Neutral Citation Number: [2021] EWHC 1538 (Admin)

Case No: CO/1951/2020

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

Birmingham Civil Justice Centre
33 Bull Street, Birmingham, B4 6DS

Date: 08/06/2021

**Before** :

**THE HONOURABLE MRS JUSTICE STEYN DBE**

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**Between :**

| | |
|---|---|
| **DR KEVIN PETER NEWLEY** | **Appellant** |
| **- and -** | |
| **GENERAL MEDICAL COUNCIL** | **Respondent** |

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The **Appellant appeared in person**
**Alexis Hearnden** (instructed by **GMC**) for the **Respondent**

Hearing date: 13 May 2021

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# Approved Judgment

**Mrs Justice Steyn :**

1. This is an appeal under section 40 of the Medical Act 1983 against a decision of the Medical Practitioners Tribunal ("the review tribunal"), made on 15 April 2020 following a review hearing ("the review decision"). The review tribunal decided that Dr Newley's fitness to practise remained impaired by reason of his misconduct and imposed conditions on his registration as a doctor for a period of 24 months. Dr Newley appeals against both the findings of impairment and the sanction.

2. Following an earlier hearing before another Medical Practitioners Tribunal ("the 2019 tribunal"), on 25 January 2019 the appellant's fitness to practise had been found to be impaired by reason of misconduct and his registration as a medical practitioner was suspended for a period of nine months. The appellant's appeal against the 2019 tribunal's determination of impairment and sanction was dismissed by Lang J: *Newley v General Medical Council* (unreported, 25 July 2019). The allegations against him, considered by the 2019 tribunal, related to his care of eight patients (known as A to H) in respect of matters such as obtaining an appropriate history from patients, record-keeping, undertaking diagnostic tests, making referrals to hospital when required and communicating with patients appropriately.

3. The 2019 tribunal made a direction under s.35D(4A) for a review by another Medical Practitioners Tribunal prior to the expiry of the period of suspension. In accordance with that direction, the review hearing which is the subject of this appeal was held.

## The original disciplinary proceedings

4. The original disciplinary proceedings took place between 13 December 2017 and 25 January 2019. The 2019 tribunal sat for about 72 days during that period. Lang J observed at [19] that:

> "The length of the hearing can be explained by the volume of evidence, the number of witnesses (including expert witnesses on both sides), the number of issues in dispute and the length of the submissions by the legal representatives."

5. There were some drafting errors in the 2019 tribunal's recording of its findings in respect of the allegations, but Lang J held the reasons given by the 2019 tribunal in the body of the determination are clear. The final, corrected version of the 2019 tribunal's determination on impairment shows the following allegations were found proved:

> "That being registered under the Medical Act 1983 (as amended):
>
> <u>Patient A</u>
>
> 1. Between June 2006 and December 2011, in providing treatment to Patient A you failed to:
>
> (a) on the dates listed in Schedule A:
>
> …

ii. record an appropriate history of Patient A; [This allegation was found proved in relation to 7 June 2006; not proved in relation to four dates in 2011.]

(b) on 2 July 2010:

i. make an entry in Patient A's medical records of your consultation with Patient A; …

Patient B

2. Between March 2014 and August 2014, in providing treatment to Patient B you failed to:

(a) on 27 May 2014:

…

ii. record an appropriate history of Patient B; …

iv. record your advice given to Patient B;

(b) on 8 July 2014:

(i) obtain an appropriate history of Patient B in that you did not question whether:

…

(2) the pain was constant;

(3) the pain was worsening; …

(ii) record an appropriate history of Patient B;

(c) on 17 July 2014:

(i) obtain an appropriate history of Patient B in that you did not question Patient B about:

(1) bladder functions;

(2) bowel functions;

(3) Patient B's perineum for sensory impairment;

(4) whether the pain was constant;

(5) whether the pain was worsening; …

(ii) record an appropriate history of Patient B;

…

(e) on 1 August 2014:

(i) question Patient B about bladder functions;

(ii) question Patient B on bowel functions; …

Patient C

3. Between June 2010 and August 2011, in providing treatment to Patient C you failed to:

…

(b) on 28 June 2010:

…

(ii) record an appropriate history of Patient C; …

(iv) recommend a digital rectal examination for Patient C;

