Neutral Citation Number: [2022] EWHC 2595 (Admin)

Case No: CO/1174/2022

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 14 October 2022

Before :

MRS JUSTICE FOSTER DBE

- -

Between :

DR NATASHA RANGA

Appellant/Claimant

- and –

GENERAL MEDICAL COUNCIL

Respondent/Defendant

- -
- -

Ms Vivienne Tanchel (instructed by **Weightmans**) for the **Appellant**
Mr Peter Mant (instructed by **GMC Legal**) for the **Respondent**

Hearing date: 11 October 2022

- -

Approved Judgment

This judgment was handed down remotely at 3.00pm on 14 October 2022 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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MRS JUSTICE FOSTER DBE:

1. This is a statutory appeal by Dr Natasha Ranga against a Direction of the Medical Practitioners Tribunal ("the Tribunal") that her name be erased from the Medical Register for misconduct. It is a challenge to sanctions only. The particulars of misconduct were in the following areas:

   (i) Dishonesty in submitting two academic exercises that were plagiarised and not her own work;

   (ii) Breaching patient confidentiality;

   (iii) Dishonesty in communication with another doctor and a patient's solicitor;

   (iv) Failure to keep records.

2. The Appellant challenges the sanction of erasure from the Medical Register on the grounds it was neither necessary nor proportionate for the maintenance of public confidence or otherwise in the public interest.

3. A relevant history is as follows.

FACTS

4. Between the end of December 2017 and the early days of January 2018 Dr Ranga submitted two essays due, indeed overdue, in respect of her MSc in Medical Leadership at De Montfort University. One was an "education" essay and one was a "research" essay.

5. It was necessary for her to sign a declaration in respect of each:

> "*By submitting this assignment online I understand that I am certifying that this is my own work and that I understand plagiarism is an academic offence. All material in this assignment which is not my own work has been referenced and no material is included which is substantially the same as material I have already submitted for assessment purposes in any other module. I have read and understood the current university document on "Bad Academic Practice" and "Academic Offences.*"

6. In truth, and as subsequently admitted, the Education Essay used a large amount of materials copied and pasted from other sources without attribution. The Research Essay had been procured from a commercial website known as "assignments.com" and had not been written by Dr Ranga.

7. When the matter was investigated at the University in April 2018 Dr Ranga declined to attend an investigation, but made a written submission. At this point she admitted plagiarism in respect of the Education Essay, but not in respect of the Research Essay which she still maintained was her own work. The Academic Practice Officer at De Montfort University made a decision to the effect that she had acquired and submitted work which was not her own. Eventually, between May and August 2019 she did admit that the Research Essay was written by somebody else. At a Performance Meeting at the University held on 16 May 2019 almost a year and a half later, she had

continued to deny wrongdoing in connection with her Research Essay. By the subsequent meeting on 14 August 2019 she admitted the true position.

8. The Responsible Officer referred the conduct to the General Medical Council ("GMC"). That Responsible Officer was prepared to support the Appellant if she provided evidence of remediation, remorse and understanding. She did not submit any evidence of this to the Officer but she undertook mentoring with three practitioners.

9. The second set of allegations against Dr Ranga arose out of an entirely different matter.

10. In February of 2018 a woman known as "Patient C" contacted Dr Ranga on Instagram because she was unhappy about treatment she had received from a practitioner referred to in the proceedings as "Dr D". She had been offered and received lip fillers and a product called Profhilo on the basis that the latter would reduce hollowness under her eyes. Her communication indicated that her confidence had been shattered - but he did not see things in that way. She explained she had wanted her money back from Dr D. She messaged Dr Ranga to discuss the treatment she had received, asking if Dr Ranga could give her some advice also about reporting somebody who had given incorrect treatment. It would appear that Dr D is a high profile practitioner with a social media following including on television.

11. Dr Ranga saw Patient C at what was described as an initial appointment on 23 February 2018. It was Patient C's evidence, accepted by the Tribunal, that Dr Ranga told her that the treatment she had received from Dr D was inadequate and/or inappropriate because she now had lumps in her lips and the product Profhilo would not, as she had been told, correct the hollowness under her eyes. Patient C and Dr Ranga did not agree about details of the consultation and what Dr Ranga had said; also, for example, Patient C was clear no one else was present whereas Dr Ranga said her assistant was there. Importantly, Patient C told the GMC that Dr Ranga had told her she was surprised Dr D had used Profhilo, it was generally for older patients and unsuitable for someone of her age. Dr Ranga was sympathetic to her and she was advised by Dr Ranga to complain to the GMC: she understood that Dr Ranga supported her complaint of inadequate treatment.

