



Neutral Citation Number: [2024] EWHC 1741 (Admin)

Case No: AC-2023-LON-003301

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 16/05/2024

Before :

MRS JUSTICE DIAS

Between :

DR REETA SINGH

Claimant

- and -

GENERAL MEDICAL COUNCIL

Defendant

Nicholas Peacock (instructed by MDU Service Limited) for the Claimant
David Hopkins (instructed by General Medical Council Legal) for the Defendant

Hearing dates: 15th May 2024

Approved Judgment

This judgment was handed down on 16th May 2024 in court and by release to the National Archives.

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MRS JUSTICE DIAS

MRS JUSTICE DIAS :

1. This is an appeal by Dr Reeta Singh under section 40 of the Medical Act 1983 (the “Act”) against a determination by a Medical Practitioners Tribunal (the “Tribunal”) made on 5 October 2023 that her registration with the General Medical Council (the “GMC”) be suspended for one month on the grounds that her fitness to practise was impaired by reason of misconduct.
2. There is no appeal against the findings made by the Tribunal at the Stage 1 determination of facts on 17 February 2023, nor against its subsequent determination at the Stage 2 hearing that those findings were sufficient to establish misconduct. The appeal relates solely to the further finding made at Stage 2 that her fitness to practise was impaired. On behalf of Dr Singh, Mr Nicholas Peacock also confirmed that there was no free-standing appeal against the sanction of one month’s suspension in the event that the court upheld the Tribunal’s decision as to impairment.

Factual background

3. It was common ground between the parties that the Tribunal’s Stage 1 and Stage 2 determinations were thorough and comprehensive so far as the facts were concerned and set out all the matters which are relevant to the appeal. In those circumstances and given that there is no issue between the parties as to the underlying conduct leading to the finding of misconduct, I can summarise the background relatively briefly.
4. From 2011, Dr Singh practised as a salaried GP and GP Principal at Ashwood Surgery in Grimsby. She was the sole PMS contract holder, providing GP services to NHS England until her contract was terminated in 2015. The surgery was owned by Dr Singh and her husband through a limited company, Ashwood Surgery Limited (“ASL”), of which they were the sole shareholders and directors. Dr Singh herself was employed by ASL.
5. As a matter of day-to-day organisation of the surgery, Dr Singh took responsibility for all clinical matters and the provision of primary services under the PMS contract. She delegated all administrative, operational and financial management to her husband. It should be noted that the practice was already failing when it was taken over by Dr Singh and that it had a number of pre-existing problems.
6. The misconduct in question relates to the administration of staff pensions between 2011 and 2015. The Tribunal found, and Dr Singh accepted, that she had failed to ensure that adequate systems were in place for the payment of correct employer and staff pension contributions and that, despite knowing from mid-2012 that there were ongoing unresolved problems in this respect, she had failed to take adequate action to resolve the issues. Instead she had relied on her husband and the practice manager to sort things out.
7. The Tribunal made the following key findings of fact:
 - (a) Delegation of responsibility for the administration of staff pensions is a usual and common practice for a GP in Dr Singh’s position and it was reasonable and proper for her to rely on others to manage the financial aspects of the practice;
 - (b) It was also reasonable at the outset for Dr Singh to rely on her husband to undertake financial management of the surgery on behalf of ASL;

