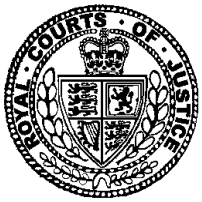

Neutral Citation Number: [2019] EWHC 390 (Admin)

Case No: CO/3367/2018

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 25/02/2019

Before:

MRS JUSTICE MAY

- -

Between:

Dr Pantula Sastry	**Appellant**
- and -	
General Medical Council	**Respondent**

- -
- -

Mary O'Rourke QC & Nicola Newbegin (instructed by **Medical Defence Shield**) for the **Appellant**
Ivan Hare QC (instructed by **GMC Legal**) for the **Respondent**

Hearing dates: 30 January 2019

- -

Approved Judgment

Mrs Justice May DBE :

Introduction

1. This is an appeal pursuant to section 40 of the Medical Act 1983 ("the MA") as amended from the decisions of the Medical Practitioners Tribunal ("MPT") which sat over 17 days between 13 November 2017 and 1 August 2018. On 1 August 2018 the MPT determined to erase the appellant (Dr Sastry) from the medical register.

2. This final determination was arrived at in three stages: at stage one, by a determination dated 16 May 2018, the MPT made findings as to which of a number of formal allegations brought against Dr Sastry had been proved ("the Stage 1 decision").

3. At the second stage, by its determination dated 18 May 2018, the MPT determined, on the basis of the charges found proved, that Dr Sastry's behaviour amounted to misconduct; further that his fitness to practice was thereby impaired ("the Stage 2 decision").

4. In the third stage the MPT considered sanction; as already indicated it decided on erasure by its determination dated 1 August 2018 ("the Stage 3 decision").

5. Dr Sastry now seeks to challenge (i) the finding of misconduct and impairment and, separately, (ii) the sanction which the MPT decided should be imposed.

6. The Respondent ("the GMC") is responsible for decisions of the MPT, such tribunals being statutory committees of the GMC (under s1(g) and (h) of the MA).

Facts

7. The allegations arose out of Dr Sastry's treatment of a lady in India, referred to as Patient A, during 2013-14 when he was working as a Consultant Medical Oncologist at Kokilaben Dhirubhai Ambani Hospital in Mumbai.

8. Dr Sastry was referred to the GMC by Witness B in December 2014 who complained about Dr Sastry's treatment of Patient A (who was his late mother). Witness B alleged that Patient A died as a result of negligent treatment by Dr Sastry. Patient A suffered from lymphoma and had relapsed in October 2013. Patient A then came under Dr Sastry's care. Dr Sastry recommended R-ICE salvage chemotherapy followed by autologous cell transplant. The R-ICE salvage chemotherapy took place between December 2013 and February 2014. Cell harvesting then took place between March and April 2014. On 16 June 2014, Patient A was admitted to hospital for high dose chemotherapy with BEAM and autologous cell transplantation. Such high intensity treatment destroys the patient's own bone marrow and survival is dependent on successful regeneration of the bone marrow from the patient's own stem cells that are infused after the chemotherapy. Between 17 and 22 June 2014, Patient A was given high dose chemotherapy. On the 24 June 2014, the cells that had been collected were reinfused. Following the transplant, Patient A developed a series of complications and her bone marrow and cell production failed to recover in response to the transplant. Shortly before her death on 10 July 2014, Patient A's family requested that Dr Sastry take no further part in her care.

9. Before the MPT, Dr Sastry faced the allegation that his fitness to practise was impaired by reason of misconduct:

> *"That being registered under the Medical Act 1983 (as amended):*
>
> *1. On 8 April 2014 your collection of stem cells from Patient A was inappropriate in that the bone marrow would not have had sufficient time to recover from the first stem cell collection on 18 March 2014.*
>
> *2. Between April 2014 and June 2014 your recommendation that Patient A undergo high dose chemotherapy with BEAM and autologous stem cell transplantation was inappropriate in that:*
>
> *a. Patient A had failed to mobilise an adequate number of CD34 positive cells; and/or*
>
> *b. you did not know the number of CD34 positive cells which Patient A had mobilised.*
>
> *3. Between 16 and 25 June 2014 you proceeded to high dose chemotherapy with BEAM and autologous stem cell transplantation on Patient A which was inappropriate in that:*
>
> *a. an adequate number of CD34 positive cells/kg had not been collected;*
>
> *and/or*
>
> *b. you did not know the number of CD34 positive cells/kg which had been collected."*

10. Dr Sastry was represented by Counsel and made no admissions. The MPT heard live evidence from:

- Witness B (Day 1);
- Dr Mahendra, Consultant Haemato-Oncologist, the GMC's expert (Day 3 and, via videolink, Day 6);
- Dr Treleaven, Consultant Oncologist, Dr Sastry's expert (Day 4);
- Professor Advani (via videolink), another expert called by Dr Sastry (Day 5); and
- Dr Sastry himself (Days 6 and 7).

