Neutral Citation Number: [2025] EWHC 87 (Admin)

Case No: AC-2024-LON-001717

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 22/01/2025

Before :

MRS JUSTICE YIP

- -

Between :

Dr Sarah Benn	**Appellant**
- and -	
The General Medical Council	**Respondent**

- -
- -

Jenni Richards KC (instructed by **TLT LLP**) for the **Appellant**
Rory Dunlop KC (instructed by **General Medical Council**) for the **Respondent**

Hearing dates: 3 & 4 December 2024

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Approved Judgment

This judgment was handed down remotely at 10.30am on 22/01/2025 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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MRS JUSTICE YIP

Mrs Justice Yip :

1. This is an appeal under section 40 of the Medical Act 1983 against the decision of the Medical Practitioners Tribunal on 23 April 2024 that Dr Sarah Benn be suspended from the medical register on the basis that her fitness to practice was impaired through misconduct.

2. The misconduct alleged and found proved arose out of Dr Benn's participation in Just Stop Oil protests, whereby she repeatedly breached a High Court injunction resulting in her imprisonment.

3. The Appellant contends that the Tribunal were wrong to find that her actions amounted to misconduct and that her fitness to practise was impaired. She further contends that the sanction of suspension for five months (with a direction for a review hearing) was excessive and disproportionate.

The facts

4. Dr Benn is a retired general practitioner. She worked in the NHS for over 30 years. By all accounts, she was a good and committed doctor, well-liked by her patients. Up until 2019, she had been a thoroughly law-abiding citizen and had never come to the regulator's attention. Dr Benn has a longstanding and deep concern for environmental issues. Having done what she could to reduce her individual environmental impact, she came to the conclusion that more needed to be done to prevent climate breakdown and resultant societal collapse. This led her into climate activism. Dr Benn firmly believes that non-violent direct action is necessary to sound the alarm and encourage action to avert irreversible climate catastrophe.

5. Against that background, Dr Benn committed a series of offences during September and October 2019, for which she was prosecuted. These all involved non-violent but unlawful acts committed through the organisation Extinction Rebellion. In relation to each offence, Dr Benn was conditionally discharged. She was arrested again in 2021 for obstructing the highway during a climate protest. Dr Benn reported her arrests and prosecution to the General Medical Council ("GMC"). In relation to the 2019 matters, the case examiner decided to close the case with advice to Dr Benn. She was advised to reflect on her actions and to remain mindful in future of her professional obligations. The 2021 arrest was deemed not to meet the threshold for formal investigation.

6. Dr Benn ceased clinical practice in 2022. Since then, she has devoted the majority of her time to environmental activism and voluntary work. She relinquished her licence to practise but has remained on the medical register.

7. During 2022, Dr Benn took part in peaceful climate protests organised by Just Stop Oil. In April 2022, a High Court injunction was issued restraining protests at the Kingsbury Oil Terminal. In deliberate contravention of the injunction, Dr Benn took part in a protest involving the obstruction of the access road into and out of the Terminal. She was arrested, brought before the court and bailed to 4 May 2022 on condition that she comply with the terms of the injunction. On 4 May 2022, Dr Benn did not answer her bail. Instead, she engaged in another protest whereby she and about 10 others stood on the grass verge outside the Terminal holding placards and banners. She was arrested once again and spent a week in custody before being returned to court. Having regard

to the total of eight days which she had spent in custody, no further order was made at that time.

8. On 14 September 2022, Dr Benn engaged in another protest at the Terminal. On that occasion, more than 50 people attended. Some of them, including Dr Benn, sat down in the road, obstructing vehicle access. The protest remained peaceful. A large number of police officers attended to clear the obstruction. The protestors were asked to leave. When they refused, they were arrested. Dr Benn appeared before HHJ Kelly on 21 September 2022 and was sentenced to 32 days' imprisonment, which she served.

The statutory framework

9. The functions of the GMC are assigned by the Medical Act 1983 ("the Act"). Section 1(3)(g) of the 1983 Act (as amended), makes provision for the Medical Practitioners Tribunal Service as a committee of the General Council. Pursuant to section 1(1A), the over-arching objective of the General Council is the protection of the public. Section 1(1B) provides:

> "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."

10. Under section 35 of the Act, the GMC may provide advice for members of the medical profession on standards of professional conduct and performance and ethics. In exercise of that power, the GMC has issued guidance entitled *Good medical practice* ("GMP"). The guidance current at the time of Dr Benn's actions was that issued in 2013 and updated in 2014 and 2019. That guidance was withdrawn and replaced in January 2024.

11. Section 35C of the 1983 Act applies to the investigation of an allegation that a registered person's fitness to practise is impaired. Section 35C(2) provides that a person's fitness to practise shall only be regarded as impaired for one of six reasons – in summary, misconduct; deficient professional performance; a criminal conviction or caution; adverse health, inadequate knowledge of English; a determination of impairment by another regulatory body. This was not a case involving criminal conviction. Dr Benn's imprisonment resulted from the breach of a civil injunction. The relevant category was "misconduct".

12. The General Medical Council (Fitness to Practise) Rules Order of Council 2004 set out the procedure to be followed by the Tribunal. This is a staged process. The first stage involves making findings of facts on the allegations presented by the GMC. The second stage involves receiving evidence and hearing submissions from the parties to determine whether, on the basis of any facts found proved, the practitioner's fitness to practise is impaired. The third and final stage is to receive evidence and hear

submissions to decide on the appropriate sanction, if any. The burden of proof rests on the GMC at the fact-finding stage. Thereafter, the Tribunal is required to make evaluative judgments on the basis of the facts found proved.

Good medical practice

13. The 2013 version of GMP began with a section headed "Professionalism in action". Paragraph 1 stated:

> "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."

Paragraph 3 explained that GMP described what is expected of all doctors and that it was the responsibility of doctors to be familiar with it and to follow the guidance it contains. The guidance was set out in four domains: 1) knowledge, skills and performance; 2) safety and quality; 3) communication, partnership and teamwork and 4) maintaining trust. Under domain 4 was a heading "Acting with honesty and integrity". Paragraph 65 stated:

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

14. Although not directly relevant given the date of the conduct under consideration, the new guidance was referred to in the course of the Appellant's submissions. It is structured differently and starts by explaining:

> "*Good medical practice* sets out the principles, values, and standards of care and professional behaviour expected of all medical professionals registered with us. It is an ethical framework, which supports medical professional to deliver safe care to a good standard, in the interests of patients."

It states that GMP is the "core guidance on professional standards". It then deals with how the professional standards relate to the fitness to practise process, noting that not every departure from the standards set out in GMP will be considered serious. The GMC must assess whether the medical professional poses any current and ongoing risk to one of more of the three parts of public protection (the statutory objectives set out in section 1(1B) of the Act). The guidance is then divided into four domains: 1) knowledge, skills and development; 2) patients, partnership and communication; 3) colleagues, culture and safety and 4) trust and professionalism. An introductory section headed "The duties of medical professionals registered with the GMC" begins:

> "Patients must be able to trust medical professionals with their lives and health. To justify that trust you must make the care of patients your first concern, and meet the standards expected of you in all four domains."

In the 2024 guidance, the only direct reference to following the law appears in domain 1 under the heading "Being competent", where it is stated:

> "You must follow the law, our guidance on professional standards, and other regulations relevant to your work."

