IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT
[2019] EWHC 493 (Admin)

CO/2751/2018

Royal Courts of Justice
Monday, 28 January 2019

Before:

MR JUSTICE SOOLE

B E T W E E N :

GENERAL MEDICAL COUNCIL — Claimant

- and -

X — Defendant

ANONYMISATION APPLIES

J U D G M E N T

A P P E A R A N C E S

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

MR M. SUTTON QC and MR D. MORRIS (instructed by BLM Law) appeared on behalf of the Defendant.

MR JUSTICE SOOLE:

1 Dr X is a medical practitioner in the paediatric (and in particular neonatal) field. By determination dated 18 December 2017 the Medical Practitioners Tribunal (MPT) upheld allegations of Dr X's sexual misconduct and dishonesty arising from an online sexual conversation with an adult who in the course of the conversation and as a member of an online paedophile vigilante group falsely self-identified as aged 15. Following a further hearing on impairment and sanction, the MPT by determination dated 15 June 2018 imposed a 12-month suspension on Dr X's registration, and subject to further review.

2 The MPT had agreed to conduct these hearings in private on the basis of evidence of a real and immediate risk that Dr X would commit suicide if the hearings were held in public and, in particular, if Dr X's sexuality and sexual misconduct were thereby exposed.

3 Following the determination on sanction, Dr X requested the General Medical Council (GMC) not to publish any part of its determination beyond the fact of the suspension for 12 months on grounds of misconduct, on the same basis of a real and immediate risk of suicide if that occurred. By a decision dated 17 July 2018 (clarified 20 July 2018) the GMC refused the request in its full width but indicated its willingness to redact the determination in terms that made it neutral as to gender and sexuality.

4 By the application for judicial review, Dr X seeks an order quashing the decision of 17 July 2018. By appeal, pursuant to s.40A Medical Act 1983, the GMC contends that the sanction of suspension was too lenient and that the MPT should have ordered erasure of Dr X from the Register.

5 By order of Walker J, dated 18 September 2018, permission was granted to proceed with the judicial review. It was further ordered that this should be heard together with the s.40A appeal and that the identity of Dr X should be anonymous until further order. In the light of further observations of Walker J, the parties agreed the terms of a consent order which provided for the publication of the MPT determination on the MPTS website in a form which was anonymised and with redaction as to gender and sexuality. This judgment is prepared in similar form.

6 Mr Mark Sutton QC, leading Mr David Morris, appeared for Dr X. Mr Ivan Hare QC appeared for the GMC. I am grateful for the clarity and quality of their submissions.

The misconduct

7 The essential facts can be taken from the MPT's findings of fact. On a date in June 2015, in the early hours, Dr X went on to an adult website and began a sexual conversation with someone identified as A. Dr X believed that the site was restricted to people over 18. After about 53 minutes, A said that they were aged 15. In the course of the continuing conversation, A told Dr X that they had been sexually abused by their father and had liked it. The conversation continued in sexual terms, although Dr X's language was more restrained than it had been previously. Dr X suggested that they needed to meet up and sent their picture and phone number to A. A then stated that they had a friend (B) aged 14, who also wanted to play, and sent Dr X a picture. Dr X said they both looked very attractive and arranged to meet both the following day.

8 The MPT did not accept Dr X's evidence that, from the time of the reference to abuse, their motive for continuing the conversation was to counsel and help A; or that by the end of the conversation Dr X had come to a firm conclusion not to keep the arrangement of meeting the

following day. Whilst accepting that Dr X had become increasingly cautious about meeting up, it was satisfied that there was sexual motivation throughout the conversation.

9 Dr X's evidence was that they still believed A to be over 18, and that saying they were 15 was just part of A's sexual fantasy which Dr X played along with. On this, the MPT concluded:

> "The tribunal does not find that you believed A was 15 but is satisfied that the information did not inhibit your language and you were prepared to have a sexually explicit conversation with someone who might have been 15.": para.26.
>
> Furthermore, there was "... clear and compelling evidence that when you were confronted with someone online who you thought at least might be 15 and/or 14, you continued a sexual conversation for over half an hour, during some of which you were tempted to meet A and B for a sexual purpose.": para.38.

10 In the conversation, Dr X asked, "How do I know that this is not one of those paedophile tricks??" The MPT rejected Dr X's explanation that this was asked because it would be easier to counsel A and B face-to-face, and that the concern was how it might look if a meeting with a 15-year-old were observed, e.g. on CCTV, and someone "got the wrong end of the stick". The MPT concluded that Dr X "... believed there was the potential of a sexual encounter but that you were being cautious. You recognised the danger of having had a highly sexualised online chat with someone you believed might be 15 years old, and that meeting them could be a trap". The tribunal rejected the contention that Dr X's intention was to counsel A and B, concluding that, "... your reason for asking if it was a paedophile trick was because your motives remained sexual and you were looking to your own safety.": para.46.

11 Dr X subsequently decided not to attend the meeting which had been arranged for the following day. There was no further contact.

12 As the MPT accepted, A was not a child of 15 but an adult member of the public, often known as an online vigilante, who reported the conversation to the police.

13 Following a police investigation, officers visited Dr X at home on 24 June 2016, i.e. over one year later. The police had likewise decided that the conversation was with an adult member of a "paedophile vigilante group"; that no criminal offence had been committed; but that the matter would be referred to Dr X's employers an NHS Trust.

14 During a meeting with the police on 27 June 2016 Dr X said that the reason for arranging to meet A was to provide support and counsel.

15 The matter was investigated by the NHS Trust. During an investigation meeting on 20 July 2016 Dr X stated that the reason for arranging to meet A was to counsel them because of the abuse they had suffered.

16 In the course of Dr X's evidence at a disciplinary hearing on 1 September 2016, Dr X again stated that they had continued with the online conversation in an attempt to counsel A.

17 The MPT found all these statements to be untrue, misleading and dishonest. These findings of fact were announced on 22 December 2017. At a later stage, the MPT summarised these findings as follows:

> "In summary, the tribunal found that in June 2015 you engaged in an online conversation of a sexual nature on the ... website with an individual who told you that they were 15 years of age. The tribunal found that during the course of a sexual conversation, you arranged to meet the individual concerned the following day for a sexually-motivated purpose. The tribunal also found that between June 2016 and September 2016, you acted dishonestly in that you made statements and gave evidence which you knew to be untrue to both the police and the Trust in respect of the reason for you wanting to arrange to meet the individual concerned.
>
> You told both the police and the Trust ... that you had wanted to support and counsel the individual concerned about abuse they had suffered previously. The tribunal found to the contrary that your actions were sexually motivated."

Impairment

18 On 14 June 2018, the MPT turned to the question of whether, on the basis of the facts admitted and found to be proved, Dr X's fitness to practise was impaired by reason of misconduct. Counsel for Dr X, Mr Morris, acknowledged that a finding of misconduct was inevitable. As to impairment, he reminded the tribunal that the question of impairment was a matter for it alone to determine, and stated that no submissions would be made on that issue.

19 The tribunal concluded that the facts proved amounted to serious misconduct. As to impairment, it took particular account of the factors identified by Dame Janet Smith in the fifth report to the Shipman Inquiry: see para.17. In concluding that Dr X's fitness to practise was impaired by reason of such misconduct, the MPT made the following particular observations as to risk to patients, integrity, insight and remediation.

20 As to risk to patients, "there has been no suggestion that you have posed a clinical risk to patients in the past. The question of whether or not you are liable to act in such a way as to put a patient or patients at unwarranted risk of harm in the future has not been the central concern of these proceedings. Nevertheless, having regard to all the circumstances of this case, the tribunal was satisfied that it was a reasonable inference for it to draw that you pose some risk to young patients.": para.18.

21 Noting Dr X's work in the paediatric field, the MPT continued:

> "... While the evidence is that you mostly work with babies, the tribunal found that you pursued a sexually-motivated online conversation with an individual who told you they were 15 years old. The tribunal determined that the content of the conversation demonstrated a level of attraction on your part to young people. While the tribunal found that you did not ultimately act on your arrangements to meet the individuals concerned, you nonetheless considered doing so. The tribunal therefore concluded that, on the basis of its findings, you pose some risk to patients.": para.19.

22 Furthermore:

> "The tribunal was satisfied that your sexually-motivated and dishonest misconduct has brought the medical profession into disrepute. Once the person told you they were 15 years old, continuation of the sexualised

> online conversation was inappropriate. While the tribunal accepted that you did not ultimately act on the arrangements you made to meet the individuals concerned, the arrangements you made demonstrated a desire on your part to act upon your apparent sexual attraction to young people." para.20.

23 As to integrity, the tribunal noted that acting with honesty was a fundamental tenet of the medical profession which Dr X had breached. It continued:

> "The tribunal accepted that once you had provided that dishonest explanation to the police, you may to some extent have felt trapped by it and that you may then have felt a need to maintain that same explanation to the Trust for the sake of consistency. However, the tribunal was satisfied that providing and then making a dishonest explanation of your conduct over a period of time was not mitigated by the context in which that dishonest explanation may have originally been conceived. In all the circumstances, the tribunal was satisfied that because of your dishonesty, your integrity cannot be relied upon.": para.21.