- (c) However, Dr Singh had ultimate responsibility under the PMS contract to ensure that correct pension contributions were paid and once it had become clear that the surgery's obligations under the NHS Pension Scheme were not being met, she had a personal responsibility to investigate and ensure compliance;
 - (d) Dr Singh was first made aware that there was a problem in July 2012. Thereafter there were repeated and ongoing failures to pay the correct contributions which persisted over a period of some three years, with concomitant potential for employees of the surgery to face a deficit in their pension remuneration;
 - (e) Dr Singh failed to act so as to ascertain the nature of the problem or what was needed to put it right, and was consequently in breach of her obligations as a PMS contract holder to ensure that adequate systems were in place for payment of the correct contributions;
 - (f) The matter was only ultimately resolved in 2019, when agreement was finally reached with NHS Pensions as to the correct outstanding amount (£24,723.40). Dr Singh took responsibility for this deficit which she made good out of her own pension fund;
 - (g) Dr Singh had not acted dishonestly. Her sins were those of inaction rather than action and she had no positive intent or motive to behave below the standards required of her. Applying the test in *Ivey v Genting Casinos UK Ltd*, [2017] UKSC 67, "*ordinary decent people would understand that it was possible for a busy clinician to get into a 'mess' with financial matters which they thought they had correctly delegated to others. Whilst they might not approve of the financial state of affairs which Dr Singh's inactions allowed to develop, they would recognise that dishonesty was of a totally different order and would not consider that Dr Singh had been dishonest*";
 - (h) There was no question that patient safety was ever placed at risk or that there were any shortcomings in Dr Singh's provision of clinical services. On the contrary, she was a good and competent doctor.
8. As regards events subsequent to the misconduct, the Tribunal made the following findings:
- (a) Dr Singh had demonstrated genuine insight into the seriousness of her conduct, albeit this had only developed during and after the Stage 1 fact hearing;
 - (b) She had taken action to remediate her misconduct by making good the contributions shortfall from her own pension pot;
 - (c) She had apologised, at times spontaneously, to NHS England, NHS Pensions, her former employees and the wider public. These apologies were genuine and sincere;
 - (d) Dr Singh had now started a new life with her husband and family in Canada. She no longer practised medicine and had established a new career in consultancy. She did not intend to return to clinical practice and, although she could not rule this out altogether, even if she did it was unlikely that she would return as an employer or in the same difficult circumstances that she had inherited when she took on the Ashwood practice;
 - (e) Accordingly, the risk that the misconduct would be repeated was very low.

Misconduct and impairment: applicable principles

9. There was unsurprisingly very little dispute as to the principles relating to the assessment of misconduct and impairment.

10. Sections 1(1A) and 1(1B) of the Act provide as follows:

“(1A) The over-arching objective of the General Council in exercising their functions is the protection of the public.

(1B) The pursuit by the General Council of their over-arching objective involves the pursuit of the following objectives –

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

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

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

11. Thus, sub-section (1A) sets out a single over-arching objective, while sub-section (1B) identifies three specific aspects of that objective. Although it makes no difference on the facts of this case, I am inclined to accept Mr Peacock’s submission that these aspects are not discrete and that there may be an overlap between them. Likewise, I agree with him that they are not necessarily exhaustive of what is required for the protection of the public, although they are clearly likely to cover the vast majority of cases. I also accept the submission of Mr David Hopkins for the GMC that sub-section (1B) of itself clearly demonstrates that “protection of the public” extends beyond matters of patient safety alone to encompass the upholding of professional standards and the maintenance of public confidence in the medical profession.

12. Part V of the Act deals with fitness to practise and the powers of the GMC in the event that a Medical Practitioners Tribunal finds that a registrant’s fitness to practise is impaired. In this regard, section 35C sets out the only six bases on which a finding of impairment can be made. The first – and the only one relevant to this case – is misconduct. However, there is no statutory definition of either misconduct or impairment and such guidance as there is must be found in the authorities.

13. As to this, Mr Peacock referred me to the set of framework submissions which he had put before the Tribunal. A materially identical version of this framework had been approved by Lang J in *Martin v GMC*, [2011] EWHC 3204 (Admin) and was accepted as accurate by Mr Hopkins. It was accordingly common ground that misconduct and impairment were separate, distinct concepts and that misconduct requires a falling short, whether by omission or commission, of the standards of conduct expected of registrants, and that the falling short be serious.

