Judgments

Sastry and another v General Medical Council

[2021] EWCA Civ 623

Court of Appeal, Civil Division

Macur, Nicola Davies and Lewis LJJ

30 April 2021

Judgment

Nicola Newbegin and Ben Jones (instructed by **Medical Defence Shield**) for the **First Appellant**

Arfan Khan and Katherine Archer (instructed by **DCK Solicitors**) for the **Second Appellant**

Ivan Hare QC and Alexis Hearnden (instructed by **GMC Legal**) for the **Respondent**

Hearing dates : 23 & 24 March 2021

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Approved Judgment

Covid-19 Protocol: This judgment was handed down remotely by circulation to the parties' representatives by email, release to BAILII and publication on the Courts and Tribunals Judiciary website. The date and time for hand-down is deemed to be

at 10.30am on Friday 30 April 2021.

Lady Justice Nicola Davies giving the judgment of the court:

1. These are two second appeals in which the appellants challenge the orders made by the Administrative Court dismissing their appeals under section 40 of the Medical Act 1983 (“the 1983 Act”) against decisions of the Medical Practitioners Tribunal (“MPT”) that their names should be erased from the medical register of the General Medical Council (“GMC”).

2. The first appellant (Dr Sastry) challenges the order of May J, made on 30 January 2019, dismissing his appeal against the decision of the MPT on 1 August 2018 to erase his name from the medical register for failings in his clinical care of Patient A in India in 2013-2014. Dr

Sastry sought permission to appeal to this court on three grounds, permission was granted on one by Leggatt LJ (as he then was) on 16 October 2019. In granting permission in respect of the sanction element of the MPT's decision, Leggatt LJ stated:

"I consider that there is a real issue as to whether the judge deferred unduly to the panel's view by approaching the appeal in effect as a challenge to the exercise of a discretion, when arguably the judge was required to exercise her own judgment as to whether the sanction imposed was excessive and disproportionate."

3. The second appellant (Dr Okpara) challenges the order of Julian Knowles J, made on 12 June 2019, dismissing his appeal against the decision of the MPT on 9 January 2019 to erase his name from the medical register for repeated acts of sexual misconduct towards a staff nurse at the University Hospital of Wales in 2014-2016. Dr Okpara sought permission to appeal to this court on three grounds. Permission to appeal was granted by Leggatt LJ on 25 March 2020 on one issue, which was identified by Leggatt LJ as follows:

"I consider that there is arguably a tension between the lines of authority reflected in *Jagjivan* at [40(vi)] and in *Bawa Garba*, which raises an important point of principle and justifies consideration by the Court of Appeal of the following issues:

(1) Whether the judge failed to have regard to the line of authority which indicates that cases of sexual misconduct fall within a category where an appeal court can more readily assess whether a particular sanction is appropriate and thus give less weight to the expertise of the tribunal; and

(2) If so, whether the judge should have concluded that the tribunal's assessment that erasure was the only proportionate sanction in this case was wrong."

4. On 6 May 2020 Rafferty LJ ordered the joinder of the appeals.

5. The respondent in each appeal is the GMC, which is the statutory regulator for the medical profession, established under section 1 of the 1983 Act.

The law and practice

6. The Medical Act 1983:

"(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”

7. Under section 1(3)(g) and (h) of the 1983 Act, the GMC has amongst its committees the Medical Practitioners Tribunal Service (“MPTS”) and the MPT. Where an allegation is made against a registered medical practitioner under section 35C of the 1983 Act, the MPTS “must arrange” for the MPT to consider the allegation. The MPT's investigation proceeds in three stages. Stage one, the MPT makes findings as to which of the factual allegations has been proved; stage two, the MPT determines, on the basis of the proven allegations, whether the medical practitioner's fitness to practise is impaired; stage three, the MPT makes a determination as to sanction. Under section 35D, the possible sanctions following a finding of impairment are: i) erasure from the medical register; ii) suspension of registration for a period of up to twelve months; or iii) conditions on continued registration.

8. A right of appeal to challenge the decision of the MPT is granted to medical practitioners. Section 40 provides:

“40. (1) The following decisions are appealable decisions for the purposes of this section, that is to say—

(a) a decision of a Medical Practitioners Tribunal under section 35D above giving a direction for erasure, for suspension or for conditional registration or varying the conditions imposed by a direction for conditional registration;

…

(4) A person in respect of whom an appealable decision falling within subsection (1) has been taken may, before the end of the period of 28 days beginning with the date on which notification of the decision was served under section 35E(1) above, or section 41(10) below, appeal against the decision to the relevant court.

(5) In subsections (4) and (4A) above, “the relevant court”—

…

(c) in the case of any other person, means the High Court of Justice in England and Wales.

…

(7) On an appeal under this section from a Medical Practitioners Tribunal, the court may—

(a) dismiss the appeal;

(b) allow the appeal and quash the direction or variation appealed against;

(c) substitute for the direction or variation appealed against any other direction or variation which could have been given or made by a Medical Practitioners 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 (or, in Scotland, expenses) as it thinks fit.

…

(9) On an appeal under this section from a Medical Practitioners Tribunal, the General Council may appear as respondent; and for the purpose of enabling directions to be given as to the costs of any such appeal the Council shall be deemed to be a party thereto, whether they appear on the hearing of the appeal or not."

9. Provision is also made for the GMC to appeal certain decisions of the MPT upon one ground. Section 40A provides:

"40A. Appeals by General Council

(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;

(ii) a direction for conditional registration, including a direction extending a period of conditional registration;

(iii) a direction varying any of the conditions imposed by a direction for conditional registration;

…

(c) a decision under section 35D—

(i) giving a direction that a suspension be terminated;

(ii) revoking a direction for conditional registration or a condition imposed by such a direction;

(d) a decision not to give a direction under section 35D;

(e) a decision under section 41 giving a direction that a person's name be restored to the register;

…

(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 (or, in Scotland, expenses) as it thinks fit."

10. CPR Rule 52.21:

"(1) Every appeal will be limited to a review of the decision of the lower court unless—

(a) a practice direction makes different provision for a particular category of appeal; or

(b) the court considers that in the circumstances of an individual appeal it would be in the interests of justice to hold a re-hearing.

(3) 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.

(4) The appeal court may draw any inference of fact which it considers justified on the evidence."

11. Practice Direction 52D:

"19.1

(1) This paragraph applies to an appeal to the High Court under –

…

(e) section 40 of the Medical Act 1983;

…

(2) Every appeal to which this paragraph applies must be supported by written evidence and, if the court so orders, oral evidence and will be by way of re-hearing."

The Sanctions Guidance

12. The GMC and MPTS issue Sanctions Guidance for use by the MPT in deciding which sanction to impose. At the time of the MPT's decisions in relation to Dr Sastry and Dr Okpara, the relevant version of the Sanctions Guidance came into force on 6 February 2018 ("the Guidance").

13. The Guidance states that the main reason for imposing sanctions is to protect the public. This is described as the "overarching objective" which includes to: a) protect and promote the health, safety and wellbeing of the public; b) promote and maintain public confidence in the medical profession; c) promote and maintain proper professional standards and conduct for the members of the profession. It reflects the terms of the statutory objective of the GMC set out at sections 1A and 1B of the 1983 Act.

14. Paras 20 and 21 set out the approach to imposing sanctions:

"20. In deciding what sanction, if any, to impose the tribunal should consider the sanctions available, starting with the least restrictive. It should also have regard to the principle of proportionality, weighing the interests of the public against those of the doctor (this will usually be an impact on the doctor's career, eg a short suspension for a doctor in training may significantly disrupt the progression of their career due to the nature of training contracts).

21. However, once the tribunal has determined that a certain sanction is necessary to protect the public (and is therefore the minimum action required to do so), that sanction must be imposed, even where this may lead to difficulties for a doctor. This is necessary to fulfil the statutory overarching objective to protect the public."

15. The Guidance identifies aggravating and mitigating factors (paras 24 to 56). Aggravating factors include lack of insight, previous findings of impairment, circumstances surrounding the event such as abuse of professional position, and certain conduct in a doctor's personal life, including offences of a sexual nature. Mitigating factors include the stage of the doctor's UK medical career, remediation of the concerns, references and testimonials to support the doctor, expressions of regret and apology, and the doctor's insight into concerns. Of note, at para 24, the Guidance states, "The tribunal is less able to take mitigating factors into account when the concern is about patient safety, or is of a more serious nature, than if the concern is about public confidence in the profession."

