Neutral Citation Number: [2020] EWHC 271 (Admin)

Case No: CO/3685/2019

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 13 February 2020

Before :

MRS JUSTICE LANG DBE

- -

Between :

MATTHEW ROGER GOODCHILD-SIMPSON	**Appellant**
- and -	
GENERAL MEDICAL COUNCIL	**Respondent**

- -
- -

The Appellant appeared in person
Nicola Kohn (instructed by **GMC Legal**) for the **Respondent**

Hearing date: 6 February 2020

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Approved Judgment

Mrs Justice Lang:

1. The Appellant appeals pursuant to section 40 of the Medical Act 1983 ("MA 1983") against the determination of the Medical Practitioners Tribunal ("the MPT"), notified in the letter of 19 August 2019, that his fitness to practise was impaired by reason of his adverse mental health and deficient professional performance, and that he should be suspended from the register for 12 months.

2. At the commencement of the hearing, I refused the Appellant's application for an adjournment, for the reasons set out in my extempore ruling.

History

3. The Appellant, whose date of birth is 3 September 1968, obtained his primary medical qualification at the University of Birmingham in 1993, and he was provisionally registered with the General Medical Council ("GMC"). He became fully registered on 12 September 2005, and he was entered on the GP Register on 11 July 2008.

4. In 1994, the Regional Postgraduate Dean raised concerns with the GMC as to the Appellant's fitness to practise. Psychiatric reports were obtained which diagnosed schizophrenia. In February 1995, the GMC's Health Committee found that his fitness to practise was found to be seriously impaired by reason of his mental health and his registration was suspended for a period of 12 months.

5. Since 1995, his case has been reviewed on about 18 occasions by the relevant body (the Health Committee; the Fitness to Practise Panel; and latterly the MPT). His fitness to practise has been found to be impaired due to adverse mental health, following a diagnosis of either paranoid schizophrenia or a schizoaffective or schizotypal disorder.

6. In April 2011, the Appellant was employed as a locum doctor in the Accident and Emergency Department of Chesterfield Royal Hospital, under the supervision of Dr Bailey, consultant clinical director. Dr Bailey referred his concerns about the Appellant's management of two patients with serious conditions to the GMC.

7. The GMC requested the Appellant to undergo a performance assessment which he did in 2012. In August 2013, a Fitness to Practise Panel found that his fitness to practise was also impaired because of his deficient professional performance. At review hearings since 2013, the finding of impairment due to deficient professional performance has been confirmed by the Fitness to Practise Panel and latterly the MPT.

8. The sanctions which have been imposed on the Appellant's registration have been as follows:

Health committee

February 1995: 12 months suspension

February 1996: 12 months suspension

February 1997: Indefinite suspension

September 2001: 12 months conditions

September 2002: 12 months conditions

October 2003: 12 months conditions

October 2004: 12 months conditions

Fitness to Practise Review Hearing

October 2005: 12 months conditions

November 2006: 18 months conditions

May 2008: 18 months conditions

March 2009: Part heard

November 2009: 18 months conditions

August 2013: 9 months suspension

February 2015: 9 months suspension

Medical Practitioners Tribunal Review Hearing

December 2015: 1 month suspension

February 2016: 18 months conditions

September 2017: 18 months conditions

March 2019: Adjourned, conditions extended for 9 months

August 2019: 12 months suspension

9. Interim orders restricting practice have also been made against the Appellant at various dates.

10. In 2013, he appealed unsuccessfully to the High Court against the MPT determination of August 2013 (Case No. CO/13501/2013, [2014] EWHC 1343 (Admin)).

11. The hearing in August 2019 was a review of the order made by the MPT in September 2017. The 2017 MPT considered the medical evidence, accepted the diagnosis of paranoid schizophrenia, and noted the concerns of the GMC medical examiners and supervisor that the Appellant had stopped taking his anti-psychotic medication, which posed a risk of relapse or deterioration, and his insight into his condition had diminished. It determined that his fitness to practise continued to be impaired by reason of his adverse mental health.

12. The 2017 MPT also found that the Appellant's fitness to practise continued to be impaired by his deficient professional performance. There was no evidence that the Appellant had developed any further insight into the concerns raised at earlier

hearings, or remediated them. The evidence of CPD was limited and did not address the specific deficiencies identified. The Appellant's personal development plan (which was intended to identify the steps taken to address the performance deficiencies) was extremely brief and did not address any of the clinical concerns. There was no testimonial evidence.

13. The sanction imposed by the 2017 MPT was an order for conditional registration for a period of 18 months. It noted that the GMC health examiners (Dr Whalley and Dr Jha) and the GMC medical supervisor (Dr O'Flynn) considered he was fit to practise, with restrictions. It considered that conditional registration was an appropriate and proportionate sanction as it could afford the Appellant the opportunity to undertake remediation and return to work in a safe and structured manner. It accepted the Appellant's evidence that the condition imposed by the MPT in February 2016, which prevented him from prescribing, had impeded his ability to find work. Accordingly, the 2017 Tribunal removed that condition but imposed a condition requiring direct supervision for prescribing and any activity involving patient contact.

14. The 2017 MPT concluded:

> "20. In deciding on the length of the period of conditional registration, the Tribunal considered that a period of 18 months would allow you sufficient time to seek employment and, if employed, sufficient time to undertake remediation and reflection in relation to your performance so that you can demonstrate to a future Tribunal that you have remediated those areas of concern. The Tribunal would wish to stress to you again that the onus is on you to undertake the necessary remediation and reflection, even if you are unable to obtain a medical post. A future Tribunal will expect to see evidence of remediation, insight and reflection and be assured that you have addressed the specific performance concerns."

15. A review hearing was listed on 26 March 2019 before an MPT ("the March 2019 MPT") comprising Mr Robin Ince (Legally Qualified Chair), Mr Keith Moore (Lay Tribunal Member), and Dr Frances Burnett (Medical Tribunal Member). At the outset, Dr Burnett disclosed a potential conflict of interest namely, that in her previous capacity as Clinical Director of acute services in Hertfordshire, she had knowledge of the Appellant's treating psychiatrist, Dr Van Huyssteen, and in 2016 she raised serious concerns about his practice, leading to his suspension from practice for a short period of time.

