Neutral Citation Number: [2011] EWHC 366 (Admin)

Case No: CO/5903/2010

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT
BIRMINGHAM DISTRICT REGISTRY
BIRMINGINGHAM CIVIL JUSTICE CENTRE

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 25/02/2011

Before :

MR JUSTICE FOSKETT

- -

Between :

DR WAFAA WADIE NAGIUB	**Appellant**
- and -	
GENERAL MEDICAL COUNCIL	**Respondent**

- -
- -

Dr Wafaa Nagiub in person
Ivan Hare (instructed by **GMC Legal**) for the **Respondent**

Hearing dates: 8th and 9th December 2010

- -

Approved Judgment

Mr Justice Foskett :

Introduction

1. The Appellant is a registered medical practitioner who has worked in a number of positions, principally as a locum Senior House Officer ('SHO'), since February 2004. I will say a little more about the history of her position shortly.

2. The Respondent ('the GMC') is, of course, the regulatory body for the medical profession under the Medical Act 1983 and the GMC (Fitness to Practise) Rules 2004. Amongst the various Panels of the GMC are an Interim Orders Panel ('IOP') and a Fitness to Practise Panel ('FPP').

3. The Appellant appeals against the decision of the FPP on 27 April 2010 that she should be suspended from the medical register for a period of 12 months on the basis that her fitness to practise was impaired by reason of misconduct, of deficient professional performance and of her health. The hearing before the FPP took place in Manchester over 29 days between 15 March and 27 April 2010. The Appellant represented herself although she had had the benefit of some legal advice and representation before the substantive hearing took place.

The powers of the FPP and the powers of the court on an appeal therefrom

4. The powers of the FPP are set out in section 35D of the 1983 Act which is in the following terms:

> (2) Where the Panel find that the person's fitness to practise is impaired they may, if they think fit—
>
> (a) except in a health case, direct that the person's name shall be erased from the register;
>
> (b) direct that his registration in the register shall be suspended (that is to say, shall not have effect) during such period not exceeding twelve months as may be specified in the direction;
>
> or
>
> (c) direct that his registration shall be conditional on his compliance, during such period not exceeding three years as may be specified in the direction, with such requirements so specified as the Panel think fit to impose for the protection of members of the public or in his interests.

5. An appeal may be brought to this court (without the need for permission) and the powers of the court are set out in section 40, the relevant part of which reads as follows:

> (7) On an appeal under this section from a Fitness to Practise Panel, the court may—

> (a) dismiss the appeal;
>
> (b) allow the appeal and quash the direction or variation appealed against;
>
> (c) substitute for the direction or variation appealed against any other direction or variation which could have been given or made by a Fitness to Practise Panel; or
>
> (d) remit the case to the Registrar for him to refer it to a Fitness to Practise Panel to dispose of the case in accordance with the directions of the court,
>
> and may make such order as to costs … as it thinks fit.

6. The way in which this court considers such an appeal has been the subject of consideration in a number of cases over the years. I endeavoured to set out the parameters by reference to those cases in *Chyc v General Medical Council* [2008] EWHC 1025 (Admin). I believe what I said remains an essentially accurate appraisal of those parameters and I take the liberty of repeating it:

> "4. An appeal under these rules does not require permission to appeal. The appeal is technically by way of rehearing, but in reality involves a review of the evidence and material before the Panel in accordance with the parameters set out in Gupta v GMC [2002] 1 WLR 1691 and Ghosh v GMC [2001] 1 WLR 1915, conveniently summarised by Stanley Burnton J, as he then was, in Threlfall v General Optical Council [2004] EWHC 2683 (Admin) at paragraph 21 where he said this:
>
> > "Because it does not itself hear the witnesses give evidence, the court must take into account that the Disciplinary Committee was in a far better position to assess the reliability of the evidence of live witnesses where it was in issue. In that respect, this court is in a similar position to the Court of Appeal hearing an appeal from a decision made by a High Court Judge following a trial. There is, however, an important difference between an appeal from a High Court Judge and an appeal from a Disciplinary Committee. The Disciplinary Committee possesses professional expertise that a High Court judge lacks …. This court appreciates that such a Disciplinary Committee is better qualified to assess evidence relating to professional practise, and the gravity of any shortcomings, and it therefore accords the decision of the Committee an appropriate measure of respect, but no more: see Ghosh v General Medical Council [2001] UKPC 29, [2001] 1 WLR 1915, at [33] and [34] and Preiss v General Dental Council [2001] UKPC 36, [2001] 1 WLR 1926 at [26] and [29]. These decisions make it clear that the court should be more ready to overrule a disciplinary tribunal than previously appeared to be the case. It however remains the position that an Appellant

> must establish an error, of law or fact or of judgment, on the part of the tribunal."

5. Although I have referred to that convenient summary, I should, I think, quote what was said in Gupta v General Medical Council [2002] 1 W.L.R. 1691 , where the following appears:

> "[T]he obvious fact [is] that the appeals are conducted on the basis of the transcript of the hearing and that, unless exceptionally, witnesses are not recalled. In this respect, these appeals are similar to many other appeals in both civil and criminal cases from a judge, jury or other body who has seen and heard the witnesses. In all such cases the appeal court readily acknowledges that the first instance body enjoys an advantage which the appeal court does not have, precisely because that body is in a better position to judge the credibility and reliability or the evidence given by the witnesses. In some appeals that advantage may not be significant since the witnesses' credibility and reliability are not in issue. But in many cases the advantage is very significant and the appeal court recognises that it should accordingly be slow to interfere with the decisions on matters of fact taken by the first instance body. This reluctance to interfere is not due to any lack of jurisdiction to do so. Rather, in exercising its full jurisdiction, the appeal court acknowledges that, if the first instance body has observed the witnesses and weighed their evidence, its decision on such matters is more likely to be correct than any decision of a court which cannot deploy those factors when assessing the position. In considering appeals on matters of fact from the various professional conduct committees, the Board must inevitably follow the same general approach. Which means that, where acute issues arise as to the credibility or reliability of the evidence given before such a committee, the Board, duly exercising its appellate function, will tend to be unable properly to differ from the decisions as to fact reached by the committee except in the kinds of situation described by Lord Thankerton in the well known passage in Watt or Thomas v Thomas [1947] A.C. 484 , 484–488."

The passage from Lord Thankerton's opinion is as follows:

> "I do not find it necessary to review the many decisions of this House, for it seems to me that the principle embodied therein is a simple one, and may be stated thus: I. Where a question of fact has been tried by a judge without a jury, and there is no question of misdirection of himself by the judge, an appellate court which is disposed to come to a different conclusion on the printed evidence, should not do so unless it is satisfied that any advantage enjoyed by the trial judge by reason of having

> seen and heard the witnesses, could not be sufficient to explain or justify the trial judge's conclusion; II. The appellate court may take the view that, without having seen or heard the witnesses, it is not in a position to come to any satisfactory conclusion on the printed evidence; III. The appellate court, either because the reasons given by the trial judge are not satisfactory, or because it unmistakably so appears from the evidence, may be satisfied that he has not taken proper advantage of his having seen and heard the witnesses, and the matter will then become at large for the appellate court. It is obvious that the value and importance of having seen and heard the witnesses will vary according to the class of case, and, it may be, the individual case in question."

6. In relation to the sanction imposed, and the approach to reviewing it in this court, my attention has been drawn to the case of Fatnani Raschid v General Medical Council [2007] EWCA Civ 46 where Laws LJ (with whom Chadwick LJ and Sir Peter Gibson agreed) said this:

> "As it seems to me the fact that a principal purpose of the Panel's jurisdiction in relation to sanctions is the preservation and maintenance of public confidence in the profession rather than the administration of retributive justice, particular force is given to the need to accord special respect to the judgment of the professional decision-making body in the shape of the Panel."

7. I must conduct my review of the FPP's decision by reference to those guidelines.

The more detailed background

8. The Appellant, who is an Egyptian national born in September 1959, studied medicine at Tanta University in Egypt between 1976 and 1982. Until August 1984 she had been respectively a House Officer in General Medicine and other specialities in two hospitals in Egypt and a Medical Officer in Medicine, General Surgery and other areas at another hospital in Egypt.

9. She came to the UK in 1984. Between September 1984 and the end of 1991 she took a career break to raise her children and also obtained an MSc in biochemistry from Leicester University. From July 1992 until January 2002 she worked as a researcher in drug safety in the pharmaceuticals industry in the UK and then set about putting herself in the position that she could resume a medical career. Between June 2002 and the end of 2003 she continued working part time in drug safety matters and also studied for the Professional and Linguistic Assessment Board ('PLAB') tests. She passed Part 1 in November 2002 (having secured an above average score) and Part 2 in May 2003. In January 2004 she was issued with a Certificate of Limited Registration as a Medical Practitioner by the GMC permitting her to engage in "supervised employment in the NHS". In May 2005 she was granted a Certificate of Full Registration as a Medical Practitioner. In February 2006 she passed her MRCPCH Part 1 examination paper and in October 2006 she passed her MRCP Part 1

examination paper. In the same month she was awarded the Diploma of the Royal College of Obstetricians and Gynaecologists ('DRCOG'). Following a course in November 2007 she was granted a certificate for having completed successfully the Advanced Life Support Course, demonstrating skills in airway management, initial assessment and resuscitation and simulated cardiac arrest.

