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IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
THE ADMINISTRATIVE COURT
[2018] EWHC 171 (Admin)

CO/2684/2017

Royal Courts of Justice
Friday, 19th January 2018

Before:

HIS HONOUR JUDGE DIGHT CBE
(Sitting as a Judge of the High Court)

B E T W E E N :

GENERAL MEDICAL COUNCIL — Appellant

- and -

PATEL — Respondent

J U D G M E N T

A P P E A R A N C E S

MR I HARE QC (instructed by the General Medical Council) appeared on behalf of the Appellant.

MR R LAMBIS (instructed by RadcliffesLeBrasseur) appeared on behalf of the Respondent.

THE JUDGE:

1 This is an appeal by the General Medical Council under s.40A(1)(d) of the Medical Act 1983 ("the Act") against the decision of the Medical Practitioners Tribunal ("MPT") dated 12th May 2017 not to take any action following misconduct proceedings which had been taken against the respondent whom I will refer to as "the doctor".

2 The sole issue before me is the narrow one of whether the MPT was wrong to make the decision to take no action. The sole statutory ground of appeal relied on by the GMC is that they consider that the decision is not sufficient as to penalty for the protection of the public in accordance with ss.40A(3) of the Act and they invite the court to quash the MPT's decision to take no action, and to remit the case to the MPT to reconsider the question of sanction in accordance with ss.40A(6)(d).

3 The factual background in brief is as follows. Between 6th and 9th March 2015, the doctor was contracted by the NHS to work as an ST5 anaesthetic registrar on call during the day shift between 8.00 a.m. and 8.00 p.m. at Charing Cross Hospital, but he also agreed to provide locum cover at the private unit of the Charing Cross Hospital on three of those four days, namely 7th, 8th and 9th March 2015. He did not work on 6th March because of ill health.

4 On 10th March 2015, the doctor submitted a claim form for undertaking work as a locum at the private unit from 8.00 p.m. to 8.00 a.m. from 6th to 9th March. This alleged duplication was investigated by the Imperial College Healthcare NHS Trust, and a formal disciplinary hearing was held on 23rd April 2015, following which the doctor was given a final warning by the Trust which was to last for 12 months.

5 The doctor himself referred the matter to the GMC, as a result of which he faced an allegation of impairment by reason of misconduct. The allegations made against the doctor, as amended, were as follows.

6 First, that between 6th and 9th March 2015 he was contracted by the NHS to work as an anaesthetic registrar at the Charing Cross Hospital. The doctor admitted this and it was found proved by the MPT.

7 Second, he also agreed to provide locum cover for a private unit at the Charing Cross Hospital on 7th, 8th and 9th March when he knew he was already contracted to work for the NHS. The doctor admitted this on a limited basis, namely that he had agreed to the locum

shifts only to the extent that he could do so without prejudicing his commitments to his NHS role at the same site. The MPT rejected this and found the allegation proved.

8 Third, that on 10th March 2015, he claimed for locum work in the private unit from 8.00 p.m. on 6th March until 8.00 a.m. on 9th March when (a) he did not work on 6th March, and (b) he worked overlapping shifts with the NHS on 7th to 9th March. The doctor admitted this allegation, and the MPT found the allegation proved.

9 Fourth, that his actions in allegations 2 and 3 were (a) misleading, and (b) dishonest. The doctor admitted that the actions in allegation 3 were misleading and dishonest. The MPT, however, found it proved in respect of both allegations 2 and 3, holding that his employers in the NHS had been misled by his actions. The doctor accepted misconduct but not impairment, but the panel found that his fitness to practise was impaired because of his misconduct.

10 The hearing took place in two stages between 5th and 8th December 2016, and between 10th and 12th May 2017. The MPT heard evidence from witnesses, including the doctor who gave evidence at all the stages of the hearing in December 2016 and May 2017, and the MPT made separate findings of fact in respect of each.

11 In respect of the doctor himself, the MPT made the following findings, recorded in their determination as to the facts which was dated 8th December 2016. First in para.7, as follows:

> "The Tribunal's view was that you were a willing and forthcoming witness, keen to assist the Tribunal by telling your version of events. However, the Tribunal noted that on a number of occasions you did not directly answer the questions that were put to you. The Tribunal could not be certain whether this was as a result of you being nervous, or because you were deliberately avoiding answering those questions."

12 Later, in respect of a series of emails that had been written by him about his NHS work, the panel said this in para.24 of the same set of findings:

> "The Tribunal has considered your evidence in which you said that the emails sent by you on 7th and 9th March 2015 were referring to your NHS work and not your private locum cover. However, for the reasons set out above, it does not accept your explanation that you were not referring to private work in the email correspondence. It was clear to the Tribunal that you were offering yourself the private shifts and that,

in fact, you were not formally booked for the private shifts, you believed yourself to be so. When asked by the Tribunal about your use of the word 'booked' you accepted that you would not use this word in relation to your NHS work. You said that you believed you had not been booked for private work that weekend but the Tribunal's view was that this assertion was not borne out by the documentary evidence."

13 In para.25 they considered the evidence of a Dr Goburdhun and conversations or communications that are said to have taken place between the doctor and Dr Goburdhun. Towards the end of para.25 it is apparent that the Tribunal preferred the evidence of Dr Goburdhun to that of the doctor. In paras.28 and 29 the panel made further adverse findings in respect of the doctor's credibility.

