



Neutral Citation Number: [2023] EWHC 100 (Admin)

Case No: CO/3715/2021

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

Tuesday, 24th January 2023

Before:

MR JUSTICE FORDHAM

Between:

SHEELA JOGULA RAMASWAMY
- and -
GENERAL MEDICAL COUNCIL

Claimant

Defendant

Daniel Matovu (instructed by Direct Access) for the **Claimant**
Ivan Hare KC (instructed by GMC Legal) for the **Defendant**

Hearing date: 13/12/22

Approved Judgment

I direct that no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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THE HON. MR JUSTICE FORDHAM

MR JUSTICE FORDHAM:

Introduction

1. This claim, pursuant to section 41A(10)(b) of the Medical Act 1983 (the “1983 Act”), asks the Court to revoke an “interim conditional registration” order (“ICRO”). The ICRO was imposed by an Interim Orders Tribunal (“Tribunal”), pursuant to section 41A(1)(b) of the 1983 Act, on 14 September 2021, after a two-day hearing. It was imposed for the statutory maximum period of 18 months (section 41A(1)(b)) to 12 March 2023. Since being imposed, the ICRO has subsequently been maintained by a Tribunal on statutorily-required reviews, pursuant to section 41A(2) of the 1983 Act, on 9 March 2022 and 25 August 2022. Provision regarding interim orders – including ICROs – is made in Part 7 (Rules 25-27) of the General Medical Council (Fitness to Practise) Rules 2004 (the “2004 Rules”). Certain alleged “non-compliance” aspects of the Claimant’s case were the subject of a three day hearing before Morris J in May 2021, culminating in a judgment (15.6.21): see Ramaswamy v GMC [2021] EWHC 1619 (Admin) (the “2021 Judgment”). The present claim for revocation first came before me for a substantive hearing on 29 March 2022 and I adjourned it at the Claimant’s request: see [2022] EWHC 732 (Admin). In the run up to the hearing, I declined the Defendant (“GMC”)’s application for a further adjournment to a date in early 2023. The Defendant submitted that such an adjournment was an appropriate course in circumstances where: (i) a substantive hearing on remitted issues of alleged “non-compliance” (2021 Judgment §155), had adjourned part-heard on 30 November 2022 to hearing dates on 9-11 and 25-27 January 2023; and (ii) the ICRO, being due to expire on 12 March 2023, was likely to require an application to this Court for an extension. The Defendant’s position was that it would make best sense for this claim for revocation of the ICRO to be considered, alongside those other matters and on an updated basis, early in 2023. That course was strongly opposed by the Claimant and I did not accede to it. I took the view that the Claimant was, in principle, entitled to have her claim for revocation heard on its merits, pursuant to her statutory entitlement of access to the Court. The substantive hearing before me was a “hybrid hearing”. That was because of travel difficulties caused by a National Rail Strike. I was in the courtroom. So was Mr Matovu, the Claimant’s barrister. The Claimant attended remotely. So did Mr Hare KC, the Defendant’s barrister. Arrangements were made to ensure that the Claimant could send mobile phone messages to Mr Matovu, to replicate the passing of notes had they been together in the courtroom. Members of the press or public could attend in person or, as published through the Cause List, remotely and open justice was secured.

The Guidance

2. There is relevant Guidance for the Tribunal on “Imposing Interim Orders”. The version of the Guidance relied on before me is dated 30 October 2018. Under a heading “Powers of the IOT” the Guidance provides as follows at §§6-7:

Powers of the IOT. 6. An IOT may make an order when it considers it necessary to do so for the protection of members of the public or it is otherwise desirable in the public interest to maintain public confidence and uphold proper standards of conduct and behaviour. The IOT may also make orders where it is in the interests of the doctor. 7. An IOT does not make findings of fact or determine the allegations against the doctor.

Under a heading “Test Applied”, the Guidance says this at §§23-27:

Test Applied. 23. The IOT must consider, in accordance with section 41A, whether to impose an interim order. If the IOT is satisfied that: (a) in all the circumstances that there may be impairment of the doctor's fitness to practise which poses a real risk to members of the public, or may adversely affect the public interest or the interests of the practitioner; and (b) after balancing the interests of the doctor and the interests of the public, that an interim order is necessary to guard against such risk, the appropriate order should be made. 24. In reaching a decision whether to impose an interim order an IOT should consider the following issues: (a) The seriousness of risk to members of the public if the doctor continues to hold unrestricted registration. In assessing this risk the IOT should consider the seriousness of the allegations, the weight of the information, including information about the likelihood of a further incident or incidents occurring during the relevant period. (b) Whether public confidence in the medical profession is likely to be seriously damaged if the doctor continues to hold unrestricted registration during the relevant period. (c) Whether it is in the doctor's interests to hold unrestricted registration. For example, the doctor may clearly lack insight and need to be protected from him or herself. 25. In weighing up these factors, the IOT must carefully consider the proportionality of their response in dealing with the risk to the public interest (including patient safety and public confidence) and the adverse consequences of any action on the doctor's own interests. 26. In assessing whether or not it is appropriate to take action, the IOT should consider the seriousness of any police charges and the acceptability of their decision on interim action should the doctor later be convicted or acquitted (including public confidence issues as above). 27. When considering whether or not to make an interim order, the IOT cannot accept any undertakings given by the doctor as it has no power to accept them and they are, in any event, unenforceable.

Under a heading "Doctor's Health", the Guidance says this at §32:

Doctor's Health. 32. Where there are issues about the doctor's health, the IOT should bear in mind that its primary duty is to protect members of the public and the wider public interest, and not to assume responsibility for, or give priority to, the treatment or rehabilitation of the doctor. However, where the IOT considers it appropriate to make an order for interim conditions, these may include conditions relating to the ongoing treatment and supervision of the doctor.

Under a heading "Reasons for Decisions" the Guidance says this at §§51-52:

Reasons for Decisions. 51. Rule 27(4)(g) of the Rules makes clear that when announcing its decision the IOT "shall give its reasons for that decision"... An IOT must therefore ensure that reasons are given for any decisions taken, including decisions not to impose an order. The courts do not expect an IOT to give long detailed reasons but the reasons given must be clear and explain how the decisions were reached, including identifying the interest(s) for which the order is considered necessary. 52. Although IOT decisions should be fairly concise, they must include the following information with specific reference to the distinct features and particular facts of each individual case. (a) The risk to patients should be clearly identified to support the proportionality of any action it was necessary to take. (b) The risk to public confidence in the profession if the doctor continued working without restriction on their registration and the allegations are later proved, to support the proportionality of any interim action taken. (c) Where an order is made primarily because it is desirable in the public interest to uphold public confidence and there are no concerns about clinical practice specific reasons should be given for why this is appropriate. (d) Reasons for the initial period of time for which an interim order is imposed. (e) Where no order is imposed, clear reasons must be given.

The Conditions of the ICRO

3. The Conditions of the ICRO imposed on the Claimant on 14 September 2021 are as follows:

(1) She must personally ensure that the GMC is notified of the following information within seven calendar days of the date these conditions become effective: (a) of the details of her

current post, including: (i) her job title (ii) her job location (iii) her responsible officer (or their nominated deputy); (b) the contact details for her employer and any contracting body, including her direct line manager; (c) of any organisation where she has practising privileges and/or admitting rights; (d) of any training programmes she is in; (e) of the contact details of any locum agency or out-of-hours service she is registered with. (2) She must personally ensure the GMC is notified: (a) of any post she accepts, before starting it; (b) that all relevant people have been notified of her conditions, in accordance with condition (6)(c) if any formal disciplinary proceedings against her are started by her employer and/or contracting body, within seven calendar days of being formally notified of such proceedings; (d) if any of her posts, practising privileges or admitting rights have been suspended or terminated by her employer before the agreed date within seven calendar days of being notified of the termination (e) if she applies for a post outside the UK. (3) She must allow the GMC to exchange information with her employer and/or any contracting body for which she provides medical services. (4) She must not work in any locum post or fixed term contract of less than 4 weeks duration. (5) She must get the approval of the GMC before starting work in a non-NHS post or setting. (6) She must personally ensure that the following persons are notified of the conditions listed at (1) to (5): (a) her responsible officer (or their nominated deputy); (b) the responsible officer of the following organisations: (i) her place(s) of work and any prospective place of work (at the time of application); (ii) all her contracting bodies and any prospective contracting body (prior to entering a contract); (iii) any organisation where she has, or has applied for, practising privileges and/or admitting rights (at the time of application); (iv) any locum agency or out-of-hours service she is registered with; (v) if any organisation listed at ((i) to (iv)) does not have a responsible officer, she must notify the person with responsibility for overall clinical governance within the organisation. If she is unable to identify this person, she must contact the GMC for advice before working for that organisation; (c) her immediate line manager and senior clinician (where there is one) at her place of work, at least 24 hours before starting work (for current and new posts, including locum posts).

This Court's Approach

4. In the cases which supply principled guidance as to the approach to be taken by this Court on a claim for revocation, what is now in this case the Tribunal is referred variously as the “Interim Orders Panel”, “IOP” or “Panel”; or the “Interim Orders Committee” or “IOC”. Both parties relied on passages from the judgment of Warby J in Martinez v General Dental Council [2015] EWHC 1223 (Admin), accepting the direct ‘read-across’ from dentists to doctors. Mr Matovu relied in particular on Martinez §20 (describing the need for a “risk assessment” paying “attention ... to the nature of the allegations and the evidence ... relied upon to support them”, including “the quality of the evidence and the possibility or prospect that it may not be sufficient to justify the view that there is a risk”, and with no applicable “threshold”). Mr Hare KC drew attention to the various points made earlier at Martinez §§16 to 19. I will set out all these passages here:

16. The approach to be taken to an application [for revocation] has been considered on several occasions in recent years and it is convenient to refer to a decision of His Honour Judge Gore QC in GMC v Anyuan-Osigwe [2012] EWHC 3984 (Admin) at §§12-14:

12. From those expressions of principle I come to the view that my approach must be as follows. First, I must decide whether the decision of the Interim Orders Panel was wrong. In making that decision what I have to consider is whether the material indicates that, firstly, the decision the Panel made was necessary for the protection of the public or otherwise is in the public interest, (there being no suggestion here of any legitimate basis for the making of the decision in question), and secondly, in accordance with paragraph 18 of the Interim Orders Panel Guidance, the Panel in deciding to suspend or impose conditions were entitled to have formed a view that there was an impairment of fitness to practise which posed a real risk to the members

of the public, and the order was necessary after balancing the interests of the doctor, that is to continue in practice and earn a living and the interest of the public to guard against the risk.