12. After this initial consultation, Patient C began proceedings against Dr D. About a year later in March 2019 Patient C contacted Dr Ranga asking her to write a letter/report in support of her claim against Dr D, reflecting their consultation. She wished her to confirm that Patient C had visited Dr Ranga and that her opinion was that Profhilo was not the correct treatment. Dr Ranga replied she could not write a report as "it was just an initial consultation". At this time, however, on about 11 March 2019, Dr Ranga contacted Dr D on Instagram herself, without having sought or received any consent from Patient C. She said she had consulted with Patient C but had found no abnormalities. On the next day Dr Ranga sent an email to Dr D's solicitor saying again there had been no abnormalities in Patient C's presentation and saying she had advised Patient C to go back and see her "initial injector". This was repeated in an email to Dr D himself on 6 April 2019.

13. Just before the trial was due to come on, when witness statements were exchanged, Patient C discovered from the statements, the breach of confidence and what Dr

Ranga had said to Dr D. In her evidence Patient C described feeling betrayed and explained that her mental health had suffered as a result.

ADMISSIONS

14. Dr Ranga admitted before the Tribunal that she knew plagiarism was an academic offence and that she had falsely stated that each of the essays were her own work as set out and knew that that was untrue. She admitted dishonesty in respect of each of the essays.

15. With respect to the treatment of Patient C, Dr Ranga admitted that she had contacted Dr D by Instagram and had inappropriately confirmed that she had consulted with Patient C and discussed her concerns about Dr D's treatment. She accepted she had failed to obtain consent for disclosing confidential information, and did not tell Patient C that she had contacted Dr D and Ms E. she also admitted she had failed to make, maintain and retain appropriate medical records of her consultation with Patient C. Save as to these admissions she did not make any admission as to what she had said in consultation nor what she had communicated to Dr D and she did not admit that she had been dishonest in the course of these transactions. In the hearing she denied the truth of Patient C's claims about the initial consultation and what was said.

THE TRIBUNAL'S DETERMINATION

16. The Tribunal, when it came to make its final Determination, found proved that Dr Ranga had informed Patient C that Dr D's treatment was inadequate and/or inappropriate in that there were lumps in her lips, Profhilo would not correct the hollowness of her eyes and had told Patient C she was not an appropriate candidate for it. The Tribunal also found proved that she had emailed Dr D's legal representative Ms E, claiming falsely that she had found no abnormalities in Patient C's presentation and saying, falsely, that she had advised Patient C to go back and see Dr D with her concerns. It was also found against her that she had said, falsely, that her assistant had been present during the Consultation. The allegation that she had falsely said that there were no abnormal findings to Dr D was also proved. In respect of each of these matters, therefore, dishonesty, although not all admitted, was determined against her.

17. On Dr Ranga's behalf Miss Tanchel who also appears before me today, had accepted that the actions amounted to misconduct and that Dr Ranga's fitness to practice was currently impaired. This she accepted on the basis of the public interest, that is to say the public interest in maintaining high standards and the reputation of the profession.

18. In considering its Determination on impairment the Tribunal reminded itself there was no burden or standard of proof as such, rather it was a matter of judgement for the Tribunal. They determined independently, consistently with the admission, that fitness to practice was impaired. They reminded themselves they should consider whether the public interest required a finding of impairment, for example where the need to uphold proper professional standards and public confidence in the profession would be undermined if they did not do so, according to the principles set out in *CHRE v NMC and Paula Grant* [2011] EWHC 927 (Admin).

19. The Tribunal made express reference to relevant principles set out in Good Medical Practice including as follows:

> "*1. Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law.*
>
> "*19. Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.*
>
> "*20. You must keep records that contain personal information about patients, colleagues or others securely, and in line with any data protection law requirements.*
>
> "*50. You must treat information about patients as confidential. This includes after a patient has died.*
>
> "*65. You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.*
>
> "*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*."