15. Domain 4 "Trust and professionalism" begins with an introductory paragraph which includes the statement:

> "Good medical professionals uphold high personal and professional standards of conduct."

The guidance that was paragraph 65 of the 2013 version appears in substantively the same terms at paragraph 81.

The proceedings before the Tribunal

16. Dr Benn self-referred these matters to the GMC. Proceedings were brought before the Tribunal.

17. The Tribunal were provided with a bundle for the hearing which included the relevant High Court orders and rulings, including the judgment of HHJ Kelly on 21 September 2022, which gave reasons for the sentence imposed.

18. Dr Benn had made two statements fully explaining her position and the motivations for her actions. She exhibited materials and provided links to scientific and medical literature, concerning the "climate crisis" or "climate emergency". Other material placed before the Tribunal included video evidence showing Dr Benn's participation in the protest on 14 September 2022; testimonials attesting to her qualities as a doctor; emails from two members of the public commenting unfavourably on the disciplinary action against Dr Benn; video statements from UN Special Rapporteur Michael Forst, condemning the "crackdown" on peaceful environmental protest.

19. Dr Benn admitted the factual allegations made against her. On that basis, no evidence was heard at the first stage. The conduct which was found proved (on Dr Benn's admissions) was summarised by the Tribunal as breaking the High Court injunction on three occasions, with the final instance resulting in a sentence of imprisonment for 32 days.

20. The Tribunal were then required to consider whether, on the basis of the factual findings, Dr Benn's fitness to practise was impaired. The Tribunal recognised that a finding of misconduct does not automatically lead to a finding that fitness to practise is impaired (*Cohen v GMC* [2008] EWHC 581 (Admin)). There were accordingly two issues to be addressed at the second stage:

    i) whether the admitted conduct was "misconduct" in the statutory sense;

    ii) if so, whether Dr Benn's fitness to practise was currently impaired taking account of the conduct and any relevant factors since then such as whether the matters were remediable and any likelihood of repetition.

21. At this second stage, Dr Benn gave evidence. She was cross-examined and questioned by the Tribunal. The Tribunal also considered the documentary evidence. Dr Benn clarified that, while she admitted the factual allegations, she did not admit that such amounted to misconduct within the meaning of the Act and that she denied that her fitness to practise was impaired. Although she had not formally sought to admit it into evidence, Dr Benn referred during her submissions to a petition supporting her, which had at that time attracted over 2000 signatures.

22. It is fair to say that Dr Benn's evidence was presented in a rational and considered manner, as the Tribunal acknowledged. In the course of her submissions, Dr Benn contended that, as a doctor, she had a moral duty to take action to protect life and health in the context of the climate emergency because of the threat it posed to the whole of humanity.

The Tribunal's findings on misconduct

23. The Tribunal approached the question of misconduct on the basis that they had to consider "whether there has been a departure from the expected standards of conduct and behaviour" and, if so, whether that departure was serious.

24. The Tribunal recognised that there were no issues in respect of Dr Benn's clinical work. They acknowledged her sincere beliefs and the passion with which she spoke about climate change, expressing respect for those views and for Dr Benn's right to hold and to express such views. It was noted that Dr Benn's actions were unrelated to any personal benefit for her.

25. Their conclusion was that Dr Benn's conduct "fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct which was serious". In reaching that conclusion, they relied on the following:

    i) The wording within paragraph 1 of GMP (2013), highlighting the words "act … within the law". The Tribunal described this as "an unambiguous and unconditional requirement to act within the law." They said that it was not for them to "seek to reframe [GMP] or to caveat the requirement to act within the law by deciding on circumstances where a doctor is permitted to deliberately act outside the law."

    ii) Upholding the rule of law is essential to maintain the fabric of society and doctors have a role to play within that process. The public must be able to trust that doctors will always act within the law.

    iii) The impact of the actions of Dr Benn and her fellow protestors on vital public services, including police resourcing, as reflected in the sentencing remarks of HHJ Kelly. The Tribunal said that the impact beyond the oil terminal made the matter more serious.

    iv) The deliberate and repeated flouting of the injunction and the custodial sentence that resulted.

    v) Their view that "the majority of members of the public would not condone breaking the law in the manner that Dr Benn repeatedly did, and with the

consequent impact on the operations of the police, courts and the administration of justice."

The Tribunal's findings on impairment

26. Having found misconduct, the Tribunal considered whether Dr Benn's fitness to practise was currently impaired. They relied upon the findings they had made on misconduct. They noted that Dr Benn had been advised as to her future conduct following the 2019 matters and that her stance since then was unchanged. She had been clear in her view that her actions were entirely justified and that she had no intention of stopping or changing her behaviour. The Tribunal said that following the standards within GMP was a fundamental tenet of the medical profession and referred again to GMP including a specific requirement to act within the law.

27. The Tribunal considered that the misconduct was, in principle, easily remediable in that Dr Benn could decide to pursue her environmental activism within the bounds of the law. However, she had openly stated that she would not refrain from unlawful conduct in the future so that there was a strong likelihood of repetition.

28. Having acknowledged that "amongst the public there would be considerable sympathy for Dr Benn's concerns about the environment", the Tribunal expressed the view that "the overwhelming majority of the public would not condone breaking the law in the way in which Dr Benn did especially given the impact, on the final occasion, to the wider public resources involved."

29. The Tribunal considered that Dr Benn's behaviour in not complying with the law on several occasions, disrupting public services and acting in a way that led to a custodial sentence would bring the profession into disrepute.

30. Determining that Dr Benn's fitness to practise was impaired, the Tribunal said that such a finding was required to protect and maintain public confidence in the profession and to promote and maintain proper professional standards and conduct.

The sanction stage

31. After the Tribunal had given their decision on misconduct and impairment, Dr Benn indicated that she wished to give further evidence and dealt specifically with the reference in the Tribunal's reasons to HHJ Kelly's sentencing remarks. It is clear from the transcript that she gave her evidence in a respectful way, acknowledging that her perception of the disruption her conduct had caused differed to that of HHJ Kelly. The thrust of her evidence was that closure of the public highway and any disruption to the public resulted from the actions of the police rather than being a direct consequence of the protestors' actions. It was her view that there was no need for police resources to be deployed in the way that happened. All the disruption beyond the immediate impact on the Terminal flowed from policing decisions for which she and her fellow protestors were not responsible. The Tribunal said of this evidence that it showed a naivety in respect of the risks that the police were managing and how those might escalate over time. The evidence enhanced concerns about her lack of insight over her actions.

32. The Tribunal had regard to the GMC Sanctions Guidance. Paragraph 68 of the Guidance explains that where a doctor's fitness to practise is impaired, it will usually

be necessary to take action to protect the public but that there may be exceptional circumstances which justify taking no action. Dr Benn submitted that this was a case in which the Tribunal could, exceptionally, decide to take no action.

33. The Tribunal decided that given their findings on misconduct and impairment, there were no exceptional circumstances to justify taking no action. Doing so would be inappropriate and insufficient and would risk damaging public trust in doctors and the system of regulation. It was not possible to formulate workable or appropriate conditions that would adequately address the need to maintain public confidence and uphold proper professional standards and conduct. Despite Dr Benn's firm stance that she would continue with her actions, the Tribunal did not wish to discount the possibility that she would develop insight into the importance of complying with the law and GMP and decided that suspension, rather than erasure, was an appropriate and proportionate sanction. It determined that suspension for five months was proportionate to the misconduct and would allow adequate time for the development of insight and remediation.

