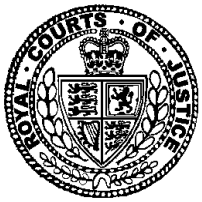

Neutral Citation Number: [2023] EWHC 967 (Admin)

Case No: CO/4796/2022

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 27 April 2023

Before :

MRS JUSTICE FOSTER DBE

- -

Between :

THE PROFESSIONAL STANDARDS AUTHORITY FOR HEALTH AND SOCIAL CARE

Appellant

- and -

(1) GENERAL MEDICAL COUNCIL

First Respondent

(2) PROFESSOR SUNDARA LINGAM

Second Respondent

- -
- -

Ms Fenella Morris KC (instructed by **Browne Jacobson LLP**) for the **Appellant**
Ms Jenni Richards KC (instructed by **GMC Legal**) for the **First Respondent**
Professor Sundara Lingam appeared in person

Hearing date: 20 April 2023

- -

Approved Judgment

This judgment was handed down remotely at 12.00pm on Thursday, 27 April 2023 by circulation to the parties or their representatives by e-mail and by release to the National Archives

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MRS JUSTICE FOSTER DBE:

The layout of this judgment is as follows:

Introduction and the Issue	paragraphs 1-4
Framework	paragraphs 5-22
Background Facts	paragraphs 23-50
Findings of the Panel	paragraphs 51-57
Challenge	paragraphs 58-70
Consideration and Decision	paragraphs 71-81

INTRODUCTION and the ISSUE

1. Before the court is an appeal by the Professional Standards Authority ("the PSA") under section 29 of the National Health Service Reform and Health Care Professions Act 2002 ("the 2002 Act") in respect of a decision of the Panel of the Medical Practitioners Tribunal ("the Panel" or "the MPT") of the General Medical Council ("the GMC"). The general functions of the PSA under the 2002 Act under section 25(2) include (a) to promote the interests of patients and other members of the public in relation to the performance of their functions by various regulatory bodies and by their committees and officers; (b) to promote best practice in the performance of those functions.

2. The PSA challenges the imposition of a sanction imposed by the Panel on 12 October 2022. It followed a finding of misconduct against the Second Respondent, Professor Sundara Lingam, and that in consequence his fitness to practise was impaired. The Panel imposed a conditions of practice order for a period of 24 months with a review before the expiry of that period. It was imposed in respect of inappropriate prescribing practice by transcribing, signing and issuing almost 300 private prescriptions between 2 January 2013 and 25 March 2014, purportedly for use outside the UK where insufficient or no relevant information was before the doctor. Evidence that was available to investigators later showed prescriptions were written for patients who did not exist. When he appeared initially before the MPT in 2015, a conditions of practice order had been imposed restricting Professor Lingam's activities, in force for seven years, until the final hearing of the case.

3. None of the allegations, including as to misconduct and impairment, was contested by Professor Lingam.

4. Ms Fenella Morris KC appeared on behalf of the PSA. Ms Jenni Richards KC appeared on behalf of the General Medical Council, adopting a neutral stance but making certain observations for the assistance of the court and of Professor Lingam. Professor Lingam appeared on his own behalf in person, as he had done before the MPT. He made no oral contribution to the hearing save to indicate he wished the sanction imposed upon him to remain unchanged. I am grateful to counsel for the economy of their submissions and for their helpful skeleton arguments.

FRAMEWORK

5. The applicable law was not in dispute. Under section 29(4) of the 2002 Act as amended the PSA may refer a case to the High Court where it considers:

> "*the decision is not sufficient (whether as a finding or a penalty or both) for the protection of the public.*"

6. Section 29(4A) indicates that whether a decision was sufficient means whether it was sufficient to:

> "*(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.*"

The Duties of the Court

7. Since this is an appeal the provisions of CPR 52 apply to the hearing and CPR 52 r 11 will be read with the provisions of the 2002 Act.

8. In *Council for the Regulation of Healthcare Professionals v GMC and Ruscillo* [2005] 1WLR 717 the correct approach was expressed as follows:

> "*70. If the Court decides that the decision as to the penalty was correct it must dismiss the appeal, even if it concludes that some of the findings that led to the imposition of the penalty were inadequate. No doubt any comments made by the Court about those findings will receive due consideration by the disciplinary tribunal if, at a later stage, it has occasion to review the standing of the practitioner.*
>
> *71. If the Court decides that the decision as to penalty was 'wrong', it must allow the appeal and quash the relevant decision, in accordance with CPR 52.11(3)(a) and section 29(8)(b) of the Act. It can then substitute its own decision under section 29(8)(c) or remit the case under section 29(8)(d).*
>
> *72. It may be that the Court will find that there has been a serious procedural or other irregularity in the proceedings before the disciplinary tribunal. In those circumstances it may be unable to decide whether the decision as to penalty was appropriate or not. In such circumstances the Court can allow the appeal and remit the case to the disciplinary tribunal with directions as to how to proceed, pursuant to CPR 52.11(3)(b) and section 29(8)(d) of the Act.*
>
> …

> *76. The test of whether a penalty is capable of appearing unduly lenient* [now "not sufficient for the protection of the public"] *in the context of section 29 is whether it is one which a disciplinary tribunal, having regard to the relevant facts and to the object of the disciplinary proceedings, could reasonably have imposed … in any particular case under section 29, the issue is likely to be whether the disciplinary tribunal has reached a decision as to penalty that is manifestly inappropriate, having regard to the petition's conduct and the interests of the public.*"

9. An element of restraint is required in the appeal court as recognised in *GMC v Jagjivan* [2017] 1 WLR 4438 [Div Ct] at paragraph 40:

> "…
> *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 professions and sanctions, with diffidence …*
>
> *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 itself and thus attach less weight to the expertise of the Tribunal…*"

10. Further the Court of Appeal in *Bawa-Garba v GMC* [2019] 1 WLR 1929 characterised a sanction for misconduct at paragraph 61 as:

> "*… 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 …*"

11. Thus, a specialist body such as the MPT is recognised as having greater experience in the field in which it operates than the appeal court so the latter should only interfere with an evaluative decision of such a body 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.*" [ibidem [67]]

12. In this case the PSA argued the conditions order was insufficient to protect the public or uphold public confidence in the profession (see *Ruscillo* at paragraph [76] above) and alternatively there had been an error of principle in the evaluation such that it is not

possible to determine whether the sanction imposed was unduly lenient or not, because the reasoning of the Panel's sanction decision was inadequate (see *Ruscillo* at paragraph [72] above).

13. The proposition that failure to provide adequate reasons for a decision constitutes a serious irregularity allowing this court to intervene is well-established and supported by *CRHP v GDC and Marshall [2006] EWHC 1870 (Admin); (1) GMC and (2) PSA v Mr Simon Bramhall [2021] EWHC (2109) (Admin)* and *PSA v (1) The General Optical Council (2) Ms Honey Rose [2021] EWHC 2888 (Admin)*.

