identifiers Act, 2014 (not commenced)

    Again this legislation will amend each of the Acts and includes a breach of its provisions as grounds for inquiry. Only the Minister for Health may make a complaint on this ground.

[19] Section 50

Manner in which Complaint made

The various disciplinary functions exercised by the regulators are dependent on the receipt of a complaint or in the case of the Dental Council, an application for an inquiry[20]. In the case of the Medical Council and Nursing and Midwifery Board the complaint is made to the Preliminary Proceedings Committee. Under the Pharmacy Act and the Health and Social Care Professionals Council Act complaints are made to the Council.

The requirement for an "allegation" to be made before disciplinary action could be taken was addressed by the Law Commission. It was of the view that regulators should be able to deal with any information coming to their attention and that it should not be necessary for that information to be framed in a particular way. It was felt that this would encourage a more proactive approach on the part of regulators:

> *"…it is right in principle that where public safety may be at risk there should be no artificial barriers to further investigation".* [21]

The Medical Practitioners Act and the Nurses and Midwives Act specify that any person "including the Council" can make a complaint. In practical terms this means that where a person brings information to the attention of the Regulator but does not wish to make a formal complaint, or where the regulator learns, say through the media, of a concern in relation to a practitioner, the matter must be brought to the Council or Board which must then decide whether to make a complaint. In contrast, the Pharmacy Act and the Health and Social Care Professionals Act provide that a complaint can be made by any person or by the Registrar. The Registrar can therefore take immediate action in relation to information giving rise to concern about a registrant.

Preliminary Investigation of Complaint

Once a complaint is received by a regulator a preliminary investigation is carried out to determine whether there is "sufficient cause to warrant further action" in relation to the complaint. Each of the statutes sets out the manner in which the complaint may be investigated at this screening stage. The determination as to whether there is sufficient cause to warrant further action is made by the Preliminary Proceedings Committee, other than in the case of the Dental Council where the Fitness to

[20] The application is made to the Fitness to Practise Committee under section 38.
[21] Para 8.9, p122

Practise Committee determines whether there is a prima facie case to refer the matter for inquiry.

In determining whether there is sufficient cause to warrant further action or whether there is a prima facie case to refer the complaint to an inquiry, the Committee must be satisfied that the complaint has a real prospect of being established at an inquiry, any doubt being resolved in favour of an inquiry being held.[22]

The manner in which the preliminary investigation of a complaint is carried out differs as between the various Acts. Under the Medical Practitioners Act 1978, the Nurses Act 1985 and under the current Dentists Act 1985, limited investigations were conducted before deciding whether to refer a matter for inquiry before a fitness to practise committee. Ordinarily observations were sought from the person against whom a complaint was made with perhaps further clarifications then being sought from the complainant and respondent. This essentially remains the position under the Pharmacy Act, 2007.

Further investigative powers are vested in the Preliminary Proceedings Committees under the Medical Practitioners Act, the Nurses and Midwives Act and, following recent amendment, the Health and Social Care Practitioners Act. Particularly, the legislation provides that persons may be appointed and warranted to assist the committee. These officers have broad powers and may interview any party who may have relevant information in relation to a complaint, take statements, prepare reports and give advice and assistance to the Preliminary Proceedings Committee. These investigations reduce the likelihood of cases being referred for inquiry where there is insufficient evidence to support a finding. Likewise where matters are referred for inquiry following such an investigation this can result in more focused inquiries.

All complaints no matter how trivial or serious[23] are referred to a Preliminary Proceedings Committee for investigation and decision. This contrasts with the procedures followed by different UK regulators which use a variety of screening processes. For example, the Registrar of the General Medical Council has an express power to sift out vexatious allegations as well as to refer allegations based on serious criminal offences directly for inquiry thereby bypassing the screening stage.

The use of alternative decision makers was considered by the Law Commission which noted that:

> *"Systems of investigation designed around an investigation committee do not always represent the most efficient or effective way of conducting an investigation…. The crucial point is to ensure that an investigation is*

[22] Law Society of Ireland v Walker [2006] IEHC 387; [2007] 3 IR 581
[23] Although see above in relation to convictions for indictable offences

conducted effectively, efficiently and fairly, and the regulators are best placed to determine how this can be achieved."[24]

One of the Commission's recommendations[25] was that regulators should not be able to refer for investigation any case that does not amount to an allegation (does not fall within grounds for complaint/disciplinary action), is vexatious, has been made anonymously and cannot otherwise be verified, and where the complainant refuses to participate and the allegations cannot be verified.

