Neutral Citation Number: [2019] EWHC 1638 (Admin)

Case No: CO/250/2019

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 28/06/2019

Before:

MR JUSTICE FREEDMAN

- -

Between:

The Professional Standards Authority for Health and Social Care

Appellant

- and –

(1) The General Medical Council
(2) Mr Andrew Hilton

Respondents

- -
- -

Ms Fenella Morris QC (instructed by **Browne Jacobson LLP**) for the **Appellant**
Mr Richard Booth QC (instructed by **DWF Law LLP**) for the **Second Respondent**

Hearing dates: 22 May 2019

- -

Approved Judgment

Mr Justice Freedman:

I Introduction

1. This is an appeal under s.29 of the National Health Service Reform and Health Care Professions Act 2002 ("the 2002 Act") against a decision of the Medical Practitioners Tribunal ("the Tribunal") of the General Medical Council ("the GMC").

2. This appeal is opposed by the Second Respondent, Mr Andrew Hilton ("the Respondent"). The GMC has stated that it is neutral in relation to the appeal and has not appeared before the Court.

3. Following a complaint by Patient A, at a meeting on 2 November 2016, the Respondent dishonestly informed Patient A that the Respondent had known from his post-operative assessment of Patient A that a screw used in the surgery was misplaced.

4. The Respondent came before the Tribunal between 12 and 23 November 2018. The Tribunal found that he was guilty of misconduct by reason of dishonesty but that his fitness to practise was not impaired, and that it was not necessary or proportionate to issue a warning in his case.

II Powers of the Tribunal

5. The powers of the Tribunal are set out in section 35D of the Medical Act 1983 in the following terms:

> (1) Where an allegation against a person is referred under [section 35C(5)(b)] above to [the MPTS—
>
> (a) the MPTS must arrange for the allegation to be considered by a Medical Practitioners Tribunal, and
>
> (b) a Fitness to Practise Panel, subsections (2) and (3) below shall apply.
>
> (2) [Where the Medical Practitioners Tribunal] find that the person's fitness to practise is impaired they may, if they think fit—
>
> (a) except in a health case [or language 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 Tribunal] think fit to impose for the protection of members of the public or in his interests.

(3) Where [the Tribunal] find that the person's fitness to practise is not impaired they may nevertheless give him a warning regarding his future conduct or performance."

III Factual Background

6. What follows is largely taken from the submissions made on behalf of the Respondent. This in turn is in large part a summary of the determination of the MPT on the facts and its conclusions as to the facts.

7. In March 2014, the Respondent performed a lumbar spinal fusion procedure on Patient A, a private patient, at the BMI Harbour Hospital. The Respondent did not recognise either intra-operatively or post-operatively that the right L2 pedicle screw ("the screw") was out of place and, as a consequence, made no mention of this to Patient A.

8. After Patient A had been discharged by the Respondent, he experienced further back problems. He contacted his private medical insurer, Aviva, who arranged a consultation with a different orthopaedic surgeon, Mr Guy Barham. An MRI scan was performed. On 19 April 2016 Patient A was seen by Mr Barham and was referred for a CT and bone scan. At a consultation with Mr Barham on 1 June 2016, Patient A was shown the scan results and was told that the screw was not in bone. Revision surgery was proposed.

9. On 19 July 2016 Patient A wrote to the Respondent complaining about the outcome of the surgery performed on him by the Respondent. Patient A's letter included the following:

> *"You carried out a spinal fusion of L2/L3 on March 26th 2014. I am still having problems with back issues …*
> *My son took a photograph of the x-ray two days after you carried out the procedure and it appears to show that one screw was not in place from day one.*
> *…*
> [There then followed various numbered questions]
> …
> *4. Why was I repeatedly informed by you over the course of my appointments that my x-rays appeared normal; evidently this is not the case?"*

10. The Respondent finally responded, after chasing by Patient A, on 25 August 2016 [2/472]. His letter included the following:

> *"I have reviewed your imaging during and since surgery …*
> *I confirm that the right superior L2 screw is placed laterally and therefore may not be in full contact with bone.*
> *…*
> [There then followed the answers to the numbered questions]

> …
> *With regard to your post-operative x-rays, there was a suggestion that the right L2/3 may be placed too laterally, however as I understood your progress was good, I felt that this did not require any further investigation."*

11. On 27 September 2016 Mr Barham performed revision surgery. On 3 October 2016 Patient A emailed the Quality and Risk Manager at the BMI hospital, reiterating his complaint about the spinal fusion procedure performed by the Respondent.

12. On 2 November 2016, a meeting took place. In attendance were Patient A and his wife, the Respondent, the BMI Quality and Risk Manager, and two other members of hospital staff, including a note taker. At that meeting, the Respondent said that he had known about the misplaced screw post-operatively, that he had not wanted to worry Patient A and that he had adopted a watch and wait approach. It was not in fact the case that the Respondent had known about the misplaced screw post-operatively.

13. Towards the end of the 2 November 2016 meeting, Patient A demanded £10,000 financial compensation from the Respondent and threatened referral to the GMC if payment was not made. The Respondent asked him to email about this, which Patient A did. The Respondent did not respond. Accordingly, on 26 November 2016 Patient A referred the Respondent to the GMC.

14. On 16 November 2017 the GMC sent a Rule 7 letter and enclosures to the Respondent. One of the allegations (not from the start) was an allegation of dishonesty regarding the 2 November 2016 meeting which was found proved by the Tribunal.

15. In oral submissions, Mr Booth QC for the Respondent showed how the allegation of dishonesty regarding the 2 November 2016 arose because in the letter of the Respondent in reply to the Rule 7 letter, his answer was that he did not deliberately mislead Patient A about the results of the x-rays. On the contrary, he did not check the x-rays until after the complaint of Patient A. This then led to the secondary case, which in the event was the one which led to the finding of misconduct, that if the Respondent did not mislead earlier, then he lied at the meeting of 2 November 2016 when he stated that he had known about the misplaced screw post-operatively.

16. The Tribunal hearing lasted for 10 days from 12 November 2018 to 23 November 2018. The Tribunal consisted of a Legally Qualified Chair, Ms Angela Black, a Lay Tribunal Member, Mr Darren Shenton, and a Medical Tribunal Member, Dr Alan Shepherd.

17. The Tribunal heard evidence from Patient A and from the Respondent. The Tribunal had reservations about the evidence of Patient A, finding his manner of dealing with the Respondent to be "unattractive". It regarded the Respondent as a credible and reliable witness, who had given his evidence in a straightforward and consistent way. It found that he had accepted that he had made a mistake in that the screw was misaligned and not

(fully) in the pedicle. The Tribunal found that "*the Respondent presented as someone who had been open with Patient A.*"

18. The Tribunal also heard expert evidence from two spinal surgeons, Mr Mohammed for the GMC and Miss Morgan for the Respondent. The key elements of this appeal do not turn on their evidence. Prior to the meeting of 2 November 2016, the Respondent requested a copy of CT scans ordered by Mr Barham and within the control of Patient A, so that he could assess properly whether the screw was in the bone or not. Patient A refused to let the Respondent see those CT scans. It was only as a result of defence requests that those CT scans were made available shortly before the Tribunal hearing.

19. At the conclusion of the evidence at Stage 1, the respective Counsel made submissions on the facts. Counsel for the GMC felt it necessary to clarify Charges 7a and 7b at that point. The GMC's primary case at that point was that what was said by the Respondent in the meeting on 2 November 2016 was true. In fact, the Tribunal went on to reject the GMC's primary case, but to accept its secondary case. The Chair set out the legal advice prior to the Tribunal's deliberations.

20. The Tribunal made its determination on the facts on 21 November 2018, day 8 of the hearing. That determination was detailed and properly reasoned.

21. The Tribunal found that the Respondent had failed on more than one occasion to review adequately Patient A's post-operative imaging in that he failed to recognise that the right L2 screw was out of place. In particular, he ought to have reviewed the evidence of the x-rays and failed to do so: he has now revised his practice and now does consult with the x-rays on such reviews. However, the Tribunal accepted the Respondent's evidence to the effect that, at all times when Patient A was his patient, he had not noted that the screw was misaligned.

22. The Tribunal found as a fact that, following the surgery performed by the Respondent, Patient A's pain was gradually reducing and his symptoms were getting better day by day. The Tribunal was satisfied that the Respondent recorded Patient A's symptoms accurately.

23. The Respondent was charged (Charges 7a and 7b) in relation to his statement on the 2 November 2016, namely that he had referred at this meeting to knowing that the screw was lateral prior to the letter of complaint, that he had not wanted to worry Patient A and that he had therefore adopted a 'watch and wait' approach. The Tribunal found that he misrepresented the facts in two ways, namely *"he told Patient A he had known earlier than was the case about his failure to identify the misplaced screw and that he had taken a positive decision to watch and wait, having identified that misplacement and not wanting Patient A to worry about it. This was a misrepresentation of the facts as he had known them to be and a repetition of the assertions he had made in similar vein in his letter to Patient A of 25 August 2016"* (paragraph 76 of the decision on misconduct).

24. The Respondent deliberately told Patient A what he knew to be false. He said that he had done this because Patient A was angry and he did not want to dispute the position of the screw although he knew that it had to be in the bone. Despite expressing sympathy to the Respondent for the threats expressed at the meeting of a report to the regulator and an action for negligence, the Tribunal found that the Respondent *"was not truthful in circumstances where he had a duty to act with integrity and honesty. Ordinary and decent members of the public would consider his assertions and inferences in that meeting to be dishonest because they were not truthful and the Respondent knew it"* (paragraph 84). The Tribunal found that Charges 7a and 7b were proved.

25. The Tribunal dealt with the issue of dishonesty of the Respondent at the 2 November 2016 meeting in a lengthy passage of its determination at paragraphs 72-85. The Tribunal was satisfied that the Respondent had no malicious intention to deceive Patient A, merely to create a positive environment in which he could apologise to Patient A for his error and reassure him that there had been no adverse outcome resulting from that error (paragraph 76). At paragraph 78, the Tribunal noted that the Respondent impressed it as a man with considerable emotional intelligence. It found that his actions were driven by his desire to put matters right for the patient and to reassure him. The Tribunal was satisfied that the Respondent was not motivated to avoid litigation or to avoid payment of financial compensation. His approach was conciliatory. In short, there was no finding of an adverse motive.

26. The Tribunal then went on to hear submissions as to whether the Respondent's fitness to practise was impaired by reason of misconduct. Having heard submissions as to misconduct, the Tribunal handed down its determination on impairment on the afternoon of 22 November 2018. The competing submissions were summarised, as were the relevant legal principles. When considering the issue of misconduct, the Tribunal cited relevant paragraphs of Good Medical Practice ("GMP"). Reference was made to the determination on the facts. The Tribunal concluded that the Respondent's actions fell far short of the standards of conduct reasonably to be expected of a doctor and therefore amounted to misconduct ("falling far short" being the test for misconduct).

