1 CROWN OFFICE ROW

The End, the Beginning of the End or the End of the Beginning:

Erasure, Remediation & Rights of Appeal in Disciplinary Proceedings

2018

Programme

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When is striking off justified?

"*The end of all things is at hand.*"[1]

William Edis QC

1. Erasure is of course the ultimate sanction available to healthcare Regulators. Additionally, all approach sanction in a vertical fashion, in other words they start with the least onerous sanction and proceed upwards to the next one only if that particular sanction is deemed insufficient to meet the mixed portfolio of considerations to which they have to have regard.

2. The purpose of this short talk is to describe the statutory power to remove a doctor's or dentist's name from the Register, to give some statistics as to that power in operation and to give some short recent examples of the power in action.

The Power

3. For doctors this is contained in s 35D of the Medical Act 1983[2], for dentists it is s. 27 of the Dentists Act 1984.

4. So as to promote consistency of approach and decision making both the MPTS and the GDC have issued guidance to their relevant panels.

5. The Sanctions Guidance of the MPTS[3] has this to say about erasure:

> *"Erase the doctor's name from the medical register*
>
> *107. The tribunal may erase a doctor from the medical register in any case – except one that relates solely to the doctor's health and/or knowledge of English – where this is the only means of protecting the public.*
>
> *108. Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if the doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor.*
>
> *109. Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).*

[1] 1 Peter Ch 4, v 8

[2] The power is to be exercised if the panel *"think* [it] *fit"* to do so

[3] February 2018 edition

a) *A particularly serious departure from the principles set out in **Good Medical Practice** where the behaviour is fundamentally incompatible with being a doctor.*

b) *A deliberate or reckless disregard for the principles set out in **Good Medical Practice** and/or patient safety.*

c) *Doing serious harm to others [patients or otherwise], either deliberately or through incompetence and particularly where there is a continuing risk to patience (see further guidance below at paragraphs 129-132 regarding failure to provide an acceptable level of treatment or care).*

d) *Abuse of position/trust…*

e) *Violate of a patient's rights/exploiting vulnerable people…*

f) *Offences of a sexual nature, including involvement in child sex abuse materials…*

g) *Offences involving violence.*

h) *Dishonesty, especially where persistent or covered up…*

i) *Putting their own interest before those of their patients…*

j) *Persistent lack of insight into the seriousness of their actions or the consequences."*

6. For its part, the GDC[4] says this:

"Erasure

7.30 The ability to erase exists because certain behaviours are so damaging to a registrant's fitness to practise and to public confidence in the dental profession that removal of their professional status is the only appropriate outcome. Erasure is the most severe sanction that can be applied by the PCC and should be used only where there is no other means of protecting the public and/or maintaining confidence in the profession. Erasure from the register is not intended to last for a particular or specified term of time. However, a registrant may apply for restoration only after the expiry of five years from the date of erasure.

[4] Guidance for Practice Committees Including Indicative Sanctions Guidance, effective 1 October 2016

7.31 A practice committee may not erase a registrant whose fitness to practise has been found to be impaired solely on health grounds.

7.32 The PCC is obliged to consider sanctions in increasing order of severity. Therefore, before considering erasure the PCC must have considered all the preceding sanctions before determining that the decision to erase the registrant is proportionate.

7.33 An order for erasure takes effect 28 days from the date the notification of the decision is served on the registrant (there is a statutory appeal period of 28 days). The PCC should therefore consider whether it is necessary, in order to protect patients and members of the public, to impose an immediate suspension in addition to the substantive order…

7.34 Erasure will be appropriate when the behaviour is fundamentally incompatible with being a dental professional: any of the following factors, or a combination of them, may point to such a conclusion:

- *serious departure(s) from the relevant professional standards;*
- *where serious harm to patients or other persons has occurred, either deliberately or through incompetence;*
- *where a continuing risk of serious harm to patients or other persons is identified;*
- *the abuse of a position of trust or violation of the rights of patients, particularly if involving vulnerable persons;*
- *convictions or findings of a sexual nature, including involvement in any form of child pornography;*
- *serious dishonesty, particularly where persistent or covered up;*
- *a persistent lack of insight into the seriousness of actions or their consequences."*

7. By way of comparison, the Royal College of Veterinary Surgeons' "Disciplinary Procedure Guidance"[5] says as follows:

"Removal from the Register

1. *Removal from the register may be directed where the respondent veterinary surgeon's behaviour is so serious that removal of professional status (and the rights and privileges accorded to this status) is the only means of protecting animals and the wider public interest. Removal is imposed in order to protect animals and the wider public interest. It is not imposed as a punitive measure, although it will almost*

[5] September 2013, available on the RCVS's website

invariably adversely affect the respondent veterinary surgeon.[26]

2. *The Privy Council has stated that a disciplinary committee should not feel bound to remove from the register:*

> *'An otherwise competent and useful [practitioner] who presents no danger to the public in order to satisfy [public] demand for blame and punishment.'*[27]

Equally, the reputation of the profession is more important than the interests of one veterinary surgeon and Lord Bingham, Master of the Rolls stated:

> *'The reputation of the profession is more important than the fortunes of an individual member. Membership brings many benefits, but that is a part of the price.'*[28]

3. *Proven dishonesty has been held to come at the 'top end' of the spectrum of gravity of disgraceful conduct in a professional respect. In such cases, the gravity of the matter may flow from the possible consequences of the dishonesty as well as the dishonesty itself.*[29] *The Privy Council has, in a case involving dishonesty, provided guidance on the distinction between removal and suspension from the register.*[30] *(See also paragraph 47)*

4. *Removal from the register may be appropriate where behaviour is fundamentally incompatible with being a veterinary surgeon, and may involve any of the following (the list is not exhaustive):*

    a. *Serious departure from professional standards as set out in the RCVS Code of Professional Conduct for Veterinary Surgeons;*
    b. *Causing serious harm (or causing a risk of serious harm) to animals or the public, particularly where there is a breach of trust;*
    c. *Offences of a sexual nature;*
    d. *Offences involving violence and/or loss of human life;*
    e. *Evidence of a harmful deep-seated personality or attitude problem;*
    f. *Dishonesty (including false certification), particularly where persistent or concealed."*

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[25] *See CHRE v GDC and* ***Fleischman*** *[2005] EWHC 87 (Admin)*

[26] *See* ***Bolton*** *v Law Society [1995] 1 WLR*

[27] *See Dr Willem* ***Bilj*** *v GMC PC 78 2000*

[28] *See Dr Prabha* ***Gupta*** *v GMC PC 44 2001*

8. At greater or lesser length, therefore, these Regulators identify key types of misconduct, and they are broadly similar, where erasure will at the very least be reasonably possible. The preparation and advice given to the member, in particular for example as to the desirability of making admissions and showing insight, will in part depend upon the ability to recognise whether the particular case is one where striking-off may be "on the cards", see the statistical analysis that follows.

9. It is sometimes thought that strike-off in a clinical, where remediation is either possible or has taken place, is wrong in principle. The sanctions guidance, however, does not support this view. It says:

> *126. However, there are some cases where a doctor's failings are irremediable. This is because they are so serious or persistent that, despite steps subsequently taken, action is needed to maintain public confidence. This might include where a doctor knew, or ought to have known, they were causing harm to a patient and should have taken steps earlier to prevent this."*

10. Obviously the most important recent case on sanction for clinical errors is *Bawa-Garba*, about which my colleague Jeremy Hyam QC will be speaking.

<u>Some Statistics</u>

11. Aside from the black letter of the sanctions guidance it is helpful to have a statistical snapshot of cases where a Regulator has imposed either erasure or suspension.

12. In October 2018 the GMC published an *"Analysis of cases resulting in doctors being erased or suspended from the medical register"*[6]. This was research into cases heard in 2014 and its key findings were that in that year:

    - 157 doctors were either suspended or erased[7]
    - 119 cases fitted the inclusion criteria;
    - 16 of those cases were categorised as cases involving misconduct in the doctors "personal life". This was split into "sexual issues" (9 cases), drink driving (3), violence 3) and dishonesty (3)
    - The balance (103 cases) involved misconduct in the doctor's professional life and were categorised in the following ways

[6] Available at https://www.gmc-uk.org/-/media/documents/Analysis_of_cases_resulting_in_doctors_being_suspended_or_erased_from_the_medical_register_FINAL_REPORT_Oct_2015.pdf_63534317.pdf

[7] This figure excludes order of the Interim Orders Panel (as was)

- Clinical issues (19 cases)
- Dishonesty (48 cases)[8]
- "Inappropriate relations" (24 cases)[9]
- "Breaking other professional standards (4 cases)

13. Further analysis showed that:

- In only "just over half" of the cases did the doctor attend the hearing
- In "just under half" of the cases was the doctor represented
- Cases involving the doctor's personal life contained a high proportion of conviction cases (6 out of 16)
- Erasure was more common in "personal life" rather than "professional life" cases. 10 out of the 16 personal life cases resulted in erasure (6 therefore in suspension) whilst the figures for professional life cases were: erasure 49; suspension 54
- Sexual misconduct in a doctor's personal life was highly likely (7 out of 9 cases) to result in erasure[10]
- Cases of dishonesty were massively likely to result in either suspension or erasure though in the "vast majority" of cases there was no evidence of patient harm
- In only 10% of cases did the panel find that there was evidence of remediation and insight
- In around half of the cases which resulted in a final outcome of suspension (31 out of 60), the doctor was present at the hearing, represented at the hearing and admitted to some or all of the allegations made. Conversely, in around half of the cases (30 out of 59) that resulted in a final outcome of erasure the doctor was not present at the hearing, not represented at the hearing and did not admit to any of the allegations made.

14. Some broad, and frankly not very surprising, conclusions may be drawn:

- Representation at a hearing is worthwhile
- Attendance at a hearing is verging on the mandatory if erasure is to be avoided[11]

[8] Split into 27 "in the role as a doctor" and 21 "in order to obtain/keep employment as a doctor"

[9] Split into 5 "with colleagues" and 19 with patients. Most but not all of these cases involved a sexual element. Those that did not included cases of ignoring boundaries (by for instance becoming a patient's *de facto* carer and using inappropriate (but not sexual) language.

[10] This is of course against the background of the need to show "misconduct" and "impairment". Mere adultery would obviously not suffice

[11] Doctors who were represented were more likely to be suspended than erased (in 41 of the 57 cases where the doctor was represented, they were suspended); whilst those not represented were more likely to be erased (in 43 out of the 62 cases where the doctor was not represented, they were erased)

- Dishonesty and sexual impropriety had the highest ratio of erasure to suspension
- Admissions and insight (as well, where appropriate, remediation) had a significant effect (at least insofar as conclusions can be drawn) upon the decision as to erasure *v* suspension[12]
- Dishonesty was the most likely conduct to lead to erasure or suspension.

Some Recent Cases

15. All cases are fact-specific but certain trends or inclinations can be noted from a study of s 40 appeals. With the caveat that no such case is binding on another court, some recent cases are worth noting.

16. In *Alghofari v GDC* [2018] EWHC 2412 (Admin) the registrant had put a false visa document into his father-in-law's passport purporting to show something that was not true, *viz* that the father-in-law had the right to reside in the UK. He had been caught, convicted by a French criminal court and fined. He did not tell the GDC about this conviction. Dismissing the appeal, HH Judge Belcher (sitting as a judge of the QBD) held that it was *"self-evident"* that the public would be discomfited and shocked if such a conspicuously dishonest dentist were allowed to remain on the register.

17. In *Abbas Neima Khalaf v GMC* [2018] EWHC 1466 (Admin) the QBD upheld erasure of a doctor who had failed to disclose to a potential employer that he was in fact under investigation[13].

18. In *GMC v Robert Stone* [2017] EWHC 2534 (Admin)[14] the QBD ordered the erasure of a doctor who had formed a consensual sexual relationship with a vulnerable patient and had, as had been found, been dishonest in writing a letter *qua* doctor in support of her benefits claim without disclosing that he was indeed in a sexual relationship with her.

19. In *GMC v Maher Khetyar* [2018] EWHC 813 (Admin)[15] the QBD ordered the erasure of a doctor who had sexually harassed a colleague and committed two sexual assaults on patients under the guise of appropriate clinical examinations.

20. In *Fopma v GMC* [2018] EWHC 714 (Admin) the doctor had been convicted of a sexual offence in the Netherlands but had appealed. Whilst the appeal was pending he applied for entry on to the GMC's specialist register. At the time there was no specific duty to disclose convictions. No action had ever been taken on the appellant's registration in the Netherlands. Erasure upheld.