The Commission recommended[26] that some allegations be referred directly to an inquiry panel – eg convictions. Similarly it recommended [27] erasure for certain serious offences.

A number of options were considered by the Law Commission regarding who should carry out preliminary investigations:

a. an investigation committee which carries out all inquires
b. the Registrar or another individual (such as member of staff, professional or lay person)
c. two or more case examiners who carry out all investigations
d. professional and lay performance assessors, medical examiners and specialist health and performance advisors
e. a combination of individuals, case examiners and an investigation committee carrying out inquiries.

The Law Commission recommended[28] that the manner in which investigations are carried out should be specified in rules made by the regulators who would have the discretion in this matter.

There are further significant differences in the various statutes in the potential outcomes from this initial screening process.

Under the Medical Practitioners Act and the Nurses and Midwives Act the Preliminary Proceedings Committee may be of the opinion that:

a. There is not sufficient cause to warrant further action
b. The complaint should be referred to another body/authority or to a professional competence scheme
c. The complaint could be resolved through mediation or other informal means. Note that if the mediation or informal process is unsuccessful the matter cannot be subject to further disciplinary proceedings.

[24] P131 para 8.37 and 8.38
[25] Recommendation 59
[26] Recommendation 60
[27] Recommendation 63 – see above in relation to convictions
[28] Recommendation 64

In each such case it informs the Council of its opinion. The Council may decide that there is not sufficient cause to warrant further action or direct the steps at b and c[29]. Alternatively the Council may decide that the complaint be referred for inquiry before the Fitness to Practise Committee.

Where the Preliminary Proceedings Committee is of the opinion that there is a prima facie case to warrant further action being taken the matter will be referred for inquiry before the Fitness to Practise Committee. The matter may be referred for inquiry on additional grounds to those specified in the complaint[30]. The Council does not have the power to overturn this decision.

Under the Pharmacy Act and the Health and Social Care Professionals Act the Preliminary Proceedings Committee advises Council as to whether there is sufficient cause to warrant further action. There is no provision for referral to a professional competence scheme or for referral to another body. Where the Preliminary Proceedings Committee advises the Council that there is not sufficient cause for further action the Council must decide whether to take further action. Where the Preliminary Proceedings Committee is of the view that there is sufficient cause to warrant further action (or where the Council overturns a decision of the Committee to take no further action) the matter will be referred either for

a. Mediation, with the consent of the parties. Note that where mediation fails the matter must then be referred to a Committee of Inquiry which is a significant difference to the procedure provided for under the Medical Practitioners Act and the Nurses and Midwives Act. See further below.
b. Health Committee inquiry
c. Professional Conduct Committee inquiry

Under the Dentists Act, the Fitness to Practise Committee is charged with determining whether an inquiry should be held. If the Committee is of the view that there is not sufficient cause to hold an inquiry the Council may disagree and decide to hold an inquiry. Where the Committee decides that there is a prima facie case for holding an inquiry the matter will then be referred for inquiry. The Council cannot overturn this decision.

None of the enactments provide for the issuing of advices or warnings where the Preliminary Proceedings Committee has decided that there is not sufficient cause to warrant further action. There may however be concerns in relation to the practice of the registrant which are not sufficiently serious to pass the real prospect test. The Law Commission was of view that at the conclusion of the preliminary investigation and where a matter was not being referred for inquiry regulators should have the power to issue advice or a warning to the registrant regarding their future conduct.

[29] In the case of the Nursing and Midwifery Board the Council can refer the matter under a cooperation agreement to another prescribed body – Section 59

[30] Section 59(1A) Medical Practitioners Act as inserted by the Health (Miscellaneous Provisions) Act 2007; Section 61(2) Nurses and Midwives Act: although note the different means used to achieve this end

A number of regulators also have the power to agree undertakings or voluntary removal at this stage.[31]

As set out above where a decision is taken by the Preliminary Proceedings Committee that there is not sufficient cause to warrant further action in relation to a complaint this decision is subject to automatic confirmation by the Council/ Board. Such decisions take a significant portion of Council's time when considering fitness to practise matters and in the vast majority of cases the decision of the Preliminary Proceedings is upheld.

The Law Commission was of the view that regulators should have the power to review a decision not to refer a matter for inquiry (and to review a decision to issue warnings, advice, accept voluntary cancellation of registration) but that this should not be automatic. Such a review would take place:

a. on regulator's own initiative
b. at the request of the complainant, the registrant, the Professional Standards Authority[32] or other interested third party.

