Neutral Citation Number: [2024] EWHC 1330 (Admin)

Case No: AC-2023-LON-000195

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 14/06/2024

Before :

MR JUSTICE JULIAN KNOWLES

- -

Between :

DR ITRAT KHAN	**Appellant**
- and -	
GMC	**Respondent**

- -
- -

Vivienne Tanchel (instructed by **Medical Defence Union**) for the **Appellant**
Peter Mant (instructed by **GMC Legal**) for the **Respondent**

Hearing dates: 02 November 2023

- -

Approved Judgment

This judgment was handed down remotely at 10.30am on 14 June 2024 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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Mr Justice Julian Knowles:

Introduction

1. This is an appeal under s 40 of the Medical Act 1983 by the Appellant, Dr Itrat Khan, against the findings of the Medical Practitioners' Tribunal (MPT) on misconduct and impairment. On 2 March 2023 he was suspended for a period of six months and an immediate order imposed. There is no separate challenge to the decision on sanction, which stands or falls on the misconduct and impairment appeal.

2. The misconduct for which the suspension was imposed involved prescribing medication to, and accessing the records of a patient (Patient B) with whom the

Appellant initially was in a sexual relationship and later in a non-sexual emotional relationship. Patient B had a history of depression and drug addiction of which the Appellant was aware.

3. The Appellant is represented by Ms Tanchel. The GMC is represented by Mr Mant. As well as my notes, I have the audio recordings of the hearing which I have consulted whilst writing this judgment.

4. The number of grounds of appeal and the nature of the issues on this appeal have required careful consideration which has taken some time.

MPT process in outline

5. Before turning to the facts, and the issues on this appeal, I think it is helpful briefly to explain the MPT process.

6. Disciplinary proceedings for alleged misconduct against doctors before the MPT potentially have three stages (see rule 17, General Medical Council (Fitness to Practise) Rules Order of Council 2004 (SI 2004/2608), as amended) (the Fitness to Practise Rules):

   a. Stage 1: the Fact Stage, where the MPT determines whether the facts alleged against the doctor by the GMC, or any of them, have been proved:

   b. Stage 2: if it so finds, it moves to the Impairment Stage, where the MPT determines whether the doctor's fitness to practice is impaired;

   c. Stage 3: if it finds his/her fitness to practice is impaired, it moves to the Sanction Stage, where it decides on the appropriate sanction.

7. Before a finding of 'impairment' at Stage 2 can be made, the MPT must first conclude that the facts it has found at Stage 1 amount to 'misconduct'. That is by virtue of s 35C(2)(a), which provides:

> "A person's fitness to practise shall be regarded as 'impaired' for the purposes of this Act by reason only of –
>
> (a) Misconduct …"

8. Stage 2 therefore has two sub-stages: (a) misconduct; and (b) impairment. In other words, a finding of misconduct is a necessary but not sufficient condition for a finding of impairment. I will return later to how 'misconduct' and 'impairment' have been defined in the authorities.

9. In *Webberley v General Medical Council* [2023] EWHC 734 (Admin), Jay J said at [62]:

> "It is standard practice for the MPT to announce its decision on the issue of misconduct, including the seriousness of that misconduct, at the same time as its decision on impairment."

Factual background

10. The Appellant faced a three-week fitness to practice hearing which was heard in three parts. The hearing commenced on 11 April 2022. The second part began on 8 December 2022, and the final part restarted on 20 February 2023 concluding on 2 March 2023.

11. The hearing concerned two sets of allegations.

12. The first set alleged that the Appellant assaulted his wife on three separate occasions in 2018 and 2019 respectively. Of these, one was dismissed following a submission of no case to answer and the remaining two were found not proven at the end of the Fact Stage of the proceedings, and so I need not say any more about them.

13. The second set (with which this appeal is concerned) alleged that the Appellant had inappropriately accessed Patient B's clinical records and prescribed him medication whilst in a relationship with him and knowing he was vulnerable.

14. At the start of the hearing, the Appellant admitted all but one of the allegations relating to Patient B. The one which was not was admitted at the outset (allegation 5) was subsequently amended during the course of the hearing, and the Appellant admitted it as amended.

15. As so amended, the allegations were as follows:

> "3. On one or more occasions as detailed in Schedule 1, you prescribed medication to Patient B.
>
> *(Admitted and found proved)*
>
> 4. On one or more occasions as listed in Schedule 2, you accessed Patient B's medical records without good reason.
>
> *(Admitted and found proved)*
>
> 5. Between 18 July 2018 and 30 January 2019:
>
> a. you were in a sexual and/or emotional relationship with Patient B;
>
> *(Admitted and found proved)*
>
> b. you knew that Patient B was vulnerable by reason of his history of:
>
> i. depression;
>
> *((Admitted and found proved))*
>
> ii. drug addiction.
>
> *(Admitted and found proved)*
>
> 6. Your actions as described at paragraphs 3 and 4 were inappropriate by reason of paragraph 5.

(Admitted and found proved)"

16. The facts which gave rise to these allegations are as follows.

17. The Appellant was a GP who qualified in 1982. From 1987 until 2019, when he retired, he practiced as a partner at the Lattimore and Village Surgery. The surgery had a patient list of some 10,000 patients.

18. The Appellant was married with children.

19. In his witness statement for the MPT, which he adopted (and to which the following paragraph numbers refer), the Appellant said that, in the course of his marriage, he began to notice that he had emotional feelings towards men [5].

20. In October 2017 he met Patient B via a dating app. They were soon in a relationship which the Appellant hid from people he knew [6].

21. In May 2018 Patient B was in danger of homelessness; the Appellant invited him to move into an annex in the garden of his house [8].

22. The Appellant was aware of Patient B's drug addiction. He asked Patient B to promise not to bring drugs to the annex [8]. However, by late June/July 2018, the Registrant noticed changes in Patient B's behaviour which caused him to suspect that Patient B was abusing drugs [9].

23. Around this time, on 17 July 2018, Patient B registered as a patient at the Surgery. In his witness statement, the Appellant said that he sought to encourage Patient B to register with a different practice and told Patient B that he could not see him as a patient [10].

24. The Appellant said that [11]:

> "Once Patient B had joined my Surgery, I did end up making appointments for him, I feared he would book appointments with me and once he was on my list, I would be forced to see him or reveal my secret relationship. I also checked on the appointments he made just to make sure this did not happen."

25. The Appellant said that he thought he was 'caught between a rock and a hard place, being in love with someone, not being able to show my sexuality and trying to hold together a family …' [12].

26. In or around August 2018, the Appellant told Patient B that, if Patient B did not stop using drugs in the annex, he would end their relationship and require Patient B to leave. Patient B continued using drugs and the Appellant ended the relationship [13]. In response to this, Patient B took an overdose [14]. This is when the relationship stopped being sexual but continued as a close emotional relationship [30].

27. Around this time the Appellant's wife found out about his relationship with Patient B and their marriage ended acrimoniously.

28. As I have said, before the MPT, the Appellant admitted all of the allegations concerning his relationship with Patient B, specifically that he (a) accessed Patient B's records without good reason (allegation 3); (b) prescribed medication to Patient B

(allegation 4), (c) was in a sexual and/or emotional relationship with Patient B (allegation 5(a)); (d) knew Patient B was vulnerable by reason of his depression and drug addiction (allegation 5(b)); and (e) that his actions were inappropriate (allegation 6).