14. As to impairment, it was likewise not in dispute that:

(a) A finding of misconduct does not inevitably entail or require a finding that the registrant’s fitness to practise is impaired: *Cohen v GMC*, [2008] EWHC 581 (Admin); *Zygmunt v GMC*, [2008] EWHC 2643 (Admin);

- (b) The registrant's fitness to practise must be currently impaired: *Cohen; Zygmunt*;
- (c) The purpose of a finding of impairment is not to punish the registrant for past misconduct but to protect the public from those who are not fit to practise. Impairment is thus essentially forward-looking whereas misconduct looks to the past;
- (d) While it is permissible and proper to take account of past conduct in order to assess whether a registrant's fitness to practise is currently impaired (see *GMC v Meadow*, [2006] EWCA Civ 390), there must always be situations where it can properly be concluded that an act of misconduct was isolated and that the risk of repetition is so low that current fitness to practise is not impaired: *PSA v HCPC and Roberts*, [2020] EWHC 1906 (Admin);
- (e) An appropriate test to apply is that articulated by Dame Janet Smith in the Shipman enquiry and approved by Cox J in *CHRE v NMC and Grant*, [2011] EWHC 927 (Admin), namely:
- “Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
- (a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
- (b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
- (c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
- (d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.”*
- (f) As emphasised in *Grant*, the need to protect the public and the public interest in declaring and upholding proper standards of conduct and behaviour so as to maintain public confidence in the profession are fundamental considerations when deciding whether fitness to practise is impaired. It is therefore necessary to consider not only whether the registrant continues to present a risk to members of the public in his/her current role, but also whether proper professional standards and public confidence in the profession would be undermined unless a finding of impairment were made in the particular circumstances: *ibid* at [71]-[75];
- (g) Further matters to be taken into account include:
- (i) Whether the material errors are easily remediable and/or have been remedied and/or are highly unlikely to be repeated;
- (ii) The level of insight shown by the registrant;
- (iii) Events/steps taken in meantime;
- (iv) Testimonial evidence as to current skills and fitness to practise generally;
- (h) The concept is a flexible one and is ultimately a question of assessment.

15. Mr Peacock pointed out that at the time of the Shipman Inquiry, the current fitness to practise regime was not yet in force and only existed in draft form. There was therefore no authority on the distinction between misconduct and impairment. He submitted that I should bear this in mind in applying the *Grant* test and be careful not to elide the two concepts. I thought I may have detected in this submission a very delicate hint that the Tribunal had done just that but, as will appear below, I reject this suggestion. The Tribunal was properly directed and had well in mind the distinction to be drawn between past misconduct and current impairment.

Misconduct and Impairment: the Tribunal's determination

16. The Tribunal concluded that Dr Singh had fallen far short of the standards expected of her over a prolonged period of time and that in failing to take adequate action to remedy the problem had demonstrated a *“lack of professional curiosity that would be expected of someone in her position”*. It noted that this had created a potential for employees at the surgery to face a financial deficit in their pension pots with consequent uncertainty and insecurity and considered this to be indicative of the seriousness of Dr Singh's conduct.

17. For those reasons, the Tribunal determined that *“Dr Singh's conduct fell so far short of the standards of conduct reasonably to be expected of her in the circumstances that it amounted to misconduct which was serious.”*

18. In relation to impairment, the Tribunal made the findings set out at paragraph 8. above. It noted expressly that there were no patient safety concerns and expressly rejected the GMC's submission that Dr Singh's mismanagement of the pension contributions gave rise to any real prospect of detrimental impact on the delivery of services.

19. Nonetheless, the Tribunal concluded that a finding of impairment was appropriate. Its reasoning was brief and I set it out in full:

“34. However, the Tribunal reminded itself that it has found there to be serious misconduct in this case. It noted that the serious misconduct was one of inaction rather than action, and that there was no positive intent or motive on the part of Dr Singh to behave below the standard required. However, it considered that Dr Singh had failed to act over a long period of time, ignored clear warning signs that there was a serious problem, and that her failure to act had the potential to cause significant problems for those who were personally affected in respect of their pensions and their security of income on retirement.

35. In these circumstances, the Tribunal considered that limbs two and three of the overarching objective to be engaged. It determined that Dr Singh failures were so serious that, in order to maintain public confidence in the profession, a finding of impairment was necessary. It also considered that it was necessary to make a finding of impairment to uphold proper professional standards and conduct.”