(v) recommend urine dipstick testing for Patient C;

(vi) make an adequate record of your consultation with Patient C in that you did not:

(1) indicate the basis of your diagnosis;

(2) record your intended follow-up plan for Patient C;

(c) on or shortly after 22 September 2010:

(i) contact Patient C following his test results asking for him to attend the surgery in the near future; …

(iii) recommend urine dipstick testing for Patient C;

(d) on 18 November 2010:

(i) urgently refer Patient C;

(ii) recommend a digital rectal examination for Patient C;

…

(g) on 2 August 2011:

(i) obtain an appropriate history of Patient C in that you did not question Patient C about urinary symptoms;

(ii) record an appropriate history of Patient C; …

(iv) recommend a digital rectal examination for Patient C; …

(vi) make an adequate record of your consultation with Patient C;

(h) on 4 August 2011:

(i) obtain an appropriate history of Patient C in that you did not refer to the presence or absence of clinical symptoms;

(ii) record an appropriate history of Patient C;

(iii) recommend a digital rectal examination for Patient C; …

4. In providing treatment to Patient C in 2011, you communicated inappropriately by saying to him:

(i) on 2 August 2011 or another date, 'Well, I'm still not referring you' or words to that effect;

(ii) on 4 August 2011 or another date, 'If it's positive, what are you going to do about your great big prostate? Have it chopped out?' or words to that effect.

Patient D

5. Between January 2008 and April 2012, in providing treatment to Patient D you failed to:

…

(b) on 15 January 2008:

…

(ii) record an appropriate history of Patient D;

(iii) recommend a digital rectal examination of Patient D;

(c) on or shortly after 23 November 2010:

…

(ii) recommend a digital rectal examination of Patient D; …

(e) on 2 August 2011:

(i) recommend a digital rectal examination for Patient D; …

(f) on or shortly after 22 September 2011:

…

(ii) recommend digital rectal examination for Patient D; …

(g) on 20 April 2012:

(i) obtain an appropriate history of Patient D;

(ii) record an appropriate history of Patient D;

(iii) recommend a digital rectal examination for Patient D; …

Patient E

6. Between February 2008 and July 2013 in providing treatment to Patient E, you failed to:

(a) on the dates listed in schedule B, record an appropriate history of Patient E [This allegation was found proved in relation to 10 July 2008, 8 October 2008, 19 January 2009, 28 April 2009, 3 August 2009, 9 November 2009, 28 April 2010, 26 July 2010, 6 April 2011, 11 January 2012, 28 March 2012, 30 May 2012, 29 April 2013 and 10 July 2012, and not proved in respect of various other dates];

…

(c) on the following dates, recommend digital rectal examination for Patient E:

(i) 8 October 2008;

(ii) 19 January 2009;

(iii) 3 August 2009;

(iv) 28 April 2010; …

(vi) 9 November 2010; …

(viii) 29 April 2013;

…

Patient F

7. In July 2013, in providing treatment to Patient F, you failed to:

(a) on the dates listed in schedule C:

…

(ii) record an appropriate history of Patient F.

…

Patient G

8. Between February 2012 and March 2014 in providing treatment to Patient G, you failed to:

(a) on 13 February 2012:

(i) obtain an appropriate history of Patient G in that you did not question Patient G about:

…

(2) neurological symptoms; …

(4) sensory symptoms; …

(ii) record an appropriate history of Patient G; …

(c) on 4 May 2012:

…

(ii) request for Patient G to undergo:

(1) an ECG;

(2) ambulatory blood pressure monitoring (‘ABPM’) or home blood pressure monitoring (‘HBPM’);

(3) chemical reagent strip testing of urine; …

(d) on 3 January 2014:

…

(ii) record an appropriate history of Patient G; …

(iv) request for Patient G to undergo:

(1) an ECG;

(2) ABPM or HBPM;

(3) chemical reagent strip testing of the urine;

(v) provide Patient G with follow up advice;

(vi) record any follow up advice given;

(e) on 27 February 2014:

…

(ii) request for Patient G to undergo:

(1) and ECG;

(2) ABPM or HBPM;

(3) chemical reagent strip testing of the urine;

(iii) provide Patient G with follow up advice;

(iv) record any follow-up advice given; …

…

And that by reason of the matters set above your fitness to practise is impaired because of your misconduct."

