Neutral Citation Number: [2022] EWHC 1651 (Admin)

Case No: CO/275/2022

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 29 June 2022

Before :

MRS JUSTICE LANG DBE

- -

Between :

GENERAL MEDICAL COUNCIL	**Appellant**
- and -	
JONATHAN EDWARD GAR-WAI MOK	**Respondent**

- -
- -

Ivan Hare QC (instructed by **GMC Legal**) for the **Appellant**
Simon Cridland (instructed by **Gordons Partnership Solicitors**) for the **Respondent**

Hearing date: 14 June 2022

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Approved Judgment

Mrs Justice Lang:

1. The Appellant ("the GMC") appeals under section 40A of the Medical Act 1983 ("MA 1983") against the determination of the Medical Practitioners Tribunal ("the MPT") on 23 December 2021 to suspend the Respondent ("Dr Mok") from the Register for 12 months, following a determination that his fitness to practise was impaired by reason of misconduct, namely, sex without consent with his male partner. The GMC appeals on the ground that this sanction is not sufficient to protect the public.

Facts

2. Dr Mok is aged 28 (date of birth 10 October 1993). He qualified as a doctor in 2018. In August 2019, when the misconduct occurred, he was completing his Foundation Year 1 at the Gloucestershire Royal Hospital and the Bristol Royal Infirmary. He subsequently completed his Foundation Year 2 training at the Bristol Royal Infirmary between August 2020 and August 2021 before commencing GP training. At the time of the MPT's determination he was undertaking his Speciality Year 1 Training as a specialist registrar on the Northwick Park GP Vocational Training Scheme.

3. The allegation against Dr Mok was as follows:

> "1. On or around 26 August 2019, you penetrated the anus of Person A with your penis, and:
>
> a. Person A did not consent to the penetration;
>
> b. you did not reasonably believe that Person A consented to the penetration.
>
> 2. Your actions at paragraph 1 were sexually motivated.
>
> And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct."

4. The facts were in dispute before the MPT. The MPT heard live evidence from Person A and from Dr Mok himself, his mother, father and aunt. The MPT also had regard to covert recordings of conversations between Dr Mok and Person A on 13 October 2019 and 18 November 2019.

5. The facts as found by the MPT were that Dr Mok and Person A met in around July 2018, and had begun a sexual relationship by October 2018.

6. Dr Mok and Person A went on holiday together to France in August 2019. On the evening of 26 August 2019, they had been drinking alcohol (4 or 5 glasses of wine each at a wine tasting, followed by a shared bottle of wine with dinner). Soon after they returned to their holiday apartment, Person A fell asleep. Dr Mok was still awake and was playing on his mobile phone. Person A woke up later that night, between 10.00 pm and 12 midnight. He found himself on his stomach with Dr Mok having initiating sexual intercourse with him whilst he was asleep, and penetrated him. In the MPT proceedings, Dr Mok denied that any sexual intercourse had taken place with Person A that evening.

7. The MPT had particular regard to the video recording made covertly by Person A on 13 October 2019 where he confronted Dr Mok regarding what had happened in Bordeaux. The MPT quoted the following passages from it in its determination on the facts:

> "PA I remember passing out and falling asleep and then I remember waking up, turned on my front, you inside of me fucking me, and when I felt down you'd lubed me up. (Pause) I thought, did I remember things differently or is that how ---
>
> JM No.
>
> PA -- things happened? So what was going through your mind when I fell asleep that you decided to just fuck me?
>
> JM (Pause) I thought it would have been hot and that you'd have found it quite hot.
>
> …..
>
> JM Well, we'd done stuff in bed before so you had always ---
>
> PA We had done stuff in bed, we've had sex when we're half asleep or whatever, but, John, I was asleep, passed out drunk…'
>
> PA Because if we're being honest about everything, what's that?
>
> JM I thought you would have found it a bit hot.
>
> PA You don't think it's important that, you know, someone's sober, someone's awake, whatever, when you're having sex with them?
>
> JM (Pause) I'm sorry.
>
> PA Sorry for what John? What did you do – because tell me, I want to hear it, what did you do?
>
> PA Touched you inappropriately and was inside of you when I shouldn't have been."

8. The MPT evaluated the evidence, and reached the following conclusions:

> "26. The Tribunal considered the context and circumstances of the video in which the video was recorded. The Tribunal noted that the recording was made the morning after Person A and Dr Mok had been arguing about their relationship. Person A's evidence was that he had previously raised the incident in conversation with Dr Mok on the day after its occurrence. However, Dr Mok's evidence was that this recorded conversation on 13 October 2019, was the first time that Person A had made the allegation to him. The Tribunal noted that Dr

Mok did not express any surprise or shock when the serious allegation was put to him by Person A. It was also noted that Dr Mok did not question the accusation further, ask for further information about it or display any confusion about the topic as one would expect if hearing it for the first time, as stated by Dr Mok. In addition, the Tribunal were of the view that Dr Mok went further than simply agreeing with Person A, as he attempted to justify the act that had occurred by saying, 'I thought you would have found it a bit hot' and said 'no' when Person A asked if he had recalled the incident incorrectly.

27. The Tribunal took into account Dr Mok's evidence that he simply had accepted everything Person A had challenged him about to placate him out of fear for his safety at the time. Dr Mok suggested that he felt under threat of violence at the time from Person A. The Tribunal noted that there was evidence of Person A having anger issues, as noted in his medical records, and had accepted himself breaking things and swearing at Dr Mok's parents in a telephone call regarding Dr Mok's birthday party. However, even so, the Tribunal considered that Dr Mok could have responded in a variety of ways, rather than admitting the very serious accusation being raised by Person A. The lack of questioning or denial in Dr Mok's response did not indicate that no sexual activity occurred that evening in Bordeaux nor that this issue was only being discussed between the two for the first time.

28. The Tribunal had regard to Mr Cridland's submissions that there had been discrepancies between the two accounts given to the GMC and to the French police. It was highlighted that the description given in the email to the GMC of how Person A woke up turned onto his stomach was starkly different to the account in the French police report where he stated 'I was facing up and Jonathan flipped me over. I was then laying facing down'. The Tribunal carefully considered the various accounts given by Person A and did take the view that in the GMC complaint email dated 2 December 2019, the complaint by Person A was embellished, as the Tribunal did not accept that the reasons given in that email for making the complaint at that time were genuinely held, namely the concerns for those under his care and supervision. Had such concerns been genuinely held, it would have expected the complaint to have been made much earlier, rather than on the day the relationship ended. The Tribunal however took the view that although Person A may have embellished his complaint in some aspects to the GMC, it was mindful that credibility is divisible and that it does not necessarily follow that his evidence ought to be rejected in relation to the facts of the Allegation, which are corroborated by the admissions made by Dr Mok in the video recording.

> 29. The Tribunal bore in mind Person A's evidence that there were some slight differences in the French notes due to issues of translation and interpretation. The Tribunal agreed that there were discrepancies in some of the statements made by Person A however, the essential element of the allegation, namely that Dr Mok penetrated the anus of Person A with his penis without his consent, has been consistent throughout the events. In addition, in the covertly recorded conversation of 13 October 2019, which is the first recorded account of the incident by Person A, the description that Person A puts to Dr Mok is consistent with his GMC complaint.
>
> 30. The Tribunal reasoned that, on the balance of probabilities, such an incident was more likely than not to have occurred, as Dr Mok stated in the video recording, 'I thought you would have found it a bit hot' and apologised at the end, explaining what he was apologising for. The Tribunal was of the view that if nothing unusual had occurred during their holiday, there would be no reason for Person A to believe that he needed to confront Dr Mok about it and record it.
>
> 31. The Tribunal determined that none of the accounts given by Person A included his consent nor does it indicate that Dr Mok reasonably believed that person A consented to the penetration. It therefore found paragraph 1(a) and (b) proved."

