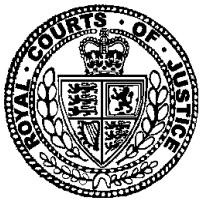

Neutral Citation Number: [2021] EWHC 2022 (Admin)

Case No: CO/3306/2016

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

Birmingham Civil Justice Centre
Birmingham, West Midlands, B4 6DS

Date: 16/07/2021

Before :

MR JUSTICE JACOBS

- -

Between :

DR FAKHRY SALAH EL-HUSEINI

Claimant

- and -

GENERAL MEDICAL COUNCIL

Defendant

- -
- -

The Claimant appearing as a **Litigant in Person**
Ivan Hare QC (instructed by **GMC Legal**) for the **Defendant**

Hearing dates: 7th – 8th July 2021

- -

Approved Judgment

Mr Justice Jacobs:

A: Introduction

1. The Appellant ("Dr El-Huseini") appeals to the court as of right under s. 40 of the Medical Act 1983 ("1983 Act") against the determination of the Medical Practitioners Tribunal ("MPT") on 24 May 2016 to suspend his registration for a period of 12 months on grounds of misconduct and health. The suspension was subsequently extended on review, but on the grounds of health only. Since the Court of Appeal restored this appeal, Dr El-Huseini has been subject to the immediate order of suspension imposed by the MPT on 24 May 2016.The Respondent ("GMC") is responsible under the 1983 Act for the decisions of the MPT.

2. At the time of the events which were the subject of the misconduct charge, Dr El-Huseini worked as an anaesthetist at the University Hospitals Coventry and Warwickshire NHS Trust ("UHCW"). In August 2008, he had suffered a stroke. This led to a diagnosis of conductive aphasia and anomia. These are forms of difficulty in processing information or speaking caused by damage to the brain. Despite these problems, Dr El-Huseini continued to work at UHCW.

3. He was working there on 17 June 2011 when an incident occurred with a patient (Patient A) at UHCW. That patient required general anaesthesia for an operation in connection with dental issues. There is no dispute that Dr El-Huseini was the anaesthetist responsible for Patient A. The events on that day were the subject of the allegation of misconduct alleged against Dr El-Huseini. In fact, the allegations of misconduct also related to events subsequent to 17 June 2011, but those allegations were found by the MPT not to have been proved, and it is therefore unnecessary to describe them in this judgment.

4. The MPT did, however, find that it had been proved that Dr El-Huseini, as the anaesthetist responsible for Patient A, had identified, prior to the anaesthetic, that the patient had a "difficulty airway". The MPT also found it proved that the patient experienced a clinical episode in the form of an airway obstruction when in the recovery room. There is no dispute about the fact that this occurred. The misconduct alleged, and proved, against Dr El-Huseini was that he was not in the immediate vicinity of the recovery area when this episode occurred. The MPT held that the facts proved amounted to misconduct and that this misconduct amounted to impairment. It held that Dr El-Huseini had failed to provide the level of care necessary to protect Patient A and so fell seriously below the standard to be expected of him.

5. The MPT formed the view that although Dr El-Huseini had stated that there would be no repetition of the misconduct, he did so in terms which did not indicate complete insight on his part into his failure to care for Patient A. The MPT's view was that there was therefore a possibility of repetition. This, together with the seriousness of the failure of care, led the MPT to conclude that the need to ensure patient safety, to maintain public confidence in the profession and to maintain proper professional standards of conduct would be undermined if a finding of impairment were not made.

6. A separate issue which was before the MPT concerned Dr El-Huseini's health. The MPT accepted the evidence of two doctors, Dr Vesey and Dr Friedman who had given evidence at the hearing. The MPT's conclusion was that Dr El-Huseini's health was

such as to put patients at risk and that accordingly his fitness to practise was impaired by reason of adverse physical/mental health. Accordingly, the MPT concluded that his fitness to practise was impaired by both misconduct and adverse physical/ mental health.

7. Dr Friedman was a consultant psychiatrist, and he was instructed to consider whether Dr El-Huseini had a cognitive disorder affecting his functioning as a doctor. He carried out what he described in his report, dated 7 November 2013, as a "very long and difficult assessment". Dr Friedman noted a number of occasions when Dr El-Huseini's "expressive aphasia" (ie difficulty with language or speech) was apparent. Dr Friedman expressed significant concerns about Dr El-Huseini's cognitive performance. He had significant concerns as to how he might perform if he was in a stressful position in an anaesthetic situation. His conclusion was that Dr El-Huseini was not currently fit for work in any way due to cognitive dysfunction. He had significant concerns about Dr El-Huseini's ability to express himself, or that there may be errors in prescribing or managing complex matters. He was also of the opinion that Dr El-Huseini did not fully appreciate the full extent of his deficits. He did not believe that he was currently fit to practise in any setting, and did not believe that psychological intervention was likely to be helpful to him.

8. Dr Patrick Vesey was a consultant neuropsychologist. He had written reports dated 9 November 2013 (on the basis of an examination of 6 hours in October and November 2013) and 10 December 2013. In his first report, he described the neuropsychological tests that had been carried out. The "low results" of those tests could not, in Dr Vesey's view, be explained by an interference with test performance from culture and language factors (English not being Dr El-Huseini's first language). Nor could they be explained by pressure or anxiety during the assessments.

9. Dr Vesey expressed the opinion that Dr El-Huseini had cognitive and language difficulties, and that some of them were very significant. There was evidence of primary neuropsychological change and areas of frank neuropsychological impairment on tasks involving complex attention, mental speed, executive functioning and language. Whilst it might be that the difficulties would be less prominent when undertaking tasks through the medium of Arabic, Dr Vesey still expected there to be significant difficulties. These cognitive difficulties were compatible with the history of "past infarct", which was a reference to Dr El-Huseini's stroke.

10. Dr El-Huseini had said that his clinical competence would be full and apparent in an anaesthetics environment, but Dr Vesey's view was that the cognitive difficulties evident in the assessment were core to "basic functional activity far removed from medical practice". He regarded these impairments as substantial and disabling. In his view, there could be little doubt that they would compromise safe clinical practice in an anaesthetics environment, and it was difficult to envisage that this situation would change in the future. It was possible that Dr El-Huseini could be capable of some form of non-clinical medical practice perhaps in a teaching environment. Dr Vesey also noted that, quite apart from the fitness to practice issues, there were "genuine welfare issues", and that Dr El-Huseini needed close support from family and friends.

11. Dr Vesey concluded:

> "The neuropsychological disabilities will also cause him difficulty in processing and responding to information pertaining to the fitness to practice proceedings, both written and oral. He is at risk of failing to properly represent his own interests in the proceedings and if possible he should be permitted additional time to prepare and respond to correspondence and to instruct a legal representative. He has subtle but distinct difficulty in understanding speech during normally-paced conversation but some of this difficulty is ameliorated when conversation is slowed down or repeated and this may be a necessary measure to employ."

12. In his second report, Dr Vesey said that he remained of the view that Dr El-Huseini's cognitive difficulties were likely to compromise safe independent clinical practice in an anaesthetics environment.

13. In the light of its conclusions, the MPT determined to suspend Dr El-Huseini for a period of 12 months. Shortly before the end of the period of suspension, his case would be reviewed by the MPT at a review hearing. The MPT also imposed an immediate order of suspension.

14. The hearing which resulted in these conclusions had started on 25 April 2016. It occupied 19 days, during which time the MPT heard oral evidence from a large number of witnesses. It concluded with the MPT's written decision dated 24 May 2016. Dr El-Huseini did not attend any of the hearing, except on the second day (26 April 2016) when he sought to adjourn the proceedings.

B: Background/procedural history to the MPT proceedings

15. There is a lengthy background and procedural history to the MPT proceedings. It is not necessary to describe this in detail. I am concerned in this case with an appeal against the decision of the MPT, where the issue is whether the MPT's decision was wrong. I am therefore not concerned with, for example, an application for judicial review of decisions made in the years prior to the April/ May 2016 hearings.

16. Substantial parts of Dr El-Huseini's written and oral arguments were nevertheless directed at prior decisions, including generalised allegations in his oral submissions concerning the alleged corruption of the GMC, the way in which interim orders had been made in the years prior to the MPT hearing, as well as arguments which sought to attack the propriety of the MPT proceedings against him by reference to the way in which other medical practitioners had been treated. The need for the appeal to be kept within its proper bounds, with a focus on the MPT decision that was being appealed and the reasons why that decision was alleged to be wrong, was recognised by Steyn J in the order which she made following a case management hearing on 30 March 2021.

17. Her order and reasons, described in more detail below, ran to 12 pages. It identified, in 11 sub-paragraphs, the reasons why – on the basis of the papers previously provided by Dr El-Huseini – the MPT's relevant decisions were alleged to be wrong or (in the case of the MPT's decision not to adjourn) unjust because of serious procedural irregularity. It also identified in detail the manner in which the materials for the appeal were to be prepared. It was apparent, however, from Dr El-Huseini's submissions at the hearing

that he considered that Steyn J should not have made the order which she did, and more generally that he did not wish to be confined to arguments which addressed the relevant decision which was under appeal.

18. It is only necessary to explain the background to the MPT's decision to the extent that it is relevant to the issues on appeal, and specifically the 11 reasons why the MPT's relevant decisions were alleged to be wrong.

Commencement of proceedings and case management hearings

19. The MPT proceedings were, in substance, commenced in February 2014 when the GMC referred Dr El-Huseini's case to a Fitness to Practise Panel ("FPP") under its Fitness to Practise rules. During the course of the proceedings, the fitness to practise rules and procedures of the GMC were altered, so that after 31 December 2015 the cases which previously came before the FPP would now come before the MPT.

20. Prior to the commencement of proceedings in February 2014, there had been a number of hearings before an Interim Orders Panel of the GMC. Those hearings had resulted in various orders including, in December 2013, an interim order for suspension in the light of the reports of Dr Friedman and Dr Vesey to which I have referred. The background also included, in March 2013, a disciplinary hearing of the UHCW, where Dr El-Huseini had received a final written warning.

21. Following the effective commencement of proceedings in February 2014, there was a case management hearing conducted by the case officer of the Medical Practitioner Tribunal Service ("MTPS"). This is one of the committees of the GMC, now referred to in the Medical Act 1983, section 1. Its responsibilities include arranging an MPT to deal with a case, and dealing with case management matters.

22. On 8 April 2014, a first listing telephone conference took place. This was attended by, amongst others, a solicitor instructed by the GMC and by Dr El-Huseini. He was not legally represented, but had a friend in attendance to provide support during the telephone conference. The GMC's solicitor indicated that its investigation and disclosure was complete. This was disputed by Dr El-Huseini, who identified documentation said to be missing. He also indicated that he did not have legal representation at that time, and that (according to the MPTS note of the hearing) "legally he should not be sitting by himself due to his disability". He said that he needed more time to obtain legal representation, and referred in that context to the Bar Pro Bono Unit. He asked for the hearing to be listed in September 2014, but the MPTS advised that it would have to be listed to start in August. The GMC solicitor indicated that if Dr El-Huseini had any difficulties with the hearing date, he could request a later listing.