[12] But it has become widely recognised that in some types of case, e.g. dishonesty, remediation is less important and, anyway, more difficult to show

[13] Note: the doctor did not attend and was not represented, never an auspicious sign.

[14] A GMC appeal against an unduly lenient sanction

[15] Another GMC appeal

21. In *Arunachalam v GMC* [2018] EWHC 758 (Admin) the doctor was guilty of "sexting" one colleague and sexually harassing another. Decision to erase overturned and replaced with a 12 month suspension.

22. Compare this last decision with *Mohammed Yasin v GMC* [2018] EWHC 677 (Admin) where a doctor was erased for sexually assaulting two female colleagues in the space of two hours but had an otherwise long and clean career.

23. *GMC v Somuah-Boateng* [2017] EWHC 3565 (Admin) was a case where the doctor had entered into a consensual sexual relationship with a patient in the apparent belief that it would be therapeutically beneficial. Erasure ordered on a GMC appeal.

24. In *Irvine v GMC* [2017] EWHC 2038 (Admin) the appellant had knowingly and dishonestly carried out private practice for 5 years without indemnity insurance. Erasure upheld.

25. In *GMC v Theodoropoulos* Lewis J made some important observations about honesty, especially in the job application process. The doctor had got access to and dishonestly changed his certificate of medical registration to show that he was more qualified than in fact he was. He had used the dishonest certificate to apply for a post as a locum. The MPT suspended him. On a GMC appeal, with the doctor not attending, the court substituted erasure. Having helpfully reviewed the authorities showing how fundamental honesty was to proper medical practice, Lewis J said this:

    "45. The Tribunal referred to two others matters. It said that the conduct did not take place in a clinical setting. That is true. It did, however, involve dishonesty in relation to the qualification system for doctors and in dishonestly seeking to obtain employment, when not eligible, for appointment as a doctor. Such conduct would undermine the trust the public places in doctors. Misconduct does not have to occur in a clinical setting before it renders erasure, rather than suspension, the appropriate sanction. The serious dishonesty here is of the sort that, as a matter of principle, and having regard to the case law, makes erasure not suspension the appropriate sanction.

    46. The Tribunal also referred to the fact that the incident was an isolated incident. Again, it is correct that there was only one attempt to obtain employment using a falsely amended certificate. That, however, does not accurately take into account the nature of what occurred. The dishonesty required forethought and planning. It involved accessing the website (legitimately) but then amending the entry, printing it out and sending it off to a locum agency intending them to act upon the falsified certificate. It involved a calculated and deliberate attempt to circumvent the regulatory system and obtain employment as a medical practitioner when not eligible to do so. It is not correct to treat that as an isolated incident of the sort justifying imposing a sanction of suspension rather than erasure".

26. This brief review of some recent cases[16] shows a number of things:

    a. A hardening of the attitudes of the Court on defending fundamental tenets of good practice;
    b. A preparedness, indeed a readiness, to intervene on GMC appeals;
    c. Something close to a zero tolerance approach to certain types of offending; and
    d. A strengthening of the idea that safeguarding the reputation of the profession, and public confidence in it, it a touchstone of the sanction process.

Chandra: Restoration Following Erasure

27. In *GMC v Shekhar Chandra* [2018] EWCA Civ 1898 the doctor, an SHO in psychiatry, had been struck off in 2005 for a sexual relationship with a vulnerable patient. After a considerable time (in fact in 2016) he applied to be restored. The MPT refused his application, a decision appealed to the Queen's Bench Division and, by way of a second appeal, the Court of Appeal upheld the refusal to restore. It is not without significance that this was a case of sexual misconduct with a vulnerable patient.

28. By s 41 (1) of the Medical Act 1983 the MPTS may *"if it thinks fit"* order the restoration of the name of a doctor who has been erased to the medical register. Sub-section (6) of the same provision provides as follows:

> *Before determining whether to give a direction under subsection (1) above, a Medical Practitioners' Tribunal shall require an applicant for restoration to provide such evidence as they direct as to his fitness to practise; and they shall not give such a direction if that evidence does not satisfy them.*

29. Sub-section (12) further provides that:

> *…In exercising a function under this section, a Medical Practitioners Tribunal must have regard to the over-arching objective[17].*

30. Whilst guidance has been issued on restoration applications the GMC was driven to accept before the Court of Appeal that it *is inadequate and needs extensive revision*

[16] The lack of any need for permission to launch a s 40 appeal and the internet means that there is, in the literal sense, a plethora of such appeals available for study

[17] Defined by s 1B of the Act as *"to protect, promote and maintain the health, safety and well-being of thepublic, (b) to promote and maintain public confidence in the medical profession, and (c) to promote and maintain proper professional standards and conduct for members of thatprofession."*

as a matter of urgency"[18]. Given this admission the Guidance is not dealt with further in this handout.

31. At paragraph 78 of the judgment McCombe LJ said as follows:

> *I accept the submission of Ms Grey that the 5 year minimum period before an application for restoration can be made, is not a 'tariff' after which only issues of public protection (ie remediation) are relevant; all three aspects of the over-arching objective must come into play. In my judgment remediation is essential but not, when coupled with the passage of time, the complete answer to the question the MPT has to ask itself which is: is the applicant now fit to practise having regard to the over- arching objective?*

32. Important to this decision are of course the passage of time, remediation, insight and contrition but the Court was well aware that if a doctor is restored (s)he is entitled to practice without restriction on his/her registration. The maintenance of the reputation of the profession and the regulatory system are just as powerful considerations on an application to be restored as they are at the original hearing. The famous dicta of Sir Thomas Bingham MR (as he then was) as to the paramount need to protect the reputation of the profession apply in full measure to medical cases, albeit that the applicant for restoration does not have to show "exceptional circumstances" before (s)he may be restored.

33. The correct test on an application for restoration is the same as at the original sanction stage. At paragraph 90 McCombe LJ says:

"In my judgment the MPT made an error of principle. The question is not whether the over-arching objective is 'compromised'. The Tribunal is required, by statute, to have regard to the over-arching objective which includes the pursuit, i.e. the active pursuit, of the objectives specified in s1(1B) MA 1983, and in my judgment it failed properly to do so. Read overall, the focus of the Tribunal was limited to issues of the applicant's acceptance of his wrongdoing, his insight, the risk of repetition and his competence. The MPT did not address, or address adequately, the issue of whether public confidence and professional standards would be damaged by restoring the applicant to the register, an applicant who had fundamentally fallen short of the necessary standards of probity and good conduct, by his sexual misconduct and dishonesty, albeit many years ago."

[18] Judgment paragraph 37

Appeals by the General Medical Council:

Lessons from the Court of Appeal

Jeremy Hyam QC & Robert Kellar

1. The correct approach to be applied on appeals by the General Medical Council and PSA was brought into sharp focus this year by two Court of Appeal of decisions: Bawa-Garba v. GMC [2018] EWCA Civ 1879 and Raychaudhuri v. GMC [2018] EWCA Civ 2027. In this talk we will consider the principles that are applicable in such appeals and reflect upon implications of those judgments more generally.

History and Statutory Background

2. Historically appeals from the General Medical Council by practitioners were to the Professional Conduct Committee of the Privy Council. This right of appeal was retained within the Medical Act 1983. In April 2003, jurisdiction was transferred from the Privy Council to the Administrative Court[19].

3. In 2003 Council for Regulation of Healthcare Professionals ("CRHCP") set up pursuant to National Health Service Reform and Healthcare Professions Act 2002. This was set up in the wake of a recommendation by Professor Kennedy that there should be an overarching body for the regulation of healthcare professionals. The CRHCP could make referrals to High Court where it considered that GMC or any other healthcare regulator had made a decision that was unduly lenient or was insufficient to protect the public. The CRHCP is now known as Professional Standards Authority for Health and Social Care ("the PSA").

4. In 2014 there was public consultation with by the Department of Health with a view to review of the GMC's adjudication system. The Department of Health proposed a new right of appeal for the GMC. The responses were by no means unanimous in their support of such an innovation. However, in January 2015, the Department published its consultation response and on 31 December 2015 the Medical Act 1983 was amended by statutory instrument to provide a new right of appeal for the GMC.

[19] This was effected by an amendment to the Medical Act 1983 by section 30 of National Health Service Reform and Healthcare Professions Act 2002

The Statutory Appeals

Right of Referral by the PSA

5. Pursuant to section 29 of the National Health Service Reform and Healthcare Professions Act 2002 the PSA my refer decisions by the MPTS (short of erasure) to the Administrative Court where it considers that the decision is not sufficient (whether as to finding or penalty or both) for the protection of the public[20]. Where such a reference is made the case is to be treated by the court to which it is referred as an appeal by the authority against the relevant decision[21]. The Court may dismiss the appeal, allow the appeal and quash the decision, substitute its own decision for any decision which could have been made by the MPTS or remit to the MPTS to dispose of the case in accordance with the directions of the Court[22].

Right of Appeal by the GMC

6. The GMC's right of appeal is provided for by section 40A of the Medical Act 1983. The GMC's right of appeal mirrors that which is available to the PSA. The GMC may appeal against any sanction short of erasure, including a finding that a doctor is not impaired (see below). It may do so where it considers that the decision is not sufficient (whether as to a finding or penalty or both) for the protection of the public. On an appeal the Court has the same powers as it has on reference by the PSA (see above).

Interaction Between GMC Appeals and PSA Referrals

7. Section 29A of the 2002 Act provides that where the PSA makes a reference to the High Court it must notify the GMC and the GMC may not then bring an appeal under section 40A. Section 40B of the 1983 Act provides that where the GMC brings an appeal under section 40A it must notify the PSA and the PSA may not then refer the case under section 29 of the 2002 Act. However, section 40B(2) states that the PSA may become a party to the GMC's appeal and section 40B(4) states that the matters which the PSA may raise on an appeal under section 40A include any matter which it could have raised on a reference of the case under section 29 of the 2002 Act.

[20] See section 29 (1) (c) (ca) and 2 (a)
[21] See section 29 (4)
[22] See section 29 (8)

The Williams Review: Repeal of GMC's Right of Appeal

8. On 6 February 2018, the wake of the controversy surrounding the Divisional Court's decision in ***Bawa-Garba***, the Secretary of State for Health and Social Care announced that he was asking Professor Norman Williams to conduct a rapid policy review into issues pertaining to gross negligence manslaughter in healthcare. The issues covered by the report included the proper scope of the GMC's right of appeal in regulatory proceedings[23]. The findings and recommendations contained within the Williams report included the following:

   a. That the decision to give the GMC a right of appeal has had "significant and unintended consequences". It had caused "fear and mistrust" among practitioners, impacting their ability and willingness to engage the regulator. This had deterred reflection and learning from errors to the detriment of patient safety (para. 11.16).

   b. Since the PSA had a near identical right of appeal to MPTS decisions, there would be no gap in the law where regulatory action was being taken as a result of serious criminal conviction (para. 11.17).

   c. In the interests of patient safety, the GMC's right to appeal should be removed. This would help address the mistrust of the GMC among doctors and contribute to cultivating a culture of openness that is central to delivering improved patient safety (para. 11.18).

   d. The PSA should continue to have a right of appeal to MPTS decisions that were insufficient for public protection and such decision would be made in a consistent manner for all healthcare professionals (para. 11.18).

   e. Removing the GMC's right of appeal would be dependent upon the availability of Parliamentary time. In the meantime the GMC should review its processes for deciding when to appeal a decision of the MPTS to ensure greater transparency (para. 11.19).

9. On the 11 June 2018 Jeremy Hunt (then Secretary of State for Health and Social Care) made a statement to the House of Commons[24] in which he accepted the conclusions of the Williams review in full including those relating to the removal of the GMC's right of appeal in all cases. It is not presently clear when Parliamentary time will be made available to repeal section 40A of the Medical Act 1983. Until such time as it is the GMC will continue to enjoy a statutory right of appeal.

[23] Part 11.
[24] HCWS75. A statement in identical terms was made on the same date to the House of Lords through Lord O'Shaughnessy (Parliamentary Under-Secretary of State for Health).

The Discretion to Appeal/Refer

10. Before either the GMC or PSA may invoke the jurisdiction of the High Court they must be satisfied that the decision of the MPTS is "not sufficient for the protection of the public". In considering whether a decision is sufficient for the protection of the public both the PSA and GMC must consider whether the decision of the MPTS is sufficient[25]:

    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 member of the public.