27. Having found misconduct, the Tribunal then considered the issue of impairment by reason of misconduct, and decided that the Respondent's fitness to practise was not impaired by reason of his misconduct, pursuant to Section 35C(2)(a) of the Medical Act 1983 as amended. The Tribunal said the following:

> *"41.* ***This is the crux of this determination on impairment. The central issue is the public interest in the promotion and maintenance of public confidence in the medical profession and the promotion and maintenance of proper professional standards and conduct in that profession*** [emphasis added]**.**

42. This was an isolated incident at a meeting with Patient A on 2 November 2016, over two years ago. The Tribunal bore in mind the particular circumstances in which the dishonest conduct occurred: this was a difficult meeting between a former patient and a conscientious doctor who knew he had made a mistake and wanted to explain his actions to the patient in such a way as to minimise worry and concern for Patient A. In so doing he lost sight of the need to be open and transparent …

…

45. The Tribunal recognises that the Respondent did not make formal admissions to the allegation of dishonesty at the meeting; nor did he formally admit that the comments asserted in the allegation were "untrue". The Tribunal is somewhat perplexed by this, given his continued and consistent admissions, but relies in any event on the Respondent's own statements and correspondence with the GMC which make it clear that he, at no time, shied away from admitting what he said to Patient A.

…

52. Dishonesty is a breach of a fundamental tenet of the profession. Being honest and trustworthy and acting with integrity are at the heart of medical professionalism.

53. The Tribunal took into account that doctors occupy a position of privilege and trust. They are expected to act in a manner which maintains public confidence in them and in the medical profession and to uphold proper standards of conduct. The Respondent's conduct was dishonest. The Tribunal concluded that his conduct brought the profession into disrepute and breached a fundamental tenet of the medical profession.

54. The Tribunal recognises that these proceedings alone are not sufficient to meet the requirement of maintaining public confidence in the profession and the regulator or standards in the profession [emphasis added]**.**

55. This is a very unusual case. The dishonesty occurred in the context of the Respondent attempting to do his best for Patient A. He was trying to help Patient A understand the context of his mistake and the impact of it. There was no financial or reputational motivation for the dishonest conduct. He apologised profusely; he was trying to help Patient A understand that no harm had come from the misplaced screw and that, even if he had recognised it earlier, the treatment would have been no different. He knew he was misrepresenting the facts but he did in the belief that it was for the good of Patient A and to help him understand.

56. A fully informed member of the public, including within medical profession, would have considerable sympathy for the Respondent who was faced with a difficult meeting. He was required to explain a complex topic

(spinal fusion) and his objective was to reassure the patient. The manner in which he chose to do so, by adopting the patient's version of events to minimise areas of dispute, was foolish and led to his dishonesty.

57. The issue of impairment is finely balanced. The balance is just in favour of the Respondent being fit to practise. The Tribunal is satisfied that because of the lack of incentive to be dishonest other than the perceived best interests of the patient, that public confidence in the profession would not be undermined by a finding that the Respondent's fitness to practise is not impaired. Similarly, the promotion and maintenance of proper professional standards and conduct in the profession would not be undermined by such a finding. A fully informed member of the public would take into account the context of the dishonesty, including the Respondent's positive motivation, and consider the circumstances to be exceptional. This is one of those rare cases where a finding of impairment of fitness to practise is not warranted. This is not a case where patients' and the public's trust in the Respondent and the medical profession generally would be undermined by not finding his fitness to practise to be impaired.

58. The Tribunal has determined that the Respondent's fitness to practise is not impaired by reason of his misconduct, pursuant to Section 35C(2)(a) of The Medical Act 1983 as amended."

28. Counsel then made their respective submissions on whether a warning ought to be issued. On the following afternoon, 23 November 2018, the Tribunal handed down its determination on warning, and decided not to issue a warning. The Tribunal said the following at paragraphs 14-23:

"14. The Tribunal recognises that a warning is appropriate when there has been a significant departure from GMP, as in this case. As indicated above, and for this reason also, the Tribunal's starting point is that a warning is appropriate. However, it also takes into account a warning is not mandatory in such circumstances: it is appropriate to take into account the merits of this case.

15. The Tribunal has considered the various factors identified in the guidance on warnings. There has been a clear and specific breach of GMP, as identified in the Tribunal's findings on impairment. The dishonesty is sufficiently serious that, if there were a repetition, it would result in a finding of impaired fitness to practise. The Tribunal bears in mind its findings on impairment as regards the impact on patient care, public confidence in the profession and the reputation of the profession. It considers there is no need to record formally the particular concerns because additional action will not be required: there will be no repetition.

16. The Tribunal acknowledges there is a presumption that the GMC should take some action when the allegations concern dishonesty (paragraph 24 of the guidance refers). However, it considers that this paragraph relates to the investigation stage, rather than to proceedings before the Tribunal. In any event, even if it were to apply to the Tribunal, the mere existence of a presumption is not, alone, sufficient to require the issue of a warning. This case should be considered in the round.

17. The Tribunal has applied the principle of proportionality. It has had regard to the guidance in Bolton v Law Society [1994] 1 WLR 512, [1993] EWCA Civ 32.

18. As regards mitigating and aggravating factors, the Tribunal finds as follows.
• The Respondent apologised to Patient A at the outset of his dealings with him, having received the letter of complaint of 19 July 2016. He reiterated that apology many times, including in these proceedings (notwithstanding the existence of ongoing litigation for the recovery of damages resulting from alleged clinical negligence);
• The Respondent has a long and unblemished record (apart from this misconduct) and there is no adverse history from the date of the incident to today's date;
• The incident was an isolated one; there has been no repetition and there will be no repetition. This was an aberration;
• There are no indicators that the misconduct will be repeated;
• The Respondent has changed his practice; he has attended relevant courses and training. He has fully reflected;
• There are exemplary wide-ranging testimonials and references which are relevant and informed. the Respondent is held in high regard by his peers and patients;
• The context of the dishonesty was a difficult meeting with a former patient who had made a complaint and who had made it clear he was seeking financial compensation and if he did not receive it he would report the Respondent to his regulator;
• The Respondent's motive (albeit misguided) was to act in the perceived best interests of the patient;
• While the dishonesty occurred in a clinical context, Patient A was no longer the Respondent's patient. He was not cooperating with the Respondent (e.g. he did not give permission for The Respondent to see his CT scans);
• The dishonesty was not exculpatory.

19. The Tribunal accepts there would be some impact on the Respondent's earnings in the private sector if a warning were issued but gives this no weight. Similarly, it accepts he would resign from various official organisations if a warning were issued but it considers that he would consider doing this in any event given the finding of misconduct. It gives this no weight therefore.

20. It is an aggravating factor that the dishonesty occurred in a clinical context (albeit in dealings with a former patient).

21. The Tribunal has taken into account the likely content of a warning if one were issued (referring to the guidance and Template A).

22. As in the case of impairment, the decision whether to issue a warning is finely balanced. However, taking the relevant factors in the round and noting the exceptional circumstances of this case and the lack of adverse motive, the Tribunal considers that while a warning would be appropriate in this case, particularly given the significant breach of GMP and the need to promote and maintain confidence and standards in the profession, it is not necessary or proportionate, given the wide ranging mitigating factors and the particular circumstances in which the dishonesty occurred."

29. The Appellant appealed by way of Appellant's Notice and Grounds of Appeal dated 18 January 2019. The skeleton argument on behalf of the Appellant is dated 30 April 2019.

IV The GMC's core guidance

30. The GMC's core guidance to doctors as to the necessary professional standards, "Good Medical Practice", includes the following:

"Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and make sure your practice meets the standards expected of you in four domains.

…

Communication, partnership and teamwork

Treat patients as individuals and respect their dignity.

…

Work in partnership with patients.

…

Give patients the information they want or need in a way they can understand.

Respect patients' right to reach decisions with you about their treatment and care.

Maintaining trust.

Be honest and open and act with integrity.

Never abuse your patients' trust in you or the public's trust in the profession.

31. You must listen to patients, take account of their views, and respond honestly to their questions.

32. You must give patients the information they want or need to know in a way they can understand.

…

49. You must work in partnership with patients, sharing with them the information they will need to make decisions about their care …

…

55. You must be open and honest with patients if things go wrong.

…

61. You must respond promptly, fully and honestly to complaints and apologise when appropriate.

…

65. You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.

…

68. You must be honest and trustworthy in all your communication with patients …

…

71. You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any documents you write or sign are not false or misleading.

a. You must take reasonable steps to check the information is correct.

c. You must not deliberately leave out relevant information."

31. A commitment to honesty and openness, known as the "duty of candour", is shared by all the healthcare professions. See, for example, the Joint Statement from the Chief Executives of statutory regulators of healthcare professionals, which provides as follows:

"Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress."

V The Tribunal's Sanctions Guidance

32. The Sanctions Guidance includes the following:

"Medical practitioners tribunals use this guidance to make sure they take a consistent approach when deciding:

a. *whether to issue a warning when a doctor's fitness to practise is not impaired*
b. *what sanction to impose, if any, when a doctor's fitness to practise is impaired.*

...

The tribunal must base its decisions on the standards of good practice established in Good Medical Practice and on the advice given in this guidance.

...

17. Patients must be able to trust doctors with their lives and health, so doctors must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession ... the reputation of the profession as a whole is more important than the interests of any individual doctor.

...

24. ... The tribunal is less able to take mitigating factors into account when the concern is ... about public confidence in the profession.

...

65. It is important that the tribunal give clear reasons for issuing, or for not issuing, a warning.

...

128. Dishonesty, if persistent and/or covered up, is likely to result in erasure ..."

VI GMC's Guidance on warnings

33. The GMC's Guidance on warnings includes:

"1. This guidance aims to help GMC case examiners, the Investigation Committee and the medical practitioners tribunal determine when it is

appropriate to issue a warning. While we recognise that individual cases must be decided on their own facts, the purpose of the guidance is to encourage consistent and appropriate decision making.

...

3. Warnings are available at both the investigation stage and the adjudication stage of the fitness to practise procedures.

...

"The purpose of warnings

10. The power to issue warnings, together with other powers available to the GMC and to MPTS panels, is central to their role of protecting the public which includes protecting patients, maintaining public confidence in the profession and declaring and upholding proper standards of conduct and behaviour.

...

13. Although warnings do not restrict a doctor's practice they should nonetheless be viewed as a serious response, appropriate for those concerns that fall just below the threshold for a finding of impaired fitness to practise.

14. Warnings should be viewed as a deterrent. They are intended to remind the doctor that their conduct or behaviour fell significantly below the standard expected and that a repetition is likely to result in a finding of impaired fitness to practise. Warnings may also have the effect of highlighting to the wider profession that certain conduct or behaviour is unacceptable.

The test for issuing a warning

...

16. A warning will be appropriate if there is evidence to suggest that the practitioner's behaviour or performance has fallen below the standard expected to a degree warranting a formal response by the GMC or by the MPTS panel. A warning will therefore be appropriate in the following circumstances:

- *There has been a significant departure from Good Medical Practice; or*

...

