Neutral Citation Number: [2018] EWCA Civ 2027

Case No: C1/2018/0034

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT
Mr Justice Sweeney
[2017] EWHC 2116 (Admin)

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 14/09/2018

Before:

LORD JUSTICE UNDERHILL
(Vice-President of the Court of Appeal)
LORD JUSTICE BEAN
and
LORD JUSTICE SALES

- -

Between:

Dr Hemmay Raychaudhuri	**Appellant**
- and -	
General Medical Council	**Respondent**
- and –	
The Professional Standards Authority for Health and Social Care	**nterveners**

- -
- -

Robert Kellar and Michael Deacon (instructed by **Medical Defence Union**) for the **Appellant**
Ivan Hare QC (instructed by **GMC Legal**) for the **Respondent**
The Interveners made written submissions but did not appear

Hearing date: 19 July 2018

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Judgment Approved

Lord Justice Sales:

1. This is an appeal in a case concerning professional disciplinary proceedings against a doctor, who is the appellant.

2. A complaint about the appellant in relation to how he had filled in a form to record the medical examination of a child patient ("Patient A") was referred to a Medical Practitioners Tribunal ("MPT"). The General Medical Council ("GMC") was the prosecuting authority.

3. The MPT was critical about aspects of the appellant's conduct, but found that he had not behaved dishonestly and that there was no impairment of his fitness to practise as

a doctor. As a result, the appellant was issued with a warning regarding his conduct but no sanction in the form of a direction for his erasure or suspension from the medical register was imposed.

4. In reliance on section 40A of the Medical Act 1983 ("section 40A"), the GMC appealed to the High Court in relation to the MPT's finding that there was no impairment of fitness to practise and on the issue of appropriate sanction. Sweeney J in the High Court, following the decision of the Divisional Court in *General Medical Council v Jagjivan* [2017] EWHC 1247 (Admin) [2017] 1 WLR 4438, accepted that the High Court had jurisdiction to entertain such an appeal by the GMC. He held that the MPT should have found that the appellant had behaved dishonestly when giving an account of what he had done to a consultant and that in the light of such a finding the MPT should have found that the appellant's fitness to practise was impaired. The judge substituted such findings and remitted the case to the MPT for consideration of the appropriate sanction to impose in respect of those findings.

5. I granted permission to appeal to this court. The implementation of the High Court's order was stayed pending the hearing of this appeal.

6. The appellant appeals to this court on three grounds: (1) he contends that the High Court has no jurisdiction under section 40A to entertain an appeal by the GMC against a finding by a MPT that a doctor's fitness to practise is not impaired, and invites us to overrule *Jagjivan*; (2) he submits that the High Court was wrong to substitute a finding that he had behaved dishonestly, where the MPT had acquitted him of dishonesty; and (3) he submits that, even if his conduct was to be characterised as dishonest, the High Court was wrong to substitute a finding that his fitness to practise was impaired and wrong to remit the case to the MPT for consideration of sanction in relation to such a finding. The appellant also submits in relation to Ground (2) that the logic of the MPT's findings generally was that it should also have found that in relation to the critical statement in respect of which the judge substituted a finding that it had been made dishonestly, the MPT ought to have found that the statement had been made by the appellant without any appreciation that it was untrue.

7. For reasons set out below, I would dismiss the appeal on Ground (1) and would hold that the High Court had jurisdiction under section 40A to entertain the GMC's appeal against the MPT's decision not to make a finding that the appellant's fitness to practise was impaired. I would allow the appeal on Ground (2), and would quash the judge's substituted finding of dishonesty on the part of the appellant; I would restore the decision of the MPT. On this basis, Ground (3) does not arise and it is neither necessary nor appropriate to address it. I would not make a substituted finding, as proposed by the appellant, that he did not appreciate that in making the critical statement referred to above, that he was making a statement which was untrue.

The legal framework

8. The 1983 establishes the role of the GMC and Part V sets out a detailed regime for investigation and sanction in respect of complaints of professional misconduct against doctors.

9. Section 1 of the 1983 Act provides that the GMC shall have functions which are to be exercised with the over-arching objective of "the protection of the public" (subsection (1A)), involving the pursuit of the following objectives (subsection (1B)):

> "(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."

10. Under section 35, an allegation of improper practice by a doctor made to the GMC may be referred by them to a MPT for investigation and, as appropriate, imposition of a sanction. In cases before a MPT, the GMC acts as the prosecuting authority.

11. Section 35D of the 1983 Act provides in relevant part that:

"…

(2) Where the Medical Practitioners Tribunal find that the person's fitness to practise is impaired they may, if they think fit–

(a) …direct that the person's name shall be erased from the register;

(b) direct that his registration shall be suspended;…:or

(c) direct that his registration shall be conditional on his compliance… with… requirements… for the protection of members of the public…

(3) Where the Tribunal finds that the person's fitness to practise is not impaired they may nevertheless give him a warning regarding his future conduct or performance……"

12. Section 40 provides for a doctor affected by a determination by a MPT to have certain rights of appeal to the High Court. So far as is relevant, subsection (1) provides:

"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;

…"

13. Section 40 does not provide for a right of appeal in respect of every kind of decision, finding or ruling which might be made by a MPT. There is no right of appeal in respect of a warning issued pursuant to section 35D(3). Nor is there a distinct right of appeal in respect of particular findings of fact which may be made by a MPT in the course of making a determination in a case. However, judicial review would be available in relation to these matters. Where a MPT makes particular findings of fact in a determination which form the basis for a finding under section 35D(2) that a doctor's fitness to practise is impaired AND THAT A SANCTION SHOULD BE IMPOSED, the doctor may seek to have those particular findings of fact set aside as

part of their appeal against the ultimate finding that their fitness to practise is impaired.