16. The Appellant, who was represented, objected to Dr Burnett sitting on the panel, and intended to apply to adjourn the hearing in any event. The March 2019 MPT decided that all three members should recuse themselves, to avoid any potential for bias, and adjourned the hearing, to be re-listed before a different panel. The registration conditions were extended accordingly.

17. The MPT hearing was re-listed before a fresh panel for 5 days from 12 to 16 August 2019. The Appellant applied to adjourn the hearing, but his application was refused, first by the Case Manager (Ms S. Bedford) and then by the MPT. The Appellant sent

an email to the MPT on the day before the hearing stating that he had applied for voluntary erasure and he was not going to attend the hearing.

18. The MPT decided to proceed in his absence. During the course of the hearing, on 14 August 2019, the Appellant made contact by email, and asked to take part in the hearing by telephone on 15 August 2019. That application was granted. The Appellant then made a further application for an adjournment which was refused.

19. The MPT considered the evidence, and the submissions, and concluded that the Appellant's fitness to practise was currently impaired by reason of his adverse mental health and his deficient professional performance.

20. The MPT concluded that it did not have the power at that time to consider the Appellant's application for voluntary erasure. After directing itself in accordance with the Sanctions Guidance, it decided that it would not be possible to formulate a set of appropriate or workable conditions, and therefore conditional registration would be insufficient to satisfy the public interest.

21. In the light of the Appellant's diminished insight into his health condition, and his failure to reflect upon or remediate his deficient professional performance, the Tribunal concluded that a period of suspension of 12 months was a necessary and proportionate sanction which appropriately balanced the public interest with the doctor's own interests.

22. The Tribunal directed a review of the Appellant's case shortly before the end of the period of suspension, and gave directions for the review.

Appellate jurisdiction

23. Section 40 MA 1983 provides for a right of appeal to the High Court from decisions of tribunals where they have, amongst other things, directed suspension from the medical register. Under section 40(7), the court may on such an appeal:

    a) dismiss the appeal;

    b) allow the appeal and quash the direction appealed against;

    c) substitute for the direction appealed against any other direction or variation which could have been given or made by an MPT; or

    d) remit the case to the Medical Practitioners Tribunal Service to dispose of the case in accordance with the directions of the court.

24. The appeal is governed by CPR part 52 and PD 52D. Under CPR 52.21(3), the question for the court is whether the decision of the Tribunal is "wrong" or "unjust because of a serious procedural or other irregularity in the proceedings in the lower court".

25. Although appeals under section 40 MA 1983 are by way of rehearing, by virtue of paragraph 19.1 PD 52D, they are not conducted as rehearings in the full sense where the appellate court hears evidence and reaches a decision unconstrained by the

conclusion of the lower court. Save in exceptional cases, the court will not hear evidence and it will accord appropriate respect to the primary findings of fact made by the first instance panel which heard the witnesses give evidence.

26. Appeals from professional regulatory bodies have three distinctive features:

> (1) The relevant statute provides that the primary decision-maker is a panel with specialist expertise in the relevant profession. Thus, it was Parliament's intention that the primary decision-making body in relation to fitness to practise in the professions would be a specialist panel and the courts would only have an appellate function.
>
> (2) The panels have power to recommend or impose sanctions whose primary purpose is to maintain public confidence in the profession, not to provide retribution or compensation. The expertise of a specialist panel will assist in assessing the appropriate sanction in order to maintain public confidence in the standards of the particular profession.
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> (3) Article 6 of the European Convention on Human Rights is likely to be engaged where the appellant's right to practise his profession may be at stake (see *Albert and Le Compte v Belgium* [1983] 5 EHRR 533).

27. In *Meadow v General Medical Council* [2007] QB 462, Auld LJ said at [197]:

> "On an appeal from a determination by the GMC, acting formerly and in this case through the FPP, or now under the new statutory regime, whatever label is given to the section 40 test, it is plain from the authorities that the court must have in mind and give such weight as is appropriate in the circumstances to the following factors:
>
> > (i) The body from whom the appeal lies is a specialist tribunal whose understanding of what the medical profession expects of its members in matters of medical practice deserve respect.
> >
> > (ii) The tribunal had the benefit, which the court normally does not, of hearing and seeing the witnesses on both sides.
> >
> > (iii) The questions of primary and secondary fact and the overall value judgment to be made by the tribunal, especially the last, are akin to jury questions to which there may reasonably be different answers."

28. In *Raschid v General Medical Council* [2007] 1 WLR 1460, which was an appeal against sanction, Laws LJ said after reviewing the authorities:

> "19. ... the fact that a principal purpose of the panel's jurisdiction in relation to sanctions is the preservation and maintenance of public confidence in the profession rather than the administration of retributive justice, particular force is given to the need to accord special respect to the judgment of the professional decision-making body in the shape of the panel. That I think is reflected in the last citation I need give. It consists in Lord Millett's observations in *Ghosh v General Medical Council* [2001] 1 WLR 1915, 1923, para 34:
>
> > 'The board will afford an appropriate measure of respect to the judgment of the committee whether the practitioner's failings amount to serious professional misconduct and on the measures necessary to maintain professional standards and provide adequate protection to the public. But the board will not defer to the committee's judgment more than is warranted by the circumstances.'
>
> 20. These strands in the learning then, as it seems to me, constitute the essential approach to be applied by the High Court on a section 40 appeal. The approach they commend does not emasculate the High Court's role in section 40 appeals. The High Court will correct material errors of fact and of course of law and it will exercise a judgment, though distinctly and firmly a secondary judgment, as to the application of the principles to the facts of the case."

29. In *Ghosh v General Medical Council* [2001] 1 WLR 1915, the Privy Council confirmed that this approach gave effect to an appellant's rights under Article 6 of the European Convention on Human Rights.

30. Most recently, in *Bawa-Garba v General Medical Council* [2018] EWCA Civ 1879, the Lord Chief Justice, giving the judgment of the court, said:

> "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: *Biogen Inc v Medeva plc* [1997] RPC 1 at [45]; *Pharmacia Corp v Merck & Co Inc* [2001] EWCA Civ 1610, [2002] RPC 41 at [153]; *Todd v Adams (t/a Trelawney Fishing Co) (The Maragetha Maria)* [2002] EWCA Civ 509, [2002] 2 Lloyd's Rep 293 at [129]; *Datec Electronics Holdings Ltd v United Parcels Service Ltd* [2007] UKHL 23, [2007] 1 WLR 1325 at [46]. It has been repeatedly stated in cases at the highest level

that there is limited scope for an appellate court to overturn such a decision…..