29. The prescribing (allegation 4) occurred on three occasions. In his witness statement, the Appellant offered the following explanations [476-478]:

a. 4 August 2018: prescriptions for (i) Benzoyl peroxide 5%/Clindamycin 1% gel (acne treatment), (ii) Lymecycline 408mg capsules (antibiotic treatment for acne), (iii) Naproxen 500mg tablets (non-steroidal anti-inflammatory):

> '"I recall my colleague Dr Richards asking me to assist her a prescription as her electronic log in was not working. I remember this distinctly as once I found out who the patient was I knew I should act differently."

b. 6 August 2018: prescription for Benzoyl peroxide 5%/Clindamycin 1% gel (acne treatment):

> "From the records it appears I was printing off a prescription. These were over the counter acne treatment; Du-ac. It is one product so perhaps my guard was not up sufficiently. I am not sure why I would have done this but it would have only been at his request."

c. 26 November 2018: Prescriptions for (i) Citalopram 20mg tablets (antidepressant), (ii) Lymecycline 408mg capsules (antibiotic treatment for acne), (iii) Naproxen 500mg tablets (non-steroidal anti-inflammatory), (iv) Ranitidine 150mg tablets (medication to reduce stomach acid):

> "I issued Patient B a repeat prescription. The usual process for this would have been that Patient B would have made a written request via the admin team and this would have been actioned by a duty doctor within 48 hours. At the time I recall thinking that none of the medications were controlled drugs but they were important. I did not feel I could stop citalopram for example due to risks of this being sudden withdrawal. I knew if it was left to Patient B to do it would not get done so I did it. I can see now that this was part of a pattern of manipulative behaviour, he would tell me had he run out but that he would not do anything to resolve this knowing that I would feel obliged to fix it."

30. The Appellant accessed Patient B's records on 19 days between 18 July 2018 and 30 January 2019. His reasons for doing so included the following:

a. Changing Patient B's pharmacy details because he knew Patient B would not make the effort to do so and would struggle without his medications (18/07/18, 29/10/18)

b. Making appointments, checking appointments, and sending an appointment letter (03/08/18, 5/09/18, 10/09/18)

c. Reading records to find out what happened at the appointment after Patient B took the overdose referred to above (14/09/18)

d. Checking whether there were entries in the records about Patient B having ADHD when he was a child (at Patient B's request) (08/08/18)

e. Printing prescriptions (04/08/18, 06/08/18, 26/11/18- as detailed above)

f. Checking if Patient B was still registered as a patient and taking steps to remove him (08/10/18, 12/10/18, 15/10/18, 19/11/18, 05/12/18, 30/01/18).

31. In his oral evidence before the MPT, the Appellant confirmed the accuracy of his witness statement and repeated similar explanations to those set out above (Evidence in Chief, D16/11-17).

32. In cross examination he said that he was 'put in a position where [he] could not speak the truth to [his colleagues]'; he confirmed that he felt 'trapped' and 'couldn't be truthful' (D16/28-29 [87-88]). He admitted lying, including telling a colleague that the man he had been in a relationship with had not been a patient of his. He accepted that he should have told his partners about his relationship with Patient B (D16/30). He said (D16/30):

> "Q. Then, what essentially is being said is you're being encouraged to tell your GP partners. Do you see that, three lines further down and then five lines further down:
>
> 'I gave Dr Khan ample opportunities to tell his business partners.'
>
> Q. Do you accept that through this period that we've just been looking at that you should have told your business partners ?
>
> A. Yes, yes. With hindsight, yes.
>
> Q. Did you choose not to tell them for the same reasons previously you said, you felt trapped?
>
> A. It was a very highly emotionally difficult period for me. This was not an easy time at all. This was a complete out of character, abnormal situation that had never happened to me in my life. Whatever I did during this period was totally out of character for me, but yes, I agree I should have told my partners, and had I come out and said, "Yes, I'm gay, and I want a divorce," etc, etc, then, yes, I would have told the partners and whoever asked. I'm normally an open book and truthful. This was a highly emotionally difficult period of time."

The MPT's determination

33. The Appellant disputed that the facts as found amounted to misconduct and also that his fitness to practice was impaired.

34. In its submissions in support of findings of misconduct and impairment, the GMC submitted that the following paragraphs of *Good Medical Practice* (GMP; the then

current edition was first published in 2013, and it was revised in 2024) were relevant and had been breached:

a. Paragraph 1: Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues are honest and trustworthy, and act with integrity and within the law.

b. Paragraph 2: Good doctors work in partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual. They do their best to make sure all patients receive good care and treatment that will support them to live as well as possible, whatever their illness or disability.

c. Paragraph 16(g): In providing clinical care you must: wherever possible, avoid providing medical care to yourself or anyone with whom you have a close personal relationship.

d. Paragraph 47: You must treat patients as individuals and respect their dignity and privacy.

e. Paragraph 53: You must not use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them.

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

g. Paragraph 67: You must act with honesty and integrity when designing, organising or carrying out research, and follow national research governance guidelines and our guidance.

35. The GMC also contended that the Appellant had breached a number of paragraphs in the its *Good Practice in Prescribing and managing medicines and devices* and its *Maintaining personal and professional boundaries*, which broadly mirrored the relevant paragraphs of *Good Medical Practice* referred to earlier.

36. It was also submitted that the breaches had gone on for a substantial period of time and that they were serious. Counsel said (D20/5):

> "So it is very, very clear that any colleague would find the conduct deplorable, which is a word or test often deployed, and it would certainly undermine the reputation of the profession and public trust in the profession, if any reasonable and objective member of the public were looking at this situation. They would regard it very serious indeed, so serious misconduct, we submit, is clearly made out."

37. It was contended that the Appellant showed limited insight and had undertaken limited remediation.

38. The following submissions were made on behalf of the Appellant:

a. Conduct has to be 'egregious' or 'deplorable' to amount to serious misconduct.

b. The events here had taken place in a limited period of time in the context of a 30-year unblemished career.

c. They took place during an extraordinary time for the Appellant in which he was struggling in very difficult personal circumstances.

d. He maintained the support of his colleagues as evidenced by the testimonials written in his support.

e. The only paragraph of *Good Medical Practice* which was relevant was [16(g)].

f. The passage of time since these incidents occurred.

g. The Appellant's reflection and remediation as set out in his reflective statement.

h. Impairment can only be found on facts proven and there was no allegation, let alone it having been found proven, of lack of integrity.

39. The MPT determined that the Appellant's behaviour amounted to misconduct and that he is currently impaired (D21/1 onwards).

40. In its determination, it said:

> "18. The Tribunal noted that the facts found proved in this case were admitted by Dr Khan. On three occasions he prescribed medication to Patient B. Dr Khan also accessed Patient B's medical records on 19 dates between 18 July 2018 and 30 January 2019, and more than once some days. Dr Khan also admitted that between 18 July 2018 and 30 January 2019, he was in a sexual and/or emotional relationship with Patient B. However, the Tribunal noted that their relationship started prior to 18 July 2018 and at a time when Patient B was not a patient at the Surgery. Dr Khan also accepted that he knew Patient B was vulnerable given his history of depression and drug addiction, and he admitted that his actions as set out above were inappropriate."

41. It went on to say that:

a. The Appellant's personal difficulties did not 'justify or excuse his conduct'.

b. He had breached [1] of *Good Medical Practice* because accessing Patient B's medical records demonstrated a lack of integrity.

c. He had continued to engage in an improper relationship with Patient B, when Patient B became a patient at the Surgery. It was the continuation of this relationship with Patient B which amounted to pursuing. It should not be read that the Appellant had used his professional position to initiate or continue their relationship.

d. The Appellant had breached [65] of *Good Medical Practice* as his conduct undermined patients' trust in doctors and the public's trust in the profession.

42. On current impairment the Tribunal concluded that:

a. The Appellant had limited insight and his reflective statement indicated that he was minimising his conduct.

b. He had failed to appreciate in any detail how his conduct had a negative impact on the reputation and public confidence in the profession.

c. His reading and reviewing of *Good Medical Practice* was limited in scope and was insufficient to demonstrate adequate remediation.

