Neutral Citation Number: [2015] EWHC 1304 (Admin)

Case No: CO/4950/2014

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 14 May 2015

Before:

THE HONOURABLE MRS JUSTICE LANG DBE

- -

Between:

PROFESSIONAL STANDARDS AUTHORITY FOR HEALTH AND SOCIAL CARE

Appellant

- and -

(1) GENERAL MEDICAL COUNCIL
(2) PARVAN KAUR UPPAL

Respondents

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- -

David Bradly (instructed by **Capsticks Solicitors LLP**) for the **Appellant**
Fiona Horlick (instructed by **Gordons Partnership LLP**) for the **Second Respondent**
The **First Respondent** did not appear and was not represented.

Hearing date: 28 April 2015

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Approved Judgment

Mrs Justice Lang:

1. The Professional Standards Authority ("the PSA") has referred to the High Court a decision of the General Medical Council Fitness to Practise Panel of the Medical Practitioners Tribunal Service ("The Panel") made on 19 September 2014, in respect of a medical practitioner, Dr Uppal.

2. The Panel found Dr Uppal's dishonesty (which was admitted) to amount to misconduct, but went on to decide that her fitness to practise was not impaired, and it was not appropriate to issue her with a formal warning.

3. The PSA has referred this case to the High Court under section 29 of the National Health Service Reform and Health Care Professions Act 2002 ("the 2002 Act") on the ground that the Panel's decision was unduly lenient and wrong, in particular:

   a) The Panel's findings and analysis of Dr Uppal's misconduct were inadequate (Ground 3);

   b) The Panel erred in concluding that Dr Uppal's fitness to practise was not impaired and it failed adequately to address her misconduct (Ground 4);

   c) In the alternative, the Panel ought to have issued a warning in respect of her misconduct (Ground 5);

   d) The Panel failed to give adequate reasons for its decision (Ground 6).

4. Initially the PSA also alleged, in its grounds 1 and 2, that the General Medical Council ("the GMC") had under-prosecuted the charge, which contributed to the errors made by the Panel. However, shortly before the hearing, the PSA withdrew those grounds and the GMC formally conceded the appeal on the other grounds. The GMC has not played any further part in this appeal.

Allegations and findings

5. The allegation against Dr Uppal was as follows:

> "**Allegation and Findings of Fact**
>
> That being registered under the Medical Act 1983, as amended:
>
> 1. Between December 2011 and January 2012, you were employed as a GP Registrar at the Birchwood Medical Practice.
>
> **Admitted and found proved**
>
> 2. On 13 December 2011, you had a telephone consolation with Baby A's mother following which Baby A was taken to A & E and was admitted to hospital.

Admitted and found proved

3. On 30 December 2011, you informed your GP Trainer that you had spoken to Baby's mother following Baby A's discharge from hospital when you had not in fact done so.

Admitted and found proved

4. Your action as set out at paragraph 3 above was:

a. Misleading,

Admitted and found proved

b. dishonest.

Admitted and found proved

And by reason of the matters set out above, your fitness to practise is impaired because of your misconduct. **Found not proved**"

6. The Panel concluded that Dr Uppal's fitness to practise was not impaired as this was an isolated episode and Dr Uppal had demonstrated insight and taken steps to avoid any repetition. She was a GP trainee, and there was evidence of her exemplary professional and personal conduct from her senior colleagues and trainers. A formal warning was not necessary, appropriate or proportionate.

Law

7. Pursuant to section 29(4) of the 2002 Act, the Authority may refer a case to the High Court where it considers that:

> "(a) a relevant decision falling within subsection (1) has been unduly lenient, whether as to any finding of professional misconduct or fitness to practise on the part of the practitioner concerned (or lack of such a finding), or as to any penalty imposed, or both
>
> …
>
> and that it would be desirable for the protection of members of the public for the Council to take action under this section."