24 As to insight, the tribunal stated:

> "In respect of the level of insight you have shown into your misconduct, its seriousness and its consequences, the tribunal was satisfied that you do not yet have insight, whatever the reasons for that may be.": para.22.

25 As to remediation, the tribunal considered in the light of the observations in *Cohen v GMC* [2008] EWHC 581 (Admin) at para.65, whether Dr X's misconduct was capable of being remediated, whether it had been remediated, and whether it was highly unlikely to be repeated. Accepting that both sexually motivated and dishonest conduct were capable of being remediated, it continued:

> "However, the tribunal has no evidence that you have remedied either your sexually-motivated misconduct or your dishonesty. Given the absence of any insight and remediation, the tribunal could not be satisfied that it is highly unlikely that your misconduct will be repeated. The tribunal therefore determined that a finding of impaired fitness to practise should be made.": para.23.

The tribunal concluded as follows:

> "In any event, given the nature of its findings and their seriousness, the tribunal was satisfied that the need to promote and maintain proper standards of conduct and to maintain public confidence in the profession would be undermined if a finding of impaired fitness to practise were not made in this case. The tribunal therefore determined that your fitness to practise is impaired by reason of your misconduct.": para.24.

Sanction

26 At the stage of sanction, the MPT heard oral evidence from Mr P, a friend who had supported Dr X throughout the proceedings and whose written testimonial had been provided to the tribunal earlier in the proceedings. It received two further testimonials on Dr X's behalf and heard detailed submissions from Counsel, Mr Morris.

27 The tribunal recorded that in his written testimonial, Mr P had described Dr X as "a person of integrity who always has the best intentions and considerations for others" and in his oral evidence had said that his knowledge of the adverse findings had not changed his perception of Dr X's integrity in any way. In response to questions from the tribunal, he said that whilst he did not have any children of his own, he did not have any concerns about Dr X being in the company of children.

28 In submissions on behalf of the GMC, Counsel who appeared below, Mr Simon Jackson QC, submitted that the appropriate and proportionate sanction was erasure; and for that purpose referred the tribunal to relevant paragraphs in the GMC/MPTS Sanctions Guidance, February 2018 edition. As the decision records, Mr Jackson pointed to the tribunal's conclusions on the issue of impairment and emphasised the issues of risk to patients, persistent dishonesty and lack of insight or any prospect of remediation. The submissions reflected provisions in the Sanctions Guidance to which I will refer later.

29 Mr Morris submitted that the appropriate and proportionate sanction was suspension. He referred to the relevant sections of the Guidance dealing with suspension and erasure and the factors which might indicate that the respective sanction was appropriate. By reference to para.92 of that Guidance, he in particular submitted that, serious as it was, the misconduct (both sexual and dishonest) was not fundamentally incompatible with continued registration.

30 As to sexual misconduct, he submitted that this was a single incident falling at the lower end of the spectrum of child sexual misconduct. He pointed to the following additional factors, namely Dr X's initial belief that it was conversation with an adult; that there was no plan to have a sexually-motivated conversation with a child; that Dr X had been entrapped by a vigilante pretending to be only 15; that no child was involved; that no indecent images of children were shared; that the conversation became less sexually explicit once Dr X thought it might be a child; that although Dr X had first suggested a meeting, the vigilante A thereafter took the lead; that Dr X did not ultimately attend the agreed meeting; and that no criminal offence was committed.

31 Mr Morris submitted that by reference to the Sanctions Guidance in respect of sexual misconduct, child sex abuse materials, predatory behaviour and dishonesty, the misconduct fell outside the criteria which would make erasure appropriate. As to dishonesty, he submitted that although repeated, it was limited to the attempts to give an innocent explanation for the single incident of sexual misconduct.

32 As to insight, he reminded the tribunal of its observation on impairment that Dr X did "not yet have insight". It was a "realistic scenario" that Dr X might develop significant insight. Mr Morris referred to the evidence of Dr C, a treating psychiatrist of Dr X, that the immediate state of mental health was such that Dr X could not think past the present hearing. Mr Morris submitted that it was understandable that there had, as yet, been no development of insight. However Dr X had instructed him to admit on Dr X's behalf that what the tribunal had found proved was serious and deplorable. He submitted that it therefore did not follow that Dr X displayed any attitudinal problem towards sexual misconduct or dishonesty.

33 The MPT concluded that the appropriate sanction was suspension for 12 months, coupled with the requirement to attend a subsequent review by the MPT pursuant to s.35D Medical Act 1983. In reaching that conclusion, it had paid particular attention to the Sanctions Guidance; and bore in mind that the purpose of sanctions was to protect the public and the principle of proportionality. It took account of the tribunal's statutory overarching objective, namely protecting, promoting and maintaining the health, safety and wellbeing of the public; promoting and maintaining public confidence in the medical profession; and promoting and maintaining

proper professional standards and conduct for members of that profession: see s.35E(3A) and s.1 Medical Act 1983.

34 The tribunal then considered the aggravating and mitigating factors. As to sexual misconduct, there were no aggravating factors. It identified as mitigating factors Dr X's previous good character; the absence of any evidence in Dr X's lifestyle to suggest that this was anything other than a single incident which occurred within a relatively short period of time on a single day; that the conversation was on an adult-only website and was thus not a premeditated sexualised conversation with a minor; that Dr X was entrapped by a vigilante purporting to be 15; that there was no child involved in the conversation and no harm caused to anyone; that no child sex abuse material was involved; that no criminal offence was committed; that although Dr X had instigated discussion of a potential meeting, the vigilante took the lead in arranging a meeting thereafter; that Dr X had not gone through with the arrangement; that the conduct did not involve abuse of position of trust as a doctor; and Dr X's uncontested oral evidence never to have had an encounter with someone spoken to online, nor indeed to have had any form of sexual liaison.

35 As to dishonesty, the MPT found aggravating factors in that the dishonesty was to the police and to official Trust enquiries, and that it was sustained.

36 As to mitigating factors, it again identified Dr X's previous good character; that the dishonesty did not impact upon patient safety or was for reasons of fraud or personal gain, but arose out of fear and/or shame and/or embarrassment for what had happened; that it was limited to denying sexual motivation; and that the single albeit repeated lie was naive and transparent.

37 The tribunal then considered the options available, starting with the least restrictive. It rejected the options of no action or the imposition of conditions.

38 Turning to suspension, it considered the provisions of the Sanctions Guidance in that respect, i.e. paras.91-102. It noted the deterrent effect of suspension and that it "can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor": para.91.

39 It noted that:

> "A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (i.e. for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession)": para.92.

and that suspension:

> "may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions.": para.93.

40 Citing paragraph 97 of the Sanctions Guidance, which sets out a non-exhaustive list of factors which would indicate that suspension may be appropriate, the tribunal concluded that the misconduct constituted a serious breach of the standards to be expected from a doctor, but was

not fundamentally incompatible with continued registration in the light of the mitigating factors identified by Mr Morris and the tribunal: see para.97 factor (a).

41 The tribunal was satisfied that the misconduct did not constitute a "blatant disregard" for the relevant principles.

42 The tribunal found that Dr X's mental health was relevant in two particular respects. First, as to the weight to be given to the admission made through Mr Morris that the proved behaviour was deplorable. The tribunal said that it would normally attach little weight to acknowledgements of faults made through Counsel alone. However "the tribunal was mindful of the state of your mental health and it accepted that in the specific circumstances of this case, more weight could be attached to that acknowledgement than might otherwise be the case".

43 On the issues of insight and remediation, "the tribunal found on the unusual facts of this case that the development of your insight is likely to have been hampered by the state of your mental health. In this regard, the tribunal gave considerable weight to the evidence of Dr C, who has treated you for a considerable period of time, that you are too unwell to practise medicine and unable to think beyond the immediate present and the issue of your family discovering your sexuality.": para.35.

44 The tribunal continued:

> "36. In respect of steps that you have taken to mitigate your misconduct, the tribunal accepted that because of your mental illness, you may only be able to mitigate your misconduct openly once the case had concluded. However, the tribunal found that in this case it was right to bear in mind that there has been no repetition of your misconduct in the intervening three years, and this is itself a significant indication for remediation and your ability to remediate.
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> 37. Having regard to the matters set out above, the tribunal was not satisfied that you are incapable of gaining full insight. It bore in mind that your recent comment made through counsel... may indicate the start of that process. There is no evidence before it that remediation is unlikely to be successful if your mental health improves. In this respect, the conclusion of these proceedings is likely to be a major step forward. Nonetheless, you will doubtless require support from the CMHT. In those circumstances, while the tribunal determined at the impairment stage that it could not be satisfied, given the level of your insight and remediation, that it is highly unlikely that you will repeat your misconduct, it was nonetheless satisfied that the likelihood of repetition is increasingly remote."