23. A further listing telephone conference took place on 30 May 2014. Dr El-Huseini had been advised of the conference, but had indicated by email that he would not be attending. The case was then relisted for October/November 2014, with an estimated length of hearing of 25 days.

24. On 8 August 2014, there was a case review hearing. Dr El-Huseini did attend, with an assistant Mr. Shabaan. He remained legally unrepresented. He indicated that documents had not been disclosed by the GMC, and there was a substantial discussion about this issue. According to the MPTS note of the hearing, it was agreed that if Dr El-Huseini "identified the particular document that he was seeking then arrangements could be made for the original to be inspected by him or a representative, as the GMC had retained the original records".

25. A further case review meeting was held on 17 September 2014 on a "face to face" basis. Dr El-Huseini attended with Mr. Shabaan. According to the MPTS note of the meeting, there was further extensive discussion in relation to disclosure of documents generally, and particularly in relation to four documents that Dr El-Huseini believed had not been disclosed. There was also discussion about other issues, with Dr El-Huseini indicating that he might serve an expert report.

26. The consequence of this hearing was a set of amended directions issued by the MPTS case officer. (There had been earlier directions, which it is not necessary to describe) This included a direction for disclosure by both parties of any documentary evidence in their possession or power relating to the allegation. It also included a direction for the service of witness statements by both parties. The direction relating to the hearing bundle required the parties to agree a joint hearing bundle. In the absence of agreement, each party was to serve on the other, no later than 13 November 2014, a paginated and indexed bundle of documents on which they intended to rely. Directions were also given for experts to meet and produce a joint report.

27. A further case review took place on 20 October 2014. By this time, the doctor had requested a postponement of the substantive hearing on the grounds of his health. Another case review hearing took place on 7 November 2014. The directions for the hearing were updated. They recorded that no agreement had been reached as to the hearing bundle, that the GMC had served its bundle on 7 November 2014, and that the date for service of Dr El-Huseini's bundle was 14 November 2014.

November 2014 adjournment of case

28. Following this series of case management hearings, the hearing before the FPP itself started on 17 November 2014. The GMC was represented by counsel, Mr. Grundy. Dr El-Huseini did not attend the proceedings at the start of the hearing before the FPP itself on the grounds of ill-health. Mr. Shabaan did attend on his behalf and submitted a written application for postponement. He made submissions in support of the application and Mr Grundy responded.

29. In support of his application, Dr El-Huseini submitted a report from Dr Ruth Telfer, a neuropsychologist, dated 10 November 2014. The conclusion of her report was that Dr El-Huseini was not functioning adequately to enable him to participate in a hearing dealing with his fitness to practise. The GMC opposed the adjournment application, submitting that the evidence in support was insufficient. The FPP referred to the legal advice received, to the effect that the FPP should approach the matter exercising the utmost care and caution.

30. In its written decision, the FPP referred to the various reports, including those from Dr Friedman, Dr Vesey and the more recent report of Dr Telfer. It also noted the fact that

Dr El-Huseini had participated in various hearings, including the (in excess of) 2-hour telephone case review on 7 November 2014, and an Interim Orders Panel hearing on 14 November, and that he had made various written submissions as well. The FPP's conclusion, in paragraph 14 of the record of the proceedings, was to adjourn the hearing.

> "Whilst the Panel notes that the assessment by Dr Telfer was not complete, it accepts her later clarification that Dr El-Huseini is not fit to attend a fitness to practise hearing at this time. The Panel considers that it would not be appropriate to go behind the opinion of a clinical psychologist who examined him on 4 November 2014. She did not make a "novel diagnosis" as alleged by the GMC. The Panel recognises that appearing at a Fitness to Practise hearing would be substantially more demanding than attending an Interim Orders Panel hearing. Dr El-Huseini may have neuropsychological problems which may have been exacerbated by the prospect of attending these proceedings. The Panel is satisfied that, at this juncture, Dr El-Huseini should be afforded the opportunity and the time to respond to therapeutic interventions which may put him in a better position such that he could appear and/or be represented at a Fitness to Practise hearing in the near future. The Panel considers it would not be in the interests of justice to refuse the application to adjourn."

31. Dr El-Huseini relied heavily on this conclusion in support of his argument that, some 15 months later, the MPT should have reached the same conclusion as to his fitness to participate in the April 2016 hearing. It is to be noted, however, that the FPP was not contemplating a lengthy or indefinite postponement, but rather that a fitness to practise hearing would take place "in the near future", and that in the meantime Dr El-Huseini would have the opportunity and time to respond to therapeutic interventions which may put him in a better position to appear or be represented at the hearing in the near future.

Medical developments following adjournment

32. The subsequent developments, in terms of "therapeutic interventions" to assist Dr El-Huseini, were described by the MPT in its 24 May 2016 decision under appeal. In summary, the only such interventions thereafter were seven sessions of cognitive behaviour therapy ("CBT") with a chartered psychologist and accredited CBT psychotherapist, Ms Kathy Lowe. In August 2015, she reported that Dr El-Huseini was showing determination to engage, and that he seemed to have a good chance of recovery. However, he was asked to attend formal meetings about his employment. These were, in Ms Lowe's view, regarded as threatening and resulted in a deterioration of his mental state and his ability to concentrate and engage with therapy.

33. The MPT also described, in its decision, various attempts to have Dr El-Huseini attend for a medical assessment. In November 2015, his employing trust referred Dr El-Huseini to a consultant neuropsychologist to obtain a medical report into his condition, as well as to obtain recommendations as to treatment and therapies that might assist him in his return to work. As at the date of the MPT hearing in April 2016, Dr Huseini had refused to attend any appointments with this consultant. His position was that he would attend an appointment with a psychotherapist for the purpose of treatment, but would not attend an appointment with the consultant for the purpose of review.

34. On 23 January 2016, Dr El-Huseini was admitted to a mental health unit under section 2 of the Mental Health Act. He was discharged on 10 February 2016. Although he had produced a letter from the supervising psychiatrist, confirming the admission, the MPT recorded that he "declined the tribunal's invitation to provide medical information from his GP and supervising psychiatrist relating to that admission on the ground that he considers the supervising psychiatrist's report to be inaccurate, misleading and incomplete".

35. The MPT also recorded a sequence of events relating to a fit note from his GP, Dr Rhodes. On 24 March 2016, Dr El-Huseini's GP, Dr Rhodes, signed a "statement of fitness for work for social security or statutory sick pay (Fit Note)" certifying that because of "post-traumatic stress disorder and acute stress reaction awaiting psychotherapy treatment" Dr El-Huseini may benefit from a phased return to work. On 31 March 2016, Dr El-Huseini attended the GP surgery unannounced and spoke to Dr Rhodes, who agreed to make a manuscript amendment to the Fit Note as follows: "able to attend meetings, able to talk to occupational health." On 28 April 2016, two days after his attendance at the hearing, Dr El-Huseini spoke to a different GP, Dr Dey, at the surgery asking for further details to be added to the certificate, specifically "fit to attend meeting with occupational health but not to attend GMC hearing." Dr Dey relayed this information to Dr Rhodes, who issued a further Fit Note again certifying that Dr El-Huseini may benefit from a phased return to work, this time by reference to the following conditions: "1) awaiting psychotherapy 2) has ongoing stressors 3) fit to attend meeting/occupational health but unable to attend hearing with GMC."

36. On 29 April 2016, after the MPT hearing had started, Dr. El-Huseini contacted his GP and was taken to an A&E department where he underwent a CT scan and was then seen in a specialist TIA unit in the hospital for a suspected transient ischaemic attack (a "TIA", sometimes known as a "mini-stroke"). The MPT was provided with a report of the hospital TIA unit which identified the principal diagnosis as a TIA, seemingly based on the history provided to them by Dr El-Huseini. Further information provided to the MPT by Dr Rhodes, by reference to the A&E discharge letter, was that the CT scan had shown no acute changes. Dr El-Huseini was discharged from hospital and referred to a local TIA clinic for a routine consultant appointment in two weeks.

37. In its decision, the MPT summarised the evidence as to developments since the November 2014 adjournment, including its views as to whether these developments justified the application which was being made for a further adjournment, as follows:

> "[18] It is clear from the available information that since November 2014 Dr El-Huseini has had only limited therapeutic intervention in the form of CBT sessions with Ms Lowe. Since then, Dr El-Huseini has failed to arrange or engage with any further therapy. Dr El-Huseini insists that successful treatment is required before he should be required to undergo any form of health assessment, a position which is evidenced by his refusal to see the consultant neuropsychologist to whom he was referred by his occupational health department and by his lack of response to the recent GMC requests for his consent to a health assessment. Most recently, he has indicated his opposition to any direction by the tribunal that he should undergo a health assessment.

> [19] In November 2014, the panel's adjournment of the hearing can be seen as providing a 'window of opportunity' for Dr El-Huseini to obtain treatment which the panel thought may put him in a better position for an appearance at a fitness to practise hearing. The optimism of that panel has not been realised because Dr El-Huseini has not taken steps to the extent expected to undergo treatment. That, together with the intransigence he appears to have adopted towards any form of medical assessment, has led the tribunal to conclude that there is no reason to think the position would be any different were the hearing to be adjourned. The logic of Dr El-Huseini's position is that nothing less than the complete abandonment of the proceedings would remove his stressors, an outcome which, in the tribunal's view, could not be in the public interest."

Procedural developments following the November 2014 adjournment

38. A review hearing took place on 23 September 2015. Dr El-Huseini did not attend. The GMC's solicitor submitted that the case review should proceed, since the GMC was anxious to have the FPP hearing relisted, even if several months away in order to give the doctor time to complete his therapy treatment. Dr El-Huseini had sent an e-mail that morning saying that it was illegal for the case review meeting to proceed, and that this was discriminating against his disability. In an email sent on the previous day, he had stated that there were various factors to be considered before a suitable date for the FPP hearing could take place. This included completion of the CBT programme, followed by updated reports. The GMC's representative made the point that Dr El-Huseini had not provided any real disclosure to date – for instance, he had not served any witness statements. There was also a discussion of reasonable adjustments to be made for the doctor.

39. A further case review was to take place on 23 October 2015, but the MPTS case manager decided to postpone this until 13 November 2015. That meeting did go ahead, in person at the MPTS hearing centre in Manchester. Dr El-Huseini did attend. There was a discussion of reasonable adjustments to be made for the benefit of the doctor. The case manager directed that the case be listed for 25 days from 25 April to 31 May 2016.

40. In reaching her conclusion, the case manager referred to a letter from Dr El-Huseini indicating that he was medically fit to attend a meeting with the UHCW, and also that he was medically fit for a phased return to work. She noted that this conflicted with the report of Ms Lowe in her report dated 24 August 2015. She was not in a position to resolve that conflict of evidence, but it did mean that she could not reasonably conclude that the doctor was unfit to participate in the FPP hearing. She reiterated a suggestion that "it would assist Dr EH to participate in GMC Health Assessments and/or his own independent assessments so that his fitness to practise and fitness to participate in a hearing can be properly assessed". She fixed the hearing 5 months hence, to allow him to continue his treatment and prepare for the hearing.

