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CO/3228/2021

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 11/02/2022

Before :

THE HONOURABLE MRS JUSTICE COLLINS RICE

Between

DR RAISAH SAWATI

Appellant

- and -

THE GENERAL MEDICAL COUNCIL

Respondent

Mr Martin Forde QC (instructed by the Medical Protection Society/Medical Defence Union)
for the **Appellant**

Ms Catherine Callaghan QC (instructed by GMC Legal) for the **Respondent**

Hearing dates: 18th & 19th January 2022

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Approved Judgment

Mrs Justice Collins Rice:

Introduction

1. Raisah Sawati had set her heart on becoming a doctor since her mid-teens. She won a place at Manchester University to study medicine, graduating in 2012. By August 2013 she had completed the first year of her foundation clinical training and was embarking on her second. But she started to encounter setbacks.
2. Matters came to a head in 2017 when, her second year of training still incomplete, she was reported to the General Medical Council (GMC). The GMC investigated concerns about both her performance and possible misconduct. These concluded in formal allegations, and regulatory proceedings before a Medical Practitioners Tribunal. Dr Sawati finally completed her foundation training in 2019. But on 17th August 2021, the Tribunal found a number of the GMC's allegations proved, and ordered her erasure from the register with immediate effect. Her career as a doctor was ended before it had got fully under way.
3. Dr Sawati appeals that decision, as is her right under section 40 of the Medical Act 1983. She says there were serious defects in the Tribunal's approach to some of its findings of fact, and to its sanction decision, making the outcome wrong and unfair.

The Tribunal proceedings

(i) The allegations, defences and findings of fact

4. Dr Sawati faced allegations of misconduct relating to six separate incidents over a period of four years between January 2014 and January 2018. She also faced allegations of deficient professional performance, based on a GMC performance assessment carried out between November and December 2018.
 - (a) *The first misconduct allegation (patient records/dishonesty)*
 5. This related to an incident during Dr Sawati's first placement. She had seen a patient in a nursing home on 6th January 2014 and noted in his records 'upper respiratory infection' and 'aggressive behaviour'. The patient died the following morning of respiratory causes. Dr Sawati agreed that a few hours later, knowing that, she added to her previous note, under the heading 'upper respiratory infection', that she had discussed the patient's case and medication with her clinical supervisor. It was accepted she had discussed the case with her supervisor. But it was alleged she had not discussed the respiratory symptoms. It was not alleged Dr Sawati's conduct had had any effect on the patient or his care. But the GMC objected that the addition to the record was made improperly, without indicating it was retrospective, and was knowingly misleading and dishonest.
 6. Dr Sawati said she '*believed*' or '*was fairly certain*' that she had discussed the respiratory symptoms as well as the aggressive behaviour. She denied dishonesty in any event. She accepted (and the performance assessment confirmed) that she had

problems with communication and record keeping. She said she had been unsure about procedure for noting an entry as being retrospective.

7. The Tribunal established as primary fact that Dr Sawati had not discussed the patient's respiratory symptoms with her supervisor, only the aggressive behaviour. It preferred the supervising doctor's evidence.
8. Turning to Dr Sawati's state of mind, the Tribunal found she knew that, as a trainee, she had to discuss the details of all the patients she saw. It was satisfied she was familiar with procedure for making retrospective entries in patients' records and noting them as such. It concluded she had in fact known she had not discussed respiratory symptoms with her supervisor. It concluded her actions were not just an example of poor record-keeping (although it accepted that was a general issue for her) and an attempt to update the records in the interests of accuracy, but '*a deliberate attempt to give the impression that she had spoken to Dr Power about Patient A's respiratory symptoms*'. It made a finding of dishonesty.

(b) *The second misconduct allegation (unauthorised absence)*

9. This related to an incident over a year later, when Dr Sawati was placed at Manchester Royal Infirmary. She agreed that on 20th January 2015, at around 11am, she asked permission from a consultant doctor to leave the main theatre block to undertake some audit work for another consultant. She accepted that around two hours later she was discovered in an on-call room lying on a bed with her eyes closed. Dr Sawati said she had been unwell but had been embarrassed to say so.
10. The Tribunal accepted Dr Sawati suffered from a longstanding and painful condition about which she was understandably sensitive. Her medical records supported that.

(c) *The third misconduct allegation (shift-swapping/dishonesty)*

11. This incident happened a further two years later, in January 2017, at another hospital placement. Dr Sawati told the hospital rota manager she had agreed with another doctor to swap shifts. It was alleged the other doctor had not agreed to swap (indeed had positively refused to do so); she had known that; and had therefore been dishonest.
12. Dr Sawati said she had formed a genuine impression that her colleague had agreed to the swap. But she acknowledged there could have been a misunderstanding, leading her to 'jump the gun'; she said other conversations about shift-swapping happened, sometimes fleeting in nature and the context of a busy hospital environment. She denied dishonesty.
13. The Tribunal found as primary fact that Dr Sawati had discussed shift-swapping with another doctor. But it preferred that doctor's account that he had not agreed to swap the shifts in question, and had said so.
14. The Tribunal rejected the idea that there could have been a misunderstanding (although it accepted that communication skills were an area of concern about Dr Sawati). In any event, it found that, on her own account, any agreement could have been provisional only (that is, expressly subject to confirmation by the other doctor). So it found that

when she reported an agreement, she must have known this at best knowingly understated its no more than provisional nature. It made a second finding of dishonesty.

(d) *The fourth misconduct allegation (self-assessment/dishonesty)*

15. On 21st January 2017, Dr Sawati was involved in the treatment of a patient brought to A&E with symptoms of cardiac arrest. She subsequently filled out a form indicating she had demonstrated a ‘leadership’ role. The GMC alleged, and Dr Sawati denied, dishonesty.
16. The Tribunal found her self-assessment had been reviewed and endorsed at the time by the consultant who had led the treatment of the patient. The Tribunal accepted that review and endorsement of these self-assessments by a more senior doctor was standard practice; they were essentially a training tool as between a doctor in foundation training and her supervisors. It had no bearing on the treatment of patients. The consultant said that on reflection his endorsement of a demonstrated leadership role was not accurate.
17. The Tribunal found the self-assessment form had been an opportunity for Dr Sawati to show she had performed well and to highlight her competencies; she had been proud of her contribution to the treatment of the cardiac patient and had wanted to show herself in the most positive light. She genuinely believed she had shown aspects of leadership and was unlikely to have been deliberately misleading in completing a form she knew would be reviewed by senior clinicians. The Tribunal was not satisfied Dr Sawati *knew* she had not demonstrated a leadership role at the time, so her actions could not be considered dishonest.

(e) *The fifth misconduct allegation (unauthorised absence)*

18. The GMC alleged that on 7th March 2017, while on duty in A&E, Dr Sawati went missing for a couple of hours and was found in the women’s changing rooms lying down on a bench, wrapped in a blanket with her eyes closed.
19. Dr Sawati said that she was again unwell and had briefly sat down to allow painkillers to work. The Tribunal accepted she had been unwell, but preferred the evidence of the senior sister who discovered her that she had been lying down, not sitting. It found she had been absent for around two hours without telling anyone she was ill.

(f) *The sixth misconduct allegation (interview/dishonesty)*

20. Dr Sawati was interviewed for a core training position on 31st January 2018. Her interviewer noted that two of her training certificates – advanced life support (ALS) and advanced trauma life support (ATLS) – had expired. It was alleged she responded that she was booked onto an ALS course in May 2018 and an ATLS course in June 2018. It was alleged she was not booked onto either course, so her reply was dishonest. Dr Sawati said her answers had been muddled and flustered and she had been confused about which course she was booked on. She denied dishonesty.
21. The Tribunal established as primary fact that Dr Sawati had said she was booked on both courses. It found she was indeed booked on the ALS course, but not the ATLS course.

22. In relation to her state of mind, the evidence of the interviewer had been that when he challenged Dr Sawati to specify exactly which courses she was booked on, she had hesitated, and then said she was not booked on either course. The Tribunal, however, rejected her account of fluster and muddle. It found she had, earlier in the interview, positively stated she was booked on the ATLS course, when she was not, and knew she was not. It made a third finding of dishonesty.

(f) *The 2018 performance assessment*

23. Her performance assessment at the end of 2018 had recorded Dr Sawati's performance as 'unacceptable' in one area (record keeping) and giving 'cause for concern' in four others (maintaining professional performance, assessment, clinical management, working with colleagues). She sought to rely on subsequent indications of improvement.

(ii) The conclusions on misconduct and impairment of fitness to practise

24. Having made its findings of fact, the Tribunal proceeded to evaluate the six misconduct allegations by reference to the standards set out in the handbook *Good Medical Practice*.
25. On the first (patient record) it found that Dr Sawati's failure to discuss the patient's respiratory symptoms with her supervisor did not fall so far short of the relevant standards as to amount to misconduct. But it held the addition to the notes, which 'suggested' she had, did amount to misconduct because it was dishonest.
26. It found the second incident (absence) did not amount to misconduct. Dr Sawati had asked to be excused, and been released from her clinical duties; she had not simply excused herself.
27. The third incident (shift-swapping) was held to be serious misconduct. She had put her colleague in a difficult position. This was a failure to work collaboratively and a failure of good communication. These, and in particular the finding that they had been failures of a dishonest nature, justified a finding of serious misconduct.
28. No misconduct was found in relation to the fourth incident (self-reporting). No finding of dishonesty had been made.
29. The Tribunal found the fifth incident (absence) of concern because Dr Sawati left the clinical area without telling anyone. Her patients were left unattended and did not have a clinical decision recorded. Nursing staff and the registrar were looking for her to ask about patients. No patients came to any harm, but she was inconveniencing colleagues and there was an inherent risk to patients in her behaviour. It was held to be unprofessional to the point of misconduct.
30. In relation to the sixth incident (interview), the Tribunal found the certificates being out of date did not amount to misconduct; they were not mandatory. But it held that dishonestly stating in interview that she was booked on the ATLS course when she knew she was not, amounted to misconduct.
31. It had therefore found four counts of misconduct proved: one relating to two hours' unauthorised absence and three in which the misconduct was dishonest.