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'.

64. In *Bowen and Stanton*, McCombe LJ went on (at [67]) to quote from Lord Clarke's judgment in *Re B (A Child) (Care Proceedings)* [2013] UKSC 33; [2013] 1 WLR 1911 at [137] as follows:

> 'In England and Wales the jurisdiction of the Court of Appeal is set out in CPR rule 52.11(3), which provides that "the appeal court will allow an appeal where the decision of the lower court was (a) wrong or (b) unjust because of a serious procedural or other irregularity in the proceedings in the lower court". The rule does not require that the decision be "plainly wrong". However, the courts have traditionally required that the appeal court must hold that the judge was plainly wrong before it can interfere with his or her decision in a number of different classes of case. I referred to some of them in *Assicurazioni Generali SpA v Arab Insurance Group* [2003] 1 WLR 577 ... at my paras 9-23. It seemed to me then and it seems to me now that the correct approach of an appellate court in a particular case may depend upon all the circumstances of that case. So, for example, it has traditionally been held that, absent an error of principle, the Court of Appeal will not interfere with the exercise of a discretion unless the judge was plainly wrong. On the other hand, where the process involves a consideration of a number of different factors, all will depend on the circumstances. As Hoffmann LJ put it in *In Re Grayan Building Services Ltd (In Liquidation)* [1995] Ch 241, 254, "generally speaking, the vaguer the standard and the greater the number of factors which the court has to weigh up in deciding whether or not the standards have been met, the more reluctant an appellate court will be to interfere with the trial judge's decision".'

65. McCombe LJ also quoted (at [71]) the case of *Smech Properties Ltd v Runnymede Borough Council* [2016] EWCA Civ 42, in which Sales LJ said as follows:

> '29. ... Where an appeal is to proceed, like this one, by way of a review of the judgment below rather than a re-hearing, it will often be appropriate for this court to give weight to the assessment of the facts made by the judge below, even where that assessment has been made on the basis of written evidence which is also available to this court. The weight to be given to the judge's own assessment will vary depending on the circumstances of each particular case, the nature of the finding or factual assessment which has been made and the nature and range of evidential materials bearing upon it. Often a judge will make a factual assessment by taking into account expressly or implicitly a range of written evidence and making an overall evaluation of what it shows. Even if this court might disagree if it approached the matter afresh for itself on a re-hearing, it does not follow that the judge lacked legitimate and proper grounds for making her own assessment and hence it does not follow that it can be said that her decision was "wrong".'

66. McCombe LJ commented on that passage as follows:

> '72. It seems to me that Sales LJ was addressing the exigencies of reviewing a first instance judge's assessment of primary facts, even where (as in our case) the evidence before the court below was entirely in writing. All will depend on the circumstances of the case and what opportunity the court has, in reality, to improve and correct the overall assessment of the evidence before the first instance judge as a whole.'

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: *Biogen* at [45]; *Todd* at [129]; *Designers Guild Ltd v Russell Williams (Textiles) Ltd (trading as Washington DC)* [2001] FSR 11 (HL) at [29]; *Buchanan v Alba Diagnostics Ltd* [2004] UKHL 5, [2004] RPC 34 at [31]. As the authorities show, the addition of 'plainly' or 'clearly' to the word 'wrong' adds nothing in this context."

31. In *General Medical Council v Jagjivan & Another* [2017] EWHC 1247 (Admin); [2017] 1 WLR 4438, Sharp LJ helpfully summarised the well-established principles to be adopted to appeals under section 40 of the 1993 Act, at [40]:

> "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)."

Statutory framework and procedure

32. Section 1(1A) MA 1983 sets out the overarching objective of the GMC in exercising its functions, namely the protection of the public. By subsection (1B), this entails 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 the profession.

33. MPTs are statutory committees established pursuant to subsection 1(3).

34. By section 35C(2) MA 1983, a registered person's fitness to practise shall only be regarded as impaired by reason of a finding of one of the following: misconduct; deficient professional performance; a conviction or caution for a criminal offence; adverse physical or mental health; not having the necessary knowledge of English; and a determination of impairment by another body.

35. Section 35D sets out the functions of a MPT. Where there is a finding of impairment, a MPT has the powers set out in subsection (2) of section 35D MA 1983, which include erasure (except in a health or language case); suspension for a period not exceeding 12 months (subject to some exceptions); and conditional registration for a period not exceeding 3 years.

36. Where an order for suspension or conditional registration is made, the MPT may direct that it is reviewed by another MPT prior to expiry (subsections (4A) and (11A)).

37. The General Medical Council (Fitness to Practise) Rules Order of Council 2004 ("the 2004 Rules") make provision in rule 22 for the procedure to be followed at a review hearing.

38. Rule 29(1)(b) gives the Case Manager power to postpone an MPT hearing before it has opened. Rule 29(2) gives the MPT a general power to adjourn a hearing which has commenced, either on its own motion or upon the application of a party to the proceedings.

39. A decision to grant or refuse an adjournment is a case management decision, in respect of which a tribunal enjoys a wide discretion. In *Teinaz v London Borough of Wandsworth* [2002] EWCA Civ 1040, [2002] ICR 1471, Gibson LJ said, at [21]:

> "21. A litigant whose presence is needed for the fair trial of a case, but who is unable to be present through no fault of his own, will usually have to be granted an adjournment, however inconvenient it may be to the tribunal or court and to the other parties. That litigant's right to a fair trial under Article 6 of the European Convention on Human Rights demands nothing less. But the tribunal or court is entitled to be satisfied that the inability of the litigant to be present is genuine, and the onus is on the applicant for an adjournment to prove the need for such an adjournment."

40. Rule 31 provides as follows:

> "Where the practitioner is neither present nor represented at a hearing, the ... Tribunal may nevertheless proceed to consider and determine the allegation if they are satisfied that all reasonable efforts have been made to serve the practitioner with notice of the hearing in accordance with these Rules."