41. She then directed that:

> "Regarding the health allegation, I direct that:

> a. By 05 February 2016, Dr EH to confirm in writing to the GMC whether he:
>
> > i. Provides his consent to undergo GMC health assessments without further delay in order to evaluate his fitness to practise and his fitness to participate in a Fitness to Practise Panel hearing;
> >
> > ii. Intends to obtain his own independent medical reports to evaluate his fitness to practise and his fitness to participate in a Fitness to Practise Panel hearing. For the avoidance of doubt, this includes any reports he intends to obtain from his treating clinician(s) and GP.
>
> b. By 01 April 2016, Dr EH to disclose to the GMC any further independent medical reports he obtains regarding his fitness to practise and his fitness to participate in a Fitness to Practise Panel hearing. For the avoidance of doubt, this includes any reports he obtains from his treating clinician(s) and GP."

42. She noted that, as indicated in her decision on relisting, there was a lack of up-to-date independent medical evidence regarding Dr El-Huseini's fitness to practise and fitness to participate in a FPP hearing. She had therefore "made the directions above to ensure that the parties have a timetable for making decisions regarding further assessments of Dr EH's health".

C: The MPT hearing

43. Dr El-Huseini did not attend on the first day of the MPT hearing, which was then adjourned until Day 2. Dr El-Huseini attended on Day 2 and applied for the hearing to be adjourned on grounds of his health. The application was supported on his behalf by his personal assistant, Mr Shabaan by telephone. Dr El-Huseini did not return to the MPT on the following day, and the MPT decided to proceed with determining the adjournment application in his absence. It rejected the adjournment application, and acceded to the GMC's application to proceed with the hearing in the absence of Dr El-Huseini. It gave detailed reasons for these decisions.

44. As regards the misconduct allegations, the MPT heard live evidence called by the GMC from a number of witnesses. These included an expert witness, Dr Anna-Maria Rollin MBE FRCA, a consultant anaesthetist. The other witnesses on the misconduct issues, and their job descriptions, were as follows: Ms Hazel Faulkner, HR Manager at the Trust; Mr Amardeep Johal, Group Manager for Theatres and Anaesthetics; Ms Barbara Nunn, Theatre Nurse; Mr Derrick Hammond, Senior Operating Department Practitioner; Ms Carolyn Bradshaw, Sister in Theatres; Ms Susan Bodinnar (nee Moore), Operating Department Practitioner; and Dr Edwin Borman, Clinical Director of Anaesthetics and Pain Management (at the material time), later Medical Director at Shrewsbury and Telford Hospital NHS Trust.

45. As regards the health allegation, the MPT heard live evidence from three health experts called by the GMC. These were the two experts whose reports have already been

summarised: Dr Trevor Friedman, consultant psychiatrist, and Dr Patrick Vesey, consultant neuropsychologist. The MPT also heard from Dr Deenesh I Khoosal, a consultant psychiatrist.

46. On Day 17, the MPT found the following allegations proved:

> (1) On 17 June 2011, you were the Anaesthetist responsible for Patient A who was under general anaesthesia, and in whom you had identified a difficult airway.
>
> (3) You were not available in the immediate vicinity of the recovery area when Patient A experienced airway obstruction ('the Clinical Episode').
>
> (7) On 24 October 2013 and 2 November 2013, you were examined by [Dr Vesey], Consultant Neuropsychologist, who identified the matters set out in Schedule 1.
>
> (8) On 6 November 2013, you were examined by Dr [Friedman], Consultant Psychiatrist, who made the diagnosis set out in Schedule 2.

47. A number of allegations, including allegations of dishonesty, were found by the MPT not to have been proven. It is not necessary further to describe these matters in this judgment. Mr Hare referred to the MPT's decision on those matters as showing the fairness with which the MPT approached its task, notwithstanding the absence of Dr El-Huseini. This was a reasonable point on the facts, and it provides a counter to the Dr El-Huseini's generalised and unsubstantiated allegations that the MPT was somehow acting vexatiously. However, I did not think that it carried the GMC's case very far in terms of the issues that actually arise on the appeal. The appeal is against the decisions which were adverse to Dr El-Huseini. Those decisions must be considered on their own merits, within the framework of the applicable legal principles governing appeals.

D: The appeal process

48. It has taken a very considerable time for Dr El-Huseini's appeal to come on for hearing. The appeal was filed on 28 June 2016. Following a hearing on 5 September 2016, pursuant to a judgment handed down on 23 September 2016, HHJ David Cooke dismissed the appeal on the grounds that it was out of time, having been filed on the last day of the 28-day period, but without payment of the requisite fee or filing of a fee remission certificate. Dr El-Huseini appealed. Shortly before Dr El-Huseini's appeal to the Court of Appeal was heard, the GMC discovered there had been administrative errors which had resulted in Dr El-Huseini not being given a fee remission certificate. The GMC conceded the appeal and by order dated 15 May 2018 the Court of Appeal allowed the appeal, set aside the amended order of HHJ Cooke sealed on 3 October 2016, reinstated Dr El-Huseini's appeal against the decision of the MPT and made a costs order in his favour.

49. Unfortunately, the Court of Appeal order reinstating the appeal did not come to the attention of the Administrative Court in Birmingham for more than 1 ½ years, and the parties did not seek to progress the appeal. On 5 March 2020, the Administrative Court Lawyer, anticipating that matters might have changed since the proceedings were commenced, made an order requiring Dr El-Huseini to file, within 21 days,

confirmation that he intended to pursue the appeal on the original grounds or an application for permission to rely on amended grounds.

50. On 30 March 2020, Dr El-Huseini applied for permission to amend his grounds of appeal. However, at that stage, he did not provide amended grounds of appeal. On 13 January 2021, the appeal was listed for a 1-day hearing. In response to that listing, on 14 February 2021, Dr El-Huseini made an application for an extension of time to submit his amended grounds of appeal and for various reasonable adjustments to be made with respect to the substantive hearing of his appeal. Both applications were put before Pepperall J on the papers. He decided to convert the 1-day hearing listed into a case management hearing.

The case management hearing

51. The case management hearing took place before Steyn J on 30 March 2021 and took a full half day. Dr El-Huseini represented himself. The GMC was represented by Mr Ivan Hare QC, who appeared on the appeal itself. The judge gave clear and detailed case management directions. She was obviously, and rightly, concerned to ensure that the appeal should be properly focused. The preamble to the order therefore summarised in some detail Dr El-Huseini's grounds of appeal. These were cross-referenced to Dr El-Huseini's Amended Grounds of Appeal, and to the decision of the MTP. In setting out the summarised grounds of appeal below, I have omitted those cross-references:

i) The MPT should have adjourned the hearing on the ground that he was medically unfit to appear because of his disability and/or his on-going therapy and/or his on-going disputes with UHCW and/or the Fitness to Practise Panel ("FTP Panel") determination of 21 November 2014.

ii) Further, the MPT's refusal to adjourn the hearing was wrong in that:

a) the MPT did not give reasonable weight to the fact that he was not given the opportunity to seek and respond to therapeutic interventions;

b) the MPT did not detail any discussion of the causes of his stress;

c) the MPT found that Dr El-Huseini "has not taken steps to the extent expected to undergo treatment";

d) the MPT found that "it could not be in the public interest" to abandon the fitness to practise proceedings;

e) at a High Court hearing regarding extension of his interim order on 9 November 2015, the GMC barrister stated that he should be considered by an FTP Panel when "his health permits".

iii) The GMC should not have requested consent to undergo Health Assessments which would interrupt his therapy.

iv) The MPT gave insufficient weight to his version of events.

v) The MPT's determination does not refer to relevant evidence and/or relies on inaccurate information, specifically:

a) The MPT does not refer to his email to Dr Borman dated 23 June 2011 in relation to the "difficult airway";

b) The MPT did not refer to evidence that it was not a "difficult airway" and/or was a "difficult intubation"; and

c) The MPT relied on the GMC's witnesses exclusively in relation to the issue of the "immediate vicinity".

vi) The GMC failed to disclose original documentary evidence to him and/or the MPT did not have original documentary evidence, specifically, slips and team briefing sheets relating to 17 June 2011.

vii) The MPT's determination was based on vexatious witness statements.

viii) The MPT's determination was based on the following contradictory, expired health reports of:

a) Dr Vesey (reports dated 9 November and 10 December 2013); and

b) Dr Friedman (health assessment dated 7 November 2013).

ix) The MPT wrongly gave more weight to the diagnosis of Dr Friedman in 2013 (mild cognitive impairment), despite being older than the report of Dr Khoosal in 2014 (which did not find this diagnosis).

x) The GMC (through Mr Shahid) gave inappropriate instructions to Dr Khoosal, which raised credibility concerns about the reports of Dr Vesey and Dr Friedman.

xi) The MPT was wrong to find that he lacked insight into his misconduct in light of his evidence to the UHCW disciplinary investigation (MPT's determination on impairment.

52. Amongst the matters specifically addressed by Steyn J was the need to make reasonable adjustments for the disability of Dr El-Huseini, who had requested various adjustments in an application dated 14 February 2021 under the Equality Act 2010. The judge noted that it was common ground that Dr El-Huseini suffered from conductive aphasia and anomia. She had not seen any evidence that he was suffering from PTSD, from which the doctor alleged that he was also suffering. Her order reflected many of the adjustments which had been requested. The hearing was listed for 2 days rather than the 1 day which, in the judge's view, would normally have been permitted. This was to enable the court to proceed at a slower pace, and to take breaks if appropriate. Dr El-Huseini had originally sought a 3 day hearing, but told the judge that it would take 2 days (an estimate with which counsel for the GMC agreed). The judge allowed 2 days, noting the importance of allocating a proportionate amount of time bearing in mind the nature of the appeal, the impact of a longer time estimate on other court users and on costs for both parties.

53. Dr El-Huseini was permitted to have one other person to assist him. The GMC was only permitted one person in court, with any other interested parties attending remotely. A large court room was made available. Dr El-Huseini was permitted to make his own audio recording of the proceedings, subject to various conditions and subject also to the possibility that the judge hearing the substantive appeal might withdraw that permission. (I did not withdraw that permission).

54. The judge gave a lengthy lead time for the filing of skeleton arguments. Dr El-Huseini's was to be served on 21 May 2021. The GMC's was to be served on 11 June 2021, some three weeks before the hearing. On the same date, the GMC was to serve a paginated and indexed authorities bundle, containing any legislative provisions and case-law referred to in the parties' skeleton arguments. In her reasons, the judge explained that the timetable ensured that Dr El-Huseini had plenty of time to prepare his skeleton argument and to process the GMC's skeleton. Dr El-Huseini agreed that 11 June date would not cause him any difficulty, on the understanding that the GMC skeleton would be about 20 pages long. In the event, the GMC's skeleton, which was served on time, was just over 17 pages.