11. In *Raychaudhuri*, Mr. Justice Bean emphasised that the GMC must – at least in some circumstances – exercise considerable restraint before concluding that an appeal is appropriate. The GMC should, for example, be slow to appeal against "evaluative judgements" in respect of findings of dishonesty. He said as follows[26]:

    "Although I agree that the High Court had jurisdiction to hear this appeal by the GMC, I wish to express my regret that it was brought. It should require a very strong case for a court to overturn a finding of the MPT (or any comparable tribunal) that a doctor has *not* acted dishonestly. In the present case, as Sales LJ has observed, the MPT gave anxious consideration to whether the appellant's conduct could be regarded as dishonest. They heard the appellant, Dr De Halpert and other witnesses give evidence over several days. They were well placed to make an evaluative judgment of the nuances of how the various individuals had interacted and that judgment should have been accorded great weight, not only by the court but by the GMC in deciding whether to bring an appeal at all. The discretion given by section 40A(3) to appeal against any decision which the GMC consider not sufficient for the protection of the public is a wide one, but in my view it is a discretion to be exercised with restraint where it involves a challenge to a finding of fact in the practitioner's favour".

12. As a matter of legal theory, the decision the exercise of the discretion to appeal is a freestanding decision which would be capable of challenge on public law grounds. Indeed, the possibility of an individual practitioner doing so was ventilated in oral argument before the Court of Appeal in *Raychaudhuri*. However, in practice, it is very difficult to envisage a case in which a High Court would refuse to permit an appeal to proceed on the basis that on grounds that the discretion to appeal/refer had been exercised irrationally or unlawfully.

[25] See section 29 (4A) of the 2002 Act and section 40A (4) of the Medical Act 1983.
[26] At paragraph 74.

Limits on the Jurisdiction of the GMC to Appeal?

13. In *Racychaudhuri* an issue arose as to the limits of the GMC's jurisdiction to appeal. Could the GMC appeal where the MPTS had found that a doctor was *not* impaired and had issued a warning? It is not immediately obvious from wording section 40A of the Medical Act 1983 that it is open to the GMC to appeal in this situation. Section 40A (1) (d) of the Act permits the GMC to appeal against: "a decision not to give a direction under section 35D". However, this may be read as referring to the situation where the MPTS determines not to impose any sanction after a making finding of impairment.

14. On behalf of Dr Raychaudhuri, it was argued that section 40A should be interpreted narrowly. Section 40A makes no express reference to a right of appeal against findings of fact (at stage 1) or findings in relation to impairment (at stage 2). Nor is there any reference to the ability of the GMC to appeal decisions to issue a warning. Providing the GMC with a right to appeal "no impairment" findings, in the absence of clear statutory language, was contrary to the interpretive principle against doubtful penalisation. Moreover, in so far as there was concern about the need to correct unduly lenient impairment decisions this could addressed by a referral by the PSA under section 29: it was unnecessary to construe section 40A broadly in order as to address this mischief.

15. Furthermore, Dr. Raychauhuri argued that a narrow construction of section 40A was required by Article 6 ECHR. Doctors have no power to appeal adverse findings at the fact finding stage unless there is a finding of impairment. That applies even if the MPTS has made serious adverse findings such as findings of dishonesty or other misconduct. Nor can a doctor appeal a decision to issue a warning. If the MPTS could appeal findings of fact (without a finding of impairment) or warnings this gives rise to an inequality of arms. The ECtHR had consistently held that inequalities in respect of right of appeal may breach Article 6 ECHR[27]. Accordingly, it was necessary to 'read down' section 40A so as to avoid a breach of Article 6.

16. These arguments were rejected by the Court of Appeal. The Court held that "decisions not to give a direction" under section 40A (1) (d) included the situation where the Tribunal made a finding that a doctor's fitness to practise was not impaired. This interpretation was supported by section 40A (3) which provided that that the GMC may appeal against a decision "whether as to finding or penalty or both" if the decision was insufficient to protect the public. This suggested that the GMC's right of appeal was not confined to an appeal against penalties but also extended to "findings". Moreover, a right of appeal which did not permit the GMC to appeal in against findings of fact or findings on impairment which were not sufficient to protect the public would not be consistent with the overarching statutory objective of the GMC.

17. As regards Article 6 ECHR the Court of Appeal held that there was no inequality of arms. This was because, had the doctor lost at the impairment stage he would

[27] Ghirea v. Moldova, App No 17778/05, Wynen v. Belgium App. No. 32576/96, Ben Naceur v. France 63879/00, Gacon v. France, Applicant No 1092/04 (cf. Berger v. France 48221/99)

have been entitled to appeal under section 40 and to challenge any adverse findings of fact upon which the finding of impairment was based. The GMC's right of appeal was only the "mirror image" of that right where the doctor has won at the impairment stage.

18. Interestingly, the Court also held that no inequality of arms arose from the fact that the GMC may appeal MPTS proceedings which culminate in a warning and without a finding of impairment yet there was no corresponding right of appeal against warnings (or adverse findings of fact) for practitioners. This was because it was open to a practitioner to bring judicial review proceedings in this situation. Sales LJ said as follows:

"….The intensity of review of such findings in judicial review proceedings could be adjusted, so far as necessary, to the same level as would be applied in an equivalent appeal by the GMC under section 40A , since the High Court in judicial review would be obliged to act in a way which is compatible with the doctor's rights under Article 6 : see section 6(1) and (3) of the HRA . The availability to a doctor of judicial review in such a case again means that there is no warrant under section 3(1) of the HRA for adopting a strained meaning in relation to section 40A."

The Approach to be Adopted by Appellate Court

19. The approach to be adopted by the High Court on appeal by the GMC was summarised by the Divisional Court in **GMC v. Jagjivan [2017] EWHC 1247 (Admin)** (para. 40):

a. 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".

b. 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.

c. 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 , *4449 para 46, and Southall's case at para 47.

d. 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) .

e. 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.

f. 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".

g. 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.

h. 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.

20. However, the guidance in *Jagjivan* must now be read in the light of the observations in **Bawa-Garba v. GMC [2018] EWCA Civ 1879**. The Court gave important guidance as to the correct approach on a GMC/PSA appeal against sanction. The may be summarised as follows:

a. The GMC's appeal from the Tribunal to the Divisional Court pursuant to section 40A of MA 1983 was by "review" and not "re-hearing". In that respect it differs from an appeal by a practitioner under section 40A[28]. [60]

b. Decisions about sanction are matters of evaluative judgment based upon many factors. Such decisions may be described as "multi-factorial decisions". This type of decision, a mixture of fact and law, may also be described as a kind of "jury question" about which reasonable people may reasonably disagree. It has been stated repeatedly in cases at the highest level that there was limited scope for the appellate court to overturn such a decision. [61]

c. Even if the Court might disagree with the Tribunal's assessment - if it approached the matter afresh for itself on rehearing - it does not follow that the Tribunal lacked legitimate grounds for its decision and hence it does not follow that the Tribunal's decision was "wrong". That general caution applied

[28] See Sub-paragraphs 19.1(1)(e) and (2) of Practice Direction 52D and CPR 52.21(1)

with particular force to specialist bodies like the MPTS because it had greater experience than the Courts in the field in which it operated [65-67].

d. A court should only interfere with an evaluative decision of this kind if there was either an error of principle in carrying out the evaluation or if the evaluation was "wrong" in the sense of falling outside the bounds of what the adjudicative body could properly and reasonably decide. [67]

21. In *Raychaudhuri*, the Court of Appeal adopted a similarly restrained approach to a judgment by the MPTS that a practitioner was not guilty of dishonesty. At paragraph 57, Sales LJ said:

"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."

22. There is a helpful review of the authorities on approach to be adopted by an appellate court in **SRA v. Leigh Day (& Ors) [2018] EWHC 2726 (Admin)**. The Divisional Court again emphasised the deference due to the primary fact finder by the appellate court. It was emphasised first instance tribunal had the considerable advantage of hearing/seeing the witnesses and had an overview of the entirety of the evidence.

Reflections on Bawa-Garba

23. On 4th November 2015, Dr Bawa-Garba was convicted of gross negligence manslaughter of a 6 year old boy. She was sentenced to two years of imprisonment suspended for two years. On 29 November 2016 the Court of Appeal Civil division refused her leave to appeal against her conviction.

24. In February 2017 she appeared before the Medical Practitioners Tribunal Service (MPTS) who imposed a suspension for the maximum period of 12 months with a review at the end of that period. The conclusion was reached having regard to the aggravating and mitigating factors which they considered they were entitled to take into account. Amongst the mitigating factors were: "the multiple systemic failures identified in the Trust investigation following the events of 18 February 2011".

25. By an appeal to the Divisional Court, the GMC appealed against the decision of the MPTS to suspend for one year on the basis that the decision was not 'sufficient to protect the public'. The High Court held that that the MPTS had reached the wrong conclusion because it did not 'respect the verdict of the jury as it should have" rather it reached its own, and less severe view of the degree of Dr Bawa Garba's personal culpability.

26. The decision, was overturned by the Court of Appeal (Lord Burnett LCJ; Sir Terence Etherton MR; and Rafferty LJ). In upholding the MPTS's original decision, the CA gave three key reasons:-

a. There was a distinction between what had been explored at the criminal trial namely whether Dr Bawa Garba's fell far below the standard expected of a reasonable doctor, and matters of circumstantial mitigation which were only explored to a limited extent.

b. There was a fundamental difference between the jury's task and that of the Tribunal. The task of the jury was to decide whether Dr Bawa Garba was guilty of the criminal offence charged, whereas the MPTS, considering the case after conviction, had to look to the future, and decide what sanction would most appropriately meet the statutory objectives – protecting the patients, preserving confidence in the profession etc.

c. The Tribunal, like the sentencing judge, was entitled to take into account in determining the appropriate sanction, systemic failings on the part of the Trust, as part of the context for Jack Adcock's tragic death as well as matters of circumstantial and personal mitigation.

27. This unhappy and unsettling case gives rise to three key reflections for all practitioners in the disciplinary field. Some of these issues have since been the subject of a Health Select Committee hearing in the House of Commons on 16th October 2018. We touch on the following three.

28. First, the case has triggered an important public debate about the definition of gross negligence manslaughter in medical cases i.e. an act or omission which is 'truly exceptionally bad'. There is a strong argument that this definition is too imprecise and uncertain and (for the jury) subjective. The jury are asked essentially to say whether they accept that the conduct is so bad that it should amount to a criminal offence, not what the true nature criminal offence is or how it should be assessed against a complex background of circumstances.

29. Second, given the establishment of a legal duty of candour there is a very real concern at the extent to which evidence of personal 'with-hindsight' reflections into what had gone wrong, was capable of being used against a doctor or dentist in context of criminal and regulatory proceedings. On this issue Sir Robert Francis QC's evidence to the select committee of is of interest. It was his view that although as a matter of law reflective materials were capable of being admitted at a criminal or regulatory hearing, the norm was that they were not usually admitted when assessing culpability, and so the real issue was the exceptional circumstances in which there is a departure from the norm. It is difficult not to agree with his conclusions:-

"*Should it [reflective material] be given to the experts who are going to opine on whether something is truly exceptionally bad? No, I do not think it should as a matter of practice. It is having a chilling effect on candour, on teamwork, and on learning. The worst and most dangerous doctor is the one who never talks to his*

or her colleagues about things that have gone wrong and never develops any insight….Do I think the regulators ought to be allowed to look at it? No, not without the consent of the practitioner"

30. Third, what is the duty of practitioners to speak out about unsafe systems? As was observed by one commentator, Professor Dacre, at the time of the first instance hearing, the Bawa Garba case leaves a real problem: unsafe conditions leave doctors having to choose between refusing to work or letting patients down. If they choose to work and errors or harm occurs, they can be exposed to career-ending criminal proceedings which, if the necessary safety systems had been in place, would either be avoided or significantly mitigated. If they decline to work they risk contractual sanctions for failing to obey reasonable instructions under their contract of employment.

31. There is no easy way to square this particular circle. Those who work in difficult conditions with inadequately resourced support services will continue to walk a tightrope until there is better understanding of how serious errors of judgment can be made by otherwise competent practitioners in the context of background system failings and how those same system failures will tend to accentuate or aggravate such failures. Doctors and dentists are often engaged in high risk procedures and like the tightrope walker, when the safety net to protect against errors is absent, the fall can be a very long one.

Reflections: Raychaudhuri

32. This case concerned a locum paediatric registrar working in an accident and emergency department. Dr. Raychaudhuri was informed of the arrival of a 5 month old child who had been diagnosed with a chronic brain malformation. In advance of seeing the patient he began making entries in a pro-forma record. In addition to filling in the history sections (from other contemporaneous records) Dr. Raychaudhuri made some entries in the examination findings section in advance of seeing the child. It was his case that these were draft notes that he intended to amend as necessary when he saw the child. The doctor was in the middle of preparing the pro-forma when he was called away urgently to see another child.