20. The decision makers should take account of the following factors to determine whether it is appropriate to issue a warning:

a. There has been a clear and specific breach of Good Medical Practice or our supplementary guidance;

b. The particular conduct, behaviour or performance approaches, but falls short of, the threshold for the realistic prospect test or in a case before a tribunal, that the doctor's fitness to practise has not been found to be impaired.

...

Dishonesty

24. There is a presumption that the GMC should take some action when the allegations concern dishonesty. There are, however cases alleging dishonesty that are not related to the doctor's professional practice and which are so minor in nature that taking action on the doctor's registration would be disproportionate. A warning is likely to be appropriate in these cases. An example of this might include, in the absence of any other concerns, a failure to pay for a ticket covering all or part of a journey on public transport.

Proportionality

25. In deciding whether to issue a warning the decision maker should apply the principle of proportionality, weighing the interests of the public with those of the practitioner. It is important to bear in mind, of course, that warnings do not restrict the practitioner's practice and should only be considered once the decision maker is satisfied that the doctor's fitness to practise is not impaired.

...

Mitigation

...

32. .... As explained above, warnings may only be issued where the decision makers have concluded that the doctor's fitness to practise is not impaired or that the realistic prospect test is not met.

33. However, if the decision makers are satisfied that the doctor's fitness is not impaired or that the realistic prospect test is not met, they can take account of a range of aggravating or mitigating factors to determine whether a warning is appropriate. These might include:

▪ The level of insight into the failings,

a. A genuine expression of regret/apology

b. Previous good history

c. Whether the incident was isolated or whether there has been any repetition;

d. Any indicators as to the likelihood of the concerns being repeated;

e. Any rehabilitative/corrective steps taken;

f. Relevant and appropriate references and testimonials."

...

34. The decision makers should record their reasons for issuing or not issuing a warning."

34. The footnote to paragraph 24 of the Guidance on warnings provides as follows:

"Paragraphs 34 to 41 of the main guidance for decision makers at the investigation stage advise that there will be a presumption that the GMC or MPTS Tribunal should take some action when the allegations concern dishonesty."

VII The statutory basis of this appeal

35. The Tribunal's decision was a *"relevant decision"* under s.29(2)(a) of the 2002 Act.

36. Pursuant to s.29(4) of the 2002 Act (as amended by the Professional Standards Authority for Health and Social Care (References to Court Order 2015)), the Appellant may refer a case to the High Court where it considers that:

> *"the decision is not sufficient (whether as a finding or a penalty or both) for the protection of the public."*

37. By s.29(4A) of the 2002 Act consideration of whether a decision is sufficient for the protection of the public involves consideration of whether it is sufficient:

> *"(a) to protect the health, safety and well-being of the public;*
>
> *(b) to maintain public confidence in the profession concerned; and*
>
> *(c) to maintain proper professional standards and conduct for members of that profession."*

Previously, a part of the applicable test had been undue leniency.

38. Where a case is referred to the High Court, it is to be treated as an appeal (s.29(7) of the 2002 Act). Under s.29(8) of the 2002 Act, the Court may:

> *"(a) dismiss the appeal,*
>
> *(b) allow the appeal and quash the relevant decision,*
>
> *(c) substitute for the relevant decision any other decision which could have been made by the committee or other person concerned, or*
>
> *(d) remit the case to the committee or other person concerned 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."*

39. The Court may allow an appeal where the decision is wrong or there has been a serious procedural or other irregularity, such that it is not possible to determine whether the decision as to sanction was not sufficient for the protection of the public. This may include a failure to provide adequte reasons for a decision (*CRHP v (1) GDC (2) Marshall* [2006] EWHC 1870 (Admin) at [31] – [32]).

VIII Grounds of appeal

Ground 1: the Tribunal was wrong to find that the Respondent's fitness to practise was not impaired

Ground 1(a)

40. The Appellant submits that the Tribunal failed to direct itself as to the relevant legal principles under this heading, and in particular that the reputation of the profession is more important than the interests of any individual doctor (*Bolton v Law Society* [1994] 1 WLR 512 at [519], and *GMC v Chandra* [2018] EWCA 1898, and see Sanctions Guidance at paragraph 17).

41. In *Bolton v Law Society* at paras 518-519, Sir Thomas Bingham MR said the following:

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

42. The normal consequence of a finding of dishonesty is severe sanction (often erasure, even in the case of a one-off instance): see *Nicholas-Pillai v GMC* [2009] EWHC 1048 (Admin) where Mitting J held *"These* cases *always result in the balancing of one public interest against another. In cases of actual proven dishonesty, the balance ordinarily can be expected to fall down on the side of maintaining public confidence in the profession by a severe sanction against the practitioner concerned. Indeed, that sanction will often and perfectly properly be the sanction of erasure, even in the case of a one-off instance of*

dishonesty." (although not referred to as a separate case, this dictum was cited in some of the cases which were cited to the Court).

43. The Appellant contends that the Tribunal gave disproportionate weight to personal matters concerning the Respondent rather than focussing as it should have done on the importance of maintaining public confidence in the profession and upholding professional standards.

The Respondent's response

44. The Respondent submits that the Tribunal did direct itself first and foremost to the reputation of the profession which is more important than the interests of any individual doctor, as appears from paragraphs 40 and 41 of the determination on impairment which read as follows:

> *"40. The Tribunal then went on to consider whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment was not made.*
> *41. This is* ***the crux of this determination*** *on impairment.* ***The central issue*** *is the public interest in the promotion and maintenance of public confidence in the medical profession and the promotion and maintenance of proper professional standards and conduct in that profession."*
> (paragraph 41 is referred to for the second time in this judgment, but this time with emphasis added).

45. The Respondent referred also to paragraph 35, in respect of the reflective statement of the Respondent, where the Tribunal said that *"it gave little weight to the statement given that the crux of the issue here was the second and third public interest limbs."* At paragraph 36, in respect of the excellent testimonials from the Respondent's clinical colleagues, the Tribunal said that *"the Tribunal gives less weight to these given the public interest concerns here."*

46. The Respondent submits that the well-known section from *Bolton v Law Society* [1994] 1 WLR 512 at 519 does not need to be repeated as a mantra in every piece of legal advice or every determination if it is clear that the relevant public interest limbs have been taken into account. That legal advice having been given by the Chair, it was not necessary for the Tribunal to cite all of those authorities or to repeat those precise words in the body of its determination. Further, and in any event, it is plain from the decision on impairment itself (see again paras 40-41 and from 52-54) that the Tribunal treated the public interest concerns in the light of the dishonesty as being at the heart of its deliberation as to impairment.

47. As regards the suggestion that the Tribunal failed to direct itself as to the "usual" approach to impairment following findings of dishonesty in professional disciplinary

proceedings, it is apparent from the advice of the Chair to the Tribunal that the Tribunal had this in mind. She made reference to *GMC v (1) Nwachuku (2) PSA* [2017] EWHC 2085 (Admin) where "*on appeal the Court held it would be an unusual case where dishonesty is found not to impair fitness to practise*". The same point was made by reference to *PSA v (1) GMC (2) Igwilo* [2016] EWHC 524 (Admin). Reference was also made to the fact that dishonesty is a serious matter of misconduct whether a doctor commits that act in the course of practice or outside: *GMC v Patel* [2018] EWHC 171 (Admin).

48. In the circumstances, the submission that disproportionate weight has been given to personal matters concerning the Respondent rather than focussing on the public interest limbs is contradicted by passages like paragraph 41 (among others) of the decision on impairment. In any event, the Tribunal was required to take 'personal' issues such as remediation and risk of repetition into account: see *Uppal* (supra).

Ground 1(b)

49. The Appellant submits that the Tribunal failed to have sufficient regard to Good Medical Practice, as set out above. In so doing, and/or in any event, the Tribunal wrongly minimised the significance of the Respondent having been dishonest to a patient in a clinical context, particularly where he had erred in his treatment of the patient, and the patient had complained about it and asked for an explanation.

The Respondent's response

50. The response of the Respondent is to set out relevant paragraphs of GMP to which the Tribunal had regard at paragraph 23 of its decision on impairment. Further, the Tribunal was best placed to assess the evidence and the context of the Respondent's dishonesty – it made findings of fact in relation to that in its previous determination on the facts. It is therefore apparent that it must have taken these matters into consideration. The decision on impairment and the decision on the facts do not exist in two separate compartments.

Ground 1(c)

51. The Appellant submitted that the Tribunal wrongly stated that the dishonesty was *"an isolated incident"* (paragraph 42 of the decision on facts). In fact, the Tribunal had previously found that the dishonesty was a *"repetition"* of what had been stated in a letter from the Respondent to the patient more than two months before (paragraph 76 of the decision on facts).

The Respondent's response

52. The Respondent draws attention to the fact that no charge was placed before the Tribunal in relation to the letter of 25 August 2016, but by reference to the meeting of 2 November

2016. In any event, the decision at paragraph 25 of its determination on impairment makes clear that the Respondent's dishonesty on 2 November 2016 was a repetition of the assertions he had made in similar vein in his letter to Patient A dated 25 August 2016. Seen this way, the reference to an isolated incident is to treat the letter and the subsequent meeting as a single episode or incident, or to view the latter as taking its character in the light of the non-charged former.

Ground 1(d)

53. The Appellant submits that the Tribunal irrationally found that the Respondent had a *positive motivation* for his dishonesty and wanted to help Patient A. This evinced on the part of the Tribunal a fundamental failure to appreciate and apply the basic principles of healthcare professional regulation, as set out above. It is not a part of modern healthcare to lie to patients "for their own good", as the Tribunal found. Certainly, doctors should not cover up their mistakes because they feel "embarrassed" by them, as the Respondent said he was. In any event, nothing in this case amounted to an exceptional circumstance justifying no action in the face of dishonesty.

54. Further, the Tribunal was wrong to find that an informed member of the public or the profession would not consider this to be a serious failing in professional conduct, having regard to the importance of the duty of candour across the healthcare professions.

The Respondent's response

55. The Respondent submits that the Tribunal should give significant weight to its findings of fact on motivation when assessing the issue of impairment and in its findings as to the Respondent's motivations. The Tribunal found that the Respondent had no malicious intention to deceive Patient A, merely to create a positive environment in which he could apologise for his error and reassure him that there had been no adverse outcome from that error. Further, that his actions were driven by his desire to put matters right for the patient and to reassure him. These findings were rooted in the Respondent's evidence which the Tribunal accepted.

56. The Respondent says that the Tribunal was entitled to find that the case was exceptional, bearing in mind the dealings of the Respondent with Patient A with which a reasonable and well-informed member of the public would be sympathetic (paragraph 84 of the facts determination). Similarly, such a person would take into account the positive motivation of the Respondent, as described at paragraph 57 on decision of impairment.

57. These were findings which the Tribunal was plainly entitled to reach at the conclusion of a lengthy hearing after weighing all the evidence and submissions. The Tribunal did not fall into error here.