32. In considering whether Dr Sawati's fitness to practise was impaired as a result of misconduct, the Tribunal directed itself to the four-fold test established by Dame Janet Smith in her fifth Shipman Report: impairment will arise where a doctor (a) presents a risk to patients, (b) has brought the profession into disrepute, (c) has breached one of the fundamental tenets of the profession or (d) has acted in such a way that her integrity can no longer be relied upon.

33. It concluded:

168. The Tribunal considered the nature and extent of Dr Sawati's misconduct generally. The Tribunal had found dishonesty in relation to three of the charges which dated from January 2014 to January 2018, a four-year period. At the time of the first incident, the Tribunal recognised that Dr Sawati was a very junior doctor in her first community placement at Alexandra Practice and she was already known to have some performance difficulties.

169. The Tribunal considered whether in the light of its further findings of dishonesty and her missing from duty at Fairfield Hospital in March 2017, Dr Sawati's conduct was part of an habitual failure on her part to deal with professional challenges and address her own shortcomings. The Tribunal considered Dr Sawati may have a capacity to deceive herself in response to particular challenges or difficulties.

...

171. The Tribunal found that Dr Sawati went missing for around two hours while on a night shift at the A&E Department at Fairfield Hospital, without informing anybody. This had the potential to put patients at risk. While there was no evidence that patients did come to harm, the Tribunal was satisfied that Dr Sawati has acted in a way whereby if repeated she is liable in the future to put patients at unwarranted risk of harm.

172. The Tribunal was satisfied that through the three instances of dishonesty and having gone missing for two hours on shift, Dr Sawati brought the reputation of the profession into disrepute.

173. The Tribunal considered that given the various breaches of Good Medical Practice identified in the three instances of dishonesty and her going missing while on shift, Dr Sawati also breached fundamental tenets of the profession.

174. Given the three findings of dishonesty, it follows that Dr Sawati has in the past acted dishonestly.

175. Accordingly, the Tribunal found that all four limbs of Dame Janet Smith's test for impairment are engaged in this case.

34. It also found her fitness to practise impaired by reason of the deficiencies detailed in the 2018 performance assessment.
35. It found little evidence of Dr Sawati's insight – a necessary precondition to the possibility of remediation. It bore in mind that dishonesty in general is difficult to remediate, and it had found three instances of it. It considered the reflections Dr Sawati had submitted demonstrated only partial insight and remediation. It concluded that the combination of the gravity of the misconduct found, Dr Sawati's limited insight and remediation, and the performance concerns in relation to which impairment was admitted, made a finding of impairment necessary to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of the profession.
36. As for impairment by reason of deficient professional performance, Dr Sawati pointed out that she had completed Foundation Training in August 2019, which she said showed that her performance had improved since the 2018 assessment. The Tribunal bore in mind that she had been suspended since April 2020, but found insufficient evidence of continuing remediation such as Continuing Professional Development certificates or evidence of completing online courses.

(iii) Sanction

37. The Tribunal addressed itself to the relevant Sanctions Guidance. It identified several aggravating factors. There was the *extent* of the dishonesty – not an isolated incident, but on three occasions. There was her 'only partial' insight '*compounded by her failure to tell the truth at the hearing*'. She had failed to reflect on her shortcomings and show timely improvement.
38. In mitigation, the Tribunal accepted she had co-operated with the performance assessment. She had made 'a number of admissions' to the Tribunal. She had no previous findings of impairment against her and had not previously appeared before a Tribunal. The first instance of dishonesty (patient record) had occurred over seven years previously when Dr Sawati was at a very early stage in her career. Workplace stress and panicked response were acknowledged to be some part of the story, but provided 'no excuse for dishonesty'. There were positive testimonials, but they were made prior to confirmation of the facts of her misconduct.
39. The Tribunal considered the aggravations outweighed the mitigations. It was concerned about her 'difficulties in adopting and embedding meaningful and positive change'. She had not learned from her mistakes – whether as to completion of forms or as to unauthorised absences. Her deficiencies were 'unlikely to be remedied during a period of suspension because of her continuing lack of insight and the failure of previous interventions'. It concluded:

The Tribunal also bore in mind its three findings of dishonesty and that dishonesty is difficult to remediate. The combination of proven dishonesty and admitted deficient professional performance, together with Dr Sawati's lack of insight and failure to learn from her mistakes, makes suspension an inadequate sanction in view of the overall seriousness of Dr Sawati's impairments.

40. Going on to consider the criteria for erasure, the Tribunal considered the following factors, any of which according to the Sanctions Guidance may indicate that erasure is appropriate, were present:

- a. A particularly serious departure from the principles set out in *Good Medical Practice* where the behaviour is fundamentally incompatible with being a doctor.
- b. A deliberate or reckless disregard for the principles set out in *Good Medical Practice* and/or patient safety.
- h. Dishonesty, especially where persistent and/or covered up.
- j. Persistent lack of insight into the seriousness of their actions or the consequences.

41. It held as follows:

243. The Tribunal concluded that Dr Sawati had breached a significant number of paragraphs of GMP [*Good Medical Practice*] over several years, which demonstrated her serious departure from the principles of GMP and her reckless disregard for them.

244. Dr Sawati's dishonesty over four years was persistent.

245. The Tribunal was concerned by the underdeveloped and incomplete nature of Dr Sawati's insight into her performance deficits and her deficits in professionalism, over a period of years. The Tribunal cannot be satisfied that any improvements made by Dr Sawati have been maintained during her suspension from practice since April 2020. Although she has not had face-to-face contact with patients, she would have had multiple opportunities to undertake CPD and other learning.

246. The Tribunal were aware that when the Performance Assessors came to their conclusion that Dr Sawati was fit to practise on a limited basis, they did not have available to them the findings of dishonesty which were determined by this Tribunal.

247. With regard to Dr Sawati's insight into her dishonesty, her insight remains partial at best. Her failure to tell the truth at the hearing is further evidence of her lack of insight.

42. The Tribunal concluded erasure was necessary in the public interest.

Grounds of appeal

43. Dr Sawati challenges the Tribunal's decision for two reasons.

44. First, she says the dishonesty findings are unsustainable. She says the Tribunal went wrong procedurally in making the first dishonesty finding (patient record) because, on the face of its determination, it was only *after* it had found dishonesty proved that it turned to consider Dr Sawati's good character and her problems with communication. She says this is wrong because the decided legal cases establish that these factors are importantly relevant to *whether* there has been dishonesty in the first place, and should therefore have been considered *before* any conclusion on dishonesty was reached. She also says that mistake then infected the subsequent findings of dishonesty as well.
45. Second, she says that on any basis the sanction of erasure was wrong and/or procedurally unfair.

Legal framework

46. This is an appeal to which CPR Part 52 applies: the High Court will allow an appeal if satisfied that the Tribunal decision was (a) wrong or (b) unjust because of serious procedural or other irregularity in its proceedings.
47. There is no dispute about the proper approach of the High Court to appeals brought under section 40 of the Medical Act 1983. I have directed myself to the judgment of Laws LJ in *Raschid & Fatnani v GMC* [2007] EWCA Civ 46; [2007] 1 W.L.R. 1460, particularly paragraphs 16-20; Cranston J's summary of the relevant principles in *Yassin v GMC* [2015] EWHC 2955 (Admin) at paragraph 32 and, most recently, this distillation by Nicola Davies LJ in *Sastry & Okpara v GMC* [2021] EWCA Civ 623; [2021] 1 W.L.R. 5029 with particular reference to appeals against sanction:
102. Derived from *Ghosh* are the following points as to the nature and extent of the section 40 appeal and the approach of the appellate court:
- (i) an unqualified statutory right of appeal by medical practitioners pursuant to section 40 of the 1983 Act;
 - (ii) the jurisdiction of the court is appellate, not supervisory;
 - (iii) the appeal is by way of a rehearing in which the court is fully entitled to substitute its own decision for that of the tribunal;
 - (iv) the appellate court will not defer to the judgment of the tribunal more than is warranted by the circumstances;
 - (v) the appellate court must decide whether the sanction imposed was appropriate and necessary in the public interest or was excessive and disproportionate;
 - (vi) in the latter event, the appellate court should substitute some other penalty or remit the case to the tribunal for reconsideration.
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).
50. Further guidance is provided by the Court of Appeal in *Bawa-Garba v GMC* [2018] EWCA Civ 1879; [2019] 1 WLR 1929, at paragraphs 60-67. A sanction decision of the Tribunal is an evaluative decision based on many factors – a 'multifactorial decision' involving a mixture of fact and law. An appellate court's approach should be conditioned by the extent to which it is at a relative disadvantage. It should interfere only if it identifies an error of principle by the Tribunal in carrying out the evaluation, or the evaluation was wrong because it falls outside the bounds of what the Tribunal could properly and reasonably decide.