33. The half-completed notes were found in the doctor's office and then reviewed by a senior nurse on duty. She confronted Dr. Raychaudhuri about making entries in the examination finding section before seeing the patient. Dr. Raychaudhuri received a telephone call from his supervising Paediatric Consultant that evening who also sought an explanation for the doctor's conduct. In the course of a subsequent Trust investigation the consultant stated that Dr. Raychaudhuri's explanation had left him with the mistaken impression that no entries had been made in the examination section of the pro-forma.

34. The GMC alleged that the doctor had acted dishonestly: both in respect of his original note keeping and in respect of his subsequent failure to give a full and frank explanation to his colleagues.

35. Before the MPTS it was Dr. Raychaudhuri's case that he had made draft findings in the examination section by way of *aide memoire*. He accepted that this was a serious departure from the standards of Good Medical Practice, but denied that he had been dishonest. He had always intended to see the patient and intended to amend his draft note as appropriate after the consultation. The doctor denied that his communications with colleagues had been dishonest. He had always admitted that the notes were his. In so far as the consultant was left with a mistaken impression this arose from confusion and misunderstanding (in the course of a telephone conversation) and there was deliberate attempt to mislead.

36. The MPTS found that Dr. Raychaudhuri's conduct had been misleading but not dishonest. The GMC appealed to the High Court. Sweeney J substituted a finding of dishonesty in respect of the doctor's telephone communications with his consultant. This finding of dishonesty was overturned by Dr. Raychaudhuri on appeal to the Court of Appeal.

37. The GMC argued the Tribunal's finding about dishonesty did not make sense. The Tribunal found that the doctor had 'knowingly misled' his consultant about the full extent of the entries had made in the pro-forma. Having made such a finding it was incumbent upon the Tribunal to find that Dr. Raychaudhuri had behaved dishonestly.

38. On behalf of Dr. Raychaudhuri it was argued that, applying **Ivey v. Genting Casinos UK Limited [2017] UKSC 67,** a careful and nuanced approach was required. A careful assessment of Dr. Raychaudhuri's state of mind at the time he discussed his record keeping with his supervising consultant was called for. Pursuant to Ivey, an objective standard applied, but by reference to what the doctor actually knew, believed and understood at the time of the index events.

39. The Court of Appeal accepted that it did not necessarily follow that because Dr. Raychaudhuri had 'knowingly misled' his consultant in some respects that he had been guilty of full blown "dishonesty". The Tribunal had been entitled to put the doctor's misleading comments in the context of his conduct as a whole and weigh its "moral significance". The doctor had understood that his consultant's main concern that was that he had filled in examination findings without ever intending to see the patient. The principal point that Dr. Raychauduri was seeking to get across (truthfully) was that he would 'never do that': he always intended to correct the records as necessary after he had seen the patient. Whilst Dr. Raychaudhuri might have been "knowingly evasive" about the full extent of the entries he made on the form before seeing the patient this was made "under the pressure of being put on the spot" by his consultant. There was no challenge to the Tribunal's finding that the doctor's original note keeping had not been dishonest. Moreover, the Tribunal had been entitled to place weight upon the fact that Dr. Raychaudhuri had been open and honest in his explanation of his conduct to other colleagues *before* speaking to his consultant (two nurses and a registrar). Against that background, the doctor's misleading communication with his consultant was part of a "venial and comparatively trivial" effort to deflect his consultant's ire and was not "part of a deliberate and dishonest plan".

40. This decision demonstrates at two things. First, the extent (in practice) to which appellate courts will defer to the evaluative judgment of the MPTS at first instance. Second, the careful and nuanced approach to dishonesty that is called for when applying the test for dishonesty affirmed in *Ivey v. Genting Casinos*.

Maintaining public confidence in the professions:

Does it undermine remediation?

Owain Thomas QC & Michael Spencer

1. The maintenance of public confidence in the professions is a core objective of professional regulation. So much is trite law and trips off the tongue of many a panel/committee/tribunal. Determining what is required in order to uphold public trust is, however, less than straightforward and explaining why X (say erasure from the register) is required rather than Y (a finding of impairment or misconduct) is even harder.

2. There is at the heart of decision making based on public confidence a fundamental difficulty and that is that while the exercise is conceptually one of deciding what the requirements of the public interest are in given case, the actual decision making very often has little to do with the particular circumstances of the case and becomes instead a means of making a finding of impairment or misconduct (or of imposing a sanction) *despite* the fact that the professional in question has sought to and has put right some or all of the problems identified by the regulator.

3. The principle inherently leaves open to a tribunal a decision making route which acknowledges that significant remediation has been done, that the person no longer poses a threat to public safety or is not likely to repeat the misconduct, but that maintaining public confidence requires the person to be found to be impaired or requires a particular sanction to be imposed. There does not seem to be any particular reasoning process of set of standards against which to measure the Tribunal's assessment of what the public interest requires.

4. That open ended nature of that judgment call is particularly important not only because it constitutes a relatively independent basis for making a finding of impairment or selecting a particular sanction; that is relatively independent of the remediation evidence and other mitigation, but also because given that it is a value judgment and one that has been specifically entrusted to the regulatory tribunals to make it will be difficult to challenge on appeal. As was stated in *Bawa Garba* [§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."

Legislation and Guidance

Healthcare professionals

5. Sections 1(1A) and (1B) of the Medical Act 1983 set out the objectives of the General Medical Council (GMC):

> "*(1A) The over-arching objective of the General Council in exercising their functions is the protection of the public.*
>
> *(1B) The pursuit by the General Council of their over-arching objective involves the pursuit of the following objectives—*
>
> > *(a) to protect, promote and maintain the health, safety and well-being of the public,*
> >
> > *(b) to promote and maintain public confidence in the medical profession, and*
> >
> > *(c) to promote and maintain proper professional standards and conduct for members of that profession.*"

6. See also in similar terms:

   a. Schedule 1 of the Health and Social Care (Safety and Quality) Act 2015 (in relation to other healthcare professionals);

   b. Section 37 of the Children and Social Work Act 2017 (in relation to social workers).

7. The GMC Sanctions Guidance states under "*public confidence*":[29]

> "*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*

[29] GMC Sanctions Guidance for members of medical practitioners tribunals and for the General Medical Council's decision makers (Feb 2018).

public's trust in the profession (see paragraph 65 of Good medical practice). Although the tribunal should make sure the sanction it imposes is appropriate and proportionate, the reputation of the profession as a whole is more important than the interests of any individual doctor."

8. The Guidance further suggests:

    a. Mitigating factors carry less weight when the concern is about patient safety or is of a more serious nature "*than if the concern is about public confidence in the profession*" (para 24).

    b. "*There are some cases where a doctor's failings are irremediable",* for example *"because they are so serious or persistent that, despite steps subsequently taken, action is needed to maintain public confidence."* (para 32).

    c. "*Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor*" (para 102).

<u>Legal professionals</u>

9. Maintaining trust is not an explicit objective of legal services regulation under section 1 of the Legal Services Act 2007, but constitutes a core principle under both the Bar Standards Board (BSB) and SRA Handbooks. See:

    a. SRA Principle 1.6: "*You must… behave in a way that maintains the trust the public places in you and in the provision of legal services."*

    b. BSB Core Duty 5: "*You must not behave in a way which is likely to diminish the trust and confidence which the public places in you or in the profession."*

10. The Solicitors Disciplinary Tribunal Guidance on sanctions states at p.3:

    "*It is the function of the Tribunal to protect the public from harm, and to maintain public confidence in the reputation of the legal profession (and those that provide legal services) for honesty, probity, trustworthiness, independence and integrity. The public must be able to expect to receive a high standard of service from a competent and capable solicitor*."

11. The BSB's penalty guidance says at para 3.2:

12. "*The primary purpose of imposing sanctions is to protect the public. This is of paramount importance and should be the fundamental guiding factor when considering what sanctions to impose. However, in fulfilling the other purposes it is also important to avoid recurrence of the behaviour by the individual as well as provide an example to other barristers in order to maintain public confidence in the profession. Decision makers must take all of these factors into account when determining the appropriate sanction to be imposed in an individual case. Decision makers should also bear in mind that sanctions are not intended to be punitive in nature but nevertheless may have that effect*."

What are the difficulties of applying these tests?

13. In response to the recent *Bawa Garba* case, the British Medical Association (BMA) commented:

> "*We have previously expressed concern that the public confidence criterion could lead to 'trial by media' and called for guidance that properly relates 'public confidence' to the GMC's overarching objective of public protection. One particular problem with the criterion is the subjectivity of public confidence considerations, which can lead to the same act being treated differently in different cases depending on the extent to which the patient is harmed. We would like to see research into the question of what members of the public would really expect in cases involving clinical error*."

14. As the authors of *Principles of Medical Law* (4th ed) note at 2.23:

> "*When all is said and done, there is no real consensus on what is meant by the term 'trust', how it can be measured, what events are capable of causing permanent damage to that trust, and what tools are effective in repairing it*."

15. Attempts to survey public expectations have met with mixed success. Research by the Professional Standards Authority into the public perception of dishonest behaviour concluded that the public "*took a pragmatic and tolerant view on the appropriate disposals for dishonesty*."[30]

16. The Solicitors Regulation Authority (SRA) also conducted a survey of members of the profession and public which concluded:

[30] Dishonest Behaviour by health and care professionals: Exploring the views of the general public and professionals (2016), p.5.

> "*There are widely differing views on what is serious and what should be done in response to any particular issue… Every person has their own value set and makes their decisions accordingly. For example, for some people, things that happen in a solicitor's private life are not relevant to their role as a lawyer. Conversely, others think that bad behaviour outside the workplace undermines public confidence in the profession… For us, this presents two issues. One is that the decisions we make will seem wrong to many people, and the second is that we must ensure that our own decision-making is consistent and in line with a validated regulatory position."*[31]

17. What follows is a selection of the case law. Given that the maintenance of public confidence permeates all regulatory decision-making, these examples are inevitably selective. However this survey is enough to demonstrate the open nature of this basis for decision making.

Principles deriving from the case law

18. The paradigm case on the maintenance of public confidence is that of *Bolton v Law Society* [1994] 1 WLR 512 at p519H, which concerned a solicitor who was struck off the roll for appropriating client account funds. Bingham MR said:

> "*The second purpose is the most fundamental of all: to maintain the reputation of the solicitors' profession as one in which every member, of whatever standing, may be trusted to the ends of the earth.* ***To maintain this reputation and sustain public confidence in the integrity of the profession it is often necessary that those guilty of serious lapses are not only expelled but denied re-admission.*** *If a member of the public sells his house, very often his largest asset, and entrusts the proceeds to his solicitor, pending re-investment in another house, he is ordinarily entitled to expect that the solicitor will be a person whose trustworthiness is not, and never has been, seriously in question. Otherwise, the whole profession, and the public as a whole, is injured.* ***A profession's most valuable asset is its collective reputation and the confidence which that inspires.***
>
> *Because orders made by the tribunal are not primarily punitive,* ***it follows that considerations which would ordinarily weigh in mitigation of punishment have less effect on the exercise of this jurisdiction than on the ordinary run of sentences imposed in criminal cases.*** *It often happens that a solicitor appearing before the tribunal can adduce a wealth of glowing tributes from his professional brethren. He can often show that for him and his family the consequences of striking off or suspension would be little short of tragic. Often he will say, convincingly, that he has learned his lesson and will not offend*

[31] SRA, A Question of Trust (2017).

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.*****"**

19. The Court of Appeal has recently confirmed that these *dicta* also apply in the medical context, both at the sanctions and restoration stages - *General Medical Council v Dr Shekhar Chandra* [2018] EWCA Civ 1898 but that different factors might have different weight at different stages. That sounds an awful lot like the decision of Moulder J at first instance which was nonetheless overturned by the Court of Appeal[32].