41. A decision on whether to proceed in the absence of a respondent to disciplinary proceedings should be assessed in accordance with the decision of the House of Lords in *R v Jones* [2002] UKHL 5, as applied to the disciplinary context in *General Medical Council v Adeogba* [2016] EWCA Civ 162, per Sir Brian Leveson P.:

> "18 It goes without saying that fairness fully encompasses fairness to the affected medical practitioner (a feature of prime importance) but it also involves fairness to the GMC (described in this context as the prosecution in Hayward at [22(5)]). In that regard, it is important that the analogy between criminal prosecution and regulatory proceedings is not taken too far. Steps can be taken to enforce attendance by a defendant; he can be arrested and brought to court. No such remedy is available to a regulator.
>
> 19 There are other differences too. First, the GMC represent the public interest in relation to standards of healthcare. It would run entirely counter to the protection, promotion and maintenance of the health and safety of the public if a

> practitioner could effectively frustrate the process and challenge a refusal to adjourn when that practitioner had deliberately failed to engage in the process. The consequential cost and delay to other cases is real. Where there is good reason not to proceed, the case should be adjourned; where there is not, however, it is only right that it should proceed.
>
> 20 Second, there is a burden on medical practitioners, as there is with all professionals subject to a regulatory regime, to engage with the regulator, both in relation to the investigation and ultimate resolution of allegations made against them. That is part of the responsibility to which they sign up when being admitted to the profession.
>
> …
>
> 23 Thus, the first question which must be addressed in any case such as these is whether all reasonable efforts have been taken to serve the practitioner with notice. That must be considered against the background of the requirement on the part of the practitioner to provide an address for the purposes of registration along with the methods used by the practitioner to communicate with the GMC and the relevant tribunal during the investigative and interlocutory phases of the case. Assuming that the Panel is satisfied about notice, discretion whether or not to proceed must then be exercised having regard to all the circumstances of which the Panel is aware with fairness to the practitioner being a prime consideration but fairness to the GMC and the interests of the public also taken into account; the criteria for criminal cases must be considered in the context of the different circumstances and different responsibilities of both the GMC and the practitioner."

42. Section 31A MA 1983 provides that the GMC can make regulations relating to voluntary erasure, including the refusal of such applications. The procedure is set out in full in the General Medical Council (Voluntary Erasure and restoration following Voluntary Erasure) Regulations 2004. Under regulation 4, where there are pending fitness to practise allegations the application will be referred to a Case Examiner, and, if necessary, to an Investigation Committee. Where there are ongoing fitness to practise proceedings, the Registrar will refer the application to the MPT for determination.

43. Guidance on voluntary erasure has been issued by the GMC, which advises that a decision on an application for voluntary erasure should have regard to the public interest, as well as a practitioner's personal circumstances. Voluntary erasure should not be granted where there is evidence to suggest the doctor has applied solely to avoid a sanction or otherwise circumvent the fitness to practise process and his intention to cease practice is not genuine. In cases where the public interest would not be compromised by allowing erasure, applications should not be refused merely because an investigation has contributed to a doctor's decision to retire or stop practising.

Grounds of appeal

44. The grounds of appeal in the Appellant's Notice are as follows, with numbers added by the Court for ease of reference:

    1. "This appeal is for a High Court resummarisation of performance impairment that would be needed by the doctor for any future personal development plan because the doctor has residual health impairment and performance impairment since the Medical Practitioners Tribunal Service suspension in August 2013.

       The General Practice Recruitment Office is now responsible for GP refreshment & returning in 2018-2019.

       The GP NRO do not accept impairment of both health and performance in their rules to refresh a previous GP on the GMC General Register. This is true even though the doctor successfully recertificated his diploma of Sexual and Reproductive Healthcare until 2022 [in 2017 during his ongoing non-medical employment]."

    2. "The practitioner Appellant asks for guidance from their Lordships, because the East of England multi professional Deanery could not find any appraiser or Dean that could provide the assistant registrars *(sic)* requested PDP in 2017-2019.

       This has led to a Parliamentary & Health Service Ombudsman complaint passed onto the PHSO by the practitioner's supporting Member of Parliament [a Government Minister] with reference number Case Ref: ZA21257. This is against the EOE Deanery/HEE from Responses."

    3. "The doctor has been in Reading Employment Tribunal and Norwich County Court since the GMC High Courts of December 2012 and April 2014 for employment matters both medical and non-medical."

    4. "The doctor seeks all Rule 4 decissions *(sic)* to be looked at since 1993 [ie decisions and rulings beyond and outside the GMC/MPTS]."

    5. "The doctor wishes the High Court to learn the GMC has no record of any medical oath he has ever taken, and that the Information Commissioners *(sic)* Office does not allow the doctor a new university of Birmingham Medical School subject access request by new GDPR at the 1990 limit, if his medical school records still exist."

    6. "The professional standards agency issued 67 days to examine a suspension with impairment and are informed by the MPTS 19 August, 2019 by letter."

    7. "The doctor might have preferred judicial review once the PHSO outcome was known."

    8. "The MPTS denied 3 adjournment requests for the hearing commencing 12-16 August, 2019 re, European fair trial law under article 6. The GMC and MPTS were aware for these multiple adjournment requests that the doctors (*sic*) MP was supporting a relevant PHSO complaint.

Despite the MPTS case manager hearing of 29 May, 2019 no hearing timetable could be made by the MPTS or manager in time for 12 August, 2019."

9. "There was argument that the doctor was not responsible for calling his new GMC superviser *(sic)* whose latest report was abscent *(sic)* in the bundle, when newly supporting the doctor, it is litigated it is the GMC to assist the doctor instead, not the doctor pursue his superviser *(sic)* to attend. The subject of Judge Robin Inces *(sic)* MPTS panel recusal [extension orders and adjournment] 26 March, 2019 was still on holiday for this hearing."

10. "The MPTS has not addressed in determination complaints that include his simulated surgery OSCE exam 15 January, 2012."