14 The ultimate conclusion was that while the doctor was guilty of misconduct and had been dishonest and his fitness to practise was impaired, nevertheless because of the existence of exceptional circumstances, it was appropriate not to take any action against him by way of sanction. The findings of the MPT fall into three parts, including the part that I have already referred to. They made separate determinations as to the facts which I have just mentioned on 8th December 2016, as to impairment on 11th May 2017, and as to sanction on 12th May 2017.

15 In respect of impairment on 11th May 2017, they said in paras.12-14 as follows:

"12. It has found proved that you agreed to provide locum cover to the private until at Charing Cross ('the private unit') on 7, 8 and 9 March 2015 when you were already contracted to work for the NHS on those dates.

13. It has been found proved that you did not work on 6 March 2015 and you knew that you had not worked in the private unit on 6 March 2015. You also knew that you had worked overlapping shifts for the NHS and the private unit on 7, 8 and 9 March 2015. On 10 March 2015 you subsequently submitted a claim form for the private locum work; this contained a false claim for payment which you knew to be false. Your actions in this regard were found to be misleading and dishonest.

14. In the Tribunal's view you breached the principles of probity contained within the GMP as outlined above. You behaved dishonestly twice and could have profited personally from your dishonest claim for payment if it had been processed. The Tribunal was in no doubt that this falls seriously short of the standards of conduct

that the public and patients are entitled to expect from all registered medical practitioners. It concluded (and it was accepted by you) that the matters admitted and found proved were sufficiently serious to amount to misconduct."

16 The panel then went on to consider the issue of remediation setting out its thought processes from para.21 onwards of its determination on the related question of impairment. The doctor accepted, as I have already mentioned, that his actions had been misleading and dishonest and he had admitted misconduct, but he denied impairment because, it was said on his behalf, that he had not put patients at risk in simultaneously covering his NHS role and the private unit because he was on call for the NHS over that period in any event.

17 The MPT rejected that argument and found that the doctor had put patients at risk of harm because he had not informed his NHS employers about his commitment to the private unit. And because there was a possibility that he could have been required to be in two separate places at the same time, as a consequence, they held that it brought his profession into disrepute and that his fitness to practise was impaired because of his misconduct.

18 In looking at remediation they held as follows from para.23 of the second tranche of their determination:

> "The Tribunal considered the oral evidence you gave on answering questions from the Tribunal members. It noted that even though you were not intending to give evidence at this stage of the proceedings, you were willing to answer questions which the Tribunal had for you. The Tribunal considered your answers to be truthful, credible and open. It found you to be full of remorse for your actions and shameful about your misconduct. It was satisfied that although you denied some allegations at the outset, you fully accepted the Tribunal's findings in relation to these. It recognised that you were humbled by the findings made at the first stage of the proceedings and by the entire regulatory process."

19 In para.27 the Tribunal concluded that the risk of repetition was low.

20 In para.30 they referred to the submissions of Mr Lambis on behalf of the doctor, and the case of *Uppal*, which he mentioned, which I will come to in due course.

21 In para.31 they concluded as follows:

> "The Tribunal acknowledged that reasonable and fully informed members of the public would be aware that you have taken considerable steps to satisfy this Tribunal

that you will not repeat your repeat your misconduct. However, its view was that your actions fell so far short of expected standards, given that you behaved dishonestly twice and may have profited from your dishonest behaviour, the Tribunal was satisfied that this was not an exceptional case which would justify a finding of no impairment. It decided that public confidence in the profession would be seriously damaged and proper professional standards would not be maintained if a finding of impairment was not made. It therefore found your fitness to practise impaired on that basis."

22 It was in their written determination in respect of the sanction to be imposed that the MPT concluded, however, that no action should be taken in respect of the doctor's registration. The GMC invited the MPT to suspend the doctor, having regard to the relevant paragraphs of the GMC's sanctions guidance issued in July 2016. The doctor, through counsel, submitted that no action should be taken, having regard to the potential impact on his career, the insight which he had shown into the wrongdoing, the steps which he had taken towards remediation and his engagement with the regulatory process.

23 One of the matters that was before the Tribunal when considering the sanctions to be imposed was an email written by a Dr Claire Shannon, Head of the London School of Anaesthetics, in respect of the potential impact of the loss the doctor's training number, which played an important part in the submissions before me. In their determination on the question of sanction, in para.12, the Tribunal identified the following aggravating factors:

> "• Your dishonest actions were premeditated. A number of months in advance, you agreed to provide locum cover in the private wing of the hospital for a number of days, full in the knowledge that you were contracted to work in your NHS post on these days;
>
> • Patients were placed at risk of harm by your actions."

24 They turned to the mitigating factors in para.13 of the determination. They said as follows:

> "The Tribunal balanced those with the mitigating factors in this case:
>
> > • Your high level of insight into your misconduct as demonstrated in your evidence and reflective logs, and your extensive remediation;
> >
> > • You have apologised for your actions and expressed genuine remorse and shame;

• You have taken this opportunity to develop yourself both professionally and personally. You have undertaken coaching training and have now developed those skills so that you take a more 'holistic' approach to your role as a doctor; you actively support to your colleagues as a consequence of your personal development during this process. The Tribunal noted that you were nominated as the 'best individual coach amongst the students present' on the coaching course;

• Your previous good character and that you are held in high esteem by patients and your colleagues both senior and junior, including your Assistant Postgraduate Dean who has been very supportive of you;

• You have been open about this hearing with colleagues, you have had full and frank discussions with many of them as demonstrated by their comments in the testimonial documentation adduced;

• It has been over two years since the events explored in this hearing and the Tribunal has been presented with no evidence of repetition of similar actions."