The Commission was of the view that a review should take place where the regulator considers the decision materially flawed or where new information would suggest a different conclusion. The Government response accepted this position in principle.

Interim suspensions

Where a regulator is concerned that a practitioner presents an immediate risk to the health and safety of the public an application can be made to the High Court for an order suspending that person's registration pending the outcome of any disciplinary inquiry. There are a number of inconsistencies in the processes set out in the different Acts with some having more streamlined processes than others.

Each of the Acts requires the convening of a meeting of the Board/Council to consider whether such an application should be made.

1. Requirement for a complaint to have been made

   The Pharmacy Act uniquely requires that a complaint has been made before an application can be made. With the exception of the Dentists Act the other enactments anticipate a complaint being made as the

[31] Recommendation 67
[32] This is a statutory body with oversight functions in relation to regulators of health professionals in the UK. For example it may appeal sanctions imposed where it is of the opinion that they are unduly lenient.

suspension is stated to be pending further steps in the fitness to practise process.

2. The magnitude of the public risk before an order can be made [33]

The Medical Practitioners Act, the Nurses and Midwives Act and the Health and Social Care Professionals Act allow the making of an application for a suspension order where the Council/Board considers it necessary to protect the public pending further disciplinary proceedings. The Dentists Act provides that the Council must be satisfied that it is in the public interest, giving perhaps a broader discretion. The Pharmacy Act specifies an arguably higher threshold, namely that such orders will be made *"only if the High Court considers that there is a risk to the health and safety of the public which is of such magnitude that the pharmacist's or pharmacy retail business' registration should be suspended…"* pending further disciplinary proceedings.

3. Circumstances in which the High Court application is held in public or private

The Medical Practitioners Act, the Nurses and Midwives Act and the Health and Social Care Professionals Act provide that the application shall be heard in private unless the Court considers it appropriate to hear the application in public. Under the Dentists Act the application shall be heard in summary manner and must be heard in private. The Pharmacy Act provides that the application shall be heard in private unless the registrant requests that the matter be heard in public and the Court is of the view that this is appropriate.

4. Requirement for notice of the making of the application

The Medical Practitioners Act, the Nurses and Midwives Act and the Health and Social Care Professionals Act specifically provide that applications for suspension can be made ex parte [34]. There is no requirement under the Dentists Act for notice to be given. However, under the Pharmacy Act the Court shall not make an order unless it is satisfied that the Council notified the registrant of its intention to make the application. Notwithstanding the provisions allowing for ex-parte applications, ordinarily registrants are notified of the Board/Council meeting and afforded the opportunity to make representations.[35]

[33] The circumstances that the Council/Board must consider in deciding whether to grant such an application were considered in O'Ceallaigh v An Bord Altranais [2000] 4 IR 54 per Barron J at 98
[34] Usually these applications are made on notice
[35] See An Bord Altranais v O'Ceallaigh [2010] JILL-HC 060901, Kearns P where he noted the registrant's entitlement to natural justice in being given notice of the Board meeting, being furnished with relevant information and having the opportunity to make representations.

Mediation

Mediation was introduced for the first time in healthcare regulation in the Health and Social Care Professionals Act 2005 as a means of resolution of disciplinary matters and its use is provided for by each of the regulators other than the Dental Council.

The Medical Practitioners Act 2007 and the Nurses and Midwives Act 2011 make provision for the resolution of disputes through mediation or other informal means. Where the Preliminary Proceedings Committee determines that there is not sufficient cause for further action in relation to a complaint it may refer the matter for mediation. As noted by the Minister for Health during the Oireachtas debate on the Medical Practitioners Bill, 2007:

> *"Many complaints are received by the Medical Council and other regulatory bodies which can be resolved in a much more satisfactory manner through mediation or discussion … We are introducing the concept of mediation in order to ensure that the Fitness to Practise Committee is the process that is used for serious issues only and that it is not used for what could be termed minor matters that can be dealt with through dialogue, discussion or mediation … Under no circumstances could one facilitate serious issues being resolved through mediation. That would be neither in the patient's interest nor in the interest of the profession."* [36]

In February 2010, the Medical Council issued guidance on mediation confirming that mediation is to deal with matters that are not suitable for a fitness to practise inquiry. The Guidelines state:

> *"The PPC shall not form an opinion that the matter is one that could be resolved by mediation if it is of the opinion that there is a prima facie case to warrant further action being taken in relation to the complaint."*