9. In the light of its findings, as set out above, the MPT concluded that Dr Mok's actions were sexually motivated. Therefore both paragraphs 1 and 2 of the allegation were proved.

10. Soon after their return from France, in early September 2019, Dr Mok and Person A moved into a flat together. Their relationship was troubled and, on 2 December 2019, Dr Mok ended it, and moved out of their shared flat. On the same day - 2 December 2019 - Person A sent an email to the GMC and Dr Mok's employer, making the allegation of rape which became the subject of these disciplinary proceedings.

11. Person A also made complaints to the British and the French police after Dr Mok left him. Neither police force took the matter any further.

MPT determination on misconduct

12. The MPT had regard to 'Good Medical Practice' (2013) and considered that paragraph 65 was engaged:

> "65. You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession."

13. The MPT was of the view that Dr Mok's behaviour was an incident of serious sexual misconduct which would be considered deplorable by fellow practitioners. It concluded that his actions fell short of the standards of conduct reasonably expected of a doctor

(paragraph 21 of the determination). Dr Mok did not dispute that the MPT's findings of fact amounted to misconduct.

MPT's determination on impairment

14. The MPT concluded that Dr Mok's fitness to practise was impaired (Dr Mok did not dispute impairment, in the light of the MPT's findings).

15. The MPT had regard to the test set out by Dame Janet Smith in the report of the Shipman Inquiry (at paragraph 25.67):

> "Do our findings of fact in respect of the doctor's misconduct, show that his fitness to practise is impaired in the sense that he:
>
> (a) Has in the past acted and/or is liable in the future to so act so as to put a patient or patients at unwarranted risk of harm and/or;
>
> (b) Has in the past brought and/or is liable in future to bring the medical profession into disrepute and/or;
>
> (c) Has in the past breached and/or is liable in the future to breach one of the fundamental tenants of the medical profession and/or;
>
> (d) Has in the past acted dishonestly and/or is liable to act dishonestly in future."

16. Applying that test, the MPT concluded that two out of the four limbs were engaged. Dr Mok's actions in the past had brought the profession into disrepute and he had breached a fundamental tenet of the profession (paragraph 27 of the determination).

17. At paragraph 26, the MPT concluded that Dr Mok's conduct had undermined public confidence in the profession. Reasonable and well-informed members of the public would expect a finding of impairment to be made in this case in order to promote and maintain proper professional standards.

18. In determining impairment, the MPT looked for evidence of insight, remediation and the likelihood of repetition, and balanced those factors against the three limbs of the statutory overarching objective in sections 1A and 1B of the MA 1983 (paragraph 22 of the determination).

19. On the issue of insight, the MPT found that Dr Mok's evidence of reflective work was mainly focussed on his professional practice, rather than the allegation. Therefore, Dr Mok had not demonstrated adequate insight into his behaviour and misconduct, and thus had not sufficiently remediated (paragraph 24 of determination).

20. The MPT acknowledged that the events had occurred two years ago. There was nothing to suggest that Dr Mok had engaged in such conduct before the incident and no concerns had been raised about his conduct since (paragraph 25 of the determination).

MPT's determination on sanction

21. The MPT considered the Sanctions Guidance and detailed submissions from both counsel. It decided that the appropriate and proportionate sanction was to suspend Dr Mok's registration for the maximum period of suspension of 12 months. It directed that a review should take place prior to the expiration of the suspension, at which Dr Mok would be responsible for demonstrating how he has addressed the MPT's concerns.

Legal framework

MA 1983

22. The over-arching objectives of the GMC are set out in section 1 MA 1983:

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

23. Under section 35D MA 1983, where a MPT finds that a practitioner's fitness to practise is impaired, it may:

    i) direct that the person's name be erased from the register;

    ii) direct that the person's registration be suspended, during a period not exceeding 12 months;

    iii) direct that the person's registration be subject to conditions, during a period not exceeding 3 years.

24. Under section 40 MA 1983, a practitioner has the right to appeal to the High Court against orders of erasure, suspension and conditional registration made against the practitioner.

25. Section 40A MA 1983 confers on the GMC a right of appeal to the High Court against orders of erasure, suspension and conditional registration made by a MPT against a practitioner, under section 35D MA 1983, "if they consider that the decision is not sufficient (whether as to finding or a penalty or both) for the protection of the public" (subsections (1) - (3) of section 40A MA 1983).

26. Subsection (4) of section 40A MA 1983 provides:

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

27. The powers of the High Court on appeal are set out at subsection (6) of section 40A MA 1983 which provide as follows:

> "(6) On an appeal under this section, the court may—
>
> (a) dismiss the appeal;
>
> (b) allow the appeal and quash the relevant decision;
>
> (c) substitute for the relevant decision any other decision which could have been made by the 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 . . . as it thinks fit."

Appellate jurisdiction

28. The appeal is governed by CPR part 52 and PD 52D. Under CPR 52.21(3), the question for the court is whether the decision of the Tribunal is "wrong" or "unjust because of a serious procedural or other irregularity in the proceedings in the lower court".

29. The leading authority on appeals under section 40A MA 1983 is *Bawa-Garba v General Medical Council* [2018] EWCA Civ 1879, in which the Lord Chief Justice, giving the judgment of the court, said:

> "60. The GMC's appeal from the Tribunal to the Divisional Court pursuant to section 40A of MA 1983 was by way of review and not re-hearing. In that respect, it differs from an appeal pursuant to section 40. Sub-paragraphs 19.1(1)(e) and (2) of Practice Direction 52D expressly state that appeals under section 40 are to be conducted by way of rehearing. Appeals pursuant to section 40A are governed by CPR 52.21(1), which provides that, subject to the exceptions mentioned there, appeals are limited to a review of the decision under appeal. That technical difference may not be significant. Whether the appeal from the MPT is

pursuant to section 40 or section 40A, the task of the High Court is to determine whether the decision of the MPT is "wrong". In either case, the appeal court should, as a matter of practice, accord to the MPT the same respect: *Meadow v General Medical Council* [2006] EWCA Civ 1390, [2007] QB 462 at [126]-[128].

61. The decision of the Tribunal that suspension rather than erasure was an appropriate sanction for the failings of Dr Bawa-Garba, which led to her conviction for gross negligence manslaughter, was an evaluative decision based on many factors, a type of decision sometimes referred to as "a multi-factorial decision". This type of decision, a mixture of fact and law, has been described as "a kind of jury question" about which reasonable people may reasonably disagree: *Biogen Inc v Medeva Plc* [1997] RPC 1 at 45*; Pharmacia Corp v Merck & Co Inc* [2001] EWCA Civ 1610, [2002] RPC 41 at [153]; *Todd v Adams (t/a Trelawney Fishing Co) (The Maragetha Maria)* [2002] EWCA Civ 509, [2002] 2 Lloyd's Rep 293 at [129]; *Datec Electronics Holdings Ltd v United Parcels Service Ltd* [2007] UKHL 23, [2007] 1 WLR 1325 at [46]. It has been repeatedly stated in cases at the highest level that there is limited scope for an appellate court to overturn such a decision. In *Biogen*, in which one of the issues raised by the defendant was whether the claimant's patent, which the claimant alleged had been infringed by the defendant, should be revoked as invalid because the patented invention was not original, Lord Hoffmann said (at [45]) as follows:

> "The question of whether an invention was obvious had been called "a kind of jury question" (see Jenkins L.J. in *Allmanna Svenska Elektriska A/B v. The Burntisland Shipbuilding Co. Ltd.* (1952) 69 R.P.C. 63, 70) and should be treated with appropriate respect by an appellate court. It is true that in *Benmax v. Austin Motor Co. Ltd.* [1955] A.C. 370 this House decided that, while the judge's findings of primary fact, particularly if founded upon an assessment of the credibility of witnesses, were virtually unassailable, an appellate court would be more ready to differ from the judge's evaluation of those facts by reference to some legal standard such as negligence or obviousness. In drawing this distinction, however, Viscount Simonds went on to observe, at page 374, that it was "subject only to the weight which should, as a matter of course, be given to the opinion of the learned judge". The need for appellate caution in reversing the judge's evaluation of the facts is based upon much more solid grounds than professional courtesy. It is because specific findings of fact, even by the most meticulous judge, are inherently an

> incomplete statement of the impression which was made upon him by the primary evidence. His expressed findings are always surrounded by a penumbra of imprecision as to emphasis, relative weight, minor qualification and nuance (as Renan said, *la vérité est dans une nuance*), of which time and language do not permit exact expression, but which may play an important part in the judge's overall evaluation. It would in my view be wrong to treat *Benmax* as authorising or requiring an appellate court to undertake a *de novo* evaluation of the facts in all cases in which no question of the credibility of witnesses is involved. Where the application of a legal standard such as negligence or obviousness involves no question of principle but is simply a matter of degree, an appellate court should be very cautious in differing from the judge's evaluation."