20. The Tribunal's analysis of Dr Ranga's behaviour followed the citation of these paragraphs, it was as in these terms:

> "*101. The Tribunal found that these paragraphs of GMP are engaged in this case. Both the public and members of the medical profession would find Dr Ranga's behaviour unacceptable. There was declaring, falsely, that submitted work was her own. There was plagiarism. There were a number of instances of dishonesty. The breach of patient confidentiality was aggravated by the particular circumstances in which it had occurred; in particular Dr Ranga's knowledge that Patient C and Dr D were in dispute. Further, the importance of making, maintaining and retaining appropriate records was demonstrated by the circumstances of this case in which a substantial dispute had arisen in relation to what was said at a medical consultation and no contemporary record of that consultation had been produced.*
>
> "*102. The Tribunal concluded that each of Dr Ranga's dishonest actions, both those admitted and those found proved, in themselves amounted to misconduct, as did her breach of Patient C's right to confidentiality.*"

21. They also stated that the failure to maintain records was sufficiently serious a departure as to amount to misconduct.

22. In deciding that her fitness to practice was currently impaired, although admitted, the Tribunal were particularly persuaded by concern about the extent of her insight into the implications of her misconduct. This was in the face of what the Tribunal recognised as positive testimonials in relation to her progress. The Tribunal said they saw little evidence in her reflective statement about the impact on the patient of her misconduct. Similarly, adequate reflection on the fundamental importance of proper record keeping was lacking. The Tribunal were troubled by factual discrepancies between what was said in the reflective piece written by Dr Ranga, for example that consultation and interaction with Patient C "have always been difficult" yet neither said so at the Tribunal and the evidence did not reflect that.

23. Further, in her reflective piece Dr Ranga claimed to have approached Dr D for "guidance" whilst the facts showed she contacted him very shortly after the initial consultation to inform him that Patient C was unhappy with the treatment but that she had found nothing wrong. Similarly they were concerned by the lack of clarity as to the existence or not of records and photographs given that Dr Ranga's evidence varied over time (including before the Tribunal) – although she admitted the relevant paragraph within the allegation. The Tribunal, in other words, were not reassured by the evidence given by Dr Ranga before them in Tribunal now some years after the relevant occasions of dishonesty.

24. The Tribunal also reflected that there were a number of incidences of dishonesty evidenced by its conclusions. They did not accept what Dr Ranga said about the consultation with Patient C and were not confident "she has yet addressed the implications of her misconduct sufficiently". The Tribunal, in a passage which is relied upon on behalf of the Appellant, went on to say:

> "*Consequently, the Tribunal is not persuaded, currently, that the risk of repetition of similar conduct is sufficiently low as to enable it to conclude that Dr Ranga has remediated the concerns to which her conduct has given rise.*"

and, the Tribunal "is in no doubt" that a finding of impairment was necessary.

25. On consideration of sanction, submissions were made on behalf of Dr Ranga highlighting the time elapsed since the events, steps taken to ensure that her Aesthetic Practice was safe and of high quality, and the undertaking of relevant Continuing Professional Development. The Tribunal highlighted the support measures that had been put in place concerning both physical and mental health: Dr Ranga had prayed in aid a very difficult period around 2017 when she had had family pressures, some significant personal illness and a difficult time.

26. Ms Tanchel relied before the Tribunal upon a number of mitigating factors which included she said the doctor's understanding of the problem, her insight and attempts to address the issue including admission of certain facts. Her submission had been that the suspension of her registration for 12 months was an appropriate and proportionate sanction. She reminded the Tribunal that it was important that

competent professionals were not prevented from practice (by reference to the case of *GMC v Giele* [2005] EWHC 2143).

27. The Tribunal, however, concluded in clear terms the only appropriate sanction was erasure from the Register.

28. They said when finding misconduct that the approach to a doctor's misconduct in *CHRE v NMC & Paula Grant* [2011] EWHC 927 (Admin) was relevant. They said the following:

> "*105. The Tribunal had regard to paragraph 76 of the judgment in the case of CHRE v NMC & Paula Grant [2011] EWHC 927 (Admin), in which Mrs Justice Cox set out the helpful and comprehensive approach of Dame Janet Smith in her 5th Shipman Report to determining issues of impairment. At paragraph 25.67 of the Shipman Report, she identified the following as an appropriate test for panels considering impairment of a doctor's fitness to practise.*
>
> *'Do our findings of fact in respect of the doctor's misconduct…show that his/her fitness to practise is impaired in the sense that s/he:*
>
> *a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> *d. has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*
>
> "*106. In the present case, the Tribunal considered that limbs (b), (c) and (d) were engaged.*"

In other words, they had found the medical profession had been brought into disrepute, that fundamental tenets of the profession had been breached, and she had acted dishonestly.