16. Para 92 considers suspension:

"92. Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession)."

17. Paras 108 and 109 give further guidance on the sanction of erasure:

"108. Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor.

109. Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).

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.

c. Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients (see further guidance below at paragraphs 129–132 regarding failure to provide an acceptable level of treatment or care).

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).

f. Offences of a sexual nature, including involvement in child sex abuse materials (see further guidance below at paragraphs 151 - 159).

g. Offences involving violence.

h. Dishonesty, especially where persistent and/or covered up (see guidance below at paragraphs 120–128).

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).

j. Persistent lack of insight into the seriousness of their actions or the consequences."

18. Paras 148, 149 and 150 consider predatory behaviour and sexual misconduct:

"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.

149. This [i.e. sexual misconduct] encompasses a wide range of conduct from criminal convictions for sexual assault and sexual abuse of children (including child sex abuse materials) to sexual misconduct with patients, colleagues, patients' relatives or others. See further guidance on sex offenders and child sex abuse materials at paragraphs 151–159.

150. Sexual misconduct seriously undermines public trust in the profession. The misconduct is particularly serious where there is an abuse of the special position of trust a doctor occupies, or where a doctor has been required to register as a sex offender. More serious action, such as erasure, is likely to be appropriate in such cases."

Case law

Ghosh v General Medical Council [2001] 1 WLR 1915

19. This was an appeal by the doctor (to the Judicial Committee of the Privy Council ("the Board")) in respect of the decision of the Professional Conduct Committee of the GMC (a predecessor to the MPT) to erase her name from the medical register. At [33] and [34] Lord Millett addressed the issue of the Board's jurisdiction and powers pursuant to section 40 of the 1983 Act as follows:

"33. Practitioners have a statutory right of appeal to the Board under section 40 of the Medical Act 1983 , which does not limit or qualify the right of the appeal or the jurisdiction of the Board in any respect. The Board's jurisdiction is appellate, not supervisory. The appeal is by way of a rehearing in which the Board is fully entitled to substitute its own decision for that of the committee. The fact that the appeal is on paper and that witnesses are not recalled makes it incumbent upon the appellant to demonstrate that some error has occurred in the proceedings before the committee or in its decision, but this is true of most appellate processes.

34. It is true that the Board's powers of intervention may be circumscribed by the circumstances in which they are invoked, particularly in the case of appeals against sentence. But their Lordships wish to emphasise that their powers are not as limited as may be suggested by some of the observations which have been made in the past. In *Evans v General Medical Council (unreported) 19 November 1984* the Board said:

"The principles upon which this Board acts in reviewing sentences passed by the Professional Conduct Committee are well settled. It has been said time and again that a disciplinary committee are the best possible people for weighing the seriousness of professional misconduct, and that the Board will be very slow to interfere with the exercise of the discretion of such a committee… The committee are familiar with the whole gradation of seriousness of the cases of various types which come before them, and are peculiarly well qualified to say at what point on that gradation erasure becomes the appropriate sentence. This Board does not have that advantage nor can it have the same capacity for judging what measures are from time to time required for the purpose of maintaining professional standards."

For these reasons the Board will accord an appropriate measure of respect to the judgment of the committee whether the practitioner's failings amount to serious professional misconduct and on the measures necessary to maintain professional standards and provide adequate protection to the public. But the Board will not defer to the committee's judgment more than is warranted by the circumstances. The council conceded, and their Lordships accept, that it is open to them to consider all the matters raised by Dr Ghosh in her appeal; to decide whether the sanction of erasure was appropriate and necessary in the public interest or was excessive and disproportionate; and in the latter event either to substitute some other penalty or to remit the case to the committee for reconsideration."

Preiss v General Dental Council [2001] 1 WLR 1926

20. An appeal by a dentist pursuant to section 29 of the Dentists Act 1984 was by way of a rehearing. The Board addressed the issues of whether there had been a fair hearing before an

independent tribunal and whether the facts as found amounted to serious professional misconduct and warranted suspension. At [27] Lord Cooke stated:

"In *Ghosh v General Medical Council* [2001] 1 WLR 1915, 1923f-h the Board has recently emphasised that the powers are not as limited as may be suggested by some of the observations which have been made in the past. … This does not mean that respect will not be accorded to the opinion of a professional tribunal on technical matters. But, as indicated in Ghosh , the appropriate degree of deference will depend on the circumstances. In the instant case the weaknesses already identified in the dental disciplinary structure and the failure to comply with rule 11(2) go to diminish any reluctance that the Board might otherwise have in differing from the PCC. Against this background the Board now gives its own opinion on the case."

21. At [28] and [31] the Board considered the issue of serious professional misconduct and sanction and found that the decision to suspend the appellant from practice was neither necessary nor just.

22. Jurisdiction to hear appeals under the 1983 Act was transferred to the High Court on 1 April 2003. Subsequent decisions in section 40 appeals, hereinafter referred to, endorsed the approach of *Ghosh* and *Preiss* which were determined under the previous regime.

Meadow v General Medical Council [2007] QB 462

23. Pursuant to section 40 of the 1983 Act, Professor Meadow had successfully appealed a finding of serious professional misconduct and the order of erasure of his name from the medical register. The GMC appealed the determination of the High Court. In dismissing the appeal, at [120] Auld LJ noted the decisions in *Ghosh* and *Preiss* and the distancing of the court from "earlier expressions of deference to specialist regulatory and disciplinary bodies." He stated:

"The change of approach, which, it seems to me, is more of emphasis than clear definition, is that, though such disciplinary bodies are in general better able than the courts to assess evidence of professional practice in their respective fields, the courts should still accord them an appropriate measure of respect: see, e g, *Council for the Regulation of Health Care Professionals v General Medical Council and Ruscillo* [2005] 1 WLR 717. …

However, the courts should be ready in appropriate cases and, if necessary, to substitute their own view for that of disciplinary bodies."

24. At [197] Auld LJ summarised the factors to which the court should have regard in a section 40 test as follows:

"197. On an appeal from a determination by the GMC, acting formerly and in this case through the FPP, or now under the new statutory regime, whatever label is given to the section 40 test, it is plain from the authorities that the court must have in mind and give such weight as is appropriate in the circumstances to the following factors. (i) The body from whom the appeal lies is a specialist tribunal whose understanding of what the medical profession expects of its

members in matters of medical practice deserve respect. (ii) The tribunal had the benefit, which the court normally does not, of hearing and seeing the witnesses on both sides. (iii) The questions of primary and secondary fact and the overall value judgment to be made by the tribunal, especially the last, are akin to jury questions to which there may reasonably be different answers."

Raschid and Fatnani v General Medical Council [2007] 1 WLR 1460

25. These were two joined appeals by two doctors against sanction. In *Raschid* Collins J had substituted a suspension of one month for a suspension of twelve months and in *Fatnani* had substituted a suspension of twelve months for erasure. The appeals of the GMC to the Court of Appeal were allowed. In a judgment with which Chadwick LJ and Sir Peter Gibson agreed, Laws LJ at [14] identified the question to be addressed by the court, namely "what is the proper reach of the High Court's discretion on an appeal under section 40 of the Medical Act 1983 to vary a sentence imposed on a doctor by the panel under section 36 or now section 35D?" At [15] the judge noted that section 40(7) in its original form, which conferred on the Privy Council the jurisdiction to hear appeals from the Professional Conduct Committee of the GMC, was necessarily couched in terms of a power to make recommendations to Her Majesty's Council, but the substantive appeal provisions were in effect the same as those provided for in the relevant and current version of section 40(7). He continued at [16]:

"16. In these circumstances it seems to me to be clear that we should follow the guidance given in the cases decided before the change in the appeal system effected on 1 April 2003. First, the Privy Council is of course a source of high authority; but, secondly, we are in any event considering an effectively identical statutory regime. As it seems to me there are in particular two strands in the relevant learning before 1 April 2003. One differentiates the function of the panel or committee in imposing sanctions from that of a court imposing retributive punishment. The other emphasises the special expertise of the panel or committee to make the required judgment."

26. At [19] and [20] Laws LJ stated:

"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. That I think is reflected in the last citation I need give. It consists in Lord Millett's observations in *Ghosh v General Medical Council* [2001] 1 WLR 1915 , 1923, para 34:

'the Board will afford an appropriate measure of respect to the judgment of the committee whether the practitioner's failings amount to serious professional misconduct and on the measures necessary to maintain professional standards and provide adequate protection to the public. But the Board will not defer to the committee's judgment more than is warranted by the circumstances.'