13. Secondly, in making that decision I exercise original powers as opposed to either appellate or for that matter what are sometimes called public law or judicial review powers and this calls upon me to consider all the relevant evidence and arguments, not only those that existed or were deployed at the time of the decision of the Panel ...

14. Thirdly, in coming to that decision, I must consider what weight, if any, to attach to the decision of the Panel but in doing so I must acknowledge that Parliament has entrusted that expert medical body of professionals powers to apply their own expertise and experience and their own knowledge of public expectations of the professionals they regulate and what is necessary in the public interest and I should not lightly substitute my own decision unless I determine that their view was wrong.

17. The second of the principles referred to by Judge Gore can also be expressed as it was by Arden LJ in GMC v Hiew [2007] 1 WLR 2007 at §32, where she said this of the opinion of an Interim Orders Panel in a General Medical Council case: “It is for the court to decide what weight to give to that opinion. It is certainly not bound to follow that opinion. Nor should it defer to that opinion. All that is required is that the court should give that opinion such weight as in the circumstances of the case it thinks fit.” Hiew was a case concerned with the extension of interim orders but I accept ... that this formulation applies equally in the present context.

18. Where factual allegations are disputed, it will normally not be possible for the IOC or the court to arrive at definitive conclusions of fact. What the Interim Orders Committee or Panel in a GMC case will normally have to determine is whether the allegations are credible. The role of the IOC is, as Underhill J emphasised in Kumar v General Medical Council [2013] EWHC 452 (Admin): “... not to undertake the definitive examination of the allegations against the doctor or to decide on the fairness of the investigation. The Panel can at most satisfy itself that there is a prima facie case that the allegations are well-founded.” Put another way, the allegations will need to be treated as disclosing a sufficient case unless they are manifestly incredible, or it appears that for some other reason they are bound to be rejected at a final hearing. This may give rise to difficulty in some cases and it may, for example, be said that if only a fuller investigation of the facts was undertaken it would be seen that what is being relied on is a misleading snapshot of the overall picture. If that is said, the IOC or the court will have to do its best to assess on the evidence that is available to it at the time whether that submission is made out. If it cannot uphold such a submission, and the allegations are credible, the tribunal will have to proceed on that basis.

19. The correct approach to risk assessment was considered by Laing J in Howells v General Medical Council [2015] EWHC 348 (Admin), where she said at §53: “It is not for the IOP or the court to quantify risk in this way. Once a risk has been shown, unless it can be seen to be a wholly fanciful risk, that in my judgement is sufficient.”

20. I accept ... that the function of the IOC and the Court in relation to an interim order is one of risk assessment. This necessarily requires that attention is paid to the nature of the allegations and the evidence which is relied upon to support them. The fact that it is an exercise of risk assessment cannot justify the Court ignoring the need to pay attention to the quality of the evidence and the possibility or prospect that it may not be sufficient to justify the view that there is a risk. But there is no threshold specified in the legislation other than the need to protect the public, the public interest and, where applicable, the interests of the registrant. It is not a question of the threshold of a prima facie case.

In relation to the Court’s approach to the Tribunal’s reasons, I was shown Ago v GMC [2020] EWHC 39 (Admin) at §21, citing this guidance from Lindblom J in Abdullah v GMC [2012] EWHC 2506 (Admin) at §102:

What the IOP had to do – no more and no less – was to explain why their decision was the one they had announced. In most cases, probably in every case, this can be done briefly. The IOP were exercising a statutory power framed in simple terms... The parties knew what the contentious issues had been. They could expect to be told how those issues had been resolved and why the decision went the way it did. The losing side could expect to learn why it had lost. But the IOP did not have to provide an elaborate explanation of their decision. Reasons were required, but not reasons for reasons.

Background and Context

5. As to the background and context of this case I think it is helpful to start by identifying a number of strands, some of which overlap. First, in the 2021 Judgment at §§27-28, Morris J referred to a background relationship, contested concerns about mental health, and contested concerns about correspondence (here “the Appellant” is the Claimant):

27. A central part of the background to this case is that the Appellant in the past had an intimate sexual relationship with a consultant doctor, to whom I refer as “the Doctor”. That relationship lasted some years. That relationship ended. The Doctor sought to deny ever having had that relationship, and as a result, the Appellant was suspected of having a delusional belief about its existence. There were historic medical reports. In the past, and more recently the Appellant has referred to herself by the Doctor’s name. The GMC maintains that she has repeatedly insisted that it refer to her by the Doctor’s surname because she is married to the Doctor. The Appellant is not legally married to the Doctor; he is married to another woman. The GMC considers that the tone and content of the Appellant’s correspondence with it is problematic, being extremely aggressive, accusatory, repetitive and conspiratorial, suggesting an unfounded belief that she is being persecuted. The GMC considers that her continued insistence that she is married to the Doctor and that her name is his name is a matter of obvious concern to the GMC about the state of her mental health. 28. The Appellant does not accept this. She maintains that her conduct is based on her cultural and religious beliefs about the sanctity of relationships. She maintains that, in accordance with Hindu custom, she was married to the Doctor at her home on 21 February 2014. In any event she has continued to practise as a doctor throughout the relevant period with no complaint about her fitness to do so. She contends that at no stage has it been suggested that she is anything other than a good and competent doctor.

6. In the 2021 Judgment at §§29-34, Morris J referred to “events between 2015 and August 2018”, involving allegations of bullying and harassment made by other employees (including the Doctor) at NHS Grampian. What Morris J records (2021 Judgment §30) is this: “On 2 July 2015, the Appellant self-referred to the GMC. In January 2016, the GMC confirmed that it would not be taking the matter further”. At that time, as Morris J explained (2021 Judgment §31):

The Appellant’s health was assessed by clinicians on various occasions between 2015 and 2016 as part of her employer’s investigations and occupational health requirements, on the basis that it was alleged that she was delusional about the existence of the relationship with the Doctor. It was found that she was not suffering from any delusional order of any kind. For example, Dr Robertson, a consultant psychiatrist, concluded that the Appellant has no diagnosable mental disorder and that all of the symptoms could be explained in terms of cultural differences.

What Morris J records (2021 Judgment §34) is this: “On 28 November 2017 the GMC issued the Appellant with a formal warning concerning the matters for which she was summarily dismissed by NHS Grampian”.

7. On 28 August 2018 the GMC opened an investigation because of concerns arising out of correspondence which the Claimant had sent to the GMC in the context of its earlier

investigation whose content and tone raised concerns about her health, on which basis the GMC would be undertaking a review of her fitness to practise: see 2021 Judgment at §35. That email correspondence was the subject of a First Expert Report of Professor Eilish Gilvarry on 16 April 2020 (2021 Judgment §§49-50) and a Second Report on 20 December 2021 (after the 2021 Judgment).

8. The next strand concerns Directions for Health Assessment (“DHAs”). Provision for DHAs is contained in rule 7(3) of, and Schedule 2 to, the 2004 Rules. Morris J referred to two DHAs: 2021 Judgment §35 (“the First Direction”) and §54 (“the Second Direction”). A first DHA notified on 28 August 2018 required the Claimant to undergo a health assessment: see 2021 Judgment §35. As Morris J explained (2021 Judgment at §35): the decision to make this DHA was said to be ““based on information... which suggests your health may be affecting your fitness to practise due to’ certain identified mental disorders”; “medical examiners would be asked to report on [the Claimant’s] health and to give an opinion on her fitness to practise”; the “background” to the DHA being that “in July 2018 a medical case examiner had reviewed the emails which had been received and decided that the tone and content raised some concerns and so an investigation was opened inviting her to undergo a health assessment”. Morris J recorded (2021 Judgment §51) that on 12 May 2020 the GMC Assistant Registrar “made” a further direction for a health assessment and (2021 Judgment §54) on 29 July 2020 the GMC “sent” the Second Direction. A related strand concerns the Claimant’s alleged “non-compliance” with the DHAs. This was at the forefront of the 2021 Judgment. What had happened was this (see 2021 Judgment §2): in October 2020 the Defendant had referred “non-compliance” with the 29 July 2020 DHA to the Non-Compliance Tribunal which, on 12 January 2021 made a Non-Compliance Determination and then a Sanction Determination imposing an immediate 9-month Suspension Order (“SO”).
9. The SO was a “final” Order which had the effect of replacing (and revoking) the ICRO which had been in effect up to 12 January 2021. What had happened regarding “interim” orders was this. A first interim order had been imposed on 1 October 2018 (2021 Judgment §36). That was an “Interim Suspension Order” (“ISO”), pursuant to section 41A(1)(a) of the 1983 Act, suspending the Claimant’s registration and thus preventing her from practising as a doctor. The ISO was replaced on 10 September 2019 with an ICRO (2021 Judgment §43) which was subsequently maintained on review on 13 December 2019, varied on 11 February 2020 and maintained on review on 3 June 2020. In July 2020 the Claimant filed an appeal against the ICRO (2021 Judgment §52). The ICRO, as an interim order, now fell away given the imposition in January 2021 of the 9-month final SO. It was for that reason that Robin Knowles J (on 16 February 2021) dismissed the appeal against the ICRO (2021 Judgment §64). In doing so, he gave detailed directions recording detailed recitals with a view to facilitating an agreed health assessment. Correspondence ensued between the parties on the topic of the nomination of a psychiatrist for the purposes of any health assessment.
10. The Non-Compliance Determination and Determination on Sanction (imposing the SO) were challenged by appeal by the Claimant to this Court. In the 2021 Judgment Morris J found that the failure to adjourn the “non-compliance hearing” in January 2021 had been procedurally unfair. He quashed the Non-Compliance Determination and the SO. Since the previous ICRO had been revoked and replaced by the SO, the consequence

of the 2021 Judgment was that no interim order – and no restriction on the Claimant’s registration – was in place from 15 June 2021. In those circumstances a decision was made on 24 June 2021 (communicated on 30 June 2021) to refer to the Tribunal the question of whether to impose an interim order. Then, on 14 September 2021, the Tribunal imposed the ICRO which the Claimant seeks to have revoked by this Court.