43. The Tribunal could not rule out the risk of repetition.

The Law

44. Section 40 of the Medical Act 1983 gives a doctor a statutory right to appeal determinations on facts, impairment and sanction reached by an MPT. Such appeals are brought pursuant to CPR Part 52.

45. CPR r 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."

46. A Practice Direction has made such provision in respect of appeals under s 40. CPR PD 52, [19.1] provides:

> "19.1
>
> (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."

47. Whilst the appeal constitutes a rehearing, it is a rehearing without hearing again the evidence: *Fish v General Medical Council* [2012] EWHC 1269 (Admin), [28]-[32].

48. In *R (Dutta) v General Medical Council* [2020] EWHC 1974 (Admin), Warby J (as he then was) said at [21]:

> "(1) The appeal is not a re-hearing in the sense that the appeal court starts afresh, without regard to what has gone before, or (save in exceptional circumstances) that it re-hears the evidence that was before the Tribunal. 'Re-hearing' is an elastic notion, but generally indicates a more

intensive process than a review: *E I Dupont de Nemours & Co v S T Dupont (Note)* [2006] 1 WLR 2793 [92-98]. The test is not the 'Wednesbury' test.

(2) That said, the appellant has the burden of showing that the Tribunal's decision is wrong or unjust: *Yassin* [32(i)]. The Court will have regard to the decision of the lower court and give it 'the weight that it deserves': *Meadow* [128] (Auld LJ, citing *Dupont* [96] (May LJ)).

(3) A court asked to interfere with findings of fact made by a lower court or Tribunal may only do so in limited circumstances. Although this Court has the same documents as the Tribunal, the oral evidence is before this Court in the form of transcripts, rather than live evidence. The appeal Court must bear in mind the advantages which the Tribunal has of hearing and seeing the witnesses, and should be slow to interfere.
See *Gupta* [10], *Casey* [6(a)], *Yassin* [32(iii)].

(4) Where there is no question of a misdirection, an appellate court should not come to a different conclusion from the tribunal of fact unless it is satisfied that any advantage enjoyed by the lower court or tribunal by reason of seeing and hearing the witnesses could not be sufficient to explain or justify its conclusions: *Casey* [6(a)].

(5) In this context, 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: *Yassin* [32(v)].

(6) The appeal Court should only draw an inference which differs from that of the Tribunal, or interfere with a finding of secondary fact, if there are objective grounds to justify this: *Yassin* [32(vii)].

(7) But the appeal Court will not defer to the judgment of the tribunal of fact more than is warranted by the circumstances; it may be satisfied that the tribunal has not taken proper advantage of the benefits it has, either because reasons given are not satisfactory, or because it unmistakably so appears from the evidence: *Casey* [6(a)] and cases there cited, which include *Raschid* and *Gupta* (above) and *Meadow* [125-126], [197] (Auld LJ). Another way of putting the matter is that the appeal Court may interfere if the finding of fact is 'so out of tune with the evidence properly read as to be unreasonable': *Casey* [6(c)], citing *Southall* [47] (Leveson LJ).”

49. CPR r 52.21(3) provides:

> "(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.
>
> (4) The appeal court may draw any inference of fact which it considers justified on the evidence."

50. I now come back to the meaning of 'misconduct'.

51. In *Adil v General Medical Council* [2023] EWCA Civ 1261, [75], Popplewell LJ said:

> "The expression 'misconduct' involves a standard of behaviour falling short of what is proper or reasonably to be expected of a doctor in the circumstances: *Roylance v General Medical Council (No 2)* [2000] 1 AC 311 at p331B."

52. The passage cited from *Roylance* (a decision of the Privy Council) is this:

> "Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances."

53. I was referred to *General Medical Council v Meadow* [2007] QB 462, which considered the change in wording in the statutory provision from 'serious professional misconduct' to 'misconduct':

> "197. On an appeal from a determination by the GMC, acting formerly and in this case through the FPP, or now under the new statutory regime, whatever label is given to the section 40 test, it is plain from the authorities that the Court must have in mind and give such weight *as is appropriate in the circumstances* to the following factors:
>
> i) The body from whom the appeal lies is a specialist tribunal whose understanding of what the medical profession expects of its members in matters of medical practice deserve respect;
>
> ii) The tribunal had the benefit, which the Court normally does not, of hearing and seeing the witnesses on both sides;
>
> iii) The questions of primary and secondary fact and the over-all value judgement to be made by tribunal, especially the last, are akin to jury questions to which there may reasonably be different answers.

> 198. As to what constitutes "serious professional misconduct, there is no need for any elaborate rehearsal by this Court of what, on existing jurisprudence, was capable of justifying such condemnation of a registered medical practitioner under the 1983 Act before its 2003 amendment. And, given the retention in the Act in its present form of section 1(1A), setting out the main objective of the GMC "to protect, promote and maintain the health and safety of the public", it is inconceivable that "misconduct" - now one of the categories of impairment of fitness to practise provided by section 35C of the Act - should signify a lower threshold for disciplinary intervention by the GMC.
>
> 199. It is common ground that Professor Meadow in giving and/or purporting to give, expert medical evidence at the trial of Mrs Clark, was engaged in conduct capable of engaging the disciplinary attention of the GMC.
>
> 200. As Lord Clyde noted in *Roylance v General Medical Council* [2000] 1 AC 311, PC, at 330F- 332E, "serious professional misconduct" is not statutorily defined and is not capable of precise description or delimitation. It may include not only misconduct by a doctor in his clinical practice, but misconduct in the exercise, or professed exercise, of his medical calling in other contexts, such as that here in the giving of expert medical evidence before a court. As Lord Clyde might have encapsulated his discussion of the matter in *Roylance v Clyde,* it must be linked to the practice of medicine or conduct that otherwise brings the profession into disrepute, and it must be serious. As to seriousness, Collins J, in *Nandi v General Medical Council* [2004] EWHC (Admin), rightly emphasised, at paragraph 31 of his judgment, the need to give it proper weight, observing that in other contexts it has been referred to as 'conduct which would be regarded as deplorable by fellow practitioners'".

54. Mr Mant for the GMC was content to accept this formulation. He said misconduct must fall below expected standards and must be serious. This is how the MPT were directed by their Legal Assessor

55. In *Webberley v General Medical Council* [[2023] EWHC 734 (Admin) Jay J gave the following helpful summary of the relevant case law:

> "65. The parties have referred me to the well-known jurisprudence in this area. In the circumstances, I will limit my consideration to the two most recent authorities.
>
> 66. In *Sastry and Okpara v GMC* [2021] EWCA Civ 623; [2021] 1 WLR 5029, the Court of Appeal (Nicola Davies LJ giving the sole reasoned judgment) reviewed the authorities which are typically cited in section 40 appeals. Her conclusions may be summarised as follows:

(1) This Court exercises an appellate and not a review function (paras 101; 102(ii)).

(2) The appeal is by way of rehearing, and the Court is fully entitled to substitute its own decision for that of the MPT (para 102(iii)).

(3) The appellate court will not defer to the judgment of the MPT more than is warranted in the circumstances (para 102(iv)).

(4) The appellate court must decide whether the sanction imposed was appropriate and necessary in the public interest, or was excessive and disproportionate (para 102(v)).

(5) In the latter event, the appellate court should substitute some other penalty or remit the case to the MPT for reconsideration (para 102(vi)).

67. Item (3) above has, in the past, given rise to the most difficulty. A degree of deference to the expert judgment of the MPT is required (paras 103 and 104), but how much is required will depend on the circumstances and on the issue under consideration. For example, the Divisional Court in *GMC v Jagjivan* [2017] EWHC 1247 (Admin); [2017] 1 WLR 4438, in the context of an appeal under section 40A of the Medical Act 1983, stated that where the issue is dishonesty or sexual misconduct the appellate court may feel that it can assess for itself what is required in the public interest more easily than in other areas.

