Neutral Citation Number: [2020] EWHC 3122 (Admin)

Case No: CO/12/2020

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 19 November 2020

Before :

MRS JUSTICE FARBEY

- -

Between :

Professional Standards Authority for Health and Social Care	**Appellant**
- and -	
General Medical Council	**First Respondent**
and	
Dr David Henry Dighton	**Second Respondent**

- -
- -

Ms Fenella Morris QC (instructed by **Browne Jacobson LLP**) for the **Appellant**
Mr Ivan Hare QC (instructed by **GMC Legal**) for the **First Respondent**
The **Second Respondent** made written submissions only

Hearing date: 22 October 2020

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Approved Judgment

I direct that no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

Covid-19 Protocol: This judgment will be handed down by the judge remotely by circulation to the parties' representatives by email and release to Bailii. The date and time for hand-down will be deemed to be 19 November 2020 at 10.30 am.

Mrs Justice Farbey :

Introduction

1. This is an appeal by the Professional Standards Authority for Health and Social Care ("PSA") against a decision of the Medical Practitioners Tribunal ("MPT") of the General Medical Council ("GMC") which is the first respondent. The MPT determined that the second respondent (who was a cardiologist regulated by the GMC) should be suspended from the register for a period of one year following disciplinary proceedings in which he was found to have excessively prescribed potentially addictive drugs to a person whom I shall call Patient A.

2. The MPT determined that the second respondent's fitness to practise was impaired by reason of misconduct. In imposing a suspension as opposed to an erasure from the register, the MPT considered that the second respondent's conduct was not fundamentally incompatible with his inclusion on the medical register.

3. The PSA challenges the MPTs decision on the basis that the suspension order is an insufficient sanction for the protection of the public: the second respondent's registration ought to have been erased. There are three grounds of appeal. First, the MPT's approach to the imposition of the sanction was irrational and wrong. Secondly, the MPT failed to have sufficient regard to the relevant guidance on sanctions. Thirdly, the MPT took an irrational approach to the second respondent's insight into his misconduct.

Factual background

4. The facts which gave rise to the MPT proceedings may be taken from the MPT's decision documents. The second respondent qualified as a doctor in 1966. His specialism was cardiology but he had a private practice as a General Practitioner ("GP"). He had undergone no formal GP training, which he regarded as unnecessary because of his work in general medicine and "the minor nature of his patients' ailments."

5. Patient A attended a consultation with the second respondent on 1 November 2011. In subsequent years until 2017, Patient A sought from him, and was on multiple occasions prescribed, the following drugs: zolpidem (a sleeping tablet); co-proxamol (a strong painkiller); dihydrocodeine (a strong painkiller); mirtazapine (an antidepressant); and diazepam (a tranquiliser).

6. Over the same period, Patient A also obtained multiple prescriptions from her GP for drugs including antidepressants, zolpidem, dihydrocodeine and diazepam. On 23 June 2017, Patient A was diagnosed with (among other things) prescription drug dependency. The second respondent has in the past confirmed in writing that he was aware from the start that Patient A demonstrated the behaviour of an addict.

7. In 2011, the second respondent was issued with a letter of advice from the GMC relating to his prescribing. In 2016, he appeared before the GMC's Investigation Committee and was issued with a warning relating to his prescribing of benzodiazepines.

8. The proceedings before the MPT took place between 25 February and 15 March 2019, and then 28 October to 29 October 2019. Before the MPT, the GMC made numerous allegations of misconduct which need only be broadly summarised for present purposes. In essence, it was alleged that the second respondent had prescribed excessively a number of different drugs to Patient A; had failed adequately to assess or appropriately refer her to mental health services; kept inadequate records; failed to inform Patient A's GP that he had issued Patient A with prescriptions; and lacked adequate expertise to treat her. The allegations were (save in one immaterial respect) either admitted by the second respondent or found proved.