11. The final strand is this. A complaint was made on 13 April 2020 by the mother (known as “Mrs RC”) of a daughter (known as “AC”) who died on 18 March 2018 having previously been in the Claimant’s care in 2017. That complaint was the subject of a Report in November 2020 of a GP expert Dr Peter Davies. This did not feature in the 2021 Judgment. As it was described in the decision of 24 June 2021:

New investigation. In April 2020 the GMC received a complaint from Mrs RC about the care and treatment provided to her adult daughter (Ms AC) by Dr Ramaswamy at the Copeland Unit in West Cumbria in 2017. Ms AC suffered a stroke in August 2017 and was admitted to the Copeland Unit for rehabilitation, she was suffering from impaired mobility and difficulties with speech and she also suffered from poor mental health; Ms AC died in March 2018. Mrs RC complained about Dr Ramaswamy’s management of her daughter; refusing to prescribe certain medicines (diazepam for muscle spasm); cancelling an investigation (transoesophageal echo) arranged by another hospital. She also complained about Dr Ramaswamy’s communication and attitude; that she was sharp and abrasive and shouted down relatives when they raised concerns about Ms AC’s care; stated that Ms AC had no consultant and that she was responsible for her care; being dismissive when Mrs RC raised concerns about the cancelled echo scan; being dismissive when Mrs RC raised concerns about the patient’s safety and mental health; not including Mrs RC in the patient’s care plan; accusing Mrs RC of lying when discussing discharge arrangements; telling the patient to ‘be quiet’. The GMC obtained a copy of the patient records and was also provided with a copy of Mrs RC’s statement for the coroner’s inquest into her daughter’s death. Following provisional enquiries (obtaining advice on the concerns raised in the complaint from an independent expert) the GMC opened an investigation into the following allegations: [i] It is alleged that the doctor shouted and the patient and her family, and was rude and unpleasant during their interactions and did not introduce herself to the complainant initially. [ii] It is alleged that the doctor cancelled the patient’s scan (transoesophageal echo) [“TOE”] despite a recommendation for the scan being made by another hospital.

The Tribunal’s Determination

12. The claim for revocation of the ICRO arises out of the Determination of the Tribunal (14.9.21) imposing it. That Determination was preceded by “legal advice” from the Chair (see §42 below). The Determination occupies 12 pages and 45 paragraphs. There is an Introduction (§§1-12), a description of the Submissions made by Counsel for the Defendant (Ms Duckworth) (§§13-19) and by Counsel for the Claimant (Mr Matovu) (§§20-29), followed by the Tribunal’s Assessment (§§30-45) which contains a paragraph (§42) setting out the Conditions. Throughout the Determination the Claimant is “Dr Ramaswamy”. The Tribunal’s Introduction (§§1-12) contains the following:

1. Dr Ramaswamy is currently the subject of a fitness to practise investigation by the GMC. On 30 June 2021, pursuant to section 35C of the Medical Act 1983 as amended (“the Act”), her case was referred to the [Tribunal] by the GMC. The role of this Tribunal is to consider whether a doctor’s registration should be restricted on an interim basis, either by imposing conditions on their registration or by suspension. In accordance with section 41A(1) of the Act, the Tribunal will make an order if it is satisfied that there may be impairment of a doctor’s fitness to practise, which poses a real risk to members of the public or may adversely affect the public interest or the interests of the practitioner and, after balancing the interests of the doctor and the public, that an interim order is necessary to guard against such risk.

2. *The Tribunal notes the background to this case. In July 2015 Dr Ramaswamy self-referred to the GMC following concerns from NHS Grampian that she had bullied and harassed two colleagues. A Trust disciplinary hearing took place which found that Dr Ramaswamy had “created an unwanted and very intimidating, hostile and offensive working environment for these two colleagues”. The Trust made a finding of gross misconduct and Dr Ramaswamy was dismissed with immediate effect in August 2016. A report in relation to these matters was submitted to the Procurator Fiscal and Dr Ramaswamy appeared at Aberdeen Sheriff Court in March 2017 where she was found not guilty. In November 2017 the GMC Case Examiners issued Dr Ramaswamy with a formal warning.*

3. *In August 2018 the GMC opened a new investigation following email communication received from Dr Ramaswamy. A GMC Medical Case Examiner reviewed the emails and advised that given their tone and content they raised serious concerns about Dr Ramaswamy’s mental health. In August 2018 the GMC invited Dr Ramaswamy to undergo a health assessment. Dr Ramaswamy did not agree to undergo such an assessment and it was alleged that she subsequently refused to communicate with the new GMC investigation officer who had been placed in charge of the new investigation.*

4. *In October 2018 Dr Ramaswamy was suspended by an IOT. The order was replaced with conditions at a review hearing in September 2019. The GMC continued to make efforts to contact Dr Ramaswamy in relation to a health assessment, but it was alleged that she had failed to engage. This matter was placed before a non-compliance hearing on 11-12 January 2021. That Tribunal found that there had been non-compliance which was not avoidable or otherwise excusable. The non-compliance Tribunal made an order of suspension for 9 months and revoked the interim order of conditions. Dr Ramaswamy appealed the non-compliance hearing outcome at the High Court in May 2021. At the appeal hearing Mr Justice Morris concluded that there had been a serious procedural irregularity which related to the Tribunal’s refusal to adjourn the non-compliance hearing for Dr Ramaswamy to be legally represented by counsel of her choice. He concluded that both the determination and the sanction had been “unjust”. The appeal was therefore upheld and the non-compliance and sanction determinations were quashed. The High Court remitted the case to a newly constituted MPT, which has yet to convene. There are currently no restrictions on Dr Ramaswamy’s registration.*

5. *The matters before the Tribunal today arise from a Case Examiner IOT referral following the revocation of the interim order at the non-compliance hearing, and the subsequent non-compliance sanction being quashed.*

6. *The Tribunal has noted that a GMC Case Manager granted a postponement for hearing scheduled for 7 July 2021 at the request of Dr Ramaswamy’s representative. An application was made on the grounds of short notice of the hearing being provided, availability of the legal representative and it being stated that matters would involve serious consideration of an abuse of process issue.*

7. *A subsequent hearing scheduled for 30 July 2021 was adjourned for lack of time available... The hearing was adjourned, the Tribunal of 30 July 2021 stating that the hearing should be relisted for two days.*

8. *The Tribunal noted that on 13 April 2020, separate to all other investigations, the GMC received a complaint from the mother (RC) of a now deceased patient (AC) who had been treated by Dr Ramaswamy in 2017, having been admitted following a stroke to the Copeland Unit of the West Cumbria Hospital in August 2017. RC alleged that Dr Ramaswamy had shouted and been rude to both her and AC, that she had cancelled a clinically indicated Trans Oesophageal Echocardiogram (“TOE”) scan, had expressed this rudely to her and had offered no explanation. RC alleged that the scan was quickly reinstated by the hospital. RC further alleged that Dr Ramaswamy had made “untrue” entries in AC’s medical records and made “totally untrue” allegations in a report she had provided. RC provided a statement which had been presented to the coroner following AC’s death, together with other documentation in support of the complaint.*

9. The Tribunal had regard to the opinion of an independent expert, Dr Nicholas Davies who provided his opinion to the coroner. Dr Davies stated that in his opinion if the complainant was correct in her description of the interactions with Dr Ramaswamy the care had fallen seriously below the expected standard. He opined that such alleged communication would be a straight breach of Good Medical Practice, paragraphs 31-34. Further, he stated that if the complainant was correct then there was evidence of clear failings, since “rudeness prevents effective communication, which can lead to poor care and risk of harm”. Dr Davies was of the opinion that if Dr Ramaswamy had cancelled the TOE scan rather than it being an administrative error on the part of the hospital, then this would be seriously below the expected standard. He stated that it would be “very unprofessional to cancel the recommendation of another doctor. It is very poor teamwork.”

10. The hearing was subsequently relisted to be heard on 12-13 August 2021. This hearing was again postponed at the request of Dr Ramaswamy’s representatives, on the grounds of Mr Matovu’s availability. The hearing was rescheduled to the current dates.

11. The Tribunal has noted the chronology of events provided by Mr Matovu relating to the new matters under consideration today, dating from 1 November 2017 to 9 September 2021.

12. The Tribunal has considered all of the information presented to it including the submissions made by Ms Duckworth, Counsel, on behalf of the GMC and those made by Mr Matovu on Dr Ramaswamy’s behalf.

13. It is not necessary for me to set out here – though I will need to return later to certain aspects of – the Tribunal’s lengthy description of the Submissions made by Ms Duckworth (§§13-19) and Mr Matovu (§§20-29). I will however set out in full the Tribunal’s Assessment (§§30-45), excluding paragraph (§42) which contains the Conditions already set out (see §3 above):

30. In reaching its decision, the Tribunal has borne in mind that it is not its function to make findings of fact, but to assess potential risk based on the information before it today. It has considered the nature of the concerns in this case namely those relating to alleged misconduct and health, namely that Dr Ramaswamy may have an unmanaged health condition, was rude and unpleasant to patient AC and family, and that she cancelled the TOE scan.

31. The Tribunal is mindful that the decision to refer Dr Ramaswamy to the IOT today arose as a result of her prior conditions being revoked following the non-compliance tribunal suspension, and this suspension being later quashed on appeal.

32. The Tribunal has borne in mind Dr Ramaswamy’s unwillingness to undergo a GMC health assessment and noted that it does not have the benefit of up to date information on her current state of mental health. It notes that Dr Ramaswamy disputes a suggestion of adverse mental health and robustly denies any allegations of non-compliance with the regulator. The Tribunal is mindful of its duty to consider the likelihood of repetition of allegations.

33. The Tribunal has borne in mind the opinion of the independent expert, Dr Davies who considered that if the complainant (RC) was correct in her description of the interactions with Dr Ramaswamy, then ‘the care had fallen seriously below the expected standard’. It notes that RC’s version of events is disputed by Mr Matovu and has considered the submissions made by him in respect of the cancelled TOE scan and Dr Ramaswamy’s alleged ‘rude’ behaviour to AC and family.

