



Neutral Citation Number: [2022] EWHC 403 (Admin)

Case No: CO/4282/2020

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

Royal Courts of Justice  
Strand, London, WC2A 2LL

Date: 25 February 2022

Before :

**THE HONOURABLE MR JUSTICE MURRAY**

Between :

**GENERAL MEDICAL COUNCIL**

**Appellant**

- and -

**ABDULKHALED AHMED**

**Respondent**

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**Mr Ivan Hare QC** (instructed by **GMC Legal**) for the **Appellant**  
**Mr Andrew Hockton** (instructed by **Hempsons**) for the **Respondent**

Hearing date: 28 June 2021  
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**Approved Judgment**

I direct that copies of this version as handed down may be treated as authentic.

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THE HONOURABLE MR JUSTICE MURRAY

**Covid-19 Protocol:** This judgment was handed down remotely by circulation to the parties' representatives by email and release to BAILII. The date and time for hand-down are deemed to be 10:30 am on 25 February 2022.

**Mr Justice Murray :**

1. This is an appeal under section 40A of the Medical Act 1983 by the General Medical Council (“GMC”) against the sanction imposed by the Medical Practitioners Tribunal (“the MPT”) on the respondent, Dr Abdulkhaled Ahmed, following a hearing before the MPT that took place on various dates between 24 October 2019 and 22 October 2020 (“the MPT Hearing”).
2. The MPT Hearing was held to consider alleged misconduct by Dr Ahmed in relation to two patients, “Patient A” and “Patient B”. The MPT found that some, but not all, of the allegations against Dr Ahmed were proved and that there was misconduct in relation to each patient. It also found that Dr Ahmed’s fitness to practise was impaired as a result of his misconduct in relation to each patient. It determined that the appropriate sanction was a suspension of Dr Ahmed’s registration for a period of two months. In reaching its decision on sanction, the MPT took into account, among other things, that Dr Ahmed had been subject to an interim order of suspension for four months. It did not direct a review in Dr Ahmed’s case as it considered that a review would serve no useful purpose. Finally, the MPT determined that it was not necessary to impose an immediate order of suspension.
3. The GMC is represented at this appeal by leading counsel, Mr Ivan Hare QC. Dr Ahmed is represented by Mr Andrew Hockton, counsel who represented him before the MPT.
4. Dr Ahmed qualified as a medical practitioner in 2003 in Libya, having studied at the University of Tripoli (then known as Al-Fateh University). He came to the United Kingdom in 2005, where he completed a post-graduate degree in 2007. He commenced working for the National Health Service (NHS) in 2008 and undertook various locum posts, including at Salford NHS Trust. From December 2014, Dr Ahmed was registered for locum work with RIG Locums and through them worked at Doncaster and Bassetlaw District General Hospital on eight occasions from January 2015.

*The MPT Hearing*

5. The MPT Hearing commenced on 24 October 2019, with further hearing dates on 25 October, 28 October–1 November, 4–7 November 2019 and 11–13 March, 28–30 April, 15 June, and 21–22 October 2020.
6. On 7 November 2019, the MPT made its determination on the facts. On 15 June 2020, having found that there was misconduct by Dr Ahmed in relation to each of Patient A and Patient B, it determined that Dr Ahmed’s fitness to practise was impaired. On 22 October 2020, the MPT made its determination on sanction, which was to impose a suspension of Dr Ahmed’s registration to practise for a period of two months.
7. Dr Ahmed attended the MPT Hearing throughout, apart from 15 June 2020 when the Determination on Impairment was handed down. The MPT was not assisted by oral evidence from Dr Ahmed in relation to impairment.

8. The MPT was comprised of a panel of two lay members and one medical practitioner member and was chaired by one of the lay members. It was advised by a legal assessor on each hearing date.
9. Before the MPT, the GMC was represented by Ms Louise Kitchin and Dr Ahmed, as already noted, was represented by Mr Hockton.

*The Record of Determinations*

10. The MPT's determinations on the facts, on impairment and on sanction are set out in its Record of Determinations ("the Record"). The Record is divided into the following sections:
  - i) the Determination on Facts dated 7 November 2019 ("the Factual Determination"), which is set out in paragraphs 1–67 of the Record;
  - ii) the Determination on Impairment dated 15 June 2020 ("the Impairment Determination"), which is set out in paragraphs 68–138 of the Record; and
  - iii) the Determination on Sanction dated 22 October 2020 ("the Sanction Determination"), which is set out in paragraphs 139–184 of the Record.
11. The Record includes four Annexes, each dealing with an application made by the GMC or Dr Ahmed during the course of proceedings, setting out submissions, relevant law and the MPT's decision on the relevant application. I refer to two of these Annexes below. No question arises on this appeal in relation to the other two Annexes, about which no more is said.
12. The allegations against Dr Ahmed are collectively referred to in the Record as "the Allegation". The MPT summarised the Allegation against Dr Ahmed in paragraphs 2–3 of the Factual Determination, as follows:

"2. ... following a consultation with Patient A on 8 February 2015, it is alleged that Dr Ahmed located her account on Facebook and sent a friend request to her, and that this was sexually motivated and in pursuit of a sexual relationship. It is also alleged that during a consultation with Patient A on 25 April 2015, Dr Ahmed failed to carry out an adequate assessment of Patient A, including failing to arrange for an x-ray of Patient A's hip, administering medication that was neither adequate nor sufficient and failing to keep an adequate record. It is also alleged that Dr Ahmed failed to ensure that Patient A's father, as her chaperone, had a full view of the consultation.

3. It is further alleged that, following a consultation with Patient B in November 2014 at Salford NHS Trust, Dr Ahmed used Patient B's medical records to obtain her personal details to send her a friend request on Facebook and WhatsApp messages to her mobile telephone. It is alleged that Dr Ahmed's messages to Patient B were of a sexual nature,

encouraging Patient B to meet with him, and that Dr Ahmed sought to engage in a sexual relationship with Patient B.”

13. Other relevant facts were that Patient A was a 14-year-old girl and that Patient B was an adult student nurse, albeit one who had never worked with Dr Ahmed.
  14. As is apparent from the summary above, the allegations involved (i) alleged clinical failings and (ii) alleged professional misconduct that was said to be sexually motivated.
  15. Dr Ahmed did not make any admissions prior to the MPT Hearing.
  16. At the outset of the MPT Hearing, the detailed allegations against Dr Ahmed were divided into five numbered paragraphs (which I will refer to in this judgment as “Paragraph 1”, “Paragraph 2” etc.), then further divided into various sub-paragraphs and sub-clauses, to reflect the different allegations made. Paragraphs 1, 2 and 3 of the original allegations related to Patient A. Paragraph 4 related to Patient B. Paragraph 5 was a joint allegation relating to both Patient A and Patient B.
  17. Following conclusion of the GMC’s case against Dr Ahmed, on 30 October 2019, Dr Ahmed made an application under Rule 17(2)(g) of the General Medical Council (Fitness to Practise) Rules 2004 (“the 2004 Rules”) that he had no case to answer in relation to some of the allegations. His application was successful in relation to two of the allegations, namely:
    - i) Paragraph 2(d): the allegation that he had administered medication to Patient A that was neither adequate nor sufficient; and
    - ii) Paragraph 3: the allegation that he had failed to ensure that Patient A’s father, as her chaperone, had a full view of the consultation (Paragraph 3).
- Dr Ahmed’s application, the submissions of the parties, the views of the legal assessor, and the MPT’s ruling on the application are set out in Annex B to the Record.
18. On 5 November 2019, the GMC made a successful application under Rule 17(6) of the 2004 Rules to amend Paragraph 5 of the Allegation, which had originally been a single allegation of sexually motivated professional misconduct against Patient A and Patient B, into two sub-paragraphs, one concerning Patient A and the other concerning Patient B. The GMC’s application, the submissions of the parties, the views of the legal assessor, and the MPT’s ruling on the application are set out in Annex C to the Record.
  19. In relation to the MPT’s determination of the factual circumstances said to give rise to the allegations, the MPT had witness statements from each of Patient A, Patient A’s father, Patient A’s mother, and a police officer, DC Stacey Lamb. The MPT heard oral evidence from each of these witnesses. Dr Ahmed provided a witness statement and gave oral evidence on day seven of the hearing.
  20. The MPT also received reports and heard oral evidence from two expert witnesses, namely, Dr Stephen Hearn, Consultant in Emergency Medicine, whose evidence was

presented as part of the GMC's case, and from Professor Patrick Nee, Consultant in Emergency Medicine and Critical Care Medicine, whose evidence was presented as part of Dr Ahmed's case. The experts also provided a joint report.