25 The MPT concluded that there were exceptional circumstances in this case which justified it taking no action. They noted in para.22 that given the "significant steps taken by you to remediate your misconduct, you could have done no more in this respect."

26 In para.23 they referred to the Reference Guide for Postgraduate Specialty Training in the UK (the Gold Guide, 6th edition) and said that it was evident from that, that:

> "**...any** suspension in these proceedings, for **any** length of time, will result in the loss of your national training number. The Tribunal carefully considered the email from Dr Shannon dated 11 May 2017. She confirmed that once the training number is lost, you may be able to apply to re-enter the training programme, but only with the support of your Postgraduate Dean, and even then, you would be obliged to re-enter the programme at the level of ST3 (whereas you are currently at ST7 level).
>
> 24. The Tribunal was aware that suspension is frequently considered to be an appropriate and proportionate sanction in a case of dishonesty where there has been insight and remediation. Further, it was aware that many doctors in these Tribunals will suffer the loss of [their] national training number if their registration is

suspended. However, its view was that the position in which you will find yourself, should a suspension be imposed in this case, was unusual and uncommon. This is because you have undergone many years of training in the anaesthetics training programme. You are now in your final year of training and will be eligible to apply for a consultant post relatively soon. Should your registration be suspended, you may not be able to return to the training programme at all; if you receive the requisite support and are permitted to reapply, you will then have to compete with others nationally to regain a place and can only apply for a place which is five years behind where you are now in your training. In the Tribunal's view, this means that you would be in a worse position than, for example, a trainee doctor at the ST2 or ST3 level, who (if given an opportunity to reapply) would not have to regress 5 years in their training programme. The Tribunal was in no doubt that whilst you have acted dishonestly, and behaved in a premeditated way in the past, such a consequence, should it occur, would be wholly disproportionate because a suspension, even if short, could effectively ruin your career. It was evident, from the documentation before the Tribunal, that you are a competent and trusted trainee who has a promising career ahead of you."

27 In para.25 the Tribunal referred to the case of *Bolton v The Law Society* [1993] EWCA Civ 32 before saying:

> "It was acutely aware that the fortunes of an individual doctor must not be given more weight than the need to maintain the reputation of the profession. However, it was similarly aware of the public interest in ensuring that the career of a competent doctor is not ended (*Giele v GMC* [2005] EWHC 2143 (Admin). It was evident to the Tribunal from the testimonials provided that your colleagues held you in high esteem" and they then referred to a number of them.

28 In para.27 they continued:

> "Overall, the Tribunal had regard to the far-reaching effects of the remediation undertaken by you, and the inevitable loss of your training number and its allied consequences if your registration was suspended. Its view was that the loss of your training number in the event of a suspension and the connected consequences was a powerful and persuasive argument when deciding the proportionality of any sanction. It concluded that this was a case in which exceptional circumstances

prevailed which would justify it in taking no action. In relation to paragraph 63 of the SG, this states that the Tribunal should consider:

(a) What the exceptional circumstances are:

The far-reaching impact that these proceedings and the remediation undertaken have had on your abilities as a professional and an individual. Also, the potential loss of your career as a consultant anaesthetist should your registration be suspended.

(b) Why are the circumstances exceptional:

This is because in the Tribunal's view, it is uncommon for a doctor who has acted dishonestly in a case where there were no clinical issues to take such significant steps to remediate his practice that they have led to an improvement in his overall abilities and qualities as a person and as a professional. In relation to your national training number, your position is exceptional because given your current seniority in the training programme, the loss of the number (if you were suspended) would set your career progression back by at least 5 years and could your damage your opportunities to become a consultant at all in the future.

(c) How the exceptional circumstances justify taking no action:

The exceptional circumstances identified have persuaded the Tribunal that given your insight, remediation, current skill level, ability to lead teams and the high esteem in which you are held by your colleagues, the public interest would be best served by allowing you to return to practice. The Tribunal concluded that conditions would serve no useful purpose, given that there is low risk of repetition, and a suspension would have far-reaching adverse consequences for your career which would be disproportionate in all the circumstances and particularly serious for you at such an advanced stage in your career.

28. The Tribunal was also mindful that a finding of impaired fitness to practise had been made, and that whilst the Tribunal has decided to take no action, this finding will remain with you. The Tribunal was satisfied that public confidence in the profession and the need to maintain proper standards of conduct and behaviour would not be undermined by its decision to take no action. Fully informed and reasonable members of the public would know about your misconduct but equally, they would know about the steps you have taken to put things right, the positive

impact of these steps on your skills and abilities as a doctor, and the devastating consequences for you and your potential patients, if your national training number was removed."

29 By its notice of appeal dated 7th June 2017, the GMC contends that the MPT's decision is not sufficient for protection of the public.

30 The legal framework that applies in this case is as follows. Appeals by the GMC from decisions made by Medical Practitioner Tribunals are governed by s.40A of the Medical Act 1983, which I have already referred to. The relevant decision here is one falling within ss.(1)(d) i.e. not to impose a sanction. By ss.(3) the GMC is given power to appeal against relevant decision if "they consider that the decision is not sufficient (whether as a finding or a penalty or both) for the protection of the public." Sub-section (4) identifies some of the factors to be taken into account:

> "(4) Consideration of whether a decision is sufficient for the protection of the public involves consideration of whether it is sufficient—
>
> (a) to protect the health, safety and well-being of the public;
>
> (b) to maintain public confidence in the medical profession; and
>
> (c) to maintain proper professional standards and conduct for members of that profession."