Approach to appeals under s.40

11. The correct approach of this Court to appeals under the MA was summarised (in the context of an appeal under s. 40A of the MA) in *General Medical Council v Jagjivan* [2017] EWHC 1247 (Admin); [2017] 1 WLR 4438:

> "As a preliminary matter, the GMC invites us to adopt the approach adopted to appeals under section 40 of the 1983 Act, to appeals under section 40A of the 1983 Act, and we consider it is right to do so. It follows that the well-settled principles developed in relation to section 40 appeals (in cases including: Meadow v General Medical Council [2006] EWCA Civ 1390; [2007] QB 462; Fatnani and Raschid v General Medical Council [2007] EWCA Civ 46; [2007] 1 WLR 1460; and Southall v General Medical Council [2010] EWCA Civ 407; [2010] 2 FLR 1550) as appropriately modified, can be applied to section 40A appeals.
>
> In summary:
>
> i) Proceedings under section 40A of the 1983 Act are appeals and are governed by CPR Part 52. A court will allow an appeal under CPR Part 52.21(3) if it is 'wrong' or 'unjust because of a serious procedural or other irregularity in the proceedings in the lower court'."
>
> ii) It is not appropriate to add any qualification to the test in CPR Part 52 that decisions are 'clearly wrong': see Fatnani at paragraph 21 and Meadow at paragraphs 125 to 128.
>
> iii) The court will correct material errors of fact and of law: see Fatnani at paragraph 20. Any appeal court must however be extremely cautious about upsetting a conclusion of primary fact, particularly where the findings depend upon the assessment of the credibility of the witnesses, who the Tribunal, unlike the appellate court, has had the advantage of seeing and hearing (see Assicurazioni Generali SpA v Arab Insurance Group (Practice Note) [2002] EWCA Civ 1642; [2003] 1 WLR 577, at paragraphs 15 to 17, cited with approval in Datec Electronics Holdings Ltd v United Parcels Service Ltd [2007] UKHL 23, [2007] 1 WLR 1325 at paragraph 46, and Southall at paragraph 47).
>
> iv) When the question is what inferences are to be drawn from specific facts, an appellate court is under less of a disadvantage. The court may draw any inferences of fact which it considers are justified on the evidence: see CPR Part 52.11(4).
>
> v) In regulatory proceedings the appellate court will not have the professional expertise of the Tribunal of fact. As a consequence,

> the appellate court will approach Tribunal determinations about whether conduct is serious misconduct or impairs a person's fitness to practise, and what is necessary to maintain public confidence and proper standards in the profession and sanctions, with diffidence: see Fatnani at paragraph 16; and Khan v General Pharmaceutical Council [2016] UKSC 64; [2017] 1 WLR 169, at paragraph 36.
>
> vi) However there may be matters, such as dishonesty or sexual misconduct, where the court "is likely to feel that it can assess what is needed to protect the public or maintain the reputation of the profession more easily for itself and thus attach less weight to the expertise of the Tribunal …": see Council for the Regulation of Healthcare Professionals v GMC and Southall [2005] EWHC 579 (Admin); [2005] Lloyd's Rep. Med 365 at paragraph 11, and Khan at paragraph 36(c). As Lord Millett observed in Ghosh v GMC [2001] UKPC 29; [2001] 1 WLR 1915 and 1923G, the appellate court "will afford an appropriate measure of respect of the judgment in the committee … but the [appellate court] will not defer to the committee's judgment more than is warranted by the circumstances".
>
> vii) Matters of mitigation are likely to be of considerably less significance in regulatory proceedings than to a court imposing retributive justice, because the overarching concern of the professional regulator is the protection of the public.
>
> viii) A failure to provide adequate reasons may constitute a serious procedural irregularity which renders the Tribunal's decision unjust (see Southall at paragraphs 55 to 56).”

12. *Jagjivan* was cited with approval by Singh LJ in *Hussain v General Pharmaceutical Council* [2018] EWCA Civ 22, at [66] and by the Court of Appeal in *General Medical Council v Chandra* [2018] EWCA Civ 1898, at [81].