The process under the Pharmacy Act 2007 and the Health and Social Care Professionals Act 2005 is entirely different. Under this legislation where the Preliminary Proceedings Committee determines that there is sufficient cause for further action in relation to a complaint it may refer the matter either to a committee of inquiry or for mediation. The Pharmacy Act specifies that the resolution may include any of the sanctions that may be imposed by the Council following an inquiry. The Health and Social Care Professionals Act does not have this

[36] Select Committee on Health and Children, Committee debate 21 March on the Medical Practitioners Bill 2007

provision. It is possible for the parties to agree an outcome not including one of these sanctions.

Significantly, in both the Pharmacy Act and the Health and Social Care Professionals Act, where the Preliminary Proceedings Committee is informed that a complaint referred for resolution by mediation cannot be resolved or can only be resolved after taking into account considerations which make the complaint more suitable for a committee of inquiry then the Preliminary Proceedings Committee is required to refer the complaint to a committee of inquiry. It follows that only serious matters that could result in a sanction of at least admonishment can be referred for mediation.

The Law Commission expressed concerns in relation to the use of mediation between the complainant and registrant in regulatory processes. It queried whether mediation was appropriate in fitness to practise matters where there is a public interest in investigation and prosecution but nonetheless recommended that there should be a power to introduce mediation[37].

The Commission was of the view that mediation would only be suitable in a limited number of cases. It noted that mediation tends to be used in disputes between individuals and outcomes are negotiated rather than imposed. This contrasts with the role of a regulator protecting the public. It felt that mediation would only be appropriate early in the process and where there was no question of an allegation of impaired fitness to being raised. This is the form of mediation used in the Nurses and Midwives Act and the Medical Practitioners Act. The Law Commission had strong concerns that the use of mediation may undermine confidence in regulatory system.

In its response to the Report the Government stated that it did not consider that mediation should have any statutory footing within fitness to practise procedures. It stated:

> *"It is not clear how mediation sits with the objective of the fitness to practise procedures to protect the public, uphold proper standards of conduct and behaviour and maintain confidence in the relevant profession".*[38]

Inquiry process

1. Number of hearing committees

[37] Recommendation 69
[38] P100 of response

Historically the regulators had one disciplinary committee (fitness to practise committee) that screened complaints and conducted inquiries into health and conduct issues. Under the Medical Practitioners Act, Nurses and Midwives Act the Fitness to Practise Committee now conducts disciplinary hearings. Hearings are ordinarily in public. They may be held in private where an application is made by the registrant or a witness to have the inquiry held wholly or partly in private and the committee is satisfied that this is appropriate.[39]

The Health and Social Care Professionals Act and the Pharmacy Act provide for two committees of inquiry, the Health Committee and the Professional Conduct Committee. The Health Committee conducts its inquiries in private and has the assistance of a medical advisor. In all other respects the procedures of the two committees are the same. Provision is made for inquiries commenced in one committee to be transferred to the other if it becomes apparent that the complaint is more suitable for a hearing before the other committee.

2. Costs

Uniquely the Professional Conduct Committee and the Health Committee of the Pharmaceutical Society have the power to award costs following an inquiry.

3. Constitution of disciplinary committees

Each of the Acts has detailed provisions regarding the membership of its disciplinary committees and again there are significant differences.

	MC	NMBI	DC	PSI	Coru
President/Vice President of Council/Board	Cannot chair	Cannot chair	Cannot chair	President cannot be member	Neither can be member
Lay majority	PPC – no FTP - yes	Yes 1/3 registrants	No	Yes 1/3 registrants	No 1/3 lay
Chair of committee	Council member	Board member	Council member	Not specified	Not specified
Number of Council/Board members	1/3	1/3	All	Not specified	Not specified

The Law Commission considered the role of Council members and recommended[40] that regulators should ensure that as far as possible members concentrate on

[39] Hearings under the Dentists Act are in private.
[40] Recommendation 14

strategic or policy matters rather than operational delivery. It also recommended that Board members should not be involved in screening of complaints and should be excluded from fitness to practise panels[41]. The Government agreed with each of these recommendations.