8. Where a case is referred to the High Court, it is to be treated as an appeal (s.29(7)).

9. In *Ruscillo v Council for Regulation of Healthcare Professionals* [2004] EWCA Civ 1356, the Court of Appeal held, applying CPR 52.11, that an appeal under section 29 should be allowed if the relevant decision was "wrong" or if there has been "a serious procedural or other irregularity". Lord Phillips MR gave the following guidance on the test of "undue leniency":

"73. What are the criteria to be applied by the Court when deciding whether a relevant decision was "wrong"? The task of the disciplinary tribunal is to consider whether the relevant facts demonstrate that the practitioner has been guilty of the defined professional misconduct that gives rise to the right or duty to impose a penalty and, where they do, to impose the penalty that is appropriate, having regard to the safety of the public and the reputation of the profession. The role of the Court when a case is referred is to consider whether the disciplinary tribunal has properly performed its task so as to reach a correct decision as to the imposition of penalty. Is that different from the role of the Council in considering whether a relevant decision has been 'unduly lenient'? We do not consider that it is. The test of undue leniency in this context must, we think, involve considering whether, having regard to the material facts, the decision reached had due regard for the safety of the public and the reputation of the profession.

…..

75. The reference to having regard to double jeopardy when considering whether a sentence is unduly lenient is not, as we have already indicated, really apposite where the primary concern is the for the protection of the public. More apposite is this passage in …. *Attorney General's Reference (No. 4 of 1989)* (1990) 90 Cr App. R. 266:

> "The first thing to be observed is that it is implicit in the section that this Court may only increase sentences which it concludes were unduly lenient. It cannot, we are confident, have been the intention of Parliament to subject defendants to the risk of having their sentences increased – with all the anxiety that this naturally gives rise to – merely because in the opinion of this Court the sentence was less than this Court would have imposed. A sentence is unduly lenient, we would hold, where it falls outside the range of sentences which the judge, applying his mind to all the relevant factors, could reasonably consider appropriate. In that connection regard must of course be had to reported cases, and in particular to the guidance given by this court from time to time in so-called guideline cases. However it must always be remembered that sentencing is an art rather than a science; that the trial judge is particularly well-placed to assess the weight to be given to various competing considerations; and that leniency is not in itself a vice. That mercy should season justice is a proposition as soundly based in law as it is in literature."

76. … We consider that the test of whether a penalty is unduly lenient in the context of section 29 is whether it is one which a disciplinary tribunal, having regard to the relevant facts and to

> the object of disciplinary proceedings, could reasonably have imposed…
>
> 77. … In any particular case under section 29 the issue is likely to be whether the disciplinary tribunal has reached a decision as to penalty that is manifestly inappropriate having regard to the practitioner's conduct and the interests of the public.
>
> 78. … Where all material evidence has been placed before the disciplinary tribunal and it has given due regard to the relevant factors, the Council and the Court should place weight on the expertise brought to bear in evaluating how best the needs of the public and the profession should be protected. Where, however, there has been a failure of process, or evidence is taken into account on appeal that was not placed before the disciplinary tribunal, the decision reached by that tribunal will inevitably need to be reassessed."

Ground 3 – inadequate findings of misconduct

10. The Panel summarised its factual findings in paragraphs 26 to 28 of its determination:

> "26. The Panel heard how on 13 December 2011, Baby A's mother telephoned Birchwood Medical Practice for a consultation as her baby had been diagnosed with a viral illness the previous day and his situation appeared to have worsened. You took the call and provided advice to the mother, informing her that there were no routine appointments available, but that if she continued to have concerns she could take the baby to A&E. At no time thereafter did you call Baby A's mother to enquire as to his condition. On 19 December 2011, you received a letter from the hospital informing you that Baby A had been admitted to hospital and had required intubation and ventilation. This was confirmed in a later letter to the practice received by Dr Baur dated 28 December 2011, who discussed the matter with Dr Nelstrop. On 30 December 2011, you told Dr Nelstrop that you had spoken to Baby A's mother following the letter from the hospital which was not true. You said that the mother had told you that baby A's condition had deteriorated after you had provided the on-call advice, and that this had made you feel relieved.
>
> 27. On 13 January 2012, you had a meeting with Dr Nelstrop and Dr Vijaykumar, GP Partner at Birchwood. At this point, Dr Vijaykumar had been informed that Baby A's mother had not spoken with you. You still maintained that you had spoken to Baby A's mother. On being told that the practice telephone records could be checked, you suggested that you may have used your mobile telephone to make the call. Dr Vijaykumar suggested that the records for this could also be

> checked. At the conclusion of the meeting when you and Dr Nelstrop were alone, you admitted that you had never called Baby A's mother.
>
> 28. As a result, the practice initiated an investigation followed by a disciplinary process at the conclusion of which you received a final written warning. Both yourself and Dr Nelstrop discussed the matter with representatives of the Deanery, who did not progress the matter further. This matter came to the attention of the GMC when you submitted your completion of training form, indicating thereon that you faced disciplinary proceedings."