Conclusions

Grounds of appeal

Ground 1

45. The Appellant added further submissions on this ground in his Appellant's Notice. At section 5 he said that, as GP "refreshment" was not possible by the rules of the General Practice National Recruitment Office ("GP NRO"), that in effect ended the medical career of a doctor. At section 8, in response to the question "what are you asking the Appeal Court to do?", he asked that the order of the MPT be varied and an order substituted in the following terms:

> "The Doctor seeks general practice refreshment at the appropriate time, outside of the GP NRO if the Court can permit a local list instead, aside for up to 24 months. This is to break the deadlock between the Doctor and HEE and GP NRO."

46. The GP NRO is the administrative body responsible for coordinating the process for recruitment to GP Speciality Training (ST1) Programmes. Health Education England ("HEE") coordinates education and training in the health sector, at national and local levels.

47. The Appellant applied to the GP NRO to be accepted on to its GP Refresher Scheme for returning GPs. However, he is not eligible for the Scheme because he cannot meet the requirement that applicants are on the GMC Register, without GMC conditions or undertakings (except those relating solely to health matters). The conditions imposed on the Appellant's registration, most recently by the MPT in 2017 and 2016, relate to his impaired performance, as well as his mental health. The Appellant has been advised that he is ineligible on a number of occasions. He has also made applications in Scotland and Northern Ireland, but he has not been accepted there either because of the conditions on his registration.

48. On an appeal under section 40 MA 1983, the Court has no power to make orders concerning training schemes for GP's, which are the province of the GP NRO and HEE. The Court's powers, as set out in subsection (7), are limited to quashing a

direction made by the MPT and substituting any direction which could have been made by the MPT. The MPT's powers are set out in section 35D MA 1983. Its functions are limited to determining the issues of impairment and sanction and any related matters.

49. Difficulty in obtaining employment as a doctor when subject to conditions is, of course, a matter in which MPTs have experience. The Appellant's difficulty was apparent from the evidence before the MPT. This issue was also considered in some detail by the 2017 MPT, when re-formulating the conditions so as to make it easier for the Appellant to obtain work (e.g. lifting the restrictions on working in general practice and prescribing). But the 2017 MPT made it clear to the Appellant that "the onus is on you to undertake the necessary remediation and reflection, even if you are unable to obtain a medical post".

50. The Appellant accepted, in his oral submissions to this Court, that he also has the option of seeking a medical post in a different setting, such as a hospital; or continuing in a non-medical post as a care manager or in some other role.

51. Therefore, the MPT was entitled to reach its conclusions on impairment and sanction despite the Appellant's ineligibility for the GP NRO.

Ground 2

52. Since at least 2015, the MPTs have advised the Appellant to submit to the next reviewing MPT a structured Personal Development Plan which specifically identified the steps taken or to be taken to address his deficient professional performance.

53. The 2017 MPT was critical of Appellant's Personal Development Plan as it was extremely brief and it failed to address any of the clinical concerns.

54. The Appellant submitted that he requested assistance in the preparation of his Personal Development Plan from the East of England Deanery, but was eventually told that there was no one available to assist him. He has made a complaint to the Parliamentary and Health Service Ombudsman about this.

55. The Personal Development Plan for the MPT hearing in August 2019 stated:

"**SKETCHPLAN PDP**
Personal Development Plan
Name: Dr Matthew R Goodchild-Simpson MB ChB DFSRH DGM
GMC No. 4036441, RCGP No. 63221.
General Register Practitioner
Date, 25 February 2019.

Last GMC Hearing 14-15 September, 2017.
Next GMC Hearing 26-27 March, 2019.

CPD Collections since last Hearing;
Abortion Care Excellence, RSM London Whole Day.
Contraception Update, MEDICONF Cardiff University Half Day.

Atrial Fibrillation for Primary Care, University of Norwich, Half Day.
Management of Heavy Menstrual and Intermenstrual Bleeding, Live Conference. Evening Session.
Birmingham NEC Best Practice Conference 2 Days.
GP Primary Care Practical Introduction to Ultrasound Course for Abdomen, Chest, Pelvis and Knees. -FUGISONIC sponsored.
RCGP Anglia Faculty AGM 2018-19, and Models for General Practice, Prof. A. Hibble et al, Barnham Broom Hotel.
23 March, 2019 Diabetes in Primary Care for General Practitioners, MEDICONF, Milton Keynes.
-As booked.

Exams
I have Recertifed the Diploma of Sexual and Reproductive Healthcare until Summer 2022.
COUNCIL OF SEXUAL & REPRODUCTIVE HEALTHCARE
This has avoided the C5 Clinical Exam, due to my passing.

Memberships
RCGPs
DFSRH [CSRH]
DGM [RCP]
Primary Care Dermatology Society
All receive regular magasines (*sic*) /periodicals.

Work Plan
To return/refresh in general practice home and abroad.

Ideas: Refreshment
Concerns: United Kingdom Refreshment is difficult due to previous reported Performance Issues, Abroad may be my only option now.
Expectations: General Practice for Civil Purpose, Prison or Military.

Other:
I consider myself now capable of Supporting Care Home and Nursing Home Lead Managers in bringing their Homes out of CQC Special Measures if need be. I also have experience and training in Sales Coordination, my business skills are much improved and are current."

56. In my judgment, the MPT addressed this issue appropriately and fairly, stating:

> "58. ….The Tribunal notes that it was over a year after the deadline when the Dr Goodchild-Simpson provided this. In the Tribunal's view this plan falls a long way short of being an acceptable and properly constructed development plan. The

> document does not demonstrate that he has addressed the four specific areas which were found to be deficient. The Tribunal recognise the efforts made by Dr Goodchild-Simpson to find a supervisor for his PDP which was made difficult given he had not worked in a clinical capacity. Notwithstanding its criticisms of the PDP, the Tribunal accepts that Dr Goodchild-Simpson's background health conditions may have impacted on his ability to develop a structured reasoned plan and obtain oversight to assist in its development."

57. Thus, the MPT took into account the difficulties which the Appellant faced in drawing up his Personal Development Plan, and I do not consider that this issue provides any basis for an appeal against the MPT's determination.

Grounds 3, 4 and 10

58. The Appellant was employed as a manager at a care home but he was dismissed and has brought legal proceedings against his former employer. The dispute with his former employer was not relevant to the proceedings before the MPT.