Ground 1(e)

58. No reasonable Tribunal could have come to the conclusion that the Respondent's fitness to practise was not impaired in the light of the importance of maintaining public confidence in the profession, and/upholding professional standards.

The Respondent's response

59. The Respondent submits that this ground is simply not made out in the light of the Tribunal's consideration and weighing of the evidence and the public interest considerations. It was open to the Tribunal to conclude that the Respondent's fitness to practise was not impaired as at November 2018, 2 years after the key event, in the light of its findings of fact, what it knew about him and his remediation, and in the light of the primary weight which it afforded to the public interest considerations.

Ground 2: the Tribunal was wrong not to warn the Respondent

Ground 2(a)

60. In addition to being critical of the decision not to find impairment, the Appellant says that the Tribunal erred in not even warning the Respondent having found dishonesty. It says that the Tribunal misdirected itself as to the Guidance on warnings, and in particular paragraph 24 of the guidance: it wrongly stated at paragraph 16 of the determination on warning as follows:

> *"16. The Tribunal acknowledges there is a presumption that the GMC should take some action when the allegations concern dishonesty (paragraph 24 of the guidance refers). However, it considers that this paragraph relates to the investigation stage, rather than to proceedings before the Tribunal. In any event, even if it were to apply to the Tribunal, the mere existence of a presumption is not, alone, sufficient to require the issue of a warning. This case should be considered in the round."*

61. In fact, says the Appellant, that was an error because the presumption applies to the proceedings before the Tribunal. It also applies to the decision as to whether to impose a warning having found that the Respondent's fitness to practise was not impaired.

The Respondent's response

62. The Respondent accepts that this may have been a misdirection in that the Guidance is aimed at helping Tribunals as well as case examiners and the Investigation Committee decide when it is appropriate to issue a warning. However, it submits that any misdirection was not material: this is shown, according to the Respondent, by the penultimate sentence of paragraph 16, considering what would happen if the presumption did apply, namely that *"the mere existence of a presumption is not, alone, sufficient to require the issue of a warning."*

Ground 2(b)

63. The Appellant submits that the Tribunal failed to have regard to the Guidance on warnings which advises that the type of dishonesty case in which a warning might be appropriate would be one that is not related to professional practice and minor. Here it is submitted that the dishonesty was about a patient in a clinical context and therefore related to professional practice and was serious.

The Respondent's response

64. The Respondent said that the Tribunal did consider the Guidance on warnings, and it was not necessary to refer to every paragraph of it. It does not have statutory force. The Tribunal made careful findings about the exceptional nature of the case, and every case depends on its own facts.

Ground 2(c)

65. The Appellant submits that the Tribunal failed to have sufficient regard to the Sanctions Guidance, in particular the obligation it imposes on Tribunals to base decisions on Good Medical Practice, which strongly emphasises the importance of doctors being open and honest with patients in the interests of maintaining public confidence and upholding standards in the profession. It did not have regard to the patient's "right" to complete and true information about his care.

The Respondent's response

66. The Respondent says that this ground is not made out. The Tribunal recorded, at paragraph 2 of its determination on warning, that Ms Fordham had taken the Tribunal through the relevant paragraphs of the Sanctions Guidance and stated expressly, at paragraph 5, that "*in making its decision as to whether a warning would be appropriate in the circumstances of the Respondent's case, the Tribunal has had regard to both SG and the Guidance*". The section of the Sanctions Guidance (p.21) on warnings is, in any event, very short. It concludes by stating that "*it is important that the tribunal gives clear reasons for issuing, or for not issuing, a warning*" (paragraph 65). It is submitted that this Tribunal gave clear reasons for not issuing a warning.

Ground 2(d)

67. The Tribunal gave undue weight to what it considered to be the mitigating factors in the Respondent's case (paragraphs 8, 10, 12, 18 and 22 of the determination on warning). The key issue was in fact the importance of upholding public confidence in the profession and maintaining public standards, in relation to which personal mitigation is of no or very limited relevance.

The Respondent's response

68. The Respondent says that there was an appropriate weighing of both aggravating and mitigating factors: paragraphs 18-20 of the determination on warning. The Tribunal noted expressly that it was an aggravating factor that the dishonesty occurred in a clinical context (albeit in dealings with a former patient). This was in line with paragraph 33 of the Guidance on warnings which makes it clear that the MPT can take account of "*a range of aggravating and mitigating factors to determine whether to issue a warning. These might include the level of insight into the failings, a genuine expression of regret/apology, previous good history, whether the incident was isolated or whether there has been any repetition, any indicators as to the likelihood of the concerns being repeated, any rehabilitative/corrective steps taken and relevant and appropriate references and testimonials*". (Paragraph 18 of the determination on warning must have been crafted with this in mind.)

Ground 2(e)

69. The Appellant contends that no reasonable Tribunal could come to the conclusion, having decided that fitness to practise was not impaired, that a warning was not necessary in order to maintain public confidence in the profession and/or uphold professional standards in the circumstances of this case.

The Respondent's response

70. Given the very detailed reasons provided by the Tribunal, the Respondent submits that the challenge cannot be substantiated on this ground. Those reasons were fully set out. The conclusion was that whilst a warning would be appropriate, it was neither necessary nor proportionate (paragraph 22 of the decision on warnings). Paragraph 25 of the Guidance on warnings says that the decision maker should apply the principle of proportionality, weighing the interests of the public with those of the practitioner. The Tribunal had in mind proportionality: see the reference to *Bolton v Law Society* [1994] 1 WLR 512 at paragraph 17 of the determination on warning. It also had in mind public interest e.g. the reference in paragraph 22 of its determination on warning to *"the need to promote and maintain confidence and standards in the profession".*

Ground 3: the Tribunal failed to give sufficient reasons for its decisions

71. The Appellant submits that the Tribunal failed to give sufficient reasons for its decision in that it did not give reasons:

    (1) for its departures from the guidance set out above.

    (2) which were capable of explaining to an informed reader why it had come to what appeared to be an aberrant decision.

The Respondent's response

72. For all of the above reasons, the Respondent submits that the Tribunal did give clear and comprehensible reasons for its decisions, and they were not aberrant. They are to be read together. They were founded on evidence, and they took into account important public interest considerations.

IX Discussion

a. Respect for decision-making body

73. It is *"important to acknowledge the expertise of the decision-making body and to recognise that the judgment being exercised by this court is 'distinctly and firmly a secondary judgment'"* (see *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council* (2011) 120 BMLR 94 per Cox J at paragraph 60).

74. This has been set out fully in *General Medical Council v Jagjivan* [2017] EWHC 1427 at paragraphs 39 and 40, where the Divisional Court (Sharp LJ and Dingemans J) issued the following guidance:

> *"39 As a preliminary matter, the GMC invites us to adopt the approach adopted to appeals under section 40 of the 1983 Act, to appeals under section 40A of the 1983 Act, and we consider it is right to do so. It follows that the well-settled principles developed in relation to section 40 appeals (in cases including: Meadow v General Medical Council [2007] QB 462 ; Raschid v General Medical Council [2007] 1 WLR 1460 ; and Southall v General Medical Council [2010] 2 FLR 1550) as appropriately modified, can be applied to section 40A appeals."*
>
> *40 In summary:*
>
> *(i) Proceedings under section 40A of the 1983 Act are appeals and are governed by CPR Pt 52 . A court will allow an appeal under CPR Pt 52.21(3) if it is "wrong" or "unjust because of a serious procedural or other irregularity in the proceedings in the lower court".*
>
> *(ii) It is not appropriate to add any qualification to the test in CPR Pt 52 that decisions are "clearly wrong": see Raschid's case at para 21 and Meadow's case at paras 125–128.*
>
> *(iii) The court will correct material errors of fact and of law: see Raschid's case at para 20. Any appeal court must however be extremely cautious about upsetting a conclusion of primary fact, particularly where the findings depend upon the assessment of the credibility of the witnesses, who the Tribunal, unlike the appellate court, has had the advantage of seeing and hearing: see Assicurazioni Generali SpA v Arab Insurance Group (Practice Note) [2003] 1 WLR 577 , paras 15–17, cited with approval in Datec Electronics Holdings Ltd v United Parcels Service Ltd [2007] 1 WLR 1325 , para 46, and Southall's case at para 47.*

> *(iv) When the question is what inferences are to be drawn from specific facts, an appellate court is under less of a disadvantage. The court may draw any inferences of fact which it considers are justified on the evidence: see CPR Pt 52.11(4) .*
>
> ***(v) In regulatory proceedings the appellate court will not have the professional expertise of the Tribunal of fact. As a consequence, the appellate court will approach Tribunal determinations about whether conduct is serious misconduct or impairs a person's fitness to practise, and what is necessary to maintain public confidence and proper standards in the profession and sanctions, with diffidence: see Raschid's case at para 16; and Khan v General Pharmaceutical Council [2017] 1 WLR 169 , para 36.***
>
> ***(vi) However there may be matters, such as dishonesty or sexual misconduct, where the court "is likely to feel that it can assess what is needed to protect the public or maintain the reputation of the profession more easily for itself and thus attach less weight to the expertise of the Tribunal …": see Council for the Regulation of Healthcare Professionals v General Medical Council and Southall [2005] EWHC 579 (Admin) at [11], and Khan's case at para 36. As Lord Millett observed in Ghosh v General Medical Council [2001] 1 WLR 1915 , para 34, the appellate court "will accord an appropriate measure of respect to the judgment of the committee … But the [appellate court] will not defer to the committee's judgment more than is warranted by the circumstances".***
>
> *(vii) Matters of mitigation are likely to be of considerably less significance in regulatory proceedings than to a court imposing retributive justice, because the overarching concern of the professional regulator is the protection of the public.*
>
> *(viii) A failure to provide adequate reasons may constitute a serious procedural irregularity which renders the Tribunal's decision unjust: see Southall's case at paras 55–56."* [emphasis added]

75. The Tribunal is involved in an evaluative judgment which was described in the recent case of *GMC v Raychaudhuri* [2019] 1 WLR 324 at 341-342 at para 57 per Sales LJ:

> *"57 In my view, the evaluative judgment made by the MPT in this regard should be given great weight. That is both because it had the advantage of seeing the appellant and the witnesses, so that it was well placed to make an evaluative judgment regarding the nuances of their interactions and the nature and seriousness of what the appellant did, and because of the practical expertise of a MPT in being able to understand the precise context in which and pressures under which a doctor is acting in a case such as this."*

76. The limited role of the appellate court has been emphasised recently in the Court of Appeal in the case of *Bawa-Garba v General Medical Council* [2018] EWCA Civ 1879 (a court comprising Lord Burnett CJ, Sir Terence Etherton MR and Rafferty LJ):