34. The Tribunal further directed that there should be a review hearing shortly before the end of the suspension when the onus would be on Dr Benn to demonstrate that matters had changed so that her fitness to practise was no longer impaired. She was encouraged to provide evidence of any reflections, insight and remediation in relation to the importance of compliance with the law.

Grounds of appeal

<u>Misconduct</u>

35. The Appellant contends, in summary:

i) It was wrong in principle to find that participation in non-violent environmental activism, undertaken pursuant to genuinely and sincerely held beliefs in the wider interests of public health, amounted to misconduct.

ii) The reasoning of the Tribunal was flawed. It focused disproportionately and too rigidly on the requirement to act within the law contained in paragraph 1 of GMP (2013), and overstated the requirement. Further, the Tribunal was wrong to consider that Dr Benn's submissions invited them to "permit" doctors to act outside the law in some circumstances.

iii) In placing weight on paragraph 1 of GMP (2013) as creating a freestanding requirement to act within the law, the Tribunal failed to consider and to invite submissions on the 2024 version which would have aided their understanding of the correct position.

iv) The Tribunal did not consider the GMC *Guidance on convictions, cautions, determinations and other methods of disposal* ("the Convictions Guidance") which recognises that not all breaches of the law will reach the Tribunal, still less amount to misconduct.

v) The Tribunal placed disproportionate weight on the impact on public services, wrongly factoring in the actions of other protestors and unfairly failing to

explore the issue with Dr Benn before making a finding about the extent of the disruption.

vi) There was no evidential basis for the view that the majority of members of the public and profession would not condone Dr Benn's actions and the Tribunal erred in its reliance on its view to that effect.

Impairment of fitness to practise

36. In addition to contending that the decision on fitness to practise was wrong for the reasons set out in relation to misconduct, the Appellant argues:

i) It was wrong to find that the Appellant's conduct would bring the profession into disrepute.

ii) In relying on their view that the overwhelming majority of the public would not condone Dr Benn's actions, the Tribunal misdirected themselves and asked the wrong question. The relevant question was whether a finding that her fitness to practise was not impaired would undermine public confidence in the profession or undermine the maintenance of proper standards and conduct for members of the profession.

iii) There was no adequate explanation for why public confidence in the profession or in regulation would be damaged in the particular circumstances of this case.

iv) The Tribunal were too narrowly focused on the fact of non-adherence to the law and did not consider other instances of law-breaking that would not even reach the Tribunal.

v) The Tribunal did not consider the provisions of the Sanctions Guidance which provided an indication of the sort of conduct in a doctor's personal life which would be considered more seriously.

Sanction

37. The Appellant contends:

i) The sanction imposed by the Tribunal was excessive and disproportionate.

ii) The circumstances of this case were exceptional such that no action should have been taken.

Principles applicable to appeals under section 40

38. An appeal under section 40 of the Medical Act 1983 is by way of rehearing rather than review and the court is fully entitled to substitute its own decision for that of the tribunal (*Sastry v GMC* [2021] EWCA Civ 623, [2021] 1 WLR 5029 [96-102]). The appeal court will accord an "appropriate measure of respect" to the judgment of the specialist Tribunal but will not defer to the Tribunal more than is warranted by the circumstances (see *Ghosh v GMC* [2001] 1 WLR 1915; *Sastry v GMC* [2021] EWCA Civ 623; [2021] 1 WLR 5029). The appeal court may more readily depart from the Tribunal's assessment of the effect on public confidence when the misconduct does not relate to

professional performance than in a case which does involve professional performance (*Khan v General Pharmaceutical Council* [2016] UKSC 64; [2017] 1 WLR 169).

39. Although a rehearing, the appeal will generally proceed on the basis of the evidence that was before the Tribunal and without rehearing that evidence (CPR 52.21(2)). The principles for the admission of fresh evidence derived from *Ladd v Marshall* [1954] 1 WLR 2318 apply to an appeal under section 40 (*GMC v Adeogba* [2016] EWCA Civ 162, [2016] 1 WLR 3867).

Application to rely on fresh evidence

40. The Appellant seeks to rely on additional material which was not before the Tribunal:

    i) The petition which Dr Benn had referred to in her submissions, which had accumulated further signatures so that the total stood at over 6000 by the date her skeleton argument was filed.

    ii) Emails from ten individuals, some of whom were medical professionals, received by the GMC following the decision and forwarded to Dr Benn. The emails expressed support for her and disappointment in /disapproval of the outcome.

    iii) Correspondence between the British Medical Association and the GMC, in which the BMA expressed concern about Dr Benn's suspension.

    iv) A statement issued by the UK Health Alliance on Climate Change on the day the decision was published.

    v) Another statement issued on the same day by the Doctors Association UK.

    vi) A letter from Greener Practice to the GMC dated 27 April 2024.

    vii) An unpublished article entitled "Public Perception of Climate Activism and Fitness to Practice among Healthcare Professionals" by Lee, Novintan et al and the data from an online survey conducted by the Doctors Association UK which underpinned the article.

41. None of this material was solicited by Dr Benn. I accept that it shows genuine support for her amongst members of the profession and members of the public. To a large extent, it consists of opinion evidence including opinion on the merits of the Tribunal's decision.

42. The parties took a pragmatic approach to the new evidence, allowing me to consider the material de bene esse and addressing me both on its admissibility and on its contents.

43. Mr Dunlop KC submitted on behalf of the Respondent that admitting this new evidence would create an unfortunate precedent, encouraging the reliance in the High Court on reactions to decisions of the Tribunal from sections of the public. I certainly agree that this is not something to be encouraged. Many high profile cases attract comment and generally an appeal court will not be assisted by consideration of statements of opinion about whether a decision is right or wrong. Indeed, that is likely only to distract from

the dispassionate analysis of the law and the application to the facts which is required on an appeal.

44. The issues that arise on this appeal include consideration of the impact of Dr Benn's conduct on public confidence and of appropriate professional standards for conduct outside medical practice. The Appellant specifically challenges the Tribunal's view that the majority of members of the public would not condone her actions. Evidence of the public and professional view of Dr Benn's conduct may therefore be relevant.

45. I consider it likely that if additional material showing support for Dr Benn had been available at the time, the Tribunal would have considered it. Even if it could be argued that the Appellant could have sought further evidence of support for her amongst the medical profession or the general public, I would not exclude the evidence on the first limb of *Ladd v Marshall*. The material did not come into existence until after the hearing, it was not actively sought by Dr Benn or her representatives but rather emerged in response to the decision.

46. No issue arises as to the credibility of the evidence nor is it material that needs to be tested by cross-examination. Admitting the evidence does not give rise to any question of adjournment. The evidence was in fact considered within the time allocated for the appeal.

47. The real issue with regard to admissibility is the relevance of the evidence and whether it is likely to have an important influence on the outcome. This requires analysis of the evidence, the extent to which it adds to what was before the Tribunal and the issues that require my determination.

48. I have concluded that it is appropriate to admit all the evidence which was the subject of the Appellant's application. I have considered all of this material and have given careful consideration to the use that can properly be made of it and the weight to be given to it when analysing the merits of the appeal.