11. Dr Uppal gave evidence to the Panel about the context within which she had lied to her senior colleagues, namely, a difficult working environment in which she was unsupported, uncomfortable and constantly monitored. She felt unable simply to explain a mistake. The Panel heard evidence from Drs Vijaykumar and Nelstrop who disputed Dr Uppal's description of relations within the practice. The Panel also heard from Dr Uppal's Programme Directors, Drs Ward and Conaty.

12. The Panel rejected the allegation that Dr Uppal had fabricated an account of the atmosphere of the practice, and accepted that she felt uncomfortable and unhappy at the practice. Her account reflected her genuine perception of the circumstances at the time, which differed from the perceptions of Drs Vijaykumar and Nelstrop.

13. The Panel found that Dr Uppal's conduct was a departure from the standards set out in paragraphs 56 and 57 of the GMC guidance *Good Medical Practice (2006)*, which provide as follows:-

> "56. Probity means being honest and trustworthy, and acting with integrity: this is at the heart of medical professionalism.
>
> 57. You must make sure that your conduct at all times justifies your patients' trust in you and the public's trust in the profession."

14. When assessing impairment, the Panel made the following observations about the nature of the misconduct:

    (a) the misconduct related to an isolated incident over a short period of time more than two years previously;

    (b) in terms of the seriousness of the misconduct, the dishonesty did not impact upon patient care, was not for financial gain and did not seem to benefit her personally in any way;

    (c) when confronted with her behaviour, she admitted lying and immediately apologised to her GP Trainer and since then had always accepted full responsibility for her actions.

15. The PSA submitted that the Panel failed to identify the true extent and nature of the misconduct, and hence its seriousness, in a number of respects.

16. First, in the course of her professional practice, Dr Uppal was lying to her senior colleagues and questioning the integrity of Baby A's mother who had complained that she had not been contacted by the practice after the telephone consultation on 13 December.

17. In my view, it is reasonable to infer that the Panel members were fully aware of those facts, and had them well in mind when making their decision. After all, those facts were the very essence of the allegation, and the reason why the Panel found that she had breached the standards of probity and trustworthiness in *Good Medical Practice*.

18. Second, the PSA submitted that the Panel erred in characterising it as an isolated incident of dishonesty because she continued in the lie from 28 December 2011 to 13 January 2012, and supplemented it on 13 January 2012 with the lie about the use of her mobile telephone.

19. In my view, it is reasonable to assume that the Panel was well aware of the evidence, and knew that the events had not all occurred on a single occasion. The Panel was making the legitimate point that this episode was an "isolated incident" in her professional career. She was a person of good character and there was nothing to indicate other episodes of dishonesty, before or since. Paragraphs 38 and 40 indicate that this was a point which was relied upon heavily by Dr Uppal's advocate, and in paragraph 48, the Panel was accepting this submission.

20. Third, the PSA submitted that there was benefit to Dr Uppal in her claim to have spoken to Baby A's mother after Baby A had been discharged from hospital, as it was exculpatory. She had been asked why she not seen Baby A, and she said that Baby A's mother told her that Baby A had deteriorated after the telephone consultation. Dr Uppal's management of the case was being assessed and so it would have created a favourable impression if she had indeed followed up her telephone conversation with Baby A's mother and Baby A had found her advice to go to the hospital helpful at the time.