6. The 2019 tribunal deleted various other allegations following a submission of no case to answer made by the appellant's representative under rule 17(2)(g) of the Fitness to Practise Rules 2004 and found a number of other allegations (including all allegations relating to Patient H) not proved. In addition, some allegations were withdrawn during the hearing by the GMC.

7. At the sanction stage, the 2019 tribunal observed that it had listed at §40 of its determination on impairment the type of evidence which would have assisted its deliberations on sanction. The appellant did not produce such evidence, despite his counsel's application for extra time to do so being granted. Instead he produced a document entitled "Reflections – 14/11/2018" which the 2019 tribunal described as "unusual". The 2019 tribunal said in its sanction determination:

> "6. … Dr Newley produced a document which continued to dispute the accuracy and validity of symptoms which patients related to him from the times of their consultations with him until this hearing, even though the progression of their illnesses was in line with their described symptoms and unwavering testimony.
>
> 7. Dr Newley also used his reflections as a means to challenge and criticise the work of his Advanced Nurse Practitioner (ANP),

the opinions of the expert witnesses, Dr Burton and Dr Middleton and the findings and determinations of this Tribunal.

8. Dr Newley's Reflections document contains the passage: '*Emails from NICE has confirmed that in the 2005 guidelines 1.8.2, 1.8.3 and 1.8.6 are interrelated and not independent as affirmed by Dr Burton in his report. According to Mr Gilbart, this makes Dr Burton an unreliable witness and all his evidence should be viewed with due caution.*' In his oral evidence, Dr Newley explained that he was not suggesting that Mr Gilbart, on behalf of the GMC, had ever disagreed with Dr Burton. He told the Tribunal that the correct reading of the extract, given the Tribunal's prior knowledge of the hearing, was that the criticism of his (Dr Newley's) inconsistencies in specific documentary and oral evidence made by Mr Gilbart, at an earlier stage, applied equally and more so, in his opinion, to Dr Burton.

9. Dr Newley directed the Tribunal's attention to the National Collaborating Centre for Primary Care (NCC-PC) Referral Guidelines for Suspected Cancer in Adults and Children Parts 1 and 2 and, most specifically, to the study of Fowler et al (2000) at page 64 of part 2 and the Urological Cancers – Prostate Flowchart at page 110 of Part 1. The aim of the study was 'to determine whether features used to detect prostate cancer are different in black and white American men'. It was noted that: '*the study subjects were 179 black and 357 white men who had undergone prostate biopsy 1992-1999 at one medical centre. The patients had an abnormal DRE, a PSA of less than 4ng/m; and no history of prostate surgery. Cancer was detected in 38 black (21%) and 65 white (18%) men. There was no difference in the overall or PSA stratified cancer detection rate.*' Dr Newley was adamant that the study corroborated his opinion and decision not to recommend digital rectal examinations (DREs) for Patients C, D and E.

10. The NCC-PC Referral Guidelines for Suspected Cancer introduced by Dr Newley were dated 2005. The NICE Guidelines were revised in 2007 and 2011; the NCC-PC publication itself has been superseded and the version put in evidence states in red on every page '*OBSOLETE: REPLACED BY NG12*'. Dr Newley relied, in particular, on the flowchart for suspected prostate cancer, which he understood as indicating that a DRE was not recommended for asymptomatic patients. Dr Newley was of the further view that this disproved the evidence of the experts and, therefore, invalidated some of the Tribunal's findings.