20. By way of sanction, the Tribunal directed a period of one month's suspension. I was informed by Mr Peacock that to the best of his knowledge this has not yet taken effect due to the lodging of the current appeal.

Principles applicable to an appeal

21. An appeal under section 40 of the Act is of right. It takes place by way of rehearing not review, and the applicable principles are authoritatively set out in *Sastry v GMC*, [2021] EWCA Civ 623; [2021] 1 WLR 5029 at [102]-[113]. As there clarified:
- (a) An appeal will be allowed where the court considers that the original decision was either wrong or unjust because of some serious procedural or other irregularity: CPR Part 52. (No suggestion of irregularity was made here; the submission on appeal is simply that the Tribunal's decision was wrong.)
 - (b) The appeal court will not defer to the judgment of the tribunal more than is warranted by the circumstances which may, in an appropriate case, include the composition of the tribunal.
 - (c) Accordingly, while the appeal court will approach a tribunal's determination regarding impairment and what is necessary to maintain public confidence and proper standards with diffidence, it will be more ready to depart from that assessment where it feels that it is in as good a position as the tribunal to make that assessment.
 - (d) The appeal court must decide whether the sanction imposed was appropriate and/or necessary in the public interest or excessive and disproportionate. If the latter, it should either substitute some other penalty or remit the case for reconsideration.
22. There was no substantial dispute between the parties as to these principles, although Mr Hopkins pointed out that *Sastry* was only concerned with an appeal against sanction and should be read in that context. While it is true that the finding of impairment was not itself under attack in *Sastry*, the principles set out by the Court of Appeal were articulated with reference to appeals under section 40 generally, and not simply such aspects of an appeal as relate specifically to sanction. Since an appeal under section 40 lies against the decision to suspend as a whole, it must necessarily include a right to challenge the underlying finding of impairment and, indeed, Mr Hopkins did not suggest otherwise. I therefore proceed on the basis that the *Sastry* principles apply to all aspects of an appeal under section 40.

Grounds of appeal

23. As confirmed by Mr Peacock, there was essentially only one ground of appeal in this case and the six sub-headings identified in his skeleton argument were simply different facets of his overarching submission that the Tribunal's decision on impairment was wrong.
24. I deal with two matters at the outset.
25. First, I can detect no error of law or principle on the part of the Tribunal in reaching its determination. On the contrary, I agree with Mr Hopkins that the Tribunal correctly directed itself on the law and thus had in mind:
- (a) the proper burden and standard of proof;
 - (b) the conceptual distinction between misconduct and impairment;
 - (c) the requirements of the overarching objective;
 - (d) the *Grant* test and the need to consider the public interest; and

- (e) the fact that conduct can be sufficiently linked to professional practice even if it is not directly related to clinical matters.
26. Mr Peacock nonetheless submitted that the Tribunal's description of Dr Singh's misconduct as "*serious misconduct*" in paragraph 34 of its Stage 2 determination (see paragraph 19. above) disclosed an error of principle. He correctly pointed out that as a matter of law, conduct must in any event fall seriously below the expected standards in order to qualify as misconduct at all. To speak of "*serious misconduct*" was therefore tautologous at best or else based on a misunderstanding of the law.
27. I agree with Mr Hopkins that this is not a fair criticism. On a fair reading in the light of the legal direction which had been given by the chair, paragraph 34 merely spells out the basis on which the Tribunal had found misconduct and says nothing more than that Dr Singh's conduct fell seriously below the standards to be reasonably expected. Further, while I accept that misconduct can extend over a range of seriousness, I do not accept Mr Peacock's further submission that this paragraph showed the Tribunal placing Dr Singh's misconduct at the top end of the range in the teeth of its previous finding that it was of a totally different order to dishonesty. The fact that the Tribunal imposed almost the minimum possible period of suspension demonstrates quite the contrary.
28. Secondly, Mr Peacock levelled various criticisms at the Tribunal for failing to explain its reasoning sufficiently or to address the specific heads of the *Grant* test and identify how they were met. In my judgment these criticisms were also unfair. This was a largely lay tribunal, not a court of law, and its determination is therefore to be read generously and fairly and not to be parsed as if it were a statute. The Tribunal was not obliged to address every single argument made to it, provided it gave sufficient reasons to show why it reached the decision it did. Mr Hopkins submitted with some force that it is nearly always the case that a tribunal could have expressed itself better or more clearly and that it was sufficient if its reasoning was plain because it was either explicitly stated or implicit: see *Phipps v GMC*, [2006] EWCA Civ 397 at [106]. I agree. Moreover, the *Grant* test is not prescriptive; it is simply a useful guideline for approaching a determination of impairment.
29. In truth, as Mr Peacock accepted, these criticisms were simply an oblique way of submitting that the Tribunal's decision was wrong.