31 By virtue of ss.(6) the court is empowered to dismiss the appeal, allow it and quash the decision or substitute for the relevant decision any other decision which could have been made by the Tribunal, or remit the case to be disposed of in accordance with the directions of the court, which is what the GMC ask for in this case.

32 The approach of the court in respect of this relatively new power to appeal has now been authoritatively stated by the Divisional Court in *General Medical Council v Jagjivan and Professional Standards Authority for Health and Social Care* [2017] EWHC 1247 (Admin) in a court consisting of Sharp LJ and Dingemans J. The court gave guidance on the first appeal by the GMC against a decision of an MPT. In para.40 of the judgment, under the heading, "The correct approach to appeals under section 40A" the court held as follows:

> "In summary:

i) Proceedings under section 40A of the 1983 Act are appeals and are governed by CPR Part 52. A court will allow an appeal under CPR Part 52.21(3) if it is 'wrong' or 'unjust because of a serious procedural or other irregularity in the proceedings in the lower court'.

ii) It is not appropriate to add any qualification to the test in CPR Part 52 that decisions are 'clearly wrong': see *Fatnani* at paragraph 21 and *Meadow* at paragraphs 125 to 128."

33 In other words, there is no need to add the word "clearly" to the appeal test, which is simply "wrong".

"iii) The court will correct material errors of fact and of law: see *Fatnani* at paragraph 20. Any appeal court must however be extremely cautious about upsetting a conclusion of primary fact, particularly where the findings depend upon the assessment of the credibility of the witnesses, who the Tribunal, unlike the appellate court, has had the advantage of seeing and hearing (see *Assicurazioni Generali SpA v Arab Insurance Group* (Practice Note) [2002] EWCA Civ 1642; [2003] 1 WLR 577, at paragraphs 15 to 17, cited with approval in *Datec Electronics Holdings Ltd v United Parcels Service Ltd* [2007] UKHL 23, [2007] 1 WLR 1325 at paragraph 46, and *Southall* at paragraph 47).

iv) When the question is what inferences are to be drawn from specific facts, an appellate court is under less of a disadvantage. The court may draw any inferences of fact which it considers are justified on the evidence: see CPR Part 52.11(4).

v) In regulatory proceedings the appellate court will not have the professional expertise of the Tribunal of fact. As a consequence, the appellate court will approach Tribunal determinations about whether conduct is serious misconduct or impairs a person's fitness to practise, and what is necessary to maintain public confidence and proper standards in the profession and sanctions, with diffidence: see *Fatnani* at paragraph 16; and *Khan v General Pharmaceutical Council* [2016] UKSC 64; [2017] 1 WLR 169, at paragraph 36.

vi) However there may be matters, such as dishonesty or sexual misconduct, where the court 'is likely to feel that it can assess what is needed to protect the public or maintain the reputation of the profession more easily for itself and thus attach less weight to the expertise of the Tribunal...': see *Council for the Regulation of*

Healthcare Professionals v GMC and Southall [2005] EWHC 579 (Admin); [2005] Lloyd's Rep. Med 365 at paragraph 11, and Khan at paragraph 36(c). As Lord Millett observed in *Ghosh v GMC* [2001] UKPC 29; [2001] 1 WLR 1915 and 1923G, the appellate court 'will afford an appropriate measure of respect of the judgment in the committee… but the [appellate court] will not defer to the committee's judgment more than is warranted by the circumstances'.

vii) Matters of mitigation are likely to be of considerably less significance in regulatory proceedings than to a court imposing retributive justice, because the overarching concern of the professional regulator is the protection of the public.

viii) A failure to provide adequate reasons may constitute a serious procedural irregularity which renders the Tribunal's decision unjust (see *Southall* at paragraphs 55 to 56)."

34 Mr Lambis, on behalf of the defendant, submits that the MPT's decision in the instant case is to be treated as correct until the contrary is shown, and that this is not a re-sentencing exercise. He referred me to the decision of *Raschid v General Medical Council* [2007] EWCA Civ 46 in that respect.

35 I agree. This is a true appeal and not a re-hearing, and the question for me, therefore, is whether the MPT decision was wrong. It is for the GMC to demonstrate it. The question is ultimately: did the MPT strike the balance and exercise their judgment in the correct way?

36 Mr Lambis also submits that the decision of the panel is to be given respect, and he referred me to the decision of Hickinbottom J, as he then was, in the case of *Odes v General Medical Council* [2010] EWHC 55 (Admin) and, in particular, to para.91. Here, of course, the decision of the panel is to be given respect, as the divisional court in the case of *Jagjivan* says. But one has to bear in mind that as the court held in that case at para.40 (vi) that where the allegation that is before the court is one of dishonesty, the position the court is entitled to take is different to where the question of expertise is in issue. In that respect, less deference is to be paid to the views of the MPT in this case.

37 In the overall regulatory framework, the role of the GMC is provided by the Medical Act 1983. And I need only refer to two specific provisions. By s.1(1A) the Act provides:

"The over-arching objective of the General Council in exercising their functions is the protection of the public.

(1B) The pursuit by the General Council of their over-arching objective involves the pursuit of the following objectives—

(a) to protect, promote and maintain the health, safety and well-being of the public,

(b) to promote and maintain public confidence in the medical profession, and

(c) to promote and maintain proper professional standards and conduct for members of that profession."