…

44. The Tribunal determined that Dr Newley's approach and attitude when giving evidence, even at this stage, demonstrated

> a marked lack of insight and, despite his evidence to the contrary, a rigid and concerning resistance to the viewpoints, observations and evidence-based conclusions of others where they differed from his own. This was emphasised by his decision to submit tangential and irrelevant material to the Tribunal as part of his mission to prove, even now, that his version of events should be preferred over every other view. In the case of patients' symptoms, he introduced new, speculative and subjective explanations to support his continued contention that patients had been asymptomatic. For example, he suggested the ingestion of beetroot juice to explain away Patient C's report of blood in his urine.
>
> 45. The flow chart (CG27 part 1 – page 110) is not entirely clear as one of its limbs does not connect with any final action. It has not been put to either of the expert witnesses for their comments. It pre-dates the version of the relevant NICE guidelines in force at the time of the events, to which the expert evidence referred. The Tribunal however accepts that Dr Newley regards the chart as giving support to his present view that a DRE was not recommended in the case of asymptomatic patients.
>
> 46. The Tribunal has no power to revisit findings that it has made and announced at an earlier stage of these proceedings. In any event, it does not regard the flowchart as indicating that any of its findings were wrong. That is, among other reasons, because all of the patients in question reported that they *were* symptomatic. The appropriate management of asymptomatic patients does not therefore affect the evidence in relation to those patients.
>
> 47. With regard to the Fowler study (part 2 – page 64 of CG27), quite apart from the fact that the purpose of the study was to identify whether there are differences between black and white American patients, so that it may be unwise to draw conclusions from it on a question to which the study was not directed, the study dealt with the incidence of cancer among patients with a normal PSA and no symptoms, but with an abnormal DRE. The study was not put to the expert witnesses for their comment and the Tribunal is not persuaded that this study sheds any light on the desirability of a DRE in patients who had a raised PSA and had symptoms."

8. Balancing the need for the protection of the public with the impact of the suspension on him, the 2019 tribunal determined that it was appropriate and proportionate to direct the Registrar to suspend the appellant's registration for a period of nine months. Under the heading "Review", the 2019 tribunal stated:

> "58. The Tribunal determined to direct a review of Dr Newley's case. A review hearing will convene shortly before the end of the period of suspension, unless an early review is sought. The

> Tribunal wishes to clarify that, at the review hearing, the onus will be on Dr Newley to demonstrate how he has remediated. It considered that a future Tribunal reviewing this matter would be assisted by the following:
>
> - A reflective statement addressing what he has learned in respect of the Tribunal's findings of facts and impairment and demonstrating his level of insight.
> - Evidence of meetings and case-based discussions with a mentor.
> - Evidence of Dr Newley's appraisal discussions to demonstrate that he has reflected upon his learning and identified any further development needs.
> - An indication as to Dr Newley's future plans in respect of the practice of medicine.
> - Evidence of Dr Newley's Continuing Professional Development (CPD).
> - Evidence that Dr Newley has maintained his clinical skills and medical knowledge.
> - Current testimonials as to Dr Newley's character and conduct during the period of his suspension, written in the knowledge of his suspension by this Tribunal and of the Tribunal's reasons."

9. As I have said, the appellant exercised his right of appeal against the 2019 tribunal's determination impairment and sanction. His appeal was heard and dismissed by Lang J in July 2019.

**The review decision**

10. The appellant provided a number of statements and gave oral evidence at the hearing before the review tribunal on 14 April 2020. The review tribunal recorded in its determination on impairment dated 15 April 2020:

> "31. Dr Newley stated that the findings of the 2019 Tribunal were incorrect, as they were based on Dr Burton's expert report. He stated that he does not agree with the expert report and some of the 2019 Tribunal's findings.
>
> …
>
> 35. Dr Newley stated that he wished to go through the list of the 2019 Tribunal's findings with new evidence that he has but he accepted that it was not appropriate for that to be done at this review hearing. Dr Newley stated that his opinion regarding his

treatment and management of Patients B, C, D and E remained unchanged. He stated his treatment was correct and that he has provided information from NICE which proves this.

…

37. Dr Newley referred the Tribunal to the High Court Judgement which concluded that the determinations made by the 2019 Tribunal, based on the evidence before it at that time, was correct. Dr Newley stated that the new evidence he has provided should be taken into account, even if it resulted in a new Fitness to Practise hearing. Dr Newley questioned what recourse he had in this respect. He stated that wishing to adduce the new evidence did not show lack of insight but showed the 'courage of my convictions', which was not a bad thing in his opinion."