GROUNDS OF APPEAL

29. Dr Ranga expresses her complaints in her appeal grounds in the following manner:

(i) The Tribunal did not find that her conduct was irremediable. In saying:

> "*…the Tribunal is not confident that she has yet addressed the implications of her misconduct sufficiently. Consequently the Tribunal is not persuaded, currently, that the risk of repetition of similar conduct is sufficiently low so as to enable it to conclude that Dr Ranga has remediated the concerns to which her misconduct has given rise.*"

she submits that the Tribunal implicitly accepted that she did have some insight and that her conduct was not irremediable.

(ii) Insufficient regard was had to the mitigation including, the passage of time, competent working since the incident, admission of certain allegations against her.

(iii) There was a double counting of aggravating factors because the Tribunal improperly considered facts found against Dr Ranga as aggravating the conduct itself.

(iv) The risk of repetition was improperly approached and too low a standard was applied which misunderstood the sanctions guidance.

(v) It was an error to classify Patient C as "vulnerable" and the consequences for Patient C were wrongly over emphasised and it was improper to ask a question of her regarding the reputation of the profession, (as was done in the course of the hearing).

30. I shall turn to the thrust of the oral submissions made after setting out the framework for this appeal.

LEGAL FRAMEWORK

31. I am content that the law as set out on behalf of Dr Ranga and not disputed by Mr Mant is correct.

32. It is well established that section 40 of the Medical Act 1983 gives a doctor a right to appeal including as to sanctions and the appeal takes effect pursuant to Part 52 of the CPR 52.11 where under (3) the Appeal Court will allow an appeal where the decision of the lower court was (a) wrong or (b) unjust because of a serious procedure or other irregularity in the proceedings in the lower court.

33. Most recently Nicola Davies LJ in *Sastry and Okpara v GMC* [2021] EWCA 623 set out the following with particular reference to appeals against sanction:

> "*102. Derived from Ghosh are the follow points as to the nature and extent of the Section 40 appeal and the approach of the appellate court:*
>
> *(i) an unqualified statutory right of appeal by medical practitioners pursuant to Section 40 of the 1983 Act;*
>
> *(ii) the jurisdiction of the court is appellate, not supervisory;*
>
> *(iii) the appeal is by way of a re-hearing in which the court is fully entitled to substitute its own decision for that of the tribunal;*
>
> *(iv) the appellate court will not defer to the judgement of the tribunal more than is warranted by the circumstances;*

> *(v) the appellate court must decide whether the sanction imposed was appropriate and necessary in the public interest or was excessive and disproportionate;*
>
> *(vi) in the latter event the appellate court should substitute some other penalty or remit the case to the tribunal for reconsideration.*"

34. It is of course also the case that the Tribunal has an advantage because it has a better opportunity to judge credibility and the reliability of oral evidence given by witnesses and the Court exercises a judgement, but a secondary one, as to the application of the principles to the facts of the case. (See *Gupta v GMC* [2002] 1 WLR 1691 and *Raschid Fatnani v GMC* [2007] EWCA Civ 46 [2007] 1 WLR 1460.) It has been well recognised and relatively recently (in *GMC v Jagjivan* [2017] EWHC 1247 (Admin) [2017] 1 WLR 4438) that in matters of dishonesty and sexual misconduct for example, the Court is able more easily to assess what is needed to protect the public or maintain the reputation of the profession than in those cases where clinical competence is called into question and the expertise of the Tribunal may play a more significant role. Accordingly, and as explored in *Bawa-Garba v GMC* [2018] EWCA Civ 1879 [2019] 1 WLR1929, a decision on sanction is a multi-factorial, evaluative decision depending on a number of factors and is a mixed question of fact and law and the Court's deference will depend upon the extent to which the Court is at a disadvantage by comparison with the Tribunal. Where the Tribunal makes an error of principle in carrying out its evaluation or its conclusion is outside the bounds of what it could reasonably decide, then the Court will interfere.

35. The case of *Sawati v General Medical Council* [2022] EWHC 283 (Admin) and the cases there cited show the Court must be astute to not penalise a practitioner for having denied dishonesty by enhancing sanctions for that reason. In this case Ms Tanchel did not seek to suggest the Tribunal had exposed Dr Ranga to this type of "double jeopardy".