10. As I indicated at the beginning of this judgment, the Appellant carried out a number of relatively short-term locum appointments as an SHO. She obtained those appointments having registered with NHS Professionals (based in Sheffield) and JCJ Locums, both organisations which, as I understand it, are effectively agencies for placing qualified doctors within NHS hospitals or, in the case of JCJ Locums, within either NHS or private hospitals. As a result of the Certificate of Limited Registration as a Medical Practitioner she was entitled to work from February 2004.

11. According to her CV, she worked at the hospitals set out in the Appendix to this judgment for the periods indicated (although there were undoubtedly other short-term positions not recorded specifically in her CV but which she certainly undertook.)

12. Given that she had returned to medical practice after a number of years away, it is inevitable that she was older than some of those around her who were also of SHO status.

13. I will indicate the nature of the allegations considered by the FPP shortly. Before I do so, however, it is right to say, given the critical nature of the ultimate findings of the FPP and the decision to suspend her, that the Appellant has received some plaudits for her work. For example, following her period at University Hospital, Birmingham, the following was said by Professor Buckels, Consultant Hepatobiliary and Transplant Surgeon:

> "We have, indeed, been very satisfied with her performance here on our Liver Unit."

14. The Consultant Gastroenterologist at University Hospital Birmingham also said that she "performed well during her time here with us" and that there was no evidence of any health concerns.

15. Other positive statements were made by others with whom she had worked: see, for example, the reference to the evidence given before the FPP by Drs Bentley and Akpan at paragraph 49 below. Furthermore, Dr Selina Lim, Consultant Physician at Mayday University Hospital, wrote this about the Appellant's period there in February/March 2008:

> "During her time on the ward there were no problems with her communication and in fact she got a very positive feedback from a ward sister on her ability to work with the nurses. There were no problems reported by my [Specialist Registrar] about any difficulties in working within the team. There were also no problems reported back from patients or relatives.

> She presented a [professional] attitude. Her clinical skills [were] those I would have expected in a doctor coming to the end of their ST1 year."

16. Unfortunately, matters did not go so well in other placements. Concerns had, apparently, been raised following a short-term placement at Lincoln County Hospital in July 2005. It was suggested by the hospital at the end of her placement that she had difficulty in working with colleagues and was not an effective member of the clinical team. This was a matter taken up within NHS Professionals and various exchanges took place between Dr MacNeill (see paragraph 17 below) and the Appellant. Those exchanges included a suggestion by the Appellant that she had been "used as a scapegoat to untangle local internal politics at Lincoln County Hospital". Following various meetings, this matter was effectively closed on 26 September 2005. NHS Professionals received a further expression of concern arising from her period in West Suffolk Hospital. The suggestion was that she had told a patient that she had liver secondaries without discussing it with the consultant. At about the same time NHS Professionals received a further adverse report, on this occasion arising from her period at Cookridge Hospital. These concerns were reflected in a letter from Dr Julian Adlard, Consultant Clinical Oncologist, to NHS Professionals dated 31 March 2006, the relevant part of which is as follows:

> "There are a number of areas in which it appears that Dr Naguib's knowledge of medical management, assessment of investigations, prescribing, and practical procedures may be below standard. There is also the impression from … members of staff that when issues of concern have been raised she has not sought more senior advice and has also been confrontational. I have personally spoken to Dr Naguib and told her that a number of members of staff have complained about her whilst she has been working at Cookridge and the general issues involved. Some of the staff were concerned that we may yet receive complaints from patients.
>
> I have advised Dr Naguib that if she does do further similar posts in the future she should look particularly at seeking advice when appropriate, following local protocols, considering that advice when it is from someone with more experience, and working on developing better relationships with colleagues.
>
> I do not know whether similar issues have been raised in previous placements. It is possible that this has been a "one off" episode. However, we would not consider re-employing Dr Naguib at this hospital."

17. These various matters, and the Appellant's response to them, prompted Dr Andrew MacNeill, Deputy Clinical Director for NHS Professionals, to write to the GMC's Fitness to Practise Directorate a lengthy letter on 17 October 2006. He drew attention to the three complaints received and two aspects of the Appellant's response to them. In relation to the complaint from Dr Adlard he reported that the Appellant had expressed the view that she suffers jealousy from "incompetent colleagues and from females who acquire status by being intimate [with] highly placed people." [redacted]

[redacted] He concluded his letter (fairly) to the GMC with this paragraph:

> "For completeness, I should add that we have received copies of assessment forms from the locum agency with whom Dr Naguib is currently working which indicate that she is above average."

18. The GMC invited the Appellant to comment on the matters raised by NHS Professionals and in the meantime sought further information from JCJ Locums. It appears that that organisation had received one specific complaint from Frimley Park Hospital in which it was suggested that the Appellant made bad clinical decisions, was not good at working in a team and sharing information and was asking for unnecessary tests to be carried out.

19. The Appellant took advantage of the invitation from the GMC to comment on Dr MacNeill's letter. She wrote a letter to the Fitness to Practice Directorate dated 22 November 2006. She said that she was under the impression that the complaints from Lincoln County Hospital had been resolved and she accepted that she had made an error of judgment at the West Suffolk Hospital. However, she articulated strong objections to the complaint emanating from Cookridge Hospital and it is plain that her view was that she had been unfairly treated and made a scapegoat at that hospital. She also complained that Dr MacNeill had treated her unfairly, the implication being that doctors "from the Indian sub-continent" were treated better than she was.

20. The GMC invited the Appellant, in a letter dated 2 February 2007, to undergo a Performance Assessment in accordance with rule 7(3) of the 2004 Rules to which she agreed in a letter dated 12 February 2007. It took place in two parts: the Test of Competence and the Peer Review on 25 May and 4 June 2007 respectively.

[redacted]

[redacted]

22. [redacted]

23. It appears that the Appellant subsequently apologised for breaking into tears and losing concentration during the Competence Test and asked the GMC not to take into account any aspect of her performance on that day, whether good or bad. However, it appears that she went on to repeat comments she had made that day which included suggestions of a cover up and "preferential treatment for equal or less competent colleagues who are White/Asian/Black or sleeping with consultants". Dr Cox, in a letter dated 7 June 2007, reported that during the peer review on 5 June the Appellant had objected to the presence of Dr Sharma (see paragraph 69 below).

24. [redacted] On the basis of the matters that had been raised by Dr MacNeill and Dr Cox the Appellant was referred to the IOP which, on 22 June 2007, imposed conditions on her registration for 18 months. Those conditions included one condition confining her medical practice to NHS posts where her work would be supervised by a named consultant and one requiring her to comply with arrangements made by the GMC for an assessment of her health.

25. [redacted] I should record first the conclusions of the assessment team under the Performance Assessment, the full report of the Performance Assessment running to some 550 pages.

26. They said this in their report of 11 August 2007:

> "We found that Dr Nagiub had an adequate knowledge base but that she was unable to apply it consistently in her work as a doctor or during the Tests of Competence.
>
> Dr Nagiub's performance was variable. For example, she managed some patients well and developed effective working relationships with some colleagues. On the other hand, some patient care was unsafe and some relationships with colleagues were unacceptable .... In our opinion Dr Nagiub's performance has been deficient and her work should be restricted to closely supervised posts but not as short-term locum."

[redacted]

[redacted]

[redacted]

[redacted]

30. On 11 December 2007 the IOP reviewed the conditions imposed on the Appellant's registration on 22 June 2007. Fairly extensive restrictions were placed upon her ability to practise, but essentially they included a confinement to medical practice in the NHS where her work would be supervised closely by a consultant known to the GMC [redacted]

31. [redacted]

32. Based upon the information that had emerged, the GMC formulated certain allegations based on (i) her performance and (ii) her health issues. These allegations were communicated to her by a letter dated 4 March 2008. They related to the complaints made to NHS Professionals, to her conduct during the Performance Assessment and to the health issues raised. Representations from her were invited. At that stage she had the benefit of advice from solicitors who, I believe, made representations on her behalf.

33. In due course, in a letter dated 8 August 2008, she was informed that the Case Examiners had decided to refer her case to the FPP. She was told that the date of the FPP hearing would be notified in due course.

34. I have already referred to the review by the IOP on 11 December 2007 of the conditions previously imposed on the Appellant's registration. Further reviews took place on 28 May 2008 and 21 October 2008 when they were continued. The conditions were extended for a period of 8 months by this court on 25 November 2008. The IOP reviewed the conditions again on 25 February and 22 April 2009. This court again renewed the conditions (for 12 months) on 19 August 2009. The final review by the IOP before the proceedings before the FPP took place was held on 5 March 2010.

35. Not long after the letter from the GMC of 8 August 2008 (see paragraph 33 above) there was a further development. On 11 October 2008, the Appellant had reported to the GMC that she had been excluded by the Trafford Healthcare NHS Trust because of an alleged incident on 17 September 2008 at the Trafford General Hospital when, it was said, she had attempted to manipulate the broken wrist of a patient ('MH') without any assistance, without administering any analgesia and without adhering to proper consent procedures.