45 The tribunal then noted from the Sanctions Guidance that the sanction of erasure may be required in cases involving sexual misconduct and dishonesty. However it concluded that the misconduct in the present case did not amount to the level of seriousness which that Guidance envisaged. In respect of predatory behaviour under the heading "Abuse of professional position" (Guidance paras.147-148) the tribunal was satisfied that Dr X's behaviour was not predatory. In going onto the adult-only website Dr X was not motivated by the desire to contact children. Nor were there present any of the aggravating features identified in the non-exhaustive list in that section of the Guidance. In respect of sexual misconduct, the tribunal acknowledged the Guidance (paras.149-150) that sexual misconduct seriously undermines public mistrust in the profession; that it was particularly serious when there is an abuse of the

doctor's special position of trust; and that erasure was likely to be appropriate in such cases (para.150). However, the Guidance made clear that sexual misconduct encompassed a wide range of conduct (para.149); and the tribunal concluded that the circumstances of this sexual misconduct did not fall into the category which made erasure appropriate.

46 In respect of dishonesty, the tribunal acknowledged the Guidance that dishonesty relating to matters outside the doctor's clinical responsibility was particularly serious because it can undermine the trust placed by the public in the medical profession (Guidance para.124). It noted that dishonesty, if persistent and/or covered up, is likely to result in erasure (para.128).

47 The tribunal concluded that it was:

> "... satisfied that your dishonesty was serious and sustained in that you were dishonest to both the police and the Trust's official inquiry into your behaviour. As already noted in its determination on impairment, however, the tribunal inferred that once you gave the police a dishonest explanation for your actions, you were, in effect, trapped by that explanation. The tribunal has also had regard to the limited scope of your dishonesty, as set out above.": para.42.

48 The tribunal then took account of the testimonial evidence which:

> "... shows that you are widely perceived to be an honest person who acts with integrity and that you are a committed and respected clinician who is capable of learning from experience. While mindful that some of the testimonials provided on your behalf were written before the tribunal made its adverse findings of fact, the tribunal noted that those who provided the tribunal with more recent testimonials were aware of the tribunal's findings. Mr P confirmed this in his oral evidence. Despite being aware of the tribunal's findings, those who know you well do not have any concerns about you repeating either your sexual misconduct or your dishonesty.": para.43.

49 The tribunal then returned to "... the question of whether your misconduct is fundamentally incompatible with continued registration." It continued:

> "... the tribunal was satisfied that the unusual facts of your sexual misconduct, the narrow ambit of your dishonesty, the lack of repetition in three years, the supportive testimonials which paid tribute to your qualities as a doctor and a person, the obstacles placed in the way of your remediation by your mental illness, taken together, mean that your misconduct is not incompatible with continued registration. In those circumstances, the tribunal was satisfied that public confidence in the profession will be maintained by a period of suspension.
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> The tribunal determined that a period of suspension would be an appropriate and proportionate sanction sufficient to protect the health, safety and wellbeing of the public, to maintain public confidence in the profession, and to maintain proper standards of conduct for the members of the profession. The tribunal was further satisfied that the risk of you repeating your misconduct is low, and that any risk you pose to patients was likely to be further reduced by a period of suspension. The tribunal was satisfied that a fully informed member of the public, cognisant of all

> the evidence presented to this tribunal, would appreciate that a period of suspension is an appropriate and proportionate sanction in this case.
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> The tribunal took into account the impact that this suspension may have upon you, your patients, and others who rely upon your contribution to medicine. However, in the circumstances, the tribunal concluded that your interests are outweighed with a need to protect the public, to maintain public confidence in the profession, and to maintain proper standards of conduct. Further, the tribunal was satisfied that a period of suspension sends a clear message to you, the profession, and the wider public that the sexually-motivated and dishonest behaviour you exhibited constituted behaviour unbefitting a registered doctor and will be taken very seriously.": paras.44-46.

50 The suspension was ordered for the maximum period of 12 months. The tribunal considered, "... that a suspension of this length would give you time to reflect on your misconduct and its consequences, and to develop insight to the point where the risk of repetition is extinguished.": para.47.

51 The tribunal then advised that shortly before the end of the period of suspension Dr X's case would be reviewed by another MPT. This was pursuant to the provisions of s.35D(4A) and (5) Medical Act 1983. At the next hearing, that tribunal would want to be assured "... that you have adequately reflected on and addressed your misconduct and that you have insight into its seriousness." It further advised that the reviewing tribunal may be assisted by evidence of the continuing management of Dr X's mental health, improvement in insight, and a "reflective statement" which "... should show that you fully appreciate the gravity of your misconduct and that you have developed insight. It should also show how you have taken steps to manage your professional and personal life to extinguish any risk of you repeating your misconduct"; and of steps taken to remediate the misconduct (para.48).

52 It then determined that the order would be made with immediate effect.

MPT hearings in private

53 All these hearings were held in private, pursuant to the permissive power in rule 41 General Medical Council (Fitness to Practise) Rules 2004. This provides that:

> "(1) Subject to paragraphs (2) - (6) below, hearings before the... Tribunal shall be held in public.
>
> (2) The... Tribunal may determine that the public shall be excluded from the proceedings, where they consider that the particular circumstances of the case outweigh the public interest in holding the hearing in public."

54 By determination on 21 September 2017 the tribunal concluded that the fact-finding stage should be heard in private. It reached that conclusion having heard the evidence of a consultant forensic psychiatrist (Dr S) called as an expert witness on behalf of Dr X. The tribunal found him to be "an impressive witness who gave a clear and balanced account of your mental state".

55 Dr S's evidence was contained in a report, dated 16 September 2017, and supplemented by considerable oral evidence before the tribunal. The conclusion in the report was that Dr X was suffering from a recognised mental disorder, namely a depressive episode of moderate severity, and was at significant and continuing risk of committing suicide. Dr X had fleeting suicidal thoughts, suicidal ideation and a plan to carry out those thoughts. Although the risk was

currently being managed, Dr S advised that any change in what he called "the dynamic factors" would lead this risk to increase. Those factors were identified as (i) the disclosure of Dr X's sexuality, and (ii) the loss of identity as a doctor, by which Dr S meant the loss of career and being unable to practise.

56 In his oral evidence Dr S stated that Dr X was at particular risk because four of the five factors indicating the likelihood of suicide were present, namely suicidal ideation, intent, a plan and access to lethal means, namely a cannula. The fifth factor, a previous suicide attempt, was absent. He concluded that because of his medical knowledge he was likely to be successful in a suicide attempt. Dr S indicated that a change in the dynamic factors "will be enough" or "very likely" to be enough to elevate the risk the risk of completed suicide from low-moderate to high. The factor of loss of identity could not be mitigated by the tribunal, however the risk from the second factor could be minimised if the hearing were to be held in private.

57 Dr M, a consultant psychiatrist who was then treating Dr X, stated that in his opinion the risk of suicide was a high one. This was based on Dr X's concerns arising from the public disclosure of their sexuality and the allegations and the likely adverse reaction from family members. Dr M advised that a private hearing would reduce the risk of suicide. The application was opposed by the GMC.

58 Having considered the evidence and the provisions of ECHR Art.2 (right to life), the tribunal determined that Art.2 was engaged. It accepted from the "compelling" medical evidence that there was a real and current risk of suicide in the event that the hearing was in public. The tribunal then balanced that risk against the public interest in holding the hearing in public. By reference to rule 41(2) it concluded that the circumstances of the risk of suicide outweighed the public interest. It held that the hearing should for the time being be held in private but that the matter should be reviewed after the facts had been determined.

59 Following that determination of the facts, at a further hearing on 14 June 2018 the tribunal considered an application for the next stages of the hearing to be in private. For this purpose the tribunal had further documentary evidence, including updated reports from Dr M, from his successor as treating psychiatrist, Dr C, and from Dr S. The tribunal also heard oral evidence from Dr C and Dr S. Dr C's opinion was that since the hearing adjourned in December 2017 Dr X's mental health had worsened. Dr X had consistently expressed suicidal thoughts and remained at a high risk of suicide. If details of Dr X's sexual orientation were made public, that would have a significant negative effect on their mental health and would increase the risk. This was described as an objective assessment which took account of Dr C's knowledge of the tribunal's finding concerning dishonesty.

60 Dr S gave evidence that there had been no significant change in mental health since December 2017 and that the risk of suicide remained real. Furthermore, the fact that the risk could be managed by the Community Mental Health Team (CMHT) did not remove the risk. Having heard the rival submissions of counsel, which included references to Articles 2, 6, 8 and 10, and the balance to be set against the public interest, the tribunal concluded that the expert evidence as to Dr X's mental state of health was compelling and indeed "overwhelming". There continued to be a real and immediate risk of suicide in the event of a public hearing. It noted the active steps which Dr X had been taking, including careful plans in respect of making a will and formalising banking arrangements.

61 Whilst accepting that Dr X's mental health was being managed by the CMHT, it was not satisfied that this would be significantly to reduce or minimise the real and immediate risk of suicide.

62 The tribunal concluded that the public interest in the proceedings being heard in public was outweighed - in its word "trumped" - by the Art.2 right to life. Accordingly, the remaining stages of the hearing were heard in private.