59. Rule 4 of the 2004 Rules makes provision for initial consideration and referral of allegations against doctors which are made to the GMC. Generally, the MPT will only be concerned with the allegations which it has been asked to determine. Other Rule 4 allegations and decisions were irrelevant to the issues which this MPT had to decide.

60. The Appellant made a complaint about his simulated surgery OSCE examination on 15 January 2012, which he failed. The heating failed in the building and it was freezing cold. Only a few candidates were supplied with fan heaters. This complaint was not relevant to the issues at the MPT hearing.

Ground 5

61. The Appellant's medical oath and records from the University of Birmingham were irrelevant to the proceedings before the MPT.

Ground 6

62. The Appellant made a subject access request under the Data Protection Act 1998/2018 to the Professional Standards Agency asking for documents relating to his GMC and MPTS proceedings. It has no relevance to this appeal.

Ground 7

63. Since the Appellant had a remedy by way of statutory appeal under MA 1983, judicial review would not have been available to him, even if he had issued a claim in time.

Case management, including Grounds 8 and 9

64. It is convenient to deal with the issues relating to case management and adjournments and non-attendance together.

65. Following the adjournment of the MPT in March 2017, a case manager was appointed (Ms Bedford) and a case management hearing took place on 29 May 2019, at which directions were made. The Appellant confirmed he would be attending the MPT hearing and that he was seeking to obtain representation and/or support at the hearing. The GMC indicated that it would be calling as witnesses the GMC health assessors, Dr Whalley and Dr Jha. The Appellant indicated that he would be calling as witnesses Dr Van Huyssteen (his treating psychiatrist), Dr Selzer (his GMC supervisor), Dr Patel (an independent psychiatrist instructed by the Appellant), and, if possible, Dr O'Flynn (his previous GMC supervisor). The parties were told that they could request a further directions hearing, if required.

66. In Ground 9, the Appellant criticises the GMC for not calling his GMC supervisor to give evidence. In my view, it was a matter for the GMC to decide which witnesses to call. If necessary, the MPT could ask for further witnesses to attend. At the case management hearing, the Appellant was permitted to list both his past and current supervisor as witnesses (though he chose not to call them). Dr Selzer's report, dated 8 August 2019, was available to the MPT. So too was the report from Dr O'Flynn dated 27 November 2017. Therefore Ground 9 cannot succeed.

67. The parties were offered a 5 day hearing from 12 to 16 August 2019, to which the Appellant agreed. An alternative date in October was offered but the Appellant asked for the earlier date. A formal notice of hearing was sent on 5 July 2019.

68. On 10 July 2019, the Appellant applied to adjourn the hearing, and he made a further application on 18 July 2019. The grounds for the applications are summarised below.

69. The Appellant had made a subject access request to the Fermoy Unit of Queen Elizabeth Hospital Kings Lynn NHS Trust (where he met Dr Whalley on 1 November 2018) for his casefile and a copy of the visitor book and CCTV. He was concerned about the recording of his car registration number which he considered was in breach of the Data Protection Act 1998/2018, and also the poor conditions at the Unit. In the absence of a response, he had contacted the Information Commissioner's Office.

70. The Appellant intended to make a complaint to the Parliamentary and Health Service Ombudsman about the Associate Dean of the East of England Multi-professional Deanery, with regards to Dr Goodchild-Simpson's Personal Development Plan.

71. The Appellant had applied to the GMC for his licence to practise to be restored, but he was notified on 9 July 2019 that a decision on his application was delayed. It was subsequently issued.

72. The Appellant wished to have the opportunity to sit GP medical examinations in Northern Ireland and start a GP placement, as well as undergo health assessments with two new GMC health assessors. He applied for the hearing to be transferred to Belfast.

73. The Appellant raised issues regarding representation, and also suggested that he may have access to assistance from lay representatives.

74. The Appellant did not suggest that the proposed hearing date would prevent any witnesses he wished to call from attending.

75. The GMC made written representations opposing the application on the ground that (1) the Appellant's applications to the Information Commissioner's Office and the Parliamentary and Health Service Ombudsman were not relevant to the issues to be considered by the MPT; and (2) the review ought to take place as soon as possible, in the light of the medical opinions that he was not fit to practise and the length of time since his fitness to practise was last considered, in September 2017.

76. On 9 August 2019 the Appellant's adjournment application was considered by the case manager. Ms Bedford considered that the Appellant's pending applications to the Information Commissioner's Office and the Parliamentary and Health Service Ombudsman did not justify a postponement of the hearing. It was unclear to her why the Appellant believed new health assessments were required, and in any event, he would have to raise that matter with the MPT, as it was outside her power to order new assessments. Whilst the Appellant's proposed GP placement in Ireland might be relevant to his future fitness to practise, the MPT was concerned with his current fitness to practise.

77. Ms Bedford attached considerable weight to the GMC's submission that it was in the public interest and in the interests of patient safety for the Appellant's fitness to practise to be reviewed without delay, because of the delay since he was last reviewed in 2017, and the medical opinion that he was now unfit to practise.

78. Ms Bedford concluded that an adjournment was not necessary, nor was it proportionate and in the interests of justice, taking account of the interests of both parties and the public interest. She advised the Appellant that it remained open to him to renew his application to the MPT.

79. On Friday 9 August 2019 the Appellant made a further application to adjourn the hearing on two grounds. First the Information Commissioner's Office was investigating delays by Health Education England in supplying data. Second, Dr Van Huyssteen was not available to attend the hearing to explain ICD codes further. The Appellant was advised to make his application to the MPT, as the hearing was due to begin on the following Monday.

80. The Appellant also asked for further details about the lay member's background with the police, and he was advised to make any application regarding a possible conflict of interest to the MPT at the beginning of the hearing.

81. On Sunday 11 August 2019 the Appellant sent an email to the MPTS Case Management Team stating he had applied that day for voluntary erasure from the Medical Register and for that reason he would not be attending the MPT hearing. It appears that a voluntary erasure application was completed online, but it was not signed.

82. The Appellant also said he intended to change his specialist from Dr Van Huyssteen to Dr O'Flynn. The MPT had Dr O'Flynn's report dated 27 November 2017. The Appellant has recently disclosed an email from Dr O'Flynn, dated 5 August 2019, in which he agreed to attend the MPT hearing on 14 August 2019.