20. These strands in the learning then, as it seems to me, constitute the essential approach to be applied by the High Court on a section 40 appeal. The approach they commend does not emasculate the High Court's role in section 40 appeals: the High Court will correct material errors of fact and of course of law and it will exercise a judgment, though distinctly and firmly a

secondary judgment, as to the application of the principles to the facts of the case."

27. At [21] Laws LJ described the exercise undertaken by Collins J as coming "very close, if it did not constitute, an exercise in resentencing".

Cheatle v General Medical Council [2009] EWHC 645 (Admin)

28. This was a clinical case in which the Fitness to Practise Panel had ordered the suspension of a surgeon. He appealed to the High Court pursuant to section 40 of the 1983 Act. Cranston J at [15] considered the approaches in *Meadow* and *Raschid* and noted the relevance of the composition of the Tribunal as to the degree of deference to be shown by the court:

"15. In my view the approaches in *Meadow* and *Raschid* are readily reconcilable. The test on appeal is whether the decision of the Fitness to Practise Panel can be said to be wrong. That to my mind follows because this is an appeal by way of rehearing, not review. In any event grave issues are at stake and it is not sufficient for intervention to turn on the more confined grounds of public law review such as irrationality. However, in considering whether the decision of a Fitness to Practise Panel is wrong the focus must be calibrated to the matters under consideration. With professional disciplinary tribunals issues of professional judgment may be at the heart of the case. *Raschid* was an appeal on sanction and in my view professional judgment is especially important in that type of case. As to findings of fact, however, I cannot see any difference from the court's role in this as compared with other appellate contexts. As with any appellate body there will be reluctance to characterise findings of facts as wrong. That follows because findings of fact may turn on the credibility or reliability of a witness, an assessment of which may be derived from his or her demeanour and from the subtleties of expression which are only evident to someone at the hearing. Decisions on fitness to practise, such as assessing the seriousness of any misconduct, may turn on an exercise of professional judgment. In this regard respect must be accorded to a professional disciplinary tribunal like a Fitness to Practise Panel. However, the degree of deference will depend on the circumstances. One factor may be the composition of the tribunal. In the present case the Panel had three lay members and two medical members. For what I know the decision the Panel reached might have been by majority, with the three lay members voting one way, the two medical members the other. It may be that some at least of the lay members sit on Fitness to Practise Panels regularly and have imbibed professional standards. However, I agree with the submission for the appellant in this case that I cannot be completely blind to the current composition of Fitness to Practise Panels."

Khan v General Pharmaceutical Council [2017] 1 WLR 169

29. This was an appeal before the Supreme Court by Mr Khan against the decision to remove him from the medical register of pharmacists following a finding by the Fitness to Practise Committee of the General Pharmaceutical Council that he was unfit to practise by reason of his criminal convictions for domestic violence. The Committee was exercising powers under article 54(2) of the Pharmacy Order 2010, however, the GMC intervened upon the basis that the powers of the Fitness to Practise Committee of the General Pharmaceutical Council under the Pharmacy Order 2010 were similar to those of the MPT under the 1983 Act.

30. At [36] Lord Wilson (with whose judgment the other Justices agreed) reiterated the test in

Ghosh as follows:

“36. An appellate court must approach a challenge to the sanction imposed by a professional disciplinary committee with diffidence. In a case such as the present, the committee's concern is for the damage already done or likely to be done to the reputation of the profession and it is best qualified to judge the measures required to address it: *Marinovich v General Medical Council* [2002] UKPC 36 at [28]. Mr Khan is, however, entitled to point out that (a) the exercise of appellate powers to quash a committee's direction or to substitute a different direction is somewhat less inhibited than previously: *Ghosh v General Medical Council* [2001] 1 WLR 1915, para 34; (b) on an appeal against the sanction of removal, the question is whether it 'was appropriate and necessary in the public interest or was excessive and disproportionate': the *Ghosh* case, again para 34; and (c) a court can more readily depart from the committee's assessment of the effect on public confidence of misconduct which does not relate to professional performance than in a case in which the misconduct relates to it: *Dad v General Dental Council* [2000] 1 WLR 1538, 1542–1543.”

31. Applying this test – whether the sanction was appropriate and necessary in the public interest or was excessive and disproportionate – the Supreme Court held that removing Mr Khan from the medical register was “harsh”, “unnecessary” and “disproportionate” ([40]). A sanction of suspension was substituted ([41]).

32. The 1983 Act was amended to include section 40A which was inserted by article 17 of The General Medical Council (Fitness to Practise and Over-arching Objective) and the Professional Standards Authority for Health and Social Care (References to Court) Order 2015 to provide for appeals by the GMC. The amendment was effective from 31 December 2015.

General Medical Council v Jagjivan and Another [2017] 1 WLR 4438

33. The Divisional Court (Sharp LJ, Dingemans J (as he then was)) heard the first appeal by the GMC pursuant to section 40A of the 1983 Act. The facts concerned a cardiology registrar who, in a consultation with a 27-year-old female patient, made inappropriate suggestions as to how her heart rate could be raised. The MPT did not find proved the allegation that the doctor's actions were sexually motivated. It did find misconduct in relation to the matters proved but did not find impairment of the doctor's fitness to practise. The GMC appealed the issue of impairment. At [39] and [40] Sharp LJ addressed the issue of the correct approach to section 40A appeals:

“The correct approach to appeals under section 40A

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 General Medical Council 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 accord 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."

Bawa-Garba v General Medical Council [2019] 1 WLR 1929

34. The medical practitioner, at the relevant time a junior doctor specialising in paediatrics, was convicted of gross negligence manslaughter following the death of a child in her care in

hospital. She was sentenced to two years' imprisonment, suspended for two years. Subsequently, the MPT pursuant to section 35D of the 1983 Act found that the doctor's fitness to practise was impaired and imposed a sanction of twelve months' immediate suspension. In so finding, the MPT had regard to the doctor's personal mitigation and to the fact that around the time of the child's death there had been systemic failures on the part of the hospital trust. The GMC appealed under section 40A of the 1983 Act against the MPT's sanction decision on the ground that it should have ordered that the doctor's name be erased from the medical register. The Divisional Court allowed the appeal, that determination was appealed by the doctor, thus a second appeal. The Court of Appeal, Lord Burnett of Maldon CJ, Sir Terrence Etherton MR, Rafferty LJ, allowed the doctor's appeal and restored the decision of the MPT.

35. At [2] of the judgment of the court, the central issue in the appeal was identified as being "the proper approach to the conviction of a medical practitioner for gross negligence manslaughter in the context of fitness to practise sanctions under the Medical Act 1983 … where the registrant does not present a continuing risk to patients."

36. At [60] the court noted that the GMC's appeal pursuant to section 40A was by way of review and not rehearing. It noted that "in that respect, it differs from an appeal pursuant to section 40". The court noted that CPR Rule 19.1(1)(e) and (2) and PD 52D expressly state that appeals under section 40 are to be conducted by way of a rehearing, whereas appeals pursuant to section 40A are governed by CPR Rule 52.21(1) which provides that, subject to certain exceptions, appeals are limited to a review of the decision under appeal. The court observed that:

"That technical difference may not be significant. Whether the appeal from the MPT is pursuant to section 40 or section 40A, the task of the High Court is to determine whether the decision of the MPT is 'wrong'. In either case, the appeal court should, as a matter of practice, accord to the MPT the same respect: *Meadow v General Medical Council* [2007] QB 462, paras 126–128."

37. At [61] the court observed that the decision of the MPT that suspension rather than erasure was an appropriate sanction for the failings of the doctor was:

"61. … 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: *Biogen Inc v Medeva plc* [1997] RPC 1, 45; *Pharmacia Corp v Merck & Co Inc* [2002] RPC 41, para 153; *Todd v Adams and Chope (trading as Trelawney Fishing Co) (The Maragetha Maria)* [2002] 2 All ER (Comm) 97, para 129; *Datec Electronic Holdings Ltd v United Parcels Service Ltd* [2007] 1 WLR 1325, para 46. 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."

At [62] the court cited Clarke LJ in *Assicurazioni Generali SpA v Arab Insurance Group (Practice Note)* [2003] 1 WLR 577 as follows:

"'15. In appeals against conclusions of primary fact the approach of an appellate court will depend upon the weight to be attached to the findings of the judge and that weight will depend upon the extent to which, as the trial judge, the judge has an advantage over the appellate court; the greater that advantage the more reluctant the appellate court should be to interfere.