21. Finally, the MPT considered a variety of documentary evidence, including character references in relation to Dr Ahmed.
22. Patient B did not provide a witness statement to the MPT and did not attend to give oral evidence. The documentary evidence included a statement that Patient B gave to the police dated 11 November 2016 and a log of WhatsApp messages that had passed between Dr Ahmed and Patient B on various dates.
23. At paragraph 14 of the Factual Determination, the MPT reminded itself that the burden of proof in relation to the determination of the factual allegations rested entirely on the GMC and that the standard of proof was that applicable to civil proceedings, namely, the balance of probabilities.
24. Following Dr Ahmed's partially successful application of no case to answer and the GMC's successful application to amend Paragraph 5 of the Allegation, the MPT had 27 separate allegations to determine, 16 of which were allegations of clinical failings and 11 of which were allegations of sexually motivated professional misconduct. The Allegation at this point was divided as follows:
  - i) Paragraphs 1, 2 and 5(a) related to Patient A; and
  - ii) Paragraphs 4 and 5(b) related to Patient B.

#### *The Factual Determination*

25. The MPT's conclusions on the facts, set out in the Factual Determination, may be summarised as follows:
  - i) Paragraph 1: The MPT found proved that, following a consultation by Patient A with Dr Ahmed on 8 February 2015, Dr Ahmed had:
    - a) located Patient A's account on Facebook; and
    - b) sent Patient A a friend request on Facebook.
  - ii) Paragraph 2: The MPT found proved that, at a consultation by Patient A with Dr Ahmed on 25 April 2015, Dr Ahmed had:
    - a) failed to carry out an adequate assessment of Patient A in that he did not assess any areas of localised tenderness; and
    - b) failed to keep an adequate record of: (1) the appearance of Patient A's hip; (2) any areas of localised tenderness; (3) the range of movement possible in Patient A's hip; (4) whether Patient A's hip was rotated or adducted; (5) the degree of discomfort Patient A was in; (6) Patient A's ability move herself from a chair to the examination couch; and (7) what techniques were attempted to reduce the dislocation.

The MPT found that eight other allegations under Paragraph 2 of clinical failings during that consultation were not proved.

- iii) Paragraph 4: The MPT found proved that, following a consultation by Patient B with Dr Ahmed on or around 16 November 2014, Dr Ahmed had:
- a) used Patient B's medical records to obtain her full name;
  - b) sent Patient B a friend request on Facebook;
  - c) contacted Patient B on her mobile telephone using WhatsApp;
  - d) on one or more occasions between 17 November 2014 and 13 February 2015 sent messages to Patient B on WhatsApp which: (1) were sexual in nature; (2) encouraged Patient B to meet up with him; and (3) sought to engage in a personal relationship with Patient B; and
  - e) continued to send messages to Patient B on WhatsApp despite her no longer responding to his messages.
- iv) Paragraph 5(a): The MPT found it not proved that the actions of Dr Ahmed described in Paragraph 1 in relation to Patient A were sexually motivated, in the sense that they were actions in pursuit of a sexual relationship with Patient A.
- v) Paragraph 5(b). The MPT found it proved that the actions of Dr Ahmed described in Paragraph 4 in relation to Patient B were sexually motivated, in the sense just described.

### *The Impairment Determination*

26. Having made its determination of the factual circumstances, the MPT turned to the stage of proceedings during which it was required to determine whether Dr Ahmed's fitness to practise was impaired in relation to any of the factual allegations that it had found proved. The MPT was reminded by the legal assessor that there is no burden or standard of proof at this stage, the decision on impairment being a matter for the MPT's judgment. The assessment of impairment involved two stages in relation to each allegation found proved, namely:
- i) whether the facts of the allegation amounted to misconduct by Dr Ahmed; and
  - ii) if so, whether that finding of misconduct meant that Dr Ahmed's fitness to practise was impaired.
27. The MPT bore in mind, in making the Impairment Determination, that there had been no previous fitness to practise concerns or GMC investigations regarding Dr Ahmed, who was deemed to be a man of good character and a competent practitioner on the whole.
28. The MPT noted that it did not have the benefit of evidence from Dr Ahmed at the impairment stage of the proceedings. It was therefore not able to question him regarding remedial action he was said to have taken since the incidents giving rise to

the allegations, including, for example, a course on maintaining professional boundaries.

29. In making the Impairment Determination, the MPT had regard to relevant guidance issued by the GMC, including the following:

- i) *Good medical practice* (2013);
- ii) *Doctor's use of social media* (2013); and
- iii) *Maintaining a professional boundary between you and your patient* (2013).

30. In relation to Patient A and the allegations under Paragraphs 1 and 2 of the Allegation that were found proved against Dr Ahmed, the MPT considered whether they amounted to misconduct, concluding as follows:

- i) Paragraph 1: The MPT accepted the opinion of both expert witnesses that there were no circumstances under which it was appropriate for Dr Ahmed to have located Patient A's Facebook account or to have sent her a friend request. Doing so was an invasion of privacy and a breach of confidentiality and trust. The relevant guidance made clear that social media communication should be treated in the same way as traditional media communication. The MPT acknowledged Dr Ahmed's admission during his evidence at the MPT Hearing that his actions in doing so were inappropriate. The MPT found that Dr Ahmed's accessing Patient A's Facebook profile fell seriously below the standards expected of a doctor and amounted to misconduct. The MPT found that this misconduct was compounded by his having sent a friend request to Patient A, however it accepted as possible that he had sent the friend request inadvertently, as Dr Ahmed had submitted.
- ii) Paragraph 2: Only some of the clinical failings alleged against Dr Ahmed under Paragraph 2 had been found proved by the MPT. In relation to these, the MPT concluded that they were part of a single, isolated incident, involving a particularly challenging patient to assess, with difficult symptoms to address, and where Dr Ahmed's overall care of the patient was good. Dr Ahmed was otherwise a competent practitioner. The failures on this occasion fell below, but not seriously below, the standards expected of a doctor. They did not amount to misconduct.

31. Having found misconduct in relation to Patient A under Paragraph 1 of the Allegation, the MPT concluded that this misconduct meant that Dr Ahmed's fitness to practise was at that time impaired. In reaching this conclusion, the MPT made the following observations:

- i) Dr Ahmed's behaviour constituting the misconduct was remediable, but the MPT had concerns regarding his continuing lack of insight, despite having completed a course on maintaining professional boundaries.
- ii) Despite his admission that accessing Patient A's Facebook profile had been inappropriate, Dr Ahmed had continued to try to justify doing so on legitimate grounds.

- iii) It was of particular concern that Patient A was a minor, whose privacy Dr Ahmed had invaded by, in effect, secretly investigating her personal life by accessing her Facebook profile.
  - iv) As set out at paragraph 65 of *Good medical practice*, trust is a fundamental tenet of the medical profession. By accessing Patient A's Facebook profile, Dr Ahmed had abused his patient's trust and the public's trust in the profession.
  - v) Dr Ahmed appeared not to take sufficient responsibility for any of his personal actions on the day that he saw Patient A and appeared to lack personal accountability. He clearly needed to undertake further meaningful reflection and analysis of his own role on that occasion.
  - vi) Public confidence in the medical profession would be undermined if the MPT did not making a finding of impairment of fitness to practice in relation to Dr Ahmed's conduct as proved in relation to Paragraph 1 of the Allegation.
32. In considering whether the allegations under Paragraphs 4 and 5(b) of the Allegation relating to Patient B that were found proved against Dr Ahmed amounted to misconduct, the MPT concluded as follows:
- i) Patient B was a patient of Dr Ahmed's when he began the conduct found proved against him under Paragraph 4 of the Allegation.
  - ii) The MPT was cautious in attributing weight to Patient B's statement of provided to the police, given that she had not attended the MPT Hearing to give evidence or have her statement tested and given proven inconsistencies in that statement.
  - iii) Nonetheless, even if Dr Ahmed was truthful in his assertion that he contacted Patient B to assist in continuity of care as he was a locum and that it was Patient B who instigated an improper emotional or sexual relationship between them, it was clear under the relevant guidance that it was Dr Ahmed's responsibility as a doctor to maintain the professional boundaries of their relationship. Instead, he immediately seized the opportunity to instigate a personal relationship and was sexually motivated in doing so.
  - iv) It made no difference that Patient B was a staff nurse. Dr Ahmed had never known her professionally and, even if he had, she became his patient when she sought medical treatment from him.
  - v) It was entirely unacceptable that he exploited his position of power as a doctor to use information obtained in the consultation in order to contact Patient B on the very day of the consultation in pursuit of a sexual relationship.
  - vi) Accordingly, Dr Ahmed's conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct.
33. Having found misconduct in relation to Patient B under Paragraphs 4 and 5(b) of the Allegation, the MPT concluded that this misconduct meant that Dr Ahmed's fitness to



practise was at that time impaired. In reaching this conclusion, the MPT made the following observations:

- i) The MPT was concerned by Dr Ahmed's apparent attitude towards women, both colleagues and patients. He admitted often sending messages to female colleagues, including nurse colleagues in Derby, seeking a "personal relationship".
- ii) The MPT noted that it was a fundamental tenet of the medical profession that patients should be treated with dignity and respect. A patient was entitled to expect that she would not be sexualised by her treating doctor.
- iii) While the MPT accepted that the messages from Dr Ahmed to Patient B prior to 31 December 2014 were not unsolicited, it was his responsibility to ensure appropriate boundaries were maintained. He entered into an improper personal relationship with her and was sexually motivated in doing so.
- iv) The MPT considered that Dr Ahmed's attitude towards female patients as prospective sexual partners was potentially remediable, but the MPT was also concerned that this was a deep-seated problem. Dr Ahmed showed little evidence of developing insight, despite having attended courses on professional boundaries.
- v) The MPT had identified no patient harm or immediate risk to patient safety in Dr Ahmed's actions in relation to Patient B, but he had breached trust and confidentiality in relation to her, potentially undermining her trust in him and in the medical profession. That loss of trust could lead her not to seek necessary medical treatment in the future and therefore his conduct had potentially put her at risk of future harm.
- vi) Dr Ahmed's actions in relation to Patient B, seeking to engage in an improper emotional relationship with a patient with a sexual motive, breached multiple guidelines and fundamental tenets of the medical profession. Public confidence in the profession would be undermined if a finding of impairment were not made in these circumstances.
- vii) Accordingly, the MPT concluded that Dr Ahmed's fitness to practise was impaired by reason of his misconduct in relation to Patient B.

### *The Sanction Determination*

34. The MPT then turned to the final stage of its proceedings, the determination of the appropriate sanction to impose having concluded that Dr Ahmed's fitness to practise was impaired by reason of his misconduct in relation to Patient A and Patient B. For this stage, the MPT did receive evidence from Dr Ahmed in the form of a reflective statement dated 20 October 2020.
35. The MPT noted that the decision on the appropriate sanction to impose on Dr Ahmed was a matter for its own independent judgment. In reaching its decision, it had taken account of the *Sanctions Guidance* (2013) published by the GMC. It bore in mind that the purpose of the imposition of a sanction on a doctor by the MPT, following a

finding of impairment of fitness to practise, was not to punish the doctor but to protect patients and the wider public interest. It acknowledged, however, that the sanction could nonetheless have a punitive effect.

36. The legal assessor advised the MPT that it should consider the relevant mitigating and aggravating features of Dr Ahmed's relevant misconduct before considering the *Sanctions Guidance*.
37. The MPT's summary of the mitigating and aggravating factors is set out at paragraphs 154–155 of the Record:

“154. The Tribunal considered the following to be mitigating factors:

- Dr Ahmed's practice history, previous good character and the fact that there have been no previous complaints made against him, according to the evidence available;
- Dr Ahmed's conduct does not demonstrate a pattern of behaviour;
- Dr Ahmed has undertaken various courses in an attempt to remediate;
- Reflective statements provided by Dr Ahmed and testimonials from his colleagues supported by 360 degree surveys by colleagues and patients;
- The length of time since the incidents occurred is almost 6 years, without any further repetition of the misconduct.

#### Patient A

- There was no inappropriate relationship with Patient A;
- It was an isolated incident with Patient A;
- Dr Ahmed recognised his serious misconduct at an early stage.

#### Patient B

- There was no inappropriate physical relationship with Patient B and the only interaction was WhatsApp messages;
- Dr Ahmed now recognises the seriousness of his misconduct with Patient B and the underlying attitudinal problems that led to it.

155. The Tribunal considered the following to be aggravating factors:

- Dr Ahmed's behaviour represents a serious departure from [*Good medical practice*] and abuse of his professional position.

Patient A

- Patient A was a child and a vulnerable patient.

Patient B

- Dr Ahmed did not, at an early stage, accept responsibility for his personal actions, lacked personal accountability, and had not developed meaningful insight. This meant that there was a disparity in his oral evidence concerning his attitude to female members of staff compared to the 360-degree patient and colleague surveys cited in Dr Clancy's testimonial.
- The Tribunal has found that Dr Ahmed has not fully integrated his learning from the courses undertaken and insight is still ongoing."

38. The MPT noted in the Record that it was careful, in determining the appropriate sanction, to consider Dr Ahmed's conduct in relation to each of Patient A and Patient B separately. The MPT considered the available sanctions in ascending order of gravity, as provided in the *Sanctions Guidance*. The available sanctions in ascending order were: (i) taking no action; (ii) imposing conditions on Dr Ahmed's registration; (3) suspension; and (iv) erasure from the register.
39. The MPT determined that, in all the circumstances, the appropriate sanction to impose on Dr Ahmed was to suspend his registration for a period of 2 months. In reaching this determination, the MPT made the following observations:
- i) The MPT considered that Dr Ahmed had shown evidence of developing insight. In his initial statement of 2 September 2019 he had apologised to Patient A and her family, admitted that what he had done was wrong, and acknowledged that he had put his reputation and that of the medical profession at risk. He outlined courses he had undertaken to help him understand the issues involved.
  - ii) In his statement of 20 October 2020, Dr Ahmed recognised an issue that had caused great concern to the MPT during earlier stages of the MPT Hearing, namely, his attitude towards women who happened to be members of staff, one of whom had become Patient B. He acknowledged that his thinking had been muddled, that a patient's job as a nurse made no difference to the importance of maintaining professional boundaries even after the end of the consultation, and that the power differential due to his role as a doctor created the potential for abuse.

- iii) This more positive approach by Dr Ahmed was supported by a testimonial from Dr Joan Clancy dated 2 August 2019, who was aware of the allegations against Dr Ahmed and who stated that she had never witnessed any lack of professionalism by Dr Ahmed or had any concerns regarding in appropriate behaviour. She also stated that she had ample objective evidence in colleague and patient reports that were referred to in her statement, which she had reviewed, and which supported her statements about Dr Ahmed.
- iv) The MPT considered and rejected the option of concluding the case by taking no action. There were no exceptional circumstances that could justify such a course, given the serious nature of the MPT's findings on impairment. It would not be sufficient, proportionate, or in the public interest to take no action.
- v) The MPT considered and rejected the option of concluding the case by imposing conditions on Dr Ahmed's registration. A period of conditional registration would not adequately reflect the serious nature of Dr Ahmed's misconduct. The MPT, in particular, considered that in a case involving sexual misconduct (towards Patient B) conditions could not be devised that would protect the public interest and maintain public confidence in the medical profession.
- vi) The MPT then considered whether suspending Dr Ahmed's registration would be appropriate and proportionate, reminding itself that it should impose the least restrictive and proportionate sanction possible to protect the public. It also properly reminded itself that in cases involving elements of sexual misconduct, considerable weight should be placed on the need to maintain public confidence in the profession and to uphold proper professional standards.
- vii) The MPT had regard to the whole of the *Sanctions Guidance* but found paragraphs 91–93 and 97 most pertinent to the question of whether the appropriate sanction in this case was suspension.
- viii) The MPT bore in mind that there was no serious harm to Patient A or Patient B. Patient A and her parents had indicated this in their oral evidence, and there had been no complaint from Patient B (or engagement by her with the proceedings before the MPT).
- ix) The MPT acknowledged the seriousness of the aggravating factors but concluded that the mitigating factors in Dr Ahmed's case were also of considerable weight and justified a finding that erasure was not the only means of protecting the public.
- x) The MPT considered that erasure would be disproportionate when balancing the doctor's interests with the public interest. The MPT took account of *Arunachalam v General Medical Council* [2018] EWHC 758 (Admin) and, in particular, the comments of Kerr J at [79], to which the legal assessor had drawn its attention. That case was factually distinct, as it involved workplace sexual misconduct, but the case underlined the principle that even in a case involving sexual misconduct it was important to consider the scale of the

offending behaviour, including aggravating and mitigating factors, and to calibrate the appropriate sanction accordingly. Erasure was not an automatic consequence in a case involving sexual misconduct.