Analysis

(i) Good character and the findings of dishonesty

51. The challenge here focuses on paragraph 46 of the Tribunal's factual determination, setting out why it found the addition to the patient's record dishonest. The Tribunal had found as fact that when the patient died, Dr Sawati, remembering she had discussed the case but knowing she had not mentioned the respiratory symptoms, made a retrospective entry under the heading 'respiratory symptoms' that she had 'discussed' *the case*. The Tribunal found this dishonest by the following route:

46. The Tribunal determined that Dr Sawati knew how to make retrospective entries in the medical records, but tried to conceal that this entry was made retrospectively. Having arrived at this view, the Tribunal took account of Dr Sawati's good character and the evidence of the Performance Assessment in relation to her poor record keeping, which included making inaccurate and imprecise records. However, the Tribunal was satisfied on the evidence before it that Dr Sawati's amendment to Patient A's medical records at 12.20 was not merely an example of poor record keeping, but a deliberate attempt to give the impression that she had spoken to Dr Power about Patient A's respiratory problems.

52. The problem with this, it is said, is that considering good character '*having arrived at this view*' is the wrong way round, and misapplies the law on the relevance of good character to approaching determinations of dishonesty.

(a) *The correct approach to good character*

53. The correct approach is set out in a series of regulatory appeal decisions. The Divisional Court in *Donkin v Law Society* [2007] EWHC 414 (Admin) held ‘cogent evidence of positive good character’ is *relevant* to consideration of dishonesty, although the *weight* to be attached to it is in the end a matter for the Tribunal. (The Tribunal in that case had completely overlooked it.)
54. *Wisson v Health Professions Council* [2013] EWHC 1036 (Admin) expanded on the *relevance* of good character (paragraphs 41-44). It has two aspects. First, it can go to credibility – how reasonable it is to believe or disbelieve what an individual says. Second, it can go to propensity – the probability that they have misconducted themselves. It may be considered less likely that an erstwhile blameless person has seriously misconducted themselves if they have never done so before. Again, the *weight* to be attached to good character is a matter for the Tribunal undertaking the factual evaluation.
55. The Divisional Court confirmed that analysis in *Martin v SRA* [2020] EWHC 3525 (Admin) at paragraphs 51-54: ‘*evidence of good character is relevant to credibility and to propensity in relation to allegations of dishonesty*’. The Court cautioned though against overstating the significance of such evidence; it should not detract from the primary focus on the evidence directly relevant to the alleged wrongdoing. And again, the Court found on the facts of that case that the challenge on this ground was ‘*in reality, no more than a challenge to the weight the Tribunal attached to Ms Martin’s previous good character. Decisions as to the weight to be attached to particular parts of the evidence are pre-eminently a matter for the fact finder and ought not to be disturbed on appeal unless the decision is one that no reasonable tribunal could have reached*’.
56. The issue was considered recently in *Khan v GMC* [2021] EWHC 374 (Admin). This was a challenge that a Tribunal had failed to have adequate regard to good character. The Judge accepted that in professional disciplinary proceedings good character is relevant to both credibility and propensity, but found it ‘impossible to infer that the Tribunal must then have left it wholly out of account’ once it was established that the Tribunal had received submissions and a proper direction from the legally-qualified Chair about how to approach good character. He said this at paragraph 92:

From these authorities I derive the following. Whilst a disciplinary Tribunal must take good character evidence into account in its assessment of credibility and propensity, *Donkin*, supra, and *Bryant*, supra, show it is an error not to do so, it is not required slavishly in its reasons to give a self-direction to that effect (although if it does do so, there can be no room for argument – a proposition Ms Hearnden did not disagree with). It is sufficient, where the matter is raised on appeal, if the appeal court is able to infer from all the material that the Tribunal must have taken good character properly into account. That is the conclusion I reach in this case. It would be simply unrealistic to suppose that the Tribunal overlooked it, given what it had received orally and in writing including, most importantly, a clear direction from its legally qualified Chair, who was a constituent member of the Tribunal. In *Donkin*, supra, Maurice

Kay LJ said at [25] that, 'I am not satisfied from the text of the stated Reasons that [good character] played any part in its consideration of dishonesty.' That, it seems to me, was a conclusion on the particular facts of that case. I have concluded that is not the situation here.

(b) *The Tribunal's handling of good character*

57. In the present case, Dr Sawati's good character (that is, the absence of previous GMC findings against her) was a formally 'agreed fact' between the parties at the outset of the Tribunal proceedings.

58. It is also agreed the Tribunal had been provided with accurate written legal advice on three specific issues: witness credibility and memory, dishonesty, and good character. The advice set the issues out in that order, but makes clear they are interrelated. About dishonesty, the advice to the Tribunal was that:

26. When considering the question of dishonesty, you must [footnote: *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67] firstly ascertain Dr Sawati's actual knowledge or belief as to the facts: that is, ascertain what she genuinely knew, or genuinely believed the facts to be.

...

28. Secondly, having determined Dr Sawati's state of knowledge or state of belief, the Tribunal must then go on to determine whether her conduct, as you have found it to be, was honest or dishonest by the standards of ordinary decent people.

59. The advice about good character was this:

31. To be clear, good character is not of itself a defence to an allegation.

32. Nevertheless, caselaw [footnote: *Wisson v. Health Professions Council* [2013] EWHC 1036 (Admin)] has established that good character can properly be material, and is material, at the facts-finding stage of your deliberations when considering a practitioner's credibility. It is not limited to allegations of dishonesty.

33. In Dr Sawati's case, 'good character' arises from the lack of any previous findings against her by the General Medical Council.

34. In general terms, 'good character' is capable of being counted in a practitioner's favour in two ways:

- The Tribunal may decide that good character evidence supports a practitioner's credibility, and so is something which the Tribunal should take into account when

deciding whether they believe her evidence (the 'credibility limb'); and

- Good character evidence may mean that the practitioner is less likely to do as alleged in the allegation (the 'propensity limb').

35. The weight that you, as a Tribunal, attach to this at the fact-finding stage is a matter for you. You must, of course, consider all the evidence that has been placed before you that bears on each fact which remains in dispute. Nevertheless, it is one thing that the Tribunal can take into account.

60. The Tribunal's determination - after setting out the preliminary details of the case but before turning to its analysis of the evidence and its factual findings - includes a summary of this legal advice. The summary includes a note (at paragraph 23) that the Tribunal had been advised that Dr Sawati was '*entitled to a good character direction*'.
61. After the summary, the determination proceeds immediately to analyse the first misconduct allegation and to find the preliminary facts: no discussion of respiratory symptoms, knowledge of that at the time, knowledge of how to flag up a record entry as retrospective but failure to do so. It deduced from these, and from the location of the note under the relevant heading, that Dr Sawati's intention had been, without saying so in so many words, to give an impression that she had discussed the respiratory symptoms and to conceal the retrospective nature of the entry. It directed itself to her good character and the evidence of the performance assessment that supported her explanation of honest poor record keeping and communications. It rejected her explanation. It found her actions dishonest by the standards of ordinary decent people.

(c) *Consideration*

62. The ground of challenge to the Tribunal's finding of dishonesty is limited to the point that the good character direction should have come earlier in this analysis than it did. The Tribunal, it is said, should have directed itself expressly, and at the outset of the analysis, to the need to take good character into account as to credibility and propensity. It went wrong because it had made up its mind about credibility before it considered good character. There is no sign, it is said, of giving Dr Sawati the benefit of the doubt to which a good character direction properly entitled her.
63. The guidance from the recent authorities is clear about the approach needed on such a question. (*Martin* at paragraph 33; *GMC v Awan* [2020] EWHC 1553 (Admin) at paragraph 12). The Tribunal's decision must be read fairly, as a whole, in context and having regard to its structure. An appeal court should decline invitations to narrow textual analysis questing after misdirection. Unless there is a compelling reason to the contrary, it is appropriate to take it that a tribunal has understood its functions and fully taken into account all the evidence and submissions. As to good character in particular, it is sufficient to be able to infer from all the material that it has been taken properly into account (*Khan*).
64. Here, the Tribunal had clear and correct advice on good character, which it recited in an accurate summary at the outset of its determination of facts. It gave itself a self-

direction – which *Khan* indicates leaves little room for doubt, on appeal – in the process of resolving both elements of its first dishonesty finding (subjective state of knowledge and objective test of standards of honesty). The challenge that it should have done so a few sentences or even paragraphs earlier, or did not sufficiently explain *how* it reached the conclusions it did consistently with its self-direction, is in my view an invitation to narrow textual analysis, and not sustainable in itself as a sign of serious procedural irregularity, unfairness or defective conclusion.