> *"61. The decision of the Tribunal that suspension rather than erasure was an appropriate sanction for the failings of Dr Bawa-Garba, which led to her conviction for gross negligence manslaughter, was* ***an evaluative decision based on many factors, a type of decision sometimes referred to as "a multi-factorial decision"****. This type of decision, a mixture of fact and law, has been described as* ***"a kind of jury question" about which reasonable people may reasonably disagree****: Biogen Inc v Medeva Plc* [1997] RPC 1 *at 45; Pharmacia Corp v Merck & Co Inc* [2001] EWCA Civ 1610, [2002] RPC 41 *at [153]; Todd v Adams (t/a Trelawney Fishing Co) (The Maragetha Maria)* [2002] EWCA Civ 509, [2002] 2 Lloyd's Rep 293 *at [129]; Datec Electronics Holdings Ltd v United Parcels Service Ltd* [2007] UKHL 23, [2007] 1 WLR 1325 *at [46]. It has been repeatedly stated in cases at the highest level that* ***there is limited scope for an appellate court to overturn such a decision.****"*
>
> *...*
>
> *67.* ***That general caution applies with particular force in the case of a specialist adjudicative body, such as the Tribunal in the present case, which (depending on the matter in issue) usually has greater experience in the field in which it operates than the courts****: see Smech at [30]; Khan v General Pharmaceutical Council* [2016] UKSC 64, [2017] 1 WLR 169 *at [36]; Meadow at [197]; and Raschid v General Medical Council* [2007] EWCA Civ 46, [2007] 1 WLR 1460 *at [18]-[20]. An appeal court should only interfere with such an evaluative decision* ***if (1) there was an error of principle in carrying out the evaluation, or (2) for any other reason, the evaluation was wrong, that is to say it was an evaluative decision which fell outside the bounds of what the adjudicative body could properly and reasonably decide****: Biogen at 45; Todd at [129]; Designers Guild Ltd v Russell Williams (Textiles) Ltd (trading as Washington DC)* [2001] FSR 11 *(HL) at [29]; Buchanan v Alba Diagnostics Ltd* [2004] UKHL 5, [2004] RPC 34 *at [31]. As the authorities show, the addition of "plainly" or "clearly" to the word "wrong" adds nothing in this context."* [emphasis added]

77. Having regard to these matters, in *PSA v Health and Care Professions Council & Ghaffar* [2014] EWHC 2723, Carr J at [48] acknowledged *"the need for appropriate deference to the Panel below and the high threshold to be passed on an appeal based on undue leniency".*

78. However, there are qualifications to this deference. In the above case of *Ghaffar*, Carr J said the following at [46]:

> *"However, the amount of weight to be attached to expertise of the Panel below, assuming regard has been had to relevant factors, will, in my judgment, depend on the circumstances of a particular case (see, for example, Council for the Regulation of Health Care Professionals v GMC and Southall [2005] EWHC 579 (Admin) at paragraph 11:*

> *"… where there is misconduct constituted by a failure to reach proper standards in treating patients, the expertise of the tribunal in deciding what is needed in the interests of the public is likely to carry greater weight … But where, for example, dishonesty or sexual misconduct is involved, the court is likely to feel that it can assess what is needed to protect the public or to maintain the reputation of the profession more easily for itself and thus attach less weight to the expertise of the tribunal …")*

79. This qualification to deference for the Tribunal, or approaching the matter with diffidence, has had the imprimatur of the Supreme Court in *Khan v General Pharmaceutical Council* [2017] 1 WLR 169, 177-178 at [36] per Lord Wilson:

> *"36. An appellate court must approach a challenge to the sanction imposed by a professional disciplinary committee with diffidence. In a case such as the present, the committee's concern is for the damage already done or likely to be done to the reputation of the profession and it is best qualified to judge the measures required to address it: Marinovich v General Medical Council* [2002] UKPC 36*, para 28. Mr Khan is, however, entitled to point out that:*
>
> *(a) the exercise of appellate powers to quash a committee's direction or to substitute a different direction is somewhat less inhibited than previously: Ghosh v General Medical Council* [2001] UKPC 29*,* [2001] 1 WLR 1915*, para 34;*
>
> *(b) on an appeal against the sanction of removal, the question is whether it "was appropriate and necessary in the public interest or was excessive and disproportionate": the Ghosh case, again para 34; and*
>
> *(c) a court can more readily depart from the committee's assessment of the effect on public confidence of misconduct which does not relate to professional performance than in a case in which the misconduct relates to it: Dad v General Dental Council* [2000] 1 WLR 1538*, pp 1542-1543."*

b. Consequence of finding of misconduct

80. It is not every case where a finding of misconduct will result in a finding of impairment. The Respondent drew attention to the Scottish Court of Session case of *PSA v Nursing & Midwifery Council* [2017] CSIH 29, where the Court stated at paragraph 27:

> *"Not every case of misconduct will result in a finding of impairment. An example might be an isolated error of judgment which is unlikely to recur, and the misconduct is not so serious as to render a finding of impairment plainly necessary. On the other hand, misconduct may be so egregious that, whatever mitigatory factors arise in respect of insight, remediation, unlikelihood of repetition, and the like, any reasonable person would conclude that the registrant should not be allowed to practise on an unrestricted basis, or at all. In such a case, to have been guilty of misconduct of such a nature is itself clear evidence that the practitioner should not be allowed to practise, or to practise unrestricted;*

and the public interest will point to a finding of impairment, and the imposition of an appropriate sanction. On the other hand, as one judge observed:
'[T]he [practitioner's] misconduct may be such that, seen within the context of an otherwise unblemished record, a Fitness to Practise Panel could conclude that, looking forward, his or her fitness to practise is not impaired, despite the misconduct." (Cheatle v General Medical Council, Cranston J, para 22).

81. As the Respondent also submitted rightly, if misconduct is established, the tribunal must consider as a separate and discrete exercise whether the practitioner's fitness to practise is impaired: *PSA v (1) GMC (2) Uppal* [2015] EWHC 1304 (Admin) at para [27] where Lang J said:

> *"In my judgment, the PSA's submission that a doctor's fitness to practise "is impaired" if he acts dishonestly does not accurately reflect the statutory scheme or the authorities, since, even in cases of dishonesty, a separate assessment of impairment is required, and not every act of dishonesty results in impairment."*

82. Lang J cited Silber J in *R (on the application of Cohen) v General Medical Council* [2008] EWHC 581 (Admin) at [64] ("*Cohen")*:

> *"There must always be situations in which a Panel can properly conclude that the act of misconduct was an isolated error on the part of a medical practitioner and that the chance of it being repeated in the future is so remote that his or her fitness to practice has not been impaired. Indeed, the Rules have been drafted on the basis that the once the Panel has found misconduct, it has to consider as a separate and discreet (sic) exercise whether the practitioner's fitness to practice has been impaired. Indeed* s 35D (3) *of the Act states that where the Panel finds that the practitioner's fitness to practice is not impaired, 'they may nevertheless give him a warning regarding his future conduct or performance'.*

83. The case of *Cohen* was one involving clinical errors or incompetence, with questions of whether the wrong can be remedied, whether it has been remedied and the risk that it will be repeated. Not so in cases of sexual misconduct where different considerations might apply. Lang J cited at length from the judgment of Cox J in *CHRE v NMC & Grant* [2011] EWHC 927 (Admin) at paras 73-74:

> *"Sales J also referred to the importance of the wider public interest in assessing fitness to practice in Yeong v. GMC [2009] EWHC 1923 (Admin) , a case involving a doctor's sexual relationship with a patient. Pointing out that Cohen was concerned with misconduct by a doctor in the form of clinical errors and incompetence, where the question of remedial action taken by the doctor to address his areas of weakness may be highly relevant to the question whether his fitness to practise is currently impaired, Sales J considered that the facts of Yeong merited a different approach. He upheld the submission of counsel for the GMC that:*
> *"… Where a FTPP considers that the case is one where the misconduct consists of violating such a fundamental rule of the professional relationship between*

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

84. Cox J then went on to say in *CHRE v NMC & Grant* supra:

"I agree with that analysis and would add this. In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances."

c. Where misconduct is dishonesty

85. The law and relevant authorities were summarised by O'Farrell J in *GMC v Nwachuku* [2017] EWHC 2085 (Admin) as follows at [45-50]:

"45 Dishonesty encompasses a very wide range of different facts and circumstances. Any instance of it is likely to impair a professional person's fitness to practise: R (Hassan) v General Optical Council [2013] EWHC 1887 per Leggatt J at paragraph [39].

46 Dishonesty constitutes a breach of a fundamental tenet of the profession of medicine: PSA v GMC & Igwilo [2016] EWHC 524. A finding of dishonesty lies at the top end in the spectrum of gravity of misconduct: Patel v GMC Privy Council Appeal No.48 of 2002.

47 A finding of impairment does not necessarily follow upon a finding of dishonesty. If misconduct is established, the tribunal must consider as a separate and discrete exercise whether the practitioner's fitness to practise has been impaired: PSA v GMC and Uppal [2015] EWHC 1304 at paragraph [27].

48 However, it will be an unusual case where dishonesty is not found to impair fitness to practise: PSA v Health and Care Professions Council & Ghaffar [2014] EWHC 2723 per Carr J at paragraphs [45] and [46].

49 The attitude of a practitioner to the allegations made and any admissions of responsibility for the misconduct will be taken into account as relevant factors in determining whether or not fitness to practise has been impaired: Nicholas-Pillai v GMC [2009] EWHC 1048 per Mitting J at paragraph [18].

50 The overarching concern is the public interest in protecting the public and maintaining confidence in the practitioner and medical profession when considering whether the misconduct in question impairs fitness to practise: Yeong

> *v GMC [2009] EWHC 1923 per Sales J at paragraphs [50] and [51]; Nicholas-Pillai (above) at paragraph [27]:*
> *"In cases of actual proven dishonesty, the balance ordinarily can be expected to fall down on the side of maintaining public confidence in the profession by a severe sanction against the practitioner concerned. Indeed, that sanction will often and perfectly properly be the sanction of erasure, even in the case of a one-off instance of dishonesty."*

86. In *GMC v Chaudhary* [2017] EWHC 2561 (Admin) at paragraph 57, in the context of a decision on impairment, Jay J said:

> *"First of all, I respectfully agree with the MPT that dishonesty is not necessarily a monolithic concept. That has two consequences. First of all, questions of degree obviously arise - that much must be self-evident - but secondly, that dishonesty in an individual does not have to be an all-pervading or immutable trait. A person can be dishonest just on one occasion. Secondly, I agree with the MPT that at least it was open for the MPT to consider the context of the respondent's dishonesty."*

87. Reference has been made above to the direction of the Chair to the Tribunal in this regard. In particular, she made reference to *GMC v (1) Nwachuku (2) PSA* supra that it would be an unusual case to find dishonesty, but not impairment, and to the fact that dishonesty was serious whether in the course of practice or outside: *GMC v Patel* supra.

d. Features about the facts in the instant case

88. The strictures about this Court exercising a secondary judgment have a particular resonance in this case. The Tribunal heard the case over a period of 10 days. It is apparent from the submissions of Counsel and from the legal advice of the Chair at the facts stage and at the impairment stage that very careful attention was given to the case. The evidence was detailed, and most importantly it heard the evidence of Patient A and the Respondent, both cross-examined.