36. The Appellant was unhappy about the allegations arising from this incident and in response to the Trust's investigation of these matters in due course she brought proceedings in the Employment Tribunal against the Trust alleging both race and sex discrimination. The gist of her complaint was that two nurses complained about her actions in relation to this patient omitting important clinical information and accusing her of not obtaining nursing assistance during the procedure she carried out. She alleged that one of the nurses "manipulated the nursing assistance that [she] should have … had from" another named nurse. She also suggested that the clinical performance on the same day by a Black Moslem doctor "fell well below any expected safety standard" and yet the nurses made no complaint about him and the consultant "fiercely defended the deficient clinical performance", as she put it, of that other doctor whereas he treated the allegation against her as well founded.

37. So far as I can judge from the papers before the court, those proceedings were heard on 7-11 December 2009, 8-11 February 2010 and 28-30 July 2010. I do not know the outcome of that case, but it is, of course, largely irrelevant to the issues before me. I believe the Appellant represented herself in those proceedings. If that is so, then she will have conducted two major sets of proceedings (in other words, those proceedings and the FPP proceedings) during the period of about 7 months between December 2009 and the end of July 2010.

38. Returning to the chronology, it appears that after investigation the GMC wrote to the Appellant on 30 April 2009 to inform her that her misconduct case (arising out of the Trafford Hospital allegations) was also being referred to an FPP. She was at that stage, I believe, in receipt of legal advice.

39. At that stage the FPP hearing was planned to commence on 29 June 2009 with a view to continuing to 17 July 2009. However, on 17 June 2009, effectively by agreement, the hearing was postponed. In fact it did not take place until March/April 2010, some years after the matters to which the allegations related. However, the Appellant's ability to work as a doctor remained subject to the conditions to which I have referred in the meantime.

40. That is, therefore, a brief history of the background before the hearing before the FPP took place. I must now turn to that.

The hearing before the FPP

41. As I have indicated, the proceedings lasted some 29 days of which the Appellant attended all bar two, namely 13 and 14 April. It appears that these were the days when it was anticipated that the Appellant would commence giving evidence and be cross-examined. She indicated in an e-mail to the FPP that she was exhausted. The FPP decided to proceed notwithstanding this, the net result being that she did not give evidence and was not cross-examined.

42. I will not set out in detail the precise terms of the allegations that she faced, but they arose from the matters to which I referred in paragraphs 16-18 above, the matters arising from the incident at Trafford Hospital on 17 September 2008 and the health issues. The Appellant did admit certain of the allegations as matters of fact, but she challenged root and branch (i) the Performance Assessment, the way it was conducted and its conclusions, (ii) the suggestion that her treatment of patient 'MH' was

inappropriate [redacted]

43. Of the allegations formulated by the GMC concerning what the Appellant had allegedly said about the reports made by others of her treatment of 'MH', these included the assertion that the Appellant had "stated that the submission of a clinical incident report was part of a 'witch-hunt' against [her] by three senior nurses including Nurses Costello and Noblett" and that she had been "treated less favourably in relation to this incident than [she] would have been [had she been] either Asian or black; and/or a Muslim; and/or in a relationship with another member of staff." It was alleged by the GMC that making these assertions was "inappropriate".

44. The Panel consisted of Mrs Eileen Carr, Chair (Lay), Mrs Susan Gilhespie (Lay), Dr Michael Sheldon (Medical, GP) and Mrs Ann Shirley (Lay). Three Legal Assessors assisted the Panel at various times, including Mr James Townend QC for the last 12 days or so. The GMC was represented by Mr Christopher Kennedy QC.

45. The procedure of the FPP is, first of all, to make its findings of fact having heard the evidence in support and against where the material fact is not admitted or is denied. It announced its findings on the allegations on 20 April 2010, Day 24 of the hearing. It appears from the transcript that the submissions on the evidence were completed by the evening of 15 April and the Panel then deliberated on Friday, 16 April, and Monday, 19 April, before announcing the findings the following day.

Findings of fact

46. The Panel found all the non-admitted allegations proved. Their reasoning in respect of their findings needs to be recorded. I will set out first the relevant parts of this reasoning in relation to the Appellant's challenge to the Performance Assessment and to her challenge to the misconduct allegations arising from her treatment of MH:

> "Deficient professional performance
>
> The Panel understands that performance assessments are routinely used to assess doctors and that the GMC procedure is now well established. The Panel accepts that the process is reasonable and structured to test the pertinent elements of professional performance, and to ensure that a doctor functions at a level at which the safety of the public can be maintained. The assessment took the form of a knowledge based test, objective structured clinical examination (OSCE), record review, case based discussion and third party interviews.
>
> The Panel found the Performance Assessors to be knowledgeable and experienced. It recognised that Dr Sharma was part of the Assessment Team specifically because of his comparable clinical experience to you. The Panel notes the evidence of the Assessors in relation to the standard expected from you, the reasons for their individual judgments and their judgments in relation to the overall Assessment Report. Dr Cox told the Panel that the Performance Assessment was a

qualitative and not a quantitative assessment. He explained that the Assessment Team do not count up the 'Acceptables', 'Unacceptables' and 'Cause for concern' judgments to reach an overall conclusion as to a doctor's performance. The Panel also notes that you have vigorously challenged the validity of the Performance Assessment and its subsequent findings.

[The Panel then made express findings concerning the conclusions of the Performance Assessment Report]

The Panel notes the findings of the Performance Assessment Report that you have a good level of medical knowledge having passed the Professional Linguistic Assessment Board Test (PLAB) with 71% of correct answers against a pass score of 63%. In addition, you also passed the more difficult Member of the Royal College of Physicians (MRCP) part 1 knowledge test in 2006. However, a further conclusion within the report was that, despite this knowledge, you were unable to apply it consistently in your work as a doctor during the tests of competence. Your performance was found to be deficient.

[The Panel then made a further finding concerning the conclusions of the Performance Assessment Report]

The Panel notes that in his evidence Dr Cox, Lead Performance Assessor, made concessions with regard to some of the individual judgments made. For example, in relation to record 306, Dr Cox accepted that in the absence of corroboration from colleagues, Dr Sharma's judgment was not a good example to quote. Additionally, Dr Cox apologised for his error regarding DVLA guidance for patients after a myocardial infarction. However, this had no impact on the overall conclusions of the report. In evidence, all the Assessors maintained their opinions and reasonings behind both individual judgments and the overall conclusions of the report. The Panel is satisfied that the overall conclusions of the Performance Assessment Report are an accurate reflection of how you performed on the day.

Misconduct

The Panel found Nurses Dickinson and Costello to be credible witnesses and their evidence to be clear and measured. Furthermore, the Panel was satisfied with the veracity of patient MH's evidence and that of his friend, Mr W, who accompanied him to Trafford General Hospital on the evening of 17 September 2008. The Panel acknowledge that there were minor discrepancies in the evidence of MH and Mr W, which were understandable due to the passage of time. However, in relation to the incident itself, their evidence was clear and consistent.

The Panel accepts the consistent version of events put forward by the GMC's witnesses, in preference to your account. Even if your account were accepted on those facts, your care of MH was substandard and the patient suffered unnecessary pain.

[The Panel then made express findings concerning the manipulation of MH's fracture]

The Panel heard from Nurse Costello, the Shift Co-ordinator on 17 September 2008. She told the Panel that whilst she was informed that you had requested the plaster trolley, morphine and Entenox, she had not been informed of the patient's x-ray results. She also stated that there had been no request for a bed in the resuscitation bay for MH to have sedation and manipulation. Nurse Costello told the Panel that she knew nothing about your plan to manipulate MH's wrist in the Minor Injuries cubicle in the A&E department. You also told the Panel that you did not discuss with Nurse Costello your plan to manipulate MH's wrist.

[Further finding of fact made]

In his evidence MH told the Panel that you returned to the cubicle, where he was waiting with a nurse and Mr W. He stated that you picked up his arm and began to pull and twist it. He told the Panel that at no point did you explain what you were about to do. Mr W corroborated this account in his oral evidence. You told the Panel that you performed the manipulation alone and confirmed that the plaster trolley was not available at that time, so you were unable to put on the back slab.

[Further finding of fact made]

The Panel has noted the evidence of Dr Stuart, Consultant in Emergency Medicine and Clinical Director, who told the Panel in cross-examination that the care you gave to MH was without adequate pain relieving medication and analgesia, and with no sedation whatsoever. He explained that the patient was treated in a seriously substandard way and suffered unnecessary pain.

The Panel also heard from Mr Burdett-Smith, Consultant Emergency Physician and GMC expert witness. He told the Panel that it is not good practice only to provide pain relief. He stated that it appeared that the procedure was carried out without adequate pain relief or sedation, inflicted pain and was not successful. He confirmed that this particular procedure has not changed much in 20 years. The manipulation of a displaced fracture in a young man should not be carried out under analgesia alone, but requires sedation or anaesthesia. It also

requires the necessary equipment to be available and two operators.

The Panel accepts the evidence of Dr Stuart and Mr Burdett-Smith. Further, it notes MH's own evidence that the manipulation was so painful that although it only took approximately 60 seconds, it felt as if he endured it for hours. Mr W also told the Panel that during the manipulation of MH's wrist, he was writhing in agony on the bed.