34. The Tribunal is mindful that Dr Ramaswamy has been subject to interim orders on her registration since October 2018. The initial suspension on her registration was replaced with conditions in September 2019, which have been regularly reviewed and extended by the High Court. At the interim order review of 11 December 2020, the conditions were reinforced to include the provision of close supervision, the Tribunal at that hearing having considered this to be necessary in view of Dr Ramaswamy’s alleged non-engagement with the GMC and in the absence of any current information about her health. The Tribunal today notes that

the conditions were revoked not based on a consideration of necessity by the IOT, but because Dr Ramaswamy was suspended by the non-compliance tribunal of January 2021.

35. The Tribunal notes that the non-compliance tribunal outcome and the appeal judgement relate to Dr Ramaswamy's engagement with the GMC investigation process (specifically the direction to undergo a health assessment). The GMC has opened a second investigation following the complaint made by RC. The Tribunal notes that no link between Dr Ramaswamy's health and alleged misconduct has been established.

36. The Tribunal has borne in mind the tone and content of Dr Ramaswamy's emails to the regulator and its staff spanning over three years and most recently in August 2021. The Tribunal is concerned that this may be indicative of a pattern of behaviour, which may be related to a health concern. The Tribunal notes that a number of clinicians with relevant medical qualifications have assessed Dr Ramaswamy as potentially having an underlying medical condition. The issue at present remains unresolved, and Dr Ramaswamy appears to be unwilling to appropriately engage with her regulator to resolve the matter.

37. The Tribunal considers that albeit relating to a single patient, there are issues of concern arising in respect in respect of Patient AC, a vulnerable patient. It has considered the 'Notes from a meeting with A's family on 28 December 2017' made by Dr Ramaswamy. Dr Ramaswamy records "we said that A had been threatening us and Blackmailing by saying Borderline, Borderline, Borderline in order to make us listen to what she wants". This reinforces the Tribunal's concern that Dr Ramaswamy may have an unmanaged health condition which has the potential to cause harm to patients.

38. In all the circumstances, the Tribunal considers the nature of the health and conduct concerns are such that Dr Ramaswamy may pose a real risk to patient safety if no interim order were in place. The Tribunal has considered that, were the allegations later proved, public confidence in the profession could be seriously undermined if Dr Ramaswamy were permitted to practise medicine unrestricted whilst concerns regarding her health and conduct are unresolved. The Tribunal is mindful that the public interest includes the need to maintain confidence in the profession and the declaring and upholding of proper standards of conduct and behaviour, including the obligation of a doctor to appropriately engage with its regulator. The Tribunal was satisfied that, in all the circumstances, the statutory test for the imposition of an order is met in this case.

39. In accordance with Section 41A of the Medical Act 1983, as amended, the Tribunal has determined, based on the information before it today, that it is necessary to impose an interim order on Dr Ramaswamy's registration. It has determined to impose an interim order of conditions for a period of 18 months.

40. The Tribunal has determined that, based on the information before it today, there are concerns regarding Dr Ramaswamy's fitness to practise which pose a real risk to members of the public and which may adversely affect the public interest. After balancing Dr Ramaswamy's interests and the interests of the public, the Tribunal has decided that an interim order is necessary to guard against such a risk.

41. Whilst the Tribunal notes that the order has restricted Dr Ramaswamy's ability to practise medicine it is satisfied that the order imposed is the proportionate response, given that conditions can be formulated to meet the risks posed in this case. The Tribunal has borne in mind that there is procedure in place with the regulator to address issues of non-compliance. The Tribunal is satisfied that an interim order of conditions, including a restriction on the length of locum work and non NHS practice, is sufficient as a proportionate, workable, enforceable and measurable means of addressing the risks presented. It considers that an interim order of conditions will open a channel of communication between an employer and the GMC and will safeguard the public and the wider public interest while investigations continue and will permit Dr Ramaswamy to remain in clinical practice.

42. The following conditions will be published [conditions set out] ...

43. The Tribunal decided on the period of 18 months given that current stage of the new GMC investigation and given that a GMC health assessment may take place.

44. The order will take effect from today and will be reviewed within six months.

45. Notification of this decision will be served upon Dr Ramaswamy in accordance with the Medical Act 1983, as amended.

The Arguments on behalf of the Claimant

14. In this section of the Judgment I will seek to encapsulate the essence, as I saw it, of the arguments which were advanced by Mr Matovu on behalf of the Claimant, in support of her claim for revocation of the ICRO.
15. The “test” which had to be “applied” by the Tribunal is identified in the Guidance at §23 (see §2 above). The starting point (Guidance §23(a)) was that the Tribunal needed to be “satisfied” that “in all the circumstances” there may be “impairment of the Claimant’s fitness to practise” which “poses a real risk to members of the public, or may adversely affect the public interest or the [Claimant’s] interests”. It is true that the Tribunal accurately recorded this in the opening paragraph of the Introduction (§1). But the Tribunal lost sight of the test when it came to its Assessment. Instead, at §38, the Tribunal said “the nature of the health and conduct concerns are such that Dr Ramaswamy may pose a real risk to patient safety if no interim order were in place”. That omitted the “impairment of ... fitness to practise”. Again, at §40, the Tribunal spoke only of “concerns regarding Dr Ramaswamy’s fitness to practise which pose a real risk to members of the public and which may adversely affect the public interest”, which omitted the “impairment” element. The Tribunal failed to adhere to the rigours of the applicable test in other ways too. It was required to address the “seriousness of risk to members of the public if the [Claimant] continue[d] to hold unrestricted registration”, by an evaluation “assessing this risk” considering “the seriousness of the allegations, the weight of the information, including information about the likelihood of a further incident or incidents” (Guidance §24(a)); and whether public confidence in the medical profession was “likely” to be “seriously damaged” (Guidance §24(b)). So far as “misconduct” is concerned, it is only “serious” misconduct which would be relevant to a finding of “impairment”: see eg. Schodlok v GMC [2015] EWCA Civ 769 at §25. But the Tribunal’s “concerns” and “real risk” (at §§38 and 40) involved no assessment of “seriousness”. The Tribunal misdirected itself as to, and misapplied, the relevant test. It did not ask the right questions.
16. As explained in Martinez §20 (see §4 above), the Tribunal’s function – and now this Court’s “function” – is one of “risk assessment” which “necessarily requires that attention is paid to the nature of the allegations and the evidence which is relied upon to support them”, with a “need to pay attention to the quality of the evidence and the possibility or prospect that it may not be sufficient to justify the view that there is a risk”, and with no “threshold ... other than the need to protect the public, the public interest and, where applicable, the interests of the registrant”. The Tribunal did not apply that approach. But in any event, this Court must do so. What this requires is a ‘qualitative assessment’ of risk and of seriousness. This is further supported by Guidance §52(a) and (b) (§2 above), which require that reasons “must include”, with “specific reference” to “distinct features and particular facts”, a “risk to patients ... clearly identified” and “the risk to public confidence in the profession if the doctor continued working without restriction on their registration and the allegations are later

proved”. The Determination (§§38, 40) speaks of “concerns” with no ‘qualitative assessment’ of risk or of seriousness.

17. The Tribunal, earlier in its Determination, set out in detail the submissions which had been made on behalf of the Defendant (§§13-19) and on behalf of the Claimant (§§20-29). But it did not then, in its Assessment, engage with those arguments or grapple with them in its reasoning. The central reasoning (§§36-41) does not do justice to the submissions, engage with the main points, or grapple with the evidence.
18. As the Tribunal recognised (at §§30 and 38) there were two central matters with which it was concerned. The first were “concerns ... relating to ... health, namely that Dr Ramaswamy may have an unmanaged health condition” (§30): the “health ... concerns” (§38). The second were “concerns ... relating to alleged misconduct ..., namely that Dr Ramaswamy ... was rude and unpleasant to patient AC and family, and that she cancelled the TOE scan” (§30): the “conduct concerns” (§38). The Tribunal was rightly not concerned with the distinct strand relating to alleged “non-compliance” with DHAs. That was a disputed matter in respect of which the High Court had recognised a defence having “some prospect of success” (2021 Judgment §154) based on the argument that the health assessment “was not necessary to investigate the fitness to practise concern” (2021 Judgment §141). That position is fortified by the fact that Professor Gilvarry’s First Opinion (16.4.20) (2021 Judgment §§49-51, 140, 150) did not identify a health assessment as being “necessary”; nor has the subsequent Opinion of Professor Gilvarry (20.12.21) identified such a necessity. The Tribunal was not entitled, in the circumstances of the present case, to rely on any suggested “non-compliance” with any DHA. For the same reason, the Tribunal introduced a legally irrelevant matter at the end of §36 of its Determination when it said: “Dr Ramaswamy appears to be unwilling to appropriately engage with her regulator to resolve the matter”.
19. Regarding the “health concerns”, it was wholly insufficient that the Claimant “may have an unmanaged health condition” (§§30, 37). This could only be a relevant health concern if the Tribunal were identifying a possible unmanaged health condition constituting an “impairment” of fitness to practise which could affect the Claimant’s ability to practise safely as a doctor. It would then need, on that basis, to identify and quantify a “serious” risk to the relevant public. The Tribunal, again, failed to ask the legally correct question. It failed to identify the prospect or possibility of a health condition of that nature. There was, moreover, no evidence before the Tribunal, and there is no evidence before this Court, that there is such a health condition or indeed any unmanaged health condition. The two Opinions of Professor Gilvarry, read in the light of the other evidence, are relevant. Neither of those reports, read fairly, identifies that the Claimant may have any unmanaged health condition, still less one which may affect her ability to practise safely as a doctor.
20. The First Gilvarry Opinion (16.4.20) had described the email correspondence which “may form part of a psychotic illness” and which “suggests there could possibly be a delusional type disorder present”. But Professor Gilvarry’s First Opinion went on to explain that:

However, it is unlikely that she would be able to maintain this persona and not be noticed by people outside the GMC.