21. It was not entirely clear what type of benefit the Panel was referring to in this part of paragraph 49. Perhaps, as Mr Bradly suggested, obtaining financial gain or other personal benefits were part of a check-list of factors which the members considered relevant in assessing dishonesty cases. In my view, it was an obvious inference from the evidence that Dr Uppal was seeking to give a more favourable account of events so as to avoid criticism from her senior colleagues over her handling of this case, and so the lie was exculpatory. This point was made forcefully by counsel for the GMC. Given that the Panel heard witnesses and submissions over a 10 day period, I think it is very unlikely that the members overlooked this obvious point or failed to take it into account.

22. Fourth, the PSA submitted that Dr Uppal did not immediately admit to lying and apologise when confronted with the lie. She sought to maintain the lie, even to the extent of suggesting she made the telephone call on her mobile telephone. In my view, on a fair reading of paragraph 50, the point which the Panel was making was that she admitted her wrongdoing at the meeting on 13 January, and thereafter accepted full

responsibility for her conduct in the internal and the GMC disciplinary investigations. The somewhat inapt phrase "confronted with her lie" must be intended to refer to her colleagues' requests for proof from the landline or mobile phone records that the telephone call was indeed made, which she could not provide, at which point she confessed that she was lying. I do not read this paragraph as suggesting that she was entitled to credit for volunteering a confession when she had no need to do so.

23. In summary, therefore, I do not accept that the Panel failed to appreciate the extent and nature of the misconduct, and hence its seriousness. The section below headed 'Ground 6 - Reasons' is also relevant to this section of my judgment.

Ground 4 – impairment of fitness to practise

24. The PSA submitted that the Panel's conclusion that Dr Uppal's fitness to practise was not impaired was unduly lenient and therefore wrong. It was a decision which, having regard to the public interest in maintaining the reputation of the profession and declaring appropriate standards of conduct, no Panel could reasonably have made.

25. The PSA relied upon the points made under Ground 3, in relation to the nature of the misconduct, and submitted that the dishonesty in this case was serious and a breach of the fundamental tenets of the profession, as summarised in *Good Medical Practice*, paragraphs 56 and 57. The PSA referred to the guidance on dishonesty in the GMC's *Indicative Sanctions Guidance* and the *Guidance on Warnings*. The PSA submitted that the Panel had given insufficient weight to the public interest and excessive weight to Dr Uppal's apology, insight, remediation, the extremely low risk of repetition and the very favourable reports from the senior doctors at her current GP practice.

26. In its review of the law, the PSA submitted that "the fitness to practice of a doctor who acts dishonestly is impaired by that dishonesty", citing *R (CR HCP) v. NMC & Kingdom* [2007] EWHC 1806 (Admin); *Parkinson v. NMC* [2010] EWHC 1898 (Admin); *Hassan v. General Optical Council* [2013] EWHC 1887 (Admin)

27. In my judgment, the PSA's submission that a doctor's fitness to practise "is impaired" if he acts dishonestly does not accurately reflect the statutory scheme or the authorities, since, even in cases of dishonesty, a separate assessment of impairment is required, and not every act of dishonesty results in impairment. The principles to be applied were helpfully summarised by Cox J in *CHRE v NMC & Grant* [2011] EWHC 927 (Admin):

> "The Statutory Scheme for Misconduct by Nurses and Midwives
>
> 64. This Scheme is set out in the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 [2004 SI No. 1761] and in particular Rule 24, which provides for staged hearings addressing the factual findings, impairment of fitness to practise and finally, as appropriate, sanctions.

65. The term "impairment to fitness to practise" has not been defined in these rules, and this is also the position in relation to those schemes which apply to other, medical practitioners. Thus, as Dame Janet Smith pointed out in her Fifth Report from The Shipman Enquiry (9 December 2004), the concept has the advantage of flexibility, being capable of embracing a multiplicity of problems, but also the disadvantages that flow from a lack of clarity and definition. Further, recognising impaired fitness to practise inevitably involves making a value judgment (see paragraphs 25.42 et seq).

66. Judicial guidance as to how the issue of impairment of fitness to practise should be approached now appears in a number of authorities. The Committee in this case were referred to the decision of Silber J in R (on the application of Cohen) v. General Medical Council [2008] EWHC 581 (Admin), and that of Mitting J, more recently in Nicholas-Pillai v. General Medical Council [2009] EWHC 1048 (Admin).