13. I was also referred to the decision in *Bawa-Garba v General Medical Council* [2018] EWCA Civ 1879 at [61]:

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

> 63 … In the recent case of R (Bowen and Stanton) v Secretary of State for Justice [2017] EWCA Civ 2181, McCombe LJ explained (at [65]) that, when the appeal is from a trial judge's multi-factorial decision, "the appeal court's approach will be conditioned by the extent to which the first instance judge had an advantage over the appeal court in reaching his/her decision. If such an advantage exists, then the appeal court will be more reticent in differing from the trial judge's evaluations and conclusions".
> …
> 67 That general caution applies with particular force in the case of a specialist adjudicative body, such as the Tribunal in the present case, which (depending on the matter in issue) usually has greater experience in the field in which it operates than the courts: see Smech at [30]; Khan v General Pharmaceutical Council [2016] UKSC 64, [2017] 1 WLR 169 at [36]; Meadow at [197]; and Raschid v General Medical Council [2007] EWCA Civ 46, [2007] 1 WLR 1460 at [18]-[20]. An appeal court should only interfere with such an evaluative decision if (1) there was an error of principle in carrying out the evaluation, or (2) for any other reason, the evaluation was wrong, that is to say it was an evaluative decision which fell outside the bounds of what the adjudicative body could properly and reasonably decide …
> …
> 94 As we said earlier in this judgment, the Tribunal was, in relation to all those matters and the carrying out of an evaluative judgement as to the appropriate sanction for maintaining public confidence in the profession, an expert panel, familiar with this type of adjudication and comprising a medical practitioner and two lay members, one of whom was legally qualified, all of whom were assisted by a legal assessor."

Grounds of Appeal

14. By his Grounds of Appeal Dr Sastry contends that:

(1) The Legal Assessor erred in law and wrongly misdirected the Tribunal in respect of the legal significance of the misconduct being alleged having taken place in India.

(2) The Tribunal erred in failing to accept the submissions made on behalf of the Appellant that he could not have a fair hearing in accordance with his rights under Article 6 ECHR.

(3) The Tribunal erred in finding the facts proved against the Appellant and/or its decision was wrong in law and/or perverse given it failed (properly or at all) to address the Indian context in its stage 1 (factual) decision making processes.

(4) The Tribunal erred in law in effectively charging the Appellant with dishonesty and making adverse findings against him.

(5) The Tribunal erred and was wrong in its consideration of impairment and in its findings at stage 2 (impairment) in that the allegations for stage 1 amounted only to a single incident single patient error many years ago in a different jurisdiction.

(6) The Tribunal erred in failing to properly take into account the Indian context and circumstances when considering Sanction and specifically when considering public confidence.

(7) In respect of protection of the public there was clear evidence this would be inapplicable as the Appellant would not find himself working in the UK in any circumstances similar to those arising in India in respect of Patient A given the vastly different circumstances of practice (eg Multi-disciplinary Teams ("MDTs") and need for specialisation) such that if and insofar as it did take protection of public into account at the sanction stage the Tribunal fell into material error.

(8) The MPT erred on Sanction by erasing the Appellant from the UK medical register. The Sanction imposed was wrong in all the circumstances and wholly disproportionate where the events occurred in India in a private healthcare facility and many years previously and specifically where the sanction sought by the GMC (as prosecutor) was only one of suspension.

15. At the hearing, these complaints were grouped and presented by Mary O'Rourke QC, for Dr Sastry, under three main heads as follows:

(1) Failure to have any or any sufficient regard to what Ms O'Rourke referred to as "the Indian context" (encompassing Grounds 1-3, 5 (in part), 6 and 7 above).

(2) Sanction (Grounds 5 and 8).

(3) Dishonesty: not charged and therefore wrong to make findings and/or to rely on such findings (Ground 4).

Indian context

16. Ms O'Rourke described (1) above as the foundation of Dr Sastry's complaints on this appeal. She accepted that the GMC's jurisdiction under s.35C of the MA specifically extends to the activities of registered doctors practising abroad but contended that such cases have invariably been founded upon foreign convictions or adverse findings by an equivalent professional body in another country. It was vanishingly unusual, she suggested, for the GMC itself to investigate and reach decisions on the behaviour of its registrants abroad in the absence of any other findings emanating from the country in question. Her searches had not been able to turn up any previous GMC decision where this had occurred.

17. On the day of the hearing Ivan Hare QC, for the GMC, produced one decision, concerning the behaviour of a Polish doctor registered with the GMC in the UK practising as a surgeon performing cosmetic surgery procedures in Poland. Complaints had been made about Dr Kalecinski to the GMC by UK citizens who had travelled to Poland for their procedures. The MPT in that case had investigated, made findings and had imposed conditions upon his registration for nine months.

18. Ms O'Rourke distinguished this case on the basis that it involved UK citizens who had travelled to Poland; moreover there was no likelihood of an appeal in circumstances where Dr Kalecinski had himself sought voluntary erasure. She contended that the present case was in a separate category as Patient A was an Indian citizen and Dr Sastry had been practising in the UK both before and after his year in India with no complaints at all made against him.