What that meant, as was acknowledged in the 2021 Judgment at §§50 and 144(1), was that if the Claimant did have a personality disorder, it is likely that this would be noticed by others including employers. Professor Gilvarry was not expressing the view that there was evidence that others, including colleagues and employers, did notice such a condition or its manifestation. Her Opinion was, moreover, seriously undermined by the fact that she was shown very limited documents. As the 2021 Judgment explained (at §§144(2) and 150) she was not provided with the “evidence gathered from employers and feedback forms” which “raised no concerns about [the Claimant’s] performance” (§144(2)). That employer and patient feedback has continued since then and is updated before this Court. It clearly shows very positive evidence from patients and colleagues. It demonstrates that the manifestation, which Professor Gilvarry reasoned would follow if there were the suggested medical condition, has not followed. That undermines any suggestion of any unmanaged health condition. The second Report (20.12.21) records that Professor Gilvarry was unable to offer a diagnosis; that the papers which by then had been supplied did not “by themselves” support a diagnosis; that it was difficult to say that the conduct complained of was potentially a manifestation of a potential health condition; and that a health assessment would be appropriate and helpful, “if only to exclude any diagnoses”. Professor Gilvarry was not asked the question whether the feedback evidence – now seen by her – showed a persona “not be[ing] noticed by people outside the GMC”, as referred to in her First Opinion.

21. The Tribunal went wrong when it described (at §36 of the Determination) “a number of clinicians with relevant medical qualifications [who] have assessed Dr Ramaswamy as potentially having an underlying medical condition”. That characterisation of the evidence was never raised at the hearing before the Tribunal. It is insupportable. The advice of the Medical Case Examiners, as recorded in the decisions directing DHAs on 1 August 2018 (Determination §3) and 12 May 2020, do not fairly fall within the Tribunal’s description of “assessment” of the Claimant by “clinicians with relevant medical qualifications”. Reading this and the other evidence fairly and as a whole, and asking the correct question, there is no evidential basis for concluding that the Claimant may have an unmanaged health condition, still less such a condition which may affect her ability to practise safely. The quality of the evidence relied on did and does not support a finding of risk, still less serious risk, to patients. The evidence was and is not sufficient to justify the view that there is a risk. The correspondence is from 2018 and 2019. Leaving aside the periods when there was the ISO (1.10.18 to 10.9.19) and the SO (12.1.21 to 15.6.21), the Claimant has continued to work. There is no evidence of any concern in a clinical environment; any fitness to practise concern. The Defendant’s own pleaded Defence to this claim for revocation recognises that the email correspondence levelling accusations at the Defendant and its staff is “not entirely unusual”, where medical practitioners “have faced or are facing regulatory interaction ... and are litigants in person” and “those elements of the Claimant’s correspondence” would not “give rise to a concern about the Claimant’s health taken alone”.
22. Turning to the conduct concerns, there are a number of serious problems. The first is that these were complaints raised by Mrs RC on 13 April 2020 which are vague. There is an allegation that the Claimant “cancelled the TOE scan” (Determination §30). But that is an allegation which is refuted by the contemporaneous documentary evidence. The Tribunal had, and this Court has, evidence from AC’s medical records. A letter dated 13 November 2017 from the Lead Consultant Interventional Cardiologist (Dr R

Moore) to the Consultant Interventional Cardiologist (Dr J Barclay) states that the TOE scan did not proceed because the patient “failed to attend”. The 2020 Report of the expert Dr Davies refers to this evidence. Dr Davies also goes on to refer to an alleged exchange, in which the Claimant is said by Mrs RC to have told her that the Claimant had decided that the TOE scan was not needed, as “perhaps unlikely”. Be all that as it may, the point raised before the Tribunal was as to whether the Claimant was even working in post and on shift at the time that the TOE scan was cancelled. The Tribunal (Determination §24) summarised Mr Matovu’s submission that the Claimant “was not employed at the Copeland Unit at the material time”. The Claimant had stated this at the hearing. On that basis, the Claimant could not have cancelled the TOE scan, which fatally undermines Mrs RC’s claim about this, and about everything else. In any event, turning to the allegation that the Claimant had been “rude and unpleasant to patient AC and family” (§30), this is addressed by Dr Davies who reported that there was no evidence of rudeness or unpleasantness in the medical notes, and that the only evidence of rudeness or unpleasantness had come from the Mrs RC. Dr Davies analysed the contemporaneous documents including a note of a meeting with the family on 28 December 2017. Dr Davies described the records as constituting “no great evidence that the doctor was unpleasant or did anything to cause the patient stress and anxiety” and said that the notes “didn’t show anything other than expected standard of care”. The allegation of being rude and unpleasant is totally out of tune with the contemporaneous records. Those records, as Dr Davies observed, “could be a reasonable defence to the allegations” absent “corroboration from other sources”. There is no corroboration from any other source. The expert report of Dr Davies, read fairly and as a whole, supports the conclusion that the allegation of rude and unpleasant conduct is unlikely. The Tribunal’s point about the Notes of the consultation (28.12.17) (Determination at §37) was a new point, not raised with Counsel at the hearing, was untenable and irrelevant; which is why Dr Davies expressed no concern about it.

23. This needs to be put alongside the other evidence. That includes the recognition, in the referral by Case Examiners (on 24 June 2021) of these conduct matters to the Tribunal, for consideration of an interim order, that although a new investigation was being opened: “In itself the allegations under investigation would be unlikely to meet the threshold for a referral to IOT”. There is also the fact that Mrs RC’s complaint made in April 2020 relates to alleged events in 2017. Five years have now passed. As described above, the Claimant has continued to work. There is a positive body of feedback from employers, colleagues and patients. There is nothing in the evidence over the course of that time which indicates any similar such conduct. Reading the evidence fairly and as a whole, and asking the correct question, there is no evidential basis for concluding that there are evidenced conduct concerns, still less such a condition which may constitute an impairment or involve a risk to members of the public. The quality of the evidence relied on did and does not support a finding of risk, still less serious risk, to patients. The evidence was and is not sufficient to justify the view that there is a risk.
24. In all the circumstances, the ICRO was and is not necessary. That includes after balancing the Claimant’s interests and the interests of the public (Guidance §23(b)). There is no impairment posing a serious risk to members of the public. There is no impairment adversely affecting the public interest. There is no likely serious damage to public confidence in the medical profession from unrestricted registration pending substantive investigation and resolution. Nor, weighing up all the relevant factors, is the ICRO a proportionate response (Guidance §25). The Tribunal’s reasons for the

maximum duration of 18 months (§§39, 43) are in any event inadequate. All of this arises in a case where there is a significant impact on the Claimant. As the Tribunal rightly recorded, the ICRO “has restricted Dr Ramaswamy’s ability to practise medicine” (Determination §41). There has been a substantial passage of time and a striking lack of progress on the part of the Defendant. Like Houshian v GMC [2012] EWHC 3458 (QB), this is a case where the interim order should be revoked; the Court should conclude that the Tribunal has imposed an interim order “without expressly identifying” the “risk posed by the [doctor] remaining in unrestricted practice pending the resolution of the allegations” and, “perhaps more importantly the degree of that risk” (see §34); where the Determination does not really explain why an interim order was required (§37); and where all relevant public interest considerations can fairly be reflected by a substantive tribunal determination to decide the facts, and any issue of impairment, and any issue regarding final sanction (§39).

25. Whether or not the Court finds any error of approach on the part of the Tribunal – and there are many – this Court, exercising its “original” jurisdiction ought to reach a different view and conclude that the ICRO is unjustified and disproportionate. This Court has the fully up-to-date position. That includes the strong, positive evidence from patients, employers and colleagues. It includes, for example, Professor Gilvarry’s Second Report.
26. That then, as I saw it, was the essence of the arguments advanced by Mr Matovu in his written and oral submissions.

Analysis

27. I am unable to accept these arguments. In my judgment, the Determination of the Tribunal, and the outcome at which it arrived, was fully justified. In my judgment, the Tribunal did not go “wrong” in its approach, in its reasoning, or in its conclusions. On the contrary – and taking my “original” jurisdiction at its most exacting in the Claimant’s favour – the outcome was, in my judgment, correct and I agree with it. I will explain why, by reference to the key submissions made by Mr Hare KC on behalf of the Defendant, I have reached these conclusions.
28. I can start with the question of “compliance” with DHAs and the absence of a health assessment. I accept, in the Claimant’s favour, that it was and is appropriate to put to one side concerns about whether, by her action of not submitting to a health assessment as directed in the DHAs, there was a regulatory “compliance” default. Mr Hare KC accepted, for the purposes of this claim in these proceedings, that the issue of “non-compliance” – currently pending in the adjourned hearing before a Non-Compliance Tribunal after the 2021 Judgment and the quashing of the Non-Compliance Determination – ought to be put to one side. He submitted that the “fact” that there has been no health assessment must, however, remain relevant to the “health concerns”. Mr Matovu, rightly, accepted that this is so. To test how there can be no “compliance” issue, but nevertheless a relevant “fact” of the absence of a health assessment, suppose this situation. Suppose there were no power (as is to be found in Rule 7(3) of the 2004 Rules) to “require by direction” that a doctor undergo a health assessment. Suppose, however, that the Defendant has “suggested” a health assessment – as a “good idea” – to assist its investigation of whether there was a health-based “impairment”. If the doctor declined the invitation, there may be no “compliance” question. But there may be an important “fact” concerning the absence of an up-to-date health assessment. This,

in substance, is how the Tribunal approached the issue. The Tribunal identified as “the nature of the concerns in this case” (Determination §30) the alleged health concerns and the alleged misconduct concerns (Determination §§30, 38). The “concerns ... relating to alleged misconduct” were the April 2020 complaints by Mrs RC that the Claimant “was rude and unpleasant to patient AC and family, and that she cancelled the TOE scan” (§30). As Mr Matovu emphasised, the Tribunal did not include “non-compliance” concerns. The Tribunal specifically recorded (§32) that the Claimant “robustly denies any allegations of non-compliance with the regulator”. However, in relation to the alleged “health concerns”, the Tribunal said it had “borne in mind Dr Ramaswamy’s unwillingness to undergo a GMC health assessment and noted that it does not have the benefit of up to date information on her current state of mental health” (§32). That was a relevant “fact”. I can find no error in that approach.