11. In its determination regarding impairment, the review tribunal stated:

"45. The Tribunal noted the practical constraints on Dr Newley in light of his serious health condition. However, it also noted that he has provided limited evidence that he has kept his clinical skills and knowledge up to date. Further, Dr Newley stated that he could not have completed more on-line courses in relation to his Continuing Professional Development in light of his health condition. The Tribunal noted that Dr Newley recognised and accepted that his record keeping was below the standard expected of a reasonably competent General Practitioner, but there is insufficient evidence that he has fully addressed all of the deficiencies identified by the 2019 Tribunal.

46. The Tribunal noted that there is an irreconcilable difference of opinion between Dr Newley and a number of the 2019 Tribunal's factual findings. Because of that, Dr Newley was unwilling to accept a number of failings found proved. Dr Newley stated that he would not be able to demonstrate insight into his failings as he was adamant that a number of the 2019 Tribunal's factual findings were wrong and that he had acted appropriately. This Tribunal found Dr Newley to be resolute and rigid in his view about his own clinical practice. The Tribunal recognises that it is not a requirement that Dr Newley accepts the 2019 Tribunal's findings in order for him to establish that he has developed insight, but the Tribunal is mindful that at this review hearing it cannot go behind the 2019 Tribunal's findings.

…

48. Notwithstanding his personal circumstances, the Tribunal considered that Dr Newley has provided limited evidence in relation to those matters that the 2019 Tribunal indicated would be useful to a future reviewing Tribunal. There is limited evidence in relation to Dr Newley's insight or remediation of the

> failings found proved, or how he has kept his skills and knowledge up to date during his suspension. The Tribunal reminded itself that there is a persuasive burden on Dr Newley to demonstrate that he is fit to return to unrestricted practice, and he has not sufficiently done so.
>
> 49. The Tribunal considered that Dr Newley has started the process of remediation, in recognising that some areas of his practice are deficient, notably in relation to record keeping. However, that process is by no means complete. The Tribunal is of the opinion that the risk of repetition has been diminished but there remains an ongoing risk. Therefore, the Tribunal cannot be satisfied it would be highly unlikely that Dr Newley would repeat his misconduct in the future, thereby presenting an ongoing risk of harm to patients."

12. The review tribunal concluded that Dr Newley's fitness to practise remained currently impaired by reason of misconduct.

13. The GMC submitted that the appropriate sanction was a further period of suspension. The review tribunal recorded:

> "3. Dr Newley stated that he appears to be in a 'catch 22' situation similar to a year ago in relation to insight. He said that he has provided evidence which has come to light since the 2019 hearing that his clinical management in some of the cases was appropriate. He submitted that the new evidence does not show a lack of insight but rather 'a flexibility of thinking'.
>
> 4. Dr Newley stated that he expects he will be in the same position again in relation to insight until the GMC has concluded its investigation into his referral of Dr Burton. Dr Newley expressed a wish to return to practice should his health allow."

14. In its determination on sanction, the review tribunal expressed the view that the appellant had demonstrated a willingness to engage with the regulatory process. The review tribunal agreed with the 2019 Tribunal that his misconduct "is capable of remediation". The review tribunal stated:

> "14. Whilst the Tribunal accepts that Dr Newley has not yet demonstrated full insight into his misconduct, nor has he fully remediated his failings, it considered that he has the potential to respond positively to conditional registration. Further, the Tribunal considered that conditions would allow Dr Newley the opportunity to demonstrate that he can fully remediate his misconduct and can practise safely with the appropriate supervision. The Tribunal considered that Dr Newley may be able to provide some objective evidence, such as passing the assessment for inclusion on the GP Performers List. The Tribunal was satisfied that a period of conditional registration

> would be sufficient to protect the public and maintain public confidence in the profession."

15. The review tribunal considered it appropriate, necessary and proportionate to impose conditions on the appellant's registration for a period of 24 months. They stated that in view of his health condition and the current pandemic, a 24 month period would allow the appellant sufficient time to return to and undertake a period of supervised clinical practice.