As I see it, that was the approach of the Court of Appeal on a "rehearing" under the Rules of the Supreme Court and should be its approach on a "review" under the Civil Procedure Rules 1998.

16. Some conclusions of fact are, however, not conclusions of primary fact of the kind to which I have just referred. They involve an assessment of a number of different factors which have to be weighed against each other. This is sometimes called an evaluation of the facts and is often a matter of degree upon which different judges can legitimately differ. Such cases may be closely analogous to the exercise of a discretion and, in my opinion, appellate courts should approach them in a similar way.'"

In respect of the caution of appellate courts to interfere with conclusions of fact which involve an assessment of a number of different factors, at [67] it was stated:

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: the *Biogen* case [1997] RPC 1, para 45; *Todd v Adams and Chope* [2002] 2 All ER (Comm) 97, para 129; *Designers Guild Ltd v Russell Williams (Textiles) Ltd (trading as Washington DC)* [2000] 1 WLR 2416, para 129; *Buchanan v Alba Diagnostics Ltd* [2004] RPC 34, para 31. As the authorities show, the addition of 'plainly' or 'clearly' to the word 'wrong' adds nothing in this context.".

38. The court noted at [85] that: "What is an appropriate and proportionate sanction always depends on the facts of the particular case in question."

39. The exercise which was carried out by the court was to identify and evaluate the findings of the Tribunal which, in allowing the appeal, it restored.

Background facts

Dr Sastry

40. Dr Sastry is registered to practise as a doctor in the UK and India. The GMC proceedings arose out of his treatment of a female, Patient A, whilst working as a consultant medical oncologist at the Kokilaben Dhirubhai Ambani Hospital in Mumbai.

41. Patient A suffered from lymphoma and came under the care of Dr Sastry following a relapse in October 2013. Dr Sastry recommended R-ICE salvage chemotherapy followed by an autologous cell transplantation, which involves the harvesting and freezing of the patient's own blood stem cells prior to chemotherapy, following which they are thawed and reinfused.

42. The chemotherapy took place between December 2013 and February 2014. This was followed by cell harvesting between March and April 2014. Between 17 and 22 June 2014 high dose chemotherapy with BEAM was administered. On 24 June 2014 the previously collected cells were reinfused.

43. The MPT noted in respect of the high dose chemotherapy that the "high intensity treatment by its nature destroys the patient's own bone marrow and survival is dependent on successful regeneration of the bone marrow from the patient's own stem cells that are infused after the chemotherapy." To ensure that the reinfusion is effective, the harvested cells should contain a sufficiently high proportion of CD34 positive cells; the CD34 count is used as a clinical marker for the presence of stem cells.

44. Following the cell transplant, Patient A developed a series of complications. Her bone marrow and cell production failed to recover in response to the transplantation. On 10 July 2014 Patient A died.

45. Shortly before her death, Patient A's family had requested that Dr Sastry took no further part in her care. In December 2014, Dr Sastry was referred to the GMC by Patient A's son, Witness B, who claimed that his mother had died as a result of Dr Sastry's negligent treatment.

46. Before the MPT, the GMC alleged that Dr Sastry's fitness to practise was impaired by reason of misconduct. It was alleged that:

"That being registered under the Medical Act 1983 (as amended):

1. On 8 April 2014 your collection of stem cells from Patient A was inappropriate in that the bone marrow would not have had sufficient time to recover from the first stem cell collection on 18 March 2014.

2. Between April 2014 and June 2014 your recommendation that Patient A undergo high dose chemotherapy with BEAM and autologous stem cell transplantation was inappropriate in that:

a. Patient A had failed to mobilise an adequate number of CD34 positive cells; and/or

b. you did not know the number of CD34 positive cells which Patient A had mobilised.

3. Between 16 and 25 June 2014 you proceeded to high dose chemotherapy with BEAM and autologous stem cell transplantation on Patient A which was inappropriate in that:

a. an adequate number of CD34 positive cells/kg had not been collected;

and/or

b. you did not know the number of CD34 positive cells/kg which had been collected."

47. At the hearing, evidence was given by Witness B, Dr Sastry and experts on behalf of the GMC and Dr Sastry. Having considered the evidence, the MPT found that allegations 1, 2a and 3a had been proved. As to allegation 2, the MPT determined that when Dr Sastry recommended high dose chemotherapy with BEAM there was no uncertainty as to the CD34 positive cell count, he knew it to be 0.05%. This figure was very significantly below the contemporaneous European and American guidelines. By reason of this determination, allegations 2b and 3b were not proved.

Evidence/misconduct

48. It was at an appointment with the family on 13 June 2014 that Dr Sastry recommended high dose chemotherapy with BEAM. By this time, Dr Sastry had seen a laboratory report which recorded the CD34 result of the third harvest on 8 April 2014 as 0.05%. Dr Sastry's evidence was that the laboratory technician had told him by telephone that the CD34 result was 0.5%. His evidence was that he had visited the laboratory between 13 and 16 June 2014 and there saw an entry in the laboratory register which stated that the result was 0.5%. Dr Sastry said that given this observed discrepancy, he relied on the mononuclear cell count instead of the CD34 count. Dr Sastry's evidence was not accepted by the MPT. It found that there was no information available to the doctor which would call into question the CD34 count of 0.05% recorded in the laboratory report. It followed, and they so found, that at the time Dr Sastry proceeded to high dose chemotherapy with BEAM he knew the CD34 count was 0.05%.

49. In answer to questions from the MPT Dr Sastry acknowledged the importance of the result, he said that had he known the result was 0.05% he would have attempted a fourth harvest. When asked what the benefit to the patient would be of such an attempt, Dr Sastry was evasive. The MPT concluded that Dr Sastry was not only "fully aware" of the low CD34 cell count, he was also aware of its significance for Patient A. He knew that Patient A had failed to mobilise an adequate number of CD34 cells but nonetheless proceeded to administer the high dose chemotherapy with BEAM.

50. In a written witness statement, Witness B said:

"Before the admission in June 2014 [Dr Sastry] simply took the day to day details i.e. what would be done on each day with regards to the administration of high dose chemotherapy and re-injection of harvested cells as well as where my mother would be staying throughout the hospitalisation. Going ahead with the cell transplant in a case of massively less than sufficient CD34 cells was never ever (during the entire period between February 2014 and June 2014) mentioned or discussed with me or my father or anyone for that matter. If it has been then we would never have gone ahead with this procedure."

51. This evidence was accepted by the MPT who found that Dr Sastry failed to communicate Patient A's low CD34 count and its implications to Patient A and thus did not obtain fully informed consent to his treatment plan.

52. Relying upon the proven facts contained in the charge the MPT determined that Dr Sastry's conduct amounted to misconduct.

Impairment

53. The MPT accepted the view of the joint experts that Dr Sastry did not have the necessary level of training sufficient to enable him to manage patients who were to undergo autologous stem cell transplantation. It determined that his misconduct was potentially remediable. The MPT thereafter considered whether the doctor's misconduct had in fact been remediated and stated:

“27. The Tribunal went on to consider if your misconduct had been remediated. It had very serious concerns about your attitude regarding the treatment you provided to Patient A. It bore in mind that you have not demonstrated any recognition regarding the concerns of this Tribunal or acceptance that you did anything wrong in your treatment of Patient A. It determined that this demonstrates very little insight into your failings.

28. Furthermore, the Tribunal considered that you had demonstrated knowledge during these proceedings in that you knew it to be inappropriate to proceed with autologus stem cell transplantation with a CD34 count lower than 0.75 x 106 CD34 cells/kg. Given this position and that you recommended and proceeded with an autologus stem cell transplantation with a CD34 cell count of 0.47 x 106 cells per/kg, the Tribunal determined that this further demonstrates your lack of insight into your failings in this case.

29. The Tribunal considered your failure to fully inform Patient A of the importance of the CD34 count, the implications that went with this failure and therefore a failure to obtain fully informed consent for your treatment plan. It determined that these factors and your failings in the management of Patient A's treatment demonstrates a lack of insight. The Tribunal determined that during this hearing you repeatedly sought to mislead it. It determined that this is a further indication that your insight is poorly developed. Whist the Tribunal acknowledged your supplementary statement and CPD undertaken, it was not satisfied that this went far enough to demonstrate insight into your actions or that you had addressed any of the concerns before this Tribunal. For these reasons the Tribunal was not persuaded that you have remediated your misconduct.”