67. In Cohen Silber J was concerned with serious professional failings by a consultant anaesthetist, on an isolated occasion, in relation to a patient undergoing major surgery. There was little dispute as to the facts, most of which appear to have been admitted.

68. Against that background the judge said as follows, in relation to impairment of fitness to practise:

> "[62] Any approach to the issue of whether a doctor's fitness to practice should be regarded as 'impaired' must take account of 'the need to protect the individual patient, and the collective need to maintain confidence [in the] profession as well as declaring and upholding proper standards of conduct and behaviour of the public in their doctors and that public interest includes amongst other things the protection of patients, maintenance of public confidence in the' (*sic)*. In my view, at stage 2 when fitness to practice is being considered, the task of the Panel is to take account of the misconduct of the practitioner and then to consider it in the light of all the other relevant factors known to them in answering whether by reason of the doctor's misconduct, his or her fitness to practice has been impaired. It must not be forgotten that a finding in respect of fitness to practice determines whether sanctions can be imposed: s 35D of the Act.
>
> [63] I must stress that the fact that the stage 2 is separate from stage 1 shows that it was not intended that every case

> of misconduct found at stage1 must automatically mean that the practitioner's fitness to practice is impaired.
>
> [64] There must always be situations in which a Panel can properly conclude that the act of misconduct was an isolated error on the part of a medical practitioner and that the chance of it being repeated in the future is so remote that his or her fitness to practice has not been impaired. Indeed the Rules have been drafted on the basis that the once the Panel has found misconduct, it has to consider as a separate and discreet *(sic)* exercise whether the practitioner's fitness to practice has been impaired. Indeed s 35D (3) of the Act states that where the Panel finds that the practitioner's fitness to practice is not impaired, 'they may nevertheless give him a warning regarding his future conduct or performance'.
>
> [65] Indeed I am in respectful disagreement with the decision of the Panel which apparently concluded that it was not relevant at stage 2 to take into account the fact that the errors of the appellant were '*easily remediable*'. I concluded that they did not consider it relevant at [that] stage because they did not mention it in their findings at stage 2 but they did mention it at stage 3. That fact was only considered as significant by the Panel at a later stage when it was dealing with sanctions. It must be highly relevant in determining if a doctor's fitness to practice is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated. These are matters which the Panel should have considered at stage 2 but it apparently did not do so."

69. It is clear, notwithstanding the references in those passages to whether fitness to practise "has been" impaired, that the question is always whether it is impaired as at the date of the hearing, looking forward in the manner indicated by Silber J in his judgment. The question for this Committee as at 21 April 2010 was therefore "is this Registrant's current fitness to practise impaired?"

70. An assessment of current fitness to practise will nevertheless involve consideration of past misconduct and of any steps taken consequently by the practitioner to remedy it. Silber J recognised this when referring, at paragraph 65, to the necessity to determine whether the misconduct is easily remediable, whether it has in fact been remedied and whether it is highly unlikely to be repeated.

71. However it is essential, when deciding whether fitness to practise is impaired, not to lose sight of the fundamental considerations emphasised at the outset of this section of his judgment at paragraph 62, namely the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession.

72. This need to have regard to the wider public interest in determining questions of impairment of fitness to practise was also referred to by Goldring J in R (on the application of Harry) v. General Medical Council [2006] EWHC 3050 (Admin) and by Mitting J in Nicholas-Pillai, where he held that the panel were entitled to take into account the fact that the practitioner had contested critical allegations of dishonest note-keeping, observing that:

> "[19] In the ordinary case such as this, the attitude of the practitioner to the events which give rise to the specific allegations against him is, in principle, something which can be taken into account either in his favour or against him by the panel, both at the stage when it considers whether his fitness to practise is impaired, and at the stage of determining what sanction should be imposed upon him."

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

> "… Where a FTPP considers that the case is one where the misconduct consists of violating such a fundamental rule of the professional relationship between medical practitioner and patient and thereby undermining public confidence in the medical profession, a finding of impairment of fitness to practise may be justified on the grounds that it is necessary to reaffirm clear standards of professional conduct so as to maintain public confidence in the practitioner and in the profession. In such as case, the efforts made by the medical practitioner in question to address his behaviour for the future may carry very less weight than in case where

> the misconduct consists of clinical errors or incompetence."