83. On 12 August 2019 the hearing commenced, but the Appellant did not attend and was not represented.

84. On 12 August 2019 (Day 1), the MPT considered a number of preliminary issues, namely: (1) a conflict of interest, (2) adjournment applications and (3) application to proceed in his absence.

85. ***Conflict of interest***. Although the Appellant had not pursued an application for recusal, the lay member, Mr Weigh, confirmed that he had been a senior serving police officer, but he had no previous connection with the Appellant. The MPT concluded that there were no grounds for recusal.

86. ***Adjournment applications***. The MPT considered all the adjournment applications, including those determined by the Case Manager on 9 August 2019, and the further application by the Appellant. The Chair correctly directed the MPT (Transcript, at pages 95 – 97 of the bundle) on rule 29 of the 2004 Rules, the MPT's overarching objectives set out in section 1 MA 1983, and the case of *Teinaz v Wandsworth Borough Council.* The MPT weighed up the need to protect the public, maintain public confidence in the medical profession and maintain proper professional standards of conduct against the Appellant's reasons for requesting an adjournment.

87. The MPT carefully considered the correspondence, the submissions of the GMC and the earlier decision of the Case Manager refusing an adjournment. The MPT did not consider that the Appellant's pending applications to the Information Commissioner's Office and the Parliamentary and Health Service Ombudsman, and his aspiration to qualify and practise in Ireland, were relevant to the issues before it. His licence to practise had been issued by the GMC. The Appellant had already been reviewed by health assessors, who had produced reports, and the MPT did not accept that there was any basis for further reviews by new assessors. The Appellant had been aware of the issues since at least March 2019, when the last MPT hearing was adjourned, and so he had had sufficient time to prepare for this hearing.

88. The GMC submitted that the Appellant's concern that Dr Van Huyssteen was not available to attend the hearing to explain the applicable ICD 10 codes further did not provide a sufficient basis on which to conclude that the MPT would not be in a position to assess current fitness to practise on the medical evidence before it. Dr O'Flynn's report appended a letter from Dr Van Huyssteen dated 28 July 2017, which gave a diagnosis of paranoid schizophrenia, and advised that the differential diagnosis of schizotypal disorder should also be borne in mind. The letter also referred to his symptoms and medication. Dr Whalley included updating information from Dr Van Huyssteen from a telephone call with him on 2 November 2018, and communications with the Appellant's GP, Dr Ahlund, on 9 October 2018. Dr Selzer's report included a discussion with Dr Van Huyssteen on 7 August 2019, who had last seen the Appellant on 21 May 2019.

89. The MPT took into consideration the evidence that the Appellant's litigation friends were not available and that he had made an unsuccessful attempt to arrange legal representation. These applications had been made very late in the day, and the Appellant had had ample time to secure legal or other representation.

90. The Appellant did not expressly rely on the application for voluntary erasure as a reason for an adjournment, but the MPT nonetheless considered it as such. The advice from the Chair was that the Appellant had only just begun a procedure which might or might not result in voluntary erasure, and so it should not weigh heavily in favour of an adjournment.

91. The MPT accepted the GMC's submission that the repeated requests for an adjournment were attempts to frustrate the process and obfuscate.

92. Weighing all the factors in the balance, the MPT concluded that it would be in the public interest and the Appellant's interests to draw matters to a speedy conclusion.

93. Following the MPT's determination on impairment, on 14 August 2019 the Appellant sent a further adjournment application by email. The MPT agreed that he could participate via telephone. The grounds for the application were (1) his pending application to the Information Commissioner's Office for the Fermoy Unit casefile, visitor's book and CCTV; (2) he wished to obtain legal representation; (3) he wished to have the opportunity to sit GP medical examinations and start a GP placement in Northern Ireland, or possibly practise outside the jurisdiction.

94. The MPT applied the same legal directions as it had done when considering the earlier adjournment applications on 12 August 2019. It concluded that the request for the adjournment was on the same grounds as before, and as there had been no change in circumstances, the MPT rejected the application.

95. In my judgment, in making its decisions on the adjournment applications, the Case Manager and the MPT properly directed themselves in law, took into account all relevant considerations, and made a legitimate exercise of discretion to refuse the applications. The decisions were not a breach of right to a fair hearing of Article 6. I consider that, on the evidence, the MPT was entitled to find that the Appellant was seeking to delay and frustrate the statutory process. Therefore Ground 9 does not succeed.

96. ***Application to proceed in absence***. The GMC applied to proceed in the Appellant's absence. The MPT was satisfied that the Appellant had been properly served with notice of the proceedings, as required by rule 31 of the 2004 Rules.

97. The MPT correctly directed itself in accordance with the principles in the cases of *R v Jones* and *General Medical Council v Adeogba*, which reflect the requirements of Article 6 ECHR. It bore in mind that the discretion to proceed in the absence of the practitioner should be exercised with the utmost care and caution, fairness to the practitioner being a prime consideration, but also taking into account fairness to the GMC and the overall fairness of the proceedings, as well as its statutory objective to protect the public, maintain confidence in the profession and maintain professional standards.

98. The MPT had regard to the fact that the Appellant voluntarily absented himself from the hearing. The reason given was that he had applied for voluntary erasure. However, since he had only just made the application online, on the day before the hearing, it had not yet been considered by the GMC or referred to the MPT. Moreover, the application appeared to be incomplete. Therefore, it could not be determined by the MPT. An email in the hearing bundle showed that the Appellant had sought informal advice from the GMC on voluntary erasure in June 2019, but did not proceed with an application at that stage.

99. The MPT appreciated that it was a disadvantage for the Appellant not to be able to give his account of his current fitness to practise, and to make oral submissions, and that he was not represented. However, those factors were outweighed by the public interest in the fair and expeditious disposal of these proceedings. Therefore, the MPT decided to proceed in the Appellant's absence.

100. At the hearing before me, the Appellant complained that the MPT had gone ahead with the hearing without informing him of its intention to do so, and he had expected some discussion to take place about his application for voluntary erasure. In my view, if the Appellant wished to know how the MPT intended to proceed, in the light of his last minute application for voluntary erasure, he could, and should, have attended the hearing and participated in the discussion which took place. Voluntary erasure is not merely a matter of completing an application – the GMC has to give its approval and there are requirements to be met.