The Duties of the Panel

14. The overwhelming public protection objective of the GMC and therefore of an MPT Panel operating within the various measures making up the Fitness to Practice Rules is reflected in section 1 of the Medical Act 1983 ("the MA") which states:

> "*(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.*"

15. It is echoed in the GMC's published Sanctions' Guidance by reference to which a Panel has power under section 35D of the MA to impose sanction on a practitioner upon making a finding of impairment. Paragraph 17 states:

> "*Maintaining public confidence in the profession*
>
> *Patients must be able to trust doctors with their lives and health, so doctors must make sure that their conduct justifies their patients trust in them and the public's trust in the profession . . . Although the tribunal should make sure the sanction it imposes is appropriate and proportionate, the reputation of the profession as a whole is more important than the interests of any individual doctor.*"

16. Importantly, *Ruscillo* also supports the proposition that an inquisitorial duty falls upon a Panel hearing a professional regulatory matter in the public interest: it is under an obligation to play "*a more pro-active role than a judge presiding over a criminal trial*" (paragraph [80]). This may involve, in an appropriate case, making sure the case is properly presented, or that the appropriate evidence is before the Panel. Necessarily this may involve questioning the witnesses where necessary to make sure the issues are investigated thoroughly.

17. Whilst deference is afforded to the expert Panel as reflected in the cases cited, this respect is more limited, or absent, in circumstances where a serious procedural or other irregularity is apprehended (see the observations of Lang J in *PSA v NMC and X* [2018]

EWHC 70).

18. The duty to give cogent reasons in this context was recently considered by Collins-Rice J in two cases. She held in *PSA and GOC v Rose* [2021] EWHC 2888 (Admin) in terms which are particularly relevant to the present proceedings:

> "*82. … the duties that expert tribunals have to the public – to ensure that the public can understand why certain decisions have been reached in its name; can be reassured that healthcare professionals on whom they must depend are well and fairly regulated; and can know that the overarching obligation professionals have to deserve the trust the public places in them, and to discharge their professional duties with the interests and safety of patients uppermost, has a secure foundation.*"

explaining in *GMC and PSA v Bramhall* [2021] EWHC 2109 (Admin) at [36] and [42] that reasons for departure from guidance issued by the relevant regulatory body should be "*(a) clear, (b) substantial and (c) specific*".

19. The Sanctions Guidance contains a number of passages to which Ms Morris KC refers when submitting that the Panel did not lawfully discharge its functions. She relies particularly on the following:

> "*Considering mitigating factors*
>
> *… 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.*
>
> *The following are examples of mitigating factors.*
>
> *a Evidence that the doctor understands the problem and has insight, and of their attempts to address or remediate it …*
>
> *b Evidence that the doctor is adhering to important principles of good practice*
>
> *…*
>
> *e Lapse of time since an incident occurred.*
>
> *…*
>
> *Remediation of the concerns*
>
> *… There are some cases where a doctor's failings are irremediable. This is because they are so serious or persistent that, despite steps subsequently taken, action is needed to maintain public confidence. This might include*

where a doctor knew, or ought to have known, they were causing harm to patients, and should have taken steps earlier to prevent this.

…

The doctor's insight into the concerns

Expressing insight involves demonstrating reflection and remediation. A doctor is likely to have insight if they:

a accept that they should have behaved differently …

b take timely steps to remediate …

c demonstrate the timely development of insight …

…

Considering aggravating factors

…

Lack of insight

A doctor is likely to lack insight if they … promise to remediate, but fail to take appropriate steps …

…

Conditions are likely to be workable where:

… the doctor has the potential to respond positively to remediation …

… conditions may be appropriate [where there is] no evidence that demonstrates remediation is unlikely to be successful e.g. because of previous unsuccessful attempts or a doctor's unwillingness to engage …

…

Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor.

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 …

Suspension may be appropriate, for example where there may have been acknowledgement of fault and where the tribunal is satisfied that the

behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions.

…

Some or all of the following factors being present … would indicate suspension may be appropriate.

• A serious breach of Good medical practice

…

• No evidence that demonstrates remediation is unlikely to be successful, e.g. because of previous unsuccessful attempts or a doctor's unwillingness to engage.

…

Aggravating factors that will also be relevant to the length of suspension

…

• The extent to which the doctor departed from the principles of Good medical practice

• Whether the doctor showed a lack of responsibility toward clinical duties/patient care

• The extent to which the doctor's actions risked public safety or public confidence

• The extent of the doctor's … sustained acts of … misconduct

…

• Whether the doctor is reluctant to take remedial action

…

• The extent to which the doctor failed to address serious concerns over a period of time

Failing to provide an acceptable level of treatment or care

Cases in this category are those where a doctor has not acted in a patient's best interests and has failed to provide an adequate level of care, falling well below expected professional standards … Particularly where there is a deliberate or reckless disregard for patient safety or a breach of the fundamental duty of doctors to 'Make the care of [your] patients [your] first concern' …

> *A particularly important consideration in these cases is whether a doctor has developed, or has the potential to develop, insight into these failures.*
>
> *… there are some cases where a doctor's failings are irremediable. This is because they are so serious or persistent that, despite steps subsequently taken, action is needed to maintain public confidence. This might include where a doctor knew, or ought to have known, they were causing harm to patients and should have taken steps earlier to prevent this.*"

20. *PSA v HCPC & Doree* [2017] EWCA Civ 319 illustrates the principle that whilst always a fact-sensitive exercise, a departure from the Guidance must be explained. A Panel is obliged to have proper regard to the Guidance and apply it as suggested by its terms unless there exist sound reasons for departing from it – in which case it has to state those reasons clearly in its decision.