9. On the basis of the facts which it had found proved, the MPT determined that the second respondent's actions amounted to misconduct. It went on to consider whether his fitness to practise was currently impaired by reason of misconduct, balancing the various factors which it regarded as weighing for and against impairment. The MPT expressed grave concerns in relation to the second respondent's poor practice over a six-year period despite an advice letter in 2011 and a warning in 2016. It described his lack of insight as "intractable" such that "he is unlikely to remediate and there is a material risk of repetition." The combination of lack of insight, unfocused training, lack of any apology and lack of reflective practice meant that the risk of repetition could not be regarded as low. The MPT concluded that the second respondent's fitness to practise was impaired.

10. On the final day of the hearing, the MPT considered sanction. At that stage, the second respondent supplied two statements and gave oral evidence. He said that he had stopped work as a GP on 18 December 2018 because of a discussion with an adviser from the Care Quality Commission who had impressed upon him that GP work was a speciality and that his experience was limited.

11. The second respondent said that he had experience of prescribed drugs, in particular lorazepam, from his time working at Charing Cross Hospital in the 1970s. He had no experience of dealing with addicted patients and their needs. He had been deceived by Patient A who was "clever and manipulative." By prescribing drugs in a manner that was different to established practice, he was "trying to make an academic point." For the first time, he apologised to the GMC for his errors. He had not apologised to Patient A, saying that she was happy with her treatment. He rejected the suggestion that he posed a risk to patients in the future: he had removed "all contentious issues."

12. In reaching its conclusion on the appropriate sanction, the MPT considered the relevant guidance. It weighed the mitigating and aggravating factors in the case. As regards mitigating factors, the second respondent had made some admissions to misconduct. During the course of a long career, he had received no complaints from patients. Patient A had been complimentary about him.

13. As regards aggravating factors, the MPT emphasised the second respondent's intractable lack of insight. He had prescribed excessive drugs without informing Patient A's GP over a sustained period of time when he knew that she was a vulnerable patient at risk of overdose. He had blamed Patient A rather than recognising her behaviour as symptomatic of addiction. Patient A was not an isolated case: by his own admission, the second respondent had prescribed benzodiazepines on a long-term basis to 20 other patients.

14. In reaching its decision to impose a suspension order, the MPT gave decisive weight to the fact that the second respondent had ceased to practise as a GP. For this reason, it held that his conduct was not fundamentally incompatible with his inclusion on the medical register.

15. By notice and grounds of appeal filed on 3 January 2020, the present appeal was launched. On 27 February 2020, the GMC's Case Examiners decided to allow the second respondent's application for voluntary erasure. On 6 March 2020, the GMC informed the parties that this decision would (in effect) be stayed pending the determination of this appeal. The PSA's position is that the MPT's order, even if now coupled with voluntary erasure, would be insufficient for the protection of the public. A court-imposed erasure is necessary in light of the importance of upholding confidence in the medical profession and the importance of the maintenance of standards.

Legal framework

The High Court's jurisdiction

16. The PSA may refer a suspension decision of a MPT to the High Court if it considers that the decision is not sufficient for the protection of the public (section 29(4) of the National Health Service Reform and Health Care Professions Act 2002). The protection of the public includes not only matters relating to the health, safety and well-being of the public but also the maintenance of public confidence in the medical profession and the maintenance of proper professional standards and conduct (section 29(4A) of the 2002 Act).

17. The court will treat any such reference as an appeal against the relevant decision (section 29(7) of the 2002 Act). The proceedings will be governed by CPR Part 52. The court's consideration is therefore limited to a review of the decision and is not a rehearing (CPR 52.21(1)). An appeal will be allowed if the panel's decision is "wrong" or "unjust because of a serious procedural or other irregularity in the proceedings" (CPR 52.2(3)).

The correct approach to the MPT's findings

18. The approach that the court should take to the factual findings and evaluative assessments of the specialist MPT is well-established in case law and is not in dispute. It has recently been summarised by Foster J in *Professional Standards Authority for Health and Social Care v Health and Care Professions Council & Andrews* [2020] EWHC 1906 (Admin). The summary includes the following propositions (at para 3 of the judgment):

> "(b) The court, as any appeal court, will correct material errors of fact and law but be very cautious about upsetting conclusions of primary fact particularly when dependent on an assessment of credibility of witnesses, whom the Tribunal has had the advantage of seeing and hearing (see *Assicurazioni Generali SPA v. Arab Insurance Group* (Practice Note: [2002] EWCA Civ 1642); *Southall v. GMC* [2010] EWCA Civ 407, [2010] 2 FLR 1550); although

(c) An appeal court may draw any inferences of fact which it considers justified on the evidence (CPR 52.11(4)).