62. In *Assicurazioni Generali SpA v Arab Insurance Group (Practice Note)* [2002] EWCA Civ 1642, [2003] 1 WLR 577, Clarke LJ cited that passage (at [19]) and also said as follows:

> "15. In appeals against conclusions of primary fact the approach of an appellate court will depend upon the weight to be attached to the findings of the judge and that weight will depend upon the extent to which, as the trial judge, the judge has an advantage over the appellate court; the greater that advantage the more reluctant the appellate court should be to interfere. As I see it, that was the approach of the Court of Appeal on a "rehearing" under the Rules of the Supreme Court and should be its approach on a "review" under the Civil Procedure Rules 1998.
>
> 16. Some conclusions of fact are, however, not conclusions of primary fact of the kind to which I have just referred. They involve an assessment of a number of different factors which have to be weighed against each other. This is sometimes called an evaluation of the facts and is often a matter of degree upon which different judges can legitimately differ. Such cases may be closely analogous to the exercise of a discretion and, in my opinion, appellate courts should approach them in a similar way."

63. These paragraphs were approved by the House of Lords in *Datec* at [46]. In the recent case of *R (Bowen and Stanton) v Secretary of State for Justice* [2017] EWCA Civ 2181, McCombe LJ explained (at [65]) that, when the appeal is from a trial judge's multi-factorial decision, "the appeal court's approach will be conditioned by the extent to which the first

instance judge had an advantage over the appeal court in reaching his/her decision. If such an advantage exists, then the appeal court will be more reticent in differing from the trial judge's evaluations and conclusions".

64. In *Bowen and Stanton*, McCombe LJ went on (at [67]) to quote from Lord Clarke's judgment in *Re B (A Child) (Care Proceedings)* [2013] UKSC 33; [2013] 1 WLR 1911 at [137] as follows:

> "In England and Wales the jurisdiction of the Court of Appeal is set out in CPR rule 52.11(3), which provides that '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'. The rule does not require that the decision be "plainly wrong". However, the courts have traditionally required that the appeal court must hold that the judge was plainly wrong before it can interfere with his or her decision in a number of different classes of case. I referred to some of them in *Assicurazioni Generali SpA v Arab Insurance Group* [2003] 1 WLR 577 ... at my paras 9-23. It seemed to me then and it seems to me now that the correct approach of an appellate court in a particular case may depend upon all the circumstances of that case. So, for example, it has traditionally been held that, absent an error of principle, the Court of Appeal will not interfere with the exercise of a discretion unless the judge was plainly wrong. On the other hand, where the process involves a consideration of a number of different factors, all will depend on the circumstances. As Hoffmann LJ put it in *In Re Grayan Building Services Ltd (In Liquidation)* [1995] Ch 241, 254, 'generally speaking, the vaguer the standard and the greater the number of factors which the court has to weigh up in deciding whether or not the standards have been met, the more reluctant an appellate court will be to interfere with the trial judge's decision'."

65. McCombe LJ also quoted (at [71]) the case of *Smech Properties Ltd v Runnymede Borough Council* [2016] EWCA Civ 42, in which Sales LJ said as follows:

> "29. ... Where an appeal is to proceed, like this one, by way of a review of the judgment below rather than a re-hearing, it will often be appropriate for this court to give weight to the assessment of the facts made by the judge below, even where that assessment has been made on the basis of written evidence which is also

available to this court. The weight to be given to the judge's own assessment will vary depending on the circumstances of each particular case, the nature of the finding or factual assessment which has been made and the nature and range of evidential materials bearing upon it. Often a judge will make a factual assessment by taking into account expressly or implicitly a range of written evidence and making an overall evaluation of what it shows. Even if this court might disagree if it approached the matter afresh for itself on a re-hearing, it does not follow that the judge lacked legitimate and proper grounds for making her own assessment and hence it does not follow that it can be said that her decision was "wrong"."

66. McCombe LJ commented on that passage as follows:

"72. It seems to me that Sales LJ was addressing the exigencies of reviewing a first instance judge's assessment of primary facts, even where (as in our case) the evidence before the court below was entirely in writing. All will depend on the circumstances of the case and what opportunity the court has, in reality, to improve and correct the overall assessment of the evidence before the first instance judge as a whole."

67. That general caution applies with particular force in the case of a specialist adjudicative body, such as the tribunal in the present case, which (depending on the matter in issue) usually has greater experience in the field in which it operates than the courts: see *Smech* at [30]; *Khan v General Pharmaceutical Council* [2016] UKSC 64, [2017] 1 WLR 169 at [36]; *Meadow* at [197]; and *Raschid v General Medical Council* [2007] EWCA Civ 46, [2007] 1 WLR 1460 at [18]-[20]. An appeal court should only interfere with such an evaluative decision if (1) there was an error of principle in carrying out the evaluation or (2) for any other reason, the evaluation was wrong, that is to say it was an evaluative decision which fell outside the bounds of what the adjudicative body could properly and reasonably decide: *Biogen* at [45]; *Todd* at [129]; *Designers Guild Ltd v Russell Williams (Textiles) Ltd (trading as Washington DC)* [2001] FSR 11 (HL) at [29]; *Buchanan v Alba Diagnostics Ltd* [2004] UKHL 5, [2004] RPC 34 at [31]. As the authorities show, the addition of 'plainly' or 'clearly' to the word 'wrong' adds nothing in this context."

30. In *General Medical Council v Jagjivan & Another* [2017] EWHC 1247 (Admin); [2017] 1 WLR 4438, which pre-dated the judgment in *Bawa-Garba*, Sharp LJ summarised the principles to be applied to appeals under section 40A of the MA 1983, at [40]:

"In summary:

(i) Proceedings under section 40A of the 1983 Act are appeals and are governed by CPR part 52. A court will allow an appeal under CPR part 52.21(3) if it is 'wrong' or 'unjust because of a serious procedural or other irregularity in the proceedings in the lower court'.

(ii) It is not appropriate to add any qualification to the test in CPR part 52 that decisions are 'clearly wrong': see *Fatnani* at paragraph 21 and *Meadow* at paragraphs 125 to 128.

(iii) The court will correct material errors of fact and of law: see *Fatnani* at paragraph 20. Any appeal court must, however, be extremely cautious about upsetting a conclusion of primary fact, particularly where the findings depend upon the assessment of the credibility of the witnesses who the tribunal, unlike the appellate court, has had the advantage of seeing and hearing (see *Assicurazioni Generali SpA v Arab Insurance Group (Practice Note)* [2002] EWCA Civ 1642; [2003] 1 WLR 577, at paragraphs 15 to 17, cited with approval in *Datec Electronics Holdings Ltd v United Parcels Service Ltd* [2007] UKHL 23; [2007] 1 WLR 1325 at paragraph 46, and *Southall* at paragraph 47).