29. This was relevant to the “concerns relating to health and an unmanaged health condition”, to which I can turn next. Mr Matovu, rightly, accepts that these health concerns constituted a key topic for the Tribunal to consider. I have been able to consider the evidence with the assistance of Mr Matovu and that of Mr Hare KC. The starting point is the series of email communications which were the subject of the notification letter of 28 August 2018, sent because of “serious concerns” arising from “tone and content” of the communications (see 2021 Judgment §3). Mr Hare KC showed me items from that correspondence. One communication to the Defendant says:

I now feel that GMC has crossed all their boundaries into the doctors personal lives and in supporting the criminals and covering up of criminals in NHS Grampian and are involved in creating fake cases and giving false warnings to doctors who are innocent. I feel that it is my responsibility to inform that the entire doctors in United Kingdom and the rest of the doctors in the world who are registered with GMC and all the medical students, their parents and the entire public and government, press and media and the whole world about GMC and they almost get involved. I must reiterate that if anyone else contact[s] me either by phone or emails that I must advise you that the next immediate step is what I had written in the above paragraph. I reiterate that you must immediately inform your staff to stop contacting me on your behalf...

Other communications, in which the Claimant was strongly insisting on being addressed as the wife of the Doctor (§5 above), said:

I must remind you... to remember my name very well and write correctly and if not that I will make a complaint for racial harassment, race hate crime, racial discrimination, bullying, harassment, coercion, treating me like a slave and religious hate crime and religious harassment and discrimination...

[If] you call me ... Dr Ramaswamy ... I will make a formal complaint against you to the police for continued racial harassment and racial discrimination and race hate crime, continue bullying, harassment and coercive and degrading behaviour and breaching human rights and religious harassment and religious discrimination against me... If you ever contact me again I will make a complaint against you to the police and start criminal proceedings.

30. Against that backcloth, I turn to the decision of 1 August 2018 to issue the first DHA. This was based – as the Tribunal recorded (Determination §3) – on this advice:

A GMC Medical Case Examiner reviewed the emails and advised that given their tone and content they raised serious concerns about Dr Ramaswamy’s mental health.

That advice, from a “Medical Case Examiner”, was to proceed with a health assessment because the correspondence “is concerning and does indicate the doctor is not mentally

well”. The subsequent decision of 12 May 2020 to issue a further DHA also contained advice from a Medical Case Examiner, recording an equivalent view that a health assessment would be appropriate, but declining to speculate on specific alleged diagnoses. The Tribunal had recorded, in its summary of Mr Matovu’s submissions (Determination §29), that “a full psychiatric assessment in 2015 found no evidence of any disorder”. On 27 February 2020 there was the GMC’s discussion with Professor Gilvarry, who had reviewed the correspondence and was asked for specialist advice. That advice, which became embodied in Professor Gilvarry’s First Report (16.4.20) included this:

Prof Gilvarry confirmed she has read the information contained within the bundle, and in her opinion these documents do raise concerns regarding the doctor’s mental health...

Prof Gilvarry reiterated that the doctor’s behaviour throughout her correspondence suggests irritability, and is persecutory, threatening and grandiose. This may form part of a psychotic illness...

Prof Gilvarry explained the correspondence suggests there could possibly be a delusional type disorder present. It could be personality traits or possible personality disorder, with the doctor able to work without significant issues being noted by employers and then send inappropriate correspondence to the GMC. However, it is unlikely that she would be able to maintain this persona and not be noticed by people outside the GMC. Prof Gilvarry confirmed that in her opinion following review of the bundle we do have a reasonable justification to investigate Dr R’s health as a fitness to practise concern, and that in this case a health assessment is appropriate.

For its part, the Tribunal had specifically set out these and other contents of this Report, in summarising Ms Duckworth’s submissions (Determination §§15-16). I accept Mr Hare KC’s submission that Medical Case Examiners are themselves “clinicians with relevant medical qualifications”. The Medical Case Examiners, and Dr Gilvarry in her First Report, did not assess the Claimant as having an underlying medical condition. But the views expressed clearly justified the Tribunal’s observation (Determination §36) that:

... a number of clinicians with relevant medical qualifications have assessed Dr Ramaswamy as potentially having an underlying medical condition.

31. The next question is whether, for the purposes of assessing “risk” and considering interim orders, this assessment – of the Claimant “potentially” having an “underlying medical condition” – can be treated as having subsided, in light of the evidence of what has been observed by others. As has been seen, as at February 2020 and April 2020 Professor Gilvarry was saying:

... the correspondence suggests there could possibly be a delusional type disorder present. It could be personality traits or possible personality disorder, with the doctor able to work without significant issues being noted by employers and then send inappropriate correspondence to the GMC. However, it is unlikely that she would be able to maintain this persona and not be noticed by people outside the GMC...

In the 2021 Judgment Morris J had said (at §144(1), emphasis in original) that:

... the true sense of that paragraph is (very arguably) that it is likely that, if the [Claimant] had a personality disorder, it would be noticed by, amongst others, her employers.

In further observations in the 2021 Judgment at §§144(2) and 150, Morris J pointed out that “evidence gathered from employers and feedback forms was not provided to” Professor Gilvarry, that “the fact that employers had raised no concerns about the [Claimant’s] performance might well have been relevant to [Professor Gilvarry’s] overall conclusion” and that “it is not known what her opinion might have been, had she seen the employer and patient feedback”. In these passages, Morris J was not expressing a conclusion that the “evidence gathered from employers and feedback forms” – including that “employers had raised no concerns about the [Claimant’s] performance” – demonstrated that there was no “personality disorder”. What he was doing was identifying the prospect that it could do so.

32. Against that backcloth, I turn to the Second Report of Professor Gilvarry (20.12.21). This post-dated the 2021 Judgment and Morris J’s observations. For the Second Report, Professor Gilvarry was specifically provided with “patient feedback, multisource feedback and staff nurse feedback”. She was also provided with her First Report. If, having been provided with this “feedback” evidence, Professor Gilvarry considered that what was “not noticed by people” now served to eliminate the possibility of the delusional type disorder being present, that is what Professor Gilvarry would have said in the Second Report. But that is not what she says. Professor Gilvarry expressly considers the “feedback” evidence. She enters a caveat in describing the general positivity of that “feedback” picture, referring to “some developmental issues”, reflected in the recognition that the Claimant at times makes “derogatory comments”. Professor Gilvarry then concludes that the materials did not, by themselves, “support a diagnosis” and that she is not therefore able to offer one. Asked whether “the documents and case history raise concerns regarding the [Claimant’s] mental health”, Professor Gilvarry responds: “Yes, I would be concerned about some aspects of the documentation”. Asked whether, if there are such concerns, this could impact on the doctor’s fitness to practise medicine, Professor Gilvarry responds: “At times [the Claimant’s] behaviour appears to be obsessive and with elements of stalking, eg. continued emails, long repetitive statements and inappropriate language...” Referring again to the feedback, and the caveat, Professor Gilvarry says:

I do note the positive multisource feedback though there are some developmental issues. I think based on this information alone and I am sure the GMC has much more available that I am unaware of, I do as I noted in 2000 think an assessment would be appropriate and indeed helpful to the doctor, if only to exclude any diagnoses.

33. The Tribunal summarised Mr Matovu’s submission about Professor Gilvarry’s advice (Determination §21): that this “advice was of little assistance, it not being supported by any information from sources outside of the GMC”. In assessing risk, from the perspective of interim orders, the Tribunal clearly did not agree with that submission. Nor do I. Reading the evidence fairly and as a whole, Professor Gilvarry has maintained the previously expressed position: that, based on the communications, the Claimant is still assessed as potentially having an underlying medical condition which could impact on her fitness to practise medicine. The “feedback” picture does not, of itself, allay the concerns which arise. The reference to an underlying medical condition “which could impact on her fitness to practise medicine” is important. It links to “impairment”. It links to risk and harm. As the Tribunal later put it (§37), the concern – which I share – is:

... that Dr Ramaswamy may have an unmanaged health condition which has the potential to cause harm to patients.

34. At this point in the analysis, it is appropriate to identify potential ‘crossovers’ in the materials, viewed as a whole. A first potential crossover is to be found in Professor Gilvarry’s caveat when describing the “feedback” evidence, where she referred to “developmental issues” and noted “derogatory comments”. A second potential crossover is between Professor Gilvarry’s expert evidence and the matters which constitute the “conduct concerns”. For her Second Report, Professor Gilvarry was provided with Mrs RC’s “complaint” and Mrs RC’s “statement to the Coroner’s court”. Asked whether, if there were concerns regarding the Claimant’s mental health, this “could ... impact on [the Claimant’s] fitness to practise medicine”, Professor Gilvarry referred to the note of Mrs RC’s complaint as one noting “concerns”. There is then this passage in the December 2021 Report, where Professor Gilvarry is asked:

The complaint received from Mrs [RC] – was the doctor’s conduct potentially a manifestation of any potential health condition.

Professor Gilvarry responds:

I find this difficult as essentially the evidence is one person against the other. Clearly if the nurse has corroborated the doctors opinion that would be most helpful or if the hospital had investigated the complaint if one was made. The entries in themselves alone and as they are cited I would not see as below the line.

What is noteworthy is that what makes the question “difficult” is whether the alleged conduct happened, hence the references to corroboration; investigation; notes. If Professor Gilvarry thought that, “even if it happened”, it could not potentially be a manifestation of any potential health condition, she could and surely would have said so. Corroboration, investigation, notes would be irrelevant to the question she was asked. The Tribunal recorded (§35), and I agree, that “no link between [the Claimant’s] health and alleged misconduct has been established”. But, in assessing risk, the potential is there.