68. I accept Mr Mant's submission that in circumstances where the MPT has made multi-factorial decisions on the basis of nuanced assessments of fact and complex expert evidence, the appellate court should be diffident. How diffident, I would add, will depend.

69. At paras 107 and 108 of her judgment in *Sastry*, Nicola Davies LJ referred to the decision of the Court of Appeal in *Bawa-Garba v GMC* [2018] EWCA Civ 1879; [2019] 1 WLR 1929, in particular to para 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.'

70. However, and as Nicola Davies LJ pointed out, para 67 of *Bawa-Garba* is appropriate only to reviews under section 40A of the Medical Act 1983 and not to appeals under section 40 (para 108). In the latter context, the Court applies its own judgment, according deference or diffidence to the extent appropriate.

71. In *Sawati v GMC* [2022] EWHC 283 (Admin), Collins-Rice J, after summarising the principles in *Sastry*, added the following helpful assistance:

> "48. Since the degree of warranted deference depends on case-specific circumstances, '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'. I am reminded of guidance in *Gupta v GMC* [2002] 1 WLR 1691 at paragraph 10 that the Tribunal has an advantage because it has had a better opportunity to judge the credibility and reliability of oral evidence given by witnesses.
>
> 49. Another important factor in the degree of deference is the expert composition of the Tribunal. Where the appellate court lacks the Tribunal's professional expertise, it must approach a challenge that a Tribunal has made 'wrong' decisions about what is necessary to protect the public, and maintain public confidence and proper standards in the profession, with a degree of 'diffidence'. But there may be matters (dishonesty or sexual misconduct are examples) 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 (*GMC v Jagjivan* [2017] EWHC 1247 (Admin), [2017] 1 WLR 4438, at paragraphs 39-40)."

Misconduct

72. Here, the relevant principles are well-established and are not in dispute. Again, the Legally Qualified Chair directed the MPT correctly. In short, in *Roylance v GMC* (No 2) [1999] UKPC 16; [2000] 1 AC 311, Lord Clyde giving the opinion of the Privy Council stated:

> ‘37. The expression "serious professional misconduct" is not defined in the legislation and it is inappropriate to attempt any exhaustive definition. It is the successor of the earlier phrase used in the Medical Act 1858 "infamous conduct in a professional respect", but it was not suggested that any real difference of meaning is intended by the change of words. This is not an area in which an absolute precision can be looked for. The booklet which the General Medical Council have prepared on Professional Conduct and Discipline: Fitness to Practise, December 1993 indeed recognises the impossibility in changing circumstances and new eventualities of prescribing a complete catalogue of the forms of professional misconduct which may lead to disciplinary action. Counsel for the appellant argued that there must be some certainty in the definition so that it can be known in advance what conduct will and what will not qualify as serious professional misconduct. But while many examples can be given the list cannot be regarded as exhaustive. Moreover the Professional Conduct Committee are well placed in the light of their own experience, whether lay or professional, to decide where precisely the line falls to be drawn in the circumstances of particular cases and their skill and knowledge requires to be respected. However the essential elements of the concept can be identified.
>
> 38. Serious professional misconduct is presented as a distinct matter from a conviction in the British Islands of a criminal offence, which is dealt with as a separate basis for a direction by the committee in section 36(1) of the Medical Act 1983. Analysis of what is essentially a single concept requires to be undertaken with caution, but it may be useful at least to recognise the elements which the respective words contribute to it. Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances. The misconduct is qualified in two respects. First, it is qualified by the word "professional" which links the misconduct to the profession of medicine. Secondly, the misconduct is qualified by the word "serious". It is not any professional misconduct which will

qualify. The professional misconduct must be serious. …'

73. At para 39 of his judgment in *Calhaem v GMC* [2007] EWHC 2606 (Admin), Jackson J distilled two principles from the authorities:

'(1) Mere negligence does not constitute "misconduct" within the meaning of section 35C(2)(a) of the Medical Act 1983. Nevertheless, and depending upon the circumstances, negligent acts or omissions which are particularly serious may amount to "misconduct".

(2) A single negligent act or omission is less likely to cross the threshold of "misconduct" than multiple acts or omissions. Nevertheless, and depending upon the circumstances, a single negligent act or omission, if particularly grave, could be characterised as "misconduct".'

Impairment

74. Here, the relevant principles are those set out by Silber J in *Cohen v GMC* [2008] EWHC 581 (Admin), at paras 62-66:

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

63. I must stress that the fact that the stage 2 is separate from stage 1 shows that it was not intended that every case of misconduct found at stage1 must automatically mean that the practitioner's fitness to practice is impaired.

64. There must always be situations in which a Panel can properly conclude that the act of misconduct

> was an isolated error on the part of a medical practitioner and that the chance of it being repeated in the future is so remote that his or her fitness to practice has not been impaired. Indeed the Rules have been drafted on the basis that the once the Panel has found misconduct, it has to consider as a separate and discreet exercise whether the practitioner's fitness to practice has been impaired. Indeed section 35D(3) of the Act states that where the Panel finds that the practitioner's fitness to practice is not impaired, "they may nevertheless give him a warning regarding his future conduct or performance".
>
> 65. Indeed I am in respectful disagreement with the decision of the Panel which apparently concluded that it was not relevant at stage 2 to take into account the fact that the errors of the appellant were "easily remediable". I concluded that they did not consider it relevant at stage because they did not mention it in their findings at stage 2 but they did mention it at stage 3. That fact was only considered as significant by the Panel at a later stage when it was dealing with sanctions. It must be highly relevant in determining if a doctor's fitness to practice is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated. These are matters which the Panel should have considered at stage 2 but it apparently did not do so.
>
> 66. The Panel must, for example, contrary to Miss Callaghan's submissions be entitled, if not obliged, to consider if the misconduct is easily remediable in the case of the doctor concerned. If this is not so, the Panel would be precluded from considering that it was not because the doctor has psychiatric or psychological problems which mean that he will be unable to remedy the misconduct and is likely to repeat it.'"

56. I was also referred to *R (Remedy UK) v General Medical Council* [2010] EWHC 1245 (Admin) and *Spencer v General Osteopathic Council* [2013] 1 WLR 1307. In the latter case, Irwin J (as he then was) said at [23]:

> "23. In my judgment, the starting point for interpreting the Osteopaths Act 1993 must be the language of the Act itself. Although one notes that "unacceptable professional conduct" has the definition in Section 20 (2) : "conduct which falls short of the standard required of a registered osteopath", there is an unhelpful circularity to the definition. Indeed one might not unfairly comment that the statutory definition adds little clarity. The critical term is "conduct". Whichever dictionary definition is consulted, the leading sense of the term "conduct" is behaviour, or

> the manner of conducting oneself. It seems to me that at first blush this simply does imply, at least to some degree, moral blameworthiness. Whether the finding is "misconduct" or "unacceptable professional conduct", there is in my view an implication of moral blameworthiness, and a degree of opprobrium is likely to be conveyed to the ordinary intelligent citizen. That is an observation not merely about the natural meaning of the language, but about the likely effect of the finding in such a case as this, given the obligatory reporting of the finding under the Act."

57. In *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), [31], Collins J observed that in other contexts misconduct has been described as 'conduct which would be regarded as deplorable by fellow practitioners.'