(iv) When the question is what inferences are to be drawn from specific facts, an appellate court is under less of a disadvantage. The court may draw any inferences of fact which it considers are justified on the evidence: see CPR part 52.11(4).

(v) In regulatory proceedings, the appellate court will not have the professional expertise of the tribunal of fact. As a consequence, the appellate court will approach tribunal determinations about whether conduct is serious misconduct or impairs a person's fitness to practise and what is necessary to maintain public confidence and proper standards in the profession and sanctions with diffidence: see *Fatnani* at paragraph 16 and *Khan v General Pharmaceutical Council* [2016] UKSC 64; [2017] 1 WLR 169, at paragraph 36.

(vi) However, there may be matters, such as dishonesty or sexual misconduct, where the court 'is likely to feel that it can assess what is needed to protect the public or maintain the reputation of the profession more easily for itself and thus attach less weight to the expertise of the tribunal ...': see *Council for the Regulation of Healthcare Professionals v GMC and Southall* [2005] EWHC 579 (Admin); [2005] Lloyd's Rep Med 365 at paragraph 11, and *Khan* at paragraph 36(c). As Lord Millett observed in *Ghosh v GMC* [2001] UKPC 29; [2001] 1 WLR 1915 and 1923G, the appellate court 'will afford an appropriate measure of respect of the judgment in the committee ... but the

> [appellate court] will not defer to the committee's judgment more than is warranted by the circumstances'.
>
> (vii) Matters of mitigation are likely to be of considerably less significance in regulatory proceedings than to a court imposing retributive justice because the overarching concern of the professional regulator is the protection of the public.
>
> (viii) A failure to provide adequate reasons may constitute a serious procedural irregularity which renders the tribunal's decision unjust (see *Southall* at paragraphs 55 to 56)."

31. In *Sastry v General Medical Council* [2021] EWCA Civ 623, Nicola Davies LJ identified the distinction between the approach of the court in re-hearings in section 40 appeals and reviews in section 40A appeals, as follows:

> "108. We endorse the approach of the court in *Bawa-Garba*, as appropriate to the review jurisdiction applicable in section 40A appeals. We regard the approach of the court in section 40 appeals, as identified in *Ghosh* and approved in *Khan*, as appropriate in section 40 appeals which are by way of a rehearing."

32. Mr Hare QC relied on the judgment of Collins Rice J. in *General Medical Council v Bramhall* [2021] EWHC 2109 (Admin) in which she reviewed authorities on applying the GMC sanctions guidance at [24] – [26]:

> "24. The MPT in this case referred to two authorities on how to direct itself to the Sanctions Guidance. *CRHP v GMC & Leeper* [2004] EWHC 319 was cited for the proposition that the aim of the Guidance is to promote the consistency and transparency of Tribunal decisions - a matter to which it must have regard although each case will depend on its own facts. The Court of Appeal in *PSA v HCPC & Doree* [2017] EWCA Civ 319 was cited for the principle that departure from the Guidance must be explained. A Tribunal should have proper regard to the Guidance, and apply it as its own terms suggest, unless it has sound reasons for departing from it - in which case it has to state those reasons clearly in its decision. Again, however, a degree of flexibility and fact-sensitivity is acknowledged.
>
> 25. The High Court in *GMC v Khetyar* [2018] EWHC 813 had before it the particular issue of applying the Guidance in determining suspension rather than erasure. It characterised the Guidance as an '*authoritative steer*' as to the application of the principle of proportionality in balancing the public interest against the interest of the individual professional. Accordingly, '*a proper conclusion that suspension is sufficient cannot be reached without reference to and careful consideration of advice in the Guidance that erasure may be or is likely to be appropriate*

where that advice is pertinent to the facts of a particular case'. The Court said this (paragraph 22):

> Again, of course, it remains advice and not prescription: tribunals must ultimately judge each case on its own merits, and are entitled in principle to depart from that steer. Doing so, however, requires careful and substantial case-specific justification. A "generalised assertion that erasure would be a disproportionate sanction and that the doctor's conduct was not incompatible with his continued registration", where the Guidance gives a clear steer towards erasure, properly considering what is says about important features of the case in question, will be inadequate and will justify the conclusion that a tribunal has not properly understood the gravity of the case before it: see *GMC v Stone* [2017] EWHC 2534 (Admin) at [53].

26. The error identified in *Stone* was failure properly to consider the objective features of the case, to demonstrate that their gravity had been fully understood, and then to address and explain how the available mitigation operated to justify the imposition of the sanction of suspension. The court emphasised that this is not elevating form over substance; proper regard to the Guidance is important in its own right, and giving clear reasons for divergence is part of the MPT's functions in articulating in the public domain how its determinations properly serve the overarching objective."

33. Mr Hare QC referred me to the passages of the judgment where the Judge considered the application of those principles to the specific facts of the *Bramhall* case: see [32] – [39] and [53] – [54].

34. In *Professional Standards Authority v The Health and Care Professions Council & Doree* [2017] EWCA Civ 319, Lindblom LJ (giving the judgment of the Court) gave guidance on the Sanctions Guidance, and said:

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

Sanctions Guidance

35. The Sanctions Guidance ("SG") is approved by the Council of the GMC, and was developed by a steering group of Medical Practioners Tribunal Service and GMC staff, for use by medical practitioners tribunals.

36. Under the heading "**Why do we impose sanctions**?", the SG explains (at [14]) that "the main reason for imposing sanctions is to protect the public" as set out in the statutory overarching objective. Sanctions are not imposed to punish or discipline doctors, but they may have a punitive effect (at [16]).

37. Under the heading "**Taking a proportionate approach to imposing sanctions**", the SG states:

> "20 In deciding what sanction, if any, to impose the tribunal should consider the sanctions available, starting with the least restrictive. It should also have regard to the principle of proportionality, weighing the interests of the public against those of the doctor (this will usually be an impact on the doctor's career, e.g. a short suspension for a doctor in training may significantly disrupt the progression of their career due to the nature of training contracts).
>
> 21 However, once the tribunal has determined that a certain sanction is necessary to protect the public (and is therefore the minimum action required to do so), that sanction must be imposed, even where this may lead to difficulties for a doctor. This is necessary to fulfil the statutory overarching objective to protect the public."

38. **Mitigating factors**. The SG advises that the "tribunal needs to consider and balance any mitigating factors presented by the doctor against the central aim of sanctions" (at [24]). At [25], it sets out "examples of mitigating factors" which include:

    a) Evidence that the doctor understands the problem and has insight, and of their attempts to address or remediate it;

    b) Evidence that the doctor is adhering to important principles of good practice;

    c) Circumstances leading up to any incidents;

    d) Personal and professional matters, such as work-related stress;

    e) Lapse of time since an incident occurred.

39. **Aggravating factors**. The SG advises that the "tribunal needs to consider any aggravating factors presented to it against the central aim of sanctions by the doctor against the central aim of sanctions" (at [50]). Aggravating factors listed are lack of insight (at [51] – [52]; previous finding of impairment at [54], circumstances surrounding the event (at [55]), conduct in a doctor's personal life (at [56]). Paragraph

56 advises that tribunals are "likely to take more serious action where certain conduct arises in a doctor's personal life" such as *inter alia* "misconduct involving violence or offences of a sexual nature (see paragraphs 149 – 150)".

40. Under the heading "**Cases that indicate more serious action is likely to be required**", the SG refers to sexual misconduct, in the following terms:

> "**Sexual misconduct**
>
> 149 This encompasses a wide range of conduct from criminal convictions for sexual assault and sexual abuse of children (including child sex abuse materials) to sexual misconduct with patients, colleagues, patients' relatives or others. See further guidance on sex offenders and child sex abuse materials at paragraphs 151–159.
>
> 150 Sexual misconduct seriously undermines public trust in the profession. The misconduct is particularly serious where there is an abuse of the special position of trust a doctor occupies, or where a doctor has been required to register as a sex offender. More serious action, such as erasure, is likely to be appropriate in such cases."