55. At the conclusion of her reasons, the judge summarised the reasonable adjustments which had been made:

> "[40] For the avoidance of doubt, I have made adjustments for the Appellant's disability:
>
> a. By allocating two days, instead of one day, for the appeal.
>
> b. By requiring that the hearing is in person and enabling the Appellant to have a supporter with him.
>
> c. By listing the case in the largest court room on the first floor.
>
> d. By permitting the Appellant to make an audio recording of the case management hearing and the appeal hearing, subject to the conditions I have prescribed.
>
> e. By permitting the Appellant to amend his grounds of appeal insofar as the additional points raise matters that can properly be raised on a s. 40 appeal, despite the 11-month delay in providing those grounds.
>
> f. By requiring the Hearing Bundle is provided to him 12 weeks before the hearing, allowing him more than 5 weeks thereafter to file and serve his skeleton argument, and by ensuring that the latest any documents are provided to him is 3 ½ weeks before the hearing.
>
> g. By putting the reasons for my case management decisions into writing.

> [41] In addition, I have imposed the burden of preparing the Hearing Bundle and the Authorities Bundle on the Respondent, although that is a measure I would have taken on the basis that the Appellant is unrepresented, irrespective of his disability."

56. The judge was particularly concerned to ensure that there was a proper hearing bundle for the appeal. She ordered the GMC to serve, by 13 April 2011, a paginated and indexed bundle for the substantive appeal. She specified the documents which that bundle was to contain. These included a transcript of the hearing before the MPT in April/May 2016, and all documents that were before the MPT at that hearing. Paragraph 8 of her order was in the following terms:

> "The parties may not place any additional material before the court at the substantive appeal hearing unless (a) both parties agree the material should be put before the court or (b) the court grants permission. Any application to place additional material before the court at the substantive appeal hearing:
>
> a. Must be served on the other party and filed, together with a supplementary paginated and indexed bundle, by 4pm on 18 June 2021.
>
> b. The aforesaid supplementary bundle shall contain only such further documents as are essential for the purpose of the appeal, having regard to the grounds of appeal summarised in the preamble to this order;
>
> c. The aforesaid supplementary bundle shall not contain any documents that are duplicates of documents contained in the Hearing Bundle;
>
> d. The application must include a written explanation, limited to a maximum of two pages, explaining why such additional documents are essential for the purpose of the substantive appeal hearing, including identifying which of the grounds (1) to (10) (as summarised in the preamble to this order) it is said the further documents are relevant."

57. In paragraphs [32] – [38] of her reasons, the judge explained why she had made this order. In the context of the time estimate, she had already said that the "nature of this appeal is such that there will be no fresh evidence". She returned to this point in the context of the order as to the hearing bundle:

> "[32] It has proved impossible for the parties to agree an appeal bundle. It was also impossible for the parties to agree a bundle for this case management hearing, despite the order of Pepperall J which sought to ensure that the bundle before me for this hearing was strictly limited to what was required to address the case management issues before me.

[33] For the case management hearing, in addition to the e-bundle prepared by the GMC which contained the documents specified in Pepperall J's order at paragraph 5, I received from Mr El-Huseini a hard copy bundle running to 908 pages, further hard copy documents at the hearing, an electric bundle which largely duplicated the GMC's bundle (but in a form that did not comply with the guidance regarding bookmarking of electronic bundles), and numerous documents electronically running to 1000s of pages. Only a handful of the pages in the additional materials provided by Mr El-Huseini were relevant to the case management hearing.

[34] in order to seek to avoid this problem arising again, I have identified with the assistance of both parties at the hearing, the contents of the bundle that should be provided to the court for the substantive appeal hearing. As the GMC has greater resources that the Appellant, I have required the GMC to bear the burden of preparing the Hearing Bundle.

[35] For the avoidance of doubt, the bundles provided to the court by the parties for the case management are not in a state to be, and will not be, put before the judge at the hearing of the appeal in July. Both parties should work from the Hearing Bundle. I have provided that this is to be prepared within two weeks of this hearing, and so the Appellant will have had it for 12 weeks before the hearing.

[36] It should not be necessary for any supplementary materials to be adduced. Appeals under s. 40 of the 1983 Act are governed by CPR 52.21(2): as such:

"Unless it orders otherwise, the appeal court will not receive-

(b) evidence which was not before the lower court"

[37] In this case, the 'lower court' is the MPT. The Hearing Bundle contains all the evidence that was before the MPT and a complete transcript of the hearing before the MPT.

[38] If there is further material that the parties agree should be adduced, this may be added. However, if the Appellant seeks to adduce any material additional to the Hearing Bundle, he must comply with the terms of paragraph 8 of this order. It is vital that he does not seek to adduce his own version of the Hearing Bundle, unnecessarily duplicating the materials before the court, or otherwise seek to add materials that are not essential to any of his grounds of appeal."

The hearing of the appeal

58. The hearing bundles were provided on time by the GMC. These were well-organised and indexed in 5 files. The first file contained the essential documents, including copies of authorities, which were relevant to the appeal. The remaining files contained the underlying materials which were available to the MPT at the hearing in 2016. This included the considerable volume of material which Dr El-Huseini had submitted in support of his arguments for adjournment of the MPT proceedings.

59. No application in accordance with the clear terms of paragraph 8 of Steyn J's case management order was made by Dr El-Huseini. He did, however, provide the court with 3 lever-arch files of various materials. At no stage was there any attempt by him to show why those additional documents were essential for the purpose of the appeal, having regard to the grounds of appeal summarised in the preamble to that order. At various stages during the oral submissions made on the hearing of the appeal, Dr El-Huseini argued (in substance) that the order of Steyn J was unfair and that he should not be required to use the bundles which had been produced by the GMC, and that the court should read through the 3 lever-arch files of material which he had provided. I made it clear to Dr El-Huseini that I intended to conduct the hearing in accordance with the order of Steyn J, which had been carefully considered at the lengthy case-management hearing. I also reminded him, during the course of his opening submissions, that I was concerned with an appeal against the decision of the MPT in 2016, and that his argument should focus on that decision.

60. Dr El-Huseini's opening oral argument occupied the majority of the first morning of the hearing. His argument was at times supplemented by points made orally by his wife. She had accompanied him to the hearing, and she was very clearly an intelligent and articulate woman. Dr El-Huseini was also, as the medical reports indicated, clearly an intelligent man, albeit that from time to time he struggled to find the words with which to express himself, with his wife helping him to do so.

61. I did not impose any time-limit upon Dr El-Huseini's opening arguments, but rather let him put forward such points as he wished to do.

62. Following the conclusion of his submissions, Mr Hare addressed me on behalf of the GMC. It appeared, during the course of Mr Hare's submissions, that Dr El-Huseini and his wife had little familiarity with the hearing bundles prepared by the GMC, even though these had been provided to them some months before the hearing. Efforts were made, both by Mr Hare and by my clerk, to ensure that Dr El-Huseini and his wife were looking at the correct page to which Mr Hare was referring. Mr Hare also complied with requests made, by Dr El-Huseini and his wife, for his submissions to be made more slowly, or to provide explanations of points that Mr Hare was making. All of this meant that Mr Hare's submissions proceeded more slowly than would normally be the case, and they were not completed by the end of the afternoon on the first day.

63. I agreed that, in order to give more time to Dr El-Huseini overnight, the second day of the hearing would start later than usual, at 11 o'clock. In the event, the hearing could not start until noon, due to train problems which prevented Dr El-Huseini and his wife (through no fault of their own) arriving on time. Mr Hare then completed his submissions in around 1 hour, including responding to various points which I had put to him on the previous day.

64. Dr El-Huseini had indicated on the previous day that he wished to have 3 hours to reply. Whilst this seemed to be excessive, I imposed no time limit. However, towards the start of his reply submissions, and prior to the lunch adjournment on Day 2, I indicated to Dr El-Huseini that there were four matters which were important on the appeal, and on which I wished to hear what he had to say. These were, in summary: (i) whether he wished to say anything about the legal principles to which Mr Hare had referred; (ii) whether the MPT should not have proceeded with the hearing in 2016; (iii) whether the MPT's conclusions, in relation to the treatment of patient A in June 2011, were wrong; and (iv) the MPT's conclusions concerning Dr El-Huseini's health.

65. Dr El-Huseini, unsurprisingly, had nothing material to say as to the applicable legal principles: his essential point was that the facts of the cases involving the doctors in the case-law were different to those in his own case. He did address the question of whether the MPT should have proceeded with the hearing, largely repeating arguments that he had previously made either to the MPT or in his written or oral submissions on the appeal. He began to address the third issue, concerning the treatment of patient A. These submissions did not, however, progress very far, principally because Dr El-Huseini wished to refer to his bundles of materials and also to discuss the approach which the GMC had taken to four doctors at the Mid-Staffordshire hospital. The failings at that hospital were the subject of a well-publicised report by Robert Francis QC in 2013 which had nothing to do with the case against Dr El-Huseini. This had nothing to do with the appeal against the MPT's decision in this case, and specifically the issues which Steyn J had identified. I again told Dr El-Huseini that I would be applying the order of Steyn J in relation to the bundles that were to be used on the appeal. In short, this was unacceptable to Dr El-Huseini, who decided to walk out of court. I indicated to his wife, who had remained in court, that I would give some time for her to talk to her husband. She indicated to me, in summary, that this would not achieve anything. Nevertheless, I indicated that I would return to court in approximately 15 minutes (at 3.25), to see if Dr El-Huseini intended to continue his arguments. I returned, but Dr El-Huseini and his wife did not do so.

66. I then stated that the appeal would be dismissed, for reasons which I would provide subsequently.

E: Legal principles

67. Section 40 of the 1983 Act provides (as relevant):

> "(1) The following decisions are appealable decisions for the purposes of this section, that is to say—
>
> > (a) a decision of a Medical Practitioners Tribunal under section 35D above giving a direction for erasure, for suspension or for conditional registration or varying the conditions imposed by a direction for conditional registration;
>
> …
>
> (7) On an appeal under this section from a Medical Practitioners Tribunal, the court may—

(a) dismiss the appeal;

(b) allow the appeal and quash the direction or variation appealed against;

(c) substitute for the direction or variation appealed against any other direction or variation which could have been given or made by a Medical Practitioners Tribunal ; or

(d) remit the case to the MPTS for them to arrange for a Medical Practitioners Tribunal to dispose of the case in accordance with the directions of the court,

and may make such order as to costs (or, in Scotland, expenses) as it thinks fit."

68. CPR 52.21 provides:

"(1) Every appeal will be limited to a review of the decision of the lower court unless—

(a) a practice direction makes different provision for a particular category of appeal; or

(b) the court considers that in the circumstances of an individual appeal it would be in the interests of justice to hold a re-hearing.

(2) Unless it orders otherwise, the appeal court will not receive—

(a) oral evidence; or

(b) evidence which was not before the lower court.

(3) The appeal court will allow an appeal where the decision of the lower court was—

(a) wrong; or

(b) unjust because of a serious procedural or other irregularity in the proceedings in the lower court."