19. Ms O'Rourke submitted that when considering an allegation of very serious professional negligence – sufficiently serious to amount to "deplorable conduct" (see *Nandi v. General Medical Council [2004] All ER (D) 25* per Collins J at [31]) – the MPT should look at the circumstances in which an individual practised abroad and take into account local laws and standards, moreover the investigation should specifically include an enquiry into what those practices, laws and standards are, in order for that to happen. Ms O'Rourke referred me in this respect to the GMC's own guidelines for doctors practising abroad:

"doctors who work wholly outside the UK must abide by whatever regulatory requirements exist in the country in which they practise."

20. It was wrong, Ms O'Rourke argued, for the MPT to have placed so much emphasis on UK experts and UK Good Medical Practice ("GMP") when Dr Sastry was providing treatment to an Indian patient in an Indian hospital, where facilities were very different. For instance, on the evidence before the MPT it was the case that, in India, consultants provided treatment alone, not as part of a multi disciplinary team (MDT), there were no national or hospital standards or guidelines for CD34 cell count sufficiency and laboratories were not subject to the same testing regimes. Ms O'Rourke used as an analogy the example of UK doctors practising in parts of Africa or in war zones: in such underdeveloped places, she pointed out, it would not be fair or right to judge doctors by the same standards of practice that apply to medical practice in the UK.

21. Ms O'Rourke contended that the MPT had not, in its reasoning at any of the three stages, taken account of the very different circumstances pertaining to oncology practice in India at the relevant time. It had relied on evidence from a UK specialist haemo-oncologist and oncologist neither of whom had ever practised in India. Moreover the MPT had rejected, without providing a reasoned analysis explaining why, the evidence from an Indian consultant oncologist who was practising in India at the relevant time (Professor Advani).

Correct approach

22. The LA's advice as to the relevant standards which the Tribunal needed to apply was as follows:

> "*[M]y advice in relation to the Indian issue would be that the doctor needs to be judged by UK standards, GMC standards, but having regard to appropriateness the tribunal should take into account the circumstances—the hospital, the patient, and the facilities, etcetera—that were available to the doctor in India*."

23. Ms O'Rourke contended that this was the wrong test: she submitted that the Tribunal should have been advised that they were to assess Dr Sastry's behaviour by reference to whatever standards applied locally at the hospital in Mumbai. Mr Hare relied on the fact that Dr Sastry's representative at the hearing before the MPT appeared to have consented to the MPT adopting this approach, but I agree with Ms O'Rourke that whatever position his representative may have taken then cannot be determinative of the issue.

24. In my view once it is accepted (as it is) that the Tribunal has jurisdiction to consider complaints about a registrant's behaviour and conduct occurring anywhere in the world, then the advice given by the LA here was right: since the GMC's remit is to protect the public of the UK and to promote and protect proper professional standards in the UK (see s.1(1B) of the MA) it is bound to assess conduct with those standards in mind.

25. That is not to say that in applying UK professional standards a tribunal simply translates the behaviour directly to a UK setting, that would obviously be wrong. In considering whether or not a registrant undertaking professional duties outside the UK has fallen short of levels of professional conduct which the UK public is entitled to expect from its doctors, a Tribunal must take account of any particular limitations or local practices which apply in the foreign location. In short, a registrant's behaviour is to be judged by reference to UK standards but taking into account local conditions and practices. That is the approach that the legal assessor advised the MPT to take here.

26. Specifically, at Stage 2, when considering impairment, I consider that the MPT was right to use GMP as a reference by which to judge Dr Sastry's behaviour, albeit being careful to take into account local conditions. The obligation to comply with GMP comes with registration. As appears from the GMC Guidance given to doctors (*Guidance for doctors: requirements for revalidating and maintaining your licence*, at para 1.2*)*, there are two types of registration: with a licence to practise and without. A doctor may not practise in the UK without a licence but doctors practising wholly outside the UK do not need to hold a licence, indeed they need not be registered with the GMC at all. However, the Guidance is clear: if doctors choose to be registered with the GMC they must follow GMP. Doctors seeking to obtain or retain GMC registration, with or without licence, are obliged to practise in accordance with GMP.

Assessing behaviour in context

Stage 1

27. Ms O'Rourke next submitted that in arriving at its findings at the first stage the MPT gave too much weight to UK standards and practices, in relying on the UK experts and expressly disregarding the evidence of Professor Advani. The charges against Dr Sastry were couched in terms of "inappropriateness", Ms O'Rourke pointed out, and therefore, given the Indian context, there should have been some reference at least to that context when the tribunal considered the charges. Other than a perfunctory reference to *"full regard to the circumstances in which you were working in India"* in the introductory paragraph (at [68] of the Stage 1 determination), the decision at stage 1 relied wholly on the UK experts' evidence, she argued; there was no reference to India and to the evidence of Professor Advani or Dr Sastry that things were done very differently there, or to the fact that there were no national or local hospital guidelines relating to CD34 cell sufficiency.