36. It should be noted there was no serious dispute as to the applicable principles or the effect of the case law.

THE ARGUMENTS OF DR RANGA

37. Ms Tanchel submitted the Tribunal had not dealt appropriately with the misconduct because it was wrong to regard the dishonesty as persistent. Further, since mitigating personal features were present it ought not to have found pursuance through time. In any event she had made important admissions by the time of the GMC case – admissions at this point were usual. Nothing adverse should have been drawn from the fact that the admissions were not immediate. She emphasised there had been no further instances of dishonesty since those of the subject of the allegations – and that was relevant, not just in clinical cases.

38. She submitted there were grades of dishonesty, and this was not the worst and in effect the Tribunal were accepting that, with time, Dr Ranga could remediate: this therefore was not an erasure case. She highlighted that nowhere did the Tribunal say these faults were irremediable and so they ought not to have ordered erasure.

39. Her case was the Tribunal had not adequately explained the sanction of erasure – absent a finding of irremediability, or reasoning to support such a conclusion, the sanction cold not stand.

40. Before me Ms Tanchel expressly made no challenge to the finding that the Tribunal had found Dr Ranga's evidence unsatisfactory or that it was relevant to their assessment of the current position.

41. Ms Tanchel presented her arguments against the Sanctions Guidance promulgated by the GMC, submitting that the Tribunal had failed to follow it and were for that reason at fault. She referred to paragraphs [31]-[33] which explain remediation, explain the fact that there are cases where failings are irremediable, and exhort the Tribunal to explain why, despite steps taken, they may feel certain action is justified.

42. Similarly, by reference to paragraph [93] she observed that the Guidance states that suspension may be appropriate where there has been acknowledgment of fault and steps to mitigate had been taken. It was not applied in this case, and should have been.

43. The use of Patient C's evidence and her characterisation as "vulnerable" was a significant flaw, in Ms Tanchel's submission. Vulnerability is defined – and mere inexperience did not come within the definition. This factor tilted the balance improperly against Dr Ranga in terms of the erasure decision she argued.

44. Patient C had been asked by the Lay Member what her view of the medical profession now was – if that was taken into account, it was improper. Another error was failure to note that "significant risk of repetition" was a reason in the guidance for imposing erasure. That phrase had not been used – merely "risk".

45. In summary, in a very detailed critique of the language used by the Tribunal in certain places in the Determination, Ms Tanchel sought to say that when it did not match precisely the wording of the Sanctions Guidance, errors of principle could be found: the Tribunal she said had departed from it, without giving of reasons for so doing.

46. She emphasised the submission that not every dishonest doctor should be erased and the Tribunal did not explain why the behaviour of Dr Ranga was incompatible with being on the Register. She, however, accepted that erasure was possible, her submission being that on these facts it was disproportionate: and asked forensically, why was Dr Ranga given no further opportunity to remediate?

CONSIDERATION

47. Mr Mant who appears for the GMC before me has emphasised, as did GMC counsel before the Tribunal, the varied nature of the dishonesty found against Dr Ranga. The first was in an academic context, partly admitted at an early point but partly concealed although later admitted. The second cluster of problems involved dishonesty in communicating with another professional and concomitant breaches of the obligation of confidentiality to a patient. The Tribunal further could not accept Dr Ranga's word concerning documentation and the apparent loss of various notes and/or photographs describing the difficulty in these terms:

> "*46. The Tribunal was also concerned with a number of aspects of the evidence offered by Dr Ranga which did not bear directly on what happened during this consultation, but which caused the Tribunal to have serious reservations about the oral evidence which she gave. Dr Ranga told the Tribunal that her documentation relating to the Consultation had been in paper form and had gone missing as a result of an office move. Then, she described how the document folders had simply fallen over and been muddled in the four locked filing cabinets when they were moved from one office to another. Subsequently, she appeared to suggest in answers to questions from the Tribunal that the paper documentation had infact been preserved in digital form. This was, when pressed about the fact that she had written to Dr D's solicitor, Ms E, on 12 March 2019 in relation to Patient C, she had stated that: 'on her medical form she had barely filled out her details which is a shame.' The phraseology used in that email suggested that Dr Ranga was consulting a document.*
>
> "*47. In the same email, Dr Ranga had written 'I am unable to find the photos as yet'. Her oral evidence to the Tribunal was that no photographs had been taken and that was an oversight.*"

48. The Tribunal also recorded that Dr Ranga asserted in the course of the hearing she had been threatened by Patient C. However, when the matter was explored there was nothing in the telephone call which she claimed to have received that linked her to Patient C: the caller was male. Further, there was no evidence from Patient C or otherwise there had been any threatening telephone call.