69. Practice Direction 52D, paragraph 19 provides:

"(1) This paragraph applies to an appeal to the High Court under –

…

(e) section 40 of the Medical Act 1983;

…

> (2) Every appeal to which this paragraph applies must be supported by written evidence and, if the court so orders, oral evidence and will be by way of re-hearing."

70. In *Yassin v the General Medical Council* [2015] EWHC 2955 (Admin), Cranston J considered the scope of an appeal under section 40 in the following terms at paragraph [32]:

> "Appeals under section 40 of the Medical Act 1983 are by way of re-hearing (CPR PD52D) so that the court can only allow an appeal where the Panel's decision was wrong or unjust because of a serious procedural or other irregularity in its proceedings: CPR 52.11. The authorities establish the following propositions:
>
> i. The Panel's decision is correct unless and until the contrary is shown: *Siddiqui v. General Medical Council* [2015] EWHC 1996 (Admin), per Hickinbottom J, citing Laws LJ in *Subesh v. Secretary of State for the Home Department* [2004] EWCA Civ 56 at [44];
>
> ii. The court must have in mind and must give such weight as appropriate in that the Panel is a specialist tribunal whose understanding of what the medical profession expects of its members in matters of medical practice deserves respect: *Gosalakkal v. General Medical Council* [2015] EWHC 2445 (Admin);
>
> iii. The Panel has the benefit of hearing and seeing the witnesses on both sides, which the Court of Appeal does not;
>
> iv. The questions of primary and secondary facts and the over-all value judgment made by the Panel, especially the last, are akin to jury questions to which there may reasonably be different answers: *Meadows v. General Medical Council* [197], per Auld LJ;
>
> v. The test for deciding whether a finding of fact is against the evidence is whether that finding exceeds the generous ambit within which reasonable disagreement about the conclusions to be drawn from the evidence is possible: *Assucurazioni Generali SpA v. Arab Insurance Group* [2003] 1 WLR 577 , [197], per Ward LJ;
>
> vi. Findings of primary fact, particularly founded upon an assessment of the credibility of witnesses, will be virtually unassailable: *Southall v. General Medical Council* [2010] EWCA Civ 407 , [47] per Leveson LJ with whom Waller and Dyson LJJ agreed;

vii. If the court is asked to draw an inference, or question any secondary finding of fact, it will give significant deference to the decision of the Panel, and will only find it to be wrong if there are objective grounds for that conclusion: *Siddiqui*, paragraph [30](iii).

viii. Reasons in straightforward cases will generally be sufficient in setting out the facts to be proved and finding them proved or not; with exceptional cases, while a lengthy judgment is not required, the reasons will need to contain a few sentences dealing with the salient issues: *Southall v. General Medical Council [2010]* EWCA Civ 407 , [55]-[56].

ix. A principal purpose of the Panel's jurisdiction in relation to sanctions is the preservation and maintenance of public confidence in the medical profession so particular force is given to the need to accord special respect to its judgment: *Fatnani and Raschid v. General Medical Council* [2007] EWCA Civ 46 , [19], per Laws LJ."

71. A degree of deference also attaches to the tribunal's assessment as a consequence of its specialist expertise. In *Fatnani and Raschid v General Medical Council* [2007] EWCA Civ 46 Laws LJ held that:

> "[18] The panel then is centrally concerned with the reputation or standing of the profession rather than the punishment of the doctor. This, as it seems to me, engages the second strand to which I have referred. In *Marinovich v General Medical Counci*l [2002] UKPC 36 Lord Hope of Craighead, giving the judgment of the Board, said:
>
> > "28. … In the appellant's case the effect of the committee's order is that his erasure is for life. But it has been said many times that the Professional Conduct Committee is the body which is best equipped to determine questions as to the sanction that should be imposed in the public interest for serious professional misconduct. This is because the assessment of the seriousness of the misconduct is essentially a matter for the committee in the light of its experience. It is the body which is best qualified to judge what measures are required to maintain the standards and reputation of the profession.
> >
> > "29. That is not to say that their Lordships may not intervene if there are good grounds for doing so. But in this case their lordships are satisfied that there are no such grounds. This was a case of such a grave nature that a finding that the appellant was unfit to practise was inevitable. The committee was entitled to give greater weight to the public interest and to the need to maintain public confidence in the profession than to

> the consequences to the appellant of the imposition of the penalty. Their Lordships are quite unable to say that the sanction of erasure which the committee decided to impose in this case, while undoubtedly severe, was wrong or unjustified."

> [19]. … As it seems to me the fact that a principal purpose of the panel's jurisdiction in relation to sanctions is the preservation and maintenance of public confidence in the profession rather than the administration of retributive justice, particular force is given to the need to accord special respect to the judgment of the professional decision-making body in the shape of the panel. That I think is reflected in the last citation I need give. It consists in Lord Millett's observations in *Ghosh v General Medical Council* [2001] 1 WLR 1915 , 1923, para 34:
>
> > "the Board will afford an appropriate measure of respect to the judgment of the committee whether the practitioner's failings amount to serious professional misconduct and on the measures necessary to maintain professional standards and provide adequate protection to the public. But the Board will not defer to the committee's judgment more than is warranted by the circumstances."
>
> [20] These strands in the learning then, as it seems to me, constitute the essential approach to be applied by the High Court on a section 40 appeal. The approach they commend does not emasculate the High Court's role in section 40 appeals: the High Court will correct material errors of fact and of course of law and it will exercise a judgment, though distinctly and firmly a secondary judgment, as to the application of the principles to the facts of the case."

72. The Court of Appeal in *Sastry and Okpara v General Medical Council* [2021] EWCA Civ 623, at [102]-[105] has recently provided the following guidance as to the correct approach to appeals under s. 40 of the 1983 Act. That case, unlike the present, was principally concerned with the approach of the court to the sanctions that the MPT had imposed.

> "[102] Derived from *Ghosh* [*Ghosh v General Medical Council* [2001] 1 WLR 1915] are the following points as to the nature and extent of the section 40 appeal and the approach of the appellate court:
>
> i) an unqualified statutory right of appeal by medical practitioners pursuant to section 40 of the 1983 Act;
>
> ii) the jurisdiction of the court is appellate, not supervisory;

iii) the appeal is by way of a rehearing in which the court is fully entitled to substitute its own decision for that of the Tribunal;

iv) the appellate court will not defer to the judgment of the Tribunal more than is warranted by the circumstances;

v) the appellate court must decide whether the sanction imposed was appropriate and necessary in the public interest or was excessive and disproportionate;

vi) in the latter event, the appellate court should substitute some other penalty or remit the case to the Tribunal for reconsideration.

[103] The courts have accepted that some degree of deference will be accorded to the judgment of the Tribunal but, as was observed by Lord Millett at [34] in *Ghosh*, "the Board will not defer to the Committee's judgment more than is warranted by the circumstances". In *Preiss* [*Preiss v General Dental Council* [2001] 1 WLR 1926], at [27], Lord Cooke stated that the appropriate degree of deference will depend on the circumstances of the case. Laws LJ in *Raschid and Fatnani [Raschid and Fatnani v General Medical Council* [2007] 1 WLR 1460], in accepting that the learning of the Privy Council constituted the essential approach to be applied by the High Court on a section 40 appeal, stated that on such an appeal material errors of fact and law will be corrected and the court will exercise judgment but it is a secondary judgment as to the application of the principles to the facts of the case ([20]). In *Cheatle* [*Cheatle v General Medical Council* [2009] EWHC 645 (Admin)] Cranston J accepted that the degree of deference to be accorded to the Tribunal would depend on the circumstances, one factor being the composition of the Tribunal. He accepted the appellant's submission that he could not be "completely blind" to a composition which comprised three lay members and two medical members.

[104] In *Khan* [*Khan v General Pharmaceutical Council* [2017] 1 WLR 169] at [36] Lord Wilson, having accepted that an appellate court must approach a challenge to the sanction imposed by a professional disciplinary committee with diffidence, approved the approach and test identified by Lord Millett at [34] of *Ghosh*.

[105] It follows from the above that the Judicial Committee of the Privy Council in *Ghosh*, approved by the Supreme Court in *Khan*, had identified the test on section 40 appeals as being whether the sanction was "wrong" and the approach at the hearing, which was appellate and not supervisory, as being

> whether the sanction imposed was appropriate and necessary in the public interest or was excessive and disproportionate."

73. An issue considered in the authorities, and relevant to Dr El-Huseini's argument, is the question of adjournment of proceedings on the grounds of alleged ill-health of the doctor. This issue was very fully discussed in the judgment of Coulson LJ, giving the judgment of the Court of Appeal, in *General Medical Council v Hayat* [2018] EWCA Civ 2796. In that case, the judge had allowed an appeal, on the basis that the MPT had erred in failing to have regard to relevant medical evidence before permitting the hearing to continue in the absence of Dr Hayat. The Court of Appeal reversed the decision of the judge, and in so doing set out (at [32]-[41]) the approach which should be taken to medical evidence relied on in support of an application to adjourn. The decision of the Court of Appeal was subsequent to the decision of the MPT in Dr El-Huseini's case, but as will become apparent it serves to strengthen the validity of the approach which the MPT took in this case.

74. At paragraph [34], Coulson LJ quotes from a judgment of Sir Brian Leveson PQBD in *General Medical Council v Adeogba* [2016] EWCA Civ 162. In the *Adeogba* judgment, Sir Brian Leveson said that the decision to continue in the absence of the doctor must be guided by the context provided by the main statutory objective of the GMC, namely the protection, promotion and maintenance of the health and safety of the public. The fair, economical, expeditious and efficient disposal of allegations made against medical practitioners was of very real importance. Fairness encompassed fairness both to the medical practitioner and to the GMC.

75. At paragraphs [37] – [41], Coulson LJ addressed the required standards of medical evidence. There must be evidence of unfitness to participate in the hearing. The evidence must identify with proper particularity the individual's condition and explain why that condition prevented their participation in the hearing. That evidence should be unchallenged. Coulson LJ cited with approval a judgement of Norris J in *Levy v Ellis Carr* [2012] EWHC 63 (Ch), describing the relevant passage as being of particular importance. Norris J said that the medical evidence showing inability to attend a hearing and participate in a trial:

> "should identify the medial attendant and give details of his familiarity with the party's medical condition (detailing all recent consultations), should identify with particularity what the patient's medical condition is and the features of that condition which (in the medical attendant's opinion) prevent participation in the trial process, should provide a reasoned prognosis and should give the court some confidence that what is being expressed is an independent opinion after proper consultation. It is being tendered as expert evidence. The court can then consider what weight to attach to that opinion, and what arrangements might be made (short of an adjournment) to accommodate a party's difficulties. No judge is bound to accept expert evidence: even a proper medical report falls to be considered simply as part of the material as a whole (including the previous conduct of the case)"

76. Coulson LJ also cited the judgment of Lewison LJ in *Forrester Ketley v Brent & Anr* [2012] EWCA Civ 324 at [26]. Lewison LJ had said that the decision whether to adjourn a hearing is a matter of discretion for the first-instance judge. The Court of Appeal would only interfere with the exercise of discretion if the judge had taken into account irrelevant matters, ignored relevant matters or made a mistake of principle.