65. The Tribunal properly maintained its ‘primary focus’ on the *specific* evidence directly relevant to the alleged wrongdoing. That included the inference raised on the face of Dr Sawati’s addition by its place under the heading ‘respiratory symptoms’ and lack of flagging as retrospective, in a factual context in which no discussion of symptoms had taken place. It included Dr Sawati’s own explanation of the events in question. It also included evidence of her knowledge of how to make proper retrospective entries, and of her motivation, as an inexperienced practitioner in the aftermath of a patient’s death, to mitigate or mask her omission.
66. It is not in all the circumstances sustainable that the Tribunal did not have her good character in mind ‘*at all*’ in this context, or that it was only mentioned as an afterthought when it had closed its mind to its relevance or the possibility of its influence. Nor is it sustainable that the Tribunal failed to give enough *explanation* for its overall conclusions on state of mind and dishonesty, based on this evidence. Dr Sawati, and other readers of the determination, can follow sufficiently why the Tribunal did not accept her position.
67. The Tribunal did not apparently give the good character evidence conclusive, or perhaps significant, *weight*. Three things may however be said about that.
68. First, as the authorities indicate, the Tribunal was entitled to weigh the *specific* factors relating to the actual events more decisively than the *general* factors relating to credibility and propensity, not least given it had seen and heard Dr Sawati for itself and, as is agreed, been properly directed on the correct approach to assessing credibility. The importance of general factors is not to be ‘overstated’.
69. Second, the weight given to an unblemished record may properly be less in the case of a doctor at an early stage in her career than a doctor with an established track record – accepting also that inexperience may be a correspondingly weightier consideration in understanding what happened.
70. Third, in any event, ‘decisions as to the weight to be attached to particular parts of the evidence are pre-eminently a matter for the fact finder and ought not to be disturbed on appeal unless the decision is one that no reasonable tribunal could have reached. (*Martin v SRA* at paragraph 54). That is not contended here, and I cannot in all the circumstances go so far.

(d) *Conclusions*

71. My conclusion is that the Tribunal’s decision on the first allegation of dishonesty (patient record) is one that was at least open to it on the *totality* of the evidence, properly addressed. It was not ‘wrong’ in that sense. I am also unpersuaded there is significant irregularity in its approach or reasoning sufficient to render its decision opaque or

unfair. The Tribunal was the proper primary fact-finder and I do not find a sufficient basis to disturb its factual findings. In the circumstances, the premise that *this* alleged defect in the first finding of dishonesty infects the others must also fail.

72. Some attempt was made in oral submissions on Dr Sawati's behalf to suggest that the dishonesty findings might be considered unsustainable for other reasons. That is not, in fairness, the basis on which this appeal has been brought. The challenge to the Tribunal's fact-finding is limited to the issue of good character, and that is the basis on which I have considered it.
73. In the circumstances, I limit myself to observing that on the face of the factual determination there is no obvious indication that the Tribunal had unfairly closed its mind on the question of Dr Sawati's credibility and honesty or adversely prejudged the other dishonesty allegations. It addressed itself to their respective merits. It did not find them all proved, or proved in all respects. If it looked for objective corroboration of Dr Sawati's accounts and explanations, and if it in all the circumstances preferred others' evidence to hers on an issue by issue basis, then it was on the face of it entitled to do that for the reasons it gave.
74. I do not, in conclusion, find a basis in this appeal for disturbing the Tribunal's factual determinations.

(ii) The sanction decision

(a) The 'rejected defence' issue

75. The challenge to the decision to erase Dr Sawati from the register raises an issue which has regularly engaged the appellate courts in recent years: how a professional can have a *fair* chance before a Tribunal to resist allegations, particularly of dishonesty, without finding the resistance itself *unfairly* counting against them if they are unsuccessful. The issue can arise at both the impairment and sanction stages of a determination, although here it is only the sanction decision which is challenged. Dr Sawati says the fact she maintained her honesty in her defences at the fact-finding stage was unfairly held against her at the sanctions stage.
76. Two possible routes to a rejected defence counting against an individual are familiar from the cases. The first is 'lack of insight'. As a general principle, insight – an acknowledgment and appreciation of a failing, its magnitude, and its consequences for others – is essential for that failing to be properly understood, addressed and eliminated for the future. Future risk – to patients or to public confidence in general – is a proper preoccupation of Tribunals. If a doctor's performance or conduct is faulty, but they do not have insight into that, that can give good grounds for concern that they are unlikely to be able to address and remediate it, and hence that they pose a continuing risk.
77. But there is a potential trap where the failing in question is a defect of honesty. Dishonesty is a serious charge against a professional, potentially putting a career at risk. Dishonesty is often said in general to be 'difficult to remediate'; it tends to be viewed as a defect of character. But if a doctor whose career is on the line denies dishonesty and finds their defence rejected, they are at risk of being found *for that reason* to 'be in denial' about, or 'lack insight' into, their fault – and 'difficult to remediate' is converted into 'irremediable'.

78. The second route is ‘not telling the truth to the Tribunal’. How a professional responds to formal proceedings may be relevant to an overall assessment of their professionalism: putting the public’s interests ahead of their own, integrity and candour, and other important considerations may be engaged, as well as insight and remediability. Lying to Tribunals and putting forward disingenuous or meretricious defences cannot be expected to be consequence-free.
79. But where a doctor unsuccessfully defends a dishonesty allegation, they are at risk of being found *for that reason* not to have told the Tribunal ‘the truth’ (about being dishonest) and therefore to be compounding the dishonesty – a predicament labelled before now as Kafkaesque.
80. Two important and fundamental public policy interests are in tension here. The first is the right to a fair trial for doctors facing charges involving dishonesty, with a proper opportunity to resist potentially career-ending allegations. The second is the necessity for protecting patients and the public, who place a huge amount of trust in doctors (as indeed they must), from practitioners on whose honesty and integrity they cannot rely. These principles may be simply stated. How the tension between them is resolved on the facts of individual cases may be difficult.

(b) *The ‘rejected defence’ caselaw: principles and relevant facts*

81. The ‘rejected defence’ issue has been exercising the appellate courts to the extent that it was put to me in legal submissions that there are now conflicting lines of authority dealing with it. I do not agree about that, but the way the courts reconcile the competing public interests engaged seems highly fact-sensitive. For that reason, in order to consider how the law and principles about rejected defences apply to Dr Sawati’s case, it is necessary to examine the caselaw in some detail, looking at both the articulation of principle and the patterning of facts.
82. There is a frequently quoted passage from the judgment of Lord Hoffmann in *Misra v GMC* [2003] UKPC 7 at paragraph 17, which dates from the time when doctors’ appeals went to the Privy Council. It is memorably cited in a later case as illustrating that his Lordship ‘*deprecated additional charges being brought [against doctors by the GMC] based on a disbelieved defence*’, and contains the following perspective on the ‘rejected defence’ issue:

Their Lordships enquired of Mr Greene, counsel for the GMC, whether it was a general GMC practice where charges of professional misconduct were being made to add to the factual allegations on which the charges were based an allegation of dishonesty in the event that the respondent doctor had had the temerity to deny any of the factual allegations. Counsel told their Lordships that it was not the general practice and that he was not aware of a previous case where that had been done. No explanation of why it was thought right to add the allegations of dishonesty in the present case was offered. In their Lordships’ opinion the addition of the allegations of dishonesty in the present case was unnecessary and oppressive. The allegations added nothing to what would have been shown to be the degree

of culpability of Dr Misra if the substantive allegations that he had declined to admit were found proved against him.

83. This passage, although directed to GMC charging practice, crisply articulates the danger of ‘oppression’ which lurks in putting doctors in a position not only of having to defend allegations of misconduct but also of having to defend their defences. That danger of oppression needs to be recognised by Tribunals also, approaching evaluative judgments about sanction. The danger lies not only in bringing secondary charges of dishonesty. It lies also in the Tribunal’s established ability to take into account conduct with which a doctor has not been formally charged at all.
84. *Nicholas-Pillai v GMC [2009] EWHC 1048 (Admin)* was a case where a doctor faced legal action by a patient over an unsatisfactory operation; he responded to the patient’s solicitors with forged clinical notes about the operation. It is often cited to illustrate the seriousness with which dishonesty can expect to be viewed in misconduct proceedings, and also for this starting-point statement of principle at paragraph 19:

In the ordinary case such as this, the attitude of the practitioner to the events which give rise to the specific allegations against him is, in principle, something which can be taken into account either in his favour or against him by the panel, both at the stage when it considers whether his fitness to practise is impaired, and at the stage of determining what sanction should be imposed upon him.

Because sanctions are imposed for public interest reasons (protecting patients and maintaining public confidence in the profession and its standards), a Tribunal is ‘*clearly entitled*’ to take into account material other than the allegations before it as potentially relevant to impairment and sanction decisions.

85. The Court noted (paragraph 17) that if the doctor had acknowledged the forgery and the intention to mislead, then ‘*hard though it may have been to make those admissions, they would have stood to his credit, and might have tended to suggest that his fitness to practise was not as impaired as otherwise it would ordinarily be found to have been. But he did not do that*’. There is also this interesting passage (paragraph 18):

In the view of the panel, which is not disputed, he contested the critical allegations of dishonesty and intention to mislead. That was a fact which the panel were entitled to take into account in determining whether or not his fitness to practise was impaired, even though it did not form a separate allegation against him. Indeed, it is hard to see how it could have done. One can envisage circumstances in which lying to a disciplinary panel may itself amount to professional misconduct such as to lead to a finding that fitness to practise is impaired and a severe sanction. In a case, for example, of alleged clinical error, where a doctor had given false evidence to the panel about it, the panel would not be entitled to treat that as a freestanding ground of impairment of fitness to practise leading to a sanction. If it found that the

original clinical error which founded the allegation did not impair his fitness to practise and it was only the lies told to the panel, then that would have to be pursued in separate proceedings, with the charge made the subject of a separate allegation. But that set of circumstances is likely to be highly unusual.