89. The Tribunal found the decision on impairment *"finely balanced"* (paragraph 57 of its decision on impairment). It also found the decision on warning *"finely balanced"* (paragraph 22 of its decision on warning). It took the view that it was a *"very unusual case"* (paragraph 55 of its decision on impairment.) In its decision on warning, and without any demur, it related Mr Hurst's submission for the Respondent that this was *"an unusual and unique case".*

90. The reasoning was detailed. In accordance with guidance from case law, the Tribunal determined first the facts, then the issue of impairment and then the issue of warning. Although the decision therefore has three parts, the decision in any one part is to be read in

the light of the other parts. It was not necessary for the Tribunal to repeat each part or to make express cross reference.

91. There are certain features about the facts which emerge from the determinations, which were the subject of argument in Court, including;

(1) the way in which the dishonesty case relating to the 2 November 2017 meeting was presented as a secondary case, and not referred to in the Rule 7 letter ("the change in the primary case");
(2) the impact of the letter of 25 August 2016 insofar as it related to the meeting of 2 November 2016;
(3) the worth of the apology which was provided by the Respondent which was used as some underpinning reason for the lie, and the question of benign motive;
(4) the absence of admission to the dishonesty;
(5) the fact that the secondary case prevailed.

e. The change in the primary case

92. By way of background, it was indicated how the primary case against the Respondent had failed in relation to deliberately not advising Patient A when he knew about the misalignment/the operation having not been a success. This was relevant in two senses, namely that (i) it led to confusion about the case, such that it had had to be clarified during the hearing, and (ii) the only reason why there was a secondary case was due to the facts leading to the findings of misconduct being identified in the response of the Respondent to the Rule 7 letter.

93. This dilemma (about an unclear case) and for the candidness leading to the identification of the secondary case by the GMC are not matters for which the Respondent deserves some adjustment in his favour. The primary case arose out of his false account on 2 November 2016. His false account about his treatment led the GMC to take the account at face value. On that basis, the Respondent would have lied to Patient A whilst acting as the treating doctor, leading him to believe that he had known that the surgery had not worked, and he deliberately chose not to tell Patient A. In fact, that was a consequence of the dishonesty to Patient A that the story was taken at face value: it took a long hearing for the primary case to be shown to be untrue and for the secondary case to prevail. Likewise, the complications inherent in a primary and a secondary case which were mutually exclusive had as its origin or an origin the dishonesty to Patient A. Thus, these matters are not to be taken into account to the credit of the Respondent. Mr Booth QC realistically recognised the foregoing during the hearing, and he rightly in the course of the hearing placed much less emphasis (than in his opening remarks) upon the matters relating to the primary and secondary case.

f. The letter of 25 August 2016

94. The letter of 25 August 2016 was not the subject of a separate charge before the Tribunal. However, as Mr Booth QC acknowledged, it did form a part of the background to the dishonesty. It helps to inform about the nature of the dishonesty on 2 November 2016. The Tribunal found the following about the letter.

> *"73… Thus he was making an admission without knowing the consequences of that admission for himself and his practice. This suggests he was attempting to be open and transparent with Patient A to some degree. That said,* ***he also stated at bullet point four in that letter that "he had previously been aware that there may have been misplacement but had felt it did not require any further investigation. That statement was not true****."*
> *76… However, Mr Hilton knowingly misrepresented the facts in two ways: he told Patient A he had known earlier than was the case about his failure to identify the misplaced screw and that he had taken a positive decision to watch and wait, having identified that misplacement and not wanting Patient A to worry about it.* ***This was a misrepresentation of the facts as he knew them to be and a repetition of the assertions he had made in similar vein in his letter to Patient A of 25 August 2016.***
> *[This was repeated almost word for word at paragraph 25 of the determination on impairment]*.
> *78…. It is wholly understandable that Mr Hilton sought to minimise areas of disagreement between them in such circumstances given his objective of apologising again to Patient A (as he had already in his letter of 25 August 2016). It would have been clear to Mr Hilton that this matter would not be resolved as a result of anything he did at that meeting: the patient had been consulting Mr B by the stage of his initial complaint and was already seeking financial recompense before the meeting in November 2016."*

95. Having said something in similar vein on 25 August 2016, as the Tribunal held, the remarks of 2 November 2016 cannot be treated as a sudden and impulsive false statement. It was part of a strategy of saying untrue statements to lend credence to the story as to why he did not intervene. The allegation of Patient A, if accepted, caused a difficulty for the Respondent as to why he had not informed Patient A before, and indeed the fourth numbered point of the letter of 19 July 2016 required him to address why he had not informed Patient A that there was anything wrong during the post-operation consultations.

96. In the determination on impairment, the Tribunal found that *"this was a single episode of dishonesty"* at [39]. Given the above findings, the single episode is to be understood as referring to the transaction of which the letter of 25 August 2016 was a part. That was the

way in which Lang J treated that expression at [19] in Uppal, namely *"…the events had not all occurred on a single occasion. The Panel was making the legitimate point that this episode was an "isolated incident" in her professional career."*

97. The letter of 25 August 2016 does not therefore provide a separate charge, but it does inform in respect of the nature of the misconduct of 2 November 2016.

g. The apology

98. The Tribunal heard the evidence and was in the best position to evaluate it. It found that the Respondent wished to apologise. In particular:

> *"79. When asked why he had created a false impression deliberately, he referred to Patient A as being an angry man and his not wanting to dispute the position of the screw although he knew it had to be in bone.* ***He agreed, in retrospect, under cross-examination, that this was not what he should have done; he wanted to apologise and "make it as easy as possible" for Patient A to understand spinal fusion and that a misplaced screw was not a failure of surgery. Mr Hilton denied being flustered; he said he had been confused by the information in front of him*** *(emphasis added)."*

99. In the paragraphs which followed, the Tribunal emphasised that although there was a duty of candour with Patient A:

(1) "*This was a doctor-patient relationship which had broken down and would not be recovered" [80*]

(2) *"Thus the information given by Mr Hilton to Patient A was not material to any future relationship between them as patient and doctor."* [80]

(3) Due to the unattractive manner of Patient A who made threats to the Respondent and refused him access to crucial medical records, which would have informed him where he had gone wrong in the treatment of Patient A, *"an ordinary decent and fully informed member of the public would have considerable sympathy for Mr Hilton in his dealings with Patient A at the meeting in November 2016."* [81]

(4) The Respondent had not acted dishonestly in the past and had no history with the GMC and he was *"a man of good character and a credible witness who has given wholly reliable evidence about his perception of the situation with Patient A. He has not sought to excuse the manner in which he dealt with Patient A's complaint. He sought to do his best for Patient A when he realised he had missed a misplaced pedicle screw…"* [82]

(5) *"He did not maliciously intend to deceive Patient A. His intention was to lay the basis for creating a dialogue between himself and Patient A such that he could apologise to Patient A for failing to identify the screw had been misplaced and to reassure Patient A that the outcome of his surgery had not been adversely affected by his failure. By doing so Patient A was misled. That said, this is not a case of Patient A being unable to make an informed choice about his treatment; nor is it a case of his not being fully informed about possible courses of action or his making a decision which he would not otherwise have made. He was by this stage being treated by Mr B."* [83].

100. The Appellant has been critical of this analysis. In particular, Ms Morris QC submits that:

(1) the lies were told in a clinical context as between a doctor and a patient about the treatment given as a doctor. This cannot be minimised by saying that the role of the Respondent as the treating doctor was over. A lie told to a patient is very serious, even in the context of a dispute after the treatment has been concluded or after the doctor has been replaced by another doctor. It undermines the public confidence in the medical profession if a doctor cannot be relied upon to be truthful in discussing the treatment given. A lie in this context violates a fundamental requirement that a healthcare professional is honest and open with a patient.

(2) it is no longer the case, if it ever was, that a doctor is able to lie so as not to upset the patient, or so as to avoid an argument, or so as to make something easier to understand. A patient is entitled to have total reliance on the accuracy of the information provided by a doctor.

(3) a lie does not amount to something less serious simply because there is alleged to be a positive motivation. It is difficult to understand what is a positive motivation when any lie between a doctor and patient is liable to have the effect of undermining the public confidence in the medical profession.

101. Ms Morris QC submitted that the notion that the lies occurred in the context of an apology called into question whether it was an apology in that:

(1) there was no admission of liability;

(2) there was a truthful account of what had been done that was wrong, but integral to what was being said were two deliberately untrue statements;

(3) in answer to the submission of Mr Booth QC that the Respondent was being empathic (he was sorry for the condition which Patient A had), he did not need to tell lies in order to do so.

h. The Respondent's failure to admit dishonesty

102. Ms Morris QC submitted that one way of testing remorse and the absence of risk of repetition would be the admission by the Respondent that he had lied. However, although the relevant facts were placed before the Tribunal, the Respondent effectively put the GMC to proof that he had been dishonest. For this, the Tribunal did not criticise the Respondent, which Ms Morris QC regarded as the wrong approach. Mr Booth QC said that the Respondent was on the horns of a dilemma because an admission of dishonesty, even about the secondary case, was likely to fuel the primary case of the GMC. The dilemma was created by the lies which themselves had fuelled the primary case.

1. The Decision on Impairment

103. The questions which here arise are as follows:

(1) are the grounds of appeal on impairment made out;
(2) does this criticism of the factual basis of the decision undermine the decision of the Tribunal on impairment to such an extent that it cannot stand?

104. As regards Ground 1(a), although the decision could have been clearer in presenting the law as per *Bolton v Law Society*, there was sufficient within the decision to indicate that the need to uphold proper professional standards and public confidence were *"the crux of the determination on impairment"* and *"the central issue"*: especially see paragraphs 40-41 of the decision on impairment. The word *"crux"* appeared also at paragraph 35 of the decision on impairment in the context of giving little weight to the Respondent's reflective statement. In the next paragraph 36, the testimonials of colleagues, the appraisals and feedback of patients, however excellent and exemplary were given *"less weight"* than *"the public interest concerns."* The language of *Bolton* is brought to bear in paragraphs 52-54 of the decision on impairment, which has been quoted above in full with emphasis added (at paragraph 27 above). I also bear in mind the legal advice given to the Tribunal which contained relevant law. In view of the foregoing, the correct test appears to have been applied, and Ground 1(a) is rejected accordingly.

105. As regards Ground 1(b), there was enough set out about Good Medical Practice at paragraph 23 of the determination on impairment about the importance of honesty for this ground to fail. The fact that there were other parts of Good Medical Practice which were of importance is not decisive. It would have been desirable to set out other parts, but not essential. It is not to be inferred that since the Tribunal said that it had regard to paragraphs 1, 55, 65 and 68 that it had no regard to anything else. Accordingly, Ground 1(b) is also rejected.