> "Judges are often faced with late applications for adjournment by litigants in person on medical grounds. An adjournment is not simply there for the asking. While the court must recognise that litigants in person are not as used to the stresses of appearing in court as professional advocates, nevertheless something more than stress occasioned by the litigation will be needed to support an application for an adjournment".

77. At paragraph [40], he cited authority to the effect that the court should adopt a rigorous approach to scrutinising the evidence adduced in support of an application for an adjournment based on medical grounds.

78. The Court of Appeal held that, applying these principles, the judge in *Hayat* had been wrong in saying that the MPT had erred in its decision to proceed with the hearing. In *Hayat*, the GMC also argued that the judge was wrong in failing to afford appropriate respect to the decision of the MPT, and in failing to recognise that the question of whether to adjourn for further investigation of Dr Hayat's condition was a case management decision which should only have been interfered with by an appellate court if it were "plainly wrong". Coulson LJ addressed these arguments at paragraphs [61] – [75] of his judgment. He said that since the MPT's decision to adjourn was an exercise of discretion, the court would have to be satisfied that a high hurdle had been surmounted before it intervenes. The court should only interfere with such decisions where the decision of the court below exceeded the generous ambit within which a reasonable disagreement is possible. The only relevant question was whether there had been an unlawful (or unfair) exercise of discretion. In the present context, unfairness and unlawfulness were essentially the same thing. Respect should be accorded to the specialist nature of the MPT, which includes medically qualified members. The court therefore held that the judge should not have interfered with the MPT's decision to proceed. It was a decision made by a specialist tribunal on the basis of all of the evidence, and it was a decision to which the MPT was entitled to come.

F: Appeal against the MPTs decision not to adjourn the 2016 hearing

The MPT's decision

79. The first three grounds of appeal, as summarised by Steyn J in her order, all concern the MPT's decision not to adjourn the hearing which began in April 2016 but instead to proceed in Dr El-Huseini's absence (after his appearance on the second day). The MPT gave detailed reasons for its approach.

80. Initially, it considered whether it should proceed to determine the adjournment application in Dr El-Huseini's absence. In fact, the MPT had no practical alternative. It had to make a decision on whether or not to continue the hearing. Dr El-Huseini had put forward a large volume of written material in support for, as the MPT described it, an application for an "indefinite adjournment of the hearing". Dr El-Huseini had also

attended in person, accompanied by his wife, on the second day of the hearing and made the application. The MPT said that it had afforded Dr El-Huseini numerous opportunities to engage effectively, and found that an adjournment would not be likely to secure his attendance within the near future. The MPT also said that it was satisfied that Dr El-Huseini had been able to present a full application for an adjournment.

81. In relation to the decision as to whether or not to adjourn the hearing itself, The MPT set out the various points which Dr El-Huseini made in support of the application. He would not be fit to attend the hearing until he had successfully completed treatment. The stressors associated with the proceedings were related to his admission as an inpatient to a mental health unit on 23 January 2016, from which he was discharged on 10 February 2016. He explained how his disability affected him. The MPT heard argument from Dr El-Huseini's assistant, Mr. Shabaan: he referred back to the decision of the FPP in November 2014, to allow time for therapeutic interventions. The MPT also heard from Dr El-Huseini's wife.

82. The Tribunal then set out the developments relating to Dr El-Huseini's health, starting with the decision to adjourn in November 2014: these are summarised in Section B above. The MPT's essential reasons for refusing an adjournment were set out in paragraphs 18 - 26 its section headed "Tribunal decision". I have already quoted (in Section B) paragraphs 18 and 19 in full. The MPT there referred to: Dr El-Huseini's failure to arrange or engage with any further therapy beyond the limited number of CBT sessions with Ms Lowe; his refusal to see the consultant neuropsychologist to whom he had been referred; his lack of response to GMC requests for his consent to a health assessment; his opposition to any direction by the tribunal that he should undergo a health assessment; his failure to take steps, to the extent expected in November 2014, to undergo treatment during the window of opportunity afforded to him; his intransigence towards any form of medical assessment leading to the conclusion that there was no reason to think that the position would be any different were the hearing to be adjourned.

83. In paragraph 20, the MPT said that it was satisfied that Dr El-Huseini could address the tribunal and put forward his case effectively. This was the MPT's assessment of Dr El-Huseini based upon the way in which he had addressed them on the second day of the hearing. The MPT attached little weight to the opinion of Dr Rhodes, as expressed in the fit note of 28 April 2016, that his current health would prevent him from participating in the hearing. The MPT recognised that reasonable adjustments would be required, and these could be addressed should Dr El-Huseini attend in the future.

84. In paragraph 21, the MPT referred to the absence of medical evidence to support Dr El-Huseini's assertion that the stress of the hearing caused his recent TIA. The MPT had regard to the stress that the doctor said that he suffers, but considered that this stress would be likely to remain should another adjournment be granted.

85. In paragraph 22, the MPT said that it had paid regard to its overarching objective to protect the public as set out in the Medical Act 1983 and this included the public interest in the timely hearing of fitness to practise cases.

86. In paragraphs 24-25, the MPT considered further arguments, unrelated to health, in support of the adjournment application. It said that the appropriate way in which to raise arguments as to the credibility of the GMC's case, or its expert witnesses, was for Dr

El-Huseini to ask relevant questions in the hearing. Similarly, witnesses could be asked about documentation which had allegedly not been produced.

87. The MPT therefore refused the application to adjourn. It then addressed, separately, the question of whether the case should proceed in the absence of Dr El-Huseini. It decided that it should, for essentially the same reasons as those which led to the rejection of the adjournment application. Dr El-Huseini had demonstrated that he was not prepared to take part in the substantive hearing, although he was aware of the MPT's power to continue the hearing in his absence. The MPT said:

> "There is a substantial public interest in the hearing going ahead, and there has been no change in circumstances such as to suggest that Dr El-Huseini would engage effectively in the event of an adjournment. The tribunal was reminded of its duty to test the GMC case and identify any weaknesses in it."

The parties' arguments

88. Dr El-Huseini's Grounds of Appeal referred extensively to the FPP's decision to adjourn the case in November 2014. He said that he was not given the rightful opportunity to properly respond to therapeutic interventions, and that the MPT had not given any reasonable weight to this. In November 2014, the FPP had considered that it should not go behind the opinion of Dr Telfer, the clinical neuropsychologist who provided the report which persuaded the FPP to adjourn. He had diligently attended his CBT sessions thereafter, and had tried his best to ensure that he complied with the expectations of the FPP. But the UHCW had re-traumatised him, by requiring him to attend meetings with them. His treatment therefore remained incomplete. He should have been permitted to complete his CBT treatment, which was "an agreed phase".

89. In his opening oral submissions on the appeal, he referred on a number of occasions to the fact that he had PTSD, and had not been treated for this. He referred to the statement by his CBT therapist that he was improving, and also to a broken promise from the head of the relevant department at UHCW that he would be treated. This resulted in him jumping from a window to commit suicide, and he was then "sectioned" for 2 weeks in early 2016.

90. In his reply submissions, he said that medicine is not like magic: it does not bring an instant cure. He had spent 2 weeks in a mental hospital, and it was evident that he was ill. His mind was still mentally traumatised 2 months after his mental health breakdown. It was improper for the MPT to have proceeded as it did.

91. On behalf of the GMC, Mr. Hare submitted that the MPT was correct to refuse Dr El-Huseini's request for an adjournment for the reasons which it gave. It had explained in detail why it found that he had not produced credible evidence that he was incapable of conducting his own case before the MPT. The MPT was best placed, having heard from the doctor, to assess that he was able to conduct his own case. He had not taken up the opportunity to obtain treatment following the adjournment decision in November 2014. The MPT was mindful of the public interest in proceeding with the hearing. The case had been listed for a 25-day hearing and there were many witneses to be heard. Dr El-Huseini's ongoing disputes with the UHCW were separate from the discharge of the MPT's responsibilities to protect the public interest. In his oral submissions, Mr. Hare

addressed each of the grounds advanced in detail. His overall submission was that the MPT was fully entitled to proceed as it did.

Discussion

92. I accept the submissions of GMC as summarised above. In my view, the initial question is whether there was medical evidence of the required standard, applying the principles in the *Hayat* case, as to Dr El-Huseini's unfitness to attend the hearing in order to represent himself, if necessary with the assistance of others and with reasonable adjustments being made. In my view, there was not, and the MPT was fully entitled to attach little weight to Dr Rhodes' opinion expressed in his fit note of 28 April 2019. The background to that fit note was, as described in paragraph 17 of the relevant section of the MPT's reasons, a statement of fitness for work which had been signed by Dr Rhodes on 24 March 2016. That note, which was signed some 6 weeks after Dr El-Huseini's discharge from the mental health unit, indicated that Dr El-Huseini could return to work on a phased basis. A week later, on 31 March 2016, Dr Rhodes amended the fit note so as to state that Dr El-Huseini was able to attend meetings, and able to talk to occupational health. That was how matters stood at the start of the hearing. However, two days after Dr El-Huseini's attendance at the hearing before the MPT, Dr El-Huseini made contact with a different GP, asking Dr Dey to add to the certificate that he was fit to attend a meeting with occupational health, but not to attend a GMC hearing. Dr Rhodes then issued a further fit note to that effect.

93. On 29 April 2016, Dr Rhodes was asked various questions, including as to the circumstances in which the 28 April 2016 fit note was issued, in an e-mail sent by Mr. Hudspith. He was the investigations officer of the GMC and who had responsibility for the case. One question was whether the 28 April 2016 note had been issued without a further assessment of Dr El-Huseini, and if so why. In his e-mailed response of 29 April 2016, Dr Rhodes explained the background: Dr El-Huseini had turned up unannounced on 31 March, demanding to be seen for a non-urgent problem. He had at that time requested a clear statement that he would be able to attend meetings, specifically occupational health meetings. Dr El-Huseini had then spoken to Dr Dey, another doctor in the practice, as to the addition of inability to attend the GMC hearing. The request was passed to Dr Rhodes. He said that the request did not seem unreasonable, since Dr El-Huseini had previously told him about the exacerbation of his acute stress reaction caused by the whole GMC process. Dr Rhodes said, that in hindsight, he should have "requested that if Dr El-Husseini wanted me to provide an opinion on his ability to attend the GMC meeting, he should have asked for a letter with such information in it".

94. It is clear that the 28 April 2016 fit note was produced quickly, and without any further assessment of Dr El-Huseini. There was no identification by Dr Rhodes of the features of Dr El-Huseini's condition which prevented participation in the GMC process, no reasoned prognosis, and nothing which reasonably gave the MPT confidence that what was being expressed was an independent opinion after a proper examination. In accordance with the principles in *Levy v Ellis Carr*, this was not sufficient evidence to warrant an adjournment and the MPT were fully entitled to attach little weight to it.