[Further finding of fact made]

MH told the Panel that you picked up his arm and began to twist and pull it. He also told the Panel that at no point prior to doing this did you explain your intentions or ask if he consented to the manipulation. Mr W also told the Panel that you did not ask MH if you could manipulate the arm before you proceeded to do so. In re-examination Mr W told the Panel that the attempt to manipulate the arm occurred so unexpectedly, without any prior discussion, that he imagined that the element of surprise was part of medical rationale. Although both MH and Mr W agreed that there was some dialogue between you and MH prior to the manipulation, both were adamant that you did not ask MH if you could manipulate his wrist. Mr Burdett-Smith told the Panel that informed consent means that the patient must understand what is to be done and then agree to that treatment.

[Further finding of fact made]

MH told the Panel that following the manipulation he informed you that he could no longer move his fingers and that the pain in his arm had increased. He told the Panel that you did not respond to this and left the cubicle.

Mr W told the Panel that MH was unable to make a fist shape with his hand after the manipulation. Mr W stated that MH asked you whether this was normal, however, he did not believe you replied before leaving the cubicle again.

[Further finding of fact made]

The Panel has read the form completed by you in relation to your Employment Tribunal case against Trafford Healthcare NHS Trust, which has been adduced in evidence. In this form you state that you have been a victim of "being witch-hunted" by three senior nurses, who have harassed and bullied you. You provide the submission of a clinical incident form as an example of this discrimination and "witch-hunt". However, the Panel accepts that you believe that you have been a victim of a

"witch-hunt" by three senior nurses, but that Nurse Noblett is not one of them.

[Further finding of fact made]

In the light of the evidence heard in relation to the incident at Trafford General Hospital, and in accordance with its findings above on the relevant facts, the Panel has found that your actions and omissions were inappropriate, not in the best interests of the patient and not of a standard to be expected of a registered medical practitioner. In this regard the Panel has attached particular weight to the evidence of Mr Burdett-Smith and Dr Stuart.

In relation to paragraph 14, the Panel has received no evidence to substantiate your claims that there was, or is, a "witch-hunt" against you. The Panel found Nurses Dickinson and Costello to be credible witnesses and it is satisfied that the actions they took, following the substandard manipulation of MH's arm, were appropriate and in accordance with their professional obligations.

In relation to paragraph 15 the Panel has, once again, received no evidence to substantiate your assertion that you were treated less favourably owing to your ethnicity, religion or marital status within the team. The Panel notes the example you gave contrasting your treatment with that of a Black, Muslim, male doctor, who you assert behaved exactly as you did in treating a fracture. However, the Panel notes the evidence of Dr Stuart and Dr Gottschalk, Consultant in Emergency Medicine, who both told the Panel that the cases were not comparable, despite your claims that the only difference was the religion, gender and ethnicity of the treating doctors.

Accordingly, the Panel finds your statements and assertions to be inappropriate."

[redacted]

[redacted]

48. The foregoing represented the reasoning behind the findings of fact made where the facts had been in issue. As I have indicated, the Panel effectively found all contested issues of fact against the Appellant.

The issue of 'impairment'

49. After the announcement of its findings of fact, in accordance with GMC procedure, the Panel went on to hear evidence and submissions on the issue of "impairment to practise". That took place on 21 April and the Appellant called two witnesses, Dr Stephen Bentley, the Divisional Medical Director for Unscheduled Care for Warrington and Halton NHS Foundation Trust, and Dr Asamgaedem Akpan, Consultant Physician in General and Elderly Medicine and Sub-Dean for Undergraduate medical students. The Panel considered its decision on this issue during 22 April and announced its conclusion on 23 April.

50. The substance of the Panel's conclusions on this issue, after reciting its approach, was as follows:

> "Deficient professional performance
>
> The Panel first considered whether your fitness to practise is impaired by reason of deficient professional performance. In doing so it has taken account of all the evidence adduced at this hearing, as well as the submissions made by you and those made by Mr Kennedy.
>
> This aspect of the case centred on the Performance Assessment Report where your overall performance in the Observed Structured Clinical Examination (OSCE) was judged to be poor and your professional performance was found to be unacceptable or giving rise to cause for concern in a number of areas. Additionally, it was found that you were unable to apply knowledge consistently to your work as a doctor.
>
> The Panel notes that you displayed an unusual reaction to the stressful performance assessment environment. [redacted]

[redacted] However, the assessors felt that you had calmed down before the OSCE clinical skills test. You performed well in the knowledge test despite being upset, answering 142 questions correctly out of 200 questions.

The Panel notes that there is evidence that you have a satisfactory level of medical knowledge. However, the Performance Assessment Report stated that despite this knowledge you were unable to apply it consistently in your work as a doctor. At the time of the GMC assessment in May 2007 your performance was very poor. However, you have worked since this time and most recently you have worked at Warrington Hospital as a full-time Locum Staff Grade in Elderly Care and General Medicine. You were in this role for approximately eight months until February 2010 when you resigned to prepare for this hearing. In their evidence before the Panel both Dr Bentley, Divisional Medical Director and Dr Akpan, Consultant Physician, were positive about your clinical ability and both confirmed that you had made a valuable contribution during your time at Warrington Hospital.

Nevertheless, the Panel is concerned by your inability to accept that there are any deficiencies with regard to your professional performance. In your closing submissions on impairment you frequently denounced the Performance Assessment as “duff” and described the assessment team as “dishonest”, “crooked” and “racially motivated”. This has been a position maintained by you since the start of this hearing and the Panel remains unconvinced, and unimpressed, by such an unsubstantiated defence. You have consistently argued that you are a good doctor who is only criticised to benefit the advancement of “inferior Asian doctors”.

The Panel is also concerned that you denounced every “Cause for concern” and “Unacceptable” judgment made against you by the Assessment Team. This team included very experienced and well-regarded medical colleagues, and not only did you disagree with their judgments but you frequently abused them during cross-examination. You refused to accept that your skills were judged to be below an acceptable standard and, implicit in your argument was that there was no need for further improvement. You maintained that it was the assessors who were wrong. You also acted unprofessionally, for example, by retaining case notes, which identified patients. This was against the advice of both the GMC and the Medical Defence Union (MDU). The Panel notes that you have not once

accepted any aspect of the rationale provided in evidence by the Performance Assessors in relation to both their individual or overall judgments.

The Panel is further concerned that you have consistently failed, or refused, to understand the distinct concepts and different elements of the Performance Assessment process. These were explained to you at the time of the assessment and during evidence at this hearing. You refused to accept that your performance was below the standard required and instead you argued that the process was flawed and racially biased.

The Panel has had regard to the case of *Zygmunt v GMC* [2008] EWHC 2643 (Admin) when Mitting J stated, at paragraph 31:

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

The Panel notes the courses you have undertaken between June 2007 and January 2010. However, it does not consider that these go far enough to remedy the deficiencies found at the Performance Assessment. With regard to acknowledgement of the failings identified, you have demonstrated no insight before this Panel. You do not accept that your performance was poor and you have not shown how the performance issues identified have been addressed to bring your performance to an acceptable level. The public has a right to expect this from a member of the medical profession.

The Panel is satisfied that your fitness to practise was impaired at the time of the Performance Assessment, and despite some recent positive feedback reports testifying to your competence, the Panel has determined that you have shown no insight or sufficient evidence of remediation for it to be satisfied that the deficiencies identified in 2007 are no longer an issue.

In the light of the above, the Panel has determined that your fitness to practise is impaired by reason of your deficient professional performance.

<u>Misconduct</u>

The Panel went on to consider whether your fitness to practise is impaired by reason of your misconduct.

In September 2008, whilst working as a clinical fellow in the Accident and Emergency department of Trafford General Hospital you treated patient MH who presented with a displaced fracture of his left wrist. You undertook a manipulation of this fracture against the department's policy, having not undertaken such a procedure for approximately 20 years. This was without the necessary equipment and support from colleagues, having given MH inadequate pain relief and no sedation and without obtaining MH's informed consent. You alleged that the submission of a clinical incident report following this manipulation was part of a "witch-hunt", and that you would have been treated differently but for your ethnicity, religion and the fact that you were not in a relationship with another member of staff.

The Panel considers that your substandard clinical treatment of MH was compounded by the way in which you treated him in general during cross-examination. You berated him for his written English and repeatedly questioned his integrity. You refused to accept MH's evidence that he was in pain. You made no apology to MH despite his evidence that he was in great pain during and following your manipulation of his wrist.

In your closing submissions to the Panel, you stated that you manipulated MH's wrist to the best of your knowledge and ability. You do not entirely accept that your conduct in this regard was inappropriate, not in the best interests of the patient and not of a standard to be expected of a registered medical practitioner. This was despite the clear evidence of Dr Stuart, Consultant in Emergency Medicine and Clinical Director; Dr Dr Gottschalk, Consultant for Emergency Care and Mr Burdett-Smith, Consultant Emergency Physician and GMC expert witness.

The Panel is, once again, concerned by the lack of insight you have shown. Despite undertaking a course entitled Assessment and Management of Colles Fracture on 29 September 2008 and having had 18 months to consider your clinical conduct, you still maintain that you did little wrong when you manipulated MH's wrist. You lay blame on "lying" colleagues and consider their actions, in filing an incident report, as a "witch-hunt". The Panel is also concerned that you did not recognise and act within the boundaries of your competence, and that you did not liaise effectively with your colleagues despite your inexperience.