49. The Tribunal also noted that Dr Ranga said she had given corrective treatment to hundreds of patients at her clinic who had received lip fillers. She said she had not charged any of them and that each consultation had lasted up to three quarters of an hour. When asked about the number of patients, she said 110 from memory: the Tribunal, having seen this witness, felt unable to accept what she said.

50. Nonetheless, and expressly, the Tribunal put to one side matters about records, photographs and phone calls. They noted, separately, that the evidence of Patient C was consistent with the contemporaneous documentation and, was in and of itself plausible.

The Tribunal's approach to Dr Ranga's insight

51. With respect to the first challenge made, the assumption underlying the ground of appeal appears to be that erasure is only proportionate and appropriate in those cases where there is no chance of remediation at all. In other words it is inconsistent with acknowledging some change from the date of the relevant defalcations for an erasure sanction to be imposed. In my judgement this is a false analysis: it is not the law that only where a practitioner has absolutely no insight at all, that erasure may be necessary. This is particularly so in a case involving dishonesty, particularly a case such as the present involving several occasions of dishonesty in different contexts. The Tribunal did not find the risk of repetition was either non-existent or so small as to be acceptable. In other words, even though steps had been taken towards remediation they were inadequate to support a conclusion that the public interest

could be protected by any lesser sanction. As Mr Mant submitted, remediation may be of less relevance in a non-clinical case where aspects of a practitioner's character are central to the allegations, such as in dishonesty cases.

52. Thus it is important to take into account the unavoidable fact that dishonesty is difficult to remediate in any event. In *Nkomo v General Medical Council* [2019] EWHC 2625 (Admin) at [35] Julian Knowles J said:

> "*The starting point is that dishonesty by a doctor is almost always extremely serious. There are numerous cases which emphasise the importance of honesty and integrity in the medical profession and they establish a number of general principles. Findings of dishonesty lie at the top end of the spectrum of gravity of misconduct [the Judge cited from Theodoropolous]. Where dishonest conduct combined with a lack of insight, is persistent, or covered up nothing short of erasure is likely to be appropriate: Naheed v General Medical Council [2011] EWHC 702 (Admin) [22]. The sanction of erasure will often be proper even in cases of one-off dishonesty: [Nicholas-Pillai]…misconduct involving personal integrity that impacts on the reputation of the profession is harder to remediate than poor clinical performance: Yeong v General Medical Council [2009] EWHC 1923 and GMC v Patel [2018] EWHC 171 (Admin) at [64]…*"

53. The citation from Sir Thomas Bingham MR in *Bolton v The Law Society* [1994] 1 WLR 512 was expressly applied to the medical profession in *Patel v General Medical Council* [2003] UKPC 16. That authority indicates that the nature of professional regulation is such that ordinary mitigation of punishment has less effect upon the exercise of applying a sanction than in criminal cases. It also diminishes the relevance of a professional's ability to show they had learned their lesson and will not do it again.

54. For these reasons there is no appealable point in the Tribunal's recognition that there was some insight by Dr Ranga, but nonetheless that the application of erasure was appropriate.

55. It cannot be avoided that given the multiple cases of dishonesty, erasure was a likely sanction if the facts and their character were either admitted or proved. The aim of imposing the sanction here was maintenance of public confidence and of conduct and standards within the profession. The risk of repetition was not the main thrust of the Tribunal's thinking, as it stated:

> "*111. Dishonesty is generally regarded as more difficult to remediate than failures in clinical practice. The Tribunal is concerned with a number of instances of dishonesty. It considered the evidence Dr Ranga offered in relation to the Consultation of 23 February 2018 to be implausible. Further, the Tribunal has noted the deficiencies in Dr Ranga's reflective statement in relation to the breach of confidentiality in 2019 and record keeping. In these circumstances, the Tribunal is not confident that she has yet addressed the implications of her misconduct sufficient. Consequently, the Tribunal is not persuaded, currently, that the risk of repetition of similar conduct is sufficiently low as to enable it to conclude that Dr*

Ranga has remediated the concerns to which her misconduct has given rise.