The Duties of a Doctor

21. The GMC's Guidance to doctors is contained in Good Medical Practice. Ms Morris KC relied particularly on the following passages which, in the circumstances of this case, are set out in full:

> "*Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and make sure your practice meets the standards expected of you in four domains.*
>
> *<u>Knowledge, skills and performance</u>*
> *• Make the care of your patient your first concern.*
>
> *<u>Safety and quality</u>*
> *• Protect and promote the health of patients and the public.*
>
> *16. In providing clinical care you must:*
>
> *• prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs*
>
> *• provide effective treatments based on the best available evidence*
>
> *• consult colleagues where appropriate …*
>
> *• check that the care and treatment you provide for each patient is compatible with any other treatments the patient is receiving, including (where possible) self-prescribed over-the-counter medications …*"

22. The guidance as to good practice in relation to prescribing at the relevant time included the following:

> "*Together with the patient, you should make an assessment of their condition before deciding to prescribe a medicine. You must have or take an adequate history, including:*
>
> *a. any previous adverse reactions to medicines*
>
> *b. recent use of other medicines, including non-prescription and herbal medicines, illegal drugs and medicines purchased online, and*
>
> *c. other medical conditions.*
>
> *…*
>
> *You should reach agreement with the patient on the treatment proposed, explaining:*
>
> *a. the likely benefits, risks and burdens, including serious and common side effects*
>
> *b. what to do in the event of a side effect or recurrence of the condition*
>
> *c. how and when to take the medicine and how to adjust the dose if necessary, or how to use a medical device*
>
> *d. the likely duration of treatment*
>
> *e. arrangements for monitoring, follow-up and review, including further consultation, blood tests or other investigations, processes for adjusting the type or dose of medicine, and for issuing repeat prescriptions.*
>
> *You should check that the patient has understood the information and encourage them to ask questions to clarify any concerns or uncertainty. You should consider the benefits of written information, information in other languages and other aids for patients with disabilities to help them understand and consider information at their own speed and to retain the information you give them.*
>
> *…*
>
> *If you prescribe for a patient, but are not their general practitioner, you should check the completeness and accuracy of the information accompanying a referral. When an episode of care is completed, you must tell the patient's general practitioner about:*
>
> *a. changes to the patient's medicines (existing medicines changed or stopped, and new medicines started, with reasons)*

b. length of intended treatment

c. monitoring requirements

d. any new allergies or adverse reactions identified, unless the patient objects or if privacy concerns override the duty, for example in sexual health clinics.

…

If a patient has not been referred to you by their general practitioner, you should also:

a. consider whether the information you have is sufficient and reliable enough to enable you to prescribe safely, for example, whether:

i you have access to their medical records or other reliable information about the patient's health and other treatments they are receiving

ii you can verify other important information by examination or testing

b. ask for the patient's consent to contact their general practitioner if you need more information or confirmation of the information you have before prescribing.

If the patient objects, you should explain that you cannot prescribe for them and what their options are.

…

You are responsible for any prescription you sign, including repeat prescriptions for medicines initiated by colleagues, so you must make sure that any prescription you sign is safe and appropriate.

You may prescribe only when you have adequate knowledge of the patient's health and are satisfied that the medicines serve the patient's needs. You must consider:

a. the limitations of the medium through which you are communicating with the patient

b. the need for physical examination or other assessments

c. whether you have access to the patient's medical records"

THE BACKGROUND FACTS

23. Professor Lingam qualified with a diploma of Licentiate of the Royal College of Physicians from the Royal College of Physicians of Edinburgh in 1974. He worked for

over 30 years in the NHS, retiring in 2004. He was also the medical director of an entity known as the Medical Express at the relevant time. By the time of the Tribunal he admitted every one of the allegations and that they amounted to misconduct, although initially he had stated he was not the prescriber, only the "*transcriber*".

24. Professor Lingam faced allegations that he had completed the prescriptions at the request of a company called Kool Pharma Ltd. This company had offices in his building and was his tenant.

25. The charges alleged that Professor Lingam had been provided with information by the Pharmacy that was insufficient to allow safe prescribing. It did not contain the patient gender, contact details, GP or specialist medical records, community GP contact details, proof of identity, medical history prescribed medication and/or over-the-counter medication, allergies etc. It was alleged and accepted that Professor Lingam had also failed to identify certain "*red flags*" including that overseas consultants requested medication to be written for patients who lived in a different country from themselves.

26. Professor Lingam argued in explanation that he understood he was prescribing as part of a humanitarian enterprise, for those who had no local access to required medication. Many prescriptions however, as Professor Lingam agreed, were for economically developed countries in which patients could be expected to acquire the medication themselves; in addition, the medications were frequently of high value, were specialist in nature to be used in an in-patient setting and under the observation of secondary care in the community: serious risks were run if the patient were not properly monitored following prescription of certain of the drugs.

27. Also alleged and admitted were the failure to obtain contact with patients, their community GPs, an overseas consultant or specialist, or a relevant specialist in the UK, and a failure adequately to assess the patients. This included failure to ascertain gender, the presenting complaint, the patient's capacity or competence, mental health history and other necessary details for safe and regular prescribing. Professor Lingam had not examined the patients and therefore had taken no blood pressure or weight, had conducted no blood tests or cardiogram screening. He did not query the quantities, medications nor type, nor ensure the prescriptions were safe, appropriate or being administered appropriately. He arranged no follow up nor supervision nor did he provide appropriate details to the patients, GPs etc.

28. The admitted allegations included prescribing medications in inappropriately large quantities without knowing what they were for nor the monitoring arrangements that they required. He was ignorant as to who was collecting them, or where they were being sent. He also admitted acting outside his level of competence. He did not have current experience in the relevant specialist fields, which included rheumatology, infectious disease, gastroenterology, blood or renal carcinomas, dermatology and oncology. He also prescribed medication to adults although himself a paediatrician.

29. It was also admitted and found proved that the issuing of the prescriptions in this manner could have led to very serious consequences indeed. Multiple and comprehensive breach of the GMC Guidance was alleged and admitted. None of the allegations asserted a motive for the behaviours. Professor Lingam admitted in his evidence that he had been reckless although it had not been alleged in terms that his disregard of the Guidance was

reckless. His evidence was that he was aware of and had looked at the Guidance before acting as he did.

30. A salaried GP, Dr Bakhtiar, who had begun working as a sessional GP at the Medical Express Clinic run by Professor Lingam, was also charged, with another doctor at the Clinic, with prescribing in the same manner, although both in respect of fewer prescriptions than Professor Lingam. The cases of Professor Lingam and Dr Bakhtiar were heard together.

31. The relevant history for Professor Lingam included evidence of correspondence in 2004 between Professor Lingam and the BMA in which he asked for and received guidance concerning prescribing for persons outside the United Kingdom who had not been seen. The BMA indicated through Professor Somerville, their Head of Ethics, that particular care was needed in this area. She stated that great caution, especially regarding potential risks of the medication in the context in which it would be administered, was necessary.

32. In January 2008 a complaint had been made to the GMC against Professor Lingam on a number of different bases. The complaint did not proceed to a disciplinary hearing, but as a result of concerns arising out of a complaint about prescribing (including for those outside the UK) the GMC reminded Professor Lingam of the guidance given in the GMC publication, Good Medical Practice, to the effect that a doctor must prescribe drugs only where he or she has adequate knowledge of the patient's health and is satisfied that the drugs or treatment serve the patient's needs.

33. The subject of this current appeal and the MPT hearing did not come before a Panel until 3 October 2022. The reason for that, canvassed at the hearing, was that the medicines' regulator the Medicines Healthcare products regulation Agency ("MHRA") had instigated a criminal investigation including into Professor Lingam and two other doctors at the Clinic, in respect of these prescribing matters.