Observations on the Doctors Association survey

49. The survey had 1,785 participants. 43% were doctors, 14% other healthcare professionals and 44% members of the general public. 95% of participants felt that Dr Benn's actions did not undermine the public's trust in doctors and 96% disagreed with the conclusion that her fitness to practise was impaired. The authors recommended further research to explore public perceptions of activism by doctors and the broader implications.

50. While this survey showed strong support for Dr Benn amongst those who responded, the study had limitations, as the authors of the article recognised. The sharing of the survey on social media and the nature of algorithms meant it was more likely that those with a pre-existing interest in climate change and healthcare responded and it could not be said that the sample was representative of the whole population. It was also recognised that the phrasing of questions and sample bias could have influenced results.

Additional materials introduced during the hearing

51. During the adjournment after the first day of the hearing, Ms Richards KC conducted some further online research and discovered on the GMC website a research report *Promoting and maintaining public confidence in the medical profession.* The research upon which the report was based had the stated aim of exploring "how the public expect the GMC to respond to specific behaviours/acts/omissions by doctors, particularly when these behaviours/acts/omissions have also been subject to action through the criminal justice system." Ms Richards sought to rely upon this report on the basis that it had been in the possession of the GMC but not the Appellant at the time of the hearing below and was relevant to the view of the MPT that the overwhelming majority of the public would not condone breaking the law in the way that Dr Benn did.

52. Through Mr Dunlop, the Respondent explained that the report had been commissioned as part of an independent review of gross negligence manslaughter and culpable homicide in the medical setting ("the Hamilton review"). The Hamilton review arose out of the well-publicised regulatory action against Dr Hadiza Bawa-Garba, following her manslaughter conviction. Having reviewed the research report, the Hamilton review concluded that "the research paints a picture of subtlety, and sometimes inconsistency, in the public view of medical error, wrongdoing and criminal conviction." The opinion was expressed that:

> "… the role of the GMC and MPT is not to react to the public mood of the moment (insofar as that can even be understood). Nevertheless, they must be cognisant of public expectations in the way in which they calibrate their regulatory sanctions if they are to maintain confidence in the profession."

53. While maintaining the stance that none of the new material should be admitted, Mr Dunlop referred me to an article by Daniel Finklestein published in The Times on 1 May 2024 "Contempt for the law shows contempt for us all". Lord Finklestein referred to the "public argument" about the decision to suspend Dr Benn, expressing strong support for the Tribunal's decision. Mr Dunlop submitted that if I admitted the evidence on which the Appellant sought to rely, Lord Finklestein's article should also be admitted by way of balance since it demonstrates that the public view of Dr Benn's conduct was not all one way. I note that when giving evidence to the Tribunal, Dr Benn acknowledged that much of the media coverage sparked by the protests at the oil terminal was negative, arguing that "history shows that social movements do not have to be universally or even predominantly supported by the public and media to bring about change that is retrospectively agreed to be moral and necessary."

54. If the Finkelstein article stood alone, it would certainly cross the line into mere comment on the decision which should not be admitted on appeal. However, the Respondent sought to make only limited use of it, that is to provide some balance to the materials the Appellant had introduced to correct what otherwise might be a misleading view that the commentary was all one way. The use that can be made of this article certainly cannot go beyond that. The Respondent is not entitled to rely upon the opinions expressed by Lord Finklestein in support of its case. However, I do consider that it is consistent with the overriding objective to deal with cases justly that, in light of the evidence I have admitted on the Appellant's application, I admit it as evidence of the fact that the commentary on the case is not all favourable to the Appellant.

55. I therefore admit the additional material which each party referred to during the appeal on the same cautious basis as above, giving careful consideration to its relevance and use.

Analysis of the Tribunal's ruling on misconduct and impairment – overview

56. It is apparent that the Tribunal carefully considered their decision and recognised that they needed to decide both whether Dr Benn's admitted conduct amounted to misconduct in the statutory sense and, if so, whether her fitness to practise was currently impaired. Although they separated these two elements out, there is some overlap between the two issues and the ruling needs to be read as a whole. I am conscious that the ruling was produced expeditiously and that the Tribunal did not have the benefit I have had of two days of legal argument from leading counsel on both sides. I do not intend to critically pick over every aspect of the ruling. Given that the appeal proceeds as a rehearing, it is unnecessary and inappropriate to do so. For the reasons that follow, I have concluded that there were some flaws in the Tribunal's reasoning. I have then stood back and looked not only at the thrust of what they decided but also at the evidence presented to the Tribunal to arrive at my own assessment on the merits.

57. Given my approach and the number of grounds of appeal advanced, I will not deal separately with each ground although I have carefully considered all the grounds and the entirety of the submissions made to me. Some of the grounds can be taken more briefly than others.

The finding about the impact on public services

58. The allegations which Dr Benn was required to answer contained no reference to any impact on public services. However, the evidence placed before the Tribunal in support of the allegations contained the sentencing remarks of HHJ Kelly, which included the following:

> "The harm also extends to the consequences of the closure of part of the public highway whilst the protests and arrests were ongoing. That will have impacted on ordinary members of the public, including in particular those living in the vicinity of the terminal, who were trying to go about their daily lives.
>
> Your actions also caused very significant harm to the police resources in Warwickshire and beyond at a time when they were already very stretched … The scale of your protest meant that multiple officers from across Warwickshire had to be diverted away from their normal policing duties to attend, including firearms, traffic and dog unit specialist officers. They attended not because there was any suggestion your protest was other than peaceful but due to the sheer number of protestors that needed to be arrested and processed. … There is also evidence … that officers had to work long past their shifts ended to process those arrested …"

59. In considering whether Dr Benn's actions amounted to misconduct which impaired her fitness to practise, the Tribunal were bound to consider the context and consequences

of her actions. The Appellant knew that the GMC relied on HHJ Kelly's sentencing remarks. However, as later became apparent, Dr Benn did not accept the findings HHJ Kelly made when sentencing her.

60. The parties agreed that since the conclusions of HHJ Kelly which informed the imposition of the sentence were findings of a civil court, the position following *GMC v Spackman* [1943] AC 628 was that the civil court's conclusion may be treated as prima facie proof of the matter alleged but that the registrant must be permitted to challenge the correctness of the conclusion and to call evidence if desired.

61. The extent of any disruption to the public or public resources was not explored with Dr Benn when she gave evidence at the misconduct and impairment stage. Dr Benn told the Tribunal that it was her intention only to contribute a small degree of disruption to the operation of the terminal. Relying on HHJ Kelly's sentencing remarks, the Tribunal did not accept that there had only been a small degree of disruption to the wider public.

62. I accept that insofar as there were factual issues about public disruption, the burden of proof rested on the GMC. I do not blame Dr Benn for not specifically challenging the conclusions of HHJ Kelly at the misconduct and impairment stage since the point only came into focus when the Tribunal gave their ruling. However, if there was any procedural unfairness in the way in which this issue was dealt with, I do not consider it to have been material to the outcome.

63. Dr Benn gave evidence on the issue at the sanction stage. It is apparent that the Tribunal considered this evidence and weighed it against the sentencing remarks of HHJ Kelly. The Tribunal also viewed video evidence which showed the large police presence at the protest on 14 September 2022. They concluded that Dr Benn's stance was naïve. That was a finding they were entitled to make on the evidence before them. I do not consider their findings would have been any different had Dr Benn been asked about this aspect before the determination on misconduct and impairment.