58. At the beginning of this judgment I explained the inter-relationship between misconduct and impairment at Stage 2 of the MPT process by reference to s 35C of the MA 1983. In *Cheatle v General Medical Council* [2009] EWHC 645 (Admin), [19], [22], Cranston J said:

> "19. Whatever the meaning of impairment of fitness to practice, it is clear from the design of section 35C that a panel must engage in a two-step process. First, it must decide whether there has been misconduct, deficient professional performance or whether the other circumstances set out in the section are present. Then it must go on to determine whether, as a result, fitness to practice is impaired. Thus it may be that despite a doctor having been guilty of misconduct, for example, a Fitness to Practice Panel may decide that his or her fitness to practice is not impaired.
>
> …
>
> 22. In my judgment this means that the context of the doctor's behaviour must be examined. In circumstances where there is misconduct at a particular time, the issue becomes whether that misconduct, in the context of the doctor's behaviour both before the misconduct and to the present time, is such as to mean that his or her fitness to practice is impaired. The doctor's misconduct at a particular time may be so egregious that, looking forward, a panel is persuaded that the doctor is simply not fit to practice medicine without restrictions, or maybe at all. On the other hand, the doctor's misconduct may be such that, seen within the context of an otherwise unblemished record, a Fitness to Practice Panel could conclude that, looking forward, his or her fitness to practice is not impaired, despite the misconduct."

59. Also relevant on impairment is this passage from *CHRE v NMC and Grant* [2011] EWHC 927 (Admin) at [74], where Cox J said that Panels:

> "… should generally consider not only whether the practitioner continues to present a risk to members of the

> public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances". At [76], she referred to Dame Janet Smith's test as set out in the Fifth Report from The Shipman Enquiry, namely:
>
> > 'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that s/he:
> >
> > a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or
> >
> > b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or
> >
> > c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or
> >
> > d) has in the past acted dishonestly and/or is liable to act dishonestly in the future'."

60. In *Yeong v General Medical Council* [2009] EWHC 1923 (Admin) at [50], Sales J (as he then was) observed the following:

> 'Where a medical practitioner violates such a fundamental rule governing the doctor/patient relationship as the rule prohibiting a doctor from engaging in a sexual relationship with a patient, his fitness to practise may be impaired if the public is left with the impression that no steps have been taken by the GMC to bring forcibly to his attention the profound unacceptability of his behaviour and the importance of the rule he has violated. The public may then, as a result of his misconduct and the absence of any regulatory action taken in respect of it, not have the confidence in engaging with him which is the necessary foundation of the doctor/patient relationship. The public's confidence in engaging with him and with other medical practitioners may be undermined if there is a sense that such misconduct may be engaged in with impunity."

61. In considering the overall approach to how an MPT Determination is to be read, in *Cascioli v v Nursing and Midwifery Council* [2024] EWHC 1109 (Admin), Hill J said at [31]:

> "It is important to avoid 'narrow textual analysis when considering the reasoning of any tribunal, especially one not composed of professional judges'; and to read a decision of this kind 'fairly, and as a whole, to assess the

sufficiency of its reasoning': see, for example, *General Medical Council v Saeed* [2020] EWHC 830 (Admin) at [75] and *General Medical Council v Awan* [2020] EWHC 1553 (Admin) at [26]."

Grounds of appeal

62. The grounds of appeal against the findings of misconduct and impairment are as follows:

    a. Ground 1: The Tribunal erred in relying on [1] and [53] of *Good Medical Practice* when concluding that Dr Khan's behaviour amounted to misconduct.

    b. Ground 2: The Tribunal's finding of misconduct is inconsistent with its acceptance of Dr Khan's account on his reasons for writing the prescriptions.

    c. Ground 3: The Tribunal erred in rejecting the proposition that Dr Khan's genuine personal difficulties explained and/or justified his conduct.

    d. Ground 4: The Tribunal erred in adopting the definition of "pursue" as set out in its determination.

    e. Ground 5: The Tribunal erred in conflating the issues relevant to misconduct with those relating to impairment and thus did not approach the issues in the two stage process identified in the jurisprudence.

    f. Ground 6: The Tribunal made a finding of impairment on matters of facts which had not been alleged and were therefore unproven.

    g. Ground 7: Dr Khan is not a risk to the public and the Tribunal failed to give proper weight to the context of his admitted failings.

    h. Ground 8: Further or alternatively, the Tribunal failed to provide any or any adequate reasons as to why it rejected Dr Khan's reflection as genuine or that the remediation undertaken by him was insufficient.

    i. Ground 9: Further or alternatively, the Tribunal's determination failed to identify what further steps they would have expected Dr Khan to undertake in order to be persuaded of his full remediation.

    j. Ground 10: Further or alternatively the Tribunal did not give adequate weight to Dr Khan's full and timeous acceptance of the allegations.

63. Ms Tanchel did not pursue ground 5.

Submissions

64. In the development of her grounds of appeal, on behalf of the Appellant, Ms Tanchel submitted orally and in her Skeleton Argument as follows.

65. Her over-arching submissions was that what the Appellant did was not *serious* misconduct given all the circumstances.

66. On prescribing, the MPT had not disbelieved his account. He had been in an unavoidable situation. The guidance does not absolutely prohibited prescribing for

those in an emotional relationship. The third 26 November 2018 prescription was more serious than the other two, but overall what he had done was not 'deplorable'.

67. She said the MPT erred in its finding that the behaviour had gone on for an extended period of time, in circumstances where the period is one of three months.

68. In relation to accessing records, Ms Tanchel said there was no evidence of any impact on Patient B. It was him who wanted to be a patient at the Appellant's surgery in the first place. On almost all of the occasions on which Dr Khan accessed the records he did not perform any actions or undertake any steps in the care of Patient B.

69. She said the MPT erred in determining that [1] of *Good Medical Practice* was relevant in this case. His behaviour had been inappropriate but he had not acted without integrity and they had been wrong so to find. There should have been an express averment in the allegation to that effect and the absence of such meant the MPT could not so conclude.

70. She said that the MPT's determination in respect of the guidance at [4] of 'Maintaining a Professional Boundary between you and your patient' (March 2013) which states 'You must not pursue a sexual or improper emotional relationship with a current patient" (and mirrors [53] of *GMP*), was erroneous in the circumstances of this case. She said the MPT had taken an overly strict definition to the word 'pursuing' by treating as meaning (in this case) 'continuing'."

71. It was submitted that the MPT gave inappropriate limited weight to the circumstances faced by the Appellant at the relevant time. The MPT found that his 'genuine' difficult circumstances did not excuse or justify his misconduct but failed to provide any reasons as to why not.

72. Turning to impairment, the MPT failed to give any indication of how it perceived the Appellant's oral evidence in its Determination on the Facts. This denied him an opportunity to fully understand how seriously the MPT considered his admitted failings to be and therefore an opportunity to address them at Stage 2.

73. By accepting the Appellant's evidence at the Facts Stage (Stage 1) but then saying in Stage 2 he had sought to minimise was inconsistent. The MPT should have given notice in its Factual Determination that this was to be its approach so that the Appellant had an opportunity to address it at Stage 2.

74. Furthermore, it is submitted that the Tribunal erred in concluding that Paragraph [13] of the Appellant reflective statement did not provide detail of the impact of his conduct on the reputation of the profession. They took too narrow an approach and did not give sufficient reasons.

75. The MPT concluded that Dr Khan's remediation was insufficient yet failed to provide any or any sufficient reasons as to why.

76. The MPT failed to take into account the context of the Appellant's conduct. They failed to acknowledge that the confluence of circumstances that occurred at the time.

77. Moreover, the MPT Tribunal erred in attributing no weight to Dr Khan's early admissions of his failings.

78. In response, on behalf of the GMC Mr Mant submitted that the MPT did not err in its approach and its judgment could not be faulted and was not wrong. I should approach the MPT's judgment on whether what the doctor had done was serious

misconduct and whether he was impaired with appropriate deference. He cited, for example, *Meadow v General Medical Council* [2007] QB 462 at [197], where Auld LJ said that an appeal court must have in mind and give such weight as is appropriate in the circumstances to the following factors:

> "(i) The body from whom the appeal lies is a specialist tribunal whose understanding of what the medical profession expects of its members in matters of medical practice deserve respect. (ii) The tribunal had the benefit, which the court normally does not, of hearing and seeing the witnesses on both sides. (iii) The questions of primary and secondary fact and the overall value judgment to be made by the tribunal, especially the last, are akin to jury questions to which there may reasonably be different answers."