41. The next section deals with sex offenders and child sex abuse materials, as follows:

> "**Sex offenders and child sex abuse materials**
>
> 151 Any doctor who has been convicted of, or has received a caution for, a sexual offence listed in Schedule 3 to the Sexual Offences Act 2003 must notify the police (register) under section 80 of the Sexual Offences Act 2003 and may need to undertake a programme of rehabilitation or treatment. Sexual offences include accessing and viewing, or other involvement in, child sex abuse materials, which involves the exploitation or abuse of a child. These offences seriously undermine patients' and the public's trust and confidence in the medical profession and breach a number of principles set out in Good medical practice (paragraph 65 regarding honesty and integrity, particularly paragraph 47 regarding respecting patients' dignity, and paragraph 27 regarding children and young people).
>
> 152 Taking, making, sharing and possessing an indecent image or pseudo-photograph of a child is illegal and regarded in UK society as morally unacceptable. For these reasons, where there is any involvement in child sex abuse materials by a registered doctor the tribunal should consider whether the public interest demands that their registration be affected.
>
> 153 While the courts distinguish between degrees of seriousness, any conviction for child sex abuse materials against a registered doctor is a matter of grave concern because it involves such a

> fundamental breach of the public's trust in doctors and inevitably brings the profession into disrepute. It is therefore highly likely that, in these cases, the only proportionate sanction will be erasure. However, the tribunal should bear in mind paragraphs 20–23 and 61–111 of this guidance, which deal with the options available to it, and the issue of proportionality. If the tribunal decides to impose a sanction other than erasure, it is important that it fully explains the reasons and the thinking that has led it to impose this lesser sanction so that it is clear to those who have not heard the evidence in the case.
>
> ……."

42. Under the heading "**Deciding what sanction to impose when a doctor's fitness to practise is impaired**", the SG advises tribunals in the following terms:

> "67 The tribunal's written decision is known as the determination. It must give clear and cogent reasons (including mitigating and aggravating factors that influenced its decision) for imposing a particular sanction. It must show that it started by considering the least restrictive option, working upwards to the most appropriate and proportionate sanction. This is particularly important where the sanction is lower, or higher, than that suggested by this guidance and/or where it differs from those submitted by the parties….."

43. The material guidance on suspension is set out below:

> "**Suspend the doctor's registration (for up to 12 months)….**
>
> 91 Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.
>
> 92 Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (i.e. for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).
>
> 93 Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be

repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions (see paragraphs 24–49).

…….

97. Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.

a A serious breach of *Good medical practice*, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors.

b In cases involving deficient performance where there is a risk to patient safety if the doctor's registration is not suspended and where the doctor demonstrates potential for remediation or retraining.

c In cases that relate to the doctor's health, where the doctor's judgement may be impaired and where there is a risk to patient safety if the doctor were allowed to continue to practise even under conditions, or the doctor has failed to comply with restrictions or requirements.

d …..

e No evidence that demonstrates remediation is unlikely to be successful, e.g. because of previous unsuccessful attempts or a doctor's unwillingness to engage.

f No evidence of repetition of similar behaviour since incident.

g The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour."

……

Determining the length of suspension

99 The length of the suspension may be up to 12 months and is a matter for the tribunal's discretion, depending on the seriousness of the particular case.

100 The following factors will be relevant when determining the length of suspension:

a the risk to patient safety/public protection

b the seriousness of the findings and any mitigating or aggravating factors (as set out in paragraphs 24–60)

c ensuring the doctor has adequate time to remediate.

101 The tribunal's primary consideration should be public protection and the seriousness of the findings. Following any remediation, the time all parties may need to prepare for a review hearing if one is needed will also be a factor.

102 The table on the next page gives examples of aggravating factors that will also be relevant to the length of suspension, under broad categories, depending on the nature of the case."

44. The SG gives the following guidance on erasure:

"**Erase the doctor's name from the medical register**

107 The tribunal may erase a doctor from the medical register in any case – except one that relates solely to the doctor's health and/or knowledge of English – where this is the only means of protecting the public.

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

109 Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).

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

b A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety.

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

d Abuse of position/trust (see *Good medical practice*, paragraph 65: 'You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession').

e Violation of a patient's rights/exploiting vulnerable people ….

> f Offences of a sexual nature, including involvement in child sex abuse materials (see further guidance below at paragraphs 151 - 159).
>
> g Offences involving violence.
>
> h Dishonesty, especially where persistent and/or covered up ….
>
> i Putting their own interests before those of their patients ….
>
> j Persistent lack of insight into the seriousness of their actions or the consequences."

45. The SG gives the following guidance on review hearings following an order of suspension:

> "163 It is important that no doctor is allowed to resume unrestricted practice following a period of conditional registration or suspension unless the tribunal considers that they are safe to do so.
>
> 164 In some misconduct cases it may be self-evident that, following a short suspension, there will be no value in a review hearing. However, in most cases where a period of suspension is imposed, and in all cases where conditions have been imposed, the tribunal will need to be reassured that the doctor is fit to resume practice – either unrestricted or with conditions or further conditions. A review hearing is therefore likely to be necessary, so that the tribunal can consider whether the doctor has shown all of the following (by producing objective evidence):
>
> a they fully appreciate the gravity of the offence
>
> b they have not reoffended
>
> c they have maintained their skills and knowledge
>
> d patients will not be placed at risk by resumption of practice or by the imposition of conditional registration.
>
> …..
>
> 168. Where a doctor's registration is suspended, the tribunal may direct that:
>
> a the current period of suspension is extended (up to 12 months)
>
> b the doctor's name is erased from the medical register ….
>
> c impose a period of conditions (up to three years).
>
> ……"

Grounds of appeal

46. The GMC appealed on three grounds:

    i) the MPT had regard to irrelevant considerations in its determination on sanction;

    ii) the MPT failed to apply the SG and give adequate reasons for its decision on sanction; and

    iii) the sanction of suspension fell outside the range of reasonable decisions open to the MPT on these facts.

Ground 1

47. The GMC submitted that the MPT had regard to the following irrelevant considerations in its determination on sanction:

    i) Absence of malicious intention;

    ii) Evidence of some sexual activity between Dr Mok and Person A while asleep;

    iii) Absence of a doctor-patient relationship;

    iv) Isolated incident and Dr Mok acknowledged what he had done and apologised on the video recording.

48. As the Lord Chief Justice held in *Bawa-Garba*, at [61], a decision on sanction is an evaluative decision, which is multi-factorial, including questions of fact and law. This type of decision is "a kind of jury question" about which reasonable people may disagree, and there is limited scope for an appellate court to overturn such a decision. The Lord Chief Justice confirmed, at [67], the well-established principle that because a specialist adjudicative body, such as an MPT, has experience in the field, an appeal court should only interfere with such an evaluative decision if (1) there is an error of principle in carrying out the evaluation, or (2) the evaluation fell outside the bounds of what the adjudicative body could properly and reasonably decide.

49. In my judgment, the MPT exercised its evaluative judgment when it identified the considerations which it considered were relevant, and that judgment was informed by its assessment of the evidence and the issues, gained over the 6 day hearing.

50. The relevant passages in the determination on sanction were as follows:

    "**Suspension**

    ……

    24. The Tribunal noted that there was no indication of malicious intention or the intention to cause distress and harm to person A as evident in the video recording where Dr Mok stated 'I thought it would have been hot and that you'd have found it quite hot'.

> 25. The Tribunal heard some evidence during these proceedings that on occasions there had been sexual activity initiated between person A and Dr Mok whilst asleep.
>
> 26. The Tribunal also took into account that the sexual activity and misconduct had occurred not in a doctor patient relationship where there is a position of trust in a professional context.
>
> 27. The Tribunal was satisfied that this was an isolated incident, and it was clear from the video recording when questioned by person A about the incident, Dr Mok had acknowledged what he had done and apologised at that time."