64. Ms Richards suggested Dr Benn may have called further evidence on the issue had the allegations included the fact that public disruption was caused. There is no indication of what that evidence might have been. No such evidence was included in the application to rely on fresh evidence. The reality is that Dr Benn accepts that there was a large police response. Her argument is that the police did not need to react in the way that they did. There is, in my judgment, no proper basis for arguing that the diversion of police resources and the disruption caused by road closures is not to be regarded as flowing from the actions of the protestors.

65. The argument that any assessment of the impact on the public or public services had to ignore the actions of other protestors and focus only on what Dr Benn did herself is plainly wrong. Dr Benn did not go out to protest alone. She knowingly joined an organised demonstration. That was a joint enterprise and there is nothing objectionable in holding her accountable for the consequences of the group action.

66. It follows that, although I acknowledge that the issue should have been explored with Dr Benn before reliance was placed on this factor at the misconduct and impairment stage, the failure to do that did not have any bearing on the outcome. The finding that there was some disruption to the public and public services reflects the evidence and it

was appropriate to take it into account when determining the issues relating to misconduct and impairment.

The legal approach to misconduct

67. The Act contains no definition of "misconduct". When first enacted, the Act used the term "serious professional misconduct". The earlier Medical Act 1858 used the phrase "infamous conduct in a professional respect." Ms Richards submitted that all three phrases had the same meaning. She relied upon *Roylance v GMC* [2000] 1 AC 311 and *Meadow v General Medical Council* [2006] EWCA Civ 1390; [2007] QB 462. In *Meadow* Auld LJ said that it was inconceivable that "misconduct" as one of the current categories of impairment of fitness to practise should signify a lower threshold for disciplinary intervention by the GMC than was the case when the statute referred to "serious professional misconduct". In reaching that conclusion, he relied upon the retention of the over-arching objective.

68. Concessions were made in cases after *Meadow* that the concept of "misconduct" in the present form of the Act was the same as "serious professional misconduct" in its original form, or at least that it did not connote a lower standard (see *R(Remedy UK) v GMC* [2010] EWHC (Admin) and *Schodlok v GMC* [2015] EWCA Civ 769).

69. Mr Dunlop accepted that there was no difference in meaning between "serious professional misconduct" under the legislation as originally enacted and "misconduct" in the current regime. However, he did not accept that it was appropriate to interpret misconduct by reference to the old phrase "infamous conduct in a professional respect." He pointed out that the regime under the 1858 Act was very different and the only sanction then available was erasure.

70. In *Beckwith v Solicitors Regulation Authority* [2020] EWHC 3231 (Admin), the Divisional Court stressed the importance of construing and applying the particular terms of the regulatory scheme under consideration. The court said [19]:

> "Great care must always be taken when seeking to apply an authority under one scheme to an appeal under a different scheme."

71. The starting point then is to look to the current statutory scheme itself. Under the current provisions, "misconduct" is one of the grounds upon which a finding that a person's fitness to practise is impaired may be made. The misconduct must therefore be of a nature that is capable of giving rise to a finding that fitness to practise is impaired. Plainly, not everything that may be described as misconduct in a dictionary sense will meet that test. The context is provided by the regulator's over-arching objective in section 1 of the Medical Act 1983. If the conduct in question does not threaten to undermine one of the objectives set out in section 1(1B), it cannot be viewed as "misconduct" in the statutory sense. Viewed in that way, the misconduct must be serious and must have some link to and/or impact on the profession of medicine if it is to meet the statutory test.

72. To that extent, the concession made in this case and in earlier authorities that there is no meaningful distinction between "misconduct" in the current statutory regime and "serious professional misconduct" is correct. It is a straightforward proposition to say

that misconduct that is not serious will not impact upon a doctor's fitness to practise. However, defining what is and is not "professional misconduct" may be more difficult and potentially open to different interpretation. As the Divisional Court said in *Beckwith* [15]:

> "What is or is not professional misconduct depends on the rules of the scheme that applies to the profession in hand."

73. In *Roylance*, Lord Clyde said that it was inappropriate to attempt any exhaustive definition of the phrase "serious professional misconduct", that the Professional Conduct Committee (who then occupied the role the Tribunal now has) were well placed to decide precisely where the line falls to be drawn and that their skill and knowledge should be respected. He referred to *Doughty v General Dental Council* [1988] A.C. 164, 173, in which Lord Mackay of Clashfern summarised the test as:

> "… conduct connected with his profession in which the dentist concerned has fallen short, by omission or commission, of the standards of conduct expected among dentists and that such falling short as is established should be serious."

74. In relation to misconduct outside clinical practice, Lord Clyde said (at 331 F-H):

> "… it is not simply misconduct in the carrying out of medical work which may qualify as professional misconduct. But there must be a link with the profession of medicine. Precisely what that link may be and how it may occur is a matter of circumstances. The closest link is where the practitioner is actually engaged on his practice with a patient …
>
> But certain behaviour may constitute professional misconduct even although it does not occur within the actual course of the carrying on of the person's professional practice, such as the abuse of a patient's confidence or the making of some dishonest private financial gain."

He continued (at 331D-E):

> "To take the point a stage further, serious professional misconduct may arise where the conduct is quite removed from the practice of medicine, but is of a sufficiently immoral or outrageous or disgraceful character."

He gave an example of a doctor who had sexually abused his child and said (332G):

> "One particular concern in such cases of moral turpitude is that the public reputation of the profession may suffer and public confidence in it may be prejudiced."

However, Lord Clyde stressed that "moral turpitude" was not the only kind of conduct outside medical practice which might constitute serious professional misconduct.

75. Auld LJ in *Meadow* suggested that Lord Clyde's discussion of the meaning of "serious professional misconduct" in *Roylance* could be encapsulated as:

> "… it must be linked to the practice of medicine or conduct that otherwise brings the profession into disrepute, and it must be serious."

76. In *Remedy UK* (a judicial review of the decision of the GMC not to bring disciplinary proceedings), the Divisional Court considered authorities on the scope of misconduct including *Roylance* and *Meadow*. Elias LJ set out the principles he derived from the authorities at paragraph 37 of his judgment. At sub-paragraph (1), he said:

> "Misconduct is of two principal kinds. First, it may involve sufficiently serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practise. Second, it can involve conduct of a morally culpable or otherwise disgraceful kind which may, and often will, occur outwith the course of professional practice itself, but which brings disgrace upon the doctor and thereby prejudices the reputation of the profession."

In relation to the second limb, Elias LJ said [37(6)]:

> "Conduct falls into the second limb if it is dishonourable or disgraceful or attracts some kind of opprobrium; that fact may be sufficient to bring the profession of medicine into disrepute. It matters not whether such conduct is directly related to the exercise of professional skills."

77. Drawing a distinction between misconduct and deficient performance (which was the ratio of the decision), Elias LJ said [37(9)] that even where deficient performance leads to a lack of confidence and trust in the medical profession that will not of itself suffice to justify a finding of gross misconduct. He said:

> "The conduct must be at least disreputable before it can fall into the second misconduct limb."