20. The following principles can be derived from the case law in the medical context:

    a. Public confidence in the profession should reflect the views of "*an informed and reasonable member of the public*" or "*the ordinary intelligent citizen"* who appreciates the seriousness of the case - *Giele v General Medical Council* [2005] EWHC 2143 (Admin) [2006] 1 WLR 942 at para 33; Holgate J in *Wallace v Secretary of State for Education* [2017] EWHC 109 (Admin), [2017] PTSR 675 (at paras 92 and 96(v).

    a. A distinction can be drawn between cases involving clinical errors or incompetence and matters of dishonesty and sexual misconduct - *Yeong v General Medical Council* [2009] EWHC 1923 (Admin) at para 48. Matters of remediation weigh more heavily in the former category with public confidence considerations holding more influence in the latter category.

    b. Misconduct is of "*two principal kinds*": (i) "*sufficiently serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practise*"; (ii) "*conduct of a morally culpable or otherwise disgraceful kind which may, and often will, occur outwith the course*

[32] The point is really common sense. While it might be justifiable on public confidence grounds to order erasure as a response to reprehensible conduct it does not follow that it will still be necessary to refuse an application for restoration on the same gounds 5 years later. It is possible, surely, for the public interest to be vindicated by the original sanction.

of professional practice itself, but which brings disgrace upon the doctor and thereby prejudices the reputation of the profession" - *R (Remedy UK Ltd) v General Medical Council* [2010] Med LR 330, para 37.

c. Public confidence may be undermined by behaviour engaged in outside of a professional context – see *Pitt v GMC* [2017] EWHC 809 (Admin) paras 43-44.

d. An appellate court will approach Tribunal determinations about what is necessary to maintain public confidence with "*diffidence*" particularly where they involve clinical matters - *Khan v General Pharmaceutical Council* [2016] UKSC 64; [2017] 1 WLR 169 at para 36.

e. However, in cases of dishonesty or sexual misconduct, the Court "*is likely to feel that it can assess what is needed to protect the public or maintain the reputation of the profession more easily for itself and thus attach less weight to the expertise of the Tribunal*" - see *Council for the Regulation of Healthcare Professionals v GMC and Southall* [2005] EWHC 579 (Admin); [2005] Lloyd's Rep Med 365 at para 11, and *Khan* at para 36(c).

Some examples

Medical cases

Clinical incompetence

21. *Bawa-Garba v The General Medical Council & Ors* [2018] EWCA Civ 1879 (conviction for manslaughter by gross negligence) at paras 92-97:

> "*As the Professional Standards Authority has emphasised, the present case is unusual …*
>
> *… The Tribunal was, in relation to all those matters and the carrying out of an evaluative judgement as to the appropriate sanction for maintaining public confidence in the profession, an expert panel, familiar with this type of adjudication and comprising a medical practitioner and two lay members, one of whom was legally qualified, all of whom were assisted by a legal assessor*."

22. Dr Vaishnavy Vilvanathan Laxman, Medical Practitioners Tribunal, 05 June 2018 (clinical incompetence leading to decapitation of baby in childbirth):

> "*The Tribunal was satisfied that any member of the public fully appraised of all the evidence placed before this Tribunal would understand that a finding of impaired fitness to practise is not required in order to uphold proper professional standards and to maintain public confidence in the profession*."

Dishonesty

23. Dishonesty often leads to erasure but it does not necessarily do so. But where there is an absence of insight or where there is a fundmental breach of good medical practice e.g. where the dishonesty goes to the heart of the doctor patient relationship, then it is invariably ordered.

24. *Alghofari v General Dental Council* [2018] EWHC 2412 (Admin) (forgery of immigration papers) at para 19:

> "*It is self-evident, in my judgment, that the public would regard continuing registration, against the background of such fundamental dishonesty and in the context of such a serious offence, as something which would mean that the trust in the dental professional would be affected as would the trust in the ability of the General Dental Council to monitor the profession."*

25. Dr Abayomi Sanusi v The General Medical Council [2018] EWHC 1388 *(Admin)* at para 69:

> *"The absence of insight and appreciation of the seriousness of his misconduct, the difficulty in showing the required "remediation" in a case of dishonesty and the overriding need to preserve public confidence in the profession, lead me to conclude that no harm was done by what went wrong in the present case and that the decision to erase Dr Sanusi's name from the medical register must therefore stand."*

26. *GMC v Patel* [2018] EWHC 171 (Admin) [2018] A.C.D. 24 (dishonesty towards employers) at para 68:

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

27. Professional Standards Authority v Health and Care Professions Council, Mohammed Ghaffar [2014] EWHC 2723 (Admin) at para 51 (conviction for making false representations for personal gain)*:*

> *"In this case, the need to uphold proper professional standards and to uphold public confidence required a finding of impairment quite separate and distinct from the criminal sanctions imposed on the registrant. The Panel failed to have due regard for the reputation of the profession and the necessity to re-affirm*

clear standards of professional misconduct so as to maintain public confidence in the profession. The registrant's misconduct violated repeatedly the fundamental rule of honesty."

Sexual misconduct

28. *GMC v Chandra [2018] EWCA Civ 1898* (sexual relationship with a vulnerable patient) at para 79:

> "*I find it hard to imagine any feature in relation to any doctor, let alone a psychiatrist, which goes so entirely to the essence, or heart, of his role as medical practitioner as the entitlement of each and every patient, (whether vulnerable or not) to be entirely confident in the sexual probity of their physician. To adopt and adapt the words of the Master of the Rolls [in Bolton]…: "If a member of the public submits him or herself to a physical or mental examination or consultation by a doctor, he or she is ordinarily entitled to expect that that doctor is a person whose trustworthiness and sexual integrity is not and never has been, seriously in question.*"

29. *Yasin v GMC* [2018] EWHC 677 (Admin) (sexual assault on colleagues) at para 40:

> "*…once [the Tribunal] had found repeated assaults on more than one junior female colleague it was then open to them to conclude that that was just too serious not to erase the doctor so as to maintain public confidence in the profession. It follows that this appeal must be dismissed*."

30. *Arunachalam v GMC* [2018] EWHC 758 (Admin) (unwanted sexual advances towards colleagues) at para 78:

> "*On balance, it seems to me likely that a reasonable, informed member of the public might well not take a harsher view than did the GMC of the pathetic and disgusting sexual pestering of the kind that occurred in this case. There are some who would regard erasure as appropriate; that would represent almost a complete zero tolerance approach to sexual harassment, which would mean that any transgression, even from a first time offender, would nearly always lead to erasure*."

31. *Anthony v Nursing and Midwifery Council* [2018] EWHC 2769 (Admin) (physical assault on a patient):

> "*The Panel was entitled to conclude that the incident, involving an assault on a vulnerable patient, even though a one-off, was deplorable and fundamentally incompatible with registration on the grounds of public safety and the wider public interest*."

Legal profession cases

Dishonesty

32. There appears to be a special rule for dishonesty in solicitors cases to the effect that unless there are "exceptional circumstances" a solicitor found guilty of dishonesty will be struck off the Roll. This stands in contrast to the medical cases where there is no clear body of case law to the same effect although, as we have noted, dishonesty is taken particularly seriously and often leads to erasure.

33. In SRA v James and others [2018] EWHC 3058 (Admin) a judgment released on 18 November 2018 the SRA appealed three decisions whereby suspensions had been imposed in place of striking off solicitors for dishonesty of various kinds. Flaux LJ summarised the position on dishonesty in solicitors cases as follows:

    (i) The almost invariable sanction for dishonesty was striking off the Roll of solicitors. The purpose of the sanction was not just punishment and deterrence but most fundamentally in order to maintain the reputation of the profession (see Sir Thomas Bingham in *Bolton*).

    (ii) At [47] the Guidance Note on Sanctions states, (citing the decision of the Divisional Court in *Solicitors Regulation Authority v Sharma* [2010] EWHC 2022 (Admin)): "The most serious misconduct involves dishonesty, whether or not leading to criminal proceedings and criminal penalties. A finding that an allegation of dishonesty has been proved will almost invariably lead to striking off, save in exceptional circumstances."

    (iii) As a matter of principle therefore the law is settled that the public interest requires striking off save in exceptional circumstances "It seems to me, therefore, that looking at the authorities in the round, that the following impartial *points of principle* can be identified: (a) Save in exceptional circumstances, a finding of dishonesty will lead to the solicitor being struck off the Roll, see Bolton and *Salsbury*. That is the normal and necessary penalty in cases of dishonesty, see *Bultitude*. (b) There will be a small residual category where striking off will be a disproportionate sentence in all the circumstances, see *Salsbury*. (c) in deciding whether or not a particular case falls into that category, relevant factors will include the nature, scope and extent of the dishonesty itself; whether it was momentary, such as *Burrowes* or over a lengthy period of time, such as *Bultitude*; whether it was a benefit to the solicitor (*Burrowes*), and whether it had an adverse effect on others."(*Sharma* at §13);

    (iv) The medical cases are different. The Court stated that "there are degrees of dishonesty and of culpability for it, …[see] *Lusinga v*

Nursing & Midwifery Council [2017] EWHC 1458 (Admin) …[But] In my judgment some caution must be exercised in seeking to draw parallels between the solicitors' cases and the medical cases. Whilst it is no doubt true that much of what Sir Thomas Bingham MR said in *Bolton* as to the purpose of the sanction, namely the need to protect the reputation of the profession, is equally applicable to the medical profession (see *Bawa-Garba v General Medical Council* [2018] EWCA Civ 1879 at [76]), it is important to have in mind that the discretion of the Medical Practitioners Tribunal as to restoring a doctor to the register is a wide one unfettered by any gloss or limitation of "exceptional circumstances": see *General Medical Council v Chandra* [2018] EWCA Civ 1898 at [49]-[51] per Eleanor King LJ".

(v) Notwithstanding mental health problems or a highly pressured work environment repeated dishonesty requires striking off as a matter of principle "I do not consider that, in cases of repeated dishonesty and misconduct of this kind, the lesser sanction of suspension (let alone suspended suspension) addresses the risk of harm to the public or the need to maintain the reputation of the profession which, as all the case law since Bolton demonstrates, is the principal purpose of the sanction"§105.

Criminal convictions

34. *SRA v Main* (10 October 2018) (unreported) (racially aggravated sexual assault):

"*Although the tribunal could regard the risk of reoffending as low, it had to consider the public trust and confidence in the profession. The tribunal had identified the need to have regard to public trust and confidence and if necessary and appropriate for suspension to coincide with the orders of the criminal court. However, the tribunal had lost sight of them. Instead of focussing on the period of suspension necessary to protect the reputation of the profession and public confidence, it referred only to the risk of reoffending. It failed to consider if public confidence would be harmed by the solicitor continuing to practise. Had the tribunal focussed on that, it could have only reasonably reached one conclusion: the profession's reputation would be harmed*."

Disclosing sensitive information

35. *Forz Khan v Bar Standards Board* [2018] EWHC 2184 (Admin) (disclosure of sensitive information) at para 52:

> "*This was not just indiscreet and ill-judged. It was, as the Tribunal evidently concluded, a serious failure of standards. In my judgment, it was a significant failure to separate the professional from the personal, and to respect the privacy of those involved on the "other side" of a legal dispute. It was conduct likely to lower public confidence in the professional standards of the Bar*." (para 55)

Manifest incompetence

36. Iqbal v Solicitors Regulation Authority [2012] EWHC 3251 (Admin), para 23*:*

> *"…trustworthiness also extends to those standards which the public are entitled to expect of a solicitor, including competence. If a solicitor exhibits manifest incompetence, as in my judgment the appellant did, then it is impossible to see how the public can have confidence in a person who has exhibited such incompetence."*

37. *SRA v Wingate and Malins* [2018] EWCA Civ 366 at para 106:

> "*In applying principle 6 it is important not to characterise run of the mill professional negligence as manifest incompetence. All professional people are human and will from time to time make slips which a court would characterise as negligent. Fortunately, no loss results from most such slips. But acts of manifest incompetence engaging the principles of professional conduct are of a different order*."

Remediation – can you teach an old dog new tricks?

Matthew Barnes

1. Remediation is largely familiar territory. However, it is worth considering the weight of remediation, and how it can be evidenced, in those cases where the justification for a finding of impairment is public confidence in the practitioner and the profession. This short talk will consider both issues in turn.