14. Under the National Health Service Reform and Health Care Professions Act 2002 a power was given to the relevant regulatory authority (previously the Council for the Regulation of Health Care Professionals, now called the Professional Standards Authority for Health and Social Care - "the PSA") to refer certain decisions of adjudicatory bodies in professional disciplinary cases against healthcare professionals to the High Court. The power of reference to the High Court is akin to a right of appeal. Section 29 of the 2002 Act provides in relevant part as follows:

> "**29 Reference of disciplinary cases by Authority to court**
>
> (1). This section applies to –
>
> …
>
> (c) a direction by a Medical Practitioners Tribunal of the General Medical Council under section 35D of the Medical Act 1983 that the fitness to practise of a medical practitioner was impaired
>
> …
>
> [sub-paragraphs (a), (b) and (e)-(j) set out various decisions by various adjudicatory bodies; sub-paragraph (ca) sets out certain other decisions by a MPT]
>
> (2) This section also applies to –
>
> (a) a final decision of the relevant committee not to take any disciplinary measure under the provision referred to in whichever of paragraphs (a) to (h) of subjection (1) applies,
>
> …
>
> (3) The things to which this section applies are referred to below as 'relevant decisions'.
>
> (4) Where a relevant decision is made, the Authority may refer the case to the relevant court if it considers that the decision is not sufficient (whether as to a finding or a penalty or both) for the protection of the public.
>
> (4A) 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 profession concerned; and
>
> (c) to maintain proper professional standards and conduct for members of that profession.

…

(7) If the Authority does so refer a case—

(a) the case is to be treated by the court to which it has been referred as an appeal by the Authority against the relevant decision (even though the Authority was not a party to the proceedings resulting in the relevant decision), and

(b) the body which made the relevant decision (as well as the person to whom the decision relates) is to be a respondent.

…

(8) 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 committee or other person concerned, or

(d) remit the case to the committee or other person concerned to dispose of the case in accordance with the directions of the court or, in the case of a relevant decision within subsection (1)(c) or (ca) or a relevant decision within subsection (2)(a) or (c) not to take a disciplinary measure under a provision referred to in subsection (1)(c) or (ca), remit the case to the Medical Practitioners Tribunal Service for them to arrange for a Medical Practitioners Tribunal so to dispose of the case,

and may make such order as to costs (or, in Scotland, expenses) as it thinks fit.

…"

15. In August 2014 the Department of Health issued a consultation paper entitled, "The General Medical Council and Professional Standards Authority: Proposed changes to modernise and reform the adjudication of fitness to practise cases". At paras. 39 to 41 of the consultation paper the Department explained that it believed that it would be appropriate for the GMC to have a right of appeal where the GMC, as a party to relevant proceedings, disagrees with a decision made by a MPT. The consultation paper referred to the power of the PSA under the 2002 Act to refer determinations by a MPT to a court and stated, "We wish to broadly replicate this power for the GMC within the Medical Act 1983 to ensure that the GMC is empowered to appeal determinations in appropriate circumstances" (para. 40). At para. 41 it was stated:

> "The GMC's appeal right would not supersede the PSA's power of referral. Rather, we intend these powers to be complementary, with the PSA having an oversight role and able to make its own referral to the court if it felt that the GMC should have appealed a decision but had not done so.

> Additionally the PSA would have the ability to intervene as an interested party in any such appeal instigated by the GMC, for example if they wanted to challenge a decision on a different point from those put forward by the GMC. We would enable a similar power for the GMC to intervene or join as an interested party in the event that the PSA made a reference to the court in the first instance. This will ensure that we do not create a situation where a respondent doctor faces the prospect of two separate appeals concerning the same decision."

Consultees were asked whether they agree with the proposal "that the GMC should have a right of appeal, corresponding to the PSA's power to refer cases, to the higher courts in order to challenge [Medical Practitioners Tribunal Service] decisions".

16. In January 2015, the Department published its consultation response report with the same title. Despite mixed responses on the proposal to introduce a right of appeal for the GMC in relation to MPT decisions, the Department's conclusion was to affirm the proposal in the consultation paper:

> "We remain confident that introducing a right of appeal for the GMC is appropriate … The policy intention … is to enable the organisation best placed to challenge a tribunal decision about a doctor's fitness to practise to be able to do so where it is considered that the outcome does not sufficiently protect the public … We have made provision for the PSA to be able to take over the case [i.e. an appeal] if they think that the GMC propose to withdraw where it should not …"

17. Following the consultation exercise amendments were introduced into both the 1983 Act and the 2002 Act to provide for a right of appeal for the GMC and to deal with the juxtaposition of the new right of appeal for the GMC and the right of the PSA to make a reference to the relevant court.

18. Section 40A of the 1983 Act provides in relevant part as follows:

> "(1) This section applies to any of the following decisions by the 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;
>
> …
>
> (d) a decision not to give a direction under section 35D
>
> …

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

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

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

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

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

(c) to maintain proper professional standards and conduct for the 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;

(d) remit the case to the [Medical Practitioners Tribunal Service] for them to arrange for a Medical Practitioners Tribunal to dispose of the case in accordance with the directions of the court…'

19. Section 29A of the 2002 Act provides that where the PSA makes a reference to the High Court it must notify the GMC and the GMC may not then bring an appeal under section 40A.

20. Section 40B of the 1983 Act provides that where the GMC brings an appeal under section 40A it must notify the PSA and the PSA may not then refer the case under section 29 of the 2002 Act. However, section 40B(2) states that the PSA may become a party to the GMC's appeal and section 40B(4) states that the matters which the PSA may raise on an appeal under section 40A include any matter which it could have raised on a reference of the case under section 29 of the 2002 Act.

21. In the present case, the PSA chose not to become a party to the GMC's appeal to the High Court. However, the PSA was granted permission to intervene on the further appeal to this court.

Factual background

22. The appellant qualified as a doctor in India in 2004. He underwent medical training in hospitals in India, Finland and the UK. He developed an interest in paediatrics and became a member of the Royal College of Paediatricians in 2012. Prior to the index

proceedings he had no previous history with the GMC of regulatory complaints or sanctions.

23. In December 2014 the appellant was working as a locum paediatric registrar at the Royal Berkshire Hospital. On 13 December he was working in the paediatric Accident and Emergency ("A & E") section of the hospital.

24. At about 5.30 pm the appellant was informed of the arrival of Patient A, a 5 month old child diagnosed with Dandy Walker Syndrome, which involves chronic brain malformation. In advance of seeing Patient A, the appellant reviewed the patient's previous medical records and a letter from the referring GP. The appellant used the information in these materials to begin filling in the hospital's standard Emergency Department Paediatric Initial Assessment Form. This included a section dealing with the history of the presenting complaint and a section dealing with aspects of examination of the patient.

25. At this preliminary stage, the appellant filled in part of the history section using the information in the records and the GP letter. Mr Hare QC, for the GMC, accepts that this was unobjectionable. However, at the same preliminary stage before he had seen Patient A, the appellant also used the records and the letter to begin filling in part of the examination section of the form. The GMC says that this was wrong and the appellant accepts that he should not have done this.