34. A referral had been made to the GMC in January 2015, but the GMC agreed to await the outcome of the MHRA investigation which lasted until August 2019, whereupon the GMC began to investigate. There was yet further delay caused by the pandemic. It appears that the clinicians were first interviewed by the MHRA only in February of 2019 under caution. No criminal allegations were pursued against the doctors.

35. The matter had initially come before the GMC as a result of a notification from the new Pharmacy Manager at the King Edward VII hospital in London, Dr Al-Nagar. His investigation in turn proceeded from an earlier CQC inspection which had raised concerns about out-patient prescriptions and inappropriate record keeping, in particular concerning the Medical Express Clinic's private prescriptions. These had no patient address and the hospital pharmacy was concerned they could only dispense prescriptions with an appropriate address on them. The matters came to light when Dr Al-Nagar took over at the Edward VII Hospital as the new Pharmacy Manager following the CQC involvement. He had been told that the Medical Express Clinic was for international patients, the prescriptions were written and then picked up from an entity called Kool Pharma Ltd who were linked to Medical Express. It was the MHRA's eventual conclusion that unbeknownst to the doctors, Kool Pharma obtained the prescription medicines in the UK and then sold them at great expense somewhere else out of the jurisdiction. The evidence of Dr Al–Nagar to the Panel was that Medical Express's

prescriptions amounted to millions of pounds worth of drugs.

36. The MPT was shown a type of document signed by Professor Lingam with no detail of the patient or their address referring to "*stock drugs*". In theory this meant they would be used on site - unless there was a dispensary pharmacy at the Medical Express Clinic. The Pharmacy Manager described the drugs as very expensive branded items which you would normally not administer in out-patients, you would need an ICU setting. Professor Lingam, he said, always asked for the branded drug, not a generic equivalent.

37. The case before the Panel was opened for the GMC on the basis that Kool Pharma had misled the doctors appearing before the tribunal. Kool Pharma had asserted to the King Edward VII Hospital that the medications were not delivered to patients overseas rather, the patients were visitors to the UK, which was false. The evidence showed that the "*vast quantity of the medication requested were for patients with cancer or HIV whereby the patient needs to have undergone various blood profiling in different clinical setting*". This was reflected in the activities of Professor Lingam in that he had requested items as "*stock*", and not on a patient-by-patient basis, yet they were not in truth stock for his clinic, nor otherwise, did he have the appropriate patient or other details, as described above. When the MHRA conducted open-source research about the alleged patient recipients suspecting they were not genuine, enquiries were made of five countries of which two responded, in the case of each of them, Australia and Poland, none of the named patients on the prescriptions existed.

38. The barrister instructed on behalf of the GMC made clear in opening that no allegations of fraud were ever pursued against the doctors and fraud or other criminal activity was not alleged by the GMC. The evidence was in terms "*the ... doctors* [which included Professor Lingam] *were duped by Kool Pharma Ltd*". The burden of the case before the MPT and the terms of the pleadings were that it was wholly inappropriate and in comprehensive breach of relevant guidance for doctors to have signed prescriptions given the scant information provided to them by Kool Pharma. The GMC emphasised that, as set out above, there had been no examination of patients and no access to medical records, medications were high value and were specialist in nature and in the vast majority of cases suitable only for use in an in-patient hospital setting. Certain of the medications were contra-indicated under certain conditions yet it was impossible to ensure that the patient was suitable for the prescribed medication.

39. As stated, part of the case against Professor Lingam was that although he was a paediatrician, he was not competent to prescribe the particular medications he prescribed unless he was working as a specialist in the relevant area. The particular prescriptions about which he was questioned in interview were hospital only prescription medications. The expert witness for the GMC described it that he was "*prescribing large quantities of potentially toxic medications to patients that he had never seen and would never likely see.*" All were for specialist use and due to their side-effect profile required regular near-patient testing, patient review and monitoring. The information that Kool Pharma gave to him lacked appropriate clinical and contact detail and was described as "*totally insufficient to allow for safe prescribing and were for larger quantities than would usually be prescribed*". In addition, there were no records of the patient nor their family physicians.

40. With regard to expert evidence about the effects or nature of the drugs Dr Campbell,

called on behalf of the GMC and whose evidence, like that of Dr Al-Nagar, was not disputed by Professor Lingam, said in respect of certain of them that they included chemotherapy agents, one of the side effects of which was abnormalities in the blood, affecting different organs; if the patient was not monitored it was "*extremely possible that it could have led to patient death*".

41. Before the Tribunal, Professor Lingam resolved initially that he would not give oral evidence, but later decided he would do so. He explained he had understood he was effectively engaged in a humanitarian venture, and that the medicines were to go to those who otherwise would not have access to them. He said Kool Pharma told him that African countries wanted access to these products, and he was happy to sign some because they were from poorer countries, he was helping people in other countries to achieve the best. Kool Pharma had asked if he would help them to buy hospital medicines and so he went to Edward VII hospital with whom the Clinic worked, and introduced Kool Pharma to them. He explained they were his tenant, and they had said they wanted to buy medicines. He said that "*stock*" really meant "*stock for Kool Pharma*" because he handed the prescription to Kool Pharma who took it to the hospital and bought the drugs.

42. In respect of the stock items which appeared to be for his clinic, he accepted the document should have read "*stock Kool Pharma*" and he accepted he did not know in such a case whether there was a specific patient who had been advised to take the medication by a consultant. The hospital created the format he said. They gave it to Kool Pharma who filled some in, and then gave it to him to write. When asked why he thought Kool Pharma needed a stock, for example, of a prostate cancer drug, he answered "*somebody in some country must have prostate cancer*". His case was that he facilitated, transcribed, and he helped, thinking the person would benefit.

43. It was put to him that the standard prescription forms contained a statement indicating that doctors were responsible for all prescriptions they wrote which were legal documents, and that doctors needed to make sure that the medication requested for the third party was suitable and would not affect them adversely in any way and this was why a consultation with a doctor was always required. He was asked why he did not follow what was set out on this standard form. He did not answer the question directly, saying, "*I did the misconduct I have accepted and that it was wrong and a gross professional mistake from which I have learnt.*" He did not ask questions, he said, "*because I was helping, as far as I understood it*".