95. Furthermore, even if any weight were to be attached to the fit note (or indeed the earlier report of Dr Telfer which had led to the November 2014 adjournment), there were significant countervailing factors which the MPT was fully entitled to take into account in reaching its decision on whether to adjourn or continue in Dr El-Huseini's absence.

These were set out in paragraphs 18 – 22 of the reasons in the relevant section of its decision, and they are described above. In my judgment, all of these matters were relevant, indeed highly relevant, considerations for the MPT to take into account in reaching its decision. The MPT also rightly said that there was a substantial public interest in the hearing going ahead. The MPT was also entitled, on the evidence, to doubt that Dr El-Huseini would engage effectively in the event of an adjournment.

96. The decision as to whether or not to proceed was, in this case as in *Hayat*, an exercise of discretion. The MPT's decision to proceed did not fall outside the generous ambit of that discretion. It was in my view a decision which it was fully entitled to reach, for the reasons which it gave.

97. For these reasons, Dr El-Huseini's grounds of appeal relating to the adjournment decision do not succeed.

G: The misconduct issue

The MPT's decision

98. The MPT found it proved that Dr El-Huseini was the anaesthetist responsible for patient A who was under general anaesthesia, and in whom Dr El-Huseini had identified a difficult airway. In paragraph 17 of the "Facts" section of its decision, the MPT referred to evidence from theatre staff and from day surgery documents for 17 June 2011 that Dr El-Huseini was the nominated anaesthetist and that he did undertake this role.

99. The MPT also referred to evidence from Ms Nunn that Dr El-Huseini himself told the theatre staff at the morning briefing that patient A could have a difficult airway. Entries to that effect appeared on the theatre list and the team briefing note. Ms Nunn was, as the MPT found, acting as a 'scrub nurse' in the theatre on the day in question. She also gave evidence in relation to Dr El-Huseini's whereabouts at the time of the clinical episode involving patient A, and the actions she took to find the doctor. The tribunal found Ms Nunn to be a credible witness.

100. The MPT also found it proved that Dr El-Huseini was not available in the immediate vicinity of the recovery area when patient A experienced airway obstruction. The MPT referred (in paragraphs 22 – 28 in the 'Facts' section of its decision) to the evidence which supported this conclusion. It accepted evidence from Mr. Hammond that, in the recovery room, there was a clinical episode with patient A showing signs of breathing difficulty, with a significant drop in his oxygen saturation level. Mr. Hammond was the practitioner in the recovery room when this episode occurred. The episode occurred and was resolved within 4 minutes. The MPT heard evidence that whilst this was occurring, Ms Nunn went to look for Dr El-Huseini at Mr. Hammond's request. She was, however, unable to find him anywhere within what she called the theatre unit or the day surgery unit. She then returned to the recovery room and operated the emergency alarm which summoned assistance from medical personnel in the main theatre suite. The MPT accepted evidence from Ms Carolyn Bradshaw, who was a nurse on duty in the main theatre, that she responded to the alarm call from the day theatre. Whilst she was responding to the alarm with a nursing colleague, they passed Dr El-Huseini who was going towards the main theatre area. Ms. Bradshaw then described how she and other colleagues arrived on the scene quickly. Those colleagues included Dr Matthews, the on call anaesthetist. Dr El-Huseini appeared in the recovery room shortly thereafter.

The MPT concluded, bearing in mind the evidence as to the layout of the theatres in the hospital, that Dr El-Huseini was not in the immediate vicinity of the recovery area when the clinical episode occurred.

101. In the section of its decision concerned with impairment, the MPT referred to its conclusion that Dr El-Huseini had identified a difficult airway in patient A and, following handover of this patient, he left the theatre 4 suite. The GMC had called, as an expert witness, a consultant expert anaesthetist, Dr Anne-Marie Rollin. She had given her opinion about the appropriateness or otherwise of Dr El-Huseini's actions on 17 June 2011. The MPT described her as credible and independent, expressing balanced opinions. The MPT accepted her evidence that Dr El-Huseini should have stayed in the immediate vicinity, ensuring the integrity of the patient's airway until he could manage independently. In this case, his requirement to remain in the vicinity was heightened as Dr El-Huseini knew that the patient had an enhanced risk of complication. In her view, Dr El-Huseini's one major lapse was to leave the immediate vicinity of an unconscious patient with an identified airway difficulty, and with an LMA (laryngeal mask airway) still in place. She described this lapse as falling seriously below the standard of a reasonably competent staff grade anaesthetist. Having left the vicinity, he was not in a position to come to the aid of the patient immediately if required.

102. The MPT said that compromise of the airway carries a significant risk for which, if it occurs, the anaesthetist may well be needed to restore the airway. It is an emergency situation which can have life-threatening consequences in a short space of time. It concluded that Dr El-Huseini failed to provide the level of care necessary to protect patient A and so fell seriously below the standard to be expected of him.

The parties' arguments

103. In his Grounds of Appeal, Dr El-Huseini relied heavily on an e-mail which he had sent to his clinical director, Dr Borman, on 23 June 2011, setting out his version of events. He complained that the MPT's decision did not even consider the contents of that e-mail. He disputed that the patient had a "difficulty airway". The potential risk was in fact a difficult intubation; ie a difficulty in inserting a tube into the patient. He disputed that he was not in the immediate vicinity when the patient went into some difficulties: he confirmed that he was in the immediate vicinity. He also said that there was no serious harm or death recorded against the patient, who was discharged the same day. He also complained of the GMC's failure to disclose original documentary evidence to him. These various points were summarised in sub-paragraphs (4) – (7) in the preamble to Steyn J's order.

104. Much of Dr El-Huseini's skeleton argument, for the appeal, was directed at various adverse decisions taken by UHCW or the Interim Orders Panel at various stages in the period prior to 2016. It also included criticism of the GMC's decision to commence proceedings against him. Reference was also made to the approach taken by the GMC in relation to various doctors practising at mid-Staffordshire, where proceedings were not taken. The skeleton argument contained, however, little or no explanation or argument as to why it was said that the MPT's conclusions, concerning the misconduct on 17 June 2011, were wrong and could therefore be the subject of a successful appeal.

105. In his oral opening submissions, Dr El-Huseini referred to the GMC having called "rented" witnesses, and hiding documents from him. He said that there was a conspiracy

or orchestrated campaign against him. He had apologised for leaving the patient. He repeated his argument that this a difficult intubation, not a difficult airway. He also made various points in relation to the misconduct allegations that the MPT had found not proven. He said that the proceedings against him were vexatious: he was now seeking justice and equitability.

106. Mr. Hare submitted that it was for the MPT to decide the weight to be attached to the evidence of witnesses and to assess their credibility. Here, the MPT had evidence from a number of witnesses and was able to make that assessment. Dr El-Huseini had the opportunity to give his version of events by attending, giving evidence and making submissions, and asking questions of witnesses, or by being represented there. He chose not to avail himself of that opportunity. In reaching its conclusions on the relevant issues, the MPT considered the evidence in various forms: documents, factual witnesses, and evidence from a well-qualified expert. There was no basis for interfering with its conclusion as to what facts had been proved on the balance of probabilities.

107. Mr Hare submitted that Dr El-Huseini had a full opportunity to adduce evidence, for example by providing his own witness statement or by indicating his intention to rely upon the e-mail to Dr Borman dated 23 June 2011. That e-mail does not appear to have been placed before the MPT, and no witness statement of Dr El-Huseini was ever provided. In the course of his oral submissions, Mr Hare showed the court the documents relating to the case management process, including the orders made which permitted Dr El-Huseini to serve witness evidence and provide his own bundle of documents. As part of the case management process, the MPTS case manager had also told Dr El-Huseini that either party could approach any witness for information. A letter was sent to Dr El-Huseini by Ms Faulkner (the Human Resources Manager of UHCW) confirming that she had written to two doctors, still employed by UHCW, to advise that Dr El-Huseini could approach them directly for a statement.

108. In relation to the production of documents, Mr Hare referred to the evidence of witnesses concerning the authenticity of the contemporaneous documents produced, and the evidence that documentation sought by Dr El-Huseini (specifically, a Team Briefing Sheet) had not been identified. If Dr El-Huseini considered that there were additional documents, then there was the opportunity to challenge the witnesses at the hearing.

Discussion

109. The authorities establish that, on an appeal under s 40, the court will correct material errors of fact. However, the court will need to be satisfied that a material error of fact was in fact made. As Cranston J said in *Yassin*: the MPT has had the benefit of hearing witnesses, which the court does not; questions of primary and secondary facts and the over-all value judgment made by the MPT, especially the last, are akin to jury questions to which there may reasonably be different answers; the test for deciding whether a finding of fact is against the evidence is whether that finding exceeds the generous ambit within which reasonable disagreement about the conclusions to be drawn from the evidence is possible; findings of fact made by the MPT, particularly founded upon an assessment of the credibility of witnesses, will be virtually unassailable.

110. In the present case, there is in my view nothing which begins to warrant the correction of the relevant findings of fact that the MPT made. The MPT heard live evidence from

various witnesses who were present at the material time, and its factual conclusions were based upon the evidence of those witnesses and contemporaneous documents. Dr El-Huseini did not himself give evidence to the MPT, and did not provide a witness statement pursuant to the orders made by the MPTS. Although reliance is now placed by Dr El-Huseini upon an e-mail sent to Dr Borman on 23 June 2011, I was not shown any documentation which supported the proposition that this e-mail was ever shown to the MPT. It is therefore not surprising that the MPT did not refer to it.

111. It is clear from other parts of the MPT's decision, however, that the MPT did not simply accept the case advanced by the GMC, relying on the evidence of witnesses called by the GMC, without regard to Dr El-Huseini's case as expressed in the materials which existed. For example, paragraph 31 of the decision (which dealt with an allegation that the MPT held was not proven) referred to an account of events that Dr El-Huseini had given at a disciplinary hearing of the UHCW in February 2013. If the e-mail of 23 June 2011 had been provided to the MPT, it is likely that the MPT would have considered it. However, it was under no obligation to carry out an exercise of sifting through large quantities of unindexed or uncategorised documentation provided by a doctor in order to determine what if any relevance it might have: see *Sanusi v General Medical Council* [2019] EWCA Civ 1172, para [84].

112. It is also important to bear in mind that the nature of the proceedings before the MPT is adversarial, not inquisitorial: see *R (Russell) v General Medical Council* [2008] EWHC 2546 (Admin) para [35]. If as in the present case, a doctor does not provide a witness statement, does not attend the hearing so as to explain his position on the facts and give evidence about them, and does not cross-examine the relevant witnesses, then there will usually be little prospect of a successful challenge to MPT's fact-findings, on disputed issues, based on evidence from witnesses who did actually give statements and oral evidence to the tribunal. This is so whether or not the doctor had made statements on disputed issues in documents after the event.