The Panel is mindful of the comments of Sir Anthony Clarke MR in the case of *Meadow v GMC* [2006] EWCA Civ 1390; 1 QB 462, when he stated:

"In short, the purpose of [fitness to practise] proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. The FPP thus looks forward not back. However, in order to form a view as to the fitness of a person to practise today, it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past" (paragraph 32).

The Panel accepted the evidence of Dr Stuart, who told the Panel that you treated MH in a "seriously substandard" manner and that he was concerned by your inability to understand the gravity of the situation. Dr Stuart stated that you focussed on what you alleged to be the substandard treatment of other patients by other doctors, but that his focus, as your clinical director, was on the index case of MH, for which a serious incident report was raised. He told the Panel that he was as concerned by your behaviour after the event as he was by your conduct during the clinical care of MH, and that he still remains as concerned now as he was then by your refusal to accept the pain and suffering caused to MH and your lack of any apology to him.

The Panel has also accepted the evidence of Mr Burdett-Smith who was categorical on what constitutes informed consent and the proper standard of care when manipulating a fracture. He told the Panel that he would be concerned about a doctor of your grade, practising at this level, who showed this level of lack of insight as to how to manage a common injury such as MH's.

The Panel did see some evidence of occasions when you sought advice from others. However, it cannot be satisfied that you have learned anything from the Trafford incident or that you would not repeat your misconduct again. The Panel is concerned that you appear to find it difficult to accept that you are not always right. This unwarranted confidence in your own ability is despite the contrary opinions of senior colleagues and experts, and as such, makes you a potentially dangerous doctor.

Furthermore, the Panel has had regard to Good Medical Practice (2006 edition) and is conscious that your treatment of MH and interaction with colleagues contradicts many of the principles contained therein. For example, the Panel has borne in mind the duties detailed in the front cover of the document, namely that doctors must:

"Provide a good standard of practice and care

- Keep your professional knowledge and skills up to date

- Recognise and work within the limits of your competence

- Work with colleagues in the ways that best serve the patients' interests"

Once again, the Panel has had reference to the case of *Meadow v GMC* which states that any misconduct has to be serious before a finding of impairment of fitness to practise can be made. In *Nandi v GMC* [2004] EWHC 2317 (Admin) Collins J stated:

"The adjective serious has to be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners."

In the light of the above, the Panel is satisfied that your behaviour at Trafford failed to meet the fundamental standards expected of a registered medical practitioner and amounts to misconduct. It is in no doubt that your actions were such that they amount to serious misconduct. The Panel has heard no evidence of any significant efforts on your part to remediate your actions. Neither has it seen nor heard any convincing evidence of insight or remorse.

The Panel has taken into account the public interest. This includes the protection of patients, maintenance of public confidence in the profession and the declaring and upholding of proper standards of conduct and behaviour. The Panel is of the view that your behaviour, towards both MH and your colleagues at Trafford General Hospital, undermines the public confidence in the medical profession as well as the trust which patients are entitled to place in medical practitioners. Such behaviour is wholly unacceptable. Accordingly, the Panel has determined that your fitness to practise is impaired by reason of misconduct."

51. That, therefore, represented the reasoning underlying the conclusion of the FPP that the Appellant's fitness to practise was impaired both by reason of her "deficient professional performance" and her "misconduct" arising out of the events at Trafford General Hospital.

[redacted]

[redacted]

[redacted]

55. [redacted]

56. I should record finally in this context what the Panel said immediately after the passages quoted in paragraph 50 above. The Panel said this:

> "Finally, the Panel has considered your behaviour throughout this hearing. The Panel is most concerned that your conduct throughout has been rude, insulting, racist, abusive and, at times, bullying and intimidating. You have abused every witness who gave evidence on behalf of the GMC, the GMC legal team, the Panel Chairman, the Panel and the Legal Assessors who sat on the first half of the case. You have refused to acknowledge the impropriety of the wild, offensive and unsubstantiated allegations and insults which you have gratuitously levelled at participants in this hearing.
>
> During the Performance Assessment and whilst giving evidence to this Panel, the Performance Assessors were subjected to a barrage of insults from you, ranging from dishonesty and racial bias to sexual promiscuity. Further, in

> cross-examination you insulted Dr Cox when you called him an ignoramus and accused him of being dishonest and unethical.
>
> In your closing submissions on impairment, you continued with this abusive and insulting behaviour. You referred to Dr Reith as an "arrogant racist" and Professor Gulati as "the twisted dishonest racist". You stated that Dr Sharma was "inflated". You also stated that the GMC was a "racially motivated institute". You referred to the conduct of the Panel Chair as "unethically appalling" and that the Panel was lacking conscience and integrity. You repeatedly referred to Dr Stuart as a "white racist" and said that he was "a dishonest, white, crooked consultant". Nurses Costello and Dickinson were branded by you as "lying" and you referred to Nurse Costello as a "white negligent nurse."
>
> The Panel has had regard to paragraphs 46 and 47 of Good Medical Practice, which state, respectively:
>
> "You must treat your colleagues fairly and with respect. You must not bully or harass them, or unfairly discriminate against them by allowing your personal views to affect adversely your professional relationship with them.
>
> You must not make malicious and unfounded criticisms of colleagues that may undermine patients' trust in the care or treatment they receive, or in the judgment of those treating them."
>
> Your behaviour, in your dealings with the GMC and your conduct before this Panel, has consistently contradicted these principles. The Panel regards this conduct most seriously."

57. I will say something about those observations later (see paragraphs 85-90).

Sanction

58. After having made a positive finding of "impairment to practise" arising from the factual matters found proved, and having made those observations, the Panel invited submissions as to the appropriate sanction, if any, to be imposed on the Appellant's registration which, it indicated, should include reference to the Indicative Sanctions Guidance (April 2009, revised August 2009), using the criteria as set out in the guidance to draw attention to the issues which appeared relevant to the case.

59. There was a fairly fraught interchange between the Appellant and the Chair on Friday, 23 April, about how her submissions were to be made, but the net result was that the Appellant sent her submissions by e-mail so that they were received and available for consideration on 26 April. The Appellant did not attend that day or on the following day when the decision on sanction was pronounced.

60. The relevant parts of the determination on sanction are set out below:

" …

Having determined that your fitness to practise is impaired by reason of deficient professional performance, misconduct [redacted] the Panel has now considered what action, if any, it should take with regard to your registration.

Mr Kennedy referred the Panel to the General Medical Council's Indicative Sanctions Guidance (ISG) (April 2009, revised August 2009) and highlighted paragraphs which he felt were of particular relevance. He invited the Panel to consider the aggravating and mitigating features of this case, and the issue of insight. Mr Kennedy submitted that if questions of adverse mental health had been absent from this case, then erasure would be the appropriate sanction. However, as the Panel had been unable to establish the effect, if any, your health had upon your performance and misconduct, the GMC stopped short of making submissions on erasure. Mr Kennedy submitted that the GMC had no specific submissions to make regarding the Panel taking no action or accepting undertakings, as he stated that such sanctions are not a proportionate response in this case.

Mr Kennedy further submitted that conditional registration was not appropriate as it was clear that many of the criteria outlined in the ISG are unfulfilled. He submitted that suspension, therefore, is the appropriate sanction in your case. He further submitted that if your registration is suspended or made subject to conditions, this should be done with immediate effect.

In a brief oral submission relating to sanction, you told the Panel that you would be submitting a list of undertakings for consideration and asked to be allowed to make your submissions in writing. In due course you provided a written document entitled "Submissions for undertakings – for 26/04/10". In this document you set out your position in relation to the whole case. You refuted many aspects of the Panel's findings on facts and impairment and referred to *Good Medical Practice*, providing examples of your consistent adherence to its principles. You submitted a list of undertakings to be considered by the Panel.

In its deliberations on sanction the Panel has considered the submissions made by Mr Kennedy on behalf of the GMC and your written submissions. However, the decision as to the appropriate sanction to impose, if any, is a matter for this Panel exercising its own judgment.

In reaching its decision, the Panel has taken account of the ISG. It has borne in mind that the purpose of sanctions is not to be

punitive, although they may have a punitive effect, but to protect patients and the wider public interest.

Throughout its deliberations, the Panel has applied the principle of proportionality, balancing your interests with the public interest. The public interest includes, amongst other things: the protection of patients, the maintenance of public confidence in the profession, and the declaring and upholding of proper standards of conduct and behaviour.

The Panel has already given detailed determinations on the facts and impairment and it has taken those matters into account during its deliberations on sanction.

In coming to its decision as to the appropriate sanction, if any, to impose, the Panel first considered whether to conclude your case by taking no action. The Panel determined, that in view of the serious nature of its findings on impairment, it would not be sufficient, proportionate or in the public interest to conclude this case by taking no further action.

In considering your proposed undertakings, the Panel has considered the ISG, paragraphs 49-55, which set out the circumstances in which undertakings may be accepted. It has also considered the GMC's guidance 'Undertakings at FTP Panel hearings' (August 2009).