The section 40A appeal

63 Section 40A(3) provides that the GMC may appeal against a relevant decision which includes a decision under s.35D(2)(b) giving a direction for suspension "if they consider that the decision is not sufficient (whether as to a finding or a penalty or both) for the protection of the public."

64 By s.40A(4) consideration of whether a decision is sufficient for the protection of the public involves a consideration of whether it is sufficient "(a) to protect the health safety and well-being of the public, (b) to maintain public confidence in the medical profession, and (c) to maintain proper professional standards and conduct for members of that profession."

65 Those matters replicate much of the elements of the GMC's overarching objectives, as identified in s.1(1B) of the Act.

66 By s.40A(6) the court has power to quash the relevant decision and to substitute any other decision which could have been made by the tribunal, alternatively to remit the matter to the MPTS. The essential principles on an appeal under s.40A are uncontroversial. They are identified by the Divisional Court in *General Medical Council v Jagjivan* [2017] EWHC 1247 (Admin) at [40]. Stripped of the authorities cited in their support, they are that:

> "i) Proceedings under section 40A of the 1983 Act are appeals and are governed by CPR Part 52. A court will allow an appeal under CPR Part 52.21(3) if it is 'wrong' or 'unjust because of a serious procedural or other irregularity in the proceedings in the lower court'.
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> ii) It is not appropriate to add any qualification to the test in CPR Part 52 that decisions are 'clearly wrong'.
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> iii) The court will correct material errors of fact and of law... 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...
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> iv) When the question is what inferences are to be drawn from specific facts, an appellate court is under less of a disadvantage. The court may draw any inferences of fact which it considers are justified on the evidence: see CPR Part 52.11(4).
>
> v) In regulatory proceedings the appellate court will not have the professional expertise of the Tribunal of fact. As a consequence, the appellate court will approach Tribunal determinations about whether conduct is serious misconduct or impairs a person's fitness to practise, and what is necessary to maintain public confidence and proper standards in the profession and sanctions, with diffidence...
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> vi) However there may be matters, such as dishonesty or sexual misconduct, where the court is likely to feel that it can assess what is needed to protect the public or maintain the reputation of the profession

> more easily for itself and thus attach less weight to the expertise of the Tribunal.
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> vii) Matters of mitigation are likely to be of considerably less significance in regulatory proceedings than to a court imposing retributive justice, because the overarching concern of the professional regulator is the protection of the public.
>
> viii) A failure to provide adequate reasons may constitute a serious procedural irregularity which renders the Tribunal's decision unjust."

67 In the subsequent decision of the Court of Appeal in *Bawa-Garba v GMC* [2018] EWCA Civ 1879, which overturned the decision of the Divisional Court to substitute the sanction of erasure for the suspension ordered by the MPT, the Court re-emphasised the general caution against interference. Thus, at para.67:

> "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."

68 It also referred to such evaluative decisions as being "... sometimes referred to as 'multi-factorial decision'. This type of decision, a mixture of fact and law, has been described as 'a kind of jury question' about which reasonable people may reasonably disagree... It has been repeatedly stated in cases at the highest level that there is limited scope for an appellate court to overturn such a decision.": para.61.

69 As to the correct approach to the Sanctions Guidance, the Court of Appeal stated:

> "The Sanctions Guidance contains very useful guidance to help provide consistency in approach and outcome in MPTs and should always be consulted by them but, at the end of the day, it is no more than that, non-statutory guidance, the relevance and application of which will always depend on the precise circumstances of the particular case.": para.83.

70 As to the sanction of erasure, it noted that the relevant paragraph in the Guidance used the permissive, not mandatory, words "may indicate" and stated that this made explicit that "what is an appropriate and proportionate sanction always depends on the facts of the particular case in question.": para.85.

71 In the earlier case of *Professional Standards Authority v Doree* [2017] EWCA Civ 319, Lindblom LJ stated:

> "I see no basis in the relevant jurisprudence for the contention that it was incumbent on the Panel to "adhere" to the guidance in the Indicative Sanctions Policy if that concept is intended to mean anything more than having proper regard to the guidance and applying it as its own terms suggest, unless the Panel had sound reasons for departing from it – in which case they had to state those reasons clearly in their decision.": para.29.

Grounds of appeal

72 The GMC submits that the sanction of suspension is insufficient to protect the public. For that purpose Mr Hare focused his oral submissions on three essential grounds. First, that the MPT determination on sanction is inconsistent with its findings on impairment, with a consequence that it has reached contradictory conclusions in relation to dishonesty, insight, remediation, likelihood of repetition and the overall seriousness of both the sexual misconduct and the dishonesty ("Inconsistency"). Secondly, that the tribunal had not properly engaged with the fact that this was also a case of dishonesty ("Dishonesty"). Thirdly, that the MPT had generally failed to engage systematically with the factors in the Sanctions Guidance which indicate that erasure may be appropriate. If it had done so, it should have concluded that erasure was the appropriate sanction ("Sanctions Guidance").

Inconsistency

73 Mr Hare pointed first to the decisions in *General Medical Council v Stone* [2017] EWHC 2534 (Admin) and *Professional Standards Authority for Health and Social Care v Onwughalu* [2014] EWHC 2521 (Admin). In S*tone*, in the course of allowing an appeal against the sanction of suspension and replacing it with an order for erasure, Jay J concluded that the "full force" of the MPT determination on impairment had not been "carried through" to its determination on sanction: see para.59. In *Onwughalu* Cox J had similarly found there to be a "striking disjuncture" between these findings: see para.37.

74 Mr Hare submitted that the MPT in the present case had failed to follow through the logic of its findings on impairment. In doing so, he acknowledged that the MPT had received further evidence at the sanction stage, namely the oral evidence of Dr X's friend, Mr P, and two further testimonials; that Mr P had maintained his view of the integrity of Dr X in the light of his knowledge of the matters which had been proved; that the authors of each testimonial had been aware of the allegations; and that Counsel for Dr X had made no submissions at the time of the issue of impairment. However none of this justified the variation in the conclusions reached on the critical issues.

75 As to Dr X's dishonesty, at the impairment stage the MPT had accepted that, once Dr X had provided a dishonest explanation to the police, he "may to some extent have felt trapped by it and that you may then have felt a need to maintain that same explanation to the Trust for the sake of consistency". However it continued that this maintenance of a dishonest explanation over a period of time "was not mitigated by the context in which that dishonest explanation may originally have been conceived" and concluded that "in all the circumstances, the tribunal was satisfied that because of your dishonesty your integrity cannot be relied upon": para.21.

76 By contrast, in the determination on sanction it had treated it as a matter of mitigation. Thus "as already noted in its determination on impairment, however, the tribunal inferred that once you gave the police a dishonest explanation for your actions, you were, in effect, trapped by that explanation. The tribunal has also had regard to the limited scope of your dishonesty as set out above.": para.42.

77 As to insight, in the determination on impairment it had found that Dr X had none: paras.23 and 24. By contrast, in the determination on sanction it had concluded that the development of insight had been hampered by the state of Dr X's mental health: see para.35. Mr Hare contrasted the Guidance on the list of factors which would indicate that suspension was appropriate. This included where "the tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.": see Guidance para.97(g).

78 As to the tribunal's reliance on the evidence of Dr C, his oral evidence that "... when I saw Dr X, Dr X was not able to think past today" was not made in answer to a question about insight; and if it was relevant to insight, it would have been equally relevant to the determination on impairment. Furthermore the findings on sanction were that the only acknowledgement of fault had been made through Counsel rather than personally. It went no further than stating that the tribunal "was not satisfied that you are incapable of gaining full insight.": see para.37. None of this could support a conclusion as to the first part of the factor identified in para.97(g) of the Guidance, namely that "the tribunal is satisfied the doctor has insight".

79 As to remediation, at the impairment stage the tribunal stated that it "has no evidence that you have remedied either your sexually-motivated conduct or your dishonesty" (para.23). By contrast, at the sanction stage, this was turned round to the statement that "there is no evidence before it that remediation is unlikely to be successful if your mental health improves": para.37. Furthermore Mr Hare pointed to the most recent report, 11 January 2019, of a consultant psychiatrist (Dr P) instructed on behalf of the GMC, which recorded Dr X's account in a consultation on 20 December 2018 that Dr X had agreed to meet A "as a means of ending the conversation". Thus there continued to be neither insight nor remediation.

80 As to likelihood of repetition, at the impairment stage the tribunal had concluded that "given the absence of any insight and remediation, the tribunal could not be satisfied that it is highly unlikely that your misconduct will be repeated": para.23. At the sanctions stage, the tribunal had noted that previous finding, but concluded that it was "nonetheless satisfied that the likelihood of repetition is increasingly remote" (para.37); and that "the risk of you repeating your misconduct is low and that any risk you pose to patients was likely to be further reduced by a period of suspension.": para.45.

81 Set against the second part of para.97(g) of the Guidance, there was no evidence to demonstrate that Dr X "does not pose a significant risk of repeated behaviour". All in all, the tribunal had failed to follow through the logic of its findings on impairment and had no evidence which justified a different conclusion at the sanction stage.