"*112. The Tribunal is required to consider whether a finding of impairment is necessary on grounds of public interest in any event. The Tribunal is in no doubt that such a finding is required. A reasonable and fully informed member of the public would be very disturbed to learn that a finding of impaired fitness to practise had not followed upon the factual findings which the Tribunal has made. Such a finding is required to promote and maintain public confidence in the medical profession and to promote and maintain proper professional standard and conduct for members of that profession.*"

The Tribunal's approach to mitigating factors

56. Express regard was had to mitigation involving the health and personal circumstances of Dr Ranga at the time of the plagiarism offences. There was no assistance for Dr Ranga in the fact that she had in effect, covered up the plagiarism of the second essay which she had bought from a website, by lying about its provenance. This was not a clinical error where further practice and/or teaching would likely show Dr Ranga the correct method of practice. The nature of the behaviours in issue went more to character than to learning. For these reasons, the mitigating feature of the passage of time is in my judgement is of less relevance in a case where the Tribunal has concluded the practitioner has not found the reflective statement and other materials without difficulty. The Tribunal found in terms it was not confident that Dr Ranga had yet addressed the implications of her misconduct sufficiently. It was that that fed into the risk of repetition which they held to be unacceptable. There is no requirement for the Tribunal to parrot the words of the Guidance: in my judgement it is quite clear they believed the risk to be significant.

57. In assessing gravity what the Tribunal did was analyse the activities themselves and the manner in which Dr Ranga dealt with the facts. They noted that she had repeated her plagiarism, that she did not admit it at the first available opportunity but it was as late as 26 May 2019 (well over a year after the submission of the work) that she still maintained the Research Essay was her own work. They emphasised the occasions upon which Dr Ranga chose a particular course of action, namely communication with Dr D and communication with Ms E, his lawyer, although knowing Patient C had a complaint and, later that she was involved in litigation. The Tribunal concluded that the nature of the conduct itself was such that erasure was the only available sanction. These matters characterised the dishonesty as very serious. Further, the Tribunal determined that it was conduct of a nature that was fundamentally incompatible with continued registration. They concluded that the paragraphs of the sanctions guidance which applied in this case included [109]:-

"*(a) a particularly serious departure from the principles in GMP and where the behaviour is fundamentally incompatible with being a doctor;*

(b) deliberate or reckless disregard for those principles;

(c) doing serious harm to others – accepted in the case of Patient C;

(d) abuse of a position of trust;

(e) violation of a patient's rights

…

(h) dishonesty where persistent and/or covered up;

(i) putting the doctor's own interests before those of the patients;

(j) persistent lack of insight into the seriousness of their actions or the consequences."

58. The Tribunal expressly found those paragraphs to be engaged. They characterised her behaviour as repeated and persistent dishonesty and the departures from principles as being breaches of the fundamental tenets of the profession and incompatible with continued registration. For these reasons evidence of Dr Ranga's clinical competence was of less relevance and "does not mitigate the impact of her serious and persistent dishonesty" [see paragraph 156 of the Determination].

Misapplication of the sanctions guidance

59. It is argued that there was a misapplication of the Sanctions Guidance, in that they did not find expressly that there was a significant risk of repetition so as to disapply the presumption that a suspension was appropriate, and by saying that they were not confident that the misconduct would not be repeated they have demonstrated an error. I do not accept that the manner in which the Tribunal dealt with the risk of repetition (which I have canvassed above) is appealably wrong. In my judgement, on the facts found, and given the character of repetition and continued denial of dishonesty, it was practically speaking almost inevitable that the Tribunal would apply the sanction of erasure. I fully accept, as case law shows, it is not every case of dishonesty that attracts this sanction. I also accept, as cases show, that this Court will feel more able to intervene on a sanctions appeal where the issue is dishonesty, as opposed to those cases which depend upon knowledge of clinical matters. The phraseology of the Tribunal is no more in my judgement than an attempt to encapsulate the Tribunal's dissatisfaction on matters of insight and actual remediation. The decision is run through with their inability to rely upon the word of Dr Ranga and the concern that these failures (effectively of character rather than competence), have not been fully gripped and remediated. That is not a conclusion that is wrong nor arguably so in my judgement. In those circumstances the suggestion that there has been a misapplication of the Sanctions Guidance must fail.