Having considered its findings on impairment, your level of insight and the public interest, the Panel is of the view that undertakings would be wholly inadequate to monitor and review your conduct, performance and health after this hearing. The undertakings you have offered did not include all the areas of health, practice, supervision and retraining which the Panel views as prudent to monitor. The Panel considers that a further review by a Fitness to Practise Panel is necessary in your own interests and the public interest. Accordingly, the Panel has determined not to accept the proposed undertakings.

The Panel next considered whether it would be sufficient to impose conditions on your registration. It has borne in mind that any conditions imposed would need to be appropriate, proportionate, workable and measurable. Paragraph 62 of the ISG states:

> "When deciding whether conditions might be appropriate the Panel will need to satisfy itself that most or all of the following factors (where applicable) are apparent having regard to the type of case...This list is not exhaustive:
>
> - No evidence of harmful deep-seated personality or attitudinal problems.

- Identifiable areas of the doctor's practice in need of assessment or retraining.

- Potential and willingness to respond positively to retraining, in particular evidence of the doctor's commitment to keeping his/her knowledge and skills up to date throughout his/her working life, improving the quality of his/her work and promoting patient safety...

- Willingness to be open and honest with patients if things go wrong…

- In cases involving health issues, evidence that the doctor has genuine insight into any health problems, has been compliant with the GMC's guidance on health…and that he/she will abide by conditions relating to his/her medical condition(s), treatment and supervision.

- Patients will not be put in danger either directly or indirectly as a result of conditional registration itself.

- It is possible to formulate appropriate and practical conditions to impose on registration."

The Panel has noted the evidence of Dr Bentley, Divisional Medical Director, and Dr Akpan, Consultant Physician. Both confirmed that the time you spent at Warrington Hospital was positive and that if you were to apply for a job they would consider your application, along with other applicants.

The Panel is not of the view that the criteria listed above are sufficiently met to warrant the imposition of conditional registration. With regard to professional performance, the Panel notes that you appear to perform well in particular clinical environments. However, this success appears to be contingent upon particular conditions where your practice is not challenged. The NHS is a dynamic and complex organisation where such working conditions cannot be guaranteed. You yourself state, on page 5 of your written undertakings, that successful working relationships depend:

"…on the ethos of the team (hospital) and its head."

The Panel considers that an aggravating feature of this case is your consistent failure to recognise the key issues and the deficiencies they highlight in your conduct and performance. [redacted] Your behaviour throughout this case has been, unfailingly, that of someone

without insight. The Panel acknowledges your limited admissions on incontrovertible facts, but this does not detract from your constant assertions that you did not fail in your treatment of MH or during the Performance Assessment.

The Panel is of the view that a period of conditional registration would not adequately address the serious nature of your misconduct and deficient professional performance when considered in conjunction with your lack of insight. [redacted]

The Panel has, therefore, determined that it would not be sufficient to direct the imposition of conditions on your registration.

The Panel then went on to consider whether suspending your registration would be appropriate and proportionate. The ISG states at paragraph 75:

> "This sanction [suspension] may therefore be appropriate when some or all of the following factors are apparent (this list is not exhaustive):
>
> - A serious breach of *Good Medical Practice* where the misconduct is not fundamentally incompatible with continued registration and where therefore complete removal from the register would not be in the public interest, but which is so serious that any sanction lower than a suspension would not be sufficient to serve the need to protect the public interest.
>
> - In cases involving deficient performance where there is a risk to patient safety if the doctor's registration were not suspended and where the doctor demonstrates potential for remediation or retraining.
>
> - In cases which relate to the doctor's health, where the doctor's judgment may be impaired and where there is a risk to patient safety if the doctor were allowed to continue to practise even under conditions.
>
> - No evidence of harmful, deep-seated personality or attitudinal problems.
>
> - No evidence of repetition of similar behaviour since incident.

- Panel is satisfied doctor has insight and does not pose a significant risk of repeating behaviour."

The Panel has considered the above criteria carefully and it considers that while some are fulfilled, there is uncertainty surrounding others and some are not met at all. The Panel wishes to make it clear that aspects of this case crossed the threshold for erasure from the Medical Register. However, as there remain outstanding questions regarding how your mental health might have affected your misconduct and your performance assessment, the Panel felt erasure would not be appropriate.

In its determination on impairment, the Panel explained that you were a potentially dangerous doctor due to your unwarranted confidence in your own ability and your refusal to acknowledge your deficiencies and weaknesses. This belief has led to you refuting the conclusions of the Performance Assessment Report, the findings of the investigation by Trafford General Hospital with regard to your treatment of MH and the differential diagnoses of the GMC's Health Assessors. Furthermore, it has resulted in wholly unacceptable behaviour throughout this hearing before your regulatory body.

As a result of your lack of insight, the Panel cannot be assured that you will not repeat past behaviour or that your practice is remediable. For example, you completed a course on the assessment and management of a Colles fracture on 29 September 2008. However, despite this training you have repeatedly asserted to the Panel that you treated MH appropriately and disputed expert views on sedation. The Panel is mindful of its duty to protect patients, maintain public confidence in the profession, and declare and uphold proper standards of conduct and behaviour.

In the light of the above, the Panel has determined to suspend your registration for a period of 12 months. [redacted] However, a Performance Assessment will need to be undertaken at some point prior to your returning to practice.

In relation to your treatment of MH and your behaviour during the Performance Assessment and throughout this hearing, the Panel has borne in mind paragraph 69 of the ISG which explains the deterrent effect of suspension, when it is used to send out a signal to the doctor, the profession and to the public

as to what is regarded as behaviour unbefitting a registered medical practitioner.

Shortly before the end of the period of suspension, your case will be reviewed by a Fitness to Practise Panel. A letter will be sent to you about the arrangements for the review hearing. At this next hearing, the Panel reviewing your case will wish to be assured that you have addressed all of the shortcomings identified at this hearing. The future Panel will be assisted by receiving the following information:

[redacted]

Performance Assessment Reports from those parts of the assessment which you are able to undertake whilst suspended from practice

• Evidence of any insight you have into the pain and suffering you caused MH when you manipulated his wrist at Trafford General Hospital

• Evidence of continuing professional development"

61. The Panel then went on to consider whether to order immediate suspension and concluded as follows:

"In view of the nature of its findings on impairment, the Panel has determined that it is in the public interest, necessary for the protection of members of the public and in the best interests of the practitioner to impose an immediate order for suspension.

This means that Dr Nagiub's registration will be suspended immediately, from the date upon which written notice of this decision is deemed to have been served upon her. Additionally, the interim order currently imposed on Dr Nagiub's registration will be revoked on this date.

The direction for substantive suspension, as already announced, will take effect 28 days from the date upon which written notice of this decision is deemed to have been served upon Dr Nagiub, unless she lodges an appeal in the interim. If she does lodge an appeal, the immediate order of suspension will remain in force until the substantive direction takes effect."

62. That completes the necessary recitation of the Panel's reasons for reaching the conclusions it did in relation to the various stages of the process ordained by the GMC's procedures. The reasoning is an important feature of my review of the decisions under challenge given the parameters of that review set out in paragraph 6 above.

Grounds of appeal

63. The Appellant's grounds of appeal were originally contained in paragraph 11 of the document attached to her Appellant's Notice dated 21 May 2010 with the preparation of which she had received some assistance from her solicitors, although it was made clear that the grounds were somewhat provisional and were intended to be perfected in due course. She was then granted permission to serve amended grounds of appeal. Those were dated 8 July 2010. On 9 August 2010 she served her Skeleton Argument (which runs to 50 pages) and a document entitled 'Facts and Chronology' which runs to some 21 pages together with a large number of supporting documents. Leaving aside any comment that might be made about the contents, the documents were neatly typed and well-presented.

64. I think that Mr Hare's analysis of the substance of the grounds of appeal is accurate in the sense that she challenges the merits of the FPP's decisions –

> (a) concerning the Performance Assessment;
>
> (b) that her misconduct impaired her fitness to practise;
>
> [redacted]
>
> (d) that the sanction of suspension was appropriate and proportionate.

65. Two additional points made, each of which has the hallmarks of legal drafting, were in the following terms:

> "d. General
>
> 1. The Appellant was not represented and was disadvantaged in the presentation of her case. There was unfairness amounting to serious procedural irregularity caused by frequent interruption when the Appellant was cross-examining witnesses. The Panel Chair obstructed the Appellant, for example by switching off her microphone. The Panel failed to have due regard to her difficulties in her presentation of the case and placed too much weight upon issues of the Appellant's behaviour during the hearing before the Panel and too little weight on the evidence of her good behaviour and as to her conduct and her fitness to practise beyond the confines of the hearing room in her day to day working life.

> 2. The Panel gave undue weight to the manner in which the Appellant conducted herself before the Panel (including inappropriate language), when considering her medical performance and professionalism as a doctor in her day to day working life. Insufficient consideration was given by the Panel to the extreme level of stress that the Appellant was under when she represented herself before the Panel and the impact of that stress on her ability to conduct her own case."

66. It is a fair observation that much of the Appellant's Skeleton Argument as drafted by her is taken up with a detailed analysis of particular aspects of the Performance Assessment. Indeed much of her argument before me, whilst divided into three sections (the Performance Assessment, misconduct and the health issues) was directed to features of the Performance Assessment exercise and her contention that it was an unfair appraisal of her abilities and was carried out unfairly and in a way that was either calculated to show her performance in a poor light or had that effect.