(d) An appellate court approaches Tribunal determinations about what constitutes serious misconduct or what impairs a person's fitness to practise or what is necessary to maintain public confidence and proper standards in a profession with diffidence (*Fatnani and Raschi v. GMC* [2007] 1 WLR 1460; *Khan v. General Pharmaceutical Council* [2016] UKSC 64, [2017] 1WLR 1693).

(e) This approach applies also to questions of sanction, which are similarly evaluative (*ibidem*, and see *Bawa-Garba* [2018] EWCA Civ 1879); although

(f) Certain matters such as dishonesty or sexual misconduct may enable a court to assess what is needed to protect the public or maintain reputation more easily for itself and, therefore, attach less weight to the Tribunal's expertise (*Council for the Regulation of Healthcare Professionals v. The GMC and Southall* [2005] EWHC 579 Admin; [2005] Lloyd's Rep Med 365, para.11; *Khan* at para.36)".

GMC guidance on the duties of doctors

19. In guidance entitled "Good Medical Practice" (25 March 2013; updated 29 April 2014 and 29 April 2019), the GMC stipulates that doctors are subject to a number of overriding duties which they must perform. Paragraph 15 states:

> "…If you assess, diagnose or treat patients, you must:
>
> a. adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient
>
> b. promptly provide or arrange suitable advice, investigations or treatment where necessary
>
> c. refer a patient to another practitioner when this serves the patient's needs".

20. Paragraph 16 states that doctors are under a duty to:

> "prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's need".

21. In guidance entitled "Good Practice in Prescribing Medicines" (September 2008) that was applicable at the material time, the GMC stipulated that:

> "8. If you are not the patient's general practitioner and you accept a patient for treatment without a referral from the patient's general practitioner, then you must:
>
> (a) explain to the patient the importance and benefits of keeping their general practitioner informed
>
> (b) inform the patient's general practitioner, unless the patient objects
>
> (c) where possible, inform the patient's general practitioner before any treatment is started, unless the patient objects to this disclosure.
>
> 9. If the patient does not want their general practitioner to be informed, or has no general practitioner, then you must:
>
> (a) take steps to ensure that the patient is not suffering from any medical condition or receiving any other treatment that would make the prescription of any medicines unsuitable or dangerous
>
> (b) take responsibility for providing all necessary aftercare for the patient until another doctor agrees to take over".

Guidance on sanctions

22. The GMC has issued guidance on sanctions for members of medical practitioners tribunals and for GMC decision-makers. The sanctions guidance contained the following provisions at the time that is material to this appeal:

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

> b. A deliberate or reckless disregard for the principles set out in Good Medical Practice and/or patient safety.
>
> ...
>
> d. Abuse of position/trust ... the public's trust in the profession.
>
> ...
>
> j. Persistent lack of insight into the seriousness of their actions or the consequences".

23. Paragraph 129 of the sanctions guidance emphasises the particular gravity of cases where "there is a deliberate or reckless disregard for patient safety."

24. The sanctions guidance makes further express reference to the importance of a registrant's insight into his or her misconduct:

> 130. A particularly important consideration in these cases is whether a doctor has developed insight or has the potential to develop, insight into these failures. Where insight is not evident, it is likely that conditions on registration or suspension may not be appropriate or sufficient.
>
> ...
>
> 132. However, there are some cases where a doctor's failings are irremediable. This is because they are so serious or persistent that, despite steps subsequently taken, action is needed to maintain public confidence. This might include where a doctor knew, or ought to have known, they were causing harm to patients and should have taken earlier steps to prevent this."