The vulnerabilities of Patient C and the impact upon her

60. The Tribunal's use of the word 'vulnerable' is qualified in the findings in the following way:

[In paragraph 137] when listing the factors which the Tribunal took into account they say:

"*Dr Ranga breached Patient C's right to confidentiality. Patient C contacted Dr Ranga for advice and guidance, from the outset, when she*

> *was unfamiliar with the aesthetic industry. In this context, Patient C was vulnerable.*"

61. No exception can be taken to the use of this word. It was not purporting to categorize Patient C as technically vulnerable in the legal sense. Patient C's evidence was that she had been very upset and her confidence had been shattered by Dr D's treatment of her. She communicated this to Dr Ranga and also communicated her lack of knowledge – and also the fact she was somewhat overawed by Dr D's profile. These characteristics would have indicated to Dr Ranga that Patient C was a distressed and a dissatisfied patient without previous knowledge of this branch of medicine. In my judgement the Tribunal do no more than encapsulate that notion, in the use of the word "vulnerable".

62. Connected to the complaint about this characterization of Patient C, is the Tribunal concerning itself with Patient C's views on the impact of Dr Ranga's behaviour on the reputation of the profession. The Tribunal were aware that Dr Ranga believed such material was irrelevant and they do not make express reference to Patient C in respect of the public interest and upholding the reputation of the profession.

63. The Tribunal cited directly from Good Medical Practice including those parts requiring honesty, trustworthiness and the duty to act with integrity. They found that the public and members of the medical profession would find Dr Ranga's behaviour unacceptable (paragraph [101]), and in [112] held that:

> "*A reasonable and fully informed member of the public would be very disturbed to learn that a finding of impaired fitness to practice had not followed upon the factual findings upon which the Tribunal has made. Such a finding is required to promote and maintain public confidence in the medical profession.*"

and then, at the sanction stage they found:

> "*...that her repeated and persistent dishonesty, her departures from the principles set out in GMP and her breaches of the fundamental tenets of the profession were incompatible with Dr Ranga's continued registration.*" [Paragraph 155]

64. The Tribunal expressly considered her clinical competence which did not mitigate the impact of her serious and persistent dishonesty.

65. All in all, it is the seriousness and the persistence that characterized the behaviour which in my judgement made erasure inevitable. Sadly this was not just one incident of not telling the truth. There was evidence also of cover up and of dishonesty in different contexts. That has real resonance when examining the seriousness and the ultimate remediability of the harms done.

66. Ms Tanchel advanced her careful submissions with clarity, but I can find no reason to interfere with the sanction findings made by the Tribunal. As Mr Mant submitted, the Tribunal reached a clear evaluation that Dr Ranga's behaviour was incompatible with registration. Certainly this Court may be better placed in a non-clinical case, but a

Tribunal is nonetheless better placed to assess a witness before them and evaluate issues such as insight.

67. Furthermore, the issue of insight is necessarily less relevant where a finding has been made that the behaviour of the professional is incompatible with registration on grounds of public interest. Likewise, the observations of Sir Thomas Bingham MR in *Bolton v Law Society* [1994] 1 WLR 512 applied in *GMC v Patel* [2018] EWHC 171 (Admin) and elsewhere reflect the fact that professional regulation differs from the criminal jurisdiction. Matters of personal mitigation are given less weight when the reputation of the profession, as here, is at stake. Similarly, questions about the risk of repetition (see *Nkomo v GMC* [2019] EWHC 2625 (Admin) at [35]).

68. Whether approached on the basis of a misapplication of the Sanctions Guidance or a failure properly to reason their conclusions, Ms Tanchel's well-crafted submissions must fail.

69. It should be noted that it is not a precondition of erasure that a practitioner had no insight; nor that since the events, there have been further incidents. The evaluative task of the Tribunal is more subtle than that, albeit guided by the Sanctions Guidance.

70. In my judgement there was no error at all in the Tribunal's approach to Patient C and her evidence: in any event the Tribunal made clear findings on their own views of the granting of what were reasonably described as persistent episodes of dishonesty and their characterisation as inconsistent with remaining on the Register.

71. Given the number of events of dishonesty, the different contexts in which they arose, the concealment of the truth about the second essay for a considerable time and doubts about insight, erasure was not disproportionate or otherwise appealably wrong.

72. For all these reasons this decision is unappealable and the challenge to the outcome must fail.