Dishonesty

82 The essential submission was that the tribunal had not properly engaged with the fact that this was a case of persistent dishonesty, as well as sexual misconduct. Mr Hare pointed first to the list of factors in para.109 of the Guidance which may indicate that erasure is appropriate. These include (h), namely "dishonesty especially where persistent and/or covered up".

83 In *Nicholas-Pillai v GMC* [2009] EWHC 1048, Mitting J had observed, at para. 27:

> "... In cases of actual proven dishonesty, the balance ordinarily can be expected to fall down on the side of maintaining public confidence in the profession by a severe sanction against the practitioner concerned. Indeed, that sanction will often and perfectly properly be the sanction of erasure, even in the case of a one-off instance of dishonesty. In this case, the panel, it seems to me, took a merciful course by deciding only to suspend... and to do so for six months."

84 The judge rejected the doctor's appeal. This passage was further cited in *Khan v GMC* [2015] EWHC 301 (Admin) and in the recent decision of *GMC v Nyamasbe* [2018] EWHC 1689 (Admin). Mr Hare submitted that the MPT had failed to grapple with the significance of the finding of dishonesty or the fact of its combination with the sexual misconduct.

Sanctions Guidance

85 On a wider canvas Mr Hare submitted that the MPT had failed to engage systematically with the Guidance factors which indicated that erasure may be appropriate (Guidance paragraph 109); or, if departing therefrom, to state sound reasons for doing so: see *Doree* at para.29.

86 He further cited *GMC v Khetyar* [2018] EWHC 813 (Admin), where Andrew Baker referred to the "very clear steer" provided by the Guidance when one or more of the factors identified in Guidance para.109 had been established (see paras.54-55) and *Stone*, already cited, where Jay J considered that the MPT had failed to grapple with the application of the salient features of the case to the Guidance on sanction (para.53).

87 By reference to the Guidance in para.109, Dr X's dishonesty had been reckless and persistent, and thus engaged factors (b) "a deliberate or reckless disregard for the principles set out in good medical practice and/or patient safety," (h) "dishonesty, especially where persistent and/or covered up". Dr X's continuing lack of insight engaged factor (j) "Persistent lack of insight into the seriousness of their actions or the consequences." Mr Hare acknowledged that the sexual misconduct did not engage factor (f), "Offences of a sexual nature, including involvement in child sex abuse materials."

88 The MPT's reasoning had stopped at the stage of the sanction of suspension and had neither engaged with the factors which might indicate erasure to be the appropriate sanction, nor give reasons for rejecting that course. The combination of factors in the present case made suspension inappropriate and compelled the sanction of erasure.

Conclusions on appeal

89 For the reasons essentially advanced by Mr Sutton, I do not accept that there is any good basis for criticism of the MPT's determination on sanction.

Inconsistency

90 First, there was a crucial distinction between the stages of determination of impairment and of sanction. At the impairment stage, Counsel for Dr X had taken the appropriate and prudent step of acknowledging that the findings of fact compelled a finding of misconduct, and made no submissions on the issue of impairment. At the sanctions stage, Counsel made submissions on all the relevant issues, i.e. including insight, remediation and likelihood of repetition. For that purpose he referred to evidence previously given, e.g. from Dr C at the impairment stage, and adduced further evidence, i.e. from Mr P and the two testimonials as to character. The tribunal was bound to consider all these matters and was not necessarily constrained by its conclusions on these issues when considering impairment. To adopt Mr Sutton's phrase, it was part of an evolving process.

91 Secondly, and in consequence, the evolution of the tribunal's conclusions on these issues was based on their further review in the light of the submissions and the further evidence. Thus Mr Morris had reminded the tribunal of its previous determination that Dr X did "yet" have insight; referred to the evidence of Dr C as to Dr X's state of mental health and inability to think past the hearing; had on instruction delivered Dr X's acknowledgement that what the tribunal had found proved was serious and deplorable; noted the absence of any repetition in the past three years; and submitted that it was a realistic scenario that upon subsequent review Dr X might be found to have developed significant insight. Those submissions found favour and were reflected in the tribunal's conclusions on the prospect of insight, remediation and repetition, as set out in paras.34-37. In my judgment this reflected not inconsistency or failure to follow through the

previous findings but appropriate and reasoned evaluation in the light of the further submissions and evidence.

Dishonesty

92 Mr Morris pointed to the evidence of Mr P and the testimonials of Dr X's character and integrity and submitted that it had occurred outwith professional practice, did not involve fraud or other financial dishonesty, and had been limited to Dr X's attempts to give an innocent explanation for their conduct in the course of the single incident. The tribunal had previously acknowledged that Dr X may have felt trapped by the initial dishonest explanation to the police. Its conclusion on dishonesty at the sanctions stage reflected that earlier observation, but also acknowledged the force of the submissions and the character evidence. In my judgment there was no inconsistency in its conclusion.

93 Nor do I accept that the tribunal failed to take proper account of the Guidance in respect of sustained dishonesty. The tribunal made express reference to para.124 of the Guidance, with its provision that dishonesty related to matters outside of a doctor's clinical responsibility was particularly serious because it can undermine the public's confidence in the profession, and further noted the Guidance (para.128) that dishonesty if persistent and/or covered up is likely to result in erasure: see paras.39 and 42 of the decision. I consider this further in the context of the broader challenge on sanctions guidance.

Sanctions Guidance

94 I do not accept that the tribunal failed to engage with the Guidance as it related to the sanction of erasure, nor failed to explain why it had determined against that course and in favour of the lesser sanction of suspension. The tribunal expressly noted that the Guidance indicated that the erasure may be required in cases involving dishonesty and sexual misconduct (para.39). That in particular reflected paras.109, 124, 128 and 150 of the Guidance.

95 The tribunal then set out in considerable detail why it had concluded that the most severe sanction was not appropriate in the case: paras.40-46. The tribunal distinguished the case from those where erasure is likely to be appropriate, including predatory behaviour of the type identified in the Guidance, sexual misconduct involving abuse of the doctor's special position of trust, the commission of a criminal offence, and dishonesty that was persistent and/or covered up.

96 The particular focus of Mr Hare's submissions was on the factors of persistent dishonesty and persistent lack of insight. These were two of the factors identified in Guidance para.109 ((h) and (j)) as indications that erasure may be appropriate. Factor (b) was relied on as covering reckless dishonesty.

97 Those factors were duly considered by the tribunal. As to insight, the tribunal had concluded that there was such a prospect and that the likelihood of repetition was increasingly remote. That was a conclusion which it was fully entitled to make. As to dishonesty, it considered that this was not of a severity which compelled the sanction of erasure. As authority makes clear, the language of the Guidance is permissive not mandatory.

98 The final stage of the tribunal's exercise was to focus upon the question whether Dr X's sexual misconduct and dishonesty were fundamentally incompatible with continued registration: see para.44. The reference to fundamental incompatibility reflected the language of paras 92 and 97(a) of the Guidance and was properly treated as the ultimate touchstone for the decision between the sanctions of suspension and erasure. In considering that question the tribunal did not fail to take account of Dr X's dishonesty as well as the sexual misconduct. Taking all the

matters together, it concluded that Dr X's misconduct was not incompatible with continued registration; and in consequence that suspension rather than erasure was appropriate.

99 In my judgment the tribunal fully engaged with the Guidance and fully and clearly explained its reasons for the sanction of suspension rather than erasure. Indeed, I consider that this was a conspicuously impressive, well-structured and thoughtful analysis of a difficult case. The decision on sanction was comfortably within the ambit of the discretion afforded to the tribunal. Accordingly the appeal must be dismissed.

100 I should deal briefly with a further argument raised by Mr Sutton in support of the decision on sanction. He submitted that the tribunal had been wrong in one respect, namely in the course of the determination on impairment to draw the inference that Dr X posed some risk to young patients: see paras.18 and 19. Set against the absence of evidence that Dr X had engaged in any inappropriate conduct in 10 years of medical practice before the single incident, nor in the subsequent three years which included one year of continuing medical practice before the suspension took effect, the facts and circumstances of this one incident in 2015 did not justify the inference. In my judgment, and having particular regard to its conclusion at the impairment stage on the issue of insight, this was an inference which the tribunal could properly draw.

101 That said, for the reasons already noted, its assessment had moved on by the time of the determination on sanction. In the light of the submissions and further evidence, the tribunal was satisfied that the risk of repetition was "increasingly remote" (para.37) and that "any risk you pose to patients was likely to be further reduced by a period of suspension" (para.45). In the meantime Dr X would not be in practice; and the ability to return would be dependent on the results of the review.

Publication of the decision: judicial review

102 In the week preceding the final determination of the MPT, dated 15 June 2018, there was correspondence between solicitors for Dr X and the GMC concerning its publication. For essentially the same reasons as had supported the successful applications to the MPT for the hearings to be held in private, Dr X sought a comparable restriction on publication of the decision.