44. When the terms of Professor Somerville's BMA warning to him in 2004 were put and he was asked why, in those circumstances he was happy to sign, he said Kool Pharma tricked him, and his colleagues. He reiterated his explanation that he understood he was giving humanitarian help to those who vitally needed it and did not have the medicines. He said he had no vested interest, no financial interest, nothing. He believed he was helping people by doing so. He said he had always reflected on good medical practice and:

> "*I always knew I must prescribe properly. I have been a consultant for many years before coming into practice … I realised there was a problem and that's why I wrote to BMA myself to ask for advice and I know this is the case.*"

He also referred to being a religious person and it was for those types of reasons that he did the prescribing. When asked why he did not have the guidance at the forefront of his mind when Kool Pharma came to him, he said he did have it in the forefront of his mind, and continued:

> "*… but in this case it is a business deal between two business people. I was only a pawn in this, I think. I didn't even consider – all I know is what I already told you. I really thought I'm doing some humanitarian help to people suffering in other countries, and if that's what God has want me to do, I simply will do it. There was no fraud intended. No financial gain intended. Nothing other than just helping on humanitarian grounds and that's always in my mind.*"

45. He referred to the fact that at the IOP seven years ago he accepted professional misconduct and stated that he had suffered enough.

46. When the Guidance was put to him, he volunteered he had breached all the paragraphs. Again, when asked why notwithstanding he stated he had read all the guidance beforehand, he did not see a problem signing the prescriptions. He said, "*I have accepted that I have not done correctly and that – therefore I accepted misconduct from day one.*" He then spoke about excellent feedback he gets from teaching courses for the BMA and how he had been providing education to the profession and he said:

> "*I even talked to my colleagues, "Do you know what, I did a silly thing, I made a mistake." You're telling me about a mistake which I have accepted. I have not followed the guidelines. I have accepted. … I have let myself down.*"

47. Reliance is put by the appellant on the position of Dr Bakhtiar. In his evidence Dr Al-Nagar made it clear that he believed Dr Bakhtiar had been fooled, tricked into acting; he thought Professor Lingam knew more about what was going on than Dr Bakhtiar. Professor Lingam knew who the personnel at Kool Pharma were, at one point they were replying on his behalf. He understood that they were Professor Lingam's tenants. Kool Pharma was introduced to King Edward hospital by Professor Lingam, and it was elicited on behalf of Dr Bakhtiar that the latter had nothing to do with that introduction. His only involvement was in terms of signing the prescriptions, he had no personal relationship with Kool Pharma.

48. In the course of his evidence Dr Bakhtiar explained that Professor Lingam had, without his knowledge or consent, made Dr Bakhtiar the Clinical Manager at Medical Express – as reflected in the documentation. He was described in the documents as chairing the clinical board of Medical Express and acting as the director of clinical governance and the registered manager for CQC, i.e., regulatory, purposes. This took place in March 2015. When asked if he could explain why the entry was made Professor Lingam said:

> "*I really can't remember or understand how that error has happened. I'm really sorry.*"

[No further questions were asked of him on this issue including by the Tribunal.]

49. When asked if it was reckless of him to have signed the prescriptions, Professor Lingam agreed and said, "*I have always said that it was wrongdoing, it is the gross professional misconduct hearing I am facing*."

50. Ms Morris KC submits, and Professor Lingam accepted before the Panel, that effectively each of the tenets of the prescribing Guidance of the Good Medical Practice had been breached by him.

THE FINDINGS of the PANEL

1. on IMPAIRMENT by reason of MISCONDUCT

51. Although Professor Lingam accepted the allegations and the misconduct and impairment allegations, properly, the Panel went on to determine for itself, on the basis of the guilty plea, the issue of impairment by reason of misconduct. The Panel's determination indicated it had received two testimonials in support, but they did not state whether they knew of the proceedings against the Professor.

52. The GMC's submissions to the Panel are recorded as including the admission by Professor Lingam that he had been reckless. Counsel emphasised the stock drugs, the use only in hospital, and the potential for serious harm. The GMC highlighted the paucity of evidence as to the actual nature of his practice since the conditions were imposed, saying the "*Tribunal will have to reach its own conclusion on [his] level of insight*." Professor Lingam submitted insight was currently "*only developing*". He had failed to provide any CPD certificates to confirm any learning he might have undertaken.

53. In their determination as to Misconduct the Panel correctly directed themselves on the relevant tests and noted in particular, breach of the prescribing guidance, and that Professor Lingam's actions "*potentially put patients at risk of harm*". I presume they meant by these words "put at risk of harm", alternatively, that there "*was a potential for harm, and Professor Lingam's actions put patients at risk of that harm*". The Panel speaks of the "*potential risk*" posed by the fact that a large quantity of hospital-only medication had "*potentially been released into the unregulated market, which could have harmed any person to whom the medication was sold or otherwise provided to* [*sic*]". I do not believe the Panel intended by this phraseology to suggest that the risk was anything less than a real and actual risk, only that there was no evidence that this is what had happened – i.e. no evidence before the Panel that the risks Professor Lingam ran had materialised.

54. Also in its misconduct determination the Panel noted that the volume of his prescribing was double that of any other doctor at the clinic, and, given the 2004 and 2008 regulatory interactions, concluded he did not heed the advice given "*taking a cavalier attitude towards remote prescribing*" in spite of it. They expressly recognised there was "*a real risk of Professor Lingam's actions resulting in serious harm and potentially death to patients*".

55. When dealing with impairment the Panel stated this:

> "*50. The Tribunal took the view that Professor Lingam's misconduct,*

> *though serious, was capable of remediation. It considered the submissions of Professor Lingam that the misconduct had largely been the result of his naivety and misguided, but genuine, belief that his role was to transcribe the Prescriptions as part of humanitarian efforts, to assist patients in other countries. In making its decision on impairment, the Tribunal noted that it had not been supplied with evidence of specific learning opportunities that had been undertaken to remediate his misconduct, or personal reflections into the impact of his actions.*
>
> *51. The Tribunal was concerned that Professor Lingam appeared to have taken no steps, between the time of the incident and now, to improve his understanding of his misconduct, as well as the impact it would have on public trust in the profession. The Tribunal noted that Professor Lingam appeared quite confused when asked specific questions relating to his misconduct and the reasoning for his actions. It noted that while Professor Lingam accepted that his actions amounted to misconduct and that what he did was wrong, the explanations he provided were unclear and he did not appear to fully understand why his actions were "wrong".*"
>
> [Emphasis has been added.]

56. These two paragraphs are passages upon which Ms Morris KC places significant reliance in support of her arguments, observing it is quite unclear, having "*considered*" the submissions of Professor Lingam about his claimed belief he was assisting humanitarian effort, whether or not that they accepted that evidence. She also adverts to the fact that the Panel noted the behaviour had continued over a long period; they expressly stated they heard Professor Lingam's remorse, but remorse was not without more evidence of insight or targeted remediation. The Panel noted in terms it had not been provided with evidence of remediation, and the Professor appeared to have "*taken no steps*" in the seven years since the incident and the imposition of interim conditions, to improve his understanding.