35. Against this evidence, there is the factual point to which I have already referred: there is no post-2015 health assessment. I agree with the Tribunal (Determination §32). The Tribunal did not “have the benefit of up to date information on [the Claimant’s] current state of mental health”. Nor do I. The absence of an up to date health assessment is a clear impediment, when assessing risk and considering interim orders. Remembering that the Claimant “robustly denied any allegations of non-compliance” (§32), this was nevertheless an “unwillingness to undergo a GMC health assessment (§32), which means the issue remains “unresolved” (§36) in circumstances where the Claimant “appears to be unwilling to appropriately engage with her regulator” in order “to resolve the matter (§36). Viewed as a fact – that the Claimant has been unwilling to undergo the assessment which would provide the up to date information – that description of the position is also, in my judgment, entirely justified.
36. In my judgment, based on this body of evidence, there was clear and cogent justification for the Tribunal’s conclusions at Determination §36: that, bearing in mind the tone and content of the Claimant’s emails to the regulator and its staff spanning over three years and most recently in August 2021 there is a concern that this may be indicative of pattern of behaviour which may be related to a health concern. In the light of this evidence, in assessing risk and considering the necessity and proportionality of interim orders, there are very real concerns relating to very real risks. It is difficult to assess them – and to “quantify” them – precisely because of the “fact” that there is not the up-

to-date medical assessment which would clearly assist. But as Mr Hare KC convincingly submits, the Tribunal, and this Court, when recognising risk and uncertainty in the context of public protection, are not obliged to wait until risk crystallises into harm, if it does, or until an assessment which clarifies the position is finally undertaken, if it is.

37. In the light of the matters to which I have referred, I turn to focus on the “conduct concerns”. That was the approach taken by the Tribunal at §37, in light of what it had said at §36. The Tribunal had already recorded key submissions made by Counsel. Ms Duckworth’s position for the Defendant was (Determination §§13, 14):

Ms Duckworth submitted that in view of the misconduct allegations relating to the single patient complaint and the ongoing health concerns raised, it is necessary for the protection of the public, is in the public interest and is in Dr Ramaswamy’s own interests to impose an interim order of conditions. Ms Duckworth referred the Tribunal to the new allegations today raised by the complaint from [Mrs] RC, and the opinion reached by the expert Dr Davies ‘if the complainant was correct in her description of the interactions with Dr Ramaswamy the care had fallen seriously below the expected standard’.

Mr Matovu’s position for the Claimant was (Determination §§21-27)

Mr Matovu submitted the matters before the Tribunal ‘are very old’ and noted that the ‘new’ complaint from [Mrs] RC dates back to 2017... Mr Matovu stated that there is no witness or corroborating evidence available in respect of the ‘new concerns’ ... He submitted that the enquiries made by the GMC do not substantiate the allegations ... Mr Matovu rehearsed the history of the proceedings with the GMC, submitting that ‘three years down the line’ the GMC have not progressed the case and have not been able to substantiate the allegation. He stated that the GMC took 5 months to notify Dr Ramaswamy of RC’s complaint and that some aspects of the case, including one relating to prescribing of diazepam were closed off. He stated that Dr Davies had noted in his discussion with the GMC that it was a difficult consultation with a complex family background, and that the GMC were correct to close the allegation in respect of diazepam... In respect of the TOE scan Mr Matovu submitted that there was evidence that AC was an inpatient though not under Dr Ramaswamy’s care (as she was not employed at the Copeland Unit at the material time) had failed to attend for the scan. AC was subsequently removed from the waiting list, after being uncontactable. He stated that Dr Ramaswamy had no involvement in the incident. AC was readmitted for a hip operation and Mr Matovu took the Tribunal to correspondence dealing with this, and the discussion between the clinicians regarding whether AC should be placed back on the list for a TOE scan, in 6 weeks’ time. AC died before a scan took place. He stated that there is no reason for the GMC to pursue an investigation against Dr Ramaswamy, who had no involvement at all in the matter. In respect of the allegation of Dr Ramaswamy’s ‘rude and unpleasant’ behaviour to AC and family, Mr Matovu submitted that there is a paucity of evidence and information. He referred the Tribunal to detailed notes made by Dr Ramaswamy from a face-to-face consultation on 28 December 2017 with RC, which he submitted has not been followed up by the GMC. He also submitted that witness evidence has not been sought. He noted that the complainants account was at odds with the detailed medical records. He stated there is no complaint made by AC, and RC did not raise a complaint with the hospital. Mr Matovu submitted that the evidence of RC could not be relied upon, noting that it took two years from AC’s death for her to raise a complaint with the GMC. Mr Matovu referred the Tribunal to the Case Examiner decision of 24 June 2021 where it is stated: “the allegations under investigation in respect of RC would be unlikely to meet the threshold for a referral to IOT...” Mr Matovu submitted that as the GMC is unable to establish a link between Dr Ramaswamy’s health and any misconduct allegations, then the new GMC case is based on supposition only, reiterating the Case Examiner note that the threshold for referral is unlikely to be met on the basis of RC’s complaint alone.

38. The first key point made by the Tribunal in its assessment of the conduct concerns (§37) was this:

The Tribunal considers that albeit relating to a single patient, there are issues of concern arising in respect in respect of Patient AC, a vulnerable patient.

The Tribunal then referred to the Notes of the consultation (28.12.17). These were the Notes to which Mr Matovu had referred in his submissions. What the Tribunal said was this (Determination at §37):

It has considered the ‘Notes from a meeting with A’s family on 28 December 2017’ made by Dr Ramaswamy. Dr Ramaswamy records “we said that A had been threatening us and Blackmailing by saying Borderline, Borderline, Borderline in order to make us listen to what she wants”. This reinforces the Tribunal’s concern that Dr Ramaswamy may have an unmanaged health condition which has the potential to cause harm to patients.

I accept that this was the Tribunal’s own observation. I also accept – having been shown no reference in the transcript – that this part of the Notes was not raised by the Tribunal with Counsel at the hearing. But, in my judgment, the Tribunal was at least entitled to have regard to this part of the Notes for the reason it gave, namely as a reference which “reinforces” the “concern” that the Claimant “may have an unmanaged health condition which has the potential to cause harm to patients”. This was the Tribunal identifying the second potential ‘crossover’ to which I referred above (§34 above). It can fairly be pointed out that Professor Gilvarry (as the expert addressing health concerns) did not specifically focus on this entry in the Notes. Nor did Mrs RC focus on this description in her complaint or witness statement to the Coroner. Nor did Dr Davies, in his expert evidence about conduct (not health) concerns. However, having said all that, I share the Tribunal’s concern. What the Claimant appears to be recording in the Notes is a vulnerable patient who had been saying “Borderline, Borderline, Borderline” – which the Claimant assessed as being done “in order to make us listen to what she wants” – and telling the “family” that this constituted “threatening” and “blackmailing”. That language is striking. Bearing in mind that the Tribunal singled it out, it is relevant that Mr Matovu did not – in my judgment – have any convincing answer to explain that language. I cannot agree that the point was or is untenable or irrelevant. It is language which needs to be put alongside the other evidence. In my judgment the Tribunal was at least entitled, as a specialist tribunal (see Martinez §16) to take that matter into account. In fact, I share the Tribunal’s view that it is relevant and reinforces concerns.

39. Turning to the “conduct concerns” themselves, the starting point is that Mr Matovu’s criticism of Mrs RC’s “complaint” as being “vague” is unpersuasive. The complaint referred to, and was accompanied by, the witness statement provided to the Coroner. That statement descended into considerable detail. So far as the cancellation of the TOE scan is concerned, the Tribunal was right to refer to this. The Tribunal, rightly, recorded that Mr Matovu was submitting that this Allegation was refuted by the fact that the Claimant was not working on the relevant unit at the relevant time. But the Tribunal was not required to adopt a fact-finding function and conclude that the Claimant had had no involvement in respect of the cancelled TOE scan. It would have been open to the Claimant, before the Tribunal or indeed in the claim before this Court, to produce the ‘hard evidence’ which is said to refute this part of the complaint. I was shown no document of that kind. In the circumstances, I decline to find as a fact that there can be nothing in this part of the complaint. Putting all of that to one side, there is the conduct concern relating to alleged rude behaviour to AC and the family (Determination §§30 and 33). I accept that there has been a substantial passage of time and that the Defendant does not have evidence which corroborates the allegations made. What it does have is the expert Report of Dr Davies (November 2020). That Report describes the alleged

comments as being “perhaps unlikely”, describes the absence of support in the medical records, and identifies the records as documents which would “clearly” form an “important” part of the Claimant’s defence to the Allegations. But Dr Davies does not and cannot say that the alleged statements made by the Claimant to AC and the family were not made. One feature which is conspicuous in his Report is that he is addressing the threshold of “seriousness” of misconduct, which Mr Matovu has emphasised. Dr Davies repeatedly poses the question of whether the Claimant’s alleged actions would – if they happened – be “seriously” below the expected standard. On numerous occasions, by reference to what is alleged to have happened, Dr Davies says that if those events did happen then this would have been action “seriously below the standards expected”. This Court is not making findings of primary fact, nor applying any particular evidential threshold, and the materials do not enable me to “clearly see that the case has little merit” (GMC v Hiew [2007] EWCA Civ 369 [2007] 1 WLR 2007 at §31) or that the claim is manifestly incredible or bound to be rejected or involves no prima facie case (Martinez at §18). It is true that an important feature of the evidence is the contemporaneous documents, but on the other hand it may be unlikely that a clinician’s contemporaneous documents would record the sort of interactions which are described in the Witness Statement to the Coroner, featuring in Mrs RC’s complaint.

40. With all of this in mind, I arrive at the Tribunal’s Determination §§38-41 and 43. As has been seen, the Tribunal concluded: that the nature of the health and conduct concerns are such that the Claimant may pose a real risk to patient safety if no interim order were in place; that, were the allegations later proved, public confidence in the profession could be seriously undermined if the Claimant were permitted to practise medicine unrestricted whilst concerns regarding her health and conduct are unresolved; that, in all the circumstances, the statutory test for the imposition of an order is met in this case; that it was necessary to impose an interim order on the Claimant’s registration; that there are concerns regarding the Claimant’s fitness to practise which pose a real risk to members of the public and which may adversely affect the public interest; that, after balancing the Claimant’s interests and the interests of the public, an interim order is necessary to guard against such a risk; that although the ICRO restricts the Claimant’s ability to practise medicine, it is the proportionate response, with conditions formulated to meet the risks, a procedure in place to address issues of non-compliance; that the ICRO is sufficient as a proportionate, workable, enforceable and measurable means of addressing the risks presented, opening a channel of communication between an employer and regulator which will safeguard the public and the wider public interest while investigations continue and will permit the Claimant to remain in clinical practice; for a period of 18 months given the stage of the new investigation into Mr RC’s complaint. In my judgment, these conclusions were fully justified. I agree with them.
41. I do not agree with Mr Matovu that the Tribunal misdirected itself as to the test which it had to apply, that it lost sight of the test, that it ignored relevant adjectives in the Guidance, that it failed to conduct the necessary qualitative assessment of risk of seriousness, that it overlooked the evidence, or that it failed to grapple with the key points. More to the point, having carefully considered the materials on which reliance is placed on the submission that are made about those materials, I have concluded in my “original” jurisdiction that there is nothing “wrong” or unjustified in the Tribunal’s conclusion or the outcome. So far as the “legal test” is concerned, the Tribunal had

opened the Determination (§1) by describing the test in precisely the terms of which Mr Matovu approves. The Tribunal had said:

In accordance with section 41A (1) of the Act, the Tribunal will make an order if it is satisfied that there may be impairment of a doctor's fitness to practise, which poses a real risk to members of the public or may adversely affect the public interest or the interests of the practitioner and, after balancing the interests of the doctor and the public, that an interim order is necessary to guard against such risk.