28. As an example of this Ms O'Rourke drew my attention to para [88] of the MPT's Stage 1 decision recording the CD34 cell count as being *"very significantly below the contemporaneous European and American Guidelines for practice"*. These guidelines were not of standard application in India, Ms O'Rourke pointed out. At para [96] the MPT referred to *"..the established method for assessing the number of available stem cells for transplantation.."* yet made no mention, Ms O'Rourke complained, of the evidence to the effect that CD34 cell count was not the established method in India.

29. Mr Hare responded by drawing my attention to references in the Stage 1 decision referring to the Indian context:

(i) the Stage 1 decision started by recording that *"[t]he Allegation in this case relates to events in India…"*

(ii) At para [6] the MPT accepted Professor Advani as an expert in relation to *"the context of India"*. At para [44] it found that Professor Advani *"gave clear evidence on the 'Indian context' generally".*

(iii) The MPT recorded, as part of the background, at para [34], the fact that the treatment took place in a private hospital in Mumbai.

(iv) At para [68] the MPT refers to having had *"full regard"* to the circumstances in which Dr Sastry was working in India.

Mr Hare argued that, in the light of the above, it was "quite a stretch" (his words) to say that the MPT had not taken account of evidence about local conditions in India when making its findings as to whether charges were proved at Stage 1.

30. In any event, Mr Hare submitted, on the facts found by the Tribunal the 'Indian context' was of very little actual relevance in this case. This was because the MPT, having heard all the evidence, was plainly satisfied that Dr Sastry was aware of the clinical importance of a sufficient number of CD34 cells and yet proceeded to give Patient A high-level chemotherapy when there was an insufficient number for a viable re-transfer after the chemotherapy had ended. Mr Hare argued that, as appears from its reasoning, the MPT arrived at its conclusions on the charges he faced by assessing Dr Sastry's behaviour against his own contemporary appreciation that Patient A's CD34 cell count was insufficient. Mr Hare referred me to the following findings in particular (refs in [] are to paras of the Stage 1 decision):

(i) the Panel preferred the evidence of Witness B that Dr Sastry had neither explained the risks of proceeding with discrepant CD34 cell count reports nor that he was relying on the mononuclear count (Dr Sastry's case in evidence was that he had had discrepant lab results and had decided to proceed on the basis of a mononuclear count) ([82]).

(ii) in reverting to a mononuclear count, as he said he had, Dr Sastry had ignored the recommendation of another (Indian) doctor's second opinion making reference to a "sufficient number" of CD34 cells ([84]).

(iii) Dr Sastry's account of the circumstances under which he had (he said, wrongly) recorded the lower, 0.05% CD34 cell count on two hospital documents was *"wholly*

implausible", further that when examined about this his answers *"lacked credibility"* ([86]).

(iv) the MPT *"[did] not believe"* Dr Sastry's evidence that he was told of a higher, 0.5% cell count result, nor his account of having gone to the lab and seen an entry in the lab register to that effect ([87]).

(v) It *"did not accept [Dr Sastry's] account that the mononuclear count justified [his] decision [to proceed with chemotherapy]"* and found that the literature which Dr Sastry presented to them in his defence *"did not support the mononuclear cell count as an alternative measure of adequacy of harvest."* ([89]).

(vi) The above led to a factual finding (not disputed by Dr Sastry on this appeal) that: *"On the balance of probability the Tribunal determined that when you recommended high dose chemotherapy with BEAM to Patient A, you believed the CD34 positive cell count from the harvest on 8 April 2014 was 0.05% and that there was no uncertainty as to the CD34 count."* ([90]).

(vii) The MPT disbelieved Dr Sastry's account that there had been any discrepancy in the reported CD34 cell count ([92]), going on to make a factual finding (again not challenged in this appeal) that *"..at the time you recommended high dose chemotherapy with BEAM there was no uncertainty as to the CD 34 cell count."*([98]).

(viii) Having reviewed and set out an excerpt from the transcript of Dr Sastry's evidence the MPT made this factual finding (unchallenged on this appeal): *"...when you proceeded to high dose chemotherapy with BEAM not only were you fully aware of the low CD34 cell count of 0.05% but also of its significance in your treatment of Patient A at Kokilaben..Hospital"* ([101]).

31. In another case I might have had some concerns about the degree to which the MPT's findings were dependent upon expert evidence from experts based here in the UK (although I note that one of them was an expert witness produced and relied on by Dr Sastry himself) but in this case I think that Mr Hare is right and that the Indian context was of marginal relevance, given the MPT's (unchallenged) findings referred to above.

32. In her written submissions in reply Ms O'Rourke argued that these findings made by the MPT should not have been the "crucial determinants". She referred me to a number of passages in the evidence of Dr Sastry explaining his case that he had had no option but to proceed: Ms O'Rourke submitted that when assessing, under the charges as brought, what was "appropriate", the MPT should have set the evidence in the Indian context. Her case was that the MPT had focussed too much on the UK experts and not the mononuclear issue and the reasons why, in the particular (Indian) circumstances which prevailed, Dr Sastry believed it appropriate to proceed "despite the CD34 issue".