The parties' submissions

25. In submissions on behalf of the PSA, Ms Fenella Morris QC (who did not appear before the MPT) emphasised the gravity of the MPT's findings of fact. The second respondent had prescribed addictive medicines to a vulnerable patient whom he considered demonstrated addictive behaviour. He had done so over a long period of time, failing to take the usual precautions in terms of assessment, recording, communicating with her GP or referring her to a psychiatrist. The MPT found that this placed the patient at real risk of harm, including death. It found that the second respondent did this in the face of extensive and clear regulatory guidance to the contrary and despite receiving from the GMC advice and a warning for similar conduct. The second respondent had followed that pattern of prescribing in respect of at least 20 other patients.

26. While recognising that questions of sanction are evaluative and so to be generally approached with appropriate respect in this court (see the *Andrews* case above), Ms Morris submitted that the particular questions raised in the present appeal were not narrow clinical questions or matters of the MPT's expertise. As she put it, everyone

can understand why a doctor should not prescribe excessive medication to an addict. The risk to the public from the second respondent included his entrenched attitude that he could ignore or disavow regulatory standards or practices because he had his own ideas about medical practice. This attitudinal failing – which had not changed despite previous advice and a warning – can be assessed in this court as effectively as it can be assessed in the MPT.

27. Under Ground 1, Ms Morris submitted that no reasonable MPT could have found that the second respondent's conduct was anything other than fundamentally incompatible with continuing to practise as a doctor. The MPT found that the conduct to which the proceedings before it related involved breaches of fundamental tenets of the profession. Prescribing is at the heart of medical practice and it is a fundamental requirement that it be done safely.

28. Under Ground 2, Ms Morris submitted that the MPT had not properly applied the relevant sanctions guidance. The number of the indicators for erasure that were applicable, and their seriousness, ought to have driven the MPT to impose erasure.

29. Under Ground 3, Ms Morris submitted that the MPT was irrational to conclude that the second respondent should be suspended when, on its own findings, his lack of insight was intractable. Given the force of that finding, the MPT could not reasonably conclude that there was any real prospect of remediation. In the absence of any prospect of change, only erasure would protect the public.

30. On behalf of the GMC, Mr Ivan Hare QC (who did not appear before the MPT) made no submissions on the grounds of appeal. The GMC had submitted to the MPT that the appropriate sanction was one of suspension and it would now be satisfied with the second respondent's voluntary erasure. In response to questions from me, Mr Hare observed that, although the GMC had submitted to the MPT that suspension was appropriate, the MPT was not constrained by the GMC's view. The MPT is quasi-independent of the GMC and exercises its own discretion. He confirmed that the subsequent decision of the GMC Case Examiners to accept the second respondent's application for voluntary erasure had been stayed pending the resolution of this appeal, in order that the court's powers should not be constrained by any development outside court.

31. The GMC's present view of the second respondent's situation is that voluntary erasure protects the public interest. If the second respondent were ever to wish to practise as a doctor again, he would need to apply for fresh registration, which would not be permitted if he were considered to be a risk to patients. Both the MPT's findings and the GMC's voluntary erasure decision will be a matter of public record: there can be no question of any lack of transparency about his history.

32. Although represented by counsel before the MPT, the second respondent did not appear before me but relied on a letter from his solicitors dated 20 April 2020 accompanied by a bundle of documents. The second respondent is concerned that the PSA has persisted with legal proceedings when it is not clear how a court-imposed erasure would provide more protection for the public than the grant of voluntary erasure by the GMC. The solicitors submit that voluntary erasure will protect the public because the second respondent will no longer be registered if his name is erased pursuant to the Case Examiners' decision. If the second respondent were to

apply to be restored to the register (which he does not propose to do), the burden would rest on him to demonstrate his fitness to practise without restriction. The second respondent invites the court to direct the GMC to implement the Case Examiners' decision granting voluntary erasure which would make the present appeal otiose.

Analysis and conclusions

33. I do not accept the second respondent's submission that this appeal is otiose because the GMC is willing to grant his application for voluntary erasure. The appeal is properly brought before the court and I have jurisdiction to determine it. Parliament's intention in bestowing the appeal right could be frustrated if a registrant could avoid the scrutiny of an appeal by deciding to opt for voluntary erasure.