51. I do not consider that any of these considerations were irrelevant as a matter of principle, or outside the bounds of what an MPT could reasonably decide. Moreover, the considerations identified were not excluded from consideration by the SG or any other guidance.

Absence of malicious intention

52. The MPT recorded at paragraph 12 of the sanctions determination:

> "Mr Cridland submitted that based on the video, Dr Mok's statement that he thought Person A would find it hot, suggested that Dr Mok did not think at the time what he was doing would cause any distress or harm to Person A. It was not a deliberate act of abuse or harm."

The MPT appears to have accepted this submission.

53. In my view, it would be an aggravating feature of any case before the MPT that the registrant acted maliciously and intended to cause distress or harm. That is recognised in the SG in respect of erasure (at paragraph 109(c)) where cases of "doing serious harm to others ….deliberately" are recognised as constituting one of the categories of case where erasure may be the appropriate sanction. Therefore it was clearly relevant that Dr Mok did not act maliciously and did not intend to cause harm or distress.

54. The fact that "malicious intention" was not alleged by the GMC did not mean that it was an irrelevant consideration. In determining sanction, it was proper for the MPT to take into account its findings on the evidence; it was not restricted to the precise wording of the allegation.

Evidence of some sexual activity between Dr Mok and Person A while asleep

55. The evidence of Dr Mok was that, on occasion, Person A had commenced sexual activities with him when he was asleep, which woke Dr Mok up.

56. The covert video recording of 13 October 2019 included the following exchange:

> "PA -- things happened? So what was going through your mind when I fell asleep that you decided to just fuck me?
>
> JM (Pause) I thought it would have been hot and that you'd have found it quite hot.
>
> …..
>
> JM Well, we'd done stuff in bed before so you had always ---
>
> PA We had done stuff in bed, we've had sex when we're half asleep or whatever, but, John, I was asleep, passed out drunk…"

57. Person A was cross-examined about Dr Mok's evidence and the video. Person A did not accept Dr Mok's account of the ways in which Person A had initiated sexual activity when Dr Mok was asleep. When asked to explain his words in the video conversation, he said:

> "When I said "We've had sex when we're half asleep", I think that there has been occasions when we've gone to bed or when we've woken up where we might start having foreplay and I think touching would include that, but there's never ever been penetration without someone being conscious fully at that time."

58. In my view, the history of previous sexual activity between the couple, including initiating sex when the other was asleep or half asleep, was a relevant part of the evidence before the MPT, given Dr Mok's explanation for his conduct that he considered that Person A would find his actions "hot", based on past experience. The MPT avoided making precise findings on the disputed evidence as to who did what to whom, and when, but appear to have accepted the evidence in the video conversation. I do not accept the GMC's submission that this evidence was only relevant to the issue of consent, not sanction. Dr Mok's explanation for his conduct, and whether or not he had intended to harm or distress Person A, were relevant to the issue of sanction.

Absence of a doctor/patient relationship

59. The GMC conceded that it would have been an aggravating factor if Person A had been Dr Mok's patient. It follows that the absence of this aggravating factor was a consideration that the MPT was entitled to take into account.

Isolated incident and Dr Mok acknowledged what he had done and apologised on the video evidence

60. The MPT's finding that this was an isolated incident, which had not been repeated was relevant to insight and ongoing risk. Paragraph 93 of the SG specifically provides suspension may be appropriate "where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated"; and where "there is no evidence of repetition of similar behaviour since incident" (paragraph 97(f)).

61. Dr Mok's acknowledgment and his apology on the video, were plainly matters the MPT was entitled to take into account. Paragraph 46 of the SG specifically states "a doctor is likely to have insight if they: (a) accept they should have behaved differently (showing empathy and understanding)."; and, at paragraph 52 "A doctor is likely to lack insight if they (a) refuse to apologise".

62. The GMC submitted that this should have been set against Dr Mok's denials and the MPT's findings of lack of insight. In my view, it was sufficient that the MPT took the following matters into account, as aggravating factors:

    i) Lack of insight and no expression of remorse since the incident;

    ii) No acknowledgment of the impact on the victim;

    iii) Dr Mok presented himself as the victim in his reflective work.

63. For the reasons set out above, I do not consider that the MPT's approach discloses any material error of fact or law. In my view, this appellate court should not interfere with the evaluative judgments made by the MPT on the factors to take into account when deciding on sanction. Therefore Ground 1 does not succeed.

Ground 2

64. Under Ground 2, the GMC submitted that the MPT did not apply the SG. It also failed to give sufficient reasons for its decision, so as to maintain public confidence in the medical profession and its proper regulation.

65. The GMC's first criticism was that the MPT quoted the SG selectively because, at paragraph 23 of the sanctions determination, it set out paragraphs 91 and 92 of the SG, but not paragraph 93 which refers to acknowledgment of fault, risk of repetition, and mitigation evidence.

66. The SG is a lengthy document, and in my view, the MPT was not required to set out every relevant paragraph. It is reasonable to assume that the members of this specialist panel would have been well aware of the provisions of such a key document. They receive training on the SG, and it is routinely used at MPT hearings.

67. Moreover, I am satisfied that the MPT had regard to the issues raised in paragraph 93 of the SG. It specifically dealt with the extent to which Dr Mok acknowledged his behaviour (see paragraphs 61 and 62 above). The MPT found, at paragraph 27 of the sanctions determination, that this was "an isolated incident", and at paragraph 18, that there was no evidence of such conduct either before or since this incident. At paragraph 25 of the impairment determination, the MPT acknowledged that the events in question occurred two years ago, and stated "[t]here is nothing to suggest that Dr Mok had engaged in such conduct before the incident and no concerns have been raised about his conduct since".

68. The MPT had regard to the steps Dr Mok had taken in mitigation. Mitigating factors included positive professional feedback and testimonial evidence and the absence of any repetition of the misconduct. The MPT also identified weaknesses in the mitigating steps taken. The MPT considered that Dr Mok's reflective work was mainly focused on

his professional practice, rather than the conduct in issue. It also regarded it as an aggravating factor that Dr Mok "presented himself as the victim in his reflective work" (paragraph 17 of the sanctions determination).

69. In my judgment, the reasons that the MPT gave on these matters were sufficient and intelligible.

70. Therefore, I do not accept the GMC's first criticism.

71. The GMC's second criticism was that the MPT made no effort to go through the factors identified in paragraph 97 of the SG indicating when suspension may be appropriate, and so did not have proper regard to them. It was common ground that sub-paragraphs (b), (c) and (d) did not apply in this case.

72. Paragraph 97(a) suggests that suspension may be appropriate where there has been a serious breach of Good Medical Practice but where the breach is not fundamentally incompatible with continued registration. The Tribunal clearly had this consideration in mind as they concluded at paragraph 29 of the determination on sanction that for the reasons set out previously "this case fell just short of being fundamentally incompatible with continued registration".

73. Paragraph 97(e) states:

> "No evidence that demonstrates remediation is unlikely to be successful, for example because of previous unsuccessful attempts or a doctor's unwillingness to engage."

74. The SG gives guidance on remediation, materially as follows:

> "**Remediation of the concerns**
>
> 31 Remediation is where a doctor addresses concerns about their knowledge, skills, conduct or behaviour. Remediation can take a number forms, including coaching, mentoring, training and rehabilitation (this list is not exhaustive) and, where fully successful, will make impairment unlikely.
>
> 32 However, there are some cases where a doctor's failings are irremediable. This is because they are so serious or persistent that, despite steps subsequently taken, action is needed to maintain public confidence. This might include where a doctor knew, or ought to have known, they were causing harm to patients and should have taken steps earlier to prevent this."