26. One charge brought by the GMC against the appellant in the proceedings before the MPT was that the appellant had acted dishonestly in partially completing the examination section of the assessment form in this way. The appellant accepted that this was a serious departure from the standards of good medical practice but denied that he had been dishonest in doing so. His intention was to treat what he had begun writing in the examination section of the form as a prompt or *aide memoire* when he came to examine Patient A and to confirm or amend what he had written in the light of that examination. The MPT accepted the appellant's evidence about this and found that his conduct in respect of his record keeping was not dishonest: see paras. [90]-[93] of the MPT's Determination on Facts dated 25 August 2016. The GMC did not appeal in respect of this.

27. At this point on 13 December the appellant was called away to see another patient. He left the partially completed assessment form on the desk in the paediatric doctor's office. At some stage thereafter the parents of Patient A complained to the nursing staff on duty that Patient A was still waiting to be seen by a doctor. A junior doctor, Dr Perriam, looked into this and found the partially completed assessment form. He brought this to the attention of Nurse Hagan who, seeing the entries in the examination section of the form, assumed that Patient A had already been seen. Nurse Hagan put this to the parents, who denied it.

28. Nurse Hagan and Nurse Park subsequently approached the appellant and queried whether he had seen Patient A. In the set of disciplinary charges against the appellant, the GMC alleged that the appellant had dishonestly told the nurses that a junior doctor must have made the entries in the assessment form rather than him. The appellant denied this. Before the MPT there was conflicting evidence about what had been said. The MPT was not satisfied that the appellant appreciated which patient the nurses were referring to when they first confronted him; it took into account that it was the usual practice for junior doctors to see patients first; it found that the appellant had not been shown the relevant assessment form when he was first confronted by the nurses, and that when it was shown to him he immediately acknowledged that the

handwriting on it was his. The MPT rejected the allegation that the appellant had been dishonest in his communication with the nurses: see paras. [94]-[97] of the MPT's Determination on Facts. The GMC appealed in respect of this finding, but its appeal on that ground was dismissed by Sweeney J in the High Court. There is no appeal in respect of this part of his decision.

29. Nurse Park and Nurse Hagan raised the issue of the appellant's conduct with Dr Nafousi, who was working as the Emergency Department Consultant that evening. Dr Nafousi called a meeting with the nurses and the appellant. The MPT found that at this meeting the appellant gave Dr Nafousi a full account of his conduct: paras. [91] and [99] of the MPT's Determination on Facts. There was no allegation that the appellant's communications with Dr Nafousi had been dishonest, nor has there been any appeal in relation to the MPT's findings at paras. [91] and [99] of its Determination on Facts.

30. Following the meeting, Dr Nafousi telephoned the Paediatric Consultant on call that night, Dr De Halpert, to explain what had happened, in particular as regards the way in which the appellant had partially filled in the examination section of the assessment form before seeing Patient A. Dr De Halpert then telephoned the appellant to see what he had to say about this. Again, what precisely was said in the conversation between Dr De Halpert and the appellant and what the appellant understood was being put to him by Dr De Halpert were in issue at the hearing before the MPT. The GMC's case was that the appellant had dishonestly denied making any entries in the examination section of the assessment form before seeing Patient A. The appellant's case was that he had understood that Dr De Halpert's real or principal concern was that he had finalised the examination section without ever intending to see Patient A at all. The appellant's evidence was that he explained to Dr De Halpert that he would never do that.

31. In relation to this part of the history, the charges brought by the GMC were that during the telephone conversation with Dr De Halpert the appellant denied writing examination findings on the assessment form before seeing Patient A (charge 5a) and stated that he had only written in the background information based on a letter from Patient A's GP (charge 5b: i.e. that he had maintained that he had only made entries in the history section of the assessment form by reference to this letter, not in the examination section); that the statements referred to in charges 5a and 5b were false (charge 6a) and were known by the appellant to be false (charge 6b); and that the appellant's actions in making the statements referred to in charges 5a and 5b were misleading (charge 7a) and were dishonest (charge 7b).

32. It should be noted that in the way in which the charges were framed, the GMC themselves drew a distinction between knowledge of falsity of the statements referred to in charges 5a and 5b and whether those statements were made dishonestly: see charge 6b and charge 7b. It seems that the GMC recognised that the mere making of a statement knowing that it was false could not automatically be equated with dishonest misleading of a colleague in the hurly burly of overnight duty in an A & E department. Things might be said in the heat of the moment without any settled and dishonest intention to deceive in relation to something important. It should also be noted that there is a close correspondence between charge 5a and charge 5b.

33. The MPT found charge 5a and charge 5b to be proved. In relation to those charges, it found charge 6a (falsity) to be proved in relation to both of them and charge 6b (knowledge of falsity) to be proved in respect of charge 5a, but not in respect of charge 5b. In relation to each of charge 5a and charge 5b, the MPT found charge 7a

(misleading actions) to be proved, but found that charge 7b (dishonest actions) was not proved. In other words, having heard the appellant and all the witnesses, the MPT acquitted the appellant of dishonesty in relation to this part of the history.

34. It is in respect of the MPT's finding that the appellant was not dishonest (i.e. finding charge 7b not proved in relation to charge 5a), even though the facts in charge 5a were found to be proved and it was found that the relevant statement in charge 5a was made by the appellant to Dr De Halpert with knowledge that it was false (charge 6b, as applied to charge 5a), that Sweeney J allowed the GMC's appeal under section 40A. He substituted a finding that the statement referred to in charge 5a had been made by the appellant dishonestly, and then proceeded to find that this meant that the appellant's fitness to practise was impaired. The appellant challenges this part of the judge's ruling under Ground (2).

35. Also in the context of Ground (2), it is the finding that charge 6b (knowledge of falsity) was made out in respect of the statement referred to in charge 5a that the appellant says is inconsistent with other findings made by the MPT (in particular, its finding that he was not dishonest in making that statement) and the general thrust of its reasoning. The result, submits Mr Kellar on his behalf, is that this court should substitute a finding that charge 6b is not made out in relation to charge 5a; i.e. that the appellant did not appreciate that the statement he was found to have made under charge 5a was untrue. Rather, in making the relevant statement he inadvertently took himself to be answering a different question, which he answered truthfully.