38 It is in the light of that, it seems to me, that the appeals framework and the role of the MPT has to be considered.

39 There is, and I have been taken to in detail, sanctions guidance approved by the GMC, which was developed for use by Medical Practitioners Tribunal, the current guidance being dated July 2016, with the intention of ensuring a consistent approach when considering, among other things, what sanctions to impose following a finding that a doctor's fitness to practise is impaired. It is plain that the guidance considers that the main purpose of imposing a sanction is to protect the public, namely to meet the objectives set out in ss.1A and 1B of the Act, not to punish or discipline the doctor.

40 The section dealing with the sanctions to be imposed when a doctor's fitness to practise is impaired starts at para.60 and provides that where a Tribunal finds a doctor's fitness to practise impaired, it can (a) take no action, (b) agree to accept undertakings, (c) impose conditions, (d) suspend the doctor's registration for up to 12 months, or (e) erase the doctor's name from the medical register.

41 So far as the option of taking no action is concerned, the guidance provides at paras.62 to 64 as follows:

"62. Where a doctor's fitness to practise is impaired, it will usually be necessary to take action to protect the public (see paragraphs 14-16). But there may be exceptional circumstances to justify a tribunal taking no action.

63. To find that a doctor's fitness to practise is impaired, the tribunal will have taken account of the doctor's level of insight and any remediation, and therefore these mitigating factors are unlikely on their own to justify a tribunal taking no action.

64. Exceptional circumstances are unusual, special or uncommon, so such cases are likely to be very rare. The tribunal's determination must fully and clearly explain:

(a) what the exceptional circumstances are

(b) why the circumstances are exceptional

(c) how the exceptional circumstances justify taking no further action."

42 The question of dishonesty is specifically dealt with in the section of the guidance headed, "Other issues relevant to sanctions" starting at para.106 where, in para.110, the guidance emphasises again that the purpose of the hearing is not to punish the doctor but to consider whether the doctor's fitness to practise is impaired. So far as dishonesty is specifically concerned, the guidance provides as follows:

> "114. *Good medical practice* [which is a reference to other guidance] states that registered doctors must be honest and trustworthy, and must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession.
>
> 115. In relation to financial and commercial dealings, paragraph 77 of *Good medical practice* also set out that:
>
> > 'you must be honest in financial and commercial dealings with patients, employers, insurers, and other organisations or individuals.'
>
> 116. Paragraphs 78-80 of *Good medical practice* and the separate guidance on *Financial and commercial arrangements and conflicts of interest*, further emphasise the duty to avoid conflicts of interest."

43 The provision relating to financial dealings and honesty in *Good medical practice*, updated on 29th April 2014 so far as this appeal is concerned, is to be found at 77 which states:

> "You must be honest in financial and commercial dealings with patients, employers, insurers and other organisations or individuals."

44 Suspension of doctors is dealt with in para.85 of the Sanctions guidance which says:

> "Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in

that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.

86. Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession)."

45 I turn then to the grounds of appeal and the GMC's submission. The first basis of challenge to the decision of the MPT is that the panel misdirected itself as to the evidence before it and placed too much weight on the alleged impact of suspension on the doctor's career. The MPT, it is submitted, reached the conclusion, as appears from the parts of the determination that I have referred to, that the doctor's suspension would effectively be career-ending or at least set back by 5 years, whereas, it is submitted that the MPT failed properly to understand the true nature and extent of the evidence of Dr Shannon which did not necessarily support such a conclusion. Doctor Shannon was asked a series of specific questions in response to which she had said, on 11th May in her email, as follows:

"1. If NTN was removed, Dr Patel could only reapply with the support of the Postgraduate Dean. It is likely (but not guaranteed), that that would be granted given the good progress he has made and the support offered by his local trainers."

46 Pausing there, it is submitted that the premise of the question and the answer to it is that the NTN would be removed. It is not part of the evidence given by Dr Shannon that, in fact, the NTN would be removed. Her evidence deals with the consequences of removal of the number. She goes on:

"2. If NTN was removed and condition (1) occurred Dr Patel would be able to reapply for an NTN but this would be in open competition.

3. It is difficult to say for sure what the future competition ratios would be but past recruitment processes have generally been in the order of 1 post for each 2-3 applicants.

4. The recruitment process is an annual National process with a recruitment window usually for anaesthetics in December to January, for a start date the following August.

5. Dr Patel would be reapplying for entry at ST3 which is 3 years lower than his current grade [I think that should be 5 years lower] than his current grade. Occasionally if a trainee is judged to have appropriate competencies they can be accelerated through training, but this is not guaranteed, is unpredictable and depends on gaps further along the training programme.

Entry at ST3 is likely to prolong his training by around 3 years."

47 It is submitted that the Tribunal did not have proper regard to this evidence, did not properly understand it, and failed to take it into account in considering whether the impact of suspension would be effectively to ruin the doctor's career. Secondly, it was submitted in respect of the same issue, that the effect of suspension is, in any event, of limited relevance given that it focuses on the impact on the doctor rather than on the purpose for which sanctions are imposed, namely to uphold the objectives of the GMC's functions, and failed to take account of the guidance given in the analogous case of *Bolton v The Law Society*, a decision of the Court of Appeal [1993] 1 WLR 512, where, in connection with a solicitor who had been guilty of dishonesty, Sir Thomas Bingham, then Master of the Rolls, considered the purpose of suspension and striking off of a solicitor. At p.518H his Lordship said:

"The second purpose is the most fundamental of all: to maintain the reputation of the solicitors' profession as one in which every member, of whatever standing, may be trusted to the ends of the earth. To maintain this reputation and sustain public confidence in the integrity of the profession it is often necessary that those guilty of serious lapses are not only expelled but denied re-admission. If a member of the public sells his house, very often his largest asset, and entrusts the proceeds to his solicitor, pending re-investment in another house, he is ordinarily entitled to expect that the solicitor will be a person whose trustworthiness is not, and never has been, seriously in question. Otherwise, the whole profession, and the public as a whole, is injured. A profession's most valuable asset is its collective reputation and the confidence which that inspires.