- xi) The MPT considered that it had evidence, including from Dr Ahmed's reflective statement, that he had taken steps to remediate his misconduct. He had apologised, shown insight, and taken steps to mitigate his actions, in particular in relation to Patient A. Dr Ahmed had engaged throughout the MPT Hearing and had shown progress since the last occasion on which the MPT sat on this case in April 2020. The MPT was satisfied that Dr Ahmed's behaviour was unlikely to be repeated and did not consider that he posed a significant risk of reoffending. There had been no similar behaviour since the incidents six years previously. The MPT weighed in the balance testimonials from colleagues in support of Dr Ahmed, which demonstrated that he was a highly valued and skilled doctor who was well-liked by colleagues and patients.
  - xii) The MPT concluded that although Dr Ahmed's behaviour was very serious and wholly unacceptable, it was not fundamentally incompatible with continued registration. It considered that an order of suspension would make it clear how far short Dr Ahmed's conduct fell from the expected standard and would have a deterrent effect, which would help to uphold proper professional standards. Given Dr Ahmed's remediation and his progress in developing insight, the MPT was satisfied that an order of suspension would be sufficient for the protection of the public in the sense that it would be sufficient (a) to protect the health, safety, and well-being of the public, (b) to maintain public confidence in the medical profession, and (c) to maintain proper professional standards and conduct for members of that profession.
  - xiii) The MPT considered that while members of the public would find the historic actions of Dr Ahmed worthy of censure, there was also a strong public interest in returning competent doctors to the workplace.
  - xiv) In determining that a suspension of two months was the appropriate sanction, it bore in mind that Dr Ahmed had already been suspended for four months under an interim order.
40. Having reached its determination on the appropriate sanction to impose, the MPT had two further matters to decide, namely, (i) whether to direct a review in Dr Ahmed's case and (ii) whether to impose an immediate order to suspend his registration in accordance with section 38 of the Medical Act 1983.
41. The MPT determined not to direct a review in Dr Ahmed's case as it would serve no useful purpose.
42. The test of whether to impose an immediate order was whether it was necessary to do so to protect members of the public or is otherwise in the public interest or is in the best interests of the doctor. Having heard submissions on this issue from counsel for the GMC and for Dr Ahmed and having regard to paragraphs 172 and 173 of the *Sanctions Guidance*, the MPT determined that, for the reasons made clear in its determination of the appropriate sanction, it was not necessary to impose an immediate suspension in order to (i) protect members of the public, (ii) uphold and

maintain professional standards, or (iii) serve the public interest. There was no suggestion that it was in Dr Ahmed's best interests to serve an immediate suspension. This meant that Dr Ahmed's suspension would take effect 28 days after notice of the MPT's decision on sanction.

*Legal principles*

43. The law in this case is not in dispute. The Medical Act 1983 is the principal statute relevant to the issues in this case. Section 40A of the Medical Act 1983 provides in relevant part as follows:

“(1) This section applies to any of the following decisions by a Medical Practitioners Tribunal—

(a) a decision under section 35D giving—

(i) a direction for suspension, including a direction extending a period of suspension;

...

(2) A decision to which this section applies is referred to below as a ‘relevant decision’.

(3) The General Council may appeal against a relevant decision to the relevant court if they consider that the decision is not sufficient (whether as to a finding or a penalty or both) for the protection of the public.

(4) Consideration of whether a decision is sufficient for the protection of the public involves consideration of whether it is sufficient—

(a) to protect the health, safety and well-being of the public;

(b) to maintain public confidence in the medical profession; and

(c) to maintain proper professional standards and conduct for members of that profession.

...

(6) On an appeal under this section, the court may—

(a) dismiss the appeal;

(b) allow the appeal and quash the relevant decision;

(c) substitute for the relevant decision any other decision which could have been made by the Tribunal;  
or

(d) remit the case to the MPTS for them to arrange for a Medical Practitioners Tribunal to dispose of the case in accordance with the directions of the court,

and may make such order as to costs . . . as it thinks fit.

... .”

44. Although the wording is not identical, sections 40A(3)–(4) of the Medical Act 1983 reflect the over-arching objective of the GMC itself as articulated in sections 1(1A)–(1B). Under section 1(3) of the Act, the MPT is a committee of the GMC constituted in accordance with Part III of Schedule 1 to the Act.
45. In *General Medical Council v Jagjivan* [2017] EWHC 1247 (Admin), [2017] 1 WLR 4438 at [39]–[40], the Divisional Court gave authoritative guidance on the correct approach to be taken by a court hearing an appeal under section 40A of the Medical Act 1983:

“39 As a preliminary matter, the GMC invites us to adopt the approach adopted to appeals under section 40 of the 1983 Act, to appeals under section 40A of the 1983 Act, and we consider it is right to do so. It follows that the well-settled principles developed in relation to section 40 appeals (in cases including: *Meadow v General Medical Council* [2007] QB 462; *Raschid v General Medical Council* [2007] 1 WLR 1460; and *Southall v General Medical Council* [2010] 2 FLR 1550) as appropriately modified, can be applied to section 40A appeals.

40 In summary:

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

ii) It is not appropriate to add any qualification to the test in CPR Pt 52 that decisions are ‘clearly wrong’: see *Raschid’s* case at para 21 and *Meadow’s* case at paras 125–128.

iii) The court will correct material errors of fact and of law: see *Raschid’s* case at para 20. Any appeal court must however be extremely cautious about upsetting a

conclusion of primary fact, particularly where the findings depend upon the assessment of the credibility of the witnesses, who the Tribunal, unlike the appellate court, has had the advantage of seeing and hearing (see *Assicurazioni Generali SpA v Arab Insurance Group (Practice Note)* [2003] 1 WLR 577, paras 15–17, cited with approval in *Datec Electronics Holdings Ltd v United Parcels Service Ltd* [2007] 1 WLR 1325, para 46, and *Southall's* case at para 47).

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

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

vi) However there may be matters, such as dishonesty or sexual misconduct, where the court 'is likely to feel that it can assess what is needed to protect the public or maintain the reputation of the profession more easily for itself and thus attach less weight to the expertise of the Tribunal ...': see *Council for the Regulation of Healthcare Professionals v GMC and Southall* [2005] EWHC 579 (Admin) at [11], and *Khan's* case at para 36. As Lord Millett observed in *Ghosh v General Medical Council* [2001] 1 WLR 1915, para 34, the appellate court 'will afford an appropriate measure of respect to the judgment of the committee ... but the [appellate court] will not defer to the committee's judgment more than is warranted by the circumstances'.

vii) Matters of mitigation are likely to be of considerably less significance in regulatory proceedings than to a court imposing retributive justice, because the overarching concern of the professional regulator is the protection of the public.

viii) A failure to provide adequate reasons may constitute a serious procedural irregularity which



renders the Tribunal's decision unjust (see *Southall's* case at paras 55–56).”

46. The summary in *Jagjivan* should now be read in light of the decision in *Bawa-Garba v General Medical Council* [2018] EWCA Civ 1879, [2019] 1 WLR 1929:

“61 The decision of the Tribunal that suspension rather than erasure was an appropriate sanction for the failings of Dr Bawa-Garba, which led to her conviction for gross negligence manslaughter, was an evaluative decision based on many factors, a type of decision sometimes referred to as ‘a multi-factorial decision’. This type of decision, a mixture of fact and law, has been described as ‘a kind of jury question’ about which reasonable people may reasonably disagree ... . It has been repeatedly stated in cases at the highest level that there is limited scope for an appellate court to overturn such a decision.

...

63 ... In the recent case of *R (Bowen and Stanton) v Secretary of State for Justice* [2018] 1 WLR 2170, para 65 McCombe LJ explained that, when the appeal is from a trial judge's multi-factorial decision:

‘the appeal court's approach will be conditioned by the extent to which the first instance judge had an advantage over the appeal court in reaching his/her decision. If such an advantage exists, then the appeal court will be more reticent in differing from the trial judge's evaluations and conclusions’.

64 In the *Bowen* case McCombe LJ went on (at para 67) to quote from Lord Clarke of Stone-cum-Ebony JSC's judgment in *In re B (A Child) (Care Proceedings: Threshold Criteria)* [2013] 1WLR 1911, para 137:

‘In England and Wales the jurisdiction of the Court of Appeal is set out in CPR r 52.11(3), which provides that “the appeal court will allow an appeal where the decision of the lower court was (a) wrong; or (b) unjust because of a serious procedural or other irregularity in the proceedings in the lower court”. The rule does not require that the decision be “plainly wrong”. However, the courts have traditionally required that the appeal court must hold that the judge was plainly wrong before it can interfere with his or her decision in a number of different classes of case. I referred to some of them in *Assicurazioni Generali SpA v Arab Insurance*

*Group* [2003] 1 WLR 577 ... at my paras 9—23. It seemed to me then and it seems to me now that the correct approach of an appellate court in a particular case may depend upon all the circumstances of that case. So, for example, it has traditionally been held that, absent an error of principle, the Court of Appeal will not interfere with the exercise of a discretion unless the judge was plainly wrong. On the other hand, where the process involves a consideration of a number of different factors, all will depend on the circumstances. As Hoffmann LJ put it in *In re Grayan Building Services Ltd (In Liquidation)* [1995] Ch 241, 254, “generally speaking, the vaguer the standard and the greater the number of factors which the court has to weigh up in deciding whether or not the standards have been met, the more reluctant an appellate court will be to interfere with the trial judge’s decision”.’