36. In order to determine Ground (2), it is necessary to examine the MPT's reasons with some care. The MPT's principal reasoning in relation to finding charge 5a to be made out is at paras. [37]-[40] of its Determination on Facts. The MPT found that in the course of their conversation or conversations on 13 December, Dr De Halpert had asked the appellant whether he had written findings in the examination section of the assessment form before seeing Patient A and that the appellant had denied this. I note that this is not inherently inconsistent with the appellant's case that he nonetheless understood the main thrust of Dr De Halpert's allegation against him to be the far more serious charge that he had done this with the intention of presenting this as the final completed version of the assessment form without ever seeing Patient A at all. The MPT's principal reasoning in relation to finding charge 5b to be made out is at paras. [41]-[43] of its Determination on Facts. It essentially follows the reasoning in relation to charge 5a, and the same comment regarding consistency with the appellant's case applies.

37. The MPT's principal reasoning in relation to finding charge 6b made out as regards charge 5a (knowledge of the falsity of the statement to Dr De Halpert) is at paras. [53]-[56] of its Determination on Facts. It took account of the appellant's good character, but concluded that it was more likely than not that he knew his statement to Dr De Halpert was false "as it did not reflect the full extent of the entries [he] made". But this has to be read with the MPT's reasons at paras. [57]-[60] why it found charge 6b *not* to be made out in relation to the closely related statement referred to in charge 5b, that the appellant had said that he had only used the GP letter to make entries in the history section of the assessment form and no other part of the form.

38. The MPT said that there was doubt about the breadth of the questions asked about the assessment form, so it could not be satisfied that the appellant was directly asked about the extent to which he had completed the assessment form ([58]):

> "The tribunal was of the view that there was some scope for misunderstanding in relation to your statement that you had only written in the background information [i.e. in the history section of the assessment form] based on a GP letter. The tribunal accepted that you may have given some information, but not all the information about what you had entered on the [assessment form]. It considered that there was potential for things to be misunderstood in a telephone conversation, without being able to see the paperwork, in contrast to having a face to face discussion." ([59])

The MPT concluded at [60] that there was doubt as to whether the appellant knew his statement to Dr De Halpert in relation to only making entries in the history section of the assessment form based on the GP letter was false, and that charge 6b was not made out in relation to charge 5a.

39. The MPT's principal reasons in relation to finding charge 7a made out in respect of charge 5a and charge 5b were set out at paras. [83]-[88] of its Determination on Facts. The MPT found that the appellant had given Dr De Halpert misleading answers to questions posed by him about how the assessment form came to be filled out.

40. The MPT's principal reasons in relation to finding that charge 7b (dishonesty) was not made out in relation to charge 5a and charge 5b were set out at paras. [98]-[101] of its Determination on Facts, including as follows as regards charge 5a:

> "99. The tribunal accepted that you were always intending to examine Patient A and to amend the [assessment form] depending on your findings. The tribunal considered that the accounts of your telephone call with [Dr De Halpert] represented 'a snapshot' of a particular moment in time. It was of the view that, while an ordinary and honest member of the public might consider your action to have been dishonest, it was not satisfied that you were aware that your actions would have been considered to be dishonest by those standards. It accepted that there may have been some confusion on your part regarding the subject matter, and that its finding that you knew your statements to be false was limited to you not providing a full account to [Dr De Halpert]. The tribunal accepted that you gave a full account to [Dr Nafousi]";

and as follows as regards charge 5b:

> "101. … the tribunal again accepted that there may have been some confusion on your part regarding the subject matter being discussed. Your concern was that others thought you had written notes without ever intending to see Patient A. It accepted that you thought that was [Dr De Halpert's] concern and you stated that you would 'never do that'. The tribunal accepted that there may have been a misunderstanding. In these circumstances, in the tribunal's view, there is insufficient evidence to prove, on the balance of probabilities, that your actions were dishonest."

41. The MPT also gave an explanation of its findings in its Determination on Impairment dated 6 February 2017, at para. [14]:

> "In respect of making a false statement to a senior colleague [i.e. Dr De Halpert] during two telephone calls where questions were being asked about what had happened, you failed to provide full and accurate information about an examination note. You misled [Dr De Halpert] by stating that you had not recorded an examination prior to seeing the patient, whereas in fact you had already made some entries in the examination section of the [assessment form]. This you failed to disclose to [Dr De Halpert]. The tribunal accepts that you thought [Dr De Halpert] was questioning the probity of someone making an examination note without ever seeing the patient, when your position was that you were simply preparing for seeing the patient. The tribunal however determined that [Dr De Halpert] was left with a false impression which was misleading and amounts to serious misconduct."

42. Notwithstanding this, the MPT found that the appellant's fitness to practise was not impaired as a result of this incident. The incident had been a one-off matter occurring on a single day; the appellant had a sufficient level of insight as to what he had done wrong to mitigate the risk of repetition, and there had been no recurrence of such problems; there were references attesting to the appellant's probity and integrity; he had sought to address concerns by attending a relevant course in ethics training; and there was no sufficient impact on public confidence arising from these events to justify a finding of impairment. See paras. [16]-[24] of the Determination on Impairment.

43. Instead, the MPT issued the appellant with a written warning. In its reasons, the MPT observed that in its view the appellant's misconduct "fell just short of a finding of impairment" and that a warning was necessary and appropriate to underline to the appellant and other members of the profession that probity and integrity must be at the forefront of every doctor's practice: para. [10] of the MPT's Determination on Warning dated 9 February 2017.

Discussion

Ground (1): the jurisdiction of the High Court under section 40A

44. The issue in relation to this Ground is whether the High Court has jurisdiction under section 40A to entertain an appeal by the GMC against a finding by a MPT that there has been no impairment of fitness to practise on the part of a doctor who is the subject of a disciplinary charge brought by the GMC. The appellant submits that there is no such jurisdiction. The GMC contends that there is.

45. The Divisional Court in *Jagjivan* held that, on its proper construction, section 40A does create jurisdiction in the High Court to entertain such an appeal. Mr Kellar submits that the Divisional Court was in error in so holding. He contends that ordinary principles of statutory construction lead to the opposite conclusion. According to Mr Kellar, section 40A(1)(d) - which identifies as a relevant appealable decision of the MPT "a decision not to give a direction under section 35D" – must be construed to apply only to that limited class of case in which a MPT finds pursuant to section 35D(2) that a person's fitness to practise *is* impaired but in exercise of its discretion under that provision nonetheless decides not to make a direction for erasure, suspension or otherwise.