The weight of remediation

2. As Mrs Justice Cox recognised in *CHRE v NMC and Grant* [2011] EWHC 927 (Admin), in order to determine whether a registrant is currently impaired, a panel will have to ask themselves two questions: *"…not only whether the Registrant continued to present a risk to members of the public, but whether the need to uphold proper professional standards and public confidence in the Registrant and in the profession would be undermined if a finding of impairment of fitness to practise were not made in the circumstances of this case."*

3. The impact of any remediation may carry less weight in respect of the second question, if a clear statement of the necessary professional standards is required. In *Yeong v GMC* [2009] EWHC 1923 (Admin), Mr Justice Sales put the position as follows: *"…where a FTPP considers that fitness to practise is impaired for such reasons, and that a firm declaration of professional standards so as to promote public confidence in that medical practitioner and the profession generally is required, the efforts made by the practitioner to address his problems and to reduce the risk of recurrence of such misconduct in the future may be of far less significance than in other cases, such as those involving clinical errors or incompetence. In the former type of case, the fact that the medical practitioner in question has taken remedial action in relation to his own attitudes and behaviour will not meet the basis of justification on which the FTPP considers that a finding of impairment of fitness to practise should be made."*

4. In such cases, it is necessary to balance the weight to be attributed to any remediation against that to be attributed to the need to maintain public confidence in the profession and to maintain proper professional standards in the profession. In *GMC v Chaudhary* [2017] EWHC 2561 (Admin), Mr Justice Jay explained that: *"…Cox J has made it clear in the case of Grant that a proper balance of all three elements of the tripartite public interest must be undertaken in these cases. If it is clear to this court that all relevant matters have been weighed then it would be only in very rare circumstances that intervention would be appropriate, either on an appeal under s.40 or in the current context of an appeal under s.40A. The whole of the public interest in this regulatory context is vital. I am not to be understood as saying that elements two and three are more important than the first element (which is public safety) and the position of the doctor, but everything must properly be placed in the balance."*

5. It is important to note that remediation does not only carry weight in respect of public safety, it carries weight even when there is no risk to public safety. In *GPC v Khan* [2016] UKSC 64, the Supreme Court noted that, whilst, *"…Mr Khan's conduct did not relate to his professional performance. No patient had been, or was likely to be, put at risk…"*, it was necessary to consider, *"…several further features of the case which militated against the removal of his registration, such as his genuine acknowledgement of fault and the positive reports of his response to the requirements of the community payback order, as set out in para 19 above…"*, and not just sections of the guidance aimed at *"behaviour is fundamentally incompatible with registration"* and *"public confidence in the profession demands no lesser sanction"*, but also, *"…para 8 of the guidance, entitled 'Mitigating Features – General'…(b) genuine insight into misconduct; (c) open admissions at an early stage…(e) genuine expression of remorse to committee; and, (f) steps taken to prevent recurrence."*

Evidencing remediation

6. In order for remediation to be persuasive, it is unlikely that it will be sufficient to simply rely on early admissions and statements of remorse, and consideration should be given as to what steps can be taken to demonstrate *"genuine insight"* and *"steps taken to prevent recurrence"***.**

7. The starting point should be considering whether it is necessary to obtain the assistance of a third party, and in particular a mentor, but possibly also a behavioural psychologist, or other therapeutic input, in order to achieve and evidence a recognition of the seriousness of the conduct in question, why it occurred, and the change in the practitioner's mindset that will prevent it recurring in the future. Any third party must be prepared to challenge the practitioner, write regular reports, and to appear as a witness in the proceedings.

8. This should be allied with steps taken by the practitioner to embed this process, by: attending courses, although it is unlikely that there will be many courses that will provide a great deal of assistance where it is conduct that is in question; reading around the subject, starting with the relevant published guidelines as to conduct, and moving on to other relevant reading such as articles and chapters from textbooks; take practical steps, such as initiating sessions in their workplace to discuss ethical issues as they arise; and, undertake reflective writing in respect of the work being done.

Conclusion

In summary, remediation will carry significant weight in those cases where the justification for a finding of impairment is public confidence in the practitioner and the profession, but in order for it to do so, it will be a substantial undertaking.

When Undertakings Should be Sufficient: A Review

Christopher Mellor

1. This is a review of the circumstances in which medical and dental disciplinary cases can, and should, be disposed of by way of undertakings. I shall first set out the relevant rules, and published guidance provisions, that apply in General Medical Council/Medical Practitioner Tribunal Service, and General Dental Council, cases; before discussing the apparent extent of the use of undertakings (particularly in GMC cases) and whether that suggests that undertakings are being appropriately agreed when they should be sufficient.

The rules and the relevant guidance

The General Medical Council (Fitness to Practise) Rules 2004

2. Undertakings can be agreed at two stages in the GMC fitness to practise process: (a) by the Case Examiners before a matter is referred to a hearing; or (b) at a hearing, after the Tribunal has made a finding of impairment. I shall deal with each scenario in turn.

Agreement by Case Examiners before referral to a Medical Practitioners Tribunal [MPT]

The Rules

3. Rule 10(1) provides that where, "*before an allegation has been determined by the Case Examiners under rule 8(2)*[33]*, or referred to the* [Investigation] *Committee or the MPTS for them to arrange for it to be determined by a Medical Practitioners Tribunal*" the Registrar may refer the allegation to the Case Examiners for consideration under Rule 10[34].

4. Rule 10(2) then states that, where it appears to the Case Examiners that:
   (a) the practitioner's fitness to practice is impaired; or
   (b) the practitioner suffers from a continuing or episodic physical or mental condition which, although in remission at the time of the assessment, may be expected to cause a recurrence of impairment of the practitioner's fitness to practise,

   they may recommend that the practitioner be invited to comply with such undertakings as they think fit (including any limitations on the practitioner's practice).

5. However, Rule 10(5) provides: "***The Registrar shall not invite the practitioner to comply with any such undertakings where there is a realistic prospect that****, if the allegation were referred to the MPTS for them to arrange for it to be determined by a Medical Practitioners Tribunal,* ***his name would be erased from the register***" (emphasis added).

[33] i.e. before the Case Examiners have decided (a) that the allegation should not proceed further; (b) to issue a warning in accordance with rule 11(2); (c) to refer the allegation to the Investigating Committee under rule 11(3) for determination under rule 11(6); or (d) to refer the allegation to the MPTS.

[34] See also Rule 8(3): "*The Case Examiners may unanimously decide to recommend that the practitioner be invited to comply with undertakings in accordance with rule 10(3) and, where they do so and the practitioner confirms he is prepared to comply with such undertakings in accordance with rule 10(4), they shall make no decision under paragraph (2) accordingly*".

6. When the Case Examiners recommend that the doctor should be offered undertakings, the Registrar will write to the doctor inviting him to state, within 28 days, whether he/she is prepared to comply with the undertakings (Rule 10(2)). If the doctor confirms in writing that he/she is prepared to comply with the undertakings, the Case Examiners shall cease consideration of the allegation and make no decision under Rule 8(2).

7. Under Rule 10(6), where undertakings have been agreed the Registrar may subsequently carry out any additional investigations that are, in the Registrar's opinion, appropriate to the consideration of: (a) whether the practitioner has complied with any undertakings in place; or (b) his/her fitness to practice. Such investigations might take the form of an assessment of the doctor's health or performance or some other form of enquiry. Further enquiries may be required, for example, to assess whether undertakings should be varied or lifted[35].

8. Lastly, if undertakings have been offered, the case can still be referred to a Tribunal if: (a) the doctor declines to accept the proposed undertakings, or fails to reply to the invitation to do so; (b) the practitioner subsequently breaches the undertakings; or (c) the GMC receive new information which suggests a deterioration in the practitioner's "*health, performance or knowledge of English… or otherwise gives rise to further concern regarding his fitness to practice*"[36].

<u>The Guidance</u>

9. The GMC "*Guidance on Undertakings*"[37] sets out the following criteria for agreeing undertakings:

***"24** In considering whether undertakings may be appropriate, the CEs shall have regard to the guidance for decision-makers on the application of the investigation stage test[38].*

***25** When considering whether to offer the doctor to accept undertakings, CEs should consider:*

***a** Whether undertakings are **workable, measurable, attainable, proportionate and offer sufficient safeguards to protect the public**.*

***b** Whether there is **reason to believe the doctor will comply** with the undertakings.*

***26** In assessing the likelihood that the doctor will comply with undertakings, Case Examiners should consider any history of non-compliance in the doctor's case or decisions*

[35] See further Rule 10(7).
[36] See Rule 10(8). As regards the consequences of a breach of an undertaking, see e.g. *Depner v GMC* [2012] EWHC 1705 (Admin) where the 9-month suspension of a doctor, who had breached an undertaking that she would agree to a professional performance assessment, was upheld.
[37] https://www.gmc-uk.org/-/media/documents/DC4595_CE_Decision_Guidance___Annex_F___Undertakings.pdf_57741459.pdf.
[38] '*The Investigation Committee or case examiner must have in mind the GMC's duty to act in the public interest which includes the protection of patients and maintaining public confidence in the profession, in considering whether there is a realistic prospect of establishing that a doctor's fitness to practise is impaired to a degree justifying action on registration'.*

made under paragraph 5A(3D) or paragraph 5C(4) of Schedule 4 of the Medical Act 1983. A previous non-compliance order may suggest that a doctor is less likely to comply with undertakings, but should only form one part of a case examiners' considerations and should not, in itself, preclude the possibility of agreeing undertakings.

***27** In particular, in performance cases, emphasis on retraining and development is likely to be more effective in addressing the cause of the problem than imposing a period of suspension. **In cases where the allegations relate solely to conduct issues such as dishonesty undertakings are not likely to be appropriate although undertakings may be appropriate in multi-factorial cases involving misconduct (where the underlying cause may be linked to a health or performance issue)**.*

***28 Under Rule 10(5) the CEs cannot consider undertakings when there is a realistic prospect of the doctor being erased** if referred to a tribunal hearing. Indicators that there is a realistic prospect of the doctor being erased if the case were referred to a tribunal include:*

***a** The allegations involve dishonesty (especially where persistent or covered up), violence or indecency and abuse of position of trust.*

***b** A particularly serious departure from or reckless disregard for the principles set out in Good Medical Practice.*

***c** Violation of a patient's rights or exploiting a vulnerable adult or child for example in relation to expressing personal beliefs.*

***d** Putting the doctor's own interests before those of a patient, for example in relation to conflicts of interest.*

29 Undertakings are also not likely to be appropriate where there is any significant disagreement as to the facts.

***30** CEs should consider any comments provided by the complainant or referring body together with other relevant considerations. The CEs are not obliged to comply with any preferences expressed by the complainant or referring body but should have regard to them.*" (emphasis added)

10. The Guidance then provides that there are three broad categories of undertaking: (a) those which relate to the **treatment of a doctor's underlying health condition**; (b) those which relate to the need to address **deficiencies in clinical performance or knowledge of English**; and (c) those which relate to **multi-factorial cases involving misconduct (where the underlying cause may relate to a health or performance issue)**. It is then stated that undertakings should normally follow the format of the standard undertakings in the bank of conditions and undertakings[39].

[39] See the most recent version of the "Undertakings Bank" is at https://www.mpts-uk.org/-/media/mpts-documents/dc4351-undertakings-bank-25416205.pdf.

11. In this regard it is also worth noting the "*Guidance on dealing with breaches of Undertakings and criteria for referral to a medical practitioners tribunal*"[40], which states, *inter alia*:

    "***8** Undertakings entered into by the doctor must be sufficient to ensure that the public are protected and confidence in the profession is maintained.* ***Factors that will need to be taken into account will include the seriousness of the issues raised and the complexity of the concerns.*** *…*

    9 Undertakings will only be appropriate if there is reason to believe that the doctor will comply with them, for example, because it is judged that the doctor has shown genuine insight into his problems/deficiencies. *The assessment report(s) and the doctor's comments may help case examiners decide whether this is the case. There may also be information about previous attempts to support the doctor at a local level.*"

At a MPT hearing

The Rules

12. Under Rules 17(4) and 22(3)[41], the MPT may, where it finds a practitioner's fitness to practise impaired, take into account any written undertakings agreed between the GMC and the doctor (including any limitations on his or her practice) which the GMC considers appropriate. The MPT can only take such undertakings into account where: (a) it considers the undertakings to be **sufficient to protect patients and protect the public interest**; and (b) the practitioner has expressly agreed to the Registrar disclosing details of those undertakings (save those relating exclusively to the health of the practitioner) to any person by whom the practitioner is employed to provide medical services or with whom he/she has an arrangement to do so; any person from whom the practitioner is seeking such employment or such an arrangement; and any other enquirer[42]. Where the GMC and the practitioner agree undertakings, the MPT may close the case with no action.

The Guidance

13. As stated in the MPTS document "*Undertakings at Medical Practitioners Tribunal hearings*"[43], the "*Sanctions Guidance*"[44] sets out the only circumstances where a MPT should accept undertakings and not make an order on a doctor's registration; those circumstances being where: (a) all of the requirements set out in paragraph 12 above are met; (b) the MPT is satisfied that the undertakings cover any conditions that it would

[40] https://www.gmc-uk.org/-/media/documents/DC4342_Guidance_on_dealing_with_breaches_of_undertakings_and_criteria_referral_to_an_MPT_57741789.pdf.