2. on SANCTION

57. Shorn of its record of submissions, the recitation of principle and the setting out of the conditions, the decision of the Panel on Sanction was in its totality as follows:

> "*73. In reaching its decision, the Tribunal has taken the S[anctions] G[uidance] into account and paid careful regard to the overarching objective. The Tribunal reminded itself that the main reason for imposing any sanction is to protect the public and that sanctions are not imposed to punish or discipline doctors, even though they may have a punitive effect. Throughout its deliberations, the Tribunal has applied the principle of proportionality, balancing Professor Lingam's interests with the public interest.*
>
> *Aggravating and Mitigating Factors*
>
> *74. The Tribunal has already set out its decision on the facts and impairment*

which it took into account during its deliberations on sanction. Before considering what action, if any, to take in respect of Professor Lingam's registration, the Tribunal considered and balanced the aggravating and mitigating factors in this case.

75. The Tribunal identified the following aggravating factors:

• The serious nature of the misconduct, creating serious risk of harm to patients and the public;
• That Professor Lingam was in a position of leadership at the Clinic, engaging other doctors to be involved in similar behaviour;
• Professor Lingam has not provided evidence of targeted remediation to the Tribunal.

76. Having identified aggravating factors in this case, the Tribunal identified the mitigating factors to be:
• Making full admissions to the Allegation from the outset and fully engaging in the proceedings;
• The events in question took place nearly 8 years ago and the conduct has not been repeated;
• Professor Lingam has complied with the conditions imposed by the IOT for the past 7 years;
• Professor Lingam has had no previous findings of misconduct;
• The allegations do not relate to dishonesty;

77. The Tribunal carefully considered these features throughout its deliberations in considering the appropriate and proportionate sanction to impose. The Tribunal considered each sanction in ascending order of severity, starting with the least restrictive.

No action

78. The Tribunal first considered whether to conclude the case by taking no action. It noted that taking no action following a finding of impaired fitness to practise is only appropriate in exceptional circumstances. The Tribunal determined that there were no exceptional circumstances in this case and that, given the seriousness of its findings, it would not be sufficient, proportionate, or in the public interest to conclude this case by taking no action.

Conditions

79. The Tribunal next considered whether to impose conditions on Professor Lingam's registration. The Tribunal noted that conditions may be appropriate and workable in certain circumstances, including where a doctor has been open, honest and has shown insight. It also noted that conditions may be appropriate where the Tribunal is satisfied that the doctor will comply with them and has the potential to respond positively to their work being supervised.

80. The Tribunal carefully considered imposing the more serious sanction of suspension, which would have a deterrent effect and may be appropriate in order to send a signal to Professor Lingam, the profession, and the public about what is regarded as behaviour unbefitting a registered doctor. The Tribunal took the view that a period of suspension would be a disproportionate sanction in this case, particularly given the passage of time since the events which make up the Allegation.

81. The Tribunal was mindful of the seriousness of the misconduct identified in this case, but also, the length of time that Professor Lingam had successfully complied with the conditions imposed by the IOT – almost eight years – which had had a significant impact on him. It took the view that whilst Professor Lingam had not yet developed full insight, he appeared, in both his submissions and oral evidence, to be developing his insight and would continue to comply with the restrictions imposed. In the circumstances, the Tribunal did not view a period of suspension as necessary to satisfy the three limbs of the overarching objective and would be a disproportionate response to the misconduct established.

82. The Tribunal was of the view that conditions could be drafted which could properly protect, promote and maintain the health, safety and wellbeing of the public, by allowing Professor Lingam to continue working while at the same time improving his insight and undertake targeted remediation to further diminish the risk of repetition. The Tribunal concluded that embarking on a process that would allow Professor Lingam to return to practice safely was in the interests of Professor Lingam and the wider public, who would ultimately continue to benefit from his skills and experience.

83. In view of the above, the Tribunal concluded that Professor Lingam's misconduct could adequately be marked with a period of conditional registration. The Tribunal determined that conditions would uphold the overarching objective, whilst at the same time, adequately mark the seriousness with which it viewed Professor Lingam's actions. Further, a period of conditional registration would allow Professor Lingam to continue to work towards completing his journey of remediation, and to be able to demonstrate, with objective evidence, that he has learnt from his past failings and that he has implemented steps to address them.

84. The Tribunal therefore determined to impose the following public conditions upon Professor Lingam's registration … [etc]"

[Emphasis has been added.]

THE CHALLENGE

58. The PSA's grounds of appeal were as follows:

(i) the MPT failed to grapple with the seriousness of Professor Lingam's misconduct

when making its decision as to sanction, in particular failing adequately to address the significance of the maintenance of standards and of upholding public confidence in the profession;

(ii) the MPT took an erroneous approach to the mitigating factors and failed to identify or take into account all of the aggravating factors;

(iv) the Panel failed to take into account the registrant's failure to understand what he had done wrong and to remediate over seven years, it was "*irrational wishful thinking*" to indicate that his insight would improve when subject to conditions; and

(v) the Panel departed from the Sanctions Guidance but failed to give reasons for doing so.

59. A further Ground, which had been opposed by the GMC, to the effect that the GMC had under-prosecuted the case in that it had failed to allege financial motivation and/or recklessness on the part of Professor Lingam was not pursued at the hearing.

60. The core submission in support of the decision that the sanction of a conditions order was appealably wrong was in essence that it appeared the Panel had misapprehended the seriousness of the defaults. In the course of her oral submissions Ms Morris KC developed her criticism principally by reference to its reasoning, and what she submitted was its failure adequately to explain the basis for its imposition only of the Conditions of Practice Order. As Ms Richards KC noted, the GMC had argued for a suspension before the Panel.

61. Ms Morris KC argued that a number of features of the evidence were of particular relevance in the case, and it appeared they had been misunderstood by the Panel or ignored when the Panel came to consider sanction. The failure to have regard to these matters produced a sanction that was wrong, alternatively contributed to the reasoning issues. The misconduct had potentially affected hundreds of patients and the doctor had run the risk of serious injury of death prescribing dangerous drugs to patients whom he had not met nor had contact with and of which he did not have any relevant knowledge. The material before the Tribunal from Dr Bakhtiar showed the leader of the enterprise was Professor Lingam, strikingly, although he admitted that against Dr Bakhtiar's will, he had placed that doctor's name as the CQC contact at the Clinic, he had no explanation for such action. He had also told Dr Bakhtiar in terms he had the GMC and the BMA's blessing for what he was doing. The Panel had itself referred to the fact that his answers were "*confused*".

62. She also points to the fact that the approach to mitigation was flawed: in the context of serious misconduct mitigation has less influence upon decision-making; this is nowhere recognised by the decision. She submitted it was not right, as suggested by the GMC, that it was possible to read across necessary reasoning from the decision on Impairment to supplement and expand the reasons for sanction. Even if it were, those reasons are not themselves adequate. The Panel indicated it had "*already set out its decision on the facts and impairment"* then listed some (but she submitted far from all of) the aggravating factors of the case. Three only were identified: the serious nature of the misconduct (without more); the Professor's leadership role; and the absence of remediation evidence.