Was the finding of impairment wrong?

30. This is the nub of the appeal.
31. It is rightly not disputed by Mr Peacock that the Tribunal was entitled in principle to find that non-clinical conduct can properly be considered so serious that it currently impairs the registrant's fitness to practise. He submitted, however, that such cases overwhelmingly fall into one of two categories: dishonesty and sexual impropriety. Both counsel agreed that neither category was engaged here and that, so far as their researches had been able to uncover, no case had reached the courts where impairment was alleged as a result of administrative failings comparable to those of Dr Singh. Certainly this question has not hitherto been considered on appeal. To that extent, this is a novel situation.

32. Mr Hopkins submitted that the Tribunal had the *Grant* test in mind and had concluded that the second and third limbs of section 1(1B) of the Act were engaged and that Dr Singh's failures were so serious that a finding of impairment was necessary in order to maintain public confidence and uphold proper professional standards. He argued that this was a matter of judgment for the Tribunal and that since its determination was within the range of conclusions which were reasonably open to it, the court should not interfere.
33. I do not accept that this is the correct approach. This is rehearing not a review, and in accordance with the principles articulated in *Sastry*, I am both entitled and bound to substitute my own decision for that of the Tribunal if I conclude that the latter was wrong. In particular, I am not required to defer to the Tribunal's determination more than is warranted by the particular circumstances, as to which two points may be made.
34. First, the Tribunal's Stage 1 findings are accepted. There is therefore no question of the court being asked to overturn the Tribunal's primary findings of fact which obviously depended on its assessment of Dr Singh herself and the other witnesses.
35. Secondly, I do not accept that there is anything in the composition of this particular Tribunal or the nature of the assessment to be carried out which renders the court less capable than the Tribunal of assessing impairment. As *Sastry* makes clear, the court is well placed to assess for itself what public protection and the reputation of the profession require. That is particularly the case where (as here) the misconduct in question, albeit connected with Dr Singh's professional practice, was not directly related to clinical matters where medical expertise might well deserve particular deference. In this case, the Tribunal was comprised of a legally qualified chair, a lay member and a consultant ophthalmologist but it is not obvious that the latter's experience had any particular relevance to the issues which arose. I therefore regard myself as sufficiently well-placed to make my own assessment of impairment, which I do as follows.
36. None of the *Grant* tests was met in this case. There was no question of patient safety or dishonesty or breach of the fundamental tenets of the profession – whether past, present or future. A finding of impairment could accordingly only have been made on grounds of public interest.
37. However, it is a fair comment that the Tribunal did not explain in any detail the basis on which it concluded that the public interest required a finding of impairment. The factors underlying its decision were those set out in paragraph 34 of its Stage 2 determination (see paragraph 19. above), principally the prolonged period of Dr Singh's defaults and the potential for serious problems to be caused to others. Mr Hopkins argued rather faintly that the Tribunal may have taken the view that the misconduct had already brought the medical profession into disrepute. However, I cannot spell this out of the determination even on the fairest of readings. That would have been a serious finding to make and if it was what the Tribunal had in mind, I am confident that it would have said so expressly.
38. Furthermore, the Tribunal had expressly found at paragraph 121 of its Stage 1 determination that "*ordinary decent people would understand that it was possible for a busy clinician to get into a 'mess' with financial matters which they thought they had correctly delegated to others. Whilst they might not approve of the financial state of affairs which Dr Singh's inactions allowed to develop, they would recognise that dishonesty was of a totally different order and would not consider that Dr Singh had been dishonest.*"