Sanction

54. The MPT took account of paras 92, 108 and 109 of the Sanctions Guidance issued by the GMC and the MPTS. It identified the following aggravating and mitigating factors in respect of Dr Sastry:

Mitigating factors:

- No previous or subsequent regulatory findings in the UK;
- Dr Sastry had been practising at an acceptable level since these events;
- There was no MDT structure in Kokilaben Dhirubhai Ambani Hospital, as Dr Sastry would

have been used to in the UK. Whilst the Tribunal considered this in mitigation, it noted that Dr Sastry had seen a documented second opinion;

- Palliative care in India is less well developed than in the UK;

- Dr Sastry provided evidence of some non-targeted Continuing Professional Development; and

- Positive testimonials from recent colleagues.

Aggravating factors:

- Dr Sastry's actions left Patient A with no realistic chance of survival;

- He was practising in an area outside his specific expertise;

- Dr Sastry made no expression of remorse, regret or apology;

- Whilst the Tribunal accepted that denial is not an aggravating factor, it found that Dr Sastry had attempted repeatedly to mislead it;

- Dr Sastry was not open and honest in his evidence to the Tribunal;

- He demonstrated a complete lack of insight into his failings and their consequences.

55. The MPT concluded that a sanction of suspension would not satisfy the overarching objective and would be neither appropriate nor proportionate. Dr Sastry had placed Patient A at "high risk of serious harm" and throughout the proceedings had demonstrated "a persistent lack of insight" into the consequences of his misconduct for Patient A, her family, the public and the medical profession. The MPT determined that Dr Sastry's misconduct was "fundamentally incompatible with continued registration" and erasing his name from the medical register "would be the only proportionate sanction to impose in order to serve the public interest, maintain public confidence in the medical profession and send a message to the medical profession that this behaviour is unacceptable".

Dr Okpara

56. Dr Okpara qualified in 1996 with an MB BS from the University of Nigeria. Between 2014 and 2016, Dr Okpara worked on three occasions as a locum registrar in the Accident and Emergency Department at the University Hospital of Wales ("UHW") in Cardiff: (i) 19 April 2014 to 16 May 2015; (ii) 2 to 12 December 2015; (iii) 4 May 2016 to 9 August 2016.

57. Ms A was a staff nurse at UHW.

58. In the proceedings before the MPT, the GMC made seven allegations of sexual misconduct. The MPT found that six were proved in full and one was proved in part. The proven allegations were as follows:

i) Allegation 1: During the periods when Dr Okpara worked at UHW, he told Ms A that he liked her bottom, or was obsessed with her bottom, or words to that effect. He pulled suggestive faces at Ms A, touched her bottom with his hands, tried to link his legs with hers whilst sitting next to her at a desk, stood closer to her than was necessary and made unnecessary physical contact ("the touching incidents").

ii) Allegation 2: On an occasion prior to 16 May 2015, Dr Okpara invited Ms A out to "drink champagne" and then gave her his telephone number ("the drinks invitation"). Shortly after the drinks invitation, Dr Okpara led Ms A into a relatives' room in the hospital having asked to speak confidentially to her about a patient. That was a pretence. He then shut the door, stood in front of it, pressed his hand against the door, told Ms A that he wanted a hug, or words to that effect, ignored Ms A's comments that she felt threatened and said "if you give me a hug I'll let you out", or words to that effect ("the incident in the relatives' room").

iii) Allegation 3: On an occasion prior to 16 May 2015, whilst Ms A was in the process of taking blood from a patient, Dr Okpara walked in and drew the curtain around the patient's bed, stood behind Ms A, and remained standing with his groin touching Ms A's bottom ("the blood sample incident").

iv) Allegation 4: Dr Okpara offered to buy Ms A underwear. Ms A was said to have "laughed it off" by "walking away" and making a flippant comment ("the underwear incident").

v) Allegation 5: During a night shift between 10 and 11 June 2016, Dr Okpara sent a message to Ms A stating "thanks gorgeous" following her acceptance of his invitation to become friends on Facebook. He then followed her into a sluice room. He stood behind her, placed his arms around Ms A's waist trapping her arms by her sides, and placed his groin against her bottom, and then placed his one hand down the waist of Ms A' s trousers and touched the right side of her bottom with the cup of his hand and commented on her underwear. He smelled her neck, made groaning noises and ignored her request for him to desist. He said, "please just a little longer" and "it's ok you just have this effect on me", or words to that effect ("the sluice room incident").

vi) Allegation 6: During a night shift at 3am on 8 August 2016, when Ms A was eating her meal in the staff room, Dr Okpara came in and stood behind her and placed his hand on her shoulder and his groin against the back of her torso. He ignored her request to stop, and said, "Why? I'm just standing here. When you like someone it's hard not to be this close", or words to that effect ("the staff room incident").

59. A seventh, overarching allegation was that Dr Okpara's conduct was sexually motivated. This was found to be proved.

60. Before the MPT, colleagues in their evidence described Ms A as an honest,

well-respected professional who came across as “timid”, “religious with strong values”, “prudish” and “a quiet and genuinely lovely girl”. The MPT found these descriptions to be consistent with the manner in which Ms A gave her oral evidence. It found her to be a credible witness.

61. Dr Okpara denied all the allegations. He made counter-allegations which included that Ms A had behaved flirtatiously towards him from their first meeting; it was Ms A who asked Dr Okpara to “invite” her as a “friend” on Facebook; for no obvious clinical reason, Ms A sought help from Dr Okpara in taking blood from a patient; Ms A wanted him to buy her an expensive handbag, which he resisted; it was Ms A who was constantly making physical contact with Dr Okpara.

62. The MPT found that Dr Okpara's credibility was undermined by a combination of his blanket denials, evasion even in respect of simple facts and his counter-allegations.

Misconduct, impairment and sanction

63. Dr Okpara, through his counsel, accepted that the facts as found proved did amount to misconduct and impairment of his fitness to practise.

64. The MPT acknowledged the mitigating factors that Dr Okpara was an excellent doctor of previous good character with a 22-year unblemished career. It also acknowledged that the public interest is served by the retention of clinically competent doctors.

65. The MPT accepted that there may have been difficult circumstances in Dr Okpara's private life but determined that “a prolonged course of persistent, escalating and targeted predatory behaviour directed to a work colleague, on shift, in a clinical setting could not be excused, or even mitigated, by personal circumstances.”

66. Positive testimonials submitted on Dr Okpara's behalf were afforded little weight by the MPT because of the unsatisfactory nature of their presentation.

67. The MPT noted that since the allegations were made, Dr Okpara had been practising under conditions imposed in an interim order and, in such circumstances, the MPT would expect him to adhere to any conditions intended to guard against repetition.

68. The MPT found that Dr Okpara's “blanket denials, and series of counter claims against Ms A” made in the proceedings “demonstrated a complete lack of insight.”

69. As to aggravating factors, the MPT described Dr Okpara's behaviour as “persistent and predatory”. It had taken place in a “hierarchical institutional context” where Dr Okpara, a doctor of 22 years' standing, was much more senior than Ms A, a nurse at the start of her career.

70. Ms A had initially reacted in the way that she did because she was timid and did not want to “ruffle any feathers” or “cause a public scene”. The MPT found that it was her timid nature which led Dr Okpara to target her. Ms A had asked Dr Okpara to “stop and desist” on a

number of occasions, but he had “ignored her requests and continued in his behaviour for his own sexually motivated self-interest.”

71. The sluice room incident had been “aggressive, threatening and a gross violation of Ms A”. Dr Okpara had engineered the situation in the relatives' room by using his position of authority, pretending he wanted to talk to Ms A about a patient in confidence.

72. The MPT took account of the fact that the incidents took place in a “demanding clinical setting” where there was “constant pressure to meet the needs of patients”. The blood sample incident took place while Ms A was performing a medical procedure on a patient. Meanwhile, Dr Okpara behaved in a sexually motivated way and showed a lack of responsibility towards clinical duties and patient care. This was found to be a further aggravating factor.

73. The MPT accepted that, should a patient learn of Dr Okpara's behaviour towards Ms A, it would have an impact on the patient's confidence in allowing Dr Okpara to undertake a physical examination upon them.

74. The MPT noted that there was no evidence of any remediation, reflection, or expressions of regret or remorse on the part of Dr Okpara.