86. A distinction is made here between proceedings involving allegations of dishonest conduct (which, in this case, the Tribunal had regarded as being ‘*compounded by the fact that you have given inconsistent and unreliable evidence at this hearing*’) and proceedings which do not involve allegations of dishonest conduct but where the allegations are defended dishonestly. The former may be considered in the round, including conduct at the hearing as part of the overall picture, but the latter ought fairly to be separately charged. There is also a hinted distinction between ‘putting to proof’ and ‘lying on oath’. In *Nicholas-Pillai* the *primary* fact of the alteration of the notes was denied as well as the *secondary* fact of intention to mislead. Between that ‘ordinary case’ and the ‘highly unusual’ example postulated, may of course lie cases where the primary facts are admitted but the secondary fact of knowledge or intention is not. That may be a harder case to analyse.
87. That issue arose in *Motala v GMC [2017] EWHC 2923 (Admin)*. This was not a case of dishonesty, but of sexual impropriety. Wide-ranging allegations were made about the doctor’s conduct, in particular about how he had touched or examined a number of patients. The doctor’s defence was that no *sexual* touching had occurred – any problem had been one of perception on the patients’ part and at most inadvertence on his own. His disciplinary procedure had been lengthy, featuring suspension and periodic review of his progress in seeing what was wrong with his touching and understanding the vulnerabilities of his patients. Eventually, the Tribunal found he had made significant progress with insight, but was still showing worrying ambiguity about the perception/inadvertence issue.
88. The appellate Court held the Tribunal entitled to find the doctor’s attitude problematic. He appeared to be regarding the demonstration of insight as a box-ticking exercise. There was no sense he really recognised the seriousness of what he had been found to have done. The Court held the finding of lack of insight was ‘*a wholly unassailable finding of fact necessarily calling for the application of judgment to the impression given by the doctor at the review hearing*’. It accepted that ‘*the fact that he continues to deny impropriety makes it more difficult for him to demonstrate his insight*’. But it also cautioned that a Tribunal ‘*should not equate maintenance of innocence with lack of insight*’. It should not ignore the fact that the doctor continued to deny the inappropriate sexual nature of his conduct when weighing up his insight; but it should not regard it as determinative. Maintenance of innocence at a Tribunal should not automatically result in a finding of failure of insight: it is of potential relevance but its relevance should be properly considered in context.
89. Allegations about sexual impropriety and about dishonesty have in common that the maintenance of innocence and the demonstration of insight may be in complex tension. The sexual quality of touching is not however constituted wholly by the state of the mind of the doctor; it is constituted also from the experience of the patient and the lack of objective clinical justification for the acts found to have been done. In *Motala*, that quality was glaring (he gave one patient complaining of earache a breast, vaginal and

rectal examination, and his personal contact details afterwards). Lack of insight was also demonstrated not only by attitude at trial but by a long period of professional supervision, support and review focusing on exactly that issue, and which had itself followed a finding of sexual misconduct in disciplinary proceedings.

90. GMC v Khetyar [2018] EWHC 813 (Admin) was another sexual impropriety case, in which the Court expressed the conundrum this way:

Of course, no sanction was to be imposed on him for his denials as such; however insight requires that motivations and triggers be identified and understood, and if that is possible at all without there first being an acceptance that what happened did happen it will be very rare, and any assessment of ongoing risk must pay close attention to the doctor's current understanding of and attitude towards what he has done.

That was of course in order to deal with whether there was a significant risk of the behaviour being repeated. It is another case therefore in which persistent denial up to and including the sanctions stage was included in an overall assessment of failure of insight.

91. But again the facts are striking. The Court in particular noted the '*objective facts*' as found by the Tribunal, which included these:

(1) Dr Khetyar had pretended to conduct legitimate medical examinations on Patients B and C, in each case fondling their breasts for sexual reasons.

(2) Dr Khetyar continued to deny that he had done any such thing, and had given unreliable and in parts incredible evidence in his attempts to describe or explain events.

(3) There had been two similar incidents only a year apart. They were both recent in the relevant chronology, that of Dr Khetyar's working life, given that he had worked for only about nine months since the second incident. The second incident occurred despite the fact that the first led to both a police investigation and a referral to the GMC that went no further only because Patient B did not want matters to be pressed.

The relevant history of the case included the doctor's attendance at courses of '*no relevance to the true gravamen of the case proved against him*'; apologies crafted to avoid the issue, and remorse going to the effect rather than the causes of the disciplinary proceedings.

92. GMC v Awan [2020] EWHC 1553 (Admin) concerned online messages of a sexual nature with someone appearing to be a 13-year-old girl but in fact an undercover police officer. The doctor persisted in a defence that he had immediately spotted an adult 'impostor' and had conducted the conversation in order to expose her and reveal her true age. On appeal, the Court noted the Tribunal had robustly rejected this 'frankly ludicrous' defence. The GMC said the Tribunal had failed to reflect this behaviour in

its decisions on impairment and sanction, but the Court considered it ‘*inconceivable that the Tribunal did not have in mind the respondent’s dogged, yet ridiculous, defence when making its findings about insight*’.

93. The Court did not criticise the Tribunal for doing so. It did however make the following trenchant observation:

I think that it is too much to expect of an accused member of a profession who has doughtily defended an allegation on the ground that he did not do it suddenly to undergo a Damascene conversion in the impairment phase following a factual finding that he did do it. Indeed, it seems to me that to expect this of a registrant would be seriously to compromise his right of appeal against the factual finding, and add very little, if anything, to the principal allegations of culpability to be determined.

Mostyn J quoted the passage by Lord Hoffman cited above and continued:

It seems to me that an accused professional has the right to advance any defence he or she wishes and is entitled to a fair trial of that defence without facing the jeopardy, if the defence is disbelieved, of further charges or enhanced sanctions.

Consistently with that right, of course, a Tribunal has a duty to protect the public.

94. The High Court recently reviewed the principles to be derived from the ‘rejected defence’ authorities on the question of ‘*denial of allegations, insight and sanctions*’ in *Sayer v General Osteopathic Council* [2021] EWHC 370 (Admin) at paragraph 25 as follows:

(1) Insight is concerned with future risk of repetition. To this extent, it is to be distinguished from remorse for the past conduct.

(2) Denial of misconduct is not a reason to increase sanction.

(3) It is wrong to equate maintenance of innocence with lack of insight. Denial of misconduct is not an absolute bar to a finding of insight. Admitting misconduct is not a condition precedent to establishing that the registrant understands the gravity of the offending and is unlikely to repeat it.

(4) However, attitude to the underlying allegation is properly to be taken into account when weighing up insight. Where the registrant continues to deny impropriety, that makes it more difficult for him to demonstrate insight.

(5) The assessment of the extent of insight is a matter for the tribunal, weighing all the evidence and having heard the registrant. The Court should be slow to interfere.

95. Subsequent, very recent, cases have, however, continued to illustrate the fact-sensitivity, and sometimes the difficulty, of solving the conundrum. In *Towuaghantse v GMC* [2021] EWHC 681 (Admin) the charge against the doctor was of clinical failings leading to the death of a baby. A coroner's inquest had made a number of findings adverse to, and criticisms of, the doctor. The Tribunal found little evidence to suggest that he had come to a full understanding and acceptance of what had caused the tragic outcome, in particular by failing to accept any of the coroner's findings. That lack of insight led to a finding of limited capacity to remediate, which critically informed the decision on impairment and hence strongly influenced the decision on sanction.
96. The appeal came before Mostyn J. He said this, at paragraphs 61 and 63:

It is clear to me that a significant component in the decision-making process, both as to determination of impairment of fitness to practise, and in the imposition of the sanction of erasure, was the conclusion that the appellant was to be seriously faulted for (a) having contested the allegations against him at the inquest, and not having accepted the Coroner's findings, and (b) having contested the allegations against him at the MPT. The pleas of not guilty (in effect) in both courts were clearly regarded by the MPT as evidence of an incapacity to remediate and therefore of a risk to the public, as well as an aggravating feature contributing to the award of the ultimate penalty.

...

In my judgment it is not procedurally fair for a registrant to face the risk of enhanced sanctions by virtue of having robustly defended allegations made against him before the MPT, or before another court.

97. The Judge reminded himself of the passage from Lord Hoffmann in *Misra*. He considered the axiom '*a plea of not guilty attracts no aggravation; a plea of guilty, however, attracts mitigation*' broadly to hold good for disciplinary proceedings. He qualified that, however, as follows (paragraphs 71 and 72):

I can see, were a defence to be rejected as blatantly dishonest, then that would say something about impairment and fitness to practise in the future. But there would surely need to be a clear finding of blatant dishonesty for that to be allowed. Absent such a finding it would, in my judgment, be a clear encroachment of the right to a fair trial for the forensic stance of a registrant in the first phase to be used against him in the later phases.

In my judgment a distinction should be drawn between a defence of an allegation of primary concrete fact and a defence of a proposed evaluation (or exercise of discretion) deriving from primary concrete facts. The former is a binary yes/no question. The latter requires a nuanced analysis by the decision-maker with a strong subjective component. If a registrant defends an allegation of primary concrete fact by giving dishonest evidence

and by deliberately seeking to mislead the MPT then that forensic conduct would certainly say something about impairment and fitness to practise in the future. But if, at the other end of the scale, the registrant does no more than put the GMC to proof then I cannot see how that stance could be held against him in the impairment and sanctions phases. Equally, if the registrant admits the primary facts but defends a proposed evaluation of those facts in the impairment phase then it would be Kafkaesque (to use Walker J's language) if his defence were used to prove that very proposed evaluation. It would amount to saying that your fitness to practise is currently impaired because you have disputed that your fitness to practise is currently impaired.