103 Pending a decision from the GMC, Dr X's solicitors, by letter dated 6 July 2018, explained their reasons for seeking a decision that publication should be limited to the fact that Dr X had been suspended for 12 months on grounds of misconduct. The grounds were identified as follows:

> "• Publication will significantly heighten the risk of suicide. Article 2 ECHR is engaged;
> • The GMC has a statutorily conferred discretion pursuant to s.35B(2) of the Medical Act 1983 to decide whether or not to publish or disclose to any person information which relates to a practitioner's fitness to practise.
> •Furthermore, the GMC is required to publish MPT decisions, pursuant to s.35B(4) "in such manner as they see fit" and this confers a discretion that it must exercise rationally having regard to Dr X's ECHR rights (Art.2 and Art.8 in particular);
> • The GMC can exercise that discretion rationally by publicising the fact that Dr X's practice has been found to be impaired and their registration suspended for 12 months, at which point it will be reviewed without needing to further disclose any other information likely to give rise to a heightened risk of suicide;

> • The GMC would retain the power under s.35B(2) of the Medical Act 1983 to provide specific information to specific persons such as a prospective employer, so long as strict confidentiality of that information was impressed upon those to whom it was provided;
> • The GMC's decision to publish is unlawful in the exceptional circumstances of this case and would be:
> (1) Wednesbury unreasonable; and.
> (2) in breach of the GMC's duty as a public authority arising under s.3 and s.6 of the Human Rights Act 1998 to give effect to and/or act in a manner which is compatible with Dr X's Convention rights.
> We do not propose in this letter to rehearse the psychiatric evidence given to, and accepted by the MPT, as the GMC are well aware of this."

104 By its email response, dated 17 July 2018, the GMC set out its decision in the following material terms:

> "Overall, we consider that in order to meet the overriding objective of the GMC, we do need to publish these documents in some format. We appreciate, however, that Dr X has grave concerns with regards to the issue of Dr X's sexuality and this does not become public knowledge.
>
> We do not consider that the fact that Dr X's sexuality goes towards the culpability of the allegations, i.e. that Dr X was speaking to an underage individual online. For the purposes of the GMC, it does not really make much difference as to whether that individual was male or female but rather that Dr X was engaging in sexualised conversations with an individual who Dr X believed to be aged 15."

105 I interpose that the tribunal's finding was that "The tribunal does not find that you believed A was 15 but is satisfied that the information did not inhibit your language and you were prepared to have a sexually explicit conversation with someone who might have been 15.": para.26.

106 The GMC email continued that it could "fulfil its publication requirements and its public interest responsibilities" by redacting the determination so as to make it neutral as to gender and sexuality. By a further email dated 20 July 2018 the GMC attached a proposed determination redacted in that way.

107 The judicial review claim form was issued on 10 August 2018, seeking a quashing of the decision of 17/20 July and further relief. The grounds reflect those foreshadowed in the letter of 6 July 2018.

108 I deal first with the challenge under the Human Rights Act 1998. The primary focus is on Article 2.

109 By s.3(1) of the Human Rights Act 1998, "So far as is possible to do so, primary legislation and subordinate legislation must be read and given effect in a way which is compatible with the Convention rights." By s.6(1), "It is unlawful for a public authority to act in a way which is incompatible with a Convention right." Article 2 provides by its first sentence that "Everyone's right to life shall be protected by law." Article 8 is the qualified right to respect for private and family life.

110 The overarching objective of the GMC is identified in s.1 of the Medical Act 1983:

"(1A) The main objective of the General Council in exercising their functions is to protect, promote and maintain the health and safety of the public.

(1B) The pursuit by the General Council of their overarching objective involves the pursuit of the following objectives.

- (a) to protect, promote and maintain the health, safety and wellbeing of the public.

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

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

111 By s.2, provision is made for the registration of medical practitioners, in particular:

"(1) There shall continue to be kept by the registrar of the General Council... a register of medical practitioners registered under this Act containing the names of those registered and the qualifications they are entitled to have registered under this Act."

112 Section 35B makes provision for notification and disclosure by the GMC in the following material terms:

"(2) The General Council may, if they consider it to be in the public interest to do so, publish or disclose to any person information -

(a) which relates to a particular practitioner's fitness to practise, whether the matter to which the information relates arose before or after his registration or arose in the United Kingdom or elsewhere...

(4) Subject to subsection (5), the General Council shall publish in such manner as they see fit (a) decisions of a Medical Practitioner's Tribunal that relate to a finding that a person's fitness to practice is impaired (including decisions in respect of a direction relating to such a finding that follow a review of an earlier direction relating to such a finding) ...

(5) The General Council may withhold from publication under subsection (4) above information concerning the physical or mental health of a person which the General Council consider to be confidential."

113 The GMC "Publication and disclosure policy - Fitness to practise" states in its introduction that:

"We publish and disclose information about fitness to practise to help meet our overarching objective of protecting the public."

It continues that the policy is informed by the following principles:

"• We are committed to transparency about our processes and decisions. We believe that being open about the action we take in response to serious concerns about doctors is in the interests of the public and the medical profession.

> • We will take a proportionate approach when displaying this information online or sharing it with those who request it."

114 Under the section headed "Legislative context" reference is made to the provisions of s.35B(2) and (4) and to a range of other legislative duties in relation to information governance, including those under the Human Rights Act 1998. Under the heading "Where do we publish information about a doctor's fitness to practise?" it states that information is published on the websites of both the GMC and the MPTS.

115 Under the sub-heading concerning the GMC website, it states that "The online medical register of doctors is called the List of Registered Practitioners (LRMP). It is publicly available via the GMC website. The LRMP records on a doctor's registration record any active measure to address concerns about a doctor's fitness to practise, including interim action. It also contains historical information about action taken in the past in relation to a doctor's fitness to practise, even if the measures are no longer active. The publication of this information is time-limited."

116 The policy provides that the information as to a substantive suspension of a doctor's registration is published on the "doctor details" page of the doctor's record on the LRMP for as long as the sanction is active. There is also a link to the relevant hearing decision "if this is publicly available".

117 Consistently with s.35B(5) the policy provides that the GMC does not publish records of hearing decisions where the issues relate solely to a doctor's health or to the extent that they do. It continues "We may not publish decisions, or parts of decisions, in other exceptional circumstances where information is considered confidential, for example, to protect the privacy of a complainant, witness or other third party."

118 Where sanctions are no longer active on a doctor's registration, the policy provides that these will continue to be published in the "Doctor history" section of the doctor's record for a period of time. In the case of the sanction of suspension for more than three months, the time limit is 15 years from the date the suspension expires.

119 The entry on the GMC website in turn provides a link to the MPT decision which is published on the MPTS website. Thus in the normal course a member of the public examining the GMC website against the name of Dr X would find the information of the suspension and a link to the decision of the MPT.

Article 2: the law

120 There is substantial agreement between the parties as to the relevant law. It is agreed that Article 2 is engaged where there is a real and immediate risk to the life of an identified individual, and it is known or ought to be known to the relevant authority: see e.g. *Osman v United Kingdom* (87/1997/871/1083; also in *Re Officer L* [2007] UKHL 36, where Lord Carswell cited with approval the proposition that "a real risk is one that is objectively verified and an immediate risk is one that is present and continuing". [20].

121 The GMC equally accepts that its duty under s.35B(4) to publish MPT decisions "in such manner as they see fit" is subject to its obligations as a public authority under the Human Rights Act 1998.

122 The GMC accepts that on the basis of the psychiatric evidence the Article 2 right to life is engaged in the present case. Thus it expressly, and in my judgment rightly, accepts that there is a real and immediate risk to the life of Dr X if the MPT decision is published in the way which it proposes, i.e. in particular without anonymisation.

123 The disagreement on law can be summarised as follows. Mr Sutton submits that, the Article 2 right being admittedly engaged, it is an unqualified right constrained only by circumstances which would impose a disproportionate burden, measured in terms of operational conditions and resources, on the relevant public authority. There is no such burden in the present case, with the consequence that Dr X's right must prevail.

124 Mr Hare submits that the constraint is not so limited. The right being admittedly engaged, the task of the court is to conduct a balancing exercise in order to determine whether publication in the manner proposed would constitute a breach of Article 2. That balancing exercise weighs the expert evidence on the risk of suicide against the public interest which is encompassed by the duties of the GMC and its statutory overriding objective.

125 Mr Sutton pointed in particular to the observations of Lord Carswell in *Re Officer L*, where in his speech with which all others agreed, he stated:

> "The standard accordingly is based on reasonableness, which brings in consideration of the circumstances of the case, the ease or difficulty of taking precautions and the resources available. In this way the state is not expected to undertake an unduly burdensome obligation: it is not obliged to satisfy an absolute standard requiring the risk to be averted, regardless of all other considerations... It has not been definitively settled in the Strasbourg jurisprudence whether countervailing factors relating to the public interest... as distinct from the practical difficulty of providing elaborate or far-reaching precautions, may be taken into account in deciding if there has been a breach of article 2." [21].