46. Mr Kellar also contends that the construction of section 40A arrived at by the Divisional Court is incompatible with Article 6 of the European Convention on Human Rights, as it has application in domestic law under the Human Rights Act 1998 ("HRA"). Article 6(1) sets out the right to a fair trial in the determination of an individual's civil rights and obligations. Mr Kellar says Article 6(1) has been held in relevant case-law to imply the right to equality of treatment between the parties to civil litigation (including litigation involving professional disciplinary charges) as regards the ability to appeal. He referred in particular to *Berger v France*, ECtHR, App. No. 48221/99, judgment of 21 May 2003; *Ben Naceur v France*, ECtHR, App. No. 63879/00, judgment of 3 January 2007; *Gacon v France,* ECtHR, App. No. 1092/04, judgment of 22 August 2008; and *Ghirea v Moldova*, ECtHR, App. No. 15778/05, judgment of 26 September 2012. The right of appeal for a doctor under section 40 of the 1983 Act does not apply in relation to findings made by a MPT, where it does not give a direction for erasure or suspension or other sanction set out in section 40(1)(a). Therefore, says Mr Kellar, to construe section 40A as creating a right of appeal for the GMC in relation to the decision of a MPT not to find an impairment of fitness to practise (or, putting it positively, where the MPT finds that there is no impairment of fitness to practise) would be to create an imbalance between the rights of the parties in respect of their ability to appeal, which would be incompatible with Article 6. The remedy for this, he argues, is that pursuant to the interpretive obligation in section 3(1) of the HRA, according to which so far as it is possible to do so primary legislation must be read and given effect in a way which is compatible with Convention rights, the court is required to construe section 40A(1)(d) in the limited sense for which he contends. He points out that this argument based on the HRA was not addressed to the Divisional Court in *Jagjivan*.

47. I do not accept Mr Kellar's submissions. In my judgment, the Divisional Court in *Jagjivan* was correct to interpret section 40A in the way it did. Section 40A creates a right for the GMC to appeal to the High Court against a decision of a MPT rejecting a charge by the GMC that a doctor's fitness to practise is impaired. Such an interpretation involves no incompatibility with Article 6 and there is no warrant for adjusting the natural construction of section 40A by reference to section 3(1) of the HRA. In my reasons which follow I shall deal first with the submissions in relation to the ordinary principles of statutory construction and then turn to address the submissions based on Article 6 and section 3(1) of the HRA.

48. In my view, on the proper construction of section 40A, the GMC has a right of appeal to the High Court in a case like the present, where the GMC have brought a charge against a doctor that his fitness to practise is impaired and the MPT rejects that charge and in consequence decides not to give a direction under section 35D:

    i) I consider that this is the natural meaning of section 40A(1)(d), in context. Although section 35D(2) provides that a MPT has a discretion whether to give a direction when it makes a finding of impairment of fitness to practise, that is likely to be a comparatively rare occurrence, given the importance within the disciplinary regime of protection of the public. The usual basis for a MPT to decide not to give a direction under section 35D(2) is that it rejects the charge brought by the GMC and finds that the doctor's fitness to practise is not impaired. In my opinion, as a matter of the natural and ordinary meaning of the language used, subsection 40A(1)(d) has the effect that the GMC has a right of appeal in such a case. This interpretation is further supported by a number of other matters, as follows;

ii) Mr Kellar rightly accepts, indeed positively contends, that the right of appeal for a doctor under section 40(1)(a) of the 1983 Act includes a right to challenge a direction made under section 35D by appealing in respect of a finding of impairment made against him as the foundation for the direction given, and also by appealing any finding of fact which in turn feeds into the finding of impairment and the decision as to what sanction by way of direction under section 35D is appropriate. This is so although the relevant appealable decision in section 40(1)(a) is defined by reference to the giving of a direction under section 35D, rather than by reference to any finding (whether as to impairment or as to the underlying facts of the case). Plainly, the right of appeal created by this form of drafting in section 40(1)(a) is not confined to an ability to challenge merely the exercise of discretion by the MPT of its discretion in section 35D(2) whether to make a direction or not, taking its finding of impairment and its findings as to the underlying facts as read and beyond challenge. By parity of reasoning, when a similar converse drafting formula was adopted in section 40A(1)(d), the intention clearly was to give the GMC a similar right to appeal in relation to findings made by a MPT as the foundation for its decision not to give a direction under section 35D;

iii) The interpretation of section 40A(1)(d) which I endorse is strongly supported by subsection (3). That provides positively that the GMC "may appeal against a relevant decision" if it considers that the decision is not sufficient "whether as to a finding or a penalty or both" for the protection of the public. These words inform the interpretation of the concept of "relevant decision" as defined in section 40A(1) and (2), including in subsection 40A(1)(d), since it would make no sense for Parliament to confer a right of appeal for the GMC by subsection (3) which could never be exercised because of an alleged constraint as regards the meaning of a "relevant decision" in subsection (1). Subsection (3) contemplates that the GMC may consider that a decision of a MPT is not sufficient to protect the public if the MPT has made a finding that the doctor's fitness to practise is not impaired (or, indeed, if it has made erroneous or insufficient findings in relation to the underlying facts of the case), and that they "may appeal" in such a case. But Mr Kellar's proposed interpretation of section 40A(1)(d) would mean that in fact the GMC *may not* appeal in such a case. That cannot be right;

iv) This view is reinforced by reference to subsections (3) and (4), taken together. Subsection (3) provides that the GMC may appeal where they consider that the decision is not sufficient for the protection of the public. Subsection (4) amplifies what is meant by this. The natural inference from these provisions is that the GMC is to have a right of appeal in relation to a finding by a MPT that a doctor's fitness to practise is not impaired, contrary to the charge brought by the GMC (or, indeed, in relation to any significant finding regarding the underlying facts of the case), since if the MPT has erred in making relevant findings it may very well be open to the GMC to consider that its decision is not sufficient to protect the public interest, e.g. because the error by the MPT means that its decision is not sufficient to maintain public confidence in the medical profession. The statutory objective in section 1 of the 1983 Act that the GMC should exercise their functions for the protection of the public and the statutory power in section 40A(3) and (4) to enable them to do just that in the context of the disciplinary regime in Part V of that Act would be undermined if, by an excessively narrow interpretation of subsection 40A(1)(d), they were disabled from doing this;