98. 'Blatant dishonesty' in defence of an allegation of 'primary fact' emerges from this analysis as relevant to the fairness of imposing sanctions consequences on account of conduct before a Tribunal. The charge the doctor faced here was however one of clinical failure, not dishonesty.
99. *Towuagbantse* was swiftly considered in *Al Nageim v GMC [2021] EWHC 877 (Admin)*. Here dishonesty was front and centre of the allegations: the doctor was found to have gained access to certain hospital premises and facilities by deception, and to have committed fraud to the tune of over £40,000 by the retention of salary payments he knew had been made in error over a period of 27 months. The Tribunal had noted as an aggravating factor that the doctor '*did not tell the Tribunal the truth in his evidence ... and did not demonstrate any insight into this*'.
100. The Court upheld the Tribunal. Although the Tribunal had not labelled the doctor's defence 'blatantly dishonest' it could aptly be so described. The doctor had advanced a 'positive defence' about believing he was entitled to use the facilities and keep the money. The Court held this defence involved an 'allegation of primary concrete facts' rather than being 'a defence of a proposed evaluation (or exercise of discretion) deriving from primary concrete facts'.
101. On the face of it, it is not straightforward to recognise a defence centred on state of mind as being a denial of a 'primary concrete fact'. The 'primary concrete facts' might have been thought of as accessing the premises and keeping the money. But in a case *about* dishonesty, where the Tribunal had made clear findings of lies told during the doctor's evidence to the tribunal on five occasions, the Court weighed the Tribunal's approach to the doctor's defence in this way:

123. I regard the Appellant's case before the Tribunal about the salary payments as having involved especially egregious untruthfulness and dishonesty. By 2013 he had been a doctor for a number of years and he knew full well how and when NHS doctors are entitled to be paid. He could not have genuinely believed for one second that he was still entitled to be paid by the Royal Liverpool Hospital even after his contract there had come to an end. His claim that he genuinely thought the payments were some sort of ex gratia 'kindness', or a loan by the Hospital, and that after he started working in Wrexham in

August 2013 it was perfectly in order for him to receive two NHS salaries, was completely absurd.

124. It follows that I do not consider the Tribunal was at fault in having regard to this dishonesty when it came to assess the Appellant's level of insight. Its approach was in line with what Mostyn J said in *Towuagbantse*, supra, [72], that dishonesty in knowingly advancing a case of false primary fact certainly 'say[s] something about impairment and fitness to practise in the future'. And there is the point that in this case nine months passed between the facts/impairment stage and the sanction stage, in which time the Appellant had still not developed full insight into his dishonesty.

125. Taking a step back and looking at the Tribunal's reasons as a whole, this was not a case where the Appellant was being punished for daring to contest the GMC's case against him. The Tribunal found that in March 2020 he had advanced a case as to his states of mind at the time of the alleged misconduct which he knew not to be true. By December 2020 the Tribunal was not satisfied that he had full insight into that dishonesty. This was a relevant factor for it to take into account in deciding whether his dishonest misconduct was fundamentally incompatible with his continued registration.

102. Most recently, '*the issue of insight and remediation in a case where dishonesty is not accepted and an appeal against a finding of dishonesty is pursued*' was considered in *Ahmedsowida v GMC [2021] EWHC 3466 (Admin)*. It was a case involving many and complex allegations, centring on a doctor obtaining work by means of a falsified CV and then committing various clinical failings. Reflecting on the correct approach, Kerr J said this:

I do not think the principle is sophisticated or complicated. It is just ordinary due process. Contesting the charges, even robustly, should not be treated of itself as evidence of lack of insight; something more must be shown. A finding that blatant lies were told to the tribunal is one possibility. A long hiatus between the fact finding, and impairment and sanction stages may be a contributing feature.

I would not go as far as to accept Mr Forde's submission that only in rare and exceptional cases should conceding dishonesty have a bearing on insight and remediation. Unfortunately, cases of blatant lying and knowingly advancing a false case of primary fact are not all that rare in the professional discipline jurisdictions.

Another way of looking at the issue is to ask whether in substance the tribunal has fallen into the trap of finding that a practitioner's fitness to practise is impaired because he has disputed that very proposition by not admitting to the dishonesty

found against him; or, to use different words but similar reasoning, whether the practitioner "admits the primary facts but defends a proposed evaluation of those facts in the impairment phase" (*Towuaghantse* at [72]).

I cannot accept Mr Mant's submission to the effect that inconsistency between facts found by the tribunal and evidence given by the doctor to the tribunal, not readily explicable as mistaken, is sufficient in itself to found a lack of insight finding through non-acceptance of the dishonesty. That submission does not meet the constitutional point that the doctor has a right to procedural fairness and in particular an unimpaired right of appeal, which would be eroded if the GMC's stance were accepted. The right of appeal is "unqualified" (per Nicola Davies LJ in *Sastry* at [102]).

In the present case, I have concluded that Dr Sowida did face the jeopardy of a more serious outcome because of having contested the charges and because of the manner in which he contested them.

...

There was no proper examination by the tribunal of the quality of the evidence given by Dr Sowida, as distinct from his resistance to and refusal to admit the charges. There were some findings about his credibility, but those were mixed with other findings accepting large parts of his evidence; notably, on the issue of mixed authorship of misleading documents and extant source material finding its way from earlier documents into later ones.

Mr Mant was driven to invite me to infer that the tribunal must have been satisfied that Dr Sowida had lied in evidence, without the tribunal having to go to the trouble of saying as much. I do not think that is enough.

(c) *Relevant factors in 'rejected defence' cases*

103. The principle of due process may not be sophisticated or complicated. The principle of protecting the public from practitioners who cannot accept or deal with findings of fault, and are at risk of repeating their failings, is not complicated either. Reconciling the two may however be difficult in an individual case, and is undoubtedly fact-sensitive. So the question is how best to approach the facts of a given case. I have recounted the caselaw at some length, to identify not just guidance of principle, but also the pattern of relevant factors to which the appellate courts have consistently attached importance. The following stand out.

104. First: the primary allegations against the doctor. The proper place of dishonesty (or other states of mind such as ‘deliberate’ and ‘knowing’) in the scheme of the allegations matters. A rejected defence of honesty may be more fairly relevant to an overall assessment of conduct where dishonesty (the noun) is the primary allegation - deceit, fraud, forgery or similar – than where ‘dishonestly’ (the adverb) is a secondary allegation, aggravating a primary allegation of other misconduct which may or may not be done honestly – or not a formal allegation at all. As Lord Hoffmann emphasised, particular alertness is needed to the ‘charging trap’: adding ‘dishonestly’ to a primary allegation to aggravate it disproportionately, colour any denial of the primary allegation with dishonesty, or characterise denial of the dishonesty as itself dishonest or lacking insight. But even short of oppressive charging, the fair relevance to sanction of a doctor’s rejected honesty defence depends on its relationship to what they were primarily defending.
105. Second: what if anything the doctor is positively denying. There is a difference between denying ‘primary facts’ – what happened and what the doctor did or did not *do* – and denying ‘secondary facts’ – the evaluation of the primary facts through the lens of what the doctor knew or thought and the choices available to them. Resistance to the objectively verifiable is potentially more problematic behaviour (and more relevant to sanction) than insistence on an honest subjective perspective. This is not of course an exclusive binary classification: what a doctor thinks or knows will often have to be deduced evidentially from objective circumstances. A secondary fact such as dishonesty may be inferred in some defended cases from an overwhelming accumulation of primary facts. If a doctor denies their alleged state of mind with a defence at the unreal, unreasonable or ‘frankly ludicrous’ end of the spectrum, that may be more fairly relevant to sanction than one where the only thing being denied is that dishonesty rather than honest mistake gives the better account of things.
106. Third: whether there is evidence of lack of insight other than the rejected defence. Before a rejected defence is held to be relevant evidence of ‘lack of insight’, it is necessary to consider what other evidence of insight or lack of insight is present. There are cases, including some of the sexual impropriety cases, where being ‘in denial’ *up to and including* sanction proceedings is a richly evidenced course of conduct, in which a range of supportive and restrictive interventions have demonstrably failed to bring a doctor to a proper, fair and reasonable acknowledgment of the reality of their established problems and failings. At the other end of the spectrum, there are cases in which the *only* evidence of failure of insight seems to be robust defence at the fact-finding stage. Damascene conversions aside, a rejected defence which on a fair analysis adds to an evidenced history of faulty understanding is more likely to be relevant fairly to sanction than one said to constitute such faulty understanding in and of itself.
107. (I am not myself assisted by analogy with criminal proceedings in this respect. A plea of guilty can secure a mitigation of sentence because it spares the victim and the public purse the human and financial cost of a trial. The risk the offender may or may not pose to the public is dealt with in other ways. Insight is a genuine and proper issue in professional regulatory proceedings in and of itself. But as such it needs to be properly considered on a substantive and not just a procedural basis.)
108. Fourth: the nature and quality of the rejected defence. ‘Not telling the truth to the Tribunal’, when not freshly charged in separate proceedings as akin to perjury, has to amount to something more than a failure to admit to an allegation (especially a

secondary allegation of dishonesty) or a putting to proof, before it can properly count against a doctor. It is likely to have to amount to more than offering an ‘honest’ alternative explanation of events alleged to be explicable as dishonesty, or it is hard to see how a dishonesty charge is to be effectively defended. It is going to require some thought to be given to the *nature* of the rejected defence. Was it a blatant and manufactured lie, a genuine act of dishonesty, deceit or misconduct in its own right? Did it wrongly implicate and blame others, or brand witnesses giving a different account as deluded or liars? Or was it just a failed attempt to tell the story in a better light than eventually proved warranted?