Citing two domestic authorities from Northern Ireland, he continued:

> "It does appear that it may be correct in principle to take such factors into account... but I would prefer to reserve my opinion on the point."

126 One of those authorities, namely in *Re Meehan's Application* [2003] NICA 34, was a decision of Carswell LCJ, as he then was, in which, giving the judgment of the court, he stated at para.18:

> "In our opinion it is useful to focus, as did the judge in the present case, on whether a breach of Article 2 has been established rather than concentrating on the question whether Article 2 has been engaged. Of course if Article 2 has not been engaged at all, there cannot be a breach, but a decision that it has been engaged does not necessarily provide a conclusive answer to the question whether the State has been in breach of the requirements of the Article... The court should ascertain the extent or degree of risk to life, take into account whether or not that risk has been created by some action carried out (or proposed) by the State, determine whether it would be difficult for the State to act to reduce the risk and whether there are cogent reasons in the public interest why it should not take a course of action open to it which would reduce the risk. It should then balance all these considerations in order to determine whether there has been a breach of Article 2."

127 Mr Sutton submitted that the reference to public interest by Carswell LCJ must be taken as a reference to operational factors and questions of resource, rather than broader questions of public interest. In doing so he emphasised the categorisation of the Article 2 right to life as fundamental and unqualified: see e.g. *Re W* [2004] NIQB 67 [15].

128 I do not accept this argument. Whilst acknowledging the reservation of the House of Lords through Lord Carswell in *Re L*, it is clear from the authorities cited by him in that paragraph, and the other authorities cited by Mr Hare, that the Court has to undertake a balancing exercise which takes account of the public interest.

129 Set against the fundamental and unqualified right in Article 2, there is of course a distinct question as to the weight to be given to such public interest as is correctly identified. In some cases there will on analysis be no legitimate public interest to put in the scale: see e.g. *Venables & Thompson v News Group Papers Ltd* [2010] 12 WLUK 925, Bean J (as he then was). However, as a matter of principle, the court does have to undertake a balancing exercise which considers the public interest and which is not limited to the question of resources or the burden of compliance. That was also the task which the GMC had to undertake.

130 Mr Sutton submits that this is a case where the admitted, real and immediate risk of suicide if the determination is published in the proposed form outweighs any public interest which the GMC can identify.

131 He pointed to the evidence which was before the MPT on the successive applications for the hearing to be in private. This included the supplementary witness statement of Dr X (12 September 2017) which spoke of Dr X's fear of their sexuality and the allegations becoming known to family members, and also the fear of violent recrimination from family members. That this related both to sexuality and to the allegations of sexual misconduct was restated in Dr X's oral evidence.

132 The tribunal recorded the evidence of Dr M that the risk of suicide was high and that the concerns involved both sexuality and the allegations. The tribunal in its first ruling had described the expert evidence as "compelling" and such as to outweigh the public interest in holding the hearing in public.

133 The further hearing on privacy had the evidence of Dr C that if the hearing was in public "including details of Dr X's sexuality and of the findings against Dr X" this would increase the risk of suicide.

134 The tribunal also questioned Dr S on the possibility of reduction in risk if the gender/sexuality neutral option were adopted. In its ruling it accepted Dr S's opinion that such a measure might reduce the risk, but that any reduction would be very difficult to quantify.

135 Turning to the expert reports obtained by the parties since the decision of 17/20 July 2018, the report of Dr S dated 30 October 2018 concluded, having considered the legal test of real and immediate risk, that the risk of suicide "even if it is published in a gender neutral way, is neither fanciful or trivial but is present but, as highlighted above, the risk can be managed by the mental health services i.e. efforts will be made to minimise the risk of completed suicide."

136 The report of Dr C dated 26 October 2018 concluded in particular that "If the MPTS decision is published and any information about the case or Dr X's sexuality is made public, there is a significant risk Dr X's mental health will deteriorate and the risk of suicide will increase". Dr C's report of 8 January 2019 was to the same effect.

137 The report of Dr P dated 11 January 2019 concluded, in particular, that "the current risk of completed suicide should be considered to be moderate in the short term. However, this is likely to escalate considerably around the time of 22/23 January 2019. Therefore, my view is that Dr X's risk of completed suicide in the longer term should be considered to be moderate to high".

138 Dr P particularly noted the risk of suicide should details of Dr X's sexual misconduct be revealed. In answer to a direct question, Dr P stated agreement with the conclusions reached by Drs. C and S.

139 In response, Mr Hare pointed first to s.1 of the Medical Act 1983 which identifies the overarching objective of the GMC. That in turn involves the three objectives identified in s.1(1B). In the light of Dr X's agreement to the publication of the anonymised determination, he did not rely on objective (c). Publication in that form was sufficient to indicate to the public that there was a lapse in professional standards and that the GMC has taken appropriate action. However he submits that objectives (a) and (b) are each engaged.

140 As to patient safety, he accepted that as a result of the suspension Dr X had no lawful access to patients. However that did not exhaust patient safety concerns. It was not unknown for doctors in such circumstances to undertake unlawful private arrangements. In such cases the potential patient could look at the register, see the cause of the suspension and any identified risk to patients; and then make an informed decision as to whether to receive the unlawful services.

141 In the present case, the tribunal had, at least at the impairment stage, found there to be some risk to young patients. That risk was not resolved by the fact of suspension.

142 However Mr Hare's central focus was on objective (b), namely "to promote and maintain public confidence in the medical profession". Section 2 of the Act required the GMC to maintain the register. Section 35B(4) was likewise framed in mandatory terms. There was a very strong public interest in maintaining public confidence in the integrity of the register and in the information which it contained as to a doctor's fitness to practise. If, as in the present interim position, the register merely stated that the identified practitioner had been suspended, those consulting it would have no idea of the reasons for suspension. This would dilute confidence in the integrity of the register. He made clear that this was not presented as a "floodgates" argument, but as a reason why there should be no departure from the principle of an open register save in the most strong and exceptional case. This was not such a case.

143 Section 35B(5) made an express exception in respect of confidential information concerning the physical or mental health of a practitioner. In consequence, members of the public had no reasonable expectation that such information would be found on the register. However, there was otherwise a reasonable expectation that information about fitness to practise would be available on the register.

144 The MPT determination was of serious misconduct involving both sexual misconduct and persistent dishonesty. The integrity of the register requires such serious matters affecting fitness to practise to be identified against the name of the practitioner with a link to the redacted version of the determination. For the reasons given in the GMC decision of 17 July, redactions as to gender and sexuality were not material to the misconduct which had been found, but provided sufficient protection in respect of the matters which provoked the risk of suicide.

145 Furthermore an order of anonymity would have a potential adverse long-term effect; as Mr Hare put it, such as to cast a long shadow and prejudice the position on publication at the stage of the further review. That review would look back at the original determination and consider whether progress had been made since the 12-month suspension was imposed.

146 As was stated by the Supreme Court in *Khan v GMC* [2016] UKSC 64 in the judgment of Lord Wilson with whom all other members of the Court agreed:

> "... the focus of a review is upon the current fitness of the registrant to resume practice, judged in the light of what he has, or has not, achieved since the date of the suspension. The review committee will note the particular concerns articulated by the original committee and seek to discern what steps, if any, the registrant has taken to allay them during the period of his suspension. The original committee will have found that his fitness to practise was impaired. The review committee asks: does his fitness to practise *remain* impaired?": para 27.

147 Thus the concerns in the original determination should appear in the review when it was published. That process would be undermined by the relief which was sought. If there were no change in Dr X's condition, the GMC would not be able to publish the historical evidence of the original proceedings. This conflicted with the informed policy that in the event of a suspension, such information should be publicly available for a 15-year period. Thus, if the reviewing tribunal concluded that Dr X's fitness to practise was no longer impaired and that they could return to practise, in the absence of change the historical information could not be publicised and prospective patients would not know the reason for the underlying decision that Dr X had not been fit to practise. Conversely, if the conclusion was that Dr X remained impaired, the MPT's options on sanction would be erasure, extension of suspension or the imposition of conditions (s.35D(5)). If it imposed a further period of suspension, the practical effect would be that it again could not publish the reasons against the name of the practitioner; and if conditions were imposed, no patient would be able to find out the concerns which had compelled those conditions. It would equally be against the public interest to provide no information as to the reasons for taking the option of erasure.

148 There was no present indication that there would be any change in Dr X's mental health or response to the prospect of publicity. Accordingly the Court had to proceed on the basis that there would not be any change.

149 The suggestion that the information could be supplied in confidence to e.g. prospective employers, pursuant to s.35B(2), did not work. It depended on the willingness of an employer to seek further information which it might not do in circumstances of great pressure for the employment of staff; and it would not assist prospective patients.

150 All this amounted to an extremely weighty public interest in this information.

151 Mr Hare turned to the other side of the balance, namely the admittedly real and immediate risk of suicide in the event of publication without anonymity.

152 First, the findings of the MPT on the issue of private hearings were of limited relevance. The tribunal's decision to conduct the hearing in private also depended on the concern that Dr X should not be inhibited from full participation, including giving evidence in the hearing: see para 33, also para.57.