Because orders made by the Tribunal are not primarily punitive, it follows that considerations which would ordinarily weigh in mitigation of punishment have less effect on the exercise of this jurisdiction than on the ordinary run of sentences imposed in criminal cases. It often happens that a solicitor appearing before the Tribunal can adduce a wealth of glowing tributes from his professional brethren. He can often show that for him and his family the consequences of striking off or suspension would be little short of tragic. Often he will say, convincingly, that he has learned his lesson and will not offend again. On applying for restoration after striking off, all these points may be made, and the former solicitor may also be able to point to real efforts made to re-establish himself and redeem his reputation. All these matters are relevant and should be considered. But none of them touches the essential issue, which is the need to maintain among members of the public a well-founded confidence that any solicitor whom they instruct will be a person of unquestionable integrity, probity and trustworthiness. Thus it can never be an objection to an order of suspension in an appropriate case that the solicitor may be unable to re-establish his practice when the period of suspension is past. If that proves, or appears likely to be, so the consequence for the individual and his family may be deeply unfortunate and unintended. But it does not make suspension the wrong order if it is otherwise right. The reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is a part of the price."

48 It is submitted that although the MPT mentioned this case in the course of the sanctions decision, it failed to apply it or take it properly into account. Secondly, it is submitted that the MPT placed too much weight on remediation at this stage of their decision making. The sanctions guidance says that remediation will be taken into account on the question of impairment but, in this case, it is submitted that the MPT placed very considerable weight on the question of remediation when considering sanction. Finally it is submitted that the alleged remediation should not have led the panel to the conclusion that in this case there were exceptional circumstances.

49 So far as the proper balance to be struck between the public interest and remediation is concerned, counsel for the appellant drew my attention to the decision of Sales J, as he then was, in the case of *Dr Cheng Toh Yeong v General Medical Council* [2009] EWHC 1923 (Admin) which was a case concerning inappropriate sexual behaviour but the principles laid

down by the learned judge are said to apply equally in this case. At paras.50 and 51, the learned judge says this:

> "50. First, in my judgment, the overarching function of the GMC as set out in s. 1(1A) of the Act informs the meaning of impairment of fitness to practise by reason of misconduct in s. 35C(2), so that under s. 35C(2) and s. 35D the FTPP (acting on behalf of the GMC) is entitled to have regard to the public interest in the form of maintaining public confidence in the medical profession 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. Where a medical practitioner violates such a fundamental rule governing the doctor/patient relationship as the rule prohibiting a doctor from engaging in a sexual relationship with a patient, his fitness to practise may be impaired if the public is left with the impression that no steps have been taken by the GMC to bring forcibly to his attention the profound unacceptability of his behaviour and the importance of the rule he has violated. The public may then, as a result of his misconduct and the absence of any regulatory action taken in respect of it, not have the confidence in engaging with him which is the necessary foundation of the doctor/patient relationship. The public's confidence in engaging with him and with other medical practitioners may be undermined if there is a sense that such misconduct may be engaged in with impunity.
>
> 51. Secondly, where a FTPP considers that fitness to practise is impaired for such reasons, and that a firm declaration of professional standards so as to promote public confidence in that medical practitioner and the profession generally is required, the efforts made by the practitioner to address his problems and to reduce the risk of recurrence of such misconduct in the future may be of far less significance than in other cases, such as those involving clinical errors or incompetence. In the former type of case, the fact that the medical practitioner in question has taken remedial action in relation to his own attitudes and behaviour will not meet the basis of justification on which the FTPP considers that a finding of impairment of fitness to practise should be made. This view is also supported to some degree by the judgment of McCombe J in *Azzam* at [51] (distinguishing the case before him, which involved clinical errors, in respect of which evidence of remedial steps and improvement was relevant, from a case involving "a rape or misconduct of that kind", in relation to which – by implication – such evidence might be less significant)."

50 It is submitted that the reasoning of the learned judge in that case applies equally to allegations of dishonesty; that one has to bear in mind the primary purpose of the process of applying the sanction, namely to uphold confidence in the profession, and one has to look at the limited effects of potential remediation in respect of non-clinical misconduct.

51 Thirdly, it is submitted that in their reasoning, that with the exception of *Bolton*, the MPT made no references to the authorities on dishonestly concerning doctors, or to the emphasis placed on the seriousness of dishonesty in the sanctions guidance that I have already referred to. My attention was drawn to the decision of Mitting J in the case of *Nicholas-Pillai v General Medical Council* [2009] EWHC 1048 (Admin) where his Lordship held in para.27 that the usual sanction for dishonesty will often be one of erasure, and that, looked at in that context, suspension is in this case something that the MPT should have looked at more seriously. At para.25 of his judgment, Mitting J said:

> "...Dishonesty and the maintenance of clinical records does go to the heart of the public's trust in medical practitioners. It is, as Mr Spencer acknowledges, a very serious matter for a doctor to be found to have prepared clinical notes with a view to misleading, and dishonestly.
>
> 26. Under the heading 'Suspension', in paragraph 27 the Indicative Guidance notes that it can be "used to send out a signal to the doctor, the profession and the public about what is regarded as unacceptable behaviour", especially in circumstances where the incident is unlikely to be repeated.
>
> 27. "In this case, the panel made no express finding whether this instance of dishonesty was or was not likely to be repeated. I am content to proceed on the basis that there is no reason to believe that it will be. But it remains a serious act of misconduct on the part of Dr Nicholas-Pillai.
>
> The panel received, and I have read, testimonials for Dr Nicholas-Pillai, and evidence from Dr Marks, in which he spoke of his long knowledge of Dr Nicholas-Pillai and of his astonishment that this act of dishonesty had occurred. I proceed on the basis that, apart from this incident, Dr Nicholas-Pillai has had an exemplary professional career, and one which is of great value to his patients, and that in depriving his patients of his services for six months, they will be deprived of something of value to them.