67. The Appellant has repeated before me her criticisms of the Performance Assessment process and the conduct of it. It is not, of course, strictly speaking, for me to say whether any of her criticisms are or are not justified: I must determine whether the FPP was justified in concluding (i) that the Performance Assessment was an appropriate way of assessing the Appellant's performance and (ii) that it was right for the assessment team to reach the conclusions it did.

68. In answer to her root and branch criticism of the whole process of the performance assessment, Mr Ivan Hare has drawn my attention to the fact that, under the Fitness to Practice Rules (see Schedule 1, paragraph 3) the GMC has a discretion as to the choice of procedure and that, in any event, the procedure adopted in relation to the Appellant was the standard Performance Assessment Procedure. That there is a discretion seems clear from the rules, but obviously if the whole system was intrinsically unfair, or a particular performance assessment could be demonstrated to have been conducted unfairly, these would be matters which this court would expect the FPP to address if the argument is raised. It is clear from the way in which the Panel spoke about the performance assessment (see paragraph 46 above) that it did consider whether its intrinsic nature was inappropriate in the circumstances and concluded that it was not. That seems to me to have been a conclusion to which the Panel was entitled to come on the evidence placed before it and I do not see how I could possibly interfere with that conclusion notwithstanding all the points that the Appellant would wish to make (and indeed has made) both orally and in her extensive written submissions.

69. In relation to this particular Performance Assessment, Mr Hare has also drawn attention to the members of the Performance Assessment Team, most of the names of whom are referred to in the findings of the FPP to which I have referred above. They were Dr James Cox, a Fellow of the Royal College of Physicians of Edinburgh and Fellow of the Royal College of General Practitioners, who had assisted the GMC to develop its performance assessment procedures and had led 23 Performance Assessments (Team Leader), Dr Sheila Reith, a former Postgraduate Tutor in her hospital and the Deputy for her speciality for the West of Scotland (Medical Assessor), Dr Ravi Gulati, a Consultant with 25 years experience in assessing trainee practitioners (Medical Assessor), Dr Vikram Sharma, a clinical research associate at

University College London and, at the time of the assessment, an SHO (Additional Assessor) and Mr Morley (Lay Assessor).

70. The Panel had evidence from Dr Cox which indicated that it was the overall impression to be gained from the Performance Assessment that mattered and that some individual areas of criticism were excluded from the consideration of the conclusion of the assessment. He was challenged strongly about this by the Appellant and I have read parts of the transcript that go to this issue. The Appellant undoubtedly felt strongly that Dr Cox had been targeting her (and the proceedings became very heated when she objected to him portraying himself "as a good person because he is not", leading to what appeared to be renewed admonitions from the Chair about her conduct) and Dr Cox equally strongly rejected the suggestion. The short point for present purposes is that the Panel was in a very good position to make an assessment of this. They might have benefited from a more measured approach to the cross-examination of Dr Cox, but nonetheless the issue was fairly and squarely placed before them. As will be apparent, the Panel was predominantly a "lay" Panel and any concerns that they would simply "favour" the medical witnesses would thus be allayed.

71. It is, as it seems to me, hardly surprising that the FPP described the team as "knowledgeable and experienced", the only exception to that in terms of experience being Dr Sharma who was chosen precisely because of his "comparable clinical experience" to that of the Appellant at the time. (I will refer to the way Dr Sharma perceived his role below: see paragraph 77). It is unfortunate that during the assessment process the Appellant asserted that Dr Sharma was on a "freebie" and that he would be "protected by the Indian consultant and the white female consultant." I imagine he was considerably younger than the Appellant, but it would, of course, have been difficult necessarily to find an SHO of the same broad age as the Appellant.

72. The suggestion that he would be "protected" by those identified above also emerged when the Appellant was cross-examining Dr Reith (presumably "the white female consultant") about what does appear to have been a mistake on Dr Reith's part when making an evaluation in the performance assessment exercise about something written in a medical note. Dr Reith considered the note to be the Appellant's note when in fact it had been made by someone else. I have read the transcript of the questioning about this – it was very fraught and the Chair was obliged to intervene on a number of occasions to pull the Appellant up for rudeness and (as the Chair saw it) shouting and time-wasting. During the course of a vigorous interchange between the Chair, Dr Reith and the Appellant, the Appellant made the comment that had she (the Appellant) been Dr Sharma, Dr Reith would have quickly protected her.

73. The Appellant made much of Dr Reith's mistake about the clinical note in her submissions to me. She complained that Dr Reith had not apologised for the mistake and that the Chair had intervened too readily in effect to protect Dr Reith.

74. Whilst it is entirely understandable that the Appellant should have felt aggrieved that she should have been criticised on the basis of a note which she never prepared, this was, in the scale of the exercise, a very small part and it is impossible to believe that had the mistake been more openly acknowledged it would have made any difference at all to the outcome.

75. Another issue raised by the Appellant was the issue of the selection of the records of the patients whose cases were to be considered in the assessment process. The FPP heard evidence from Dr Cox and all of the other assessors. Again, the Panel will have been very well placed to assess whether there was any deliberate or non-deliberate, but unfair, bias in the selection of cases. They did not conclude that this was so and I am in no position to say that that was an incorrect analysis. Indeed I can see how the conclusion was reached that the process was intrinsically fair. There was the occasional "glitch" in the analysis, but that is hardly surprising given the scale of the operation. Those glitches were exposed in most cases and thus taken into account by the Panel. The reasoning set out in paragraph 46 above demonstrates that the members of the Panel had these matters were in mind. A conclusion that they made no substantial difference to the general picture created by the Performance Assessment exercise was entirely justified.

76. It is quite impossible for me to reflect on every aspect of the criticism that the Appellant makes of the Performance Assessment process. As I have previously indicated, my task is to see whether the FPP's evaluation of the Performance Assessment exercise was itself flawed. I am quite unable so to conclude. The Panel heard from all the assessors, had all the records and, whilst its members may have found the Appellant's conduct of her case at times distracting and irritating, they had a full opportunity to understand and reflect upon her criticisms. Their reasoning indicates that they had in mind the points she had made and those features of the process that I have described as "glitches". Their conclusion was as I have already recorded it to have been and it cannot, in my judgment, be faulted.

77. The FPP also had before it the essential argument that the Appellant put forward (and which she repeated before me), namely, that her performance was assessed by a "textbook" or a "picky" approach rather than by reference to the accepted standards of everyday practice. Dr Reith was questioned about this. She said specifically that the bar was not set too high for the Appellant. She said, in the context of one of the patients whose case was under consideration, that the standard being applied was one "set for someone qualifying in medicine" and thus was not set at a "high level" but at a basic level "for maintaining patient safety". The evidence given to the Panel by Dr Sharma is, of course, relevant in this regard. He was asked by Mr Kennedy what he understood his role to be and he said this:

> "My role was explained to me before the starting of the assessment and, essentially, when I did the assessment I was working at SHO and my role was to ensure that the assessment that was being carried out was held at an appropriate level for an SHO and that the standard was not set too high or too low for the purposes of the assessment."

78. Again, against the background of that evidence, which the Panel was entitled to accept if it felt it appropriate to do so, I do not consider that I am in a position to conclude that the Panel was wrong in deciding that the performance assessment was carried out fairly and represented a legitimate means of deciding on the standard of performance of the Appellant.

79. I have set the Panel's reasoning out in some detail because it illustrates clearly that it addressed the material issues with care and made an assessment of the evidence called

to support the allegations made. Against the background of that reasoning any appellant would face considerable difficulty in persuading this court, given the parameters referred to in paragraph 6 above, to conclude that the findings were wrong or not supported by the evidence. Addressing, as I do for present purposes, the issue of whether the findings of fact in relation to the Performance Assessment were justified, I am unable to accept that there was anything deficient in the Panel's conclusions.

80. Turning to the Appellant's challenge to the Panel's findings in relation to the misconduct issue, as will be apparent from the reasons given for its conclusions, the Panel heard oral evidence from the patient (MH), Mr W (who accompanied MH to the hospital), Nurse Costello (Sister and Shift Coordinator at the hospital on the day in question), Nurse Dickinson (Sister and Emergency Nurse at the hospital on the day), Dr Stuart (the Lead Consultant in Emergency Medicine and Clinical Director), Dr Gottschalk (who was responsible for the Appellant's induction and was a supervising consultant at the hospital and Dr Burdett-Smith (Consultant Emergency Physician and the GMCs expert witness on the issues that arose). The Appellant cross-examined each of these witnesses.

81. She complains that the GMC did not call Nurse Noblett as a witness which would have enabled the Appellant to cross-examine her. It appears that the GMC sent Nurse Noblett a draft witness statement and served a witness summons upon her with a view to compelling her attendance. However, the GMC received a letter from her GP dated 22 March 2010 stating that she suffered with "a long history of severe migraine attack" and that she was currently unfit to appear before the Panel. The Panel was plainly entitled to continue in her absence and no legitimate criticism can be made of the decision to do so.