75. The MPT took account of paras 92, 109, and 148 to 150 of the Sanctions Guidance and concluded that Dr Okpara's misconduct was “sufficiently serious and extensive as to be fundamentally incompatible with continued registration”. Erasing Dr Okpara from the medical register would be the only proportionate sanction.

The approach of the High Court – Dr Sastry

76. In considering the proportionality of sanction, May J referred to [39] and [40] of *Jagjivan*, and [61], [63] to [67] of *Bawa-Garba*. At [65] she stated that she was “satisfied that there has been no error of approach by the MPT in this case. … the MPT considered a number of features in detail, including the fact that it was 'one episode of misconduct, relating to one patient' and that Dr Sastry was not providing similar treatment in the UK.” At [66] and [67] she continued:

“66. The observations in *Bawa-Garba*, set out above, are of particular relevance here. Where it comes to an evaluation of clinical behaviour and the treatment of patients, particularly in connection with a sophisticated procedure like autologous cell transfer, a court is totally ill-equipped to arrive at a view of what public protection and reputation of the profession requires. It would be wrong to substitute its own untutored view for that of a panel drawn from the profession in question.

67. The MPT here was not obliged to apply the sanction sought by the GMC. For the reasons which it gave, it came to the view that proper protection of the public and the profession required the more serious sanction. I can see no proper reason for interfering with that decision.”

Dr Okpara

77. At [42] to [44] Julian Knowles J stated:

"42. The proper approach of an appeal court to the sanctions determination of a Tribunal was recently discussed in *Bawa-Garba v General Medical Council* [2018] EWCA Civ 1879, [60]-[67]. The Court of Appeal (Lord Burnett of Maldon CJ, Sir Terence Etherton MR and Rafferty LJ) said that a Tribunal's sanctions determination (in that case, that suspension rather than erasure was an appropriate sanction for the failings of Dr Bawa-Garba which had led to her conviction for gross negligence manslaughter) is 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: *Biogen Inc v Medeva Plc* [1997] RPC 1, 45; *Pharmacia Corp v Merck & Co Inc* [2002] RPC 41, [153]; *Todd v Adams (t/a Trelawney Fishing Co) (The Maragetha Maria)* [2002] 2 Lloyd's Rep 293, [129]; *Datec Electronics Holdings Ltd v United Parcels Service Ltd* [2007] 1 WLR 1325, [46].

43. 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. At [64] the Court of Appeal quoted Lord Clarke in *Re B (A Child) (Care Proceedings)* [2013] 1 WLR 1911, [137]:

'… 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".'

44. At [67] of *Bawa-Garba* the Court said that this general caution applies with particular force in the case of a specialist adjudicative body, such as the Medical Practitioners Tribunal, which (depending on the matter in issue) usually has greater experience in the field in which it operates than the courts: see *Smech Properties Ltd v Runnymede Borough Council* [2016] EWCA Civ 42, [30]; *Khan v General Pharmaceutical Council* [2017] 1 WLR 169 at [36]; *Meadow* at [197]; and *Raschid v General Medical Council* [2007] 1 WLR 1460, [18]-[20]. It therefore said that an appeal court should only interfere with such an evaluative decision on sanction if (a) there was an error of principle in carrying out the evaluation, or (b) 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 (citations omitted)."

78. In considering whether the MPT was wrong to have ordered erasure of the doctor's name from the medical register, the judge at [100] stated:

"The starting point is, as I have said, that the Tribunal is the body best equipped to determine the sanction to be imposed. The assessment of the seriousness of the misconduct is essentially a matter for the Tribunal in the light of its experience. It is the body best qualified to judge what measures are required to maintain the standards and reputation of the profession: *Bawa-Garba*, supra, [67] and [94]. I remind myself that I can only intervene if (a) there was an

error of principle in carrying out the evaluation, or (b) 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."

79. The judge considered the Guidance and the nature of the conduct found proved against Dr Okpara. At [108] he stated that the conduct could "properly be described as sexually predatory behaviour towards Ms A over a sustained period of two years. The Tribunal so characterised it … it was right to do so." The judge observed that some of Dr Okpara's conduct was capable of amounting to the criminal offence of sexual assault. At [109] the judge addressed the MPT's decision and the approach of the appellate court as follows:

"In its decision the Tribunal said that Dr Okpara's conduct fell within [148], [149] and [150] of the Sanctions Guidance. In my judgment it was right to do so. Therefore, erasure was open to the Tribunal as a sanction which was likely to be appropriate for Dr Okpara's misconduct. The question for me is whether the Tribunal made an error of principle in carrying out its evaluation that erasure was in fact the appropriate sanction, or for any other reason, that that 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."

80. At [111] the judge observed:

"The Tribunal said that Dr Okpara's misconduct was fundamentally incompatible with continued registration, and for that reason suspension was not appropriate. In my judgment it was not wrong (in the sense I have explained) so to conclude, whether or not Dr Okpara had acknowledged fault (which, in my judgment, he had not). As a specialist Tribunal, it was entitled to conclude that sustained sexually predatory behaviour by Dr Okpara towards a colleague whilst on duty, once in the presence of a patient, and once following deception that he wanted to discuss a patient, was fundamentally incompatible with his continued work as a doctor."

81. At [112] and [113] the judge addressed the issue of the testimonials which the doctor contended had been wrongly discounted and found that the MPT was entitled to attach little weight to them. He concluded by stating that "In any event … given the very serious nature of Dr Okpara's misconduct, the testimonials were not capable of requiring the Tribunal to suspend Dr Okpara rather than ordering erasure."

Grounds of appeal

Dr Sastry

82. On behalf of Dr Sastry it is contended that May J erred in law as regards the correct approach to be taken by an appellate court when considering an appeal against sanction. The judge's approach effectively confined itself to a judicial review-type review of the decision on sanction taken by the MPT. This was despite:

i) CPR Rule 52.21(1A) and PD 52D para 19.1(1)(e) and (2) expressly providing that the appeal be by way of rehearing and not by way of review; and

ii) Privy Council and Supreme Court authority that the test to be applied is whether the sanction was necessary and appropriate as opposed to excessive and disproportionate. The High Court did not purport to apply that test.

83. It is Dr Sastry's case that the current case law on the role of the court when considering section 40 appeals against sanction is inconsistent. Appeals pursuant to section 40 of the 1983 Act are by way of rehearing not review: *Ghosh*, *Khan* and *Cheatle*. The Court of Appeal in *Bawa-Garba* took a different approach concerning an appeal by the GMC. At [60], the Court of Appeal merged the tests of rehearing and review. It identified a far more restrictive approach than that set out by the court in *Khan*. The approach identified at [67] is akin to a judicial review approach. The authorities of *Ghosh* and *Khan* identify the authoritative position on appeals from the MPT in respect of sanction. Alternatively, if the approach in *Bawa-Garba* is correct, it is limited to appeals by the GMC which are by way of review.

84. The Court of Appeal in *Bawa-Garba* also differed from the approach of a differently constituted Court of Appeal whose decision was handed down on the same day: *General Medical Council v Chandra* [2019] 1 WLR 114. In *Chandra* the court applied a more detailed and interventionist approach to the reasoning of the MPT when deciding to restore the name of Dr Chandra to the medical register. Having decided that the same principle should apply to restoration as applied to sanction ([59], [70]), the court in *Chandra* conducted a critical evaluation of whether sufficient weight had been given by the MPT to aspects of the overarching objective.

85. On the facts of Dr Sastry's case, the scope of deference to be accorded to the decision of the MPT by the court is limited. The appellate court was as well placed as the MPT to consider what is required in terms of promoting public confidence and proper conduct in the medical profession. The one medical member of the MPT was a pathologist, a different area of medicine from that of Dr Sastry.

86. The judge abrogated her responsibilities in holding that the court was ill-equipped to decide what public protection and the reputation of the medical profession required and was wrong to hold that the court could not substitute its own “untutored” view for that of a “panel drawn from the profession in question”. The judge failed to conduct any analysis of what was appropriate and necessary and whether or not the sanction was excessive or disproportionate. She impermissibly deferred to the MPT, stating that “I am satisfied that there has been no error of approach by the MPT” ([65]).