v) Mr Kellar rightly accepts that where some direction short of erasure has been given by a MPT under section 35D(2), the GMC has a right of appeal by virtue of section 40A(1)(a), and that such right of appeal would entitle the GMC to appeal in relation to underlying findings of fact made by the MPT which the GMC wished to contend were erroneous or did not go far enough in terms of acceptance of their case against the doctor. But this being so, it makes no sense to construe subsection 40A(1)(d) in the narrow way for which Mr Kellar contends. If the GMC has the right to appeal in relation to the insufficiency of findings of fact where, say, a MPT decides only to direct suspension rather than erasure and the GMC wishes to contend that it ought to have made different and more serious findings against the doctor, it is difficult to see why an interpretation of subsection 40A(1)(d) should be adopted which would prevent the GMC from raising similar grounds of appeal at the more serious end of the spectrum; i.e. where they wish to say that the MPT erred by finding there was no impairment of fitness to practise, when in fact it ought to have found that there was. A similar point was made by this court in *Council for the Regulation of Health Care Professionals v General Medical Council and Ruscillo* [2004] EWCA Civ 1356; [2005] 1 WLR 717 at [45] in the context of construing the extent of the PSA's power of reference under section 29 of the 2002 Act;

vi) The right of the PSA under section 29 of the 2002 Act to refer a MPT decision to the court as a form of appeal covers (and at the time when section 40A was enacted, covered and was known to cover) a decision of a MPT by which it decides in respect of a disciplinary charge that the fitness to practise of a doctor is not impaired: see section 29(1)(c) read with section 29(2)(a), set out above, and the judgment of this court in *Ruscillo*. The intended effect of section 40A, as explained in the consultation paper and analysis of responses referred to above, was that it should create a right of appeal in the GMC which would replicate the existing right of reference/appeal of the PSA. The consultation paper and analysis document are equivalent to a White Paper explaining the purpose of legislation, and as such are legitimate aids to construction to assist in identifying such purpose in the context of construing the legislation enacted in consequence: cf *Black-Clawson International Ltd v Papierwerke Waldhof-Aschaffenburg AG* [1975] AC 591. Moreover, the specific provisions introduced alongside section 40A to govern the interaction of an appeal by the GMC and the power of reference by the PSA indicate that the right of appeal for the GMC and the right of reference for the PSA were intended to cover the same subject matters. It is therefore legitimate to have regard to the extent of the PSA's power to make a reference as an indication of the intended extent of the GMC's right of appeal under section 40A and as to the intended meaning of section 40A(1)(d). Again, this supports the meaning of that provision for which the GMC contends.

49. I turn to Mr Kellar's submissions based on Article 6 and section 3(1) of the HRA. In my judgment, they cannot be accepted. There are several reasons for this.

50. First and foremost, in my opinion there is no incompatibility so far as concerns this case between the appellant's right of appeal under section 40 of the 1983 Act and the GMC's right of appeal under section 40A. The GMC brought a disciplinary charge against the appellant that his fitness to practise was impaired on the basis of a series of findings regarding the underlying facts which they invited the MPT to make. If the MPT had found that the appellant's fitness to practise was impaired and it gave a direction under section 35D(2), the appellant would have been entitled to appeal in

relation to the finding regarding impairment and in relation to findings in respect of the underlying facts. Conversely, what has happened in this case is that the MPT made various findings regarding the underlying facts which were contrary to the GMC's case and as a result made a finding that there was no impairment of the appellant's fitness to practise. The GMC has sought to appeal in relation to the finding regarding impairment and in relation to findings in respect of the underlying facts which were relevant to that impairment finding. That is the mirror image of what the appellant would have been entitled to do by way of appeal if he had lost on those points in the MPT. The GMC's right of appeal under section 40A can be read and given effect in this case according to its natural meaning as set out above without that giving rise to any incompatibility with the appellant's equivalent right of appeal under section 40.

51. In another case, it is perhaps possible that the GMC might seek to exercise its right of appeal under section 40A simply to challenge an underlying finding of fact by a MPT, rather than seeking to challenge a particular direction (or absence of direction) made by the MPT and (in the context of such a challenge) seeking to impugn findings made by it. I do not express a final view about whether this would be possible. But even if it were, that is not what has happened in this case. The appellant cannot properly argue that by virtue of section 3(1) of the HRA a strained meaning should be given to section 40A as it is to be applied in his case, different from its ordinary and natural meaning, just because in another speculative case, not his own, some incompatibility with Article 6 might arise. The position in the appellant's case, in my view, is that on its facts the application of section 40A according to its ordinary and natural meaning is compatible with the appellant's rights under Article 6. There is therefore no proper basis for recourse to section 3(1) to try to arrive at a different meaning for section 40A in this case.

52. I also accept the submission by Mr Hare that, insofar as an incompatibility with a doctor's rights under Article 6 might be said to arise by reason of an attempt by the GMC to employ its right of appeal under section 40A to attack underlying findings of fact by a MPT in circumstances where the doctor would not have an equivalent right of appeal under section 40, the complaint would be shown to be ill-founded once it is borne in mind that the doctor would in fact be able to challenge such findings in a similar way by bringing judicial review proceedings in the High Court. There would be no unfairness, lack of equivalence of recourse to the courts or inequality of arms. The intensity of review of such findings in judicial review proceedings could be adjusted, so far as necessary, to the same level as would be applied in an equivalent appeal by the GMC under section 40A, since the High Court in judicial review would be obliged to act in a way which is compatible with the doctor's rights under Article 6: see section 6(1) and (3) of the HRA. The availability to a doctor of judicial review in such a case again means that there is no warrant under section 3(1) of the HRA for adopting a strained meaning in relation to section 40A.

53. Finally, I consider that the grounds for interpreting section 40A(1)(d) as the GMC proposes, as set out above, are so strong that it is in any event not "possible" for a different meaning to be adopted pursuant to section 3(1) of the HRA. It is a fundamental feature of the 1983 Act that the GMC should exercise its functions in order to protect the public and a fundamental feature of section 40A that it should have the right of appeal to the High Court to secure that objective in a case where a MPT has failed to make a finding of impairment of a doctor's fitness to practise when it should have done: see *Ghaidan v Godin-Mendoza* [2004] UKHL 30; [2004] 2 AC 557, at [30] (Lord Nicholls) and [110]-[122] (Lord Rodger of Earlsferry). In my opinion, it is no answer to this point to say that the PSA has a distinct right of reference, so the GMC needs no equivalent right of appeal. That is because the same

argument regarding incompatibility of rights as between the individual doctor and the relevant public authority would presumably be raised in relation to a reference/appeal brought by the PSA.