4. Standard of Proof

This is not a matter that is addressed in the legislation but it is an issue that was considered by the Law Commission. Regulators in this jurisdiction apply the criminal standard of proof in establishing the both facts in relation a complaint and in establishing whether those facts, whether proved or admitted amount to one of the grounds for complaint.[42] Regulators in the UK have moved to the civil standard following criticism in the wake of a series of scandals in the Health Sector. The Law Commission recommended the civil standard[43] noting that

> *"It is not acceptable that registrant who is more likely than not to be a danger to the public should be allowed to continue practising because a panel is not certain that he or she is a danger."*[44]

Sanctions

The following table sets out the range of sanctions that may be imposed by the Council/Board where a complaint has been substantiated.

	MC	NMBI	DC	PSI	Coru
Advice	y	y	y		
Admonish	y	y	y	y	y
Censure	y	y	y	y	y
Censure and fine	Y – max fine €5000	Y – max fine €2000			
Transfer to another division of register	y	y			
Conditions	y	y	y	y	y
Suspension	y	y	y	y	y
Cancellation	y	y	y	y	y
Prohibition	y	y		y	y

[41] Recommendations 57 and 74
[42] See O'Laoire v Medical Council Unrep High Court 25 July 1997, Keane J at P115 and Law Society of Ireland v. Walker [2006] IEHC 387 at para 31
[43] Recommendation 81 and accepted by the Government
[44] p164

on making registration application					

The Law Commission recommended that all fitness to practise panels have the same powers to impose sanctions or otherwise dispose of cases.

Sanctions other than advice, admonishment or censure must be approved by the High Court before they can take effect. The registrant can appeal the imposition of these more serious sanctions. Where the registrant does not appeal the Council/Board must apply to the High Court for confirmation of these sanctions. Some differences between the enactments are as follows:

	MC	NMBI	DC	PSI	Coru
Time to appeal[45]	21	21	21	30	30
Confirmation:					
Ex-parte	y	y	y	n	n
Time to bring application	As soon as practicable	As soon as practicable	Not specified but will be after expiry of 21 days for appeal	60 days from notification of decision	60 days from notification of decision
HC decision	Confirm unless good reason not to	Confirm unless good reason not to	Confirm unless sees good reason not to	May but need not confirm	Confirm unless good reason not to
Appeal to Supreme Court[46]	Specified question of law	Specified question of law	Specified question of law	Question of law of public importance	Specified question of law

Publication and Notification

Again there are inconsistencies in relation to the extent to which public notice should be given of the outcome of an inquiry and the parties to whom specific

[45] From date of decision in case of Dental Council. From date of notification of decision in case of other regulators

[46] In relation to appeal or application for confirmation

notification of sanction must be given. With the exception of the Dental Council each Council is required, if it is in the public interest to do so, to give public notice of sanctions imposed. Other than for the Pharmaceutical Society the Council/Board can publish all or part of the transcript of the hearing following consultation with the hearing committee. Publication is ordinarily made on the publicly accessible register of practitioners, the regulator's website or in other periodic publications.

There is no indication in the legislation as to the length of time this information is to be available and is therefore a matter of policy for individual regulators. The Law Commission recommended[47] that the public registers should indicate all current sanctions imposed on a registrant and that it should include details of all previous sanctions (other than warnings which are over 5 years old). The Government agreed in part but wanted to consider the maximum duration that sanctions should be recorded in the register and the extent to which previous sanctions should be shown.

The Commission also recommended[48] that regulators be required to publish all fitness to practise decisions. The Government agreed that substantive fitness to practise decisions should be published or agreed undertakings or warnings.

Specific notifications is required to be given to the following parties:

	MC	NMBI	DC	PSI	Coru
Minister	Y	Y	Y	Y	Y
Employer	Y	Y		Y	Y
HSE	Y	Y			

Conclusion

The disciplinary processes provided for in the different Acts are complex and confusing for those who may wish to make a complaint or who may find themselves the subject of a complaint. The legislation has been amended in a piecemeal fashion and continues to be so amended. Different professionals can be disciplined in different ways in respect of the same matters leading to loss of public confidence in the process. The system can be cumbersome and inefficient. As noted earlier similar criticisms have been made of the system in the UK.

The Law Commission recommended[49] that there should be a single statute governing all regulators (to include all functions). They were of the view that there

[47] Recommendation 41
[48] Recommendation 43
[49] Recommendation 1

was a clear public interest in having greater consistency across regulators with arguments for consistency particularly compelling in fitness to practise. They noted that it is difficult to justify different professionals being disciplined in different ways for the same misdemeanors. Such a structure would lead to more robust regulatory standards and guarantee certain core procedural safeguards. Differences in regulatory performance would also be easier to identify.

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