65 McCombe LJ also quoted (at para 71) the case of *R (Smech Properties Ltd) v Runnymede Borough Council* [2016] JPL 677, para 29, in which Sales LJ said:

‘Where an appeal is to proceed, like this one, by way of a review of the judgment below rather than a re-hearing, it will often be appropriate for this court to give weight to the assessment of the facts made by the judge below, even where that assessment has been made on the basis of written evidence which is also available to this court. The weight to be given to the judge’s own assessment will vary depending on the circumstances of each particular case, the nature of the finding or factual assessment which has been made and the nature and range of evidential materials bearing upon it. Often a judge will make a factual assessment by taking into account expressly or implicitly a range of written evidence and making an overall evaluation of what it shows. Even if this court might disagree if it approached the matter afresh for itself on a re-hearing, it does not follow that the judge lacked legitimate and proper grounds for making her own assessment and hence it does not follow that it can be said that her decision was “wrong”.’

66 McCombe LJ commented on that passage (at para 72):

‘It seems to me that Sales LJ was addressing the exigencies of reviewing a first instance judge’s

assessment of primary facts, even where (as in our case) the evidence before the court below was entirely in writing. All will depend on the circumstances of the case and what opportunity the court has, in reality, to improve and correct the overall assessment of the evidence before the first instance judge as a whole.’

67 That general caution applies with particular force in the case of a specialist adjudicative body, such as the Tribunal in the present case, which (depending on the matter in issue) usually has greater experience in the field in which it operates than the courts: see the *Smech* case [2016] JPL 677, para 30; *Khan v General Pharmaceutical Council* [2017] 1 WLR 169, para 36; *Meadow’s* case [2007] QB 462, para 197; and *Raschid v General Medical Council* [2007] 1 WLR 1460, paras 18–20. An appeal court should only interfere with such an evaluative decision if (1) there was an error of principle in carrying out the evaluation, or (2) for any other reason, the evaluation was wrong, that is to say it was an evaluative decision which fell outside the bounds of what the adjudicative body could properly and reasonably decide ... As the authorities show, the addition of ‘plainly’ or ‘clearly’ to the word ‘wrong’ adds nothing in this context.

...

94 As we said earlier in this judgment, the Tribunal was, in relation to all those matters and the carrying out of an evaluative judgement as to the appropriate sanction for maintaining public confidence in the profession, an expert panel, familiar with this type of adjudication and comprising a medical practitioner and two lay members, one of whom was legally qualified, all of whom were assisted by a legal assessor. ...”

47. In *Haris v General Medical Council* [2021] EWCA Civ 763 [10]–[13], the Court of Appeal recently confirmed that *Jagjivan* and *Bawa-Garba* continue to reflect the correct approach to an appeal under section 40A of the Medical Act 1983.

#### *Grounds of appeal*

48. The GMC appeals under section 40A(1)(a) of the Medical Act 1983 on the ground that the MPT’s determination of a sanction of two months’ suspension is insufficient to protect the public since it: (i) failed to address adequately the *Sanctions Guidance* on erasure; and (ii) imposed a sanction that was simply insufficient to reflect the seriousness of Dr Ahmed’s misconduct.

*Submissions*

49. On behalf of the GMC, Mr Hare submitted that this was not a case where the MPT enjoyed a significant advantage over this Court in reaching its determination as this appeal does not relate to any clinical matters alleged against Dr Ahmed. It concerns sexual misconduct, which is a matter where the Court will attach less weight to the expertise of the MPT: *Jagjivan* at [40(vi)]. Also, although Dr Ahmed submitted a Reflective Statement before the sanctions stage, he did not attend the MPT Hearing at that stage to be cross-examined on it. Therefore, the MPT enjoyed no benefit over this Court in assessing Dr Ahmed's insight at that stage.
50. Mr Hare noted that although the MPT set out parts of the *Sanctions Guidance* in the Sanction Determination, it did not set out paragraph 109, which sets out a non-exhaustive list of factors that, if present, may indicate that erasure is appropriate. Mr Hare submitted that the following factors set out in paragraph 109 are of particular relevance in this case:
- “a A particularly serious departure from the principles set out in *Good medical practice* where the behaviour is fundamentally incompatible with being a doctor.
  - b A deliberate or reckless disregard for the principles set out in *Good medical practice* and/or patient safety.
  - ...
  - d Abuse of position/trust (see *Good medical practice*, paragraph 65: ‘*You must make sure that your conduct justifies your patients’ trust in you and the public’s trust in the profession*’).
  - e Violation of a patient’s rights/exploiting vulnerable people (see *Good medical practice*, paragraph 27 on children and young people, paragraph 54 regarding expressing personal beliefs and paragraph 70 regarding information about services).
  - ...
  - i Putting their own interests before those of their patients (see *Good medical practice* paragraph 1: - ‘*Make the care of [your] patients [your] first concern*’ and paragraphs 77-80 regarding conflicts of interest).
  - ... .”

51. Mr Hare submitted that the MPT failed to explain its conclusion that erasure would be disproportionate by reference to relevant parts of the *Sanctions Guidance*. For example, although the MPT address factor (a) of paragraph 109 at paragraph 172 of the Sanction Determination, factors (b), (d), (e), and (i) are not addressed. For example, in relation to factor (e), Patient A was a vulnerable 14-year-old girl, and the rights of both patients were violated by Dr Ahmed’s actions.
52. Mr Hare submitted that other relevant provisions of the *Sanctions Guidance* emphasise the seriousness of Dr Ahmed’s conduct, including paragraph 143 (in the section headed “Abuse of professional position”):
- “143 Doctors must not use their professional position to pursue a sexual or improper emotional relationship with a patient ... .”
53. Mr Hare submitted that paragraph 147 of the *Sanctions Guidance* (in the section headed “Predatory behaviour”) is also relevant:
- “147 If a doctor has demonstrated predatory behaviour, motivated by a desire to establish a sexual or inappropriate emotional relationship with a patient, there is a significant risk to patient safety, and to public confidence and/or trust in doctors. More serious action is likely to be appropriate where there is evidence of (this list is not exhaustive):
- a inappropriate use of social networking sites to approach a patient outside the doctor-patient relationship
- b use of personal contact details from medical records to approach a patient outside their doctor-patient relationship
- ...”
54. Mr Hare submitted that, given that erasure was sought by the GMC and at least indicated by the *Sanctions Guidance*, the MPT was required to explain by reference to the *Sanctions Guidance* why erasure was not the appropriate sanction. The MPT was required to have proper regard to the *Sanctions Guidance* and to apply it as its own terms suggest or explain clearly its reasons for departing from it: *Professional Standards Authority v Health and Care Professions Council, Doree* [2017] EWCA Civ 319, [2017] Med LR 301 (CA) at [29]. It was not sufficient to rely on a “generalised assertion that erasure would be a disproportionate sanction”: see *General Medical Council v Stone* [2017] EWHC 2534 (Admin) at [53]. Mr Hare submitted that the MPT in this case failed to state clearly its reasons for departing from the *Sanctions Guidance*, and that is sufficient for this appeal to be allowed.
55. Mr Hare submitted that, in any event, the MPT erred in directing suspension without a review. This was a case where evidence of insight emerged very late and was found by the MPT to be “developing” (Sanction Determination at paragraph 157). Mr Hare

submitted that it is relevant that Dr Ahmed's reflective statement was untested by cross-examination. He noted the observation of Yip J in *Yusuff v General Medical Council* [2018] EWHC 13 (Admin) at [30] that "[i]t is difficult to assess things like remorse and insight on paper."