Ground (2): the judge's substitution of a finding of dishonesty

54. At the time of the decision of the MPT, the approach to dishonesty was taken to be that set out in *R v Ghosh* [1982] QB 1053, according to which it is necessary to consider whether the person in question had acted dishonestly by the standards of ordinary and honest people and, if so, whether he himself realised that what he was doing was dishonest by those standards. This approach is reflected in what the MPT said at para. [99] of its Determination on Facts, set out above. However, following the hearing before Sweeney J this approach to dishonesty was disapproved by the Supreme Court by its judgment in *Ivey v Genting Casinos (UK) Ltd* [2017] UKSC 67; [2018] AC 391 and replaced with a different approach. Before Sweeney J and before us it was common ground that the approach to dishonesty in relation to findings made by a MPT should be that set out in *Ivey*. Under the approach in *Ivey*, when dishonesty is in question the fact-finding tribunal must first ascertain the actual state of the person's knowledge or belief as to the facts, and then should determine the question of dishonesty by applying the standards of ordinary decent people. There is no requirement that he should appreciate that what he has done is, by those standards, dishonest.

55. Sweeney J rejected the submission for the appellant that in relation to charge 6b in respect of the statement referred to in charge 5a he should substitute a finding that the appellant did not know that the statement was false: [49]. On the other hand, the judge accepted the submission of the GMC that he should substitute a finding in relation to charge 7b in respect of charge 5a, that the statement by the appellant referred to in charge 5a had been made dishonestly. In doing that, the judge directed himself by reference to the approach to the standard of proof set out by the House of Lords in *In re D* [2008] UKHL 33; [2008] 1 WLR 1499, and held that even on the test in *Ghosh* he considered that it was necessary to substitute a finding of dishonesty in relation to charge 5a, and that this conclusion was even clearer on application of the test in *Ivey*: paras. [43]-[54]. What weighed particularly strongly with the judge was that the MPT had found that in their telephone conversation or conversations the appellant knowingly misled Dr De Halpert about whether he had made entries in the examination section of the assessment form before he saw Patient A. In the judge's view, this could only be regarded as dishonest behaviour by the appellant. The judge was unimpressed by the emphasis placed by Mr Kellar on the honesty and openness of the appellant in the account he gave to Dr Nafousi and the nurses at his meeting with them before the conversations with Dr De Halpert: para. [49].

56. I have not found this part of the case easy. However, with respect to Sweeney J, I consider that the appeal should be allowed on Ground (2). In my view, the judge adopted an approach which was too 'cut and dried' in analysing the position as he did by reference to parts of the MPT's findings, whereas it was a case which the MPT plainly regarded as finely balanced, involving circumstances which required subtle but important and morally significant distinctions to be drawn. It seems clear that the MPT gave anxious consideration to whether the appellant's conduct could be regarded as dishonest and that it thought that there was an important moral distinction to be drawn in the particular circumstances of the case, with the appellant falling on the right side of the line so far as the charge of dishonesty in relation to the statements referred to in charge 5a and charge 5b was concerned.

57. In my view, the evaluative judgment made by the MPT in this regard should be given great weight. That is both because it had the advantage of seeing the appellant and the witnesses, so that it was well placed to make an evaluative judgment regarding the nuances of their interactions and the nature and seriousness of what the appellant did, and because of the practical expertise of a MPT in being able to understand the precise context in which and pressures under which a doctor is acting in a case such as this.

58. It can fairly be said that the reasoning of the MPT is not easy to understand in all respects and that there are points of tension between different parts of its reasoning. Both sides have sought to exploit this in different ways. The GMC's case before Sweeney J and before us relied primarily on the contrast between the MPT's finding on charge 6b (knowledge of falsity) and its finding on charge 7b (absence of dishonesty) in relation to charge 5a, in order to assert that logic should have dictated that the MPT should have resolved that tension by finding that charge 7b (dishonesty) was made out as well. The appellant's case before Sweeney J and before us relied on that same contrast, but for the submission that the tension should be resolved by substituting a finding in respect of charge 6b that the appellant did not know that the statement referred to in charge 5a was false, because he had understood Dr De Halpert to be pressing him with an allegation that he had filled in the examination section of the assessment form without ever intending to see Patient A. In further support of that submission, the appellant also points to the tension between the MPT's analysis of the position in relation to charge 5b and its analysis in relation to charge 5a, even though the statements in reflected in those charges are very closely related, and are in effect different sides of the same coin.

59. Like the judge, I do not accept Mr Kellar's submission that a different finding should be substituted for that of the MPT in relation to charge 6b, as regards charge 5a, so as to say that the appellant did not know that any statement he made to Dr De Halpert was false. The MPT gave good and sufficient reasons for its finding on this point. In my opinion, there is no such simple 'cut and dried' solution in favour of the appellant.

60. However, reading the various parts of the MPT's decision as a whole, I consider that the basic thrust of its findings of fact is tolerably clear and that its conclusion on the question of dishonesty as regards the appellant's conversations with Dr De Halpert was defensible and legitimate. As I read its decision, the tensions in its reasoning reflect the anxious care with which it sought to weigh and evaluate the moral significance of the appellant's conduct in the particular context of this case. Given the tensions in the MPT's reasoning, I think there is merit in giving weight to the way in which the MPT itself characterised its findings, in particular at para. [14] in its Determination on Impairment, set out above. Doing that points away from the conclusion arrived at by the judge. I also think that the judge should have given greater weight to the MPT's finding at paras. [91] and [99] of its Determination on Facts that before the appellant spoke to Dr De Halpert, he had given a full and honest account of what he had done to Dr Nafousi and the nurses. The MPT attached weight to this feature of the case (see, in particular, para. [99] of its Determination on Facts) and I think the judge was wrong to discount it.

61. On my reading of its decision, the MPT's assessment was that the appellant had acted wrongly in starting to make entries in the examination section of the assessment form before he saw Patient A, but he made those entries with the intention that he would proceed to examine Patient A and would check and amend them as necessary in light of that examination. (I would add that, although this was wrong, it is difficult to believe that the appellant was the first or will be the last doctor working in an A & E

department who tries to save time in this way). He did not hand the assessment form over to anyone in that partially completed state, but through an unfortunate set of circumstances it was taken from his desk by others and various erroneous assumptions were made in light of its contents.