33. Notwithstanding Ms O'Rourke's determined and well-reasoned submissions I remained unpersuaded (a) that the MPT failed to take the Indian context into account and/or (b) that in this particular case the MPT's factual findings referred to above were insufficient to ground their conclusions on the charges brought. I think Mr Hare is right to say that, in this case, Dr Sastry was condemned out of his own mouth.

Stage 2

34. Moving to the Stage 2 decision, I have indicated above why I reject Ms O'Rourke's case that it was wrong to assess Dr Sastry's conduct by reference to GMP. I agree with Mr Hare that the principles of good practice set out in GMP are sufficiently high-level to be able to be adapted as necessary to accommodate differing guidelines and conditions which may exist in another country.

35. The examples of directions in the booklet setting out GMP to which Ms O'Rourke referred me were either expressed to be specific to UK or they were couched in sufficiently general terms to be applied flexibly depending on circumstances. The specific extracts from GMP relied upon by the MPT in this case fell into the latter category: for instance *"7. You must be competent in all aspects of your work…".*

36. It was alleged that the failure to take account of the Indian context also permeated Stage 2. Ms O'Rourke pointed out that when assessing Dr Sastry's treatment of Patient A against para 7 of GMP, quoted above, the MPT had referred exclusively to the opinions of the UK experts, noting that there were no requirements in India for the specific training course cited in the extract from their joint statement relied on by the MPT at para 15 of its Stage 2 Decision. Likewise, in relation to consent, where the GMP principle quoted by the MPT at para [17] of its Stage 2 decision is:

    "You must be satisfied that you have consent or other valid authority before you carry out any examination or investigation, provide treatment or…"

    Ms O'Rourke submitted that whereas the law of informed consent is very well developed in the UK the position was different in India when Dr Sastry was treating Patient A. The MPT had taken no account of this difference in its conclusions, she said; there was no reference at para [17] of the Stage 2 decision or elsewhere to what India required by way of informed consent.

37. Looking at the Stage 2 decision as a whole, I am quite satisfied that the MPT did take account of the Indian context when making its decision on Misconduct and Impairment. In particular the MPT recorded, at paras [6]–[8], the submissions made by Dr Sastry's representative, including a number of matters to do with circumstances in India, taken from the evidence of Dr Sastry and Professor Advani. The MPT noted, at para [10], that it had taken those submissions into account, along with all the evidence. Later in the Stage 2 decision there was a full discussion of the Indian context in connection with clinical record-keeping (at para [18]).

38. It is right that the MPT referred (at paras [15] and [21]) to the evidence of the UK experts when evaluating Dr Sastry's behaviour by reference to principles of practice taken from GMP. However I accept, as Mr Hare pointed out, that the evidence relied on was not of a failure to comply with UK-specific training or CDP requirements: at para [15] the MPT took into account a clinical view expressed by both experts (one of which was Dr Sastry's own expert) regarding the (inadequate) level of experience which Dr Sastry had attained in the area of autologous cell transfer; likewise at para [21] when expressing a clinical view regarding safe levels of CD34 cells prior to chemotherapy. As to the latter the MPT had seen, and had taken account of, the second opinion report from another Indian doctor referring to a "sufficient level" of CD34 cells.

39. In any event, at the second stage also, the Indian context was only of limited relevance given the findings made about Dr Sastry's actions based on his own evidence (see above). It was his evidence which prompted the MPT to find that Dr Sastry had *"not demonstrated any recognition regarding the concerns of this tribunal or acceptance that [he had done] anything wrong in [his] treatment of Patient A"* (para [27]), that he *"knew it to be inappropriate to proceed [with chemotherapy].."* (para [28]), that he *"fail[ed] to obtain fully informed consent for [his] treatment plan"* and that he had *"repeatedly sought to mislead [the MPT]"* (para [29]).

40. The central importance of Dr Sastry's own evidence appears from the MPT's conclusion set out at para 30 of the Stage 2 Impairment decision:

> *"..you were aware of a clear opinion in India regarding the need for sufficient CD34 cells. For reasons that are entirely unclear, you choose [sic] to ignore that opinion. The Tribunal was concerned that your attitude and behaviours evident in this case might not be confined to a particular medical procedure…The Tribunal considered that ..similar behaviour in your practice as a medical oncologist might occur in future"*

41. A further criticism made by Ms O'Rourke in relation to the Stage 2 decision was that the MPT had erred in focussing on a single event in India over 4 years before. She pointed out that the test for impairment should look forward, (relying on *Cheatle v. GMC* [2009] EWHC 645, per Cranston J at [21]-[22]), saying that the MDT had placed too much emphasis on Dr Sastry's behaviour in relation to one patient in India in 2014. Ms O'Rourke submitted that there was a failure to consider the contrast between the events and practice in India and the Appellant's UK practice. Dr Sastry's UK practice, she pointed out, was in an entirely different oncology setting.