82. Since the Panel was "in a far better position to assess the reliability of the evidence of live witnesses" (see paragraph 6 above) than I am, and its members expressed their reasons for arriving at the conclusions they did fully and clearly, again there is no basis for legitimate criticism of the conclusions to which the Panel came. Those conclusions were amply justified by the evidence that was accepted and nothing that the Appellant has raised in her argument, oral or written, persuades me that the Panel should not have come to the conclusions that it did. I recognise that the Appellant disagrees significantly with those conclusions, but that is asking me to come to a different decision on the merits when I have not heard or seen the live witnesses who could testify to the relevant matters. For those reasons, there are no grounds for impugning the conclusions reached on the conduct issue.

83. 

84. Once those findings of fact had been made, the issue of whether in consequence the Appellant's capacity to practise had been impaired was essentially a matter of judgment. However, the Panel received the evidence on the issue to which its reasoning referred and it made the judgment set out in that reasoning. Whilst again the Appellant disagrees in a fundamental way with the conclusion of the Panel, my task at this review is simply to determine whether I can conclude that the decision on this issue made by the Panel was invalid or in some other way flawed.

85. There is only one matter that has concerned me about the phraseology of the reasoning put forward by the Panel. It derives from the observations recorded in paragraph 56 above and the second Ground of Appeal to which I drew attention in paragraph 65 above. I have not read every word of the transcript of the hearing before the FPP, but I have read sufficient passages to obtain the flavour of the way the proceedings were conducted. There is no doubt at all that the Appellant referred to many of the participants either directly or indirectly in very offensive terms. Each member of the Performance Assessment team was characterised as "racist" and "biased" (and in the case of Dr Reith "corrupt"), each of the three Consultant Psychiatrists was branded a "crook" and virtually every other witness was the subject of some offensive remark. Those remarks were extended to members of the Panel (including the Chair about whom the Appellant threatened making a complaint), certain of the legal assessors and even the shorthand writers.

86. Had any of these things been said by a member of the Bar or a solicitor, he or she would have been before the relevant disciplinary tribunal very quickly.

87. Any tribunal of fact, such as the FPP is at one stage of the overall process, must from time to time see witnesses challenged strongly, even on occasions being accused of lying. That is a well recognised scenario. It is also well recognised that Litigants in Person are not as well-versed as an established practitioner in making a strong point in cross-examination in a forceful, yet not intrinsically offensive, way. However, apparently gratuitously offensive remarks are not tolerated and, leaving aside any questions of propriety, can be distracting and irritating for a tribunal endeavouring to get to the bottom of contentious issues. Having read those parts of the transcript that I have, I am very sympathetic to what I suspect was a feeling of despair on the part of the Panel that the Appellant should choose to express herself in the way that she did and, to the extent that the Panel were themselves subjected to similar comments, a feeling of affront.

88. The Appellant said nothing about this particular passage in the observations of the Panel in her argument before me. However, since she was acting as a Litigant in Person, my broader task is to see if there is any worthwhile argument that she could deploy in support of her appeal upon which she has not herself focused. As I have already hinted (see paragraph 65), I think that her previous legal advisers had seen this as one area of legitimate criticism.

89. I should emphasise that I have not had the benefit of argument on this issue: I took the deliberate decision not to interfere significantly in the hearing before me and to that extent I did not invite Mr Hare's observations on the issue. However, I would, for my part, have said that some caution was required before expressing an observation of this kind in the way that it was and in the context that it was. The essential issue in the proceedings was how the Appellant reacted in the daily workplace of medical

practice. The proceedings before the FPP did not constitute such a setting. The setting is an unfamiliar one for anyone who is not a trained lawyer or who has other experience of the process. Even those with training and experience will find participation in such proceedings a strain. Someone such as the Appellant, who is trying to defend her professional reputation from what she sees (rightly or wrongly) as unjustified and unfair criticism will find observing the normal courtesies difficult. That is not a defence of discourtesy and gratuitous offence; merely an observation of the obvious. I do not doubt that the Panel realised that. However, the context of the observation made by the Panel was that of whether her fitness to practise was impaired by the matters that had been found against her, including her health issues. It does seem to me to be stretching things somewhat to say that her behaviour before the Panel (which, on any view, was on occasions reprehensible) was relevant to that issue. Indeed the Panel's conclusion, following those observations, was that it regarded "this conduct most seriously". Those are the words one might expect before the imposition of a penalty rather than a judgment of the nature under consideration. [redacted]

90. The question, however, is whether this defect (as I see it) in the process of reasoning is such as to render the whole process from that point onwards flawed. I am quite satisfied that it does not. There was ample other material to sustain the view that the Appellant's fitness to practise was impaired by the matters previously found.

91. Since the process of reasoning that led to the sanction of suspension was, in my judgment, beyond legitimate criticism, the outcome of the hearing would have been the same notwithstanding what I perceive to have been the mistaken reference at that point in the reasoning to the Appellant's conduct before the Panel. Given the way that this court approaches the issue of deciding whether the sanction was appropriate (see paragraph 6 above), I can see no basis for saying that a suspension for 12 months was wrong or disproportionate.

92. The Appellant did, from time to time in her submissions to me, refer to the conduct of the Chair of the FPP. The criticism articulated in paragraph 1 of the grounds to which I referred in paragraph 65 above was the more measured way of putting forward the criticism. Having read a number of passages in the transcript where there were interchanges between the Chair and the Appellant, it is quite plain that the Chair was doing what any Chair would have sought to do in such a situation, namely, to keep control of the proceedings and endeavour to prevent them becoming a forum for the expression of gratuitous offence at the same time as endeavouring to ensure fairness to the Appellant whose ability to follow her chosen career was under scrutiny and possible threat. The Chair did speak very firmly to the Appellant on a number of occasions, asked her to leave the room occasionally and, on occasions, switched her microphone off. Looking at those parts of the transcript that I have, it seems to me that she was fully justified in dealing with the Appellant in the way she did. I can see no basis for any legitimate criticism.

Conclusion

93. The Appellant I saw was somewhat more restrained in the presentation of her case before me than the person who appeared before the Panel. I say "somewhat" because for much of the time before me she advanced her arguments in a detailed and persistent way that demonstrated that she was unable to stand back from the detail and see the broader picture. When she engaged in this aspect of her submissions she spoke loudly. I would not myself have characterised it as shouting (neither did Dr Cameron), though some might have taken a different view. There were, however, glimpses of the positive side of her character that some have seen and which were reflected in the positive references to which I have referred [redacted] There were a few moments when she spoke clearly with a degree of humour and, in some respects, in a rather engagingly self-deprecating manner. They were, I have to say, rare moments, but they did occur. She was not rude to me, but I could see that, if challenged, she had the capacity to lose her focus and become rude. She also acknowledged at the outset of her submissions that she had made an error of judgment in relation to the treatment of MH and regretted any pain that was caused to him during the procedure.

94. My only observation, borne of having listened to her for the best part of two days and having looked at some of the positive things said about her, is that it would be sad if such a highly motivated and obviously intelligent doctor should never practise again. However, I can well understand that a significant change in outlook is going to be necessary before her professional body will be satisfied that she can do so without very extensive restraints. It seems to me that this is what the FPP was hoping might be achieved [redacted] in the 12 months period of suspension imposed. One can only hope that the Appellant has seen it that way as the remedy lies very much in her own hands.

95. However, for the reasons I have given, I can see no sustainable grounds for interfering with the decision of the FPP and this appeal must be dismissed.

APPENDIX

DATES	HOSPITAL and POSITION
4 February 2004 – 3 February 2005	University Hospital of Wales, Cardiff, SHO in Nephrology (3 months), Endocrinology (3 months) and Chemical

	Pathology (6 months)
21 March 2005 – 3 June 2005	Gosport War Memorial Hospital, SHO in Elderly Medicine
13 March 2006 – 31 March 2006	Cookridge Hospital, Yorkshire. SHO in Oncology
19 June 2006 – 7 July 2006	Frimley Park Hospital, Camberley. SHO in Respiratory and General Medicine
17 July 2006 – 24 August 2006	Queen Elizabeth Medical Centre, Birmingham. SHO in liver surgery and gastroenterology
8 December 2006 – 6 February 2007	Peterborough and Stamford Hospitals, Peterborough. SHO in Medicine for the elderly
10 March 2007 – 29 April 2007	West Moreland General Hospital, Kendal. SHO in General Medicine
30 April 2007 – 31 July 2007	Calderdale Royal Hospital, Halifax. SHO in Obstetrics and Gynaecology
4 September 2007 – 31 December 2007	Norfolk and Norwich University Hospital, Norwich. SHO in Oncology and Medicine for the Elderly

6 February 2008 – 7 March 2008	Mayday University Hospital, Surrey. SHO in Elderly Medicine
10 March 2008 – 5 August 2008	Bridlington and District Hospital, East Yorkshire. Fixed Term Specialty Training Appointment in Medicine
6 August 2008 – 18 September 2008	Trafford General Hospital, Manchester. Clinical Fellow in Accident and Emergency.
27 April 2009 – 4 August 2009	Warrington Hospital, Cheshire. Specialty Training in Medicine/Stroke Medicine.
14 September 2009 – 26 February 2010	Warrington Hospital, Cheshire. Specialty Doctor in Medicine/Elderly Medicine.