> These cases always result in the balancing of one public interest against another. In cases of actual proven dishonesty, the balance ordinarily can be expected to fall down on the side of maintaining public confidence in the profession by a severe sanction against the practitioner concerned. Indeed, that sanction will often and perfectly properly be the sanction of erasure, even in the case of a one-off instance of dishonesty. In this case, the panel, it seems to me, took a merciful course by deciding only to suspend Dr Nicholas-Pillai, and to do so for six months. I find it quite impossible to say that that sentence was disproportionate to the professional misconduct which it found proved, or is in any way open to criticism."

52 It is submitted that had the MPT properly taken into account that decision, they would not have reached the conclusion which they did in this case.

53 Mr Lambis, on behalf of the doctor submitted that the decision of the MPT displays no error of law or fact; that taking a holistic view of the reasons given by the MPT, it directed itself correctly as to the relevant legal principles which are apparent from their determinations and that its decision is sound.

54 Secondly, it is submitted that the MPT was in the best position to weigh the questions of insight, remorse and remediation, and form a view about the doctor's sincerity. In response to the suggestion that the MPT appeared to have changed its mind about the credibility of the doctor between the findings of fact in December 2016 and the hearings in May 2017, it was submitted that it was open to them to do so, and that they were justified in reaching the conclusions which they expressed in the final stage of their determination.

55 Thirdly, it was submitted that the MPT was entitled to attach additional weight to the remediation in considering sanction, and to find that it weighed heavily in the doctor's favour because the balance to be struck was a matter for the panel. It was submitted that this was not a case such as the one before the Court of Appeal in *Bolton*. All such cases are fact specific. The panel in this case looked at and weighed all the factors, reached its judgment, and explained clearly how it had done so, in the passages which I have already referred to.

56 My attention was drawn to a number of other cases, including the case of *Professional Standards Authority for Health and Social Care v Uppal* [2015] EWHC 1304 (Admin), a decision of Lang J, and the Scots case of *Professional Standards Authority for Health and Social Care v Nursing and Midwifery Council* [2017] CSIH, in support of the submission that it was open to the panel in the case of dishonesty to take no action if, having carefully

weighed all the factors to which it was obliged to have regard, it reached the conclusion that that was the appropriate course to take.

57 Mr Lambis submitted that in all the circumstances of this case, a well-informed individual looking at the facts of this doctor's case would, while saying that the doctor had made a considerable error of judgment, acknowledge that he had made proper admissions, and conclude that the regulatory mechanism will have satisfied the public interest by making the public feel confidence in the system and feel that in the circumstances the system was a safe one; that the finding of impairment itself was significant because of the impact on the doctor and the signals it sent to the outside world; that in all the circumstances, therefore, the decision of the MPT was not wrong. It was one that was properly open to them on the material before them.

58 It seems to me that one has to go back to the section that I quoted earlier of the Medical Act 1983, s.1(1A) the over-arching objective provided for the GMC which is protection of the public, defined in s.1(1B) as including pursuit of, among the following objectives, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

59 There is no doubt that dishonesty is a serious matter of misconduct whether a doctor commits such an act in the course of his practice or indeed outside. In this particular case, the dishonesty was in relation to his employers. It was, as has been submitted, and found by the panel, premeditated, and deliberate. Secondly, there cannot be any doubt that the decision to put himself potentially in two different places at the same time in the same hospital created a risk of harm to the patients whose care he had at the material time.

60 In my judgment, turning to the first ground of appeal, the MPT's decision did, for the reasons advanced by the appellant, misdirect itself as to the evidence and place too much weight on the impact of suspension. They plainly, in their determination of sanction, assumed the worst outcome of suspension, when that was not the correct analysis of the material before it.

61 First, Dr Shannon's evidence was based on the premise that the doctor’s training number would be removed, whereas she appeared not have been asked the question whether the training number would in fact be removed. Secondly, the evidence that she gave did not lead, it seems to me, to the inevitable conclusion that the doctor's career would be automatically ended if the training number were to be removed.

62 The evidence of Dr Shannon plainly showed that there was a number of factors in play which had to be weighed up, and the outcomes could be various, and the MPT, in my judgment, misconstrued that evidence and accordingly misdirected themselves as to the consequence of suspension. In any event, I was taken to at para.6.39 and 6.41 of what is referred to as the Gold Guide, which appears to show that suspension would not automatically lead to the removal of the training number in any event.

63 However, the question of the impact of suspension on the doctor is, for the reasons given by the appellant in reliance on the case of *Bolton*, of limited relevance, in my judgment. The over-arching purpose of the imposition of a sanction is not punitive, but for the protection of the public, and the effect of the suspension on the doctor has to be looked at in that context. While the MPT referred to the *Bolton* decision in its determination on the question of sanction, it seems to me they failed to follow the guidance which the Court of Appeal gave in that case, and that was, in my view, a wrong judgment call.