79. The Appellant could have avoided prescribing for Patient B by refusing to do anything and explaining confidentially to his partners why he could not. Prescribing did not stand alone but had to considered alongside his accessing of Patient B's records over six months from July 2018 until January 2019. The Tribunal was right to find that the misconduct occurred over a sustained period. Irrespective of any impact (or not) on Patient B, accessing his records had been inherently serious.

80. The Tribunal had been entitled to find what the Appellant had done lacked integrity, given the accepted definition of that term (see *Wingate v Solicitors Regulation Authority* [2018] EWCA Civ 366, [97], [101]), and there had been no need for an express averment.

81. Regarding 'pursuit', the MPT had not erred and having regard to the GMC's overarching objective had been right to treat 'pursuing' in the relevant Guidance as meaning 'continuing'.

82. The MPT had taken proper account of the Appellant's personal circumstances but was right to find as they did because a doctor is always required to put compliance with professional standards ahead of their personal interests.

83. In relation to impairment, there could be no criticism of the MPT's approach. It did not need to pass comment on the Appellant's acceptance of the allegations re Patient B and the rules did not require it. There had been nothing inconsistent about the MPT's approach in accepting his evidence and saying he had minimised aspects of his conduct.

84. The MPT had been right to find that the Appellant had failed to appreciate in any detail the negative impact of his actions on the reputation of the profession. There was, for example, no recognition of the inherent seriousness of a registered doctor prescribing for, and accessing the records of, a vulnerable patient in the circumstances of the Appellant and Patient B.

85. In relation to remediation, the MPT's reasons had been clear and they had been entitled to conclude the steps he had taken were insufficient.

86. In relation to context, the MPT had not fail to take into account the context in which the Appellant's misconduct occurred and had been entitled to find that a risk of repetition could not be ruled out if similar circumstances arose.

87. Finally in relation to the Appellant's early admissions, Mr Mant said it was wrong that admissions were made at the start of the local investigation. He said the Appellant had made 'piecemeal' admissions and initially denied matters that he eventually admitted.

Discussion

Introduction

88. This is a case about how the Appellant went about his clinical practice. It is not concerned with matters not directly related to clinical practice (eg sexual misconduct), where the Court is more free to make its own assessment, as I explained earlier. I therefore accept that I should approach the MPT's decision with due deference for the reasons given by Mr Mant.

89. I consider that the MPT was properly directed as to the law, in particular about the meaning of 'misconduct' by reference to the relevant authorities, including in particular *Roylance*. They were told that they had to find the misconduct to be serious. They were also told that behaviour that is trivial, or inconsequential, or is a mere temporary lapse, or is something that is otherwise excusable or forgivable is not misconduct.

90. During the hearing I queried with Mr Mant about whether 'serious' should be read into the statutory test, but as I have said, he was content to accept that it should. I therefore adopt that approach to the MPT's findings.

91. Applying this approach, I do not consider it can be said that the MPT's decision was 'wrong'. Approaching the matter with the necessary deference, I do not think that the MPT made any material errors of fact; it applied the correct law; and it had regard to all relevant considerations. Its key conclusion on misconduct was at [29] when it said:

> "29. Given the Tribunal's findings, the requirements of GMP and the guidance set out above, the Tribunal determined that fellow members of the profession and members of the public would regard Dr Khan's misconduct as significantly below the standards expected of the medical profession and as such his misconduct was serious."

92. I will divide my analysis into two parts. First, the submissions in relation to misconduct, then those in relation to impairment.

Submissions on misconduct

93. I turn first to the Appellant's submissions that that his actions did not breach the requirements of *GMP* because they were 'unavoidable' . Paragraph 1 of GMP provides:

> "1. Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues,1 are honest and trustworthy, and act with integrity and within the law."

94. I completely accept that he was in a very difficult personal position. The Tribunal acknowledged this at [18], which I quoted earlier, and [19] (I will set them both out together for convenience):

> "18. The Tribunal noted that the facts found proved in this case were admitted by Dr Khan. On three occasions he prescribed medication to Patient B. Dr Khan also accessed Patient B's medical records on 19 dates between 18 July 2018 and 30 January 2019, and more than once some days. Dr Khan also admitted that between 18 July 2018 and 30 January 2019, he was in a sexual and/or emotional relationship with Patient B. However, the Tribunal noted that their relationship started prior to 18 July 2018 and at a time when Patient B was not a patient at the Surgery. Dr Khan also accepted that he knew Patient B was vulnerable given his history of depression and drug addiction, and he admitted that his actions as set out above were inappropriate
>
> 19. The Tribunal acknowledged that Dr Khan stated that he felt 'trapped' and unable to disclose his sexuality. However, these genuine difficulties do not justify or excuse his misconduct."

95. Like the MPT, I do not think he had to prescribe for Patient B. Whilst the Appellant was in a difficult personal position, there was nothing practically to prevent him refusing to prescribe and being open with colleagues (on a limited and confidential basis). The relevant paragraph of *GMP* ([97] of the current edition) refers to the need not to provide care for those with whom a doctor is in a relationship 'wherever possible'. The relevant paragraphs in 'Good practice in prescribing and managing medicines and devices' (April 2021) which are referenced in paragraph 16(g) of *GMP* (the version in force at the relevant time) state as follows:

> "67. Wherever possible, you must avoid prescribing for yourself or anyone you have a close personal relationship with.
>
> 68. If you prescribe any medicine for yourself or someone close to you, you must:
>
> a. make a clear record at the same time or as soon as possible afterwards; the record should include your relationship to the patient, where relevant, and the reason it was necessary for you to prescribe."

96. I consider that was the situation here. It was possible for the Appellant not to have provided care for Patient B even if he was a patient of the surgery. The MPT found that the Appellant had breached both [67] and [68] and it was right to do so.

97. In relation to prescribing, I agree with Mr Mant that the Appellant's actions in prescribing for Patient B on three occasions in August and November 2018 have to be considered alongside his actions in accessing records over a period of six-months (18 July 2018 to 30 January 2019). It would be artificial to divide it up. These actions all formed part of a course of conduct whereby the Appellant acted (prescribing, making

appointments, sending an appointment letter, changing pharmacy details, attempting to de-register the patient) and obtained information (checking appointments, reading records in relation to the overdose) in medical matters concerning a patient of his practice with whom he was in a sexual or emotional relationship. In the circumstances, the MPT was right to find that the misconduct occurred over a sustained period. This was a matter for their judgment which I do not think I should interfere with.

98. The most serious of the three prescribing incidents occurred on 26 November 2018, when the Appellant issued a repeat prescription for Patient B. If the prescribing matters had stood alone then I might have been persuaded that what the Appellant did was not serious misconduct. However, they do not. I consider the Appellant's actions in accessing Patient B's records on the whole to be more serious. I agree with the GMC's position that the absence of evidence from Patient B as to the impact that accessing records had on him does not detract from the inherent seriousness of the Appellant's conduct. On multiple occasions, he took positive steps when accessing the records. Mr Mant highlighted, for example, the Appellant's actions following Patient B's overdose, after which he saw another doctor, and the Appellant accessed the records thereafter. He said in his statement that on 14 September 2018:

> "Based on the records I believe I was reading what occurred at that appointment as this was after Patient B's overdose."