75. There was no evidence that remediation was unlikely to be successful in this case. This was not a case where the scope for remediation was exhausted because of persistent failings and a history of unsuccessful attempts at remediation. The MPT considered that Dr Mok had not demonstrated adequate insight into his behaviour and misconduct, and thus had not yet sufficiently remediated (paragraph 24 of the impairment determination). However, there was no evidence to suggest that Dr Mok was unwilling to engage in effective remediation. The GMC's counsel did not identify any such evidence in her submissions in respect of sanction. The MPT decided to suspend Dr

Mok, rather than erase him from the register, in the expectation that he would undertake further remediation work, in regard to his insight and reflection, including an appreciation of the gravity of the offence and the potential impact on the victim, which would be reviewed shortly before the end of the suspension period. In my view, the MPT would not have given Dr Mok this further opportunity to remediate if it considered that his "failings" were "irremediable".

76. Paragraph 97(f) states:

> "no evidence of repetition of similar behaviour since incident."

77. The MPT found, at paragraph 27 of the sanctions determination, that this was "an isolated incident", and at paragraph 18, that there was no evidence of such conduct either before or since this incident.

78. Paragraph 97(g) states:

> "The Tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating the behaviour."

79. In its determination on impairment, the MPT considered the issues of insight and risk of repetition:

> "23. In determining impairment, the Tribunal looked for evidence of insight, remediation and the likelihood of repetition and balanced those against the three limbs of the statutory overarching objective. The Tribunal noted that in cases of sexual misconduct, such misconduct is not easily remediable.
>
> 24. In considering the issue of insight, while the Tribunal considered that Dr Mok has provided evidence of reflective work, it was mainly focused on his professional practice than addressing the Allegation in question. It therefore concluded that Dr Mok had not demonstrated adequate insight into his behaviour and misconduct, and thus had not sufficiently remediated.
>
> 25. The Tribunal acknowledged that the events in question occurred two years ago. There is nothing to suggest that Dr Mok had engaged in such conduct before the incident and no concerns have been raised about his conduct since."

80. This passage indicates that the MPT appreciated the link between insight, remediation and the risk of repetition. In its determination on sanction, the MPT then went on to identify lack of insight as an aggravating feature (paragraph 17), so it clearly had in mind the significance of a lack of insight on the sanction to be imposed. It did not, however, find that there was a risk of repetition. It considered that the misconduct was an "isolated incident" (paragraph 27) and that there was no evidence of such conduct either before or since this incident (paragraph 18). I agree with Dr Mok's submission that it does not follow from a lack of insight *per se*, that suspension would not be a sufficient sanction.

81. In my judgment, the MPT had proper regard to the factors in paragraph 97 of the SG in reaching its decision. Furthermore, the reasons that the MPT gave for its findings and conclusions on these issues were adequate and intelligible.

82. The GMC's third criticism was that the MPT made no effort to go through the factors in paragraph 109 of the SG indicating when erasure may be appropriate, and so did not have proper regard to them. It was common ground that sub-paragraphs (e), (g), (h) and (i) were not applicable in this case.

83. The MPT's evaluation and judgment that the sanction of suspension, not erasure, was appropriate in this case, was set out at paragraphs 28 to 30 of its sanctions determination:

> "28. The Tribunal carefully considered the GMC's submission that erasure was the only appropriate sanction in this case. It reminded itself of the aggravating and mitigating factors it had identified in this case and noted the following paragraphs of the SG were relevant to its deliberations:
>
> > *108 Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor.*
> >
> > *150 Sexual misconduct seriously undermines public trust in the profession. The misconduct is particularly serious where there is an abuse of the special position of trust a doctor occupies, or where a doctor has been required to register as a sex offender. More serious action, such as erasure, is likely to be appropriate in such cases.*
>
> 29. Having balanced all the factors in this case, it determined that neither of these categories expressly referred to in paragraph 150 of the SG applies in this specific case and that erasure would be disproportionate in the circumstances. The Tribunal concluded that this case fell just short of being fundamentally incompatible with continued registration.
>
> 30. The Tribunal bore in mind the need to act proportionately and impose the least restrictive sanction to meet the public interest. Having regard to all of the circumstances, the Tribunal concluded that the sanction of suspension would sufficiently mark the seriousness of the misconduct and protect public confidence in the profession. The Tribunal also considered that a sanction of suspension would send a message to members of the profession that Dr Mok's misconduct was wholly unacceptable. The Tribunal further considered that a period of

> suspension would demonstrate to Dr Mok how far below the standards of behaviour expected of a doctor his conduct fell."

84. Paragraph 109(a) refers to:

> "A particularly serious departure from the principles set out in *Good medical practice* where the behaviour is fundamentally incompatible with being a doctor".

85. At paragraph 28 of its determination on sanction, the MPT noted the advice in paragraph 108 of the SG to the effect that erasure may be necessary to maintain public confidence in the profession, "for example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor". When considering sanction, the MPT "concluded that this case fell just short of being fundamentally incompatible with continued registration", taking into account all the factors and for the reasons it gave in paragraphs 29 and 30. In my view, the MPT's choice of words demonstrates that it was referencing paragraph 109(a), but decided that it did not apply in this particular case.

86. It is convenient to consider the next three paragraphs together. Paragraph 109(b) refers to:

> "A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety."

87. Paragraph 109(c) refers to:

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

88. Paragraph 109(d) refers to:

> "Abuse of position/trust (see *Good medical practice*, paragraph 65: '*You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession*')."

89. The GMC submitted that sub-paragraphs (b) and (c) applied in this case. In my view, on the MPT's findings, only sub-paragraph (d) applied. The MPT found, in its misconduct determination (at paragraph 20), that paragraph 65 of Good Medical Practice was engaged by reason of Dr Mok's serious sexual misconduct, which undermined public confidence in the medical profession (impairment determination, paragraph 26). Therefore sub-paragraph (d) applied. However, there was no evidence that, when behaving as he did in August 2019, Dr Mok had in mind the principles of Good Medical Practice, and deliberately or recklessly disregarded them. This was a breach of paragraph 65, but not one which was aggravated by a deliberate or reckless disregard. The MPT found that there was no indication of malicious intention or an intention to cause distress and harm to Person A, and the MPT accepted Dr Mok's

account that "I thought it would have been hot and that you'd have found it quite hot". There was evidence from Person A as to the effect of Dr Mok's actions upon him, but the MPT made no findings in respect of this evidence, perhaps because there was other evidence which cast doubt upon its reliability. Just 9 days after the incident in August 2019, Person A chose to start living with Dr Mok. The MPT found, contrary to Person A's evidence, that the timing of the complaint to the GMC, on the day Dr Mok ended their relationship in December 2019, "suggests that the complaint was a direct reaction to Dr Mok leaving" (paragraph 15 of the determination on facts).

90. Paragraph 109(f) refers to:

> "Offences of a sexual nature, including involvement in child sex abuse materials (see further guidance below at paragraphs 151 - 159)."

91. In my view, the GMC was mistaken in submitting that this sub-paragraph applied to Dr Mok. It is clear from paragraphs 151 – 159 of the SG that it refers to "Sex offenders and child sex abuse materials". The SG describes, at paragraph 149, the wide range of different types of sexual misconduct.

92. The MPT correctly had regard to paragraph 150 of the SG which states that "sexual misconduct seriously undermines public in the profession". It goes on to identify types of sexual misconduct that are "particularly serious" where erasure is likely to be appropriate. It is clear that Dr Mok did not fall within those categories of sexual misconduct either.

93. Paragraph 106(j) refers to:

> "Persistent lack of insight into the seriousness of their actions or the consequences."

94. As I have already indicated, the MPT had the issue of insight well in mind, and found that Dr Mok had not demonstrated adequate insight, which was an aggravating factor.