87. Dr Sastry relies on the following in support of the contention that the sanction of erasure was disproportionate and that the appropriate sanction is suspension:

i) it was a single incident of alleged negligence four years earlier, in an otherwise unblemished record;

ii) Dr Sastry was providing care for a seriously ill patient in a jurisdiction that did not have the benefit of support mechanisms for doctors such as multidisciplinary team meetings, national or hospital guidelines and where the alternative of palliative care is less well developed;

iii) in appearing before the MPT, Dr Sastry was in a difficult position due to ongoing proceedings in India where doctors do not have the benefit of the protection of the Compensation Act and where expressions of apology or regret are viewed differently;

iv) at the hearing before the MPT, the GMC had proposed a lesser sanction, namely suspension. In *Arunachalam v General Medical Council* [2018] EWHC 758 at [76], Kerr J, when substituting a sanction of suspension for a sanction of erasure, stated that the stance of the GMC was "strong evidence" of what a reasonable and informed member of the public would think.

Dr Okpara

88. On behalf of Dr Okpara it is submitted that Julian Knowles J erred in law and applied the wrong test in determining whether he could interfere with the MPT's decision. Further, the judge was wrong to hold that the sanction of erasure rather than suspension was appropriate.

89. In contending that the judge wrongly applied the case law and conducted a review rather than a rehearing, counsel on behalf of Dr Okpara made submissions as to the conflicting approach of the court in *Bawa-Garba* which reflected those of Dr Sastry. Further, and separately, it is submitted that the judge failed to give any weight to the fact that Dr Okpara's case is one of sexual misconduct, whereby an appellate court can more readily determine for itself matters of weight at a rehearing and thus attach less weight to the expertise of the Tribunal: *Jagjivan*, *Chandra* and others.

90. In deferring to the expertise of the Tribunal in this appeal, the judge's approach should be contrasted with the approach he has subsequently taken to a sexual misconduct case in another section 40 appeal: *Gupta v General Medical Council* [2020] EWHC 38 (Admin). This was an appeal by a doctor, resulting from the sanction of erasure which followed a conviction for the possession of extreme pornography and prohibited images of children. At [36] the judge referred to the sexual misconduct authorities identified in *Jagjivan* and at [73] acknowledged that sexual misconduct cases may fall into a different category which allows the appellate court to more readily make its own assessment as follows:

"73. Dr Gupta referred to the passage in *Jagjivan*, supra, at [39(vi)], referring to *Southall*, supra, where the Court said that 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 MPT. To the extent that that suggests a different approach, and permits me more readily to make my own assessment, I bound to say I fully agree with the MPT's decision. That is because the crimes Dr Gupta committed are shocking. No amount of mitigation could have produced an outcome which allowed a man who became sexually aroused by the violent genital abuse of distressed women to continue working as an obstetrician, even after a period of suspension. Realistically, erasure was the only appropriate sanction that could have been imposed."

91. Counsel on behalf of Dr Okpara identifies a tension between the sexual misconduct cases referred to in *Jagjivan*, which permit the appellate court to decide issues of weight for itself without deferring to the expertise of the Tribunal, and the approach in *Bawa-Garba*, where the court defers to the expertise of the Tribunal by adopting a restrictive error of principle

approach on appeal, akin to a review rather than a rehearing. It is this tension to which Leggatt LJ was referring when granting permission to appeal.

92. As to sanction, the appropriate sanction was suspension by reason of:

i) the unblemished record of the doctor. The MPT accepted that the public interest was served through the retention of clinically competent doctors, which is relevant to public confidence. The alleged misconduct was not with a patient, it did not relate to the doctor's professional performance;

ii) the appellant did not pose any risk. A witness stated that following the incident she was assured that Ms A felt safe and not at risk;

iii) the appellant accepted fault and responsibility, it was accepted on his behalf that it would be appropriate for the MPT to find misconduct and impairment;

iv) the testimonials pointed away from the risk of repetition.

The GMC

93. The respondent contends that the test to be applied by the appellate court is the same, whether pursuant to section 40 or section 40A of the 1983 Act, and whatever the ground of impairment. The approach is set out in *Jagjivan* and refined in *Bawa-Garba*. The composition of the MPT is irrelevant. If there is a tension, as identified by Leggatt LJ, this court has the opportunity to resolve that tension. There is a clear and unified test guiding all parties and the lower courts. It is clear from *Meadow* that the issue of whether the appellate hearing was a review or rehearing makes no real difference to the approach of the court. In this appeal, the real question is: “What is the appropriate measure of diffidence/deference to be accorded to the MPT?”

94. Leading counsel on behalf of the GMC accepted that there is no real difference as between the test set out in *Bawa-Garba* and that identified in *Ghosh* and affirmed in *Khan*. If a sanction is not necessary and appropriate it falls outwith the range open to a reasonable tribunal. If a court properly bore in mind the need for due deference, and the purpose underlying sanctions, and if it reached a decision on the facts that the sanction imposed was not necessary or appropriate in the public interest, because it was excessive and disproportionate, that would necessarily meet the test in *Bawa-Garba* [67(ii)]. It was accepted that a decision which was excessive and disproportionate necessarily fell outside the bounds of what an MPT could properly and reasonably decide, namely that on the GMC's interpretation the standard *Khan* approach would lead to the same result as [67(ii)] of *Bawa-Garba*.

95. It is the GMC's case that the test should apply to all appeals, there is no different test as between clinical and sexual misconduct cases, although the intensity of the appellate court's scrutiny may vary depending on the subject matter of the alleged misconduct.

Discussion and conclusions

96. The appeals falling for determination by this court are brought pursuant to section 40 of the 1983 Act. They are brought by medical practitioners and not by the GMC. In each appeal, the primary issue for this court is the approach to be taken by the High Court to appeals against sanction under section 40 of the 1983 Act. Dr Okpara's appeal raises a further issue, namely the approach of the appellate court in cases of sexual misconduct.

97. Section 40 provides a right of appeal to a person in respect of whom an appealable decision has been taken, i.e. to a medical practitioner who has been made the subject of sanction by the MPT. There is no requirement for permission to appeal. No limitations are imposed upon the ambit of the appeal. Section 40A of the 1983 Act permits the GMC to appeal against a relevant decision to the relevant court on the limited basis that “they consider that the decision is not sufficient (whether as to a finding or a penalty or both) for the protection of the public.” It is of note that the statutory purpose of section 40 is to provide an unlimited right of appeal to a medical practitioner, whereas section 40A provides only a limited right of appeal to the GMC on the ground of “sufficiency”.

98. In accordance with CPR Rule 52.21(1) and CPR Practice Direction 52D, para 19.1, (see [10] and [11] above) the general rule is that appeals under section 40 of the 1983 Act are by way of rehearing. There is no equivalent provision in the CPR Practice Direction in respect of section 40A and hence, appeals of the GMC under section 40A are by way of review. Under CPR Rule 52.21(3) 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 of the lower court.

99. Thus, from the outset of the appellate process, as set out in the 1983 Act and as currently reflected by the CPR, a distinction is made between the medical practitioner's unfettered section 40 appeal by way of rehearing and the GMC's section 40A appeal by way of review, in cases where it considers the sanction is insufficient to protect the public.

100. Drawing from the principles to be derived from the authorities we cite in [19] to [39] above, the following is of note.

101. The breadth of the section 40 appeal and the appellate nature of the court's jurisdiction was recognised by the Judicial Committee of the Privy Council in *Ghosh* and set out at [33] and [34] of the judgment of the Board given by Lord Millett. At [33] Lord Millett noted that the statutory right of appeal of medical practitioners under section 40 of the 1983 Act “does not limit or qualify the right of the appeal or the jurisdiction of the Board in any respect. The Board's jurisdiction is appellate, not supervisory. The appeal is by way of a rehearing in which the Board is fully entitled to substitute its own decision for that of the committee.”

102. Derived from *Ghosh* are the following points as to the nature and extent of the section 40 appeal and the approach of the appellate court:

i) an unqualified statutory right of appeal by medical practitioners pursuant to section 40 of the 1983 Act;

ii) the jurisdiction of the court is appellate, not supervisory;

iii) the appeal is by way of a rehearing in which the court is fully entitled to substitute its own decision for that of the Tribunal;

iv) the appellate court will not defer to the judgment of the Tribunal more than is warranted by the circumstances;

v) the appellate court must decide whether the sanction imposed was appropriate and necessary in the public interest or was excessive and disproportionate;

vi) in the latter event, the appellate court should substitute some other penalty or remit the case to the Tribunal for reconsideration.