99. I turn to the Appellant's ground relating to the MPT's finding of a lack of integrity. In a different context, but still relevant, the Court of Appeal said in *Wingate v Solicitors Regulation Authority* [2018] EWCA Civ 366 at [97] and [102]):

> "97. In professional codes of conduct, the term 'integrity' is a useful shorthand to express the higher standards which society expects from professional persons and which the professions expect from their own members … The underlying rationale is that the professions have a privileged and trusted role in society. In return they are required to live up to their own professional standards.
>
> …
>
> 102. Obviously, neither courts nor professional tribunals must set unrealistically high standards, as was observed during argument. The duty of integrity does not require professional people to be paragons of virtue. In every instance, professional integrity is linked to the manner in which that particular profession professes to serve the public … "

100. The MPT said:

> "20. The Tribunal considered the following paragraphs from GMP are engaged:
>
> '1. Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with

> patients and colleagues, are honest and trustworthy, and act with integrity and within the law.'
>
> 21. With regards to paragraph 1 of GMP, given the facts found proved in this case, the Tribunal determined that Dr Khan lacked integrity in inappropriately accessing Patient B's medical records and prescribing for him."

101. I do not consider that the MPT erred in finding that the Appellant's actions demonstrated a lack of integrity. They as the expert tribunal were entitled to find that the proven conduct involved a breach of the professional standards expected of doctors and so amounted to a lack of integrity. As I have said, he admitted lying to them and on any view that shows a lack of integrity. The Appellant admitted that he had behaved 'inappropriately', but the MPT was entitled in its judgment to go further and make the finding that it did.

102. I come to the question of whether the absence of an express allegation that the Appellant's actions 'lacked integrity' precluded the MPT making the finding it did.

103. Rule 15(1)(a)(i) of the Fitness to Practice Rules provides:

> "(1) After an allegation or non-compliance matter has been referred to the MPTS for them to arrange for it to be considered by a Medical Practitioners Tribunal under rule 17 or 17ZA (as the case may be)—
>
> 104. (a) the Registrar shall give notice to the practitioner of
>
> 105. (i) the allegation against the practitioner and the facts upon which it is based; …

106. Rule 17(2)(k) provides (my emphasis):

> "(k) the Medical Practitioners Tribunal shall receive further evidence and hear any further submissions from the parties as to whether, on the *basis of any facts found proved*, the practitioner's fitness to practise is impaired;"

107. I quoted [1] of GMP earlier which requires doctors to act with integrity.

108. As I have said, the MPT's finding of lack of integrity was clearly founded on the alleged facts of accessing Patient B's records and prescribing for him.

109. Mr Mant said that the GMC was not required to plead every aggravating factor or breach of standards. It is not the usual practice of the GMC to particularise individual breaches of GMP, and there is no requirement in the Rules to do so.

110. *In Kearsey v NMC* [2016] EWHC 1603 (Admin) at [25], [38], Ouseley J said that

> "25 … the NMC bears the burden of proving the disputed facts of an allegation. I accept from that, as a general proposition, that the required particularisation of the allegation by charges means that particulars which are not charged cannot be relied on in relation to the allegation of misconduct. Fairness and significance determines how far

> particulars need to be broken down in separate charges. There are obviously instances where specific notice is required, as in *El-Baroudy*, but there may be others were particulars are sufficiently precise to give proper notice, even though they could be broken down further. I also consider that there may be circumstances where the nature of the defence or of mitigation may make such conduct admissible without particularisation, as I come to. General propositions are not universal rules devoid of context or qualification."

111. I do not consider there was any unfairness here. The facts were all admitted. There was no question here of the GMC trying at Stage 2 to rely on evidence outside the scope of the allegations made at Stage 1 in order to prove a lack of integrity. Its finding was founded entirely on the pleaded and admitted allegations. The Appellant could have been in no doubt what the GMC's case was against him, and he had ample opportunity to meet it. Counsel for the GMC expressly made reference to lack of integrity being part of its case on misconduct:

> "What this is not about, and I think I have said it once already and I will repeat it, this is not about the doctor's sexuality. The fact that one must not act as the doctor did in relation to someone who was your patient applies across the board. So the fact that the doctor gives his explanation as he does about the difficulties of coming out as a gay man and also the fact he did it whilst also having an affair, whilst those are explanations, they do not excuse, in any way, the breaches that occurred because the protections within Good medical practice, the guidance given, apply across the board irrespective of sexual orientation, age, race, anything and they must be held to and those standards must be declared and they must be upheld by yourselves.
>
> …
>
> Pausing there, we say the doctor here did not make Patient B their first concern. Ultimately, their first concern was the desire to hide the fact of the relationship. It also includes within paragraph 1 the key principles of being honest, trustworthy and acting with integrity. *We say here that the doctor has not acted with integrity by acting for his own reasons, his own motivations, and he accepted, did he not, that he misled his professional colleagues and effectively lied to them by omission when I was cross-examining him?*"

112. The Legal Assessor advised the MPT:

> "… you should take note of the standards set out in the GMC's Good medical practice. You must decide whether the misconduct is serious …
>
> ….

> The assessment of seriousness is a matter for you exercising your own skilled judgement on the facts and circumstances of the case, light of all the evidence before you and the submissions that you've heard. You are of course not bound by the parties' submissions. In considering misconduct and indeed impairment, if you get there, you must have regard to Rule 17(2)(k) which makes clear that your consideration cannot go beyond the scope of the facts found proved as per the amended allegations."

113. I consider that this advice was correct and the submission made on behalf of the Appellant is not made out.

114. I come to the submission about the MPT's treatment of the word 'pursue'. The MPT said at [22]-[23] of its Determination:

> "22. It also considered paragraph 4 from 'Maintaining a professional boundary between you and your patient' (March 2013). It stated:
>
> > '4 You must not pursue a sexual or improper emotional relationship with a current patient.'
>
> 23. The Tribunal noted that this paragraph is also engaged given that Dr Khan continued to engage in an improper relationship with Patient B, when Patient B became a patient at the Surgery. It was the continuation of this relationship with Patient B which amounted to pursuing. It should not be read that Dr Khan used his professional position to initiate or continue their relationship."

115. Paragraph 53 of the GMP said:

> "You must not use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them."

116. There is a slight difference in wording and emphasis between [4] and [53]. The latter emphasises the prohibition on a doctor using their position to 'pursue' a sexual relationship, whereas the former is arguably broader and is not limited to the use of position but simply imposes a blanket prohibition on doctors having sexual, etc, relationships with patients.

117. Paragraph 23 of Ms Tanchel's Skeleton Argument argued:

> "We submit that the correct definition to be applied to 'pursue' in this case is that of 'pursuit of a relationship" the commonly understood meaning of the word "pursue" in the context of a relationship is to chase after, to diligently seek. It is contended that the Tribunal fell into error in setting out that it meant to 'continue'."

118. I do not accept that the MPT fell into error in the way suggested. Its reading of 'pursuing' as including 'continuing' was entirely apt. Earlier I set out how a Determination is to be read, that is, 'fairly, and as a whole, to assess the sufficiency of its reasoning'. The relevant paragraphs of the relevant professional guidance are

plainly intended to make sure doctors do not have sexual, etc, relationships with their parents. The reasons for this prohibition are too obvious to need spelling out. It does not matter whether the doctor uses their position to initiate a relationship with a patient that did not exist before; or whether the sexual relationship already existed before the patient became a patient of the doctor. Both are prohibited.

119. As I see it, Ms Tanchel's formulation would exclude the latter from the scope of [4], and I cannot see the logic of this, or how it would protect patients, which is one of the overarching objectives of the GMC as set in s1(1A) and (1B) of the MA 1983, as is promoting and maintaining proper professional standards and conduct for members of the medical profession. Ms Tanchel's formulation would not advance the latter objective either.

120. I come next to the complaint that the MPT did not give enough weight to the circumstances faced by the Appellant. Ms Tanchel argued at [34] of her Skeleton Argument:

> "34. [The] Tribunal gave inappropriate limited weight to the circumstances faced by Dr Khan at the relevant time. The Tribunal found that his 'genuine' difficult circumstances did not excuse or justify his misconduct but failed to provide any reasons as to why not. A breach of GMP does not necessarily amount to misconduct. There are circumstances in which breaches of GMP does not amount to misconduct and thus a careful examination of the prevailing circumstances must be taken into account, including, it is submitted, consideration of the circumstances in which the Doctor found himself at the time of making the flawed decisions. The Tribunal failed to explain why in this case the genuine difficulties did not excuse or justify Dr Khan's behaviour."