There were additional important considerations of context. There had been two previous warning shots, one by the BMA and one by the GMC following the earlier complaint, which resulted in advice to consider the guidance from the GMC about foreign prescribing. This was mentioned but its significance misapprehended. When he was asked about purported humanitarian prescribing to countries which patently were not needy areas of the world, the Professor had no satisfactory answers – this was not dealt with, nor its implications explored in the tribunal's reasoning.

63. A further aspect of the unsatisfactory nature of the sanction decision she said was the apparent failure of the Panel to consider why the registrant acted in the way he did. Hundreds of prescriptions were issued, and he was paid for issuing them, which he did in breach of fundamental tenets contained in the guidance for doctors of Good Medical Practice. The Panel ought to have been led to an inference that Professor Lingam had a financial motive in prescribing as he did or had chosen to put those interests above patients. It is not possible to see that the Panel considered that matter and reflected it in their reasoning.

64. Ms Morris KC argued there was a significantly flawed approach to matters of aggravation or mitigation, the latter having on authority, less relevance in a patient safety matter (see above, where this principle is reflected in the Sanctions Guidance). The finding that Professor Lingam was not dishonest (see paragraph 76 of the determination cited above) was irrelevant to mitigation - the Professor had not been charged with dishonesty. The GMC agreed with this last submission but suggested it made no difference.

65. The PSA noted that Professor Lingam had admitted his recklessness in evidence, as had the GMC in its submissions but as Ms Morris KC submits, it was not noted in the record of the determination other than comprehended perhaps in a reference to him taking a "*cavalier attitude to remote prescribing*" in the Impairment findings - it was not adverted to with regard to sanction.

66. The MPT's approach she submitted had resulted in an erroneous conclusion as to the relevant factors pertaining to his conduct and thus to a penalty that did not adequately protect the public. The same matters supported the conclusion that the reasoning was inadequate to determine whether or not the penalty was in fact wrong. Such a serious procedural error requires the court to remit the matter since the outcome could be different.

67. Ms Morris KC also relied upon a failure to recognise the significance of Professor Lingam's failure to understand his wrongdoing, and his consequent failure to show remediation. The Panel were not shown any steps taken to improve his understanding, they acknowledged they found little evidence of efforts to undergo training or remediation. He remained "*confused*"; this she argued showed his lack of insight and yet there was no proper appreciation of the impact of this. This was inconsistent with the Sanctions Guidance which gave direct guidance about the requirement for insight.

68. There was no factual basis for their finding, therefore, that Professor Lingam's insight would improve during a period of conditions. Considerable time, namely seven years since 2015 under conditions of practice, had passed and yet he still failed to display a proper understanding.

69. The approach of the Panel she submitted demonstrated a departure from the Sanction's Guidance, but the Panel did not acknowledge or give reasons for this departure.

70. The GMC made helpful observations in light of the fact that Professor Lingam was unrepresented. Ms Richards KC suggested that it could be said it was necessary to read the decision as a whole, the Court might feel that, taken overall, the MPT had identified the relevant risks. It should be taken as reflecting the seriousness of the behaviour in its use of the word "*cavalier*". She referred to the finding in the Misconduct determination to the effect that:

> "*Professor Lingam appeared quite confused when asked specific questions relating to his misconduct and the reasoning for his actions … the explanations he provided were unclear and he did not appear to fully understand why his actions were wrong*",

although he had accepted misconduct. She submitted, contrary to Ms Morris KC's argument, that the Professor's evidence was clear- the lack of clarity noted by the Panel did not relate to motive. Other than some general observations, the GMC was neutral in stance.

CONSIDERATION AND DECISION

71. I have come to the clear conclusion that the decision of the Panel must be quashed and remitted to them for reconsideration on the basis of a serious procedural error in the form of inadequate and unclear reasoning as to sanction. The reasoning process is inadequate for the Court to determine whether or not certain important issues were appreciated, and if so, how they were reasoned through. It is therefore not possible to determine whether the sanction imposed was "*wrong*" in the statutory sense. There has been a serious procedural error engaging the Court's appellate jurisdiction.

72. I accept the PSA's case essentially for the reasons put forward in argument by Ms Morris KC as to the inadequacies of reasoning by the Panel and the impact of those failures on the issues they were required to decide.

73. In particular I highlight the following:

    a. Seriousness. There is a significant risk that the Panel may have misapprehended the seriousness of the actions of Professor Lingam. The exiguous reasoning dealing with the context of the prescribing does not reassure that they appreciated the extent or import of the factual background for the question of sanction. Importantly, it is impossible to know certainly whether the Panel in fact accepted Professor Lingam's explanation about humanitarian assistance, which was central. They did not say as much in the decision. They said they "*considered*" the "*submission*". The evidence however had some features inconsistent with the explanation given – in particular, prescribing to developed countries where humanitarian need was hardly an obvious requirement; also, the fact that the Clinic received remuneration, albeit at the usual rate of £40.00 a prescription, this was many thousands of pounds over the period in question. It may be that the Panel accepted everything that was said - since the imposition of a conditions sanction may be thought consistent with

acceptance of the genuineness of that answer, (but this is a somewhat teleological approach). If, as the GMC suggested, this is the proper reading of the decision, then there might be support for a sanction of the nature of that imposed here, in a context where dishonesty had not been alleged. However, the Panel's treatment of Professor Lingam's evidence in paragraph 50 is laconic, indeed opaque. It is to be contrasted with elsewhere in the determination where, when dealing with evidence from him concerning the value of the stock items he wrongly prescribed, they said (in paragraph 46) they had "*noted his evidence and accepted that he may not have realised the value of the stock that he was requesting.*" The Panel do say in terms they found the Professor's evidence "*unclear*", and they described him as "*confused*", but I note from the transcript, all of which I have read, that the MPT was not probing in the course of the Professor's oral evidence. The lack of clarity was not sought to be remedied. A Panel has a duty to interrogate where necessary to understand the issues clearly (see *Ruscillo* at paragraph [80]). The context here suggests the Professor may have exhibited significant blindness to obvious risks, or, alternatively, have possessed awareness of risks yet taken a decision to run those risks in any event. It is not clear what analysis the Panel engaged in upon these matters because they did not set out their reasoning in any detail on the important factual context - which would have assisted them in determining seriousness. In the context particularly of a man of the intelligence and learning of the Professor, the Panel ought in my judgement have asked itself what the facts told them about the admitted recklessness, and thus the seriousness of the matters found proved. Careful analysis of what happened and what its significance and seriousness are goes directly to public protection and is the best means of achieving that statutory objective. The same obtains for the duty of upholding the good name of the profession: a clear articulation of the impact of the behaviour upon reputation is called for in order properly to apply the sanctions criteria. In order to do that, a careful decision on the character and seriousness of the actions in question is required.