62. The appellant was later challenged about the form and how he had filled it in by the nurses and then by Dr Nafousi, and once the matter in question was clarified the appellant was open and honest in saying what he had done. The MPT found he gave a full account to Dr Nafousi and the nurses at the meeting held to clarify what was going on.

63. The appellant continued on duty on his shift in A & E that night, and it seems that the next relevant event is that he was called by Dr De Halpert (who had been called by Dr Nafousi) and put on the spot about what had happened. It does not appear that Dr Nafousi had warned the appellant that he would call Dr De Halpert and that this might happen. The MPT found that the appellant understood that the main allegation that Dr De Halpert was making against him was the very serious one that he had filled in the assessment form without ever intending to examine Patient A, and that the appellant's position in response was that he had made entries in the form as a preparatory matter before proceeding to examine Patient A (see in particular para. [99] of the Determination on Facts and para. [14] in the Determination on Impairment, set out above). This was the focus of the appellant's concern in his conversation with Dr De Halpert that night, and the principal point that he was seeking to get across to Dr De Halpert. At the same time, however, under the pressure of being put on the spot about this, he was deliberately and knowingly evasive with Dr De Halpert about precisely what entries he had made and in which sections of the assessment form. However, it was clear from his conduct in relation to Dr Nafousi and the nurses that this was not part of a deliberate and dishonest plan by the appellant to cover up what he had done. Rather, it was a venial and comparatively trivial effort by him to deflect Dr De Halpert's ire that night.

64. On this reading of the MPT's reasons, I consider that this was a defensible and legitimate assessment for the MPT to make. It provides a legitimate basis on which the MPT was entitled to find that the appellant had not been dishonest in his dealings with Dr De Halpert. That is so whether the relevant approach to dishonesty is that in *Ghosh* or, as has now been clarified, that in *Ivey*.

65. Of course, at para. [99] in its Determination on Facts the MPT focused on the *Ghosh* test, since that was the test which the parties had agreed was to be applied. But it is significant that the MPT did not say that an ordinary and honest member of the public *would* consider the appellant's action to have been dishonest, but only that they might have done. The MPT then gave reasons focusing on the appellant's subjective state of mind to justify its conclusion that he had not acted dishonestly.

66. In my view, recasting the MPT's assessment on the question of dishonesty in terms of the approach now laid down in *Ivey*, its findings regarding the subjective understanding of the appellant (in particular, in para. [99] of the Determination of Facts and para. [14] of the Determination on Impairment, set out above) remain highly germane to the assessment of dishonesty. In light of the very serious allegation which the appellant understood Dr De Halpert to be raising with him (that the appellant had filled in the form without ever intending to see Patient A), it was entirely understandable that this was the main focus of his response to Dr De Halpert. The appellant answered that allegation truthfully, as the MPT found, because he had made the entries with the intention of then examining Patient A and confirming or

amending them. Although he was deliberately evasive about which entries he had made on the assessment form and knowingly misled Dr De Halpert, that was in context a venial and obviously short term expedient. The fact that the appellant had already given a full and truthful account to Dr Nafousi and the nurses made it clear that it was not part of a truly dishonest effort to cover up what he had done.

67. I have considered whether the appropriate course might be to allow the appeal against the judgment below and to remit the case to the MPT for it to make further findings or give further reasons in relation to the dishonesty question in light of the guidance in *Ivey*. However, I have come to the conclusion that the basic thrust of the MPT's reasoning is already sufficiently clear and that the just and appropriate course in the circumstances is simply to allow the appeal on Ground (2) and to restore the MPT's finding that the appellant was not dishonest in his conversations with Dr De Halpert, contrary to what had been charged by the GMC in charge 7b.

68. On that basis, it is clear that the MPT was entitled to find, as it did, that the appellant's fitness to practise was not impaired. Accordingly, no question of the giving of a direction under section 35D(2) of the 1983 Act arises.

Ground (3): the judge's substitution of a finding of impairment of fitness to practise

69. Since I would allow the appeal on Ground (2) and restore the MPT's finding that there was no dishonesty on the part of the appellant, the question whether the judge was entitled to substitute a finding that the appellant's fitness to practise was impaired by reason of his dishonesty does not arise. It is not necessary or appropriate to say anything more about that part of the case.

Conclusion

70. For the reasons set out above, I would dismiss the appeal on Ground (1). The High Court had jurisdiction under section 40A to entertain the appeal by the GMC in respect of the finding by the MPT that the appellant's fitness to practise was not impaired and in respect of the underlying findings of fact made by the MPT which supported its conclusion on impairment.

71. However, I would allow the appeal on Ground (2). The MPT was entitled to make the finding which it did that the appellant had not acted dishonestly and the judge was wrong to substitute a finding of dishonesty. Accordingly, the GMC's appeal to the High Court against the decision of the MPT, and in particular in respect of its finding that the appellant's fitness to practise was not impaired, should have been dismissed.

72. On this footing Ground (3) does not arise.

Lord Justice Bean:

73. I agree with Sales LJ, for the reasons he gives, that the High Court had jurisdiction under section 40A to entertain the GMC's appeal against the MPT's decision not to make a finding that the appellant's fitness to practise was impaired and that the appeal on Ground (1) should accordingly be dismissed. Like him, I would allow the appeal on Ground (2) and quash the finding of dishonesty substituted by Sweeney J.

74. Although I agree that the High Court had jurisdiction to hear this appeal by the GMC, I wish to express my regret that it was brought. It should require a very strong case for a court to overturn a finding of the MPT (or any comparable tribunal) that a doctor has *not* acted dishonestly. In the present case, as Sales LJ has observed, the MPT gave

anxious consideration to whether the appellant's conduct could be regarded as dishonest. They heard the appellant, Dr De Halpert and other witnesses give evidence over several days. They were well placed to make an evaluative judgment of the nuances of how the various individuals had interacted and that judgment should have been accorded great weight, not only by the court but by the GMC in deciding whether to bring an appeal at all. The discretion given by section 40A(3) to appeal against any decision which the GMC consider not sufficient for the protection of the public is a wide one, but in my view it is a discretion to be exercised with restraint where it involves a challenge to a finding of fact in the practitioner's favour.

Lord Justice Underhill:

75. I agree with both judgments.