103. The courts have accepted that some degree of deference will be accorded to the judgment of the Tribunal but, as was observed by Lord Millett at [34] in *Ghosh*, "the Board will not defer to the Committee's judgment more than is warranted by the circumstances". In *Preiss*, at [27], Lord Cooke stated that the appropriate degree of deference will depend on the circumstances of the case. Laws LJ in *Raschid and Fatnani*, in accepting that the learning of the Privy Council constituted the essential approach to be applied by the High Court on a section 40 appeal, stated that on such an appeal material errors of fact and law will be corrected and the court will exercise judgment but it is a secondary judgment as to the application of the principles to the facts of the case ([20]). In *Cheatle* Cranston J accepted that the degree of deference to be accorded to the Tribunal would depend on the circumstances, one factor being the composition of the Tribunal. He accepted the appellant's submission that he could not be "completely blind" to a composition which comprised three lay members and two medical members.

104. In *Khan* at [36] Lord Wilson, having accepted that an appellate court must approach a challenge to the sanction imposed by a professional disciplinary committee with diffidence, approved the approach and test identified by Lord Millett at [34] of *Ghosh*.

105. It follows from the above that the Judicial Committee of the Privy Council in *Ghosh*, approved by the Supreme Court in *Khan*, had identified the test on section 40 appeals as being whether the sanction was "wrong" and the approach at the hearing, which was appellate and not supervisory, as being whether the sanction imposed was appropriate and necessary in the public interest or was excessive and disproportionate.

106. In *Jagjivan* the court considered the correct approach to appeals under section 40A. At [39] Sharp LJ accepted that the "well-settled principles" developed in relation to section 40 appeals "as appropriately modified, can be applied to section 40A appeals." At [40], Sharp LJ acknowledged that the appellate court will approach Tribunals' determinations as to misconduct or impairment and what is necessary to maintain public confidence and proper standards in the profession and sanctions with diffidence. However, at [40(vi)], citing [36] of *Khan* and the observations of Lord Millett at [34] of *Ghosh*, she identified matters such as dishonesty or sexual misconduct as being matters 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.

107. The court in *Bawa-Garba* (a section 40A appeal) at [60] identified the task of the High

Court on an appeal pursuant to section 40 or section 40A as being whether the decision of the MPT is "wrong". At [67] the court identified the approach of the appellate court as being supervisory in nature, in particular in respect of an evaluative decision, whether it fell "outside the bounds of what the adjudicative body could properly and reasonably decide". It was this approach which was followed by the judge in the appeal of Dr Sastry and which led to the ground of appeal upon which Leggatt LJ granted permission. In so granting, Leggatt LJ stated that there was a real issue as to whether the judge deferred unduly to the Panel's view by approaching the appeal, in effect, as a challenge to the exercise of a discretion when arguably the judge was required to exercise her own judgment as to whether the sanction imposed was excessive and disproportionate. The words and reasoning of Leggatt LJ reflect the approach of the court to section 40 appeals identified in *Ghosh* and approved in *Khan*.

108. We endorse the approach of the court in *Bawa-Garba*, as appropriate to the review jurisdiction applicable in section 40A appeals. We regard the approach of the court in section 40 appeals, as identified in *Ghosh* and approved in *Khan*, as appropriate in section 40 appeals which are by way of a rehearing.

109. We agree with the observations of Cranston J in *Cheatle* that, given the gravity of the issues, it is not sufficient for intervention to turn on the more confined grounds of public law review such as irrationality. The distinction between a rehearing and a review may vary depending upon the nature and facts of the particular case but the distinction remains and it is there for a good reason. To limit a section 40 appeal to what is no more than a review would, in our judgment, undermine the breadth of the right conferred upon a medical practitioner by section 40 and impose inappropriate limits on the approach hitherto identified by the Judicial Committee of the Privy Council in *Ghosh* and approved by the Supreme Court in *Khan*.

110. Accordingly, we agree with the view expressed by Leggatt LJ that the judge, in the section 40 appeal of Dr Sastry, was required to exercise her own judgment as to whether the sanction imposed was excessive and disproportionate. It follows from the above that we do not agree with her observation at [66] that when it comes "to an evaluation of clinical behaviour and the treatment of patients … a court is totally ill-equipped to arrive at a view of what public protection and reputation of the profession requires. It would be wrong to substitute its own untutored view for that of a panel drawn from the profession in question." As has been previously recognised, a court is able to arrive at a view of what public protection and the reputation of the profession requires. To describe the view of the court as being "untutored" pays no or little regard to the ability of an appellate court to evaluate issues of public protection and the reputation of the medical profession and to its role, demonstrated in previous cases, in deciding whether the sanction imposed was necessary and appropriate in the public interest or was excessive or disproportionate.

111. Further, reliance upon the MPT as drawn "from the profession in question" may not be appropriate. Only one member of the MPT is a member of the medical profession and in this case his area of expertise was not that of the appellant.

112. Appropriate deference is to be paid to the determinations of the MPT in section 40 appeals but the court must not abrogate its own duty in deciding whether the sanction imposed was wrong; that is, was it appropriate and necessary in the public interest. In this case the judge failed to conduct any analysis of whether the sanction imposed was appropriate and necessary in the public interest or whether the sanction was excessive and disproportionate, and therefore impermissibly deferred to the MPT.

113. In granting Dr Okpara permission to appeal, Leggatt LJ identified "a tension between the authorities reflected in *Jagjivan* at [40(vi)] and to *Bawa-Garba*", namely whether the judge failed to have regard to the line of authority which indicates that cases of sexual misconduct fall within a category where an appeal court can more readily assess whether a particular sanction is appropriate and thus give less weight to the expertise of the Tribunal. We conclude that the judge, in following *Bawa-Garba* in this case, did fail to have regard to the line of authority reflected in *Jagjivan* but note that in the subsequent case of *Gupta* ([90] above) he acknowledged that *Jagjivan* would permit the appellate court to more readily make its own assessment. We agree that in matters such as dishonesty or sexual misconduct, the court is well placed to assess what is needed to protect the public or maintain the reputation of the profession and is less dependent upon the expertise of the Tribunal. It follows that we find that the approach of the judge to the sanction imposed upon Dr Okpara was wrong in that he did not assess whether the sanction was necessary or appropriate in the public interest or was excessive or disproportionate.

114. Consequently, we go on to determine whether the sanction imposed in each case was "wrong", that is, was the sanction appropriate and necessary in the public interest, or as asserted by the appellants, excessive and/or disproportionate.

Dr Sastry

115. The essence of the GMC's case in respect of Dr Sastry was that he recommended to Patient A that she undergo high dose chemotherapy and autologous stem cell transplantation when he knew the same to be inappropriate because she had failed to mobilise an adequate number of CD34 positive cells. Critically, when Dr Sastry at the meeting with the family on 13 June 2014 recommended such radical treatment, he knew that there were insufficient CD34 positive cells for such a procedure. Not only was he aware of this, he was aware of its significance for Patient A. It follows that Dr Sastry was recommending a course of radical treatment to a patient when he knew it was clinically inappropriate. Further, in so recommending, Dr Sastry did not tell the family of the knowledge he possessed, namely that an adequate number of CD34 positive cells had not been collected.

116. In our judgment, the proven allegations were grave and properly so considered by the MPT. The fact that these matters arose in India, where there is no multidisciplinary approach and systems may differ, cannot detract from the fact that Dr Sastry knew what he was doing in embarking upon such a course of treatment when he knew the same to be clinically inappropriate. The fact that there are no other regulatory findings against Dr Sastry does not minimise the gravity of his misconduct in treating Patient A. We are in no doubt that the sanction of erasure was both necessary and appropriate for the protection of the public and to ensure public confidence in the medical profession. Accordingly, the appeal of Dr Sastry is dismissed.

Dr Okpara

117. The proven allegations represented a consistent, predatory and escalating course of sexual misconduct by a doctor to a nurse. Dr Okpara rightly accepted that the facts amounted to misconduct and impairment of his fitness to practise. The MPT recorded that the behaviour had taken place in a "hierarchical institutional context" where Dr Okpara, a doctor of 22 years' standing, was much more senior than Ms A, a nurse at the start of her career. We agree. We also accept the MPT's assessment of the sluice room incident as aggressive, threatening and a

gross violation of Ms A. The MPT were entitled to find that Dr Okpara, in denying the allegations and making a series of counterclaims against Ms A, had demonstrated a complete lack of insight. In our judgment, this was a continuing and consistent course of predatory sexual misconduct which wholly warranted the sanction of erasure. We agree with the finding of the MPT that such misconduct was fundamentally incompatible with continued registration. Accordingly, the appeal of Dr Okpara is dismissed.