121. I consider that the MPT properly took this factor into account, and it expressly said so (at [18]-[19] see above). What weight it attached to it was a matter for its professional judgment as was its determination whether or not it excused the Appellant's conduct. I do not accept the final sentence of Mr Tanchel's submission. The MPT spent a number of paragraphs (from [20]-[29]) carefully going through the relevant professional standards to explain itself. At bottom, as Mr Mant said, and as [1] of the GMP makes clear, a good doctor is required to put compliance with professional standards ahead of their personal interests. The Appellant was in a difficult position, to be sure, but there were options open to him which he did not take. And some or much of what he did, eg by accessing Patient B's records, was not necessary. The evaluation of what the Appellant had done amounted to the necessary serious misconduct was for the MPT to determine as a specialist tribunal (see *Meadow*)

Submissions on impairment

122. I now turn to the Appellant's submissions relating to impairment. For the following reasons, I am not satisfied that the MPT fell into error.

123. I set out the case law on impairment earlier. I did not understand there to be any challenge to the correctness of the advice tendered by its Legal Assessor, nor to the approach it adopted. It said at [31]:

> "31. In determining whether a finding of current impairment of fitness to practise is necessary, the Tribunal looked for evidence of remediation and insight, and the likelihood of repetition, balanced against the three elements of the overarching statutory objective."

124. The overarching statutory objective, which I referred to earlier, is in s (1A) and 1(1B) of the 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."

125. In relation to the submission that the MPT erred in failing to pass comment on the Appellant's oral evidence at Stage 1, I do not consider this is made out. Under Rule 17(2)(e) of the Fitness to Practise Rules, where allegations are admitted, the MPT is simply required to announce that the relevant facts have been found proved. There is not a provision that permits or requires the MPT then to give supplemental reasons at that stage.

126. I agree with Mr Mant that the MPT's finding that the Appellant minimised his actions in his written reflection was not inconsistent with its acceptance of his evidence on the domestic abuse allegations. It said:

> "32. The Tribunal considered Dr Khan's reflective statement in that he quotes the following.
>
> > 'When Patient B joined the surgery, he was asking me to be his GP. I told him that under no circumstances could I or would I treat him or prescribe new medication to him, as this would be a breach of my professional code of practice.'
> >
> > 'I wanted to help him as a friend in any way I could. I saw him going downhill and wanted to support him in getting help, whilst staying on the right side of my professional obligations. I wanted to 'help from the wings" but made it clear to him that I wouldn't do anything in breach of my professional obligations. Evidently, I've made a series of mistakes about where that line was, but I can honestly say that, at the time, I was trying to do the right thing personally and professionally.'

> 33. In relation to insight, the Tribunal noted that Dr Khan had admitted the allegations, and in his reflective statement there is some evidence of insight. However, the Tribunal was of the view that this insight was limited and appeared to seek to minimise his actions. For example, as set out above:
>
> > 'Evidently, I've made a series of mistakes about where that line was, but I can honestly say that, at the time, I was trying to do the right thing personally and professionally.'
>
> 34. The Tribunal found that there were other examples in his reflective statement where Dr Khan sought to minimise or excuse his actions, which the Tribunal did not find convincing. For example
>
> > 'At that time, I truly did not appreciate that I was doing would count as "prescription" within the meaning of my professional rules of conduct. I honestly did not have any lingering doubts about my actions at that time; and this was my mistake and lack of understanding on my part.'"

127. It was not inconsistent to accept his evidence, but then to find his added explanations had been attempts at minimisation. This formed part of its evaluative exercise conducted with the advantage of having seen the Appellant give evidence.

128. The next submission made by Ms Tanchel was that (Skeleton Argument, [38]) the MPT had erred in concluding that [13] of the Appellant's reflective statement did not provide detail of the impact of his conduct on the reputation of the profession. She contended that the MPT applied a very narrow definition. She argued:

> "38. Furthermore, it is submitted that the Tribunal erred in concluding that Paragraph 13 of Dr Khan's reflective statement did not provide detail of the impact of his conduct on the reputation of the profession. It is contended that they have applied a very narrow definition to the words on the page. In this paragraph, Dr Khan clearly sets out the impact on the profession of his misconduct and is simply citing an example. The Tribunal does not provide any or any sufficient reasoning or explanation of what further detail they expected to see."

129. In [13] of his statement the Appellant said:

> "13. If a member of the public were to have found out about prescribing in these circumstances, they could rightly feel that someone was 'jumping the queue'. They might also assume that Patient B was getting access to medication that they wouldn't be entitled to, or that he was not entitled to. Whilst this was not the case, I understand to an outsider that it could have appeared that way."

130. The MPT said at [36]:

> "36. The Tribunal was concerned that Dr Khan failed to appreciate in any detail the negative impact of his actions on the reputation and the public confidence in the profession. He inappropriately accessed patient B's records, a patient who he was in a sexual and/or emotional relationship with and who he knew was vulnerable by reason of that patient's depression and drug addiction. Furthermore, he inappropriately prescribed medication to that vulnerable patient."

131. I have considered the Appellant's criticisms but they are not made out. The MPT was engaged in an evaluative exercise and was entitled to say what they did and reach the conclusions that they did. Contrary to Ms Tanchel's submissions, on a fair reading they *did* indicate what they expected to see, namely, an appreciation of the negative impact his actions would have on the reputation and the public confidence in the profession. I agree that the Appellant's reflections did not really address these matters or show an awareness of public perceptions of his breach of boundaries and/or the potential for conflicts, impaired judgment and abuse of position that his admitted conduct had potentially involved.

132. In relation to the criticisms of the MPT's grounds for finding that the Appellant's remediation was not sufficient, its reasons were clear: the steps taken by the Appellant were limited to self-directed reading of various GMC documents which the MPT found to be 'limited in scope' ([38]). The Appellant did not attend any courses, or undertake any work or reflection with any colleagues or mentors, or take any other substantive steps towards remediation. It is true that the MPT did not list for itself other forms of remediation but I do not consider that it needed to. It was for the Appellant to demonstrate what he had done; having done so, the MPT was entitled to say that it did not go far enough.

133. The MPT then directed itself in relation to the *CHRE* case I quoted earlier and found the Appellant had breached the following parts:

a. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

b. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession.

134. It went on:

> "42. The Tribunal determined that the public expects to be able to trust doctors. The public also expects doctors to act with integrity and to adhere to the principles set out in GMP. Where doctors fail to do so in a significant way, public trust in the profession is undermined.
>
> 43. Therefore, the Tribunal determined that given Dr Khan's lack of insight and inadequate remediation his fitness to practise is currently impaired by reason of misconduct."

135. I do not accept either that the MPT failed to take into account the context in which the misconduct occurred. That context was the foundation of the Appellant's case and it is not credible that the MPT would not have had it in mind. I touched on some of this earlier. In the absence of insight and full remediation, the Tribunal was right to find

that a risk of repetition could not be ruled out if similar circumstances arose. The references to 'similar circumstances' should not be read narrowly as applying only if the Appellant was hiding his sexuality. It could apply in other circumstances where the Appellant was conflicted.

136. In relation to the Appellant's suggestion about his early admissions, it suffices to say I accept the GMC's submissions. Mr Mant's Skeleton Argument at [29(o)] set out the sequence of events, which I accept.

Conclusion

137. Deciding this case has required detailed reconsideration of many of the matters argued below and the hundreds of pages that have been filed. No error of law or principle was identified which would allow this court to intervene. This appeal is therefore dismissed.