[41] Which apply to initial MPT hearings, and review hearings, respectively.
[42] See Rules 17(5) and 22(4).
[43] At https://www.mpts-uk.org/-/media/mpts-documents/dc4253-undertakings-at-medical-practitioners-tribunal-hearings_pdf-3799534.pdf.
[44] https://www.mpts-uk.org/-/media/mpts-documents/dc4198-sanctions-guidance-feb-2018-76246001.pdf.

otherwise impose; and (c) the MPT is satisfied that the doctor has sufficient insight to abide by the written undertakings given before the Tribunal.

14. The *Sanctions Guidance* further deals with undertakings at paras.71-78. At para.73 it is stated that undertakings are likely to be appropriate in cases: (a) involving a doctor's health; (b) involving issues around the doctor's performance; (c) where there is evidence of shortcomings in a specific area or areas of the doctor's practice; or (d) where a doctor lacks the necessary knowledge of English to practise medicine without direct supervision. Para.74 then states that they are likely to be workable where: (a) the doctor has insight that they need to restrict their practice; (b) a period of retraining and/or supervision is likely to be the most appropriate way of addressing any findings; (c) the Tribunal is satisfied that the doctor will comply with them; and (d) he/she has the potential to respond positively to remediation, or retraining, or to their work being supervised. It is highlighted that this exactly mirrors paras.81 and 82 of the Guidance which deal with conditions.

The General Dental Council (Fitness to Practise) Rules 2006

15. In contrast to GMC cases, the GDC Rules only provide for the agreement of undertakings before referral to a Practice Committee.

The Rules

16. The 2006 Rules provide the GDC's Case Examiners, and the Investigating Committee, with the power to agree undertakings with a registrant. The relevant provisions in relation to the Case Examiners are set out at Rules 6(6) and (7), 6A, and 6B (dealing, in particular, with the variation and breach of undertakings), and they substantively mirror those in the GMC Rules as they relate to the GMC Case Examiners[45].

The Guidance

17. As to the relevant Guidance, the "*Case Examiner Guidance Manual (November 2016)*" includes detailed guidance at paras.67 to 126; and, for present purposes, I would particularly highlight paras.76, 78, 83 and 90, which, for ease of reference, provide as follows:

"*76.* ***Erasure is not available where a registrant's fitness to practise is impaired solely on grounds of adverse physical or mental health, and undertakings may be particularly suitable in such cases.***

…

78. Undertakings must also be workable, and are therefore likely to be appropriate where: (i) it is ***possible to fully address the issues of impairment*** *of fitness to practise* ***by agreeing actions which are specific, unambiguous, and can be objectively assessed*** *(for example,*

[45] Rules 8(4), 8(5), 8A and 8B give similar powers to the Investigating Committee, which will consider allegations of impaired fitness to practise, particularly, where the Case Examiners have failed to make a determination: see Rules 6(2); but also 7(1) and 9(8)(b). The "*Investigating Committee Guidance Manual*" for cases considered on or after 1 November 2016, deals with undertakings at paras.119-179 and is in the same terms as the provisions in the "*Case Examiner Guidance Manual*".

by completing a training course and providing evidence and reflection on what was learned); and
(ii) a registrant is likely to accept and agree to comply with them.
…
83. Undertakings may, as a matter of general principle, be ***inappropriate*** *where:*
(i) it is ***not possible to formulate workable undertakings*** *to address the potential issues;*
(ii) there ***remains a substantial*** *(rather than minor)* ***dispute over the facts*** *alleged,* ***or*** *a dispute* ***as to whether those facts alleged amount to impairment of fitness to practise****;*
(iii) any deficiencies identified are such that patients may be put at risk directly or indirectly, even with undertakings in place;
(iv) ***they would fail to maintain public confidence in the professions*** *and their regulation and/****or would fail to declare and uphold proper professional standards****, and as a result it may be in the wider public interest for the issues engaged by the case to be examined by a Practice Committee* ***(this may occur where the case raises concerns about dishonesty, abuse of trust, serious violence, sexually motivated conduct, or financially motivated conduct to the detriment of the patient)****. There may, however, be circumstances where undertakings would still be appropriate if they fully addressed the risk of any harm to the public and/or to the public interest; and/or*
(v) ***there is reason to believe that the registrant will not comply with them*** *(for example, if the respondent has limited or no insight into their shortcomings, or has in the past failed to comply with undertakings or conditions of practice, imposed by the GDC or otherwise). Undertakings can only be considered to provide adequate public protection if the Case Examiners can reasonably be confident in the registrant's capacity and intent to comply with them.*
…
90. The registrant may also, as part of that process, ***proactively offer to accept undertakings.*** *If so, the Case Examiners should give careful consideration to the registrant's offer."*

18. As with the GMC/MPTS, the GDC have an Undertakings Bank[46].

DISCUSSION AND CONCLUSIONS

19. For these purposes, I propose to focus primarily on the GMC's (rather than the GDC's) approach to undertakings, principally because information as to the GMC's agreement of undertakings is more readily available (and because of my own experience).

20. Obviously, undertakings are only a possibility if they can be agreed with the regulator; and that applies both to undertakings offered without recourse to a fitness to practise hearing, as well as to those agreed after a MPT has made a finding of impairment.

21. As regards the latter, that appears to be a relatively rare phenomenon. On the basis of those fitness to practise cases reported on the MPTS website, of the last **371** decisions, dating back to 23 November 2017, in **only one case** were undertakings agreed. Furthermore, that case constituted a review hearing where the doctor's registration had

[46] See the link to the Undertakings Bank at https://www.gdc-uk.org/about/who-we-are/committees/case-examiners.

already been subject to conditions for two years; those conditions had been fully complied with; and the undertaking was principally that the practitioner would not carry out operative surgery, in circumstances where his practice had previously been found to be impaired on a single factor, namely his operative practice.

22. Indeed, whilst others may have had a different experience, I have never had a case where undertakings have been agreed following a finding of impairment at an initial fitness to practise hearing. That may, arguably, seem unsurprising given that one can perhaps see why, having put a case 'in the hands of' the MPT, the GMC would rather leave decisions as to sanction/appropriate conditions entirely to the Tribunal. That being said, the provisions in relation to the agreement of undertakings at that stage in the process may not be being utilised to the extent that was perhaps intended.

23. As regards undertakings being agreed by the Case Examiners, according to the GMC website it appears to have agreed undertakings relating to the relevant doctor's practice, without recourse to a fitness to practise hearing, in **26 cases** since February 2018.

24. Again, for my part, that also seems like a relatively low number bearing in mind the circumstances where undertakings can be agreed given the Rules and guidance set out above. I would be surprised if there had not been more cases where:

    (a) erasure was not a realistic prospect;
    (b) there was no significant disagreement in relation to the facts (or impairment);
    (c) undertakings would have been "*workable, measurable, attainable, proportionate*" and would have offered sufficient safeguards to protect the public; and
    (d) there was no reason to believe that the doctor would not comply with the undertakings, there clearly being the necessary insight.

25. Indeed, my own recent experience suggests that undertakings are <u>not</u> being agreed, despite being proactively proposed by a practitioner, in some cases where they arguably should (and ultimately, clearly, would) have been sufficient: as was evident when the matter in question came before the MPT and all of the allegations, and serious misconduct, were admitted; the doctor did not dispute a finding that his fitness to practice was currently impaired; and the GMC agreed that conditions were appropriate and proportionate.

26. That being said, I would be interested whether others have had a different experience.

Richard Booth QC

Year of call: 1993

Year of silk: 2013

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Richard Booth QC

@DickBoothQC

Head of Chambers, Richard has practised at 1 Crown Office Row since being called to the Bar by Middle Temple in 1993. He grew up in South Wales before taking degrees in Cambridge and Brussels. As a junior, he had a broad base of advocacy experience in a variety of courts and tribunals the length and breadth of the country. He specialises in clinical negligence, disciplinary / regulatory law, personal injury (especially brain and sports injuries), costs, inquests and sports law.

Richard is instructed in cases of the highest value and complexity with his clinical negligence practice is split approximately 50/50 between claimants and defendants.

Richard generally defends healthcare and veterinary professionals before disciplinary tribunals, but has also prosecuted in the First-Tier Tribunal in performers list appeals. Additionally experienced in hearings involving Medical Practitioners Tribunal Service, General Dental Council, General Chiropractic Council, Royal College of Veterinary Surgeons and various sporting bodies.

He was nominated for 'Professional Discipline Silk of the Year' Chambers Bar Awards 2018 and has been consistently recognised as a 'Leading Silk' by Chambers & Partners and Legal 500.

Having originally studied Modern Languages at Cambridge, Richard has a good working knowledge of Spanish and French.

Appointments:
Appointment of Junior Counsel to the Crown (Attorney-General's Regional Panel) from 2000 to 2012.
Recorder on the Wales Circuit since 2008.

Memberships:
PNBA
PIBA
Wales & Chester Circuit

Qualifications:
MA (Cantab)
Lic. Spec. Dr. Eur. (Brussels)

Publications:
Contributed Chapter to *An Introduction to Human Rights and the Common Law* (Hart Publishing, 2000)

Awards:
Awarded Fellowship of the British Chiropractic Association in 2012 after defending over 500 BCA members against disciplinary charges regarding the content of their websites.

Directories:
"Intelligent and very easy to work with." "Superb with experts and always well prepared." "Hard-working and very bright." Chambers & Partners 2019

'Very client friendly – registrants have great confidence in him.' (Legal 500 2018)

"An excellent negotiator with exceptional analytical and organisational skills." "Great with the intricacies and complexities of high-value quantum cases." Chambers & Partners 2018

"He appears in high-profile medical cases." Legal 500 2017

"Incredibly thorough in his preparation." "A very good advocate." Chambers & Partners 2018

"A first-rate, impressive advocate who is regularly retained on challenging cases." Chambers & Partners 2017

Clodagh Bradley QC

Year of call: 1996

Year of silk: 2016

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Clodagh Bradley QC

@ClodaghBradley

Clodagh Bradley QC specialises in healthcare regulatory law, clinical negligence and inquests with a medical or psychiatric element to them, including in custodial settings.

Clodagh has dealt with a broad range of disciplinary cases predominantly on behalf of doctors before the Medical Practitioners Tribunal Service (previously GMC), and also cases brought by the General Dental Council (GDC), the General Osteopathic Council (GOsC), the General Optical Council (GOC) and the Nursing and Midwifery Council (NMC), ranging from those relating to criminal offences including fraud and other dishonesty (including allegations of rendering a patient in a comatose state through excessive opiates and persuading her to include him in her will, having deemed her to be terminally ill), rape and other sexual assaults, the practitioner's health (physical and mental), and cases involving concerns about alcohol and opiate misuse, including self-prescription, and performance issues.

Clodagh has successfully challenged regulatory decisions in the Administrative Court. She represented Dr Waney Squier, consultant paediatric neuropathologist, in a high profile MPTS / GMC case and subsequent successful appeal which has significant implications for expert witnesses where concerns are raised about straying outside of their expertise or allegations of bias are made (Squier v GMC). Clodagh is experienced in dealing with matters relating to conflicts of interest and apparent bias (GOsC v X).

Qualifications:
Magdalene College, Cambridge University, MA (Law) (1992-1995)

Awards:
Middle Temple Astbury Major Scholar (1995-1996)

Middle Temple Harmsworth Major Entrance Exhibitioner (1995–1996)

Directories:
Clodagh has been recommended for many years by legal directories.

"A brilliant litigator. She is excellent on her feet and her paperwork is excellent. She is a real all-rounder and a robust negotiator." "Very bright and easy to deal with." (Chambers & Partners UK, 2019)

'She has extraordinary capacity to absorb detail.' 'Fiercely bright, asks the right questions and is a tenacious and fearless advocate.' 'A highly effective advocate who never fails to impress.' (Legal 500 2018)

""Her attention to detail is exceptional and she is very user-friendly."
"Extremely thorough and excellent with clients." (Chambers & Partners UK, 2018)

"Supremely confident and unrelenting."
(Legal 500 2016)

"A first-class barrister who fights to the end and provides sound advice." (Chambers & Partners UK 2017)

"*A reassuring presence in conference and a real fighter in the courtroom."*
(Legal 500 2016)

William Edis QC

Year of call: 1985

Year of silk: 2008

william.edis@1cor.com

Recognised as a leading Silk in his field, William Edis QC has a wide practice covering healthcare law, clinical negligence, disciplinary and regulatory inquiries, inquests, employment, public law and personal injury.
He regularly acts in cases of the highest value and importance and complexity. He has appeared before the Supreme Court, the House of Lords, the Court of Appeal and all courts relevant to his practice areas. He has acted as a mediator.