39. While the two are not necessarily irreconcilable, there is an undoubted tension between this finding and the Tribunal's ultimate determination that a finding of impairment was necessary to maintain public confidence in the profession and uphold proper professional standards. At the risk of repetition, Dr Singh's misconduct was nothing to do with her continuing abilities to practise as a clinician as opposed, for example, to administrative failings with regard to the proper storage of drugs in the surgery. And I am not persuaded that public confidence in the medical profession would be undermined by the fact that a busy doctor innocently concentrated on providing clinical services to patients in need to the detriment of her administrative obligations. In my judgment, the focus of the Act is primarily on upholding the standards of the medical profession as medical practitioners, rather than as corporate or financial administrators. In one sense, it is only as an incidental and adventitious result of the multifarious reforms to the delivery of NHS services that doctors have been required to assume such administrative responsibilities at all.
40. It is also pertinent to point out that, while the Tribunal properly took account of the detrimental effect of Dr Singh's misconduct on others, it only affected a very small and limited number of people, namely employees and (arguably) prospective employees of the surgery. This was a small surgery and it is unlikely that more than a handful of people were adversely affected. Certainly, a failure to administer staff pensions would have had no effect on the public at large and although Mr Hopkins submitted that it might affect the confidence of potential users of the surgery, I regard that as rather far-fetched. It might conceivably affect potential employees but even then only in relation to their employment rather than their relationship to the medical profession *per se*. Realistically, it went no further than that.
41. In these circumstances, it must be doubtful whether the public conscience would be so outraged by administrative failings affecting a tiny number of individuals that it would feel concerned if no finding of impairment was made. Likewise it is questionable whether the public at large required such protection against these failings as could only be achieved by finding that Dr Singh's ability to continue delivering good and competent medical treatment was impaired.
42. In this latter connection, I note that the court in *Grant* at [71], [89]-[91] regarded the need to uphold proper standards and maintain public confidence as particularly important to an assessment of impairment in cases where there was no power under the relevant rules to issue a warning in the event that no impairment was found. In other words, it contemplated that a finding of impairment could more readily be made where there was no other mechanism to mark disapproval of the misconduct in question. *Grant* of course was just such a case concerning the NMC. However, the court expressly noted that the position was different in relation to the GMC which does have the power to issue a warning in the event that misconduct is proved without any finding of impairment.
43. Although this power was drawn to the attention of the Tribunal by Mr Peacock, it did not expressly comment on it. I make no criticism of that in itself but it does seem to me that it was a relevant consideration to be weighed in the balance.
44. There is obviously no conceptual limit to the matters which might be relevant to an assessment of impairment in any particular case but I agree with Mr Peacock that the focus on current impairment means that insight and remediation are very important considerations. Indeed, the level of the registrant's insight into his/her misconduct was

said in *Grant* at [116] to be “central” to the decision. Mr Hopkins suggested on the basis of *Roberts (supra)* at [3(k)] that questions of remediation were primarily only relevant to cases of clinical error. I do not accept this. There can be no hard and fast rules. Clearly if the misconduct involves a clinical blind spot, the extent to which it is remediable and/or has been remedied will be very important. However, I do not see why this should be any the less so in relation to administrative failings.