The Determination needs to be read fairly and as a whole. When the Tribunal (at §38) referred to the “statutory test” being “met”, that was clearly a reference back to the test which it had set out (§1). When the Tribunal was describing (at §39) section 41A of the 1983 Act as amended, that too was a deliberate reference back to the very provision whose essence had accurately been set out at the outset (§1). It was not losing sight of the test. On the contrary, it was bringing the test back to the forefront. The Tribunal did not need to keep restating the test.

42. What is more, prior to the Determination, and contained within the transcript at the hearing is the two-page description of the “legal advice” which the legally qualified Chair (Margaret Obi) gave openly at the hearing and on which the parties’ Counsel were able to comment (I have inserted the paragraph numbers):

[1] This is a new case. [2] The statutory test for imposing an interim order is set out in section 41A of the Medical Act 1983 (as amended). It requires the Tribunal to consider whether there may be impairment of Dr Ramaswamy's fitness to practise which poses a real risk to members of the public, may adversely affect the public interest or is in the interests of the doctor herself. The GMC's application is based on all three grounds: concerns about Dr Ramaswamy's health and concerns in relation to Patient [AC]. It is a matter for the Tribunal to determine which, if any, of these features are engaged and whether it is appropriate to impose an interim order to guard against any risks that have been identified based on the concerns that have been raised. [3] As has already been mentioned during this hearing, the Tribunal's role is not to make any findings of fact or resolve any inconsistencies that may appear on the face of the papers. It is to conduct a comprehensive risk assessment bearing in mind the nature and seriousness of the concerns, the cogency of the information and the weight to be attached to it. The Tribunal will also want to take into account the likelihood of incidents, or further incidents occurring if Dr Ramaswamy is permitted to continue to practise without restrictions. [4] The options available to the Tribunal are, one, to make no order; two, to impose an interim order of conditions or, three, to impose an interim order of suspension. The Tribunal should first consider whether it is necessary to make any order at all. Before an interim order can be made on public protection grounds, it must be necessary for the protection of the public and the tribunal must be satisfied that there is a real risk to patients if an order is not made. It would not be appropriate to impose an order “just in case” or in an abundance of caution. The test is necessity. [5] With regards to the wider public interest, the High Court has made it clear that it would be rare for an order to be made on public interest grounds alone, particularly an interim suspension order. A useful test to consider is whether a reasonable, fully-informed member of the public would be surprised or alarmed to know that a doctor in these circumstances was allowed to continue in practice, without restriction or at all, whilst the allegations remain outstanding and unresolved. [6] The Tribunal should also consider whether there are any features of this case which make the order appropriate in the interests of Dr Ramaswamy. It is only if the Tribunal determines that it is appropriate to impose an order that it should first consider conditions. Any conditions imposed must be appropriate, workable and measurable. If the Tribunal decides that conditions are appropriate, there is an expectation that it will refer to the Interim Orders Tribunal's conditions bank. [7] If conditions do not meet the Tribunal's objectives, it will then have to determine if a period of suspension is the appropriate measure to address its concerns. The principle of proportionality requires the Tribunal to weigh up and balance the interests of the public with those of Dr Ramaswamy and, in so doing, impose no greater restriction on her ability to

practise medicine than is necessary. Dr Ramaswamy's interests include her personal, financial and professional interests. [8] The Tribunal can impose a conditions of practice order or a suspension order for up to 18 months and separate reasons are required for imposing an order for a particular period. In determining the length of any order, the Tribunal should not automatically impose the maximum period. Its decision on length must be informed by the current stage of the investigation, the complexity of the case and the extent of the further enquiries the GMC will have to make in the interim. The Tribunal will also, of course, take into account the guidance on making interim orders.

Neither Counsel, when given the opportunity, had anything to suggest. As Mr Matovu accepted, and accepts, that legal advice stood as a clear, accurate and complete self-direction as to the approach in law.

43. When the Tribunal spoke about “concerns relating to alleged misconduct and health” it was doing so in the context of the statutory test and the Guidance, which it clearly had in mind. I too have addressed the concerns, the evidence and the arguments made before me in light of that legal framework, together with the authoritative guidance relating to this Court’s function and jurisdiction. It was undoubtedly challenging to seek to specify the harm and quantify the risk, where the concern is that there is a “potential unmanaged health condition” which has “the potential to cause harm to patients”, where the Tribunal (and now the Court) lacks “the benefit of up to date information on [the doctor’s] current state of mental health”; where an expert has identified a potential “psychotic illness” and a possible “delusional type disorder”, and where the expert has identified “concerns regarding the doctor’s mental health” which “could impact on their fitness to practise medicine”, because of “behaviour” which “appears to be obsessive” and because of the nature of Mrs RC’s complaint. The Tribunal expressed itself as follows: that the Claimant “may pose a real risk to patient safety” if no interim order were in place. It also considered that if the allegations were later proved, public confidence in the profession could be seriously undermined if the Claimant had been permitted to practise medicine unrestricted while concerns regarding her health and conduct were unresolved. The “legal advice” spoke of a “comprehensive risk assessment”. It said: “the test is necessity”. The Determination concluded (§39) that it was “necessary to impose an interim order”; and the ICRO was “necessary to guard against” the “real risk to members of the public” (§40). The Tribunal was plainly well aware, as am I, of the question whether the “concerns” were linked to a relevant risk of relevant “harm”. It plainly had in mind, as have I, the question of whether the underlying or unmanaged health condition was one which could affect the Claimant’s ability to practise safely.
44. It is right to remember that this is not an ISO. Nor, as Mr Hare KC pointed out, is it a highly intrusive species of ICRO involving close “supervision” conditions. It was a measured set of, less intrusive, conditions giving an appropriate – but necessary – degree of safeguarding for the public and the public interest. As has been seen, the Tribunal explained (§41) the conditions including the restriction on the length of locum work and non-NHS practice, which stood as a sufficient and proportionate, workable, enforceable and measurable means of addressing the risks presented; and that it would open a channel of communication between employer and regulator, safeguarding the public and the wider public interest what investigations continued, while permitting the claimant to remain in clinical practice. As has also been seen, the legal advice recorded that “separate reasons” were required for imposing an order for a particular period; and the decision on length must be “informed by the current stage of the investigation, the complexity of the case and the extent of the further enquiries the [Defendant] would

have to make in the interim”. The Tribunal (at §41) made clear that it had considered the question of length and, in my judgment, gave adequate reasons why 18 months (§39) was chosen, based on what the Tribunal had been told about the current stage of the new investigation which moreover was understandably linked to the prospect that the health assessment may take place (§43). The Tribunal recorded the fact that an ICRO would restrict – and the previous ICRO had restricted – the Claimant’s ability to practise medicine (Determination §41). It had earlier recorded Mr Matovu’s submission “that an interim order of conditions would make it ‘difficult’ for Dr Ramaswamy to obtain work” (§29). The Tribunal recorded (§41), correctly, that the ICRO would “permit Dr Ramaswamy to remain in clinical practice”. The Tribunal had well in mind, as have I, the impact on the Claimant.

Conclusion

45. Throughout my analysis in this case I have borne in mind the principled guidance in the authorities (§4 above), and that the Tribunal has a specialist front-line role. This case exemplifies the general truth, identified in the Guidance and in the authorities, that it is not the function of the Tribunal or this Court – in dealing with “interim” orders – to try to arrive at definitive conclusions on contentious factual matters. As the Tribunal recognised, the question of interim orders raises questions of risk-assessment, questions about the sufficiency of the quality of the evidence, questions of necessity and of proportionality. This claim is, as I have explained, a sustained challenge to the ICRO invoking a statutory entitlement to access this Court for that purpose. In my judgment, the outcome at which the Tribunal arrived was wholly justified. Indeed, I agree with it. In all the circumstances, and for all these reasons, the claim will be dismissed.

Costs

46. Having circulated this judgment as a confidential draft I am able to deal here with consequential matters. The Defendant, having succeeded, seeks an order for its costs of this hearing (£10,063.80, after the deduction of costs referable to the failed application for a postponement) and the costs (£3,462.00) of the skeleton argument (which I reserved) prepared for the March 2022 hearing. The Claimant submits that the additional £10k is unreasonable in circumstances where the Defendant was already prepared in March 2022. I do not agree. This was a sustained challenge on multiple grounds with voluminous materials in a complex factual setting. The work undertaken was necessary, appropriate and foreseeable. I will, however, apply a broad-brush reduction – as an exercise of discretion and judgment – to reflect the fact that I am not ordering costs on an indemnity basis. I order that the Claimant pay the Defendant’s costs of this hearing summarily assessed in the sum of £8,000 and the costs of the preparation of the skeleton argument for the hearing on 29 March 2022 summarily assessed in the sum of £2,750.

Permission to appeal

47. Mr Matovu seeks permission to appeal on three grounds – the first of which has 8 sub-grounds – framed by reference to what is said to have been wrong in the approach of the Tribunal, and which as I see it is effectively a root and branch re-run of the arguments advanced before me. I cannot see, in those grounds or otherwise, that there is a viable appeal to the Court of Appeal with a realistic prospect of success. I refuse permission to appeal.