42. As to this, the MDT correctly directed itself that the question of impairment was to be decided at the date of the hearing (at para [13] of the Stage 2 decision). I accept Mr Hare's submission that there was a finding of misconduct aggravated by the fact that, as the MPT had found, Dr Sastry had lied to it repeatedly. In going on to consider the likelihood of repetition the MPT explicitly took into account the fact that Dr Sastry was not going to work in the same area of stem cell transplantation in the UK (para [30]), however the MPT also had regard to what they concluded, having heard from Dr Sastry, was a lack of insight and a want of remediation (para [29]). It was these matters that prompted the MPT's conclusion at para [30], set out above.

Stage 3

43. Ms O'Rourke contended that when it took into account the principles of GMP at Stage 3 the MPT erred, given the Indian context. I reject this, for the reasons given above.

44. I find that in assessing sanction the MPT did have regard to the Indian context: at para [2] of the Stage 3 decision the MPT referred to having given careful consideration to the evidence and to the submissions made by Dr Sastry's representative. It went on to record those submissions at paras [10] to [19], including a variety of references to the different conditions which prevailed in India. In its list of mitigating factors at para [24]

the MPT included references to the absence of an MDT structure and to the fact that palliative care was less well-developed in India.

45. I deal below with complaints about the proportionality of the sanction imposed.

Article 6

46. Ground 2 of Dr Sastry's Grounds of Appeal alleged a breach of Dr Sastry's right to a fair trial. Ms O'Rourke relied on the fact that the GMC did not itself seek evidence from an oncologist practising in India and did not obtain medical notes or summon witnesses from the local hospital in Mumbai. She submitted that Dr Sastry was thereby denied a fair hearing.

47. In response Mr Hare drew my attention to the case of *R(Johnson) v Professional Conduct Committee of the Nursing and Midwifery Council* [2008] EWHC 885, where the court held that there is no free-standing duty on those bringing disciplinary proceedings to gather evidence for the purposes of Art 6. The question of whether or not a doctor has had a fair hearing before the MPT is to be determined by looking at all the facts of an individual case.

48. At no stage prior to the appeal hearing had any particular documents or evidence been identified as material to the outcome. At lunchtime on the day of the hearing before me Ms O'Rourke read out a list of documents which she said should have been obtained and whose absence rendered the hearing before the MPT unfair. Yet such documents had not been identified as necessary prior to the hearing before the MPT, nor was any application made. On the contrary, at an Interim Orders Hearing before an Interim Orders Tribunal ("IOT") on 24 June 2016 Dr Sastry's representative referred to Dr Sastry having obtained all the original medical notes and to his having instructed an Indian expert "who works in this very field" (a reference to Professor Advani).

49. There was no suggestion at that stage that the MPT should of its own motion obtain further documents or evidence, or that the hearing would be unfair if it did not. Mr Hare told me that over 2000 pages of medical records were placed in a joint bundle before the MPT for the hearing. Moreover the MPT permitted Dr Sastry to put in further evidence during the hearing itself (as recorded at para [39] of the Stage 1 decision).

50. Thus, the MPT had relevant notes and other evidence from India and it had evidence from Dr Sastry about the Indian context generally. It also had evidence over the videolink from Professor Advani in addition to his witness statement/expert report.

51. I have concluded that there was no breach of Dr Sastry's Article 6 right to a fair hearing.

Expert evidence – Professor Advani

52. I have dealt above with specific criticisms concerning the MPT's use of UK experts when considering events taking place in India, although as I have already noted, one of those experts was called by Dr Sastry himself in support of his defence.

53. There was a repeated complaint made by Ms O'Rourke that the MPT failed to have regard to the evidence of Professor Advani, as an oncologist working in India,

concerning practices and procedures relating to CD34 autologous cell transplantation. The MPT was wrong, she submitted, to leave Professor Advani's evidence out of account when considering whether Dr Sastry had acted "inappropriately" in his treatment of Patient A in India; she contended that there was no reasoned analysis as to why the MPT had rejected his evidence.

54. As I have indicated above, the MPT did accept Professor Advani's evidence as to the Indian context generally. However Ms O'Rourke is right that the MPT did not specifically refer to Professor Advani's evidence in connection with its decisions regarding the appropriateness of treatment at Stage 1, or in relation to Misconduct and Impairment at Stage 2. The MPT rejected Professor Advani's evidence insofar as it purported to give expert evidence on these matters.