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

75. I regard that as an important consideration in cases involving fitness to practise proceedings before the NMC where, unlike such proceedings before the General Medical Council, there is no power under the rules to issue a warning, if the committee finds that fitness to practise is not impaired. As Ms McDonald observes, such a finding amounts to a complete acquittal, because there is no mechanism to mark cases where findings of misconduct have been made, even where that misconduct is serious and has persisted over a substantial period of time. In such circumstances the relevant panel should scrutinise the case with particular care before determining the issue of impairment.

76. I would also add the following observations in this case having heard submissions, principally from Ms McDonald, as to the helpful and comprehensive approach to determining this issue formulated by Dames Janet Smith in her Fifth Report from Shipman, referred to above. At paragraph 25.67 she identified the following as an appropriate test for panels considering impairment of a doctor's fitness to practise, but in my view that test would be equally applicable to other practitioners governed by different regulatory schemes.

> "Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, convictions, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:
>
> a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk or harm; and/or

> b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or
>
> c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession: and/or
>
> d. has in the past acted dishonestly and/or is liable to act dishonestly in the future.""

28. There was further guidance given in *Cheatle v. General Medical Council* [2009] EWHC 645 (Admin), where Cranston J. said:

> "21. There is clear authority that in determining impairment of fitness to practise at the time of the hearing regard must be had to the way the person has acted or failed to act in the past. As Sir Anthony Clarke MR put it in Meadow v General Medical Council [2006] EWCA Civ 1390; [2007] 1 QB 462:
>
> > "In short, the purpose of [fitness to practise] proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. The FPP thus looks forward not back. However, in order to form a view as to the fitness to practise today, it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past" (para 32).
>
> 22. In my judgment this means that the context of the doctor's behaviour must be examined. In circumstances where there is misconduct at a particular time, the issue becomes whether that misconduct, in the context of the doctor's behaviour both at the time of the misconduct and to the present time, is such as to mean that his/her fitness to practise is impaired. The doctor's misconduct at a particular time may be so egregious that, looking forward, the panel is persuaded that the doctor is simply not fit to practise medicine, without restrictions or maybe at all. On the other hand, the doctor's misconduct may be such that, seen within the context of an otherwise unblemished record, the fitness to practise panel could conclude that, looking forward, his/her fitness to practise is not impaired, despite the misconduct."

29. Applying these principles, the Panel was correct to assess whether or not Dr Uppal's fitness to practise was currently impaired, having regard to her conduct since the misconduct occurred, as well as the nature and extent of her misconduct. Thus, her apology, insight and remediation were all relevant to that assessment, as was the extremely low risk of recurrence.

30. In my judgment, lying to senior colleagues about communications with patients and their families, is a very serious breach of trust and of professionalism, particularly where the doctor's handling of the case is under scrutiny. It would be likely to result in a finding of impairment of fitness to practise in many cases. However, on the evidence, this was an exceptional case. The Panel was convinced by the evidence of Dr Uppal, Dr Clarke and Dr Warwick that the misconduct was a "one-off" lapse which would not be repeated. Dr Uppal had accepted full responsibility for her actions, recognised how serious they were, and taken steps to avoid any repetition. As Ms Horlick said, the fact that Dr Uppal was an inexperienced, young trainee doctor, who had been experiencing difficulties with her senior colleagues at the time, was relevant to the context of the misconduct. Although Mr Bradly suggested that Dr Uppal's problems at the practice were not taken into account when considering impairment, I note that when the Panel gave its oral decision on impairment (Day 9/Bundle page 347), it referred to this issue in the context of impairment. The Panel gave considerable weight to the evidence of her exemplary professional and personal conduct in her new practice from her GP trainers, Dr Clarke and Dr Warwick (who was also a training director for the region).