106. As regards Ground 1(c), the criticism about the isolated incident is not made out. The incident of 2 November 2016 was considered in the light of the letter of 25 August 2016, as is clear from the face of the determination. It took its character in the light of that. The expression *"isolated incident"* can be understood to encompass the meeting seen against the background of the letter: see *Uppal* supra at [19]. Of greater concern was whether the

Respondent might have been under-charged, but this was not pursued by the Appellant. That was sensible because the letter of 25 August 2016 was something against which the meeting of 2 November 2016 was to be considered (and that was what the Tribunal did on a number of occasions in passages identified above). Some of the expressions about the meeting were susceptible to question, particularly the difficulties in front of an accusatory patient and "*being confused on the basis of the information before him*" (paragraph 79 of the determination of facts). The striking similarity between what was said in paragraph numbered 4 of the letter of 25 August 2016 and the meeting of 2 November 2016 makes it appear that the lies on 2 November 2016 were planned in advance rather than something suddenly and irrationally made up in the heat of the moment. The Tribunal at least referred to the fact that *"Mr Hilton denied being flustered"*, which is consistent with this. The reference to being confused might equally be said about having to deal with the letter of complaint. In the light of the foregoing, Ground 1(c) is not made out.

107. As regards Ground 1(d), the overriding matter was that the lies which the Respondent told amounted to misconduct, and there was no excuse for such lies. Ms Morris QC submitted that the times are long gone (assuming for this purpose that there ever were such times) when it can be acceptable in a professional context for a doctor to lie to a patient whether as a treating doctor or as a doctor considering treatment having been given previously in the context of a professional complaint. The Tribunal did not find that these circumstances justified the lies: on the contrary, it found misconduct and dishonesty. There were matters of impression in respect of the lies about the Respondent having a positive motivation or about the conduct of Patient A or about the impact of the circumstances on an informed member of the public. In the context of the judgment as a whole, these matters of impression were just that, and they fell short of erroneous directions of law or matters which were so fundamental that they invalidated the determinations as a whole or as regards impairment. They do not enable the Court to require that the matter be considered afresh.

108. In the end, the central question is whether in all the circumstances, in deciding not to find impairment, the Tribunal acted irrationally or perversely in coming to a conclusion that no reasonable Tribunal could come to in these circumstances, having regard to the importance of the duty of candour across the healthcare professions (Ground 1(e), but also closely related to Ground 1(d)). Before coming to this conclusion, the Court has to balance against it the considerations of deference to the decision of the Tribunal, or in the language of Lord Wilson in *Khan* of diffidence in departing from the Tribunal, referred to above. In this regard, the Tribunal heard the matter over a period of 10 days including hearing especially the evidence of Patient A and the Respondent. The Court bears in mind the advantage of the Tribunal referred to above particularly in the cases to which reference has been made of *Bawa-Garba v General Medical Council* and *GMC v Raychaudhuri*. It is necessary to give full weight to the fact that this was a decision of a specialist Tribunal.

109. It is right to say that the decision was about the effect of dishonesty and not about specialist medical practice. Nevertheless, there is still an extent to which this Court is making a secondary judgment in that the specialist tribunal is particularly well equipped to consider what does and does not constitute impairment and to the question of the appropriate sanction. To that extent, this is a secondary judgment, albeit with less diffidence having regard to the speech of Lord Wilson in *Khan* at [36] cited above.

110. Whilst recognising that no two cases are the same, I have derived assistance from the decision of Lang J in *Uppal* referred to above at [30-34]. In that case, the doctor's lies were characterised as *"lying to senior colleagues about communications with patients and their families, is a very serious breach of trust and of professionalism, particularly where the doctor's handling of the case is under scrutiny."*

111. Lang J noted that the Tribunal was satisfied that the misconduct was a *"one-off lapse"* which would not be repeated. Full responsibility had been accepted for the actions. The doctor was an inexperienced, young trainee doctor, who had been experiencing difficulties with her senior colleagues at the time. It was apparent from the face of the decision that the panel in that case had regard to the public interest factors. The panel had found that *"the public interest will be satisfied by the finding of misconduct, which is serious in itself."*

112. Lang J went on to accept the submission *"the Panel was in a better position than this Court to assess Dr Uppal's fitness to practise. It took 10 days to consider the evidence and submissions in this case. It saw and heard Dr Uppal giving evidence in chief and being vigorously cross-examined. It also heard evidence from Dr Clarke and Dr Warwick, the highly experienced doctors supervising her. In contrast, I have only heard legal submissions from counsel and have had no opportunity to assess Dr Uppal myself."* The Judge went on to consider whether the decision was unduly lenient (then a part of the applicable test), and concluded that *"the Panel had regard to all the relevant factors in reaching its decision, including the public interest, and it correctly directed itself in law."* She considered that the Panel was justified in concluding that fitness to practise was not impaired on the basis of the evidence and for the reasons it gave. It was an exceptional case on the facts.

113. However, for reasons which have to be considered later in this judgment, Lang J found that the decision not to issue a warning was unduly lenient, and ordered that there be a warning to Dr Uppal.

114. In the instant case with which this Court is now concerned, the Tribunal found the issue of impairment *"finely balanced"*, and that the balance was *"just"* in favour of the Respondent: see decision on impairment at [57]. There are of course very substantial factual differences between *Uppal* and the instant case (having regard to the seniority of

the Respondent and the difficulties which she experienced with senior colleagues). I have been concerned as to whether this decision was reached only on the basis of defective reasoning, and here I refer again to the matters relating to Ground 1(d) in particular. I have considered all the points of criticism of the Appellant, including without limitation:

(1) the reference to the confusion of the Respondent on 2 November 2016 is difficult to accept having regard to the earlier letter of 25 August 2016, but noting that the Tribunal did consider the meeting of 2 November 2016 against the background of the earlier letter;
(2) the criticisms of the shortcoming of the apology and the failure to admit dishonesty before the Tribunal;
(3) the criticism about any acceptance of positive motivation, albeit that it was recognised by the Tribunal that the Respondent was dishonest, and the Tribunal reminded itself about how serious dishonesty was.

115. The question then is whether this Court should take the view that either these matters are capable of founding a challenge to the decision of the Tribunal such that it was arrived at by a material misdirection such that this Court can find the matter for itself or remit it to the same or a freshly constituted Tribunal for reconsideration. Alternatively, was the decision one which no reasonable Tribunal could reach?

116. It is necessary to bear in mind (a) the advantages which the Tribunal had in seeing the witnesses, (b) the advantages of trying a case over 10 days relative to the assessment of this Court, (c) the multi-factorial nature of the assessment, which makes it the more difficult to disturb because of points of emphasis, (d) my conclusion that Grounds 1(a)-1(c) are not established, (e) the diffidence in overturning the overall decision of a professional disciplinary body which has examined matters so closely.

117. When taking into account these matters, I have come to the view that the above criticisms are not so fundamental that they impair the multi-factorial nature of the assessment. The Tribunal still found misconduct in the nature of dishonesty, and recognised that it would have to be an exceptional case where there was dishonesty without impairment. On balance, the criticisms do not have as their effect that the Court should interfere with the decision on impairment. Given the rejection of Grounds 1(a)-1(c) and my conclusions in respect of Ground 1(f), the ultimate question involves an assessment either that the decision which was made was on a false basis or that no reasonable tribunal could come to a decision other than one of impairment. Just as the Tribunal came to a finely balanced view which it "just" reached, so this Court, despite the narrower scope to interfere, also comes to a balanced view not to interfere with the decision on impairment. This was an exceptional case on the facts. It was an isolated lapse in an otherwise unblemished career. The risk of repetition was extremely low. The testimonials of colleagues and patients all told a story. The Tribunal had well in mind that the central issue and the crux of the matter was the upholding of professional standards. The matters of impression which it reached about the lies were not such as to undermine the very basis of the decision.

Further, the decision reached on impairment was not one which no reasonable tribunal could reach. I am persuaded that this is not a case where this Court can conclude on all the material before it that professional standards cannot be upheld or public confidence in the profession maintained without a finding of impairment. It therefore follows that the appeal in respect of Ground 1 generally is rejected.

2. Decision on warning

118. Upon the decision not to make a finding of impairment, the Tribunal was then mandated, as it did, to go on to determine whether it should give a warning as to future conduct. This aspect is now considered.

119. The Tribunal decided that it was not necessary or proportionate to issue a warning. The Tribunal referred to the GMC's Guidance on Warnings. The Guidance is not statutory and, as it says at the start, individual cases must be decided on their own facts. Nevertheless, the purpose of the Guidance is to encourage consistent and appropriate decision making. Material parts of the Guidance appear above.

120. Reference is made to the determination on warnings quoted above. The Tribunal rightly considered two purposes of warnings, first a deterrent to the particular doctor, and second to highlight to the wider profession conduct or behaviour which is unacceptable: see paragraphs 12-13 of its determination on warnings. As regards the former, it found that there was no prospect of repetition of his dishonesty and no requirement of a deterrent in this case: it found that the Respondent was a conscientious and caring doctor. However, as regards the latter, it stated that there had been a finding of misconduct.

121. The central question at this stage of the analysis is whether a decision not to warn was sufficient in respect of the second purpose, namely to highlight to the wider profession and the public that the dishonesty here in a clinical context was conduct or behaviour which was unacceptable. This Court has to consider whether the decision not to issue a warning was, in all the circumstances, not sufficient for the protection of the public. This involves consideration, especially of whether it was sufficient to maintain public confidence in the profession and/or to maintain proper professional standards and conduct for members of the profession.

122. The Tribunal made a mistake in respect of the presumption in finding that it only applied to the investigative stage, as was acknowledged by Mr Booth QC: it also applied at the stage of the determination of the Tribunal. The Respondent submits that the Tribunal, in the alternative at paragraph 16 of the determination on warning, also approached the matter as if the presumption applied to the Tribunal. However, the Tribunal said that "*the mere existence of a presumption is not, alone, sufficient to require the issue of a warning. This case should be considered in the round."* That is not correct. The effect of a

presumption is that without more, the presumption will give rise to a warning. It has to be seen in the round in the sense that the presumption can be displaced. I am prepared not to adopt too legalistic a framework to this aspect, and to assume that the Tribunal had this in mind even if it is not expressed as clearly might have been the case. I also bear in mind the fact that the Tribunal twice referred to having a warning as a starting point on two occasions at paragraphs 11 and 14 of the determination on warning.

123. The Tribunal found that a warning would be required if it were necessary to remind the Respondent that his conduct fell significantly below the standard expected and that a repetition would be likely to result in a finding of impaired fitness to practise. However, it found that there was no requirement for a deterrent in this case, and that he did not need such a reminder. While the Tribunal recognised the need to mark the fact that his conduct fell seriously below the standards expected of him, there was no prospect of repetition of his dishonesty. There is no reason to interfere with those findings of the Tribunal. The Tribunal was in a much better position to judge the Respondent in this regard than this Court: it had the advantages of seeing him give evidence, of his being cross-examined and it sat for 10 days in assessing the case. There was no error in principle in respect of the reasoning in this regard and this was a decision available to the Tribunal.