Memberships:
PNBA
PIBA
LCCBA
ARDL

Qualifications:
Dip Law (City University)
MA (Oxon)

Publications:
He regularly gives lectures as an invited speaker and writes the Chapter on settlement of personal injury claims involving protected parties in *The Law and Practice of Compromise* by Sir David Foskett (Sweet & Maxwell)

Directories:

'An excellent advocate with a silky tongue.' (Legal 500 2018)

"A class act." "Absolutely brilliant." "He has the ear of the court and is very persuasive." "He is brilliant at cross-examination and also summing up." (Chambers & Partners 2017)

“He appears in big judicial reviews.” (Legal 500 2017)

"A highly intelligent and fluent advocate. He is caring with clients and does a lovely summing-up of the case. He's really first class." "Very effective at producing results." (Chambers & Partners 2018)

"Meticulous, thorough and hard-working." "A really impressive performer." (Chambers & Partners 2018)

"A brilliant analytical mind." "Erudite and eloquent, and has a real charm about him." (Chambers & Partners 2017)

"One of the more cerebral advocates; he brings the power of intellect to cases, which has proven invaluable to clients." "One of the leading silks in this area of work, with a gift for knowing how to cut to the chase and get to the real issue." (Chambers & Partners 2017)

Jeremy Hyam QC

Year of call: 1995

Year of silk: 2016

Jeremy.hyam@1cor.com

Jeremy Hyam QC is a specialist in Administrative and Public Law, Human Rights, Clinical Negligence, Public Inquiries, Professional Discipline and
Environmental Law. He has particular experience in all aspects of health law, including Mental Health, the regulation and discipline of doctors; GMS
contracts, the Health and Social Care Act, the Care Standards Tribunal, and cases concerning eligibility for and access to treatment including cases
concerning community care.

Appointments:
Attorney General's A Panel of Counsel (present)
Attorney General's B Panel of Counsel

Special Advocate (present)

Publications:
Supreme Court Yearbook (Public Law) with Philip Havers QC (2017)

Supreme Court Yearbook (Public Law) with Philip Havers QC (2016)

Clinical Negligence (APIL) Medical Treatment and Human Rights (2013) with Philip Havers QC
"Human Rights and Mental Health" (Chapter in Human Rights and the Common Law: Hart Publishing 2000)

Directories:
Jeremy has been recognised by the Legal 500 and Chambers & Partners since 2010.

"He gives robust advice and is a confident negotiator." "Thorough, succinct and positive to deal with." (Chambers & Partners 2019)

'Superb judgement and an impressive work ethic.' (Legal 500 2018)

"Jeremy is a smooth operator in court." "He is clever, sees all the angles and is reasonable. He will tell you if an argument won't fly." (Chambers & Partners 2018)

"Authoritative and commanding." "He has a fantastic legal mind." (Chambers & Partners 2018)

"*Good on strategy and an excellent negotiator."* (Chambers & Partners 2017)

'He has superb judgement and an astonishing work ethic.' (Legal 500 2017)

"Incredibly bright. He always sees the argument when it may not be immediately apparent." "A reflective, imaginative and creative barrister, with a very attractive advocacy style. He's always thinking of new ways in which the law can be deployed." (Chambers & Partners 2017)

"*Highly intelligent. He is an excellent advocate and superb on his feet." "He's very good and very cerebral. It's like being against an academic."* (Chambers & Partners 2017)

Owain Thomas QC

Year of call: 1995

Year of silk: 2016

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Owain Thomas QC

@OwainThomasQC

Owain Thomas QC has a broad practice with an emphasis on the areas of medical law, professional discipline, public law (in particular relating to healthcare) and taxation.

Owain has considerable experience in all areas of professional regulation and regularly appears on behalf of doctors, dentists and other professionals before the GMC, GDC etc.

Owain has wide experience of representing doctors in all forms of GMC hearings including FTP hearings, IOPs, Investigations Committee hearings and reviews.

Owain has considerable experience of representing dentists in all forms of GDC hearings including FTP hearings.

Has experience of representing other professionals before their professional bodies e.g. Insurance Brokers, Structural Engineers, Accountants and Psychotherapists.

Appointments:
Recorder on the Midland Circuit
Junior Counsel to the Attorney General's A Panel (2008)
Junior Counsel to the Attorney General's B Panel (2003)
Junior Counsel to the Attorney General's C Panel (2001)

Memberships:
HRLA
LCLBA

PIBA
PNBA

Directories:
Recommended as leading silk by Chambers & Partners and the Legal 500.

"He is incredibly bright and knows tax very well." (Chambers & Partners 2019)

'Approachable, friendly and a skilled advocate.' (Legal 500 2018)

"Incredibly good in court and exceptional at dealing with cases that are uniquely and finely balanced on the facts: He has a real eye for detail." "Delightful to work with, he is intelligent, calm, modest and a real fighter."
(Chambers & Partners 2018)

"A persuasive advocate with a good feel for difficult issues. He has a good eye for the evidential shaping of a case and is very nice to work with."
(Chambers & Partners 2018)

"He has the impressive ability to identify the relevant issues and construct persuasive arguments." "He brings clarity to complex situations."
(Legal 500 2018)

Robert Kellar

Year of call: 1999

Robert.kellar@1cor.com

Robert has a broad civil, regulatory and public law practice which encompasses: clinical negligence, personal injury, professional discipline, judicial review/human rights, healthcare inquests and employment law.

In clinical negligence he is instructed by both Claimants and Defendants and has considerable experience in complex, multi-party and high value claims. He deals with all types of case including claims involving brain injury, spinal injury, vascular injury and missed cancer diagnoses. He was recently instructed as junior counsel for the Claimants in the Paterson Group ligation.

Robert is recognised as a leading junior in personal injury law and is instructed by both Claimants and Defendants, including by major Government Departments. He has experience in all types of personal injury, road traffic cases and accidents at work. Robert is also instructed in cases involving allegations of historic assault and sexual abuse.

He is highly recommended as a leading junior in the Legal 500 and Chambers & Partners.

Appointments:
Junior Counsel to the Crown (A Panel)
Panel of External Advisers to the Legal Services Board

Qualifications:
LLM (Cantab) (First Class) – Queens College, Cambridge
BA (Oxon) – Magdalen College, Oxford
Academic Awards: Scholar of Queens' College, Cambridge;
Scholar of Magdalen College, Oxford;
Winner of Lee Essay Prize, Gray's Inn

Directories:

"He's brilliant at every stage of a case." (Chambers & Partners 2019)

‘Very strong court advocate and a good strategic thinker.’ ‘Able to take on the most complex cases and can turn his hand to any aspect of public law.’ (Legal 500 2018)

"Detailed and gives good practical advice. He was clear in advising clients while also being sensitive given the nature of the cases." "Calm and can make what might seem complicated simple." (Chambers and Partners 2018)

‘An exceptional talent.’ He is very approachable and gives excellent practical advice.’ ‘Always very thorough and detailed, and very approachable too.’
(Legal 500 2017)

"I find him very easy to deal with, very pragmatic and a good communicator. He always turns things around on time." (Chambers and Partners 2017)

"Extremely persuasive, charming and affable." (Legal 500 2016)

Matthew Barnes

Year of call: 2000

Matthew.Barnes@1cor.com

Matthew Barnes has a civil and public law practice focused on all aspects of medical law, including clinical negligence, inquests, regulatory, and public law. He also deals with personal injury. He is a highly recommended junior by both Legal 500 and Chambers & Partners.

His practice includes work for both claimants and defendants, covering a range from low value claims up to the highest value catastrophic brain injuries.

He is regularly instructed to act for Defendants in regulatory proceedings, including the GDC, the GMC, the NMC, the British Acupuncture Council, internal NHS Trust disciplinary hearings, and the Performers Lists for GPs and dentists. He has experience of cases involving criminal charges, and has been instructed to defend doctors in the magistrates' court and crown court.

He has extensive experience of public law, both from his time as junior counsel to the crown and in respect of medical issues, and has been involved in challenges to treatment decisions and appeals from the GDC and GMC.

Appointments:
Junior counsel to the Crown B Panel (2009-2014)

Qualifications:
MA, Bristol University (1997)

Directories:

Recommended as a leading junior by Chambers & Partners and in Legal 500. In the last two years, those recommendations have included the following:

"Very helpful and very experienced." "A really superb tactician who is good at cutting through a case and getting clear solutions. Brilliant on his feet." "His advice is always very

much on point." "Absolutely lovely. Really nice to work with." (Chambers & Partners 2019)

'Incredibly tenacious, pragmatic and tactical; consistently achieves good results.' 'He defends medics in fitness to practice cases' (Legal 500 2018)

'Tenacious and robust on his feet' 'An exceptionally bright mind blended with great pragmatism and practical thinking'

"A very confident advocate with a lovely style that manages to get people on his side and that demonstrates his really detailed knowledge." "He was extremely peasant and relaxed in his manner, which was very reassuring for the client." (Chambers & Partners 2018)

"He has a natural talent for advocacy and getting to the nub of complex issues with ease' 'Excellent on the papers, quick on his feet and a source of tactical advice throughout' (Legal 500 2017)

Christopher Mellor

Year of call: 1999

christopher.mellor@1cor.com

Christopher has a common law and public law practice. In addition, he has wide-ranging experience in other professional negligence work and personal injury.

He has extensive experience in clinical negligence (acting for both claimants and defendants); in medical disciplinary and regulatory work (e.g. MPTS hearings; before the GDC and NMC; and in Trust disciplinary hearings); in cases involving medical treatment decisions (including emergency injunctions and declarations); in inquests; and in other medical law related matters.

He has been instructed in a number of high profile GMC cases, including *GMC v Dr Andrew Wakefield and others* (the prosecution of the three doctors involved in the research connected with the MMR debate), and in judicial review proceedings brought against the GMC.

Christopher's public law practice also includes work in Public Inquiries. He was Junior Council for the West Midlands Strategic Health Authority in the Mid Staffordshire NHS Foundation Trust Public Inquiry chaired by Robert Francis QC.

Appointments:
London-Westminster Research Ethics Committee (REC)

Memberships:
ARDL
HRLA
PIBA
PNBA
South Eastern Circuit

Qualifications:
MA, Cambridge University (2002)
BVC (1999)
BA (Hons), Cambridge University (1998)

Publications:
"*A duty of candour: A change in approach*" Clinical Risk January/March 2014 20: 36-46

Co-author "*Third Party Interventions by the Government and the Public Interest*" [2004] JR 130 (Vol 9, Issue 2)

Regularly gives talks and seminars on topics such as "What puts the "*mis*" into "*misconduct*" and should the 'three stage test' be applied before referral to the Case Examiners?"

Directories:
Recommended as leading junior by Chambers & Partners.

"Extraordinary skill in managing difficult clients." "Always on top of all the detail, he is incredibly diligent in his role." (Chambers & Partners)

"He is very user-friendly, prepares unbelievably well and has a very reassuring manner in front of coroners." "He is extraordinarily calm in front of juries and sensitive in cases that are difficult for all involved." (Chambers & Partners)

"His ability to assimilate a very large volume of information in a short time is extremely impressive." "He is clear and concise in his advice, and has an absolutely thorough understanding of the matters he deals with." (Chambers & Partners)

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Chambers has a strong and varied team of qualified mediators and barristers ready and willing to undertake mediation work in all areas of practice.

Mediation is an informal, flexible process with the added advantage of being confidential and “without prejudice”. It works in the majority of cases if the parties want it to work. Where successful, it produces an agreement which both parties want, not a result imposed by a Court, which may satisfy neither side. It saves costs. It avoids the emotional expense of litigation. It cuts out the risks entailed in litigating. It can help maintain business and personal relationships that might otherwise be undermined by the tensions of litigation. It can be arranged, and concluded, quickly.

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- Environmental regulation
- Workplace disputes in the NHS

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The 1COR Bundle

The 1COR Bundle is the annual newsletter of 1 Crown Office Row which features case analysis from all of 1COR's cases across the year in each of our practice areas. The current edition, The 1COR Bundle 2017 – 2018 is currently available, please email to receive your copy.

The UK Human Rights Blog

Up to date analysis and discussion on Human Rights Law in the UK from the specialists at One Crown Office Row.

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Each week sees new posts and updates on the most high profile cases with comments and features written by our Human Rights and Public Law specialists. Please subscribe for regular updates.

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Law Pod UK

1 Crown Office Row have recently launched a new regular podcast, **Law Pod UK**, with presenter Rosalind English, to discuss developments across all aspects of Civil and Public Law in the UK.

It comes from the creators of the UK Human Rights Blog and is produced by the barristers at 1 Crown Office Row and Whistledown Productions, and each week features interviews with our QCs and barristers.

Please visit iTunes, Audioboom or Overcast to download and listen or find us on twitter @LawPodUK1.

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