31. It is apparent from the face of the decision that the Panel had regard to the public interest factors. The Panel expressly stated at the beginning of its oral decision on impairment (Day 9/Bundle page 347):

> "In considering the question of impairment, the Panel has taken account of all the evidence, both oral and documentary, and the submissions made by … Counsel …The issue of impairment is one for the Panel to determine exercising its own judgment. The Panel has taken into account the public interest which includes the need to protect patients and the public, to maintain public confidence in the profession, and to declare and uphold proper standards of conduct and behaviour."

32. At the conclusion of its reasoning on impairment, it stated (Day 9/Bundle page 348):

> "In the circumstances, the Panel finds that your fitness to practise is not impaired by reason of your misconduct. In reaching its decision, the Panel has taken account of the public interest, and has determined that insofar as the issue of impairment of fitness to practise is concerned, the public interest will be satisfied by the finding of misconduct, which is serious in itself."

33. I accept Ms Horlick's submission that the Panel was in a better position than this Court to assess Dr Uppal's fitness to practise. It took 10 days to consider the evidence and submissions in this case. It saw and heard Dr Uppal giving evidence in chief and being vigorously cross-examined. It also heard evidence from Dr Clarke and Dr Warwick, the highly experienced doctors supervising her. In contrast, I have only heard legal submissions from counsel and have had no opportunity to assess Dr Uppal myself.

34. However, the question whether or not its decision was unduly lenient is ultimately one for this Court, applying the test set out in *Ruscillo*: whether, having regard to the

material facts, the decision reached had due regard for the safety of the public and the reputation of the profession (per Lord Phillips at [73]). In this case, the Panel had regard to all the relevant factors in reaching its decision, including the public interest, and it correctly directed itself in law. I consider that the Panel was justified, in the exercise of its judgment, in concluding that Dr Uppal's fitness to practise was not impaired, on the basis of the evidence before it, and for the reasons it gave. This was an exceptional case, on the facts. It does appear, on the evidence, that this was an isolated lapse in an otherwise unblemished career, and that the risk of repetition was extremely low, not least because of her insight and the steps taken to remediate. The Court has received updating evidence from Dr Warwick describing her "exemplary professional behaviour" as a "dedicated and effective G.P". On the basis of these findings, I consider that the Panel was entitled to conclude that patients and the public were not at risk. Professional standards have been upheld, and public confidence in the profession maintained, by the fact that Dr Uppal has undergone a rigorous disciplinary assessment of her fitness to practise, resulting in a finding of misconduct on her record, with the option of a warning, by way of sanction.

Ground 5 - warning

35. Under section 35D(3) of the Medical Act 1983, the Panel had the power, having found that Dr Uppal's fitness to practise was not impaired, to give her a warning as to her future conduct.

36. The Panel decided that it was not necessary, appropriate or proportionate to issue the Second Respondent with a warning either as a deterrent or in the wider public interest. In the light of the mitigating factors (her apology; the misconduct was an isolated incident at odds with her previous and subsequent good history; her insight; remediation and the low risk of repetition) it would be disproportionate to place a warning on her record for 5 years.

37. Ms Horlick supported the Panel's decision and submitted that an official warning would be damaging to Dr Uppal's career, and could affect her ability to obtain indemnity insurance, which would prevent her practising as a GP.

38. The GMC's '*Guidance on Warnings*' states, so far as is material:

> "The purpose of warnings
>
> 10 The power to issue warnings, together with other powers available to the GMC and to MPTS panels, is central to their role of acting in the public interest which includes protecting patients, maintaining public confidence in the profession and declaring and upholding proper standards of conduct and behaviour.
>
> 11 Warnings allow the GMC and MPTS panels to indicate to a doctor that any given conduct, practice or behaviour represents departure from the standards expected of members of the profession and should not be repeated. They are a formal response from the

> GMC and MPTS panels in the interests if maintaining good professional standards and public confidence in doctors. The recording of warnings allows the GMC to identify any repetition of the particular conduct, practice or behaviour and to take appropriate action in that event. Breach of a warning may be taken into account by a panel in relation to a future case against a doctor, or may itself comprise misconduct serious enough to lead to finding of impaired fitness to practise.