153 Furthermore the MPT made clear that the question of publication by the GMC was a quite separate matter and that its decision was "not intended in any way to act as a steer to the relevant entities which would make such a decision about what details should or should not be published": para.60.

154 Secondly, as emphasised in cases such as *ZY v Paul Higgins and NI Courts and Tribunal Service* [2013] NIQB 8 at [25], it was necessary for the Court to scrutinise the psychiatric evidence with great care. In each case it was necessary to identify the question which the expert was addressing and consider the response.

155 Turning to the most recent report which post-dated the GMC decision, the report of Dr S dated 30 October 2018 noted the absence of self-harm incidents and other positive events which "... indicates Dr X's depression is not as severe as it had been in the past" (para.39); that the suicide risk was reduced as time passed since initial ideation without suicide being attempted (para.42); and that the risk can be managed by the mental health services (para.45).

156 In oral evidence in June 2018 Dr S had likewise stated the belief that the care team "will be able to manage the risks". The report of Dr C dated 26 October 2018 gave the opinion that if the decision is published "and any information about the case or Dr X's sexuality is made public, there is a significant risk Dr X's mental health will deteriorate and the risk of suicide will increase". This indicated that excision of the reference to sexuality would remove one of the identified triggers.

157 The same report opined that if the decision were posted on the website and/or the present hearing were held in public, in each case with anonymisation, this would increase the risk of suicide. Those events had occurred, but without ill-effect. Dr C's report of 8 January 2019 recorded Dr X's distress at the recent referral to the Disclosure and Barring Service (DBS); but again nothing had been triggered.

158 Turning to the report of Dr P dated 11 January 2019 this recorded Dr X's continuing account of agreeing to meet A as a means of ending the conversation; and thus a continuing state of denial. In the opinion section Dr P responded to three identified scenarios: without anonymisation, namely publication of the decision in full; publication with the GMC proposed redaction; and publication of suspension for sexual misconduct but with no further details. Dr P recorded Dr X's assertion that there was no practical difference between these scenarios. Dr P stated that this perhaps reflected Dr X's "rather concrete interpretation of the case".

159 Mr Hare submitted that this expert evidence demonstrated that the risk can be managed by the medical team; that several supposed triggers had passed without incident; and that to some extent Dr P was simply reporting what Dr X had stated. All this called into question both the authenticity of Dr X's statements and whether the identified risk would eventuate.

160 Furthermore there had been a change of the suggested triggers over time. Dr S's report of 30 October 2018 observed that Dr X had initially asserted that the concern was a discovery by family members of their sexuality, whereas this now appeared to be generalised to sexual misconduct.

161 In oral evidence in June 2018 Dr S had identified the "two major dynamic factors" as (i) family knowledge of the proceedings and Dr X's sexuality and (ii) loss of identity as a doctor. In turn, the MPT in its decision on privacy had referred to the dynamic factors of "the disclosure of your sexuality and the loss of your identity as a doctor": para.7.

162 Likewise Dr P had identified what appeared to be two strands to Dr X's decision-making, namely the inability to contemplate revelation of sexuality to family members and the public at large, or to contemplate a life outside medicine. This supported the contention that the GMC proposal to redact references to sexuality and gender would sufficiently reflect the balance of the right to life against the public interest in the open register.

Conclusions on Article 2

163 For the reasons essentially advanced by Mr Sutton, and on the present evidence in this most unusual case, I am clear that the balance points firmly in favour of the anonymisation which Dr X seeks.

164 I readily acknowledge, of course, the public interest which is measured by the statutory objectives which the GMC is required to pursue in order to achieve its overarching objective of the protection of the public; by its statutory obligation to maintain the register of medical practitioners; by its statutory obligation to publish "in such manner as they see fit" decisions of the MPT that relate to a finding that a person's fitness to practise is impaired; and by the publication and disclosure policy which is informed by those objectives and obligations.

165 The importance of the integrity of the register as a source of information for members of the public as to the fitness to practise of medical practitioners is self-evident. This is further emphasised by the time for which historical sanctions remain on the register. In the case of a suspension in excess of three months this is for a period of 15 years. This all amounts to a very weighty public interest.

166 However, and as the GMC rightly recognises it its submissions, the public interest is not absolute. Thus section 35B(5) provides an exception which permits the GMC to withhold publication of the decision on impairment if it concerns confidential information concerning the physical or mental health of a practitioner. That could be information which, e.g., in cases of suspension from practise would be of considerable and proper interest to members of the public.

167 Furthermore, whether identified through the operation of s.3 or s.6 of the Human Rights Act 1998, the duties of the GMC are subject to the requirement to act in a way which is compatible with Convention rights and not least the right to life under Article 2. In my judgment the reasonable expectation of members of the public is subject to that constraint, just as it is to the express limitation provided by s.35B(5).

168 On the other side of the balance is the evidence which supports the admittedly real and immediate risk of suicide in the event that the decision is published in the redacted but open form proposed by the GMC. I do not accept the submission of Mr Sutton that there is inconsistency in the GMC both acknowledging that risk and questioning the supporting evidence in the various ways which I have recorded. This is all potentially relevant to the balancing exercise; and in particular to the question of whether the proposed redactions would sufficiently protect Dr X's right to life. However, that exercise having been conducted, I am quite satisfied that the expert evidence demonstrates the true gravity of the risk which would result from publication in the open but redacted form.

169 I do not accept that the evidence supports a material distinction between the risk which arises from disclosure of sexuality and the risk which arises from disclosure of sexual misconduct. On the contrary the evidence most recently contained in the expert reports of January 2019 from Dr C and Dr P demonstrates the risk which arises from publishing details of the allegations and findings of sexual misconduct. Nor do I accept that the report of Dr P can be criticised as somehow limiting itself to a record of statements made by Dr X or otherwise. The report provides an objective assessment and expressly agrees with the conclusions of Drs C and S.

170 The evidence provides no basis to doubt the genuineness of Dr X's concerns. Nor does the undivided breadth of Dr X's fears of publicity provide any comfort that a redaction in respect of gender and sexuality would diminish that risk. I take account of the potential trigger events which have been identified in the past; and that time and those events have passed without incident. However it is relevant that at each stage this matter has in fact proceeded without identification of Dr X. In the context both of sexuality and the findings of sexual misconduct, that is the critical matter. In that respect, the most recent and agreed expert opinion is of real and immediate continuing risk.

171 I do not accept that the various references to the management of the risk provide any significant reassurance. In particular, the evidence of Dr S concerning the ability of the mental health team to "manage the risks" must be seen in the context of Dr S' overall conclusion that the risk remains even with redaction in the proposed form. Nor is there any evidential basis to suggest that Dr X might act in breach of the suspension by undertaking unlawful private practice. In my judgment patient safety is met by the fact of the suspension and the pending process of review.

172 As to the argument of the 'long shadow' and the potential effect when the matter returns to the MPT for review, I consider that this provides no counterweight to the present position where there is clear and cogent evidence in support of the admittedly real and immediate risk if publication proceeds in the form proposed by the GMC. It is the present position and evidence which the Court has to scrutinise for the purpose of the balancing exercise.

173 My conclusion is that, on the very particular facts of this case, this risk overwhelms the public interest which informs the duties of the GMC; and that accordingly publication in the proposed form would constitute a breach of Dr X's right to life under Article 2.

Article 8/*Wednesbury*

174 In the circumstances, I need only deal briefly with the arguments on Article 8 and *Wednesbury*. As to Article 8, I do not consider that this adds anything to the case. If Dr X's unqualified right to life under Article 2 does not defeat the identified public interest, the qualified right to privacy under Article 8 would provide no better reason to defeat open publication in the redacted form.

175 As to *Wednesbury*, the contention that the GMC decision was one which no reasonable authority exercising its functions could properly reach must equally succeed in the light of my conclusions on Article 2 and the balancing exercise. Whilst I have had the benefit of further reports since the decision on 17/20 July 2018, the evidence before the GMC was essentially to the same effect.

176 As to the alternative contention, described by Mr Sutton as one of "process", that the GMC failed to take into account the psychiatric evidence which supported the conclusion of a real and immediate risk of suicide, there is some force in the argument that the language of the GMC decision does not demonstrate real engagement with this material. The decision emails of 17/20 July made no reference to that evidence and referred only to Dr X's concerns as to publication in respect of sexuality. The concerns and the expert evidence went much further.

177 That said, the letter from Dr X's solicitors dated 6 July 2018 which provoked that response referred to the expert evidence only in the most general terms: "We do not propose in this letter to rehearse the psychiatric evidence given to, and accepted by, the MPT, as the GMC are well aware of this".

178 In contrast to the major issues, this question rightly occupied only a small part of the hearing and the arguments were relatively limited. On balance, I am not persuaded that the *Wednesbury* challenge succeeds on this additional or alternative ground.

Disposal

179 It follows that the decision of 17 July 2018 must be quashed and the s.40A appeal dismissed. I will hear Counsel on the terms of the appropriate consequential orders.

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This transcript has been approved by the Judge.