109. In short, before a Tribunal can be sure of making *fair* use of a rejected defence to aggravate sanctions imposed on a doctor, it needs to remind itself of Lord Hoffmann’s starting place that doctors are properly and fairly *entitled* to defend themselves, and may then find it helpful to think about four things: (i) how far state of mind or dishonesty was a primary rather than second-order allegation to begin with (noting the dangers of charging traps) – or not an allegation at all, (ii) what if anything the doctor was positively denying other than their own dishonesty or state of knowledge; (iii) how far ‘lack of insight’ is evidenced by anything other than the rejected defence and (iv) the nature and quality of the defence, identifying clearly any respect in which it was itself a deception, a lie or a counter-allegation of others’ dishonesty.
110. These are all evaluative matters. Tribunals need to make up their own minds about them, and their relevance and weight, on the facts they have found. But they do need to direct their minds to the tension of principles which is engaged, and check they are being fair to both the doctor and the public. They need to think about what they are doing before they use a doctor’s defence against them, to bring the analysis back down to its simplest essence.

(d) *Consideration*

111. Applying all of this to Dr Sawati’s case, it seems to me to fit into the pattern of the decided cases in the following ways.
112. First, considering the six allegations of misconduct in the case, two were about unauthorised absence and did not include allegations of dishonesty. Four included allegations of dishonesty, of which three were found proved. Of those three, one incident was about a failure to make a proper record; one was about a failure to swap shifts in good order – a failure of teamwork and communication; and one was about defective communication in an interview for a training place. Dr Sawati was found to have committed all of these breaches of Good Medical Practice *dishonestly*.
113. These look like allegations of secondary rather than primary dishonesty – that breaches were committed deliberately and for dishonest reasons rather than through inadvertence or mistake. Care is needed here, including alertness to the charging trap. Dishonesty does not become the salient feature of an allegation simply because the rest of the allegation lacks a strong character of its own. Dishonesty is always a serious allegation; where a dishonesty charge lends potentially disproportionate secondary gravity to a primary charge about something else, the risk of oppression lurks.
114. Second, considering what Dr Sawati actively denied, it appears that (a) she admitted the addition to the record, she offered a recollection about discussion of the respiratory

symptoms and put the GMC to proof that it had not in fact happened, and she denied knowledge and dishonesty; (b) she admitted representing that she had swapped shifts, she offered an account of muddle and jumping the gun and put the GMC to proof that she had not in fact obtained clear agreement, and she denied knowledge and dishonesty and (c) she admitted saying in interview that she was booked on the ALS course, she offered an account of fluster and muddle and put the GMC to proof that she said she was booked on the ATLS course also and that she was in fact not booked on either course, and she denied knowledge and dishonesty. Her positive denials, in other words, were not of primary facts but of secondary or evaluative/inferential facts relating to her state of mind.

115. Third, as to insight into *misconduct*, the Tribunal had evidence before it about Dr Sawati's faltering progress in a number of areas, and about concerns over the lack of clear results from past training or support interventions and her ability to demonstrate that she reliably learned from her *mistakes* (including, for example, the importance of telling someone when her underlying medical condition caused her difficulties while on duty). It speculated on a possible propensity to *self-deception* ('*she may have a capacity to deceive herself in response to particular challenges or difficulties*'). I cannot see that it had before it, or at any rate that its determinations made reference to, a history of failure of insight into *dishonesty*. What it did have was three rejected defences of honest mistake and the proposition that 'dishonesty is hard to remediate'. The failure of insight in this respect appears to be constituted wholly or mainly in the rejected defences.
116. Fourth, although the Tribunal's sanction determination makes reference more than once to 'not telling the truth at or during the hearing' it does not identify what is being referred to. No aspect of her defences is singled out for criticism – indeed her defences are not otherwise criticised at all. The Tribunal made a specific finding (paragraph 157 of its determination) that in relation to the shift-swapping incident Dr Sawati was '*putting forward her case and she was careful not to directly criticise or undermine*' the other doctor's evidence. It made a positive finding that paragraph 72 of *Good Medical Practice* – which enjoins doctors to '*be honest and trustworthy when giving evidence to courts or tribunals*' was not engaged. It made an express finding (paragraph 166 of its determination) that paragraph 72 was not engaged by the interview incident either. It did not make a similar express finding in relation to the patient records incident, but in the list of paragraphs of *Good Medical Practice* it considered she had breached on that occasion, paragraph 72 is conspicuous by its absence.
117. It is hard, reading the references to failure to 'tell the truth at the hearing' in this context, to infer anything other than that they refer to failure to admit dishonesty and having the 'temerity' to offer defences which were rejected ('on balance') on the evidence, other witnesses' evidence being preferred.
118. The question I am considering is whether the Tribunal went seriously wrong in approach, analysis and reasoning and aggravated Dr Sawati's sanction unfairly by reason of the undue weight it gave to her rejected defences of her honesty. How a Tribunal deals with the rejected defences issue so as to avoid unfairness depends on it recognising the issue, and its potential for unfairness, in the first place. I am not satisfied that the Tribunal in Dr Sawati's case gave its mind sufficiently to the issue at all. It did not ask itself whether there was any possible issue of oppressive charging in these dishonesty allegations (bearing in mind the relative lack of gravity of the primary

charges, as discussed further below). It did not think about the balance between the primary misconduct alleged and the secondary dishonesty. It did not acknowledge that Dr Sawati was *actively* denying nothing other than dishonesty. It seems to have relied disproportionately and without analysis on her rejected defences to infer both failure of insight and tertiary dishonesty ('not telling the truth in the hearing') without giving any or any sufficient explanation of why; and having in two out of the three cases of dishonesty positively ruled out the relevance of paragraph 72 of *Good Medical Practice* and not mentioned it in relation to other misconduct.

119. These are in my view serious failures of approach, analysis and explanation in handling a matter which the authorities are clear needs to be handled mindfully because of the real risk of injustice and failure of due process inherent in aggravating sanction by reference to rejected defences, particularly to (secondary) dishonesty charges. I am not satisfied that Dr Sawati was treated fairly in this respect.
120. The 'rejected defences' issue is itself, however, only one facet of the task on which the Tribunal was engaged in determining how to sanction Dr Sawati. I turn now to its wider context.

(e) *Assessing the gravity of the misconduct*

121. Sanction must be proportionate to the gravity of the misconduct and impairment found. Failure properly to consider the *objective* features of a case, to demonstrate that their gravity had been fully assessed in context, and then to address and explain how aggravations and mitigations operate to justify sanction, is capable of amounting to a serious procedural irregularity rendering a sanctions decision unjust (*GMC v Stone* [2017] 4 WLR 207, [2017] WLR(D) 681, [2017] EWHC 2534 (Admin), at paragraph 53). The most secure route to a proportionate sanction is the 'authoritative steer' provided by the Sanctions Guidance.
122. Here, the Tribunal's findings on the objective features of the primary misconduct (leaving dishonesty briefly aside), were that (a) it was wrong to have added to a patient's record retrospectively without making that clear, albeit there was no practical consequence in this instance; (b) in the shift-swapping incident there had been a failure of communication, of collaborative working and of self-awareness, and she had put her colleagues in a difficult position; (c) her absence for two hours from her shift while unwell meant she was not properly available to patients and had inconvenienced colleagues, and amounted to failure of teamworking and communication; and (d) there was a failure of communication in her interview.
123. All of these are breaches of *Good Medical Practice*. Having said that, I do not understand from the sanctions determination that, absent dishonesty, these breaches, individually or together, per se constituted '*a particularly serious departure from the principles set out in Good Medical Practice where the behaviour is fundamentally incompatible with being a doctor*' (paragraph 109a of the Sanctions Guidance) or otherwise led to a conclusion that erasure was necessary. Had Dr Sawati's defences of honest mistake been accepted, it is not clear that a Tribunal would have considered this to be an erasure case on conduct grounds alone. The misconduct findings on which the Tribunal approached its sanctions consideration were, accordingly, dominated by its conclusions on dishonesty.