55. The MPT's reasons for doing so are set out at paras [42]-[44] of the Stage 1 decision. The MPT found that Professor Advani was *"neither an independent, nor impartial expert witness"*, setting out six separate aspects of the evidence which drove them to this conclusion, such as the fact that he had met and collaborated regularly with Dr Sastry and had relied on others for the CD34 calculations in his report. Mr Hare pointed out that none of this evidence appeared from Professor Advani's statement provided in advance, but had only emerged in questioning at the hearing.

56. In my view the MPT was entitled, for the reasons which it gave, to disregard the evidence of Professor Advani as it related to the specific issues surrounding Dr Sastry's behaviour in relation to the CD34 cell count and high-dose chemotherapy. Professor Advani admitted at the hearing that he was not an expert in CD34, since the same kind of high-dose chemotherapy with autologous cell transplant given to patients at his hospital did not use a CD34 cell count.

Proportionality of sanction

57. I have already dealt with Ms O'Rourke's criticisms regarding the MPT's attention paid to the Indian context when considering sanction at Stage 3.

58. Ms O'Rourke's principal complaint in relation to sanction was that Dr Sastry's erasure from the register was disproportionate. She pointed out that the GMC itself had only asked for suspension and referred me to the case of *Arunachalam v. General Medical Council [2018] EWHC 758*, a decision of Kerr J last year.

59. In that case the doctor had behaved inappropriately to female colleagues, sending personal messages and "transgressing personal boundaries" in ways which the tribunal in that case concluded were sexually motivated. The key issue on the appeal was whether erasure was disproportionate. Kerr J found that it was. He took into account that the doctor had had two years of trouble-free service and highlighted (at [72]) the absence of any weighing up by the tribunal of the mitigating features which it had recorded. He found that its decision was flawed thereby.

60. Kerr J went on to consider what sanction would be appropriate, taking as "strong evidence" of what a reasonable and informed member of the public would think the stance of the GMC itself in that case, which had advocated suspension. Kerr J put it like this (at [78]):

> "On balance, it seems to me likely that a reasonable, informed member of the public might well not take a harsher view than did the GMC of the pathetic and disgusting sexual pestering of the kind that occurred in this case…"

61. Ms O'Rourke submits that here, as in *Arunachalam*, the MPT failed to subject the aggravating and mitigating features which it listed at paras [24] and [25] of its Stage 3 decision to any analysis. It was not possible to determine, she said, which of these factors had weighed more heavily than others in the MPT's consideration. Further, she argued, the MPT should have attached considerable weight, as Kerr J did, to the fact that Dr Sastry had been practising in the UK for 4 years since coming back from India, without incident.

62. Mr Hare responded by drawing attention to the obvious difference between *Arunachalam* and the present case: the complaints made against Dr Arunachalam did not involve clinical behaviour in relation to patients. He submitted that what happened in *Arunachalam* was of a totally different order to, and could not be compared with, what happened to Patient A here.

63. Referring to the indicature for erasure contained in the GMC *Sanctions Guidance*, Mr Hare pointed out that the MPT in this case found that four of the indicators were engaged, as opposed to just two in Dr Arunachalam's case.

64. Mr Hare also reminded me of the observations of the court in *Jagivan*, above, to the effect that in matters of sexual misconduct the court may be in as good a position as a tribunal to decide on public protection, or the reputation of the profession.

65. I am satisfied that there has been no error of approach by the MPT in this case. The failure of analysis of aggravating features to which Kerr J referred in *Arunachalam* must been seen against his observation that there had been negligible discussion of erasure by the tribunal in that case: "really just an announcement of the decision to impose that sanction" (at [70]). In this case the MPT considered a number of features in detail, including the fact that it was *"one episode of misconduct, relating to one patient"* and that Dr Sastry was not providing similar treatment in the UK.

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

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

Dishonesty

68. The complaint regarding dishonesty is that the tribunal effectively made and relied on findings about Dr Sastry's (dis)honesty without there being any formal charges for him to meet through evidence. Ms O'Rourke referred me in this context to *Chauhan v.*

General Medical Council [2010] EWHC 2093 (Admin). In that case a tribunal had made findings, inter alia, that the appellant had dishonestly exaggerated his evidence in interview for a post, which findings King J overturned on appeal on the basis that there had been no formal charge setting out the complaint.

69. The situation in *Chauhan* is to be distinguished, however, from one where a tribunal has decided that a doctor has given dishonest evidence in relation to the allegations which he faces. A doctor's credibility and the way he gives his evidence are clearly relevant matters going to his fitness to practise generally. In case authority were needed for what seems to me to be a self-evident proposition, Mr Hare referred me to *Nicholas-Pillai v. General Medical Council* [2009] EWHC 1048 (Admin), per Mitting J at [18]-[21].

Conclusion

70. For the reasons given above, this appeal is dismissed.