34. The second respondent submitted to the MPT that it would be a sufficient sanction that his registration be subject to conditions. That was plainly unrealistic. Although the GMC submitted that a suspension should be imposed, the MPT was bound to apply the relevant guidance properly. It was under a duty to reach its own decision on sanction in a way that would protect the public.

35. In my judgment, the MPT was wrong to conclude that the second respondent need not be erased from the register. For the reasons advanced by Ms Morris, its conclusion was unreasonable and its reasoning was flawed. The second respondent's willingness to give up practice as a GP cannot reasonably be regarded as weighing decisively in favour of his suspension and against his erasure. As Ms Morris submitted, he has only decided to give up what he should not have been doing in the first place. This factor cannot reasonably outweigh the numerous other findings of the MPT which weigh in favour of erasure.

36. The MPT found that the second respondent was not competent and lacked expertise to prescribe drugs to Patient A. The second respondent's sustained, excessive prescription of drugs to a vulnerable patient in an area of medicine beyond his expertise placed Patient A at risk of harm including death. Conduct which puts patient safety at risk is a breach of an overriding duty of doctors in any branch of medicine (see para 15 of "Good Medical Practice" above). It undermines public confidence in the profession (see para 108 of the sanctions guidance above).

37. The MPT found that the second respondent's misconduct was deliberate. He prescribed drugs in excessive quantities in the knowledge that Patient A was an addict and vulnerable to accidental or deliberate overdose (contrary to para 16 of "Good Medical Practice" above). He failed to inform her GP of those prescriptions (contrary to para 8 of "Good Practice in Prescribing Medicine" above). As a result, there was no protection against the risk that she would seek the same medication from a second source as part of her addictive behaviour. The MPT concluded that he had demonstrated a "blatant disregard for safeguards and jeopardised [Patient A's] well-being." In my judgment, the MPT's findings of deliberate, risky actions are inconsistent with continued registration as a doctor - as indicated in paras 108, 109 and 129 of the sanctions guidance above.

38. The MPT found that the second respondent had shown no insight into his misconduct. He believed that there was no wrongdoing on his part, blaming Patient A for what he

regarded as her own manipulative behaviour. The MPT held that he believed that his own knowledge and experience was superior to clinical guidance from expert bodies such as NHS England. He indicated that he was able to recognise through his experience and clinical judgment what he termed "exceptional" patients who could handle long-term benzodiazepines. This dangerous lack of respect for accepted clinical practice was characterised by the MPT as amounting to an "intractable" lack of insight. The MPT recognised the importance of insight to its decision on sanction under the guidance. However, it reached an unreasonable decision: the second respondent's intractability is inconsistent with the prospect of remediation in a one-year suspension period or at all.

39. The MPT found that the second respondent was resistant to the regulatory regime to which doctors must adhere in the public interest. His evidence "had a sense that he knew better than the regulators because reliance on his own clinical judgment was a sufficient safeguard." The statutory regulation of the medical profession is designed to prevent the sort of risks which the second respondent caused to Patient A. The second respondent's resistance to regulatory control is a further facet of his lack of insight that means that he cannot be trusted to practice as a doctor again. That may only be reliably achieved by erasure.

40. I accept Ms Morris's submission that, by overturning the MPT's decision on sanction, this court does not enter any territory reserved by Parliament for the MPT. The consequences and import of the MPT's own findings are not dependant on specialist clinical judgment or on the assessment of oral evidence which the MPT would be in a better position than me to assess.

41. The suspension order will therefore be quashed.

Disposal

42. I am asked by Ms Morris to substitute my own decision rather than remit the case to the MPT for a fresh decision in relation to sanction. Neither of the respondents suggested that I should remit the case and I see no purpose in doing so. I am in no doubt that the second respondent's name must be erased from the register.

43. I have considered whether I should order the erasure of the second respondent or whether his voluntary erasure would be adequate. Ms Morris emphasised the three elements of the public interest which I must consider: the protection of patients; the maintenance of standards; and public confidence in the profession. In my judgment, public confidence in the medical profession means not only that the flawed decision of the MPT cannot be permitted to stand but that the court should order erasure.

44. For these reasons, the appeal is allowed and I shall substitute my own decision in the form of an order for erasure.