78. In *Adil v GMC* [2023] EWCA Civ 1261; [2024] ICR 445, Popplewell LJ said [at 71] that he did not think Elias LJ was intending any rigid classification of cases into two categories and said that such would not be helpful. I agree with the submission made by Mr Dunlop that it would be wrong to treat Elias LJ's summary in *Remedy UK* as creating a separate test for cases involving conduct outside the exercise of professional practice. I was referred also to *Nandi v GMC* [2004] EWHC 2317, in which Collins J said [32] about serious professional misconduct:

> "There are no closed categories and the appropriate standard is a matter for the Committee to decide. It is not restricted to conduct which is morally blameworthy."

79. I agree that there are and can be no closed categories of what is and is not misconduct. The authorities make clear that exhaustive definition is not possible. I agree also that

"moral blameworthiness" forms no part of the definition. Reading the judgment as a whole, I do not understand Collins J to have meant that the appropriate standard was a matter for the Professional Conduct Committee alone. Had he intended that, I would have disagreed. The standard must be assessed by reference to the statutory provisions (including the section 1(1B) objectives) and the published guidance contained in GMP.

80. The need to have regard to identifiable standards was stressed in *Beckwith*. In that case, the standards were to be ascertained by construction of the contents of the SRA Handbook, because that was the legally recognised source for regulation of that profession. This facilitated a principled approach to the extent to which it is legitimate for professional regulation to reach into personal lives of those who are regulated. That point also arises in this case.

81. The Divisional Court said:

> "There is a qualitative distinction between conduct that does or may tend to undermine public trust in the solicitor's profession and conduct that would be generally regarded as wrong, inappropriate or even for the person concerned, disgraceful. Whether that line between personal opprobrium on the one hand and harm to the standing of the person as a provider of legal services or harm to the profession *per se* on the other hand has been crossed will be a matter of assessment for the Tribunal from case to case, but where that line lies must depend on a proper understanding of the standards contained in the Handbook."

82. Drawing the above together, I approach the issue of misconduct on this basis:

i) Whether any particular conduct amounts to misconduct for the purpose of the statutory regulatory scheme is to be determined by reference to the wording of the scheme itself. Care should be taken in applying old cases and/or those decided under a different statutory scheme.

ii) There are no fixed categories of what is and is not capable of amounting to misconduct.

iii) It should be recognised that the conduct relied upon in this case occurred outside medical practice and in the context of Dr Benn's private life. That fact does not result in the application of a wholly different test but it is a relevant factor which must be considered in making the assessment within the statutory framework.

iv) Focus on the statutory provisions and the guidance set out in GMP is important to avoid overreach into the personal lives of those who are regulated.

v) Conduct committed outside medical practice that is disgraceful, immoral or outrageous may fall within the definition of misconduct for the purposes of the statute. While these are examples of statutory misconduct, they do not define the test.

vi) Conduct wholly outside medical practice is only capable of being considered misconduct within the meaning of the statute if it is conduct capable of undermining one of the three objectives set out in section 1(1B) of the Act.

vii) Focusing on those objectives fulfils the requirements that there is a link to the profession of medicine and that the misconduct is serious. Misconduct in a dictionary sense that has no bearing on the statutory objectives cannot be considered to have a link to the profession and so will fall outside the scope of regulation.

viii) In this case, the relevant objectives are (b) maintaining public confidence in the medical profession and (c) maintaining proper professional standards and conduct for members of that profession.

ix) Not all conduct that would generally be regarded as wrong, or even disgraceful, will tend to undermine public confidence in the profession. Where the line lies is generally a matter for assessment by the Tribunal but such assessment must have a proper basis.

x) *Good medical practice* is the core guidance on professional standards for all registered medical professionals. Regard must therefore be had to it, particularly in assessing whether the conduct in question may undermine proper professional standards and conduct.

xi) Appropriate deference is to be afforded to the judgment of the Tribunal, but the weight to be given to assessments relating to conduct wholly outside medical practice may be less than in cases involving clinical performance.

Analysis of the finding of misconduct

83. The Tribunal's essential finding on misconduct was that Dr Benn's actions fell so far below the standard of conduct to be expected of a doctor as to amount to serious misconduct. The reasoning that underpinned that finding focused heavily on the unlawfulness of Dr Benn's actions.

84. In my judgment, the Tribunal overstated the requirement for a doctor to act within the law at all times. It was argued on behalf of the GMC, both at the hearing below and on appeal, that doctors have a particular responsibility to uphold the rule of law. The guidance in GMP did not then (and does not now) impose an obligation to uphold the rule of law. (This can be contrasted with the SRA Principles considered in *Beckwith*, which do contain the requirement for solicitors to "uphold the rule of law and the proper administration of justice".)

85. The rule of law arguments detract from the proper scope of regulation in this case. I consider them unhelpful arguments, which fed into the Tribunal's statement that it was not for them to decide on circumstances where a doctor is permitted to deliberately act outside the law. A doctor cannot be permitted to deliberately act outside the law, nor can anyone else. The rule of law applies to everyone. The rule of law was applied to Dr Benn when the High Court enforced its orders and sentenced her to a period of imprisonment. It was therefore a mischaracterisation of the issue to suggest that Dr Benn's arguments would result in the Tribunal permitting doctors to act outside the law.

86. It was also putting matters too highly to state that paragraph 1 of GMP (2013) contained an unambiguous and unconditional requirement to act within the law.

87. The guidance in force at the time was the 2013 version. It would be wrong to apply the 2024 version retrospectively in considering Dr Benn's actions in 2022. However, the Appellant invited consideration of the later version as an aid to interpretation of the relevant 2013 guidance. That point was not raised before the Tribunal and they properly had regard to the guidance that applied at the time of the relevant conduct. I reject the argument that they should have invited submissions on the 2024 guidance. I have though considered the submissions made to me about the 2024 guidance.

88. The guidance needs to be construed sensibly according to the ordinary meaning of the words used, taking it as a whole and in light of its context and purpose. Paragraph 1 of the 2013 GMP set out in general terms what was expected of a doctor. It was an introduction to the guidance that followed and appeared under the heading "Professionalism in action". That section is to be read across all four domains. When read in context and with paragraph 65, it contains an expectation that doctors will maintain high standards of professional and personal conduct. The reference to acting within the law is not qualified as relating only to medical practice and I accept paragraph 1 did reflect a general expectation that doctors will conduct themselves within the law.

89. Ms Richards argued that the carefully structured 2024 guidance does not contain an equivalent to paragraph 1 in the 2013 version and that this demonstrated that there was no fundamental obligation to act within the law as the Tribunal had found. It is right that in the 2024 version the only express reference to following the law is under the heading "Being competent" but domain 4 "Trust and Professionalism" is explicit in the expectation that medical professionals uphold high personal and professional standards of conduct. High personal standards of conduct generally include abiding by the law. Taken as a whole, I consider that both versions of the guidance convey the message that doctors are expected to maintain high standards of conduct personally as well as professionally and that professional standards may have a bearing on personal conduct.

90. It is apparent that the Tribunal were well aware that not every breach of the law would amount to misconduct and/or be referred to the Tribunal. They noted Dr Benn's criminal convictions in 2019, which did not result in referral to the Tribunal but distinguished her conduct on this occasion as being more serious. The Convictions Guidance does not assist the Appellant. This was not a conviction case. If the Tribunal had considered the Convictions Guidance, they would have noted that all convictions resulting in a sentence of imprisonment are to be referred to the Tribunal. In other words, the guidance uses imprisonment as a marker of seriousness. It could not help Dr Benn's case.