56. Mr Hare noted that the MPT had relied on a testimonial from Dr Clancy dated 9 August 2019, which pre-dated the MPT Hearing. That testimonial was therefore not evidence that Dr Ahmed had put his belated insight into practice, and there was no other such evidence apart from Dr Ahmed's untested reflective statement. Mr Hare also made various criticisms of Dr Ahmed's reflective statement, which he said showed an inappropriate focus on his own interests, a surprising lack of awareness of clear guidance about doctor's use of social media to search for information about patients, and a failure to make a full apology.
57. Mr Hare submitted that the MPT had failed to provide a full explanation for its decision not to order a review, contrary to paragraph 166 of the *Sanctions Guidance*, which provides that they should so. The MPT's assertion that a review "would serve no useful purpose" was not sufficient. Mr Hare submitted that even if the Court is not satisfied that erasure is the only adequate sanction, the absence of a review requires the decision to be quashed.
58. Finally, Mr Hare submitted that the MPT gave undue weight to the fact that Dr Ahmed had been subject to an interim suspension order of four months. It appeared, he submitted, that the MPT regarded a suspension of Dr Ahmed's registration for a period of six months as an appropriate sanction and then made an allowance for Dr Ahmed's interim suspension. Mr Hare noted that, in announcing its sanction, the MPT referred at paragraph 173 of the Sanction Determination to suspending Dr Ahmed's registration "for a *further* period of 2 months" (emphasis added).
59. Mr Hare submitted that although the MPT was permitted to have regard to an interim suspension in deciding its sanction in an appropriate case, it was inappropriate to treat it analogously to a period of imprisonment on remand, which would normally be deducted from a subsequent custodial sentence: *Ujam v General Medical Council* [2012] EWHC 683 (Admin) at [5] (Eady J) and *Abdul-Razzak v General Pharmaceutical Council* [2016] EWHC 1204 (Admin) at [85] (Sir Stephen Silber).
60. Mr Hare submitted that the combination of a sanction of only two months' suspension coupled with the absence of an order for a review means that the sanction imposed on Dr Ahmed was simply insufficient to reflect the seriousness of Dr Ahmed's conduct.
61. On behalf of Dr Ahmed, Mr Hockton submitted that this appeal appeared to be based, at least in part, on a misunderstanding of the evidence and issues in the case and a lack of appreciation as to where, on the spectrum of misconduct, the case properly lies. He submitted that the GMC, in its submissions on this appeal, appeared to conflate the findings in relation to Patient A and Patient B. It was important to bear in mind, however, that the MPT found no sexual motivation in respect of Dr Ahmed's misconduct in relation to Patient A and found no pattern of conduct linking the cases of Patient A and Patient B (paragraphs 64–65 of the Factual Determination).

62. Mr Hockton noted that the MPT found that the only non-clinical interaction between Dr Ahmed and Patient A was his sending of a Facebook friend request, which the MPT accepted may have been inadvertent. He did not send any messages to her, via Facebook, WhatsApp, or otherwise. His explanation for accessing her Facebook profile was that he had doubts about the genuineness of her symptoms. This was not implausible, given that the agreed expert evidence was that she was a difficult and challenging patient who presented herself to the Accident and Emergency Department on some 60 occasions over a period of a few months complaining of dislocations (in her hips, shoulders, or jaw) for which there was no physical explanation. The GMC guidance *Doctor's use of social media* was of limited assistance in this case. It does not proscribe any use of social media. Dr Ahmed accepted, with hindsight, that he should not have accessed Patient A's Facebook profile.
63. Mr Hockton submitted that it was important to bear in mind that, in contrast to Patient A, Patient B was not vulnerable. Patient B was not a complainant to the GMC or the police. The private WhatsApp messages between Dr Ahmed and Patient B were discovered by the police during the investigation into the case of Patient A. Patient B refused to take part in the police or GMC investigations. Patient B had a single consultation with Dr Ahmed. His role as a treating doctor had terminated when social media exchanges began between them. Patient B was at the beginning of these exchanges a willing participant, to the point of sending Dr Ahmed a photograph of herself in her underwear. There was no social contact between Dr Ahmed and Patient B apart from the WhatsApp messages between them, and there was never any physical encounter between Dr Ahmed and Patient B. This case, Mr Hockton submitted, was far removed from the more serious cases involving physical sexual misconduct.
64. Patient B had given a statement to the police in connection with its investigation into Patient A's complaint against Dr Ahmed, which had resulted in no further action by the police and no prosecution. Mr Hockton noted that, notwithstanding Dr Ahmed's objection to its admissibility, the MPT had admitted Patient B's statement to the police but had concluded that the statement was demonstrably false by reference to the WhatsApp messages exchanged between Dr Ahmed and Patient B and that therefore little or no weight could be given to it.
65. Mr Hockton submitted that Dr Ahmed's reflective statement did demonstrate insight and remorse. Dr Ahmed had apologised for his actions in relation to both patients. He had already paid a heavy toll in terms of his career and the impact of this case on his family. Erasure would be a wholly disproportionate sanction in all the circumstances. There was a legitimate public interest in not unnecessarily depriving the public of the services of an otherwise excellent doctor.
66. Finally, Mr Hockton submitted that the MPT was entitled to take into account the interim suspension of four months to which Dr Ahmed's registration had already been subject in considering the proportionality of the sanction it imposed: *Akhtar v General Dental Council* [2017] EWHC 1986 at [18]. The MPT rightly concluded, he submitted, that a review would serve no useful purpose. Several months had elapsed between submissions on impairment on 12 March 2020 and the submissions and decision on sanction on 21–22 October 2020. This was more than enough time to determine whether a further review was needed.

*Analysis*

67. I accept the submissions of Mr Hare on behalf of the GMC that in a case concerning sexual misconduct the Court will attach less weight to the expertise of the MPT, as is made clear in *Jagjivan* at [40(vi)]. I also bear in mind, however, that the decision to suspend a doctor rather than to erase him or her from the register is an evaluative decision based on many factors, about which reasonable people may reasonably disagree. As such, there is limited scope for an appellate court to overturn it: *Bawa-Garba v GMC* at [61].
68. Although, for the reasons given by Mr Hare, it may be appropriate to give less deference to the decision of the MPT given the finding of sexually motivated misconduct by Dr Ahmed in relation to Patient B, nonetheless a significant degree of deference should be shown. The MPT will have had the advantage of all of the evidence considered during the course of the MPT Hearing, including oral evidence during the Factual Determination stage. In this regard, I note the comment of Sales LJ in *R (Smech Properties Ltd) v Runnymede Borough Council* at [29], which was set out in *Bawa-Garba v GMC* at [65] and quoted by me at 46] above. I also bear in mind the observation of Hoffmann LJ in *Re Grayan Building Services Ltd* at 254 that is quoted in *Bawa-Garba v GMC* at [64]. Although the MPT's factual assessment is not, *per se*, disputed by the GMC on this appeal, that factual assessment informed the multi-factorial decision that resulted in a sanction of suspension rather than erasure.
69. I also bear in mind the following observation of Laws LJ in *Raschid v GMC* at [19]:
- “As it seems to me the fact that a principal purpose of the panel’s jurisdiction in relation to sanctions is the preservation and maintenance of public confidence in the profession rather than the administration of retributive justice, particular force is given to the need to accord special respect to the judgment of the professional decision-making body in the shape of the panel.”
70. *Raschid v GMC* concerned two conjoined appeals by individual doctors (Dr Raschid and Dr Fatnani) under section 40 of the Medical Act 1983 against, in each case, the sanction imposed by a Fitness to Practise Panel (which performed a function corresponding to that of the MPT under the legislation in effect at the relevant time), rather than, as in this case, an appeal by the GMC under section 40A. *GMC v Jagjivan* at [39] makes clear that the well-settled principles developed in relation to section 40 appeals, including in *Raschid v GMC*, can be applied, appropriately modified, to section 40A appeals.
71. Dr Ahmed gave a reflective statement to the MPT before the Sanction Determination stage but did not attend to be cross-examined. I have noted at [55] above Mr Hare’s reference to the comment of Yip J in *Yusuff v GMC* at [30] that it is difficult to assess issues such as remorse and insight on paper. I set against that, however, the observation of Sales LJ in *R (Smech Properties Ltd) v Runnymede Borough Council* at [29] that, even where a first instance court’s determination is made on the basis of written evidence that is also available to the appellate court, as in the case of Dr Ahmed’s reflective statement dated 20 October 2020, “it will often be appropriate for [the appellate] court to give weight to the assessment of the facts made by the judge



below”. Sales LJ goes on to make a number of related observations, all of which I bear in mind. The key point, in my view, is that I should be wary of differing from the MPT’s multi-factorial decision on sanction given the extent of oral and written evidence that was available to the MPT, including Dr Ahmed’s oral evidence (and the oral evidence of the other witnesses, factual and expert) at the Factual Determination stage.

72. In relation to the MPT’s assessment of Dr Ahmed’s level of insight and remorse, I also note the following passage from the judgment of Lindblom LJ in *Professional Standards Authority v Health and Care Professions Council & Doree* [2017] EWCA Civ 319 at [38]:

“38. ... I do not accept that, in principle, a professional disciplinary committee may only reasonably find that a registrant has shown insight or remorse after he has himself given oral evidence to demonstrate it, and has made himself available for cross-examination or other questioning on that evidence – even if it has rejected his evidence on some or all of the allegations he faced. *Whether a registrant has shown insight into his misconduct, and how much insight he has shown, are classically matters of fact and judgment for the professional disciplinary committee in the light of the evidence before it.* Some of the evidence may be matters of fact, some of it merely subjective. In assessing a registrant’s insight, a professional disciplinary committee will need to weigh all the relevant evidence, both oral and written, which provides a picture of it. This may include evidence given by other witnesses about the registrant’s conduct as an employee or as a professional colleague, and, where this is also relevant, the quality of his work with patients, as well as any objective evidence, such as specific work he has done in an effort to address his failings. Of course, there will be cases in which the registrant’s own evidence, given orally and tested by cross-examination, will be the best evidence that could be given, and perhaps the only convincing evidence. And such evidence may well be more convincing if given before the findings of fact are made. But this is not to say that in the absence of such evidence a professional disciplinary committee will necessarily be disabled from making the findings it needs to make on insight, or bound to find that the registrant lacks it.” (emphasis added)

73. It is clear from an impartial reading of the Record that the MPT had regard throughout the various stages of its proceedings to the question of the level of Dr Ahmed’s insight and the genuineness of his remorse. Mr Hare has made some criticisms of Dr Ahmed’s reflective statement, picking out individual phrases in it, to raise a doubt about the MPT’s assessment of the extent of Dr Ahmed’s insight. For example, Mr Hare criticises Dr Ahmed for his use of the word “my” in the following sentence:

“In light of this case I will take a cautious approach to anything that I think could affect my professional standing.”