b. Dr Bakhtiar. The extraordinary and unexplained conduct in respect of Dr Bakhtiar being placed without his knowledge in a position of regulatory responsibility for the Clinic, particularly given Dr Bakhtiar's demonstrably subsidiary role, was a matter that plainly could influence the Panel's view of the gravity of the matter but is not mentioned in either decision. Questioning from the Panel did not probe the Professor's answers, yet the Panel must have formed a view. It ought to have weighed the important parts of the evidence it heard in its reasoning, given its potential influence upon their view of the gravity of Professor Lingam's actions.

c. Landlord of Kool Pharma. The closeness or otherwise of the relationship between the Professor and his tenant Kool Pharma, whom he had introduced to the Edward VII Hospital, was another matter that was not mentioned in any of the reasoning except obliquely. All these matters were opened to the Panel or were canvassed in evidence, and they must have formed a view on them, and whether they fed into the question of seriousness is not clear, as reasoning about them did not feature. These matters highlight the failure properly to examine and explain the question of seriousness.

d. Aggravation and Mitigation. Although the Panel states it took into account its Impairment decision when it was deliberating on sanction, the consideration of

mitigation and aggravation even in that decision does not adequately reflect a number of the relevant factors that were present. Among them in particular are the involvement by the Professor of other practitioners. Although it is mentioned that it was Professor Lingam who had personally introduced Kool Pharma to the hospital and involved Dr Bakhtiar and another doctor , these are not matters that receive much attention from the Panel in terms of the light they might shed on the seriousness of the case, possibly as matters of aggravation in respect of sanction.

e. Proportionality. The considerations of the Panel concerning the imposition of conditions recognised in terms (see [79] above) that conditions are possibly appropriate and workable where the doctor has been open and has shown insight. It then stated that suspension would be disproportionate "*particularly*" given the passage of time – but without giving any further reasoning to support disproportion, or to indicate what level of seriousness or impact it attributed to the misconduct in question. It said it was mindful of "*the seriousness*" but no more. Once again, this reasoning is inadequate to demonstrate the particular factors that impressed the Panel and to help the public understand what it was that drove the MPT to the conclusion it reached on a conditions of practice order.

f. Remediation and Insight. The Guidance emphasises the centrality of insight and remediation. The Panel noted only however ([81]) that Professor Lingam was "*developing his insight*". Allowing him to work while "*improving his insight*" or to complete "*his journey of remediation*" was said to be proportionate and sufficient to protect the public interest - including upholding the good name of the profession. The Panel however did not specify what evidence of remediation it had accepted to date, its reasoning ([53] within the Impairment determination) had hitherto stated that the Professor had presented no evidence of CPD, and that although remorse was accepted, there was "*little evidence … of specific efforts to complete further training to improve his compliance*" and "*insufficient evidence of insight or targeted remediation*". No analysis is shown of the implications of the fact that fully seven years had passed since interim conditions were imposed, and yet still the development of insight was apparently only partial – indeed there was "*insufficient evidence of insight".* All of this has implications for public protection and reputation, but it is not explained.

g. The Guidance. The conclusion that a conditions order was appropriate appears to be inconsistent with the Sanctions Guidance given the paucity (possibly absence) of evidence of insight and remediation - and yet no reason for this departure is given, there is no explanation of how the particular features of this case took it out of a more serious category. The passage of time whilst obviously a relevant factor is not the only feature of relevance, again, the seriousness of the activities should explicitly be set against these factors. That is not, I say again, to determine that the sanction imposed was appealably wrong – but it may have been: the reasoning does not allow of an informed decision . As Collins-Rice J said in *Bramhall*:

> "*42. The discipline of fully addressing the application of the Sanctions Guidance to the facts, and clearly articulating reasons for any departure determined upon, is itself the surest route to a secure assessment of gravity of misconduct and hence of proportionality. Shortcuts must be resisted,*

> *particularly where they risk being – or, as importantly, being seen to be – unduly influenced by considerations of personal mitigation.*"

74. I therefore agree with Ms Morris KC that the reasoning of the Panel in imposing sanction evinces a serious procedural error in relation to the reasoning process. The Panel may be correct concerning proportionality and it is possible that the imposition of conditions, even in an acknowledged serious case where there was insufficient evidence of insight, was within the range of available decisions, but on its face it is not possible to accept that the Panel complied with its duty carefully to apply the Sanctions Guidance due to the inadequacy of their reasoning. This appeal is allowed.

75. I add this, I am mindful of the fact that this Panel saw the Professor give evidence and were therefore in a good position to make judgements that are central to the seriousness of the events in question and as to genuine understanding and insight. For that reason and what I regard as clear failure of reasoning, possibly concealing failures of analysis, I quash the decision on the basis only of procedural error, for a reconsideration and revisiting of the decision on sanction.

76. Panels are required to make sanction decisions in various situations. The task in a case like the present is the more onerous because there has been no contest on the facts, nor upon impairment. This means the MPT have not had days of evidence including cross-examination in which to acquaint themselves fully with the nuance of the behaviour which is under examination. It is more difficult where a comprehensive plea is entered for a Panel to make the judgements as to context, character and seriousness that they are obliged to make.

77. In such cases it is incumbent on the presenting officer to prepare the facts fully (as was done here). However the *Ruscillo* [80] duty to engage is of paramount importance in these circumstances.

78. Any unclearness or lack of clarity should, where central to the task at hand, be resolved by the Tribunal where possible.

79. Here, some oral evidence was given. There was some cross-examination, and a few Panel questions. A Panel should feel bold, where the facts have been opened only, (not canvassed thoroughly in evidence), to resolve any material issues they have by questioning as far as they need to do so, to clarify the central issues arising.

80. In the criminal jurisdiction (far different from this), the 'Newton hearing' [*R v Newton* (1982) 77 Cr App R 13] has evolved to resolve issues as to the factual basis for a sentence. A decision is necessary because the Court must sentence on a true and proper basis. In the present case, of course, the facts led were all accepted by Professor Lingam. However it underscores the context of establishing carefully the factual basis, context and seriousness of any behaviour which falls to be sanctioned.

81. These matters are relevant because the giving of cogent and informative reasons, the duty of a Panel, is rendered much easier when central questions or uncertainties have been resolved. Cogent analysis at sanction stage is easier where the context and the

significance of the evidence has been explored. As stated, this exploration may, in a case where the facts are admitted wholesale, and no, or only a short, hearing takes place, need to be accomplished by the Panel itself. They must then, in the reasoning they set out, expose the relevant analysis so the reader understands what the principal issues were, and what the Panel made of them. This is part and parcel of their function in protecting the public interest.