124. Dishonesty and lack of insight are the dominant features of the aggravating factors applied. The *extent* of the dishonesty ('not a single dishonest incident' but three occasions in four years) was aggravating. Lack of insight into her misconduct '*compounded by her failure to tell the truth at the hearing*' was aggravating. Lack of insight into and failure to reflect on her performance shortcomings were aggravating.
125. It was the '*serious nature of the misconduct found in this case*' – presumably the dishonesty – together with Dr Sawati's performance which led the Tribunal to conclude that nothing short of suspension would uphold the overarching objective of protecting the public.
126. It was the dishonesty which constituted the *particularly serious* departure from *Good Medical Practice*; and the *deliberate or reckless* disregard for the principles set out there (paragraph 109b of the Sanctions Guidance); and which engaged paragraph 109h ('*dishonesty, especially where persistent and/or covered up*'). It was persistent lack of insight into the seriousness of her dishonesty, as well as of her performance failings, that engaged paragraph 109j. These are the 'factors which may indicate erasure' on which the Tribunal relied. And it was '*serious dishonesty*' as referred to in paragraph 30 of the Guidance that allowed the Tribunal to give little weight to her inexperience and the fact that she was at an early stage only in her career. Dr Sawati was struck off because of a combination of performance failings and dishonesty.
127. The authorities consistently emphasise the inherent gravity of dishonesty in a doctor (see *GMC v Theodoropoulos* [2017] 1 WLR 4794 at paragraphs 35-36; *Nkomo v GMC* [2019] EWHC 2625 (Admin) at paragraph 45; both of these cases were, however, examples of particularly egregious dishonesty). Dishonesty – of any sort whatever – is unquestionably at least a yellow card issue for a doctor. But whether it is a red card issue in any case is a matter for the Tribunal to evaluate. Erasure for dishonesty is not automatic, so it is not exempt from the general requirement to assess the seriousness of misconduct in every case before a sanction is imposed. The nature and extent of dishonesty may be variable, and must be evaluated on a case by case basis.
128. The Sanctions Guidance – which itself acknowledges in terms that some dishonesty is more serious than others – provides a useful perspective on that. It addresses 'considering dishonesty' in a short separate section. It is, again, clear about the importance of honesty and integrity in general. It gives some examples of 'particularly serious' dishonesty: defrauding an employer; falsifying or improperly amending patient records; submitting or providing false references; inaccurate or misleading information on a CV; failing to take reasonable steps to make sure that statements made in formal documents are accurate; research misconduct. It also picks out dishonesty *if* persistent and/or covered up as *likely* to result in erasure.
129. Some of the Guidance's examples are familiar from the 'rejected defence' caselaw – primary dishonesty in the form of fraud, forgery or deceit. Some of the examples cross the threshold of criminality. Some of them are acquisitive or carried out for personal gain, including the obtaining of employment. With one exception, the examples given indicate conduct involving a degree of deliberation. (The exception is failure to take reasonable steps to make sure that statements made in formal documents are accurate. It is not obvious what that is about, not least because it is framed in terms of negligence rather than dishonesty. 'Statements made in formal documents' is however apparently a significant limitation: perhaps this is directed to signed statements warranting truth.

The wording of paragraph 72 of *Good Medical Practice*, which is explicitly about giving evidence to courts or tribunals, is drafted similarly.)

130. The Tribunal's task was to assess the seriousness of the three instances of dishonesty it had found in Dr Sawati's case. I cannot see from the sanctions determination that it did so, by proper reference to the Sanctions Guidance or at all. One factor alone gives any indication that the Sanctions Guidance was considered on this point – the reference to 'persistence'.
131. That reference, including its juxtaposition with 'covering up', itself suggests a measure of deliberateness. ('Covering up' is obviously not, on the analysis set out above, to be equated with the mere act of defending a dishonesty charge.) But persistence in this case can have been constituted by only two factors: the fact that there had been three incidents in a period of four years - and the rejected defences of Dr Sawati's honesty she had put forward at the fact-finding stage. The former was specifically mentioned by the Tribunal, but as between a single isolated incident and 'persistence' there may be thought to be quite a spectrum of behaviours to be evaluated. I cannot see that the Tribunal gave its mind to that evaluation.
132. The three instances of Dr Sawati's dishonesty come nowhere near the criminal threshold. Their place on the scale of seriousness does not speak for itself. A considered assessment of their seriousness was called for.
133. The first incident was certainly about a patient record. Some assessment was therefore needed as to whether this was 'dishonestly falsifying or improperly amending' a record – or something at a different point on the scale of seriousness. The Tribunal might have reflected on the measure of ambiguity in the change Dr Sawati made and the fact that it had been found to invite misleading inference ('suggest') rather than to tell a lie, and to be deficient in stating expressly that it was retrospective. It might have asked itself whether this was a case of serious falsification or a weak attempt by Dr Sawati to make her performance look a bit better than it had been (bearing in mind that it had found the failure to discuss respiratory symptoms not even to have 'crossed the threshold' of misconduct in the first place: the amendment was worse than the original lapse) – or something in between. But it does not appear to have evaluated it at all.
134. The shift-swap incident is not easy to map on to the Guidance's steer on seriousness. It was something in the nature of an attempt by Dr Sawati to control her working pattern while cutting the procedural corners which would have entitled her to it, embarrassing her colleague in the process. The Tribunal might have asked itself whether it was, albeit reprehensible in its dishonesty, well towards the bottom of the scale of seriousness – or whether there were features about it which brought it closer to the examples given by the Guidance. It does not seem to have done so.
135. The interview incident was found to have been an attempt by Dr Sawati to claim she was all set to go on an advanced course when she was not. The Tribunal might have asked itself whether it came close to 'inaccurate or misleading information on a CV' – or whether, in all the circumstances (including the fact that she appears, albeit mistakenly, to have resiled from the claim she was booked on any courses when challenged in the interview – here at least there was no 'persistence' – and the fact she had not been required to be booked on these courses anyway) it did not. The Tribunal does not seem to have thought to do so.

136. The Tribunal did not sanction Dr Sawati on the basis that any of the dishonesty in fact worked out to her advantage or to anyone else's disadvantage beyond minor inconvenience. It had not made any such findings.
137. The Tribunal had not lost sight of the fact that the first incident had happened seven years before. It also accepted that workplace stress and panicked responses were context for all the incidents – what they all had in common. That did not excuse dishonesty, but was potentially relevant to its seriousness, and to be some part of the answer to another question that the Tribunal might have asked itself, which was *why* Dr Sawati had told untruths on three occasions. The incidents all had the quality of improvised and unsophisticated fibs under pressure – in reaction to being confronted with what turned out to be a minor and largely inconsequential failing. Of course, responding to stress with panicky fibbing raises all sorts of issues about an inexperienced doctor's performance and coping mechanisms (not to mention her wellbeing), but viewed from that perspective, three examples in four years may or may not be thought to indicate a *serious* (or indeed irremediable) issue of *integrity*. The Tribunal's determination gives no sign that it addressed itself to that fundamental issue.
138. All of this indicates error of principle, similar to that in *Stone*, namely a failure by the Tribunal properly to assess and/or articulate the gravity of conduct before it, and hence correctly to apply itself to the question of sanction. That was the essence of the task before it. It is a serious error of principle and procedure leading to a failure of fairness.

(f) *Conclusions*

139. The Tribunal's determination of sanction discloses serious irregularity and error of principle, sufficient in themselves to make it unjust. It failed properly to assess and/or articulate the gravity of the misconduct it had established, by failing to make any, or any sufficient, assessment of the seriousness of the primary misconduct by reference to Dr Sawati's actions and their consequences; and of the seriousness of the dishonesty, including by reference to the 'authoritative steer' of the Sanctions Guidance and the examples given there. It failed to direct itself properly, fairly or at all to risks of injustice in regarding Dr Sawati's rejected defences to the allegations of dishonesty as grounds for aggravating sanction and it is not possible to be satisfied from its determination that it nevertheless avoided those risks. I am not satisfied that it handled Dr Sawati's case fairly, and reached a conclusion on sanction which was demonstrably just.

Remedy

140. The Tribunal erased Dr Sawati from the register, however, for a combination of reasons: not just on misconduct but also on performance grounds. The Tribunal took an overall view of the appropriateness of erasure without distinguishing between the two strands – misconduct and performance – or indicating the relative weight it attached to each. It was entitled to do that: it was making an overall evaluative decision, considering the case in the round. But it is not as a result possible to have any reliable sense of the relative weight attached to each component. It is apparent that the misconduct played a considerable part. It may well have played a determinative part. The determination relied, in its concluding paragraphs, on the fact that '*when the Performance Assessors came to their conclusion that Dr Sawati was fit to practise on a limited basis, they did*

not have available to them the findings of dishonesty which were determined by this Tribunal’.

141. It is not possible however to be confident about this. Unlike dishonesty (or sexual misconduct), a doctor’s performance is not a matter on which an appellate court is well-placed to come to its own views: it is an issue where a real measure of deference must be given to the judgment of the relevant professionals and the expertise of the Tribunal. I am not able to judge from this determination either what weight the Tribunal gave to the performance issues it had found, or what weight it should have given to them.
142. It is not possible to be satisfied therefore either that erasure was so clearly the inevitable outcome on performance grounds that the decision can stand notwithstanding its defects in relation to the misconduct component, or conversely that erasure was inevitably the ‘wrong’ decision overall. In these circumstances, the right way forward is to quash the sanctions decision and remit it to a differently-constituted Tribunal to make a fresh decision about it. That Tribunal will need to address the performance issues, and make a proper assessment of the seriousness of the misconduct on a basis which is considered and fair as regards Dr Sawati’s rejected defences. And it will have to consider matters of insight and remediation on all the evidence before it.
143. It may be therefore that another Tribunal will ultimately conclude that Dr Sawati cannot remain on the register, whether on performance grounds alone or on any combination of performance and misconduct grounds. Or another Tribunal may instead see a possible future for her as a doctor. Dr Sawati is entitled to a full and fair consideration of that question by the expert decision-making body Parliament has appointed for that purpose.

Decision

144. The appeal is allowed in part. The Tribunal’s sanction determination is quashed and remitted to a differently constituted Tribunal for a fresh determination of sanction.