74. Mr Hare submitted that this suggested an inappropriate focus on Dr Ahmed's own interests rather than the interests of patients or the public. While that is perhaps a fair comment, it seems a bit harsh, particularly bearing in mind that it is a matter of nuance, and English is not Dr Ahmed's first language. Perhaps more significantly, Mr Hare criticises the phrasing of some of Dr Ahmed's apologies in the reflective statement, particularly his use of the word "perceived" in the following sentences:

“...  
I fully appreciate the seriousness of my mistake and I am sorry  
I was perceived to lack insight into its seriousness when I was  
explaining my reasons for undertaking such an action.  
...  
I am sorry that during the MPTS hearing I was perceived to  
view women inappropriately. ... I do not feel I have a deep  
seated attitudinal issue toward females and I do not see female  
patients as sexual partners, I am sorry if I was perceived this  
way.”

75. Mr Hare submitted that these are very far from full apologies. While this is also perhaps fair comment, Dr Ahmed makes a number of other expressions of regret and apology, as well as acknowledgements of inappropriate conduct, in the reflective statement, which of course must be read as a whole.
76. Mr Hare's criticisms of a few sentences in Dr Ahmed's reflective statement, while perhaps fair as individual comments, do not come close to establishing that the MPT's assessment of the degree of Dr Ahmed's insight and remorse falls outside the bounds of what it could properly and reasonably have decided. The MPT will have made its assessment having regard to the totality of the evidence it considered, throughout the various states of the MPT Hearing.
77. Mr Hare submits that there was no evidence before the MPT at the time of the Sanction Determination that Dr Ahmed "had put his words into practice" because the testimonial from Dr Clancy on which the MPT relies was provided before the MPT Hearing began in October 2019. It is clear, however, that the MPT found that Dr Ahmed's insight had developed over the time during which the MPT Hearing took place and that it bore in mind that there had been no repetition of misconduct by Dr Ahmed in the nearly six years since the incident with Patient A in 2015, which had occurred after Dr Ahmed's interactions with Patient B in 2014. That was an important mitigating factor highlighted by the MPT. In my view, the MPT was entitled to conclude on the totality of the evidence that Dr Ahmed had put his words into practice or, to put it a different way, that his words as set out in the reflective statement showed Dr Ahmed's favourable evolution away from the attitudes that had led to the misconduct.
78. I accept Mr Hare's submission that the MPT must have regard to the relevant provisions of the *Sanctions Guidance* and, if choosing to depart from it, should explain its reasons for doing so. I have noted above the reference made by Mr Hare to

*GMC v Stone* at [53], where Jay J criticised the MPT’s analysis of the question of sanction in relation to the facts of that case, noting that it was:

“... merely a generalised assertion that erasure would be a disproportionate sanction and that the doctor’s conduct was not incompatible with his continued registration.”

79. In *GMC v Stone*, an appeal by the GMC under section 40A of the Medical Act 1983 against a sanction of suspension imposed on the respondent doctor, Jay J agreed with counsel for the GMC that the MPT had failed properly to consider the objective features of the case, to demonstrate that the gravity of those features had been fully understood by the MPT, and then to address and explain how the available mitigation operated to justify the imposition of the sanction of suspension. I also note the allegation against the respondent in *GMC v Stone* was of considerably more serious and sustained misconduct than in this case, the respondent having been found to have engaged in an improper sexual and emotional relationship with one of his patients, a vulnerable woman, over a period of some two years and eight months, during the final months of which his patient’s health deteriorated and she attempted to take her own life on three occasions.
80. The MPT, in my view, had proper regard to the *Sanctions Guidance* and gave sufficient reasons for departing from it. I have summarised the MPT’s approach and its reasons at 39] above. It is not fair, in my view, to say that the MPT simply made a generalised assertion that erasure was a disproportionate sanction. In my view, the following reasons given by the MPT support the view reached by the MPT that Dr Ahmed’s misconduct was not incompatible with continued registration and that erasure would be a disproportionate sanction:
- i) While Patient A was only 14 years old and was vulnerable, the MPT found that the extent of Dr Ahmed’s misconduct towards her was to access her Facebook profile and, possibly inadvertently, send her a Facebook friend request. The MPT rejected the GMC’s allegation that Dr Ahmed’s actions in accessing the Facebook profile and sending the friend request were sexually motivated. This was not, therefore predatory behaviour on Dr Ahmed’s part. He recognised his misconduct toward Patient A at an early stage. There was no inappropriate relationship with Patient A, and it was an isolated incident.
  - ii) There was no pattern of conduct as between the incident involving Patient A and the earlier misconduct in relation to Patient B.
  - iii) In relation to Patient B, there was no inappropriate physical relationship and the only interaction was via WhatsApp. Dr Ahmed belatedly recognised the seriousness of his misconduct with Patient B and the attitudinal problems that led to it.
  - iv) Dr Ahmed treated Patient B on a single occasion and made contact with her, wholly inappropriately, after that treatment was finished. She was, however, an adult, not vulnerable, and at the outset a willing participant in the WhatsApp exchanges between them, although after a certain point she stopped engaging with Dr Ahmed.

- v) Dr Ahmed was of previous good character. There was no question of the safety of either Patient A or Patient B having been in danger. Dr Ahmed was a skilled practitioner. A relevant factor in the multi-factorial analysis was the public interest in retaining the services of a competent practitioner within the NHS.
81. While the MPT quite rightly found that Dr Ahmed had committed serious professional misconduct in relation to Patient B, which was sexually motivated, it appears that it considered that, on the spectrum of sexual misconduct, this fell toward the less serious end. I agree. The judgment of Kerr J in the case of *Arunachalam v GMC* underlines the importance of considering the scale of the offending behaviour, even in a case of sexual misconduct, and appropriately evaluating it by reference to the relevant aggravating and mitigating factors. Erasure is not an automatic consequence in a case involving sexual misconduct. It all depends on the relevant facts. In my view, the MPT properly approached the assessment of the sanction on this basis and reached a decision on sanction that fell within the bounds of what it could properly and reasonably decide.
82. In determining the appropriate sanction in this case, the MPT followed the approach set out in paragraph 67 of the *Sanctions Guidance*, which reads:
- “67 The tribunal’s written decision is known as the determination. It must give clear and cogent reasons (including mitigating and aggravating factors that influenced its decision) for imposing a particular sanction. It must show that it started by considering the least restrictive option, working upwards to the most appropriate and proportionate sanction. This is particularly important where the sanction is lower, or higher, than that suggested by this guidance and/or where it differs from those submitted by the parties. In addition, the determination should include a separate explanation as to why the sanction should last for a particular period.”
83. As I have noted at [38] above, the MPT started its consideration with the possibility of taking no action and then considered imposing conditions on Dr Ahmed’s registration. It rejected each of these options as insufficient to meet the seriousness of this case. It then considered suspension and determined that, in the circumstances, suspension was the appropriate and proportionate sanction. Even though it did not set out paragraph 109 of the *Sanctions Guidance* in detail, it is clear that it had the *Sanctions Guidance* in mind, and there is no reason to consider that it did not have proper regard to paragraph 109. Mr Hare acknowledged that the MPT had addressed paragraph 109(a) in its Sanction Determination but had failed to address the other apposite clauses of paragraph 109, namely, (b), (d), (e) and (i). It is important, however, to bear in mind that paragraph 109 merely sets out a list of factors that, if present, may indicate that erasure is appropriate. An evaluative judgment is still required. The factors highlighted by clauses (b), (d), (e) and (i) are likely to be present, to a greater or lesser extent, in many cases where a doctor’s misconduct requires the serious sanction of suspension (which will itself have a significant punitive effect even though punishment is not the purpose of sanction by the MPT)

but an erasure would be disproportionate. The reasons given by the MPT, which I have summarised, are relevant to the assessment of these factors.