101. In all the circumstances, the MPT was entitled in the exercise of its discretion to proceed in his absence.

The MPT's determinations

102. Although the Appellant has not made submissions about the substantive determinations made by the MPT on impairment and sanction, as he is unrepresented, I have considered whether they afford any grounds of appeal.

Impairment on grounds of adverse mental health

103. The diagnosis of paranoid schizophrenia was not in dispute, although Dr Van Huyssteen in his report of 28 July 2017 also said that the differential diagnosis of schizotypal disorder should be borne in mind.

104. Dr Van Huyssteen confirmed that the Appellant stopped his medication in February 2017, of his own accord. On 9 October 2018, Dr Ahlund (the Appellant's GP) expressed concern about his mental state and thought he was relapsing, and Dr Van Huyssteen advised that the Appellant should go back on to his antipsychotic medication. However, the Appellant had not done so.

105. Dr Whalley, GMC Health Examiner, had previously reported in 2015 and 2017. She saw him in November 2018, and considered he had deteriorated. His behaviour was inappropriate and at times bizarre, and he was clearly thought disordered. He lacked insight. Schizophrenia is a relapsing condition and, in the Appellant's case, there was

a risk of a major relapse, particular when he was under stress, and when not taking antipsychotic medication. Dr Whalley concluded that he was not fit to practise.

106. Dr Jha, GMC Health Examiner, had previously reported in 2017, and saw the Appellant in November 2018. He did not detect any psychotic or paranoid symptoms or thought disorder. He concluded that he was symptom-free and fit to practise.

107. Because of the difference in opinion between Dr Whalley and Dr Jha, they met to discuss their areas of agreement and disagreement and produced a joint statement in February 2019. Both doctors agreed that the Appellant had behaved in a bizarre and inappropriate manner over several months in 2018. However, there remained a difference in their assessment of him as at November 2018. Therefore, they agreed that a further performance assessment was necessary to explore the extent to which any thought disorder impacted on his clinical abilities, and on any differences in his behaviour towards women. Any practice would have to be under close supervision. Dr Whalley agreed that if the results of this assessment were satisfactory then he could be considered fit to practise under close supervision at an F2 level subject, if he was taking antipsychotics and after a satisfactory review by his GMC supervisor.

108. Dr Jha gave evidence at the hearing. He accepted that symptoms of thought disorder, even if intermittent, could mean that a practitioner was not fit to practise, as it indicated a psychotic process which would impact upon his insight and his judgment.

109. Dr Selzer, GMC Medical Supervisor, assessed him in June 2019, and following discussions with treating clinicians, she reported on 8 August 2019. In her opinion, he displayed symptoms of schizophrenia or a paranoid personality disorder. His lack of insight and difficulties in reflecting on his own behaviour were likely to cause him problems in clinical practice, as these deficiencies could affect his clinical judgment and his interactions with staff and patients. She concluded that he was not fit to practise.

110. In the light of this evidence, the MPT could not accept the opinion of Dr Patel, the independent psychiatrist instructed by the Appellant, that that the Appellant was fit to practise as he had not seen the Appellant since 30 May 2018 and had not had sight of any of his recent medical assessments. Dr Patel had also been told that the Appellant had stopped taking medication on medical advice, which was incorrect.

111. The MPT expressed its concern at the Appellant's cessation of medication, given that schizophrenia is a recurring condition, and there was evidence that, in particular circumstances, such as when he was under stress, his condition was liable to deteriorate.

112. In the light of the medical evidence, the MPT concluded that the Appellant's fitness to practise was impaired, and it was not necessary to carry out a further performance assessment. In my judgment, there was sufficient evidence upon which the MPT could properly reach that conclusion.

Impairment on grounds of deficient professional performance

113. In relation to deficient professional performance, the MPT had regard to the concerns raised at the earlier tribunal hearings, in particular the six specific areas identified by the September 2017 MPT.

114. The MPT found that the Appellant had not addressed the four identified areas of deficiencies: assessment of patient's condition, providing/arranging treatment, relationships with patients and record keeping. The MPT concluded that he lacked insight into what was required to address these deficiencies. The MPT's findings in respect of his Personal Development Plan are set out at paragraph 55 above.

115. The MPT concluded that the Appellant's fitness to practise remained impaired by reason of his deficient professional performance. In my judgment, the MPT was entitled to reach that conclusion on the evidence before it.

Sanction

116. At the stage of determining sanction, the MPT heard submissions from the Appellant by telephone, and from the GMC.

117. Counsel for the GMC had obtained further instructions in respect of the voluntary erasure application, indicating that the GMC would not accede to the application. New allegations had recently been made against the Appellant arising out of his dismissal for gross misconduct because of his alleged ill treatment of a patient at a care home. The new allegations potentially had a bearing on the application for voluntary erasure. The MPT disregarded them for the purposes of determining sanction as they had not yet been investigated.

118. The MPT correctly directed itself on the statutory objectives of sentencing, and the 'Indicative Sanctions Guidance'. It considered whether to impose conditions on the Appellant's registration, bearing in mind that any conditions imposed would need to be appropriate, proportionate, workable and measurable. The MPT concluded, at paragraph 28:

> "The Tribunal has determined that Dr Goodchild-Simpson has displayed a worsening level of insight into his health since the 2017 hearing. Given the findings made about Dr Goodchild-Simpson's health a period of retraining and/or supervision would not be capable of addressing the findings made in relation to his deficient professional performance. The Tribunal noted that Dr Goodchild-Simpson had already been given an opportunity to do so following the 2017 hearing and the doctor was unable to evidence positive progress. The Tribunal therefore is not satisfied that he will comply with further conditions."

119. The MPT applied the principle of proportionality, balancing the Appellant's interests with the public interest. In the light of the Appellant's diminished insight into his health condition, and his failure to reflect upon or remediate his deficient professional

performance, the Tribunal concluded that a period of suspension of 12 months was a necessary and proportionate sanction which appropriately balanced the public interest with the doctor's own interests.

120. In my judgment, the sanction imposed by the MPT cannot be characterised as "wrong", in the circumstances of this case.

Final Conclusion

121. For the reasons set out above, the appeal is dismissed.