113. I was referred by Mr Hare to underlying contemporaneous documents which supported the MPT's conclusion that, at the time, patient A was recognised as having a difficult airway. A "difficult airway" is expressly identified as a "Potential Hazard" in a document headed "Rugby St. Cross THEATRE TEAM BRIEF" dated 17 June 2011 which identified Dr El-Huseini as the anaesthetist. Ms. Nunn described this document in her oral evidence to the MPT. She described it as the team brief from that morning's surgical list. It identified any potential hazards and the order in which the patients would be dealt with, and what they are actually having done. She said that it came into her possession because after the incident she thought that it would be a good idea to get a copy just in case she needed it. It was a photocopy of the original, which she had put back where she had found it. She also referred in her evidence to notes which she made shortly after the incident, probably around lunchtime on that day. The notes referred to "Problems [with] airway high probability so DH [Derrick Hammond] present also". Another document (headed "Rugby Theatre List") also dated 17 June 2011, had the handwritten word "Airway" written against patient.

114. In the light of Ms Nunn's evidence, and the contemporaneous documents, there was therefore a clear and firm evidential basis for the finding that the MPT made, to the effect that Dr El-Huseini had identified a difficult airway in patient A.

115. Dr El-Huseini submitted that the problem was a difficult intubation. This was not, however, the effect of the documents or Ms Nunn's evidence. In any event, Mr Hare showed me the UHCW Anaesthetists Handbook, 20th edition in support of the proposition that a difficult intubation was an example of a difficult airway. The handbook describes "Known previous, or anticipated difficult intubation" under the heading "Managing difficult airways".

116. There was, similarly, a clear and firm evidential basis for the MPT's conclusion that Dr El-Huseini was not in the immediate vicinity of the recovery room when the clinical episode occurred. This was the effect of Ms Nunn's evidence, both in her witness statement and in her oral evidence to the MPT. A plan had been annexed to Ms Nunn's witness statement in order to explain the relevant layout of the theatres. The transcript of the MPT hearing shows that the panel asked pertinent questions of Ms Nunn as to the layout as well as the circumstances of her attempt to find Dr El-Huseini when the clinical episode occurred. Ms Bradshaw also gave evidence as to Dr El-Huseini's whereabouts, including saying in her witness statement that she was surprised that Dr El-Huseini left the theatre area when there was a potentially difficult patient in recovery. Her evidence was also appropriately explored by the MPT during the hearing.

117. These conclusions are not affected, still less undermined, by Dr El-Huseini's allegation that documents were not disclosed to him.

118. Copies of relevant documents were exhibited to witness statements served by the GMC, including a statement from Ms Faulkner. These included a copy of the "Patient Theatre Sending Slip" for 17 June 2011. This set out various timings relating to the patient. In a letter to the GMC investigations officer dated 26 September 2014, Ms Faulkner addressed various assertions made by Dr El-Huseini as to the authenticity of documents, and confirmed that she had provided copies of authentic documents. She also indicated that UHCW had been unable to locate a "Team Brief" document for 17 June 2011 despite an extensive search. Evidence to similar effect was given by another UHCW witness, Mr. Johal. However, the MPT (in paragraph 8 of the "Facts" section of its decision) said that the absence of this document had no significance, because Ms. Nunn had kept a copy of the document which "she unexpectedly brought with her to the hearing".

119. In addition to providing copies, which were exhibited to her witness statement, Ms Faulkner told Dr El-Huseini in a letter dated 9 October 2014 that he could view original documents on the UHCW premises. With that in mind, Ms Faulkner had requested the return by the GMC's solicitor of any original documents which were in his possession as a result of being given them by the UHCW.

120. Various complaints relating to disclosure, or requests for further documents, were made by Dr El-Huseini during the case management process. It is not necessary to describe these in detail. There were disputes as to whether Ms Faulkner was telling the truth as to whether there had been full disclosure of the UHCW documents. In a case management hearing on 20 November 2015, the MPTS case manager concluded as follows:

> "Mr Ince has previously explained, and I agree with him, that these are not matters that a Case Manager can assist with further. Directions regarding disclosure have been made previously and the extent of information the Trust claims is available has been disclosed. If Dr EH wishes to dispute whether a witness is telling the truth or suggest that they are concealing evidence, he will have the opportunity to do so by cross-examining those witnesses and by making submissions to the Fitness to Practise Panel."

121. Against the background described above, there is in my view no evidence that either the GMC, or the UHCW, was in some way concealing documents from Dr El-Huseini. Copies of documents were provided, originals were made available, and a search was carried out for the document that Dr El-Huseini wished to see.

122. Furthermore, the MPTS case manager's conclusion at the hearing on 20 November 2015 was sensible: the MPTS had taken the disclosure issues as far as they could be taken. If there were to be a challenge to the authenticity of documents, or pursuit of the argument that the UHCW had not disclosed all documents, then that was a matter which Dr El-Huseini could have put to the witnesses who were called at the hearing.

123. The MPT clearly looked at the contemporaneous documents with care, and asked pertinent questions to witnesses, in particular Ms Nunn, about them. Ultimately, it was for the MPT to decide whether there was sufficiently reliable evidence to enable it to make the findings that it did. The MPT was satisfied that it could. Dr El-Huseini's unproven allegations that documents were hidden from him, or were not disclosed, does not provide a basis for challenging the conclusions that were reached by the MPT on the facts, after considering the documents and factual and expert evidence.

124. Accordingly, I reject the appeal in so far as it seeks to challenge the MPT's findings of misconduct.

H: Health impairment

The MPT's decision

125. I have already summarised the reports of Dr Vesey and Dr Friedman in Section B above.

126. The MPT described Dr Vesey as a measured, helpful, impartial and fair witness. In the MPT's view, his reports were made after a thorough assessment using appropriate testing mechanisms. Dr Vesey had considered Dr Telfer's report dated 13 November 2014. Dr Telfer had not, as Dr Vesey explained, carried out the full range of testing which he had carried out during the 6 hours that he had spent with Dr El-Huseini. However, her results were consistent with his own. The MPT accepted the findings of Dr Vesey in full.

127. The MPT also described Dr Friedman as impartial and fair when giving evidence. He told the tribunal that he had observed behaviours by Dr El-Huseini which were consistent with the results of testing reported by Dr Vesey. The MPT concluded, after considering evidence from another psychiatrist (Dr Khoosal) that there was no

persuasive evidence to contradict Dr Friedman's diagnosis, and the MPT accepted the findings in his report as full.

The parties' arguments

128. Dr El-Huseini's grounds of appeal relied upon the fact that the reports of Dr Vesey and Dr Friedman were relatively old, having been written in November 2013. He argued that more weight should have been given to a report of Dr Khoosal in 2014 which did not diagnose the mild cognitive impairment which Dr Friedman had diagnosed. He raised arguments as to the credibility of Dr Vesey and Dr Friedman in the light of the way in which they were instructed.

129. Dr El-Huseini's written skeleton argument for the hearing did not expand upon these arguments. Towards the end of his oral submissions, he indicated that there was no need for him to go back to work as an anaesthetist, but that he could go into management or training.

130. For the GMC, Mr. Hare submitted that the reports of Dr Vesey and Dr Friedman were commissioned for the hearing before the FPP in 2014 and that Dr El-Huseini had not consented to further assessments thereafter. The MPT had received oral evidence from these two doctors, and had found their evidence as a whole persuasive. There was no basis for challenging the conclusions of the MPT. He also submitted that there was a degree of unreality to Dr El-Huseini's challenge to the MPT's finding that his fitness to practise was impaired by reason of his health, as he accepts that he is still not fit to return to practise.

Discussion

131. The written reports of Dr Vesey and Dr Friedman were thorough, and were clearly written after careful examinations of Dr El-Huseini. Dr Vesey gave evidence in person, and the MPT asked him various questions following the evidence given in response to questions by the GMC's counsel. Dr Friedman gave evidence by telephone link, and again the MPT asked pertinent questions. The MPT explored whether there were differences as between the opinions of Dr Friedman and Dr Khoosal. In its decision, the MPT referred to the evidence that Dr Friedman had considerable experience as a neuropsychiatrist, whereas Dr Khoosal was a general adult psychiatrist. It also referred to Dr Khoosal's evidence that his report did not mean that Dr El-Huseini had no cognitive deficiencies.

132. Ultimately, it was for the MPT to assess the evidence of Dr Vesey and Dr Friedman, and to decide what weight to attach to their evidence in the light of such other evidence as was available. The MPT decided that they were both fair and impartial witnesses, despite Dr El-Huseini's arguments to the contrary. The MPT, who heard from the witnesses concerned, was entitled to come to that assessment. I consider that there is no basis on which its conclusions can be successfully challenged on appeal. I bear in mind too that the MPT has medical expertise, which obviously puts it in a far better position than this court to evaluate the quality of evidence from medical experts.

133. I accept that the reports were, by the time of the hearing in 2016, comparatively old. However, there was nothing in the evidence which suggested that Dr El-Huseini's health issues described in their reports were either likely to improve, or had indeed

improved, thereafter. Dr El-Huseini did not serve any up-to-date neuropsychological or psychiatric expert evidence of his own, but instead decided not to participate in the hearing.

134. Dr El-Huseini was also uncooperative in relation to undergoing a more up-to-date health assessment, or providing reports as to his fitness. In a case management order made on 13 November 2015 (described in Section B above) the MPTS case manager had directed Dr El-Huseini to confirm in writing to the GMC whether he provided his consent to undergo GMC health assessments in order to evaluate his fitness to practise and fitness to participate in the hearing before the tribunal. Such confirmation was to be given by 5 February 2016. The same direction required confirmation of whether he intended to obtain his own independent medical reports on those issues. Dr El-Huseini did not provide any confirmation in writing: the directions were effectively ignored. The direction also required Dr El-Huseini to disclose any independent medical reports he obtained regarding his fitness to practise and to participate in the hearing. This included any reports from his treating clinicians and GP. Such disclosure was to be made by 1 April 2016, with the clear intention that the tribunal should have up to date information. Again, the direction was disregarded. In paragraph 17 of its decision on adjournment, the MPT referred to Dr El-Huseini (through his assistant Mr. Shabaan) declining the tribunal's invitation to provide medical information from his GP and supervising psychiatrist about the mental health admission on 23 January 2016.

135. Against this background, the MPT was fully entitled to pay regard to the expert evidence of the two doctors, and to accept their conclusions, even though their reports were based on work carried out in 2013.

I: Insight and the investigation by UHCW

136. The final point raised concerns the MPT's finding, in the context of impairment, that Dr El-Huseini had not shown "complete insight on his part into his failure to care for patient A". I can deal with this point briefly.

137. The MPT based its conclusion on the findings of the UHCW's disciplinary investigation. That process had resulted in a final written warning to Dr El-Huseini. The UHCW's disciplinary panel had expressed "concerns that during the hearing itself you did not understand the significance and seriousness of the incident". Dr El-Huseini did not of course give any direct evidence to the MPT of his insight into his failure to care for patient A, and which might have served to counterbalance the conclusion of the disciplinary panel. In these circumstances, there was no reason why the MPT should not have reached its conclusion as to the lack of insight.

Conclusion

138. For the above reasons, the relevant decisions of the MPT were neither wrong, nor unjust because of serious procedural or other irregularity in the proceedings. Accordingly, Dr El-Huseini's appeal is dismissed.