84. Paragraphs 147–148 (Predatory behaviour) of the *Sanctions Guidance* are relevant to Dr Ahmed’s misconduct in relation to Patient B:

“147 If a doctor has demonstrated predatory behaviour, motivated by a desire to establish a sexual or inappropriate emotional relationship with a patient, there is a significant risk to patient safety, and to public confidence and/or trust in doctors. More serious action is likely to be appropriate where there is evidence of (this list is not exhaustive):

a inappropriate use of social networking sites to approach a patient outside the doctor-patient relationship

b use of personal contact details from medical records to approach a patient outside their doctor-patient relationship

...

148 More serious action, such as erasure, is likely to be appropriate where a doctor has abused their professional position and their conduct involves predatory behaviour or a vulnerable patient, or constitutes a criminal offence.”

85. These provisions do not apply to Dr Ahmed’s conduct in relation to Patient A. Patient A was a vulnerable patient, but the *Sanctions Guidance* is not to be construed as though it were a statute. Paragraph 148 forms part of the section of the *Sanctions Guidance* that concerns predatory behaviour, which was not found by the MPT in relation to Patient A.
86. In relation to Patient B, both of these paragraphs, in addition to the relevant factors in paragraph 109, do mean that the MPT is required to consider erasure as a sanction in respect of Dr Ahmed’s proven misconduct. The MPT did consider erasure and gave reasons that were open to it for concluding that erasure, on the facts of this case, would be a disproportionate sanction.
87. The MPT made it clear, for the purposes of the Sanction Determination, that it had regard to the whole of the *Sanctions Guidance*. It only highlighted and quoted from a few provisions. It did not specifically refer to or quote from paragraphs 109, 147 or 148, but it would have had those provisions in mind when reaching its decision. In my view, the GMC has failed to establish that the MPT made an error of principle in concluding that suspension rather than erasure was the appropriate sanction in this case, having regard to the *Sanctions Guidance*.

88. As I have already noted, paragraph 67 of the *Sanctions Guidance* requires that the MPT give reasons for deciding why suspension should last a particular period, in this case, two months. In giving its reasons, the MPT referred to the fact that Dr Ahmed had already been subject to an interim suspension order for a period of four months.

89. Paragraph 22 of the *Sanctions Guidance* provides:

“22 The doctor may have had an interim order to restrict or remove their registration while the GMC investigated the concerns. *However, the tribunal should not give undue weight to whether a doctor has had an interim order and how long the order was in place.* This is because an interim orders tribunal makes no findings of fact, and its test for considering whether to impose an interim order is entirely different from the criteria that medical practitioners tribunals use when considering an appropriate sanction on a doctor’s practice.” (emphasis added)

90. The GMC submits that the MPT has given “undue weight” to the interim suspension order. I have already noted that Mr Hare referred during his submissions to the cases of *Ujam v GMC* and *Abdul-Razzak v GPC*, which indicate that it is inappropriate to treat an interim suspension order as analogous to a period of imprisonment on remand that counts toward a subsequent custodial sentence. It was unfortunate, in my view, that the MPT referred to its imposition of a suspension of two months as the imposition of a “further” suspension, given, as paragraph 22 of the *Sanctions Guidance* makes clear, that an interim suspension order and suspension as a sanction have different purposes.

91. Nonetheless, it is clear that the fact that a doctor has been subject to an interim suspension order is a factor that the MPT is permitted to take into account when making its multi-factorial decision as to the appropriate sanction. It is also correct as a matter of language, albeit infelicitous in this context, that the imposition of the sanction of suspension would involve for Dr Ahmed a “further” period of suspension from his practice.

92. In *Kamberova v Nursing and Midwifery Council* [2016] EWHC 2955 (Admin), Dingemans J considered the question of whether a period of suspension under an interim suspension order in relation to a nurse should be taken into account by the Conduct and Competence Committee of the Nursing Midwifery Council, a body with a role comparable to that of the MPT in relation to doctors, following findings of misconduct and incompetence against a nurse. Dingemans J said at [4] and [40]:

“4. ... For the detailed reasons which appear below, in my judgment a [Conduct and Competence Committee] should take into account the time spent by a registrant suspended under an [interim suspension order] as a relevant factor when considering what is the appropriate and proportionate sanction.

...

40. Ms Fleck [counsel for the Nursing and Midwifery Council] accepted that the Committee must take account of any interim order and its effect on the registrant in deciding whether any sanction was proportionate. This is no more than common fairness dictates. If proceedings are long delayed and a person is subject to suspension in the interim period, that period of suspension may affect the proportionality of the length of the subsequent period of suspension. Whether it has that effect is for the Committee to determine. If the appropriate sanction is one of striking off, then the fact that there has been an ISO may be of no relevant effect. However if the appropriate sanction is a short period of suspension, the fact that there has been an interim period of suspension may be relevant. This is particularly the case given the number of cases before this court in which ISOs of considerable length have, because of delays in arranging hearings, had to be extended.”
93. Mr Hare supposed that the MPT must have considered that a sanction of six months was appropriate and then must have, impermissibly, deducted the four months of interim suspension. The MPT does not set the matter out in those terms, although its use of the word “further” lends some support to Mr Hare’s supposition.
94. As I have already noted, Mr Hare relied on the cases of *Ujam v GMC* and *Abdul-Razzak v GPC* for the proposition that a period of interim suspension is not analogous to a period of imprisonment on remand that would normally be deducted from a subsequent custodial sentence. It is relevant, however, when considering those cases, to bear in mind that each was an appeal by a doctor on whom a sanction of suspension was imposed and who argued on appeal that the period he had spent subject to an interim suspension order should have been deducted from the period of his suspension. Undue weight should not be given to the fact that a doctor has been subject to an interim suspension order when imposing suspension as a sanction, but *Kamberova v NMC* makes clear that it is a factor that should, in fairness, nonetheless be taken into account, at least where the sanction is a short period of suspension. It is therefore a matter of judgment for the MPT as part of its multi-factorial decision on sanction.
95. In this case, it is necessary, in my view, to step back and consider the whole of the MPT’s reasoning. In deciding that a short period of suspension was sufficient for the protection of the public in this case, the MPT appears to have been influenced by a number of considerations, including those that I have highlighted at [80] above.
96. Taking all that together with the remedial work that Dr Ahmed had done and the evidence in his reflective statement of 20 October 2020, the MPT was entitled to conclude, in all the circumstances, including Dr Ahmed’s having already served an interim suspension of four months, and bearing in mind that this was not a case involving any threat to patient health or safety, that a suspension of two months in this case was sufficient to maintain public confidence in the medical profession and to

maintain proper professional standards and conduct for members of the medical profession.

97. The MPT considered, as it was required to do under paragraph 98 of the *Sanctions Guidance*, whether it needed to impose an immediate order of suspension, having regard to the considerations set out in paragraphs 172 to 178 of the *Sanctions Guidance*. The GMC does not criticise this aspect of the Sanction Determination.
98. The GMC does, however, criticise the MPT's decision not to order a review, giving no reason beyond the assertion that a review "would serve no useful purpose". Paragraphs 163–164 and 166 of the *Sanctions Guidance* are relevant in this case.
99. The GMC submitted that the failure to order a review is, alone, sufficient in this case to allow the appeal and quash the sanction of suspension. I do not agree. It would have been better had the MPT spelled out its reasons in more detail, but it did give a reason, namely, that it considered that a review would serve no useful purpose. I note that paragraph 164 of the *Sanctions Guidance* begins:

"In some misconduct cases it may be self-evident that, following a short suspension, there will be no value in a review hearing."
100. Paragraph 164 goes on to say that "in most cases" where a period of suspension is imposed a review hearing is "likely to be necessary", however it is clearly a fact-specific determination. Paragraph 166 makes it clear that it is important that the MPT "fully explain" any instance where they decide not to direct a review hearing.
101. It is sufficiently clear from a reading of the Sanction Determination as a whole that the MPT reached the view that ordering a review would serve no useful purpose on the basis of the same factors that led it to conclude that a suspension of only two months would be sufficient in this case. As Mr Hockton pointed out, it is a feature of this case that there was a gap of over seven months between submissions on impairment on 12 March 2020 and submissions and the MPT's decision on sanction on 21–22 October 2020.
102. Having regard to paragraph 166 of the *Sanctions Guidance*, it would have been better had the MPT provided a fuller explanation of its decision not to order a review. In my view, however, it was open to the MPT, having regard to all the circumstances, to conclude that a review in this case would serve no useful purpose.

### *Conclusion*

103. For all of the foregoing reasons, the GMC's appeal under section 40A of the Medical Act 1983 against the sanction of two months' suspension imposed on Dr Ahmed by the MPT on 22 October 2020 is dismissed.