64 Secondly, I also accept that the MPT placed too much weight on remediation at the sanction stage. The sanctions guidance says that remediation will be taken into account on the question of impairment but the MPT, wrongly, in my view, relied on it very considerably at the later stage in deciding what sanction to apply, and in reaching a conclusion that this was an exceptional case. The correct approach is, in my judgment, with the greatest respect, that identified by Sales J, as he then was, in the *Yeong* case which I have already referred to, the reasoning of which applies equally to allegations of the misconduct of dishonesty as it does to inappropriate sexual contact between doctor and patient.

65 He sets out plainly the balance to be struck between the public interest and remediation. One doubts the impact of remediation in non-clinical cases, particularly where there is an allegation of dishonesty. I can see perfectly well why remediation may be of crucial importance in cases of clinical decisions, but that is not this case. One has to take into account that the misconduct here was for financial gain. It was premeditated, and it put patients at risk. That should, in my judgment, for the reasons given by Mitting J in the *Nicholas-Pillai* case, lead to a serious sanction. In my judgment, the panel in this case struck the wrong balance.

66 I also bear in mind the submission made that the conclusion which they reached on sanction appears to be in contrast to the earlier findings about credibility. While of course it is possible for a panel to reach different views about credibility at different stages of the process it is a change of view which needs to be explained. It seems to me that the panel did

not reflect in their reasoning on sanction the fact that they had on the face of it changed their view, and they failed to take into account in looking at sanction the adverse findings that they had made in respect of the question of misconduct itself at the earlier stage. And that is, in my view, a non-sequitur unless explained, which it was not.

67 In my judgment, the panel was wrong to conclude that exceptional circumstances were made out. Exceptional circumstances are unusual, special, or uncommon. It said, such cases are likely to be rare, very rare. The doctor's case was not one of exceptionality.

68 I return then to s.40A(4) of the Act. In my judgment, the decision made by the panel was not sufficient for the protection of the public because it failed properly to maintain public confidence in the medical profession and to maintain proper professional standards of conduct for members of that profession. It was not sufficient to protect the public in the light of the MPT's own findings about the earlier dishonesty of the doctor. In my judgment, the mere facts of the regulatory process having been undertaken does not send a sufficient signal either to the public or to the members of the profession.

69 For all those reasons, I would therefore allow this appeal, and remit the decision to the panel to reconsider.

MR HARE: My Lord, we are very grateful for that. The GMC does apply for its costs of the appeal. My learned friend has seen a copy of the cost schedules. I hope they have reached your Lordship, but if they haven't I have brought a spare copy.

THE JUDGE: I was given one on the last occasion. I don't think I've seen one since then.

MR HARE: Well, there was that one, and then there is the further one. Could I just hand them both up; that might be the easiest way. And then your Lordship has them both together. Thank you very much.

So, my Lord, we say obviously we have succeeded in relation to the ground of appeal advanced and therefore in principle we are entitled to our costs. We invite the court to assess them summarily. Obviously the hearing took less than one day, so that is the presumption. Unless you want----

THE JUDGE: Can I just ask you: is there any objection to the costs in principle?

MR LAMBIS: My Lord, the only matter that we'd raise, obviously you can appreciate that the cost is having on my lay client (sic). The only issue we would raise is whether it was really

necessary, my Lord, forgive my voice, whether it was strictly necessary for two solicitors to be present on the last occasion.

THE JUDGE: Yes. But in principle, you accept?

MR LAMBIS: Yes.

THE JUDGE: Yes. So the only -- there is no issue about the rates. Can the GMC recover VAT?

MR HARE: Yes, just in relation to counsel fees but there is no VAT on there obviously for solicitors' fees because it was dealt with in house.

THE JUDGE: Oh, I see. Attendance at the hearing, it is true: you had two solicitors here. There is no need for that, is there?

MR HARE: Yes. The reason for that, my Lord, I would say quite simply is that there is a solicitor who is responsible for the conduct of the case before the Medical Practitioners Tribunal, who attended.

THE JUDGE: Mmm.

MR HARE: But then also Mr Percival, who sits behind me, is responsible overall as senior legal counsel for the GMC for all its appeals. So that's why both attended. They are obviously slightly different exercises, but we would say it was reasonable to have both, in the circumstances, my Lord.

THE JUDGE: Yes. No, I'm afraid not. It seems to me you could have done with one. So that takes £868 plus VAT, I think, out of the----

MR HARE: Just the £868, yes, my Lord. There is no VAT on that.

THE JUDGE: Sorry.

MR HARE: And there is only a claim for one solicitor submitted for today, in the schedule for today, my Lord.

THE JUDGE: Right. Okay. So if we take £868 off the total. Has someone got a calculator?

MR HARE: £11,920, I think, for the main hearing, my Lord. And 50 pence; sorry.

THE JUDGE: £12,954.50.

MR HARE: Yes, I think.

THE JUDGE: I don't have a calculator.

MR LAMBIS: I (inaudible) give my Lord a calculator.

THE JUDGE: No, no, no.

MR LAMBIS: I agree with figure I think.

THE JUDGE: Yes. So I will summarily assess the costs at £12,954.56. Anything else?

MR LAMBIS: Nothing else from us, my Lord.

MR HARE: My Lord, no.

THE JUDGE: Well, thank you both very much for your submissions. I am sorry I didn't manage to get you a draft in advance, but I thought it was better just to give judgment rather than wait for it.

MR HARE: Thank you, my Lord.

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