124. However, the Tribunal also acknowledged that *"warnings may also have the effect of highlighting to the wider profession that certain conduct or behaviour is unacceptable. It adopts its earlier findings with regard to the overarching objective, particularly the maintenance and promotion of confidence in the profession and the maintenance and promotion of standards within it. There is a finding of misconduct in this case."* (paragraph 14 of the determination on warning). The acknowledgment is in almost the exact words of the last sentence of paragraph 14 of the Guidance on Warnings.

125. The question is whether the Tribunal erred in finding that a warning was neither necessary nor proportionate. This Court must here too act with diffidence to the determination of the Tribunal for all the same reasons as were stated in respect of the determination on impairment.

126. However, this decision on warning is not justifiable. It must be seen in the context of the following matters, namely
    (1) The Tribunal had not just found misconduct, but the nature of the misconduct was dishonesty in a clinical context to a patient;
    (2) The Tribunal had found that the dishonesty was so serious that the decision as to impairment was *"finely balanced"* and the balance was *"just in favour of the Respondent"*;
    (3) The Tribunal recognised that the starting point was that there should be a warning because there has been something falling just below impairment and

there has been a clear departure from Good Medical Practice (paragraphs 11 and 14 of the determination on impairment).

(4) The Tribunal's decision on warning was said also to be *"finely balanced",* and also *"just in favour of the Respondent"*.

127. I find that the question as to whether to issue a warning should have had regard to the following matters, namely

(1) this was a case not simply where there was a clear and specific breach of Good Medical Practice, but the breach was lying amounting to dishonesty;

(2) the dishonesty related to the Respondent's professional practice irrespective of the fact that the doctor was no longer the treating doctor. It was to a patient wishing to review his treatment. It is of the utmost importance to confidence in the medical profession that a doctor does not lie, and especially in that context;

(3) the effect of the dishonesty was to mislead the patient when he was about to bring litigation and to make a complaint to the GMC;

(4) in fact, the lies had an effect on the GMC because they must have helped to found the primary case referred to above, namely that the Respondent had deliberately not told the patient about the results of the x-rays. One of the problems about lying is that it is difficult to know when the person who lies is telling the truth and when he or she is lying, and at lowest the Respondent must bear some of the responsibility for the primary case brought against him, albeit that it failed: the allegation was not correct, but his lies taken at face value might have indicated that it was true;

(5) the dishonesty gave rise to a presumption under the Guidance on Warnings to take some action;

(6) mitigation such as absence of misconduct in the past, personal reflective statement, remorse and testimonials of patients and colleagues are of less importance than the need to protect the confidence in the profession.

128. It therefore follows that what has happened in this case is that the Respondent has been the beneficiary of exceptional circumstances twice both as regards the determination on impairment and the decision on warning. In a case which got so close to impairment, and where this was not just misconduct, but dishonesty related to the doctor's professional practice, the Respondent has emerged without a sanction.

129. It is said that the finding of misconduct is sufficient. The Court was told in the course of the hearing that the Respondent had notified misconduct to his colleagues, his professional indemnity insurers and to fellow committee members of various professional committees

on which he served. Of course, he was able to relate to them that despite the misconduct, no sanction had been imposed.

130. I have in the end come to a similar view to Lang J in the case of *Uppal* above. I recognise that no two cases are the same, and they can easily be distinguished on the particular facts. But there are some similarities, and in the end my reasoning on warning is very similar to her reasoning at [39-41]. In that case, the Tribunal had considered dishonesty in a professional setting of the doctor and determined that there should be neither impairment nor a warning. Lang J found at [41] that *"the decision not to have a warning was unduly lenient, given the nature of the misconduct. In particular, I consider that the failure to impose any sanction did not uphold standards in the profession and was capable of undermining public confidence in the profession."*

131. In my judgment, applying paragraphs 16, 20a, 20b and 24 of the Guidance on Warnings, this was a case in which a warning was appropriate and necessary because the Respondent was in clear breach of the standards in Good Medical Practice. In this case, the Respondent lied to a patient about the steps that he took in considering his case and about his determination of how to treat the patient. This was in circumstances where the nature of his treatment was under consideration both in the context of an intended negligence claim and an intended complaint to the regulator.

132. The Tribunal was entitled to have regard to the mitigating factors, as identified in paragraph 33 of the 'Guidance on Warnings', to determine whether a warning was appropriate. However, I do not agree, in the circumstances of this case, that a warning was not necessary, appropriate or proportionate. I recognise that this Court can only intervene if it finds that the sanction was not sufficient for the protection of the public involving consideration of the matters referred to in s.29(4A) as set out at paragraph 37 above. I recognise everything said about the respect to be accorded to the professional decision-making body, entrusted with the statutory function of determining sanction.

133. Having made due allowances for the position of the Tribunal and the advantages which it has, I have come to the clear conclusion that it is wrong to take the view that public confidence in the profession would not be undermined by a finding that there should no sanction for the dishonesty, neither impairment nor a warning. Even accepting at face value the difficult finding that the Respondent was acting in what he perceived to be the best interests of the patient, I agree with the reservations expressed by Ms Morris QC that the times are long gone (assuming for this purpose that there ever were such times) when it can be acceptable in a professional context for a doctor to lie to a patient whether as a treating doctor or as a doctor considering treatment having been given previously in the context of a professional complaint. It may be that there are certain extreme circumstances where there could be a good reason not to tell the truth or serious extenuating circumstances for not telling the truth, but it is not necessary to imagine what

they might be. Suffice it to say, there were no reasons or extenuating circumstances in this case. The Tribunal accepted that by finding misconduct.

134. Whilst this Court has concluded that it is able not to interfere with the determination that there was no impairment, the notion that a doctor can be found to have told the lies which occurred here in a professional setting and can emerge without any sanction is not acceptable on the facts of the instant case. I have come to the view that the decision not to have a warning was, given the nature of misconduct and the circumstances of this case, not sufficient for the protection of the public and especially to maintain public confidence in the profession and/or to maintain proper professional standards and conduct for members of the profession. It was one which no reasonable tribunal properly directed and applying the law could reach on the facts of the case. In particular, I consider that the promotion and maintenance of proper professional standards and conduct in the profession would be undermined by a finding that there should not be imposed any sanction. On the contrary, it was necessary to issue a warning in order not to undermine public confidence in the profession. I take the view that a fully informed member of the public would consider that a warning was necessary.

135. There is no contradiction between this conclusion of substituting the Court's judgment for that of the Tribunal in respect of the warning, but not in respect of impairment. Having been persuaded not to interfere as regards impairment, and having noted the finely balanced nature of the decision of the Tribunal in that regard, the necessity to have the response of the issue of a warning is abundantly clear. What has happened has been that, despite findings of dishonesty in respect of the conduct of his professional practice, the Respondent has been able to leave the Tribunal without any sanction. The Tribunal sought to pile exceptional circumstance on exceptional circumstance. In so doing, even allowing for the advantages which the Tribunal has over the appellate court, and even having exercised diffidence, I have come to the clear conclusion that the Tribunal acted in error. The evaluation not to give a warning, albeit multi-factorial, fell outside the bounds of what the Tribunal could properly and reasonably decide. This Court concludes very clearly that a warning was necessary in order to maintain public confidence in the profession and/or to uphold professional standards in the circumstances of this case.

136. One approach to this is that the Tribunal, in coming to a view not open to it, must have misdirected itself as to the law or the application of the law. In other words, albeit that the Tribunal may have stated properly the law, it must have made an error of law, which then explains how it came to a decision which no Tribunal acting properly could have done. It could have been in respect of (a) not applying the presumption to issue a warning, (b) not recognising that this was not a case of dishonesty which was not related to professional practice and/or minor, (c) failing to have sufficient regard to the importance of doctors being honest and open with patients or giving too much weight to mitigating circumstances. This was expressed by Lord Radcliffe in *Edwards v Bairstow* [1956] AC 14 at 36 in the following terms:

> *"If the case contains anything ex facie which is bad law and which bears upon the determination, it is, obviously, erroneous in point of law.* ***But, without any such misconception appearing ex facie, it may be that the facts found are such that no person acting judicially and properly instructed as to the relevant law could have come to the determination under appeal. In those circumstances, too, the Court must intervene. It has no option but to assume that there has been some misconception of the law and that this has been responsible for the determination. So there, too, there has been error in point of law.*** *I do not think that it much matters whether this state of affairs is described as one in which there is no evidence to support the determination or as one in which the evidence is inconsistent with and contradictory of the determination or as one in which the true and only reasonable conclusion contradicts the determination. Rightly understood, each phrase propounds the same test."* [emphasis added].

Lord Radcliffe stated that he preferred the third formulation that there was only one true and reasonable conclusion.

137. With this in mind, I revert to the Grounds referred to above. I have decided that a warning should have been given. The decision in this appeal rests on Ground 2(e), namely that no reasonable tribunal could come to the conclusion that a warning was not necessary in order to maintain public confidence in the profession and/or uphold professional standards in the circumstances of this case. Having made allowance for the way in which the presumption was dealt with in the alternative and not adopted an over-legalistic position in that regard, this is a case where there is no misconception which appears *ex facie* in the determinations. However, the fact that the Tribunal reached a decision which was not open to it, gives the Court, in the words of Lord Radcliffe, no option but to assume that there has been some misconception of the law and that this has been responsible for the determination. It might have been a failure to apply the presumption properly (Ground 2(a)) and/or to have adequate regard to the Guidance on warnings in a dishonesty case (Ground 2(b)) and/or to have adequate regard to the importance of doctors being honest and open with patients (Ground 2(c)), and/or to give too much weight to mitigating circumstances (Ground 2(d)). All or any of these matters could have caused or contributed to the error of law in this case. It is not necessary to determine which it was because whatever it was, it caused or contributed to the error referred to in Ground 2(e), namely reaching a conclusion not available to it.

138. Even allowing for diffidence and the appreciable advantages of the Tribunal over this Court, and reiterating especially paragraphs 73-79 and 116 above, I am satisfied in all the circumstances that the decision reached by the Tribunal not to issue a warning was wrong, and one which was not available to a tribunal properly applying the law to the instant facts. The Tribunal was wrong to consider that a warning was not necessary in order to maintain public confidence in the profession and/or to maintain proper professional standards and conduct for members of the profession.

3. Ground 3: failure to provide reasons

139. The third ground is that the Tribunal failed to give sufficient reasons for its decision in that (a) there were no reasons for the departure from the guidance above, and (b) there were no reasons capable of explaining to an informed reader why it had come to an "aberrant decision." In my judgment, this adds nothing. The reasons were full. If there was a departure from guidance, and if this was not justified, then it might give rise to a substantive ground: if it was justified, then it would not give rise to a substantive ground. I have founded the decision on a substantive ground, namely Ground 2(e) above, and so the attempt to shoe-horn these circumstances into a failure to provide reasons does not arise.

Conclusion

140. For the reasons given above, the appeal is allowed in respect of the second ground and the failure to issue a warning. Having decided that the decision of the Tribunal was wrong to this extent, namely that it ought to have issued a warning, there is nothing to remit to the Tribunal. All that remains is the terms of the warning. The Court will receive submissions from the parties as to the terms of an appropriate warning.