91. The issue for the Tribunal was not whether Dr Benn's actions should be condoned or excused but rather whether they amounted to the sort of misconduct that could potentially impair her fitness to practise.

92. I accept that the Tribunal's view that the majority of the public would not condone breaking the law in the manner in which Dr Benn did was supposition. The evidence presented to the Tribunal did not establish a majority view one way or another. The same can be said of the fresh evidence. There is evidence of some strong support for

Dr Benn but the evidence does not go further. The acknowledged limitations of the Doctors Association survey do not allow it to be viewed as representative of the views of the public as a whole.

93. In any event, even if the view of the majority of the public could be ascertained, this is not determinative of whether the conduct amounted to statutory misconduct. It was for the Tribunal to form their own evaluative judgment as to whether Dr Benn's actions fell so far below the standards to be expected of a doctor as to amount to misconduct in the statutory sense. To the extent that, in arriving at their conclusion on misconduct, the Tribunal relied upon their view that the majority of the public would not condone what Dr Benn did, they were wrong to do so.

94. The essential question is whether the Tribunal were right to find that Dr Benn's conduct fell "so far short of the standards of conduct reasonably to be expected of a doctor" such that they amounted to misconduct in the statutory sense.

95. Whatever her motivations, there is no doubt that Dr Benn's conduct amounted to misconduct in the ordinary sense of the word. Dr Benn recognised this when giving evidence (D1/46-47 in the transcript), describing it as a "no brainer" and saying "of course it is misconduct" in the ordinary sense. She acknowledged that it was not acceptable conduct and that "it's not within the norms of behaviour and boundaries set by the governing body of the profession". There is also no doubt that it was serious. It was sufficiently serious as to be marked with a term of imprisonment. As I have said, the Tribunal were right also to take account of their findings about public disruption.

96. Dr Benn relied on her motivations to explain and justify her deliberate and unlawful misconduct. She invited the Tribunal to endorse her views on the climate emergency and the need for real action in the findings that they made. The views themselves are entirely reputable, supported as they are by credible medical and scientific papers. The Tribunal expressed respect for her right to hold and express those views. It is important though not to elide respect for the underlying cause with support for deliberate and unlawful misconduct. It was her conduct not her beliefs that brought Dr Benn before the Tribunal.

97. The motivations that underpinned Dr Benn's conduct undoubtedly have a significant role to play in considering whether Dr Benn's fitness to practise is impaired but they do not convert that which is otherwise obviously misconduct into something less.

98. As is clear from her own evidence, Dr Benn intended to act in a way that did not meet the standards of behaviour to be expected of a doctor. That was a deliberate part of her tactics. She referred (Transcript D1/38) to the need for something "eye-catching", actions which were "more visible and potentially upsetting to the public" than conduct limited to that which was non-disruptive and entirely legal. She said in her written and oral evidence to the Tribunal:

> "When a health professional or scientist steps into civil disobedience it can bring a laser focus to the climate emergency and a sense of urgency to the public."

99. On her own evidence, Dr Benn brought her profession into her actions. She made it clear that she was conducting herself as a doctor. She intended that her misconduct

would attract additional attention because she was a doctor and doctors are trusted voices within society. She relied upon that public trust and the fact that it would be considered shocking for a doctor to act unlawfully to spread her message. In doing so, she recognised that she was acting outside the boundaries set for the medical profession. These factors provide the connection with the medical profession that the authorities require such that, although the acts were committed outside medical practice, they crossed the dividing line into professional misconduct.

100. It follows that, although I have disagreed with some of the Tribunal's reasoning, I consider that the Tribunal were ultimately right to conclude that this was misconduct in the statutory sense.

Impairment of fitness to practise

101. The Tribunal correctly recognised that their finding of misconduct did not lead automatically to a finding that fitness to practise was impaired. In determining whether Dr Benn's fitness to practise was impaired, the Tribunal was required to assess whether there was a current or ongoing risk to one or more of the objectives set out in section 1(1B) of the Act.

102. In concluding that Dr Benn's fitness to practise was impaired, the Tribunal relied on both the need to promote and maintain public confidence in the profession and the need to promote and maintain proper professional standards and conduct for members of the profession.

103. The Tribunal found that Dr Benn's behaviour in not complying with the law on several occasions, disrupting public services and acting in a way that led to a custodial sentence would bring the profession into disrepute.

104. The reasons for Dr Benn's conduct were undoubtedly relevant at this stage, as the Tribunal recognised. They had regard to what a well-informed member of the public or profession would think of her actions. They expressly acknowledged that amongst the public there would be considerable sympathy for Dr Benn's concerns about the environment. However, they said that "the overwhelming majority of the public would not condone breaking the law in the repeated way that Dr Benn did, especially given the impact, on the final occasion to public services."

105. In *Samuel v Royal College of Veterinary Surgeons* [2014] UKPC 13, Lord Toulson identified the impact on public opinion of detailed factual information about offences and offenders. He concluded that it should not be assumed that the public would think that someone convicted of offences including theft and assault which led to a suspended sentence of imprisonment ought not to be allowed to practise as a vet. If members of the public knew that Dr Samuel had lost his self-control in circumstances which included him being racially insulted, they might have thought that had very little impact on his fitness to practise. Ms Richards suggested that Dr Benn's motivations would similarly lead the public to conclude that her misconduct has very little impact on her fitness to practise.

106. The circumstances in *Samuel* differed from those here. Dr Samuel had expressed regret for his actions, which were apparently out of character, and there was no likelihood of

repetition. Dr Benn had clearly and frankly stated that she had no intention of changing her behaviour so as to stay within the law in future.

107. The extent to which an individual doctor's misconduct is capable of bringing the profession as a whole into disrepute is not necessarily an easy issue, as is apparent from the *Promoting and maintaining public confidence in the medical profession* research report. The Hamilton review concluded that the research demonstrated inconsistency in the public view of wrongdoing by doctors. In relation to criminal offending, repetition was a factor that influenced the public's views of whether action should be taken. Conviction and sentence was considered to be of less relevance. Opinion was more divided about when regulatory action is expected in relation to conduct outside the workplace. Overall, the suggestion was that wrongdoing by an individual doctor was unlikely to affect trust in the profession as a whole as members of the public took the view that incidences of wrongdoing amongst doctors are isolated to 'a few bad apples'.

108. It is apparent that there is strong support for Dr Benn, at least amongst some sections of the public and the profession. The letter from the Chair of the British Medical Association dated 29 April 2024 states:

> "It is not a universally held view by doctors that Dr Benn's conduct had been such as to bring the profession into disrepute."

Concerns are raised about the worrying message to doctors about the regulation of matters not directly related to patient care or their clinical skills. However, there is no doubt that regulation extends beyond that. It follows that, although the letter provides some support for Dr Benn, it does not represent a unified view from the profession nor does it reflect the same careful evaluative judgment which the Tribunal were required to make.

109. It is not straightforward to ascertain what the majority of the public would think about Dr Benn's conduct after taking account of all the circumstances, including her motivations and her stated intention to continue to act outside the law. In *Beckwith* the court said [54] that popular outcry is not proof that a particular set of events gives rise to any matter falling within a regulator's remit. Equally, popular outcry cannot form a basis for concluding that misconduct falls outside the regulator's remit.