12 If any individual allegation is serious enough to amount to a finding of impairment, if proved, then more serious measures are likely to be required at the outset. These more serious measures include undertakings and conditions which restrict the doctor's practice. A warning will not be appropriate where there is a requirement to restrict the doctor's future practice in any way, following a finding of impaired fitness to practise. Warnings are not available in cases which have resulted in, or in which there is a realistic prospect of a finding of impairment, and the GMC is not able to actively monitor how the doctor responds to a warning.

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

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

…

The test for issuing a warning

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

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

…

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

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

…

Dishonesty

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

Proportionality

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

…

Mitigation

…

32 If the decision makers have concluded that the doctor's fitness to practise is impaired or that the realistic prospect test is met they cannot then take account if personal mitigation to decide that a warning is appropriate. As explained above, warnings may only be issued where the decision

> makers have concluded that the doctor's fitness to practise is not impaired or that the realistic prospect test is not met.
>
> 33 However, if the decision makers are satisfied that the doctor's fitness is not impaired or that the realistic prospect test is not met, they can take account of a range of aggravating or mitigating factors to determine whether a warning is appropriate. These might include:
>
> - The level of insight into the failings,
>
> a. A genuine expression of regret/apology
>
> b. Previous good history
>
> c. Whether the incident was isolated or whether there has been any repetition;
>
> d. Any indicators as to the likelihood of the concerns being repeated;
>
> e. Any rehabilitative/corrective steps taken;
>
> f. Relevant and appropriate references and testimonials."

39. Applying paragraphs 16 and 20a of the *Guidance on Warnings*, this was a case in which a warning was appropriate because Dr Uppal was in clear breach of the standards in *Good Medical Practice*. Moreover, both the *Guidance on Warnings* and the *Indicative Sanctions Guidance* emphasise the gravity of dishonesty in the course of professional practice. In this case, Dr Uppal lied to her senior colleagues about her communications with a patient's family, and called into question the account given by Baby A's mother, to deflect criticism of the care which she provided. The Panel was entitled to have regard to the mitigating factors, as identified in paragraph 33 of the '*Guidance on Warnings*', to determine whether a warning was appropriate. However, I am unable to agree with the Panel that, in the circumstances of this case, a warning was not necessary, appropriate or proportionate.

40. I recognise that, under section 29, it is not enough for the PSA to show that the sanction was lenient, as leniency may be appropriate in the circumstances of the case. The sanction must be shown to be <u>unduly</u> lenient. I also recognise that respect should be accorded to the judgment of the professional decision-making body, entrusted with the statutory function of determining sanction.

41. However, in my view, the decision not to issue Dr Uppal with a warning for her misconduct was unduly lenient, given the nature of the misconduct. In particular, I consider that the failure to impose any sanction did not uphold standards in the profession and was capable of undermining public confidence in the profession.

Ground 6 - failure to give adequate reasons

42. Failure to provide adequate reasons for a decision was held to be a serious irregularity leading to a remittal in *Council for the Regulation of Health Care Professionals v. General Dental Council & Marshall* [2006] EWHC 1870 (Admin) because the Judge was unable to determine whether or not the sanction was appropriate.

43. In this case, I did not find the reasons to be inadequate, bearing in mind that they are the reasons of a regulatory panel (comprising of health practitioners and a lay member, with a legal assessor), which is not expected to give reasons to the same standard as a court. I found them intelligible and sufficient to enable the parties to know why they won or lost, and for the PSA to consider whether the decisions were too lenient.

44. At times the PSA embarked upon a forensic examination of the determination, seeking to identify ambiguities, omissions or infelicities of expression. The Panel is comprised of lay members, not lawyers, and the determination is drafted under pressure of time during the hearing, so allowance must be made for imperfect drafting. Its reasons will be adequate if they summarise the Panel's findings on the principal important issues. The Panel need not record every point made to it in evidence and submissions in order to show that it has taken it into account. This is particularly so in fitness to practise hearings where the parties and the appeal court has a full transcript of the hearing.

Conclusion

45. For the reasons I have given, the PSA's appeal is allowed on one ground only, namely that the failure to issue Dr Uppal with a warning was unduly lenient. I will receive submissions from the parties on the terms of an appropriate warning to be imposed by this Court.