45. Mr Hopkins also submitted that immediate insight should somehow carry more intrinsic weight than insight acquired later or more gradually. I had some difficulty in following this submission. Insight is insight, whenever it is gained. If the registrant has gained proper and genuine insight by the time of the hearing, I do not see that it necessarily makes any difference whether it dawned slowly or sprang fully-formed like Athena from the head of Zeus in some sort of early “light-bulb” moment. I accept that in a particular case, earlier insight offering an earlier opportunity for remediation could be relevant but not in a case like this where the only significant remediation possible was to make good the contribution deficit which had already been done. Since Dr Singh was no longer practising, the possibility of her undertaking some form of training in how to handle NHS pension contributions would have been a somewhat pointless exercise.
46. Having considered the questions of insight, remediation and risk of repetition, the Tribunal made findings entirely in favour of Dr Singh. I agree with Mr Peacock that in those circumstances it is difficult to follow the leap which led it to regard all these factors as overridden by the nature and seriousness of the misconduct.
47. The fact that Dr Singh is no longer practising medicine or intending to return to practice and has taken a completely different career path in a different country is clearly relevant to whether her fitness to practise is currently impaired.
48. Furthermore, this was not the archetypal case of dishonesty or sexual impropriety where the misconduct can readily be seen to be so serious as to justify, in and of itself, a conclusion that fitness to practise is currently impaired. On the contrary, these were purely administrative failings characterised in part by the Tribunal as a “*lack of professional curiosity*”. I accept, of course, that administrative failings in connection with professional practice can amount to misconduct, but it is difficult to see how such failings - many years in the past, which have not been repeated, which are in no realistic danger of being repeated, which had no impact on Dr Singh’s clinical abilities and where Dr Singh had shown appropriate and genuine insight – can properly be said to lead to a conclusion that public confidence in the medical profession would be undermined unless impairment was found, or that such a finding was necessary in order to uphold professional standards. In my judgment the public, which (as the Tribunal expressly held) would have understood that a busy clinician had simply got into a mess administratively, would be very reassured by knowing that Dr Singh had accepted full responsibility for her actions, made full reparation, gained genuine insight and shown genuine remorse. I do not accept that it would regard itself as being let down in any way by the GMC if no impairment were found in these circumstances, particular where, as here, there were other ways open to the GMC of marking its disapproval of Dr Singh’s misconduct.
49. In these circumstances, I am not persuaded that finding of impairment was necessary in order to maintain public confidence in the profession or to uphold proper professional standards. I remind myself of the caution in *PSA v NMC*, [2017] CSIH 29 at [30] (another case, like *Grant*, involving the NMC where there was no power to issue a

warning absent a finding of impairment) that a perceived need for a penalty should not be allowed to drive the decision on impairment. There is also force in Mr Peacock's submission that the public nature of the proceedings against Dr Singh, which were protracted and involved serious allegations of dishonesty, was sufficient cauterisation of this particular wound, and sufficient deterrent to other members of the profession, particularly if combined with a warning which would remain on Dr Singh's record for two years.

50. For all these reasons, the Tribunal was in my judgment wrong to conclude that Dr Singh's fitness to practise was currently impaired.
51. In reaching this conclusion, I have effectively dealt with the specific grounds of appeal set out in Mr Peacock's skeleton. It is therefore unnecessary for me to address them separately.
52. It follows that the finding of impairment and consequent sanction must be set aside. Both sides agreed that in that event, it would be appropriate for Dr Singh to be given a warning in accordance with the Guidance published by the GMC. It is unnecessary for these purposes to decide whether it is the Guidance in force at the date of the determination or the current updated version which is relevant for these purposes since they are materially identical. Both versions make clear that a warning is an appropriate way of dealing with concerns which fall just below the threshold for a finding of impairment and also an effective deterrent, as it serves both to remind the registrant that his/her conduct fell significantly below the standard expected and to highlight to the wider profession that certain conduct or behaviour is unacceptable. In my judgment that is the correct approach here. The parties were agreed that they should seek to agree a form of wording in the first instance with any disagreement being resolved by the court on paper if necessary.
53. In conclusion, I wish to pay tribute to the Tribunal for its very careful findings in this matter. It approached its task conscientiously and with great care and in accordance with the correct legal principles and while I have differed from it on the question of impairment, this should not detract from the otherwise excellent job that it performed. I am likewise grateful to counsel on both sides for their clear and helpful submissions.