110. I agree with Ms Richards that asking what the overwhelming majority of the public would think is not the right question. I disagree that the Tribunal failed to ask the correct question, namely whether a finding that Dr Benn's fitness to practise was not impaired would undermine public confidence or undermine the maintenance of proper standards and conduct for members of the profession. This is exactly what the Tribunal addressed in their conclusion.

111. I have accepted that the Tribunal overstated the requirement to act within the law at the misconduct stage. That was carried into their findings on impairment. However, I do not accept that the Tribunal were narrowly and rigidly focused on the mere fact of non-adherence to the law. On the contrary, it is apparent that the Tribunal gave careful consideration to all the unusual circumstances of this case, including Dr Benn's motivations and her stated intention to continue to act outside the law.

112. It is not helpful to draw on the Convictions Guidance or Sanctions Guidance at this stage. The Tribunal did not proceed on the basis that all law-breaking would lead to a finding of impairment of fitness to practise. They properly focused on the misconduct they had found proved and the circumstances surrounding that. Dr Benn's motivations for her misconduct were relevant, and were taken into account. They were not decisive of the issues the Tribunal had to decide. Drawing comparison with motivations for other forms of misconduct is not helpful.

113. Ms Richards accepted that, even if the compelling scientific case in relation to climate change and the need for action is accepted, there is room for difference of opinion about what needs to happen and how it should be achieved. These are matters that society as a whole has to tackle. Dr Benn takes the view that the situation is so desperate that what is now required cannot be achieved by lawful means. However, society functions by all citizens abiding by the law. A doctor's status as a trusted professional is called into question if she not merely breaks the law but refuses to be bound by the law.

114. The respectability and merits of the cause do not lead to a different conclusion. The Tribunal expressed respect for Dr Benn's views, for her right to hold them and her right to express them. She was perfectly entitled to campaign vigorously and to protest. She was entitled to do so invoking her status as a doctor to engender trust and support for her views. (Contrast the position in *Adil* where the doctor was expressing views on the Covid 19 virus which did not have any proper medical or scientific support.) What she was not entitled to do was to rely on her status as a member of the medical profession and the special trust that brings while repeatedly defying a court order (causing public disruption on the final occasion) resulting in her imprisonment.

115. In advancing the environmental cause, Dr Benn relied upon her status as a doctor and the public expectation that doctors are law-abiding citizens. The respect which the medical profession commands within society generally depends on the exercise of high personal and professional standards by the profession as a whole. Dr Benn knew that what she was doing was outside the "norms and boundaries" set for the profession. The special trust which she relied upon to bring greater attention to the cause she sought to advance would be lost, or significantly undermined, if doctors generally decided that they could disregard the law in pursuit of a cause they felt very strongly about. That is so notwithstanding that many members of the public and other doctors would be sympathetic to Dr Benn and to her cause. To that extent, Dr Benn's conduct was capable of undermining public trust in the medical profession.

116. Even if that were not so, the need to maintain proper professional standards and conduct must be considered. The finding on misconduct was that Dr Benn's behaviour had fallen far below what was reasonably to be expected of a medical professional. The Tribunal did not treat that as automatically leading to a finding that her fitness to practise was impaired. They considered that:

> "…in principle, matters were easily remediable in that Dr Benn could decide for herself not to break the law again, and doing this would not preclude her continued involvement in environmental activism."

117. In other words, the finding that Dr Benn's fitness to practise was impaired was not based merely on historical wrongdoing which fell below the standards of personal

conduct expected of a doctor but also took account of Dr Benn's stated intention to continue to behave in the same way. In my judgment, it is not wrong to regard Dr Benn's conduct in repeatedly breaching the injunction (to the extent she was imprisoned) and her stated intention to continue to act outside the law as being incompatible with her status as a member of the profession, whatever her motivations for that.

118. It follows that I do not consider that the Tribunal were wrong to find that Dr Benn's fitness to practise was impaired.

Sanction

119. No issue arises as to the legal approach taken on sanction. The Tribunal recognised the need for proportionality and that the purpose of any sanction was not punitive but to protect patients and the wider public interest. The Tribunal had regard to the Sanctions Guidance. The challenge is to the application of the principles to the facts.

120. The courts show an appropriate degree of deference and respect to the Tribunal, recognising their greater expertise in judging the relationship between the nature and gravity of the offending on the one hand, and promoting professional standards and maintaining public trust on the other (see *Adil* [90]). However, that is not to abrogate responsibility for deciding whether the sanction was appropriate and necessary in the public interest (*Sastry* [112]).

121. Having regard to my conclusions in relation to misconduct and impairment of fitness to practise, I consider that suspension was a necessary and proportionate response. That may well not have been the case had Dr Benn recognised that she should conduct herself within the standards expected of the profession in the future. As the Tribunal noted, that would not be to preclude her continued involvement in environmental activism, including taking part in lawful protests.

122. I have taken account of Dr Benn's motivations in reaching my conclusions on misconduct and impairment. In light of those conclusions, there were no exceptional circumstances justifying taking no action. Dr Benn had demonstrated that she intended to continue to act as she had done previously. Her desire was to remain registered as a doctor while continuing to commit acts found to amount to misconduct in the statutory sense. In those circumstances, action is necessary to uphold the relevant statutory objectives.

123. The Tribunal referred back to their finding at the misconduct stage that it was not for them to "seek to reframe [the obligations of a doctor under GMP] or to caveat the requirement to act within the law by deciding on circumstances where a doctor is permitted to deliberately act outside the law." That may have been expressed a little clumsily but, in the context of sanction, it perhaps addresses a proper concern: if a doctor can continue to act outside the law whilst maintaining her status as a medical professional, the Tribunal would not be upholding expected standards of conduct for the profession as a whole.

124. It is not suggested that any workable conditions could be formulated. Dr Benn had made it clear that she would not be bound by any conditions that impacted on her intended actions in connection with climate activism. Although Dr Benn had suggested

that if the Tribunal were to take any action they should erase her, the Tribunal acted proportionately in imposing a period of suspension allowing for the possibility of demonstrating insight into the impact of a medical professional repeatedly acting outside the law.

125. The Tribunal's consideration of the question of insight was fair. I have found that Dr Benn's arguments about the impact of her actions are not realistic. The simple fact is that Dr Benn believes that it is appropriate to continue to take action that is unlawful to draw attention to her very real concerns about climate change. She minimises the impact of her actions on public resourcing.

126. It was reasonable to allow Dr Benn the opportunity to reflect on the impact of her stated intent to continue her misconduct on her standing as a medical professional. On the other hand, her clearly stated belief is that the need for action to avert climate disaster overrides the requirement to act within the law or the normal bounds of the profession. In those circumstances, the fact and length of the suspension was necessary and proportionate and it was also necessary and reasonable to direct a review hearing.

127. Accordingly, I agree with the Tribunal's decision on sanction.

Conclusion

128. For the reasons I have set out in detail above, I would uphold the decision of the Tribunal that Dr Benn's fitness to practise was impaired through misconduct and that her registration should be suspended for a period of five months with a review hearing to be convened shortly before the end of that period.

129. This appeal is accordingly dismissed.