95. In my judgment, the MPT had proper regard to the factors in paragraph 109 of the SG in reaching its decision. Furthermore, the reasons that the MPT gave for its findings and conclusions on these issues were sufficient and intelligible.

96. The GMC went on to submit that, the presence of any one of the factors in paragraph 109 may indicate that erasure is appropriate. Therefore the MPT was required to do more than assert that erasure would be disproportionate and should have explained why suspension was sufficient despite the authoritative steer in the SG. This was an error of principle or a failure to give adequate reasons for the decision: see the judgment of Collins Rice J. in *Bramhall* (cited above).

97. In my view, it is important not to lose sight of the fact that the SG is a guide to decision-making by MPTs, not a tariff which prescribes the sanction to be imposed. Paragraph 67 of the SG envisages that a sanction may be imposed which is higher or lower than that suggested by the SG. As paragraph 109 of the SG states, the factors listed therein "may indicate erasure is appropriate" (e*mphasis added)*; erasure is not mandatory where one or more of those factors is found. A MPT is a specialist tribunal whose members

are entrusted by Parliament to impose such sanction "as they think fit" under section 35D(2) MA 1983. The language of the subsection indicates that MPTs have a wide discretion. As the courts have recognised, this involves a multi-factorial evaluative judgment, based on the evidence before it, including its assessment of the registrant. After a 6 day hearing, the MPT had a greater knowledge and understanding of this case, and were better equipped to form a judgment about Dr Mok, than this Court, or Mr Hare QC and the GMC officers who bring this appeal.

98. In this case, the MPT expressly stated that it had taken the SG into account in reaching its decision (paragraph 14). It followed the proportionate approach advised by the SG at paragraph 20, beginning with the least restrictive sanction and working upwards. It identified the mitigating and aggravating factors. As I have found, it had proper regard to the specific guidance on suspension and erasure. It undertook a careful weighing and balancing of what it considered to be the competing considerations, and concluded, at paragraph 29 of the determination, that Dr Mok's misconduct fell just short of being fundamentally incompatible with continued registration. At paragraph 30 of the determination, the MPT correctly reminded itself of the need to act proportionately and to impose the least restrictive sanction that met the public interest, and concluded that suspension for 12 months would adequately mark the seriousness of the misconduct and maintain public confidence. There was no error in principle in the MPT's reasoning or approach. The fact that the GMC officers would have made a different evaluation does not justify interfering with the judgment made by the MPT.

99. In my view, the MPT's reasons for its decision, in particular, the imposition of a suspension order rather than erasure, were adequate and met the required standard. Generally, I consider that the GMC sought to impose too high a standard for the drafting of reasons by a disciplinary tribunal.

100. Therefore Ground 2 does not succeed.

Ground 3

101. Under Ground 3, the GMC submitted that the order of suspension was unreasonable, as it failed rationally to reflect the gravity of the misconduct and its own findings. Mr Hare QC referred to paragraph 40(vi) of the judgment in *Jagjivan* which stated "there may be matters, such as dishonesty or sexual misconduct, where the court "is likely to feel that it can assess what is needed to protect the public or maintain the reputation of the profession more easily for itself and thus attach less weight to the expertise of the tribunal…".

102. I agree with the observations of Murray J. in *General Medical Council v Ahmed* [2022] EWHC 403 (Admin), which was an appeal under section 40A MA 1983 against a suspension order:

> "67. I accept the submissions of Mr Hare on behalf of the GMC that in a case concerning sexual misconduct the Court will attach less weight to the expertise of the MPT, as is made clear in *Jagjivan* at [40(vi)]. I also bear in mind, however, that the decision to suspend a doctor rather than to erase him or her from the register is an evaluative decision based on many factors,

about which reasonable people may reasonably disagree. As such, there is limited scope for an appellate court to overturn it: *Bawa-Garba v GMC* at [61].

68. Although, for the reasons given by Mr Hare, it may be appropriate to give less deference to the decision of the MPT given the finding of sexually motivated misconduct by Dr Ahmed in relation to Patient B, nonetheless a significant degree of deference should be shown. The MPT will have had the advantage of all of the evidence considered during the course of the MPT Hearing, including oral evidence during the Factual Determination stage. In this regard, I note the comment of Sales LJ in *R (Smech Properties Ltd) v Runnymede Borough Council* at [29], which was set out in *Bawa-Garba v GMC* at [65] and quoted by me at [46] above. I also bear in mind the observation of Hoffmann LJ in *Re Grayan Building Services Ltd* at 254 that is quoted in *Bawa-Garba v GMC* at [64]. Although the MPT's factual assessment is not, *per se*, disputed by the GMC on this appeal, that factual assessment informed the multi- factorial decision that resulted in a sanction of suspension rather than erasure.

69. I also bear in mind the following observation of Laws LJ in *Raschid v GMC* at [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."

…

71. Dr Ahmed gave a reflective statement to the MPT before the Sanction Determination stage but did not attend to be cross-examined. I have noted at [55] above Mr Hare's reference to the comment of Yip J in *Yusuff v GMC* at [30] that it is difficult to assess issues such as remorse and insight on paper. I set against that, however, the observation of Sales LJ in *R (Smech Properties Ltd) v Runnymede Borough Council* at [29] that, even where a first instance court's determination is made on the basis of written evidence that is also available to the appellate court, as in the case of Dr Ahmed's reflective statement dated 20 October 2020, "it will often be appropriate for [the appellate] court to give weight to the assessment of the facts made by the judge below". Sales LJ goes on to make a number of related observations, all of which I bear in mind. The key point, in my view, is that I should be wary of differing from the MPT's multi-

> factorial decision on sanction given the extent of oral and written evidence that was available to the MPT, including Dr Ahmed's oral evidence (and the oral evidence of the other witnesses, factual and expert) at the Factual Determination stage."

103. As Mr Cridland rightly observed, the context in which the findings of fact were made in this case was nuanced and complex. The MPT, having heard and seen Person A and Dr Mok give evidence, was best placed to weigh the misconduct in that context. The MPT carefully considered the relevant competing considerations in respect of sanction. It appears from the terms of the determination that the choice between 12 months' suspension or erasure was finely balanced in the minds of the MPT. However, the MPT concluded that Dr Mok's misconduct fell just short of being fundamentally incompatible with continued registration, and that erasure would be disproportionate in the circumstances of this case.

104. As the Court of Appeal observed in *Bawa-Garba*, the decision of a tribunal that suspension rather than erasure is the appropriate sanction constitutes an evaluative decision based on many factors, and a kind of jury question about which reasonable people may disagree.

105. In the circumstances of this case, the MPT found that:

   i) the sanction of suspension would sufficiently mark the seriousness of the misconduct and protect public confidence in the profession;

   ii) the sanction of suspension would send a message to members of the profession that Dr Mok's misconduct was wholly unacceptable; and

   iii) the period of suspension would demonstrate to Dr Mok how far below the standards of behaviour expected of a doctor his conduct fell.

106. The MPT ordered a review before the end of the period of suspension, and advised that it may assist the reviewing tribunal if Dr Mok provides:

   i) evidence of insight and reflection;

   ii) evidence that he appreciates the gravity of the offence and the potential impact on the victim;

   iii) evidence that he has kept his medical knowledge and skills up to date; and

   iv) any other matters which Dr Mok would wish to bring to the Tribunal's attention.

107. No doubt the MPT had well in mind that the reviewing tribunal could decide to erase Dr Mok's registration, particularly if he failed to remediate his lack of insight into his conduct and its effect on Person A.

108. In my judgment, the MPT was reasonably entitled to reach these conclusions on the evidence before it, and it cannot be said that the MPT reached a decision on sanction which was not reasonably and properly open to it. This was not a case where the only sanction reasonably and properly open to the Tribunal was one of erasure.

109. Therefore Ground 3 does not succeed.

Conclusion

110. Grounds 1 to 3 do not succeed, and the appeal is dismissed.