**The legal framework**

16. Section 35D of the Medical Act 1983 provides, so far as material:

> "(2) Where the Medical Practitioners Tribunal find that the person's fitness to practise is impaired they may, if they think fit –
>
> > …
> >
> > (b) direct that his registration in the register shall be suspended (that is to say, shall not have effect) during such period not exceeding twelve months as may be specified in the direction; …
>
> (4) Where a medical Practitioners Tribunal have given a direction that a person's registration be suspended –
>
> > (a) under subsection (2) above;
> >
> > …
>
> subsections (4A) and (4B) below apply.
>
> (4A) The Tribunal may direct that the direction is to be reviewed by another Medical Practitioners Tribunal prior to the expiry of the period of suspension; and, where the Tribunal do so direct, the MPTS must arrange for the direction to be reviewed by another Medical Practitioners Tribunal prior to that expiry.
>
> …
>
> (5) On a review arranged under subsection (4A) or (4B), a Medical Practitioners Tribunal may, if they think fit –
>
> > (a) direct that the current period of suspension shall be extended for such further period from the time when it would otherwise expire as may be specified in the direction;
> >
> > (b) except in a health case or language case or a case of suspension under paragraph 5A(3D) or 5C(4) of Schedule 4, direct that the person's name shall be erased from the register;

> (c) direct that the person's registration shall, as from the expiry of the current period of suspension or from such date before that expiry as may be specified in the direction, be conditional on his compliance, during such period not exceeding three years as may be specified in the direction, with such requirements so specified as the Tribunal think fit to impose for the protection of members of the public or in his interests; or
>
> (d) revoke the direction for the remainder of the current period of suspension,
>
> but subject to subsection (6) below, the Tribunal shall not extend any period of suspension under this section for more than twelve months at a time."

17. The 2019 tribunal made directions under s.35D(2)(b) and (4A), in accordance with which hearing before the review tribunal was arranged. In making its determination on sanction, the review tribunal applied s.35D(5)(c).

18. The procedure to be adopted at a review hearing is set out in rule 22 of the General Medical Council Fitness to Practice Rules 2004 (SI 2004/2608, as amended). In *Abrahaem v General Medical Council* [2008] EWHC 183 (Admin), Blake J observed at [23]:

> "The statute is to be read together with the 2004 Rules … and Rule 22 a) to i) makes clear that there is an ordered sequence of decision making, and the Panel must first address whether the fitness to practise is impaired before considering conditions. In my judgment, the statutory context for the Rule relating to reviews must mean that the review has to consider whether all the concerns raised in the original finding of impairment through misconduct have been sufficiently addressed to the Panel's satisfaction. In practical terms there is a persuasive burden on the practitioner at a review to demonstrate that he or she has fully acknowledged why past professional performance was deficient and through insight, application, education, supervision or other achievement sufficiently addressed the past impairments."

19. The Sanctions Guidance issued to tribunals by the GMC provides further direction in relation to review hearings:

> "163. It is important that no doctor is allowed to resume unrestricted practice following a period of conditional registration or suspension unless the tribunal considers that they are safe to do s.
>
> 164. In some misconduct cases it may be self-evident that, following a short suspension, there will be no value in a review hearing. However, in most cases where a period of suspension is imposed, the tribunal will need to be reassured that the doctor is

fit to resume practice – either unrestricted or with conditions or further conditions. A review hearing is therefore likely to be necessary, so that the tribunal can consider whether the doctor has shown all of the following (by producing objective evidence):

a. they fully appreciate the gravity of the offence

b. they have not reoffended

c. they have maintained their skills and knowledge

d. patients will not be placed at risk by resumption of practice or by the imposition of conditional registration."

## The approach on appeal

20. Section 40 of the Medical Act 1983 provides, so far as material:

"(1) The following decisions are appealable decisions for the purposes of this section, that is to say –

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

…

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

(5) In subsections (4) and (4A) above, "the relevant court" –

…

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

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

(a) dismiss the appeal;

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

> (c) substitute for the direction or variation appealed against any other direction or variation which could have been given or made by a Medical Practitioners Tribunal; or
>
> (d) remit the case to the MPTS for them to arrange for a Medical Practitioners Tribunal to dispose of the case in accordance with the directions of the court,
>
> and may make such order as to costs … as it thinks fit."

21. The Appellant's notice makes clear that the decision appealed is that of the review tribunal dated 15 April 2020. The appeal against the review tribunal's determination was brought in time. The "*direction ... appealed against*" within the meaning of s.40(7)(b) and (c) is that made by the review tribunal, not the 2019 tribunal.

22. The appeal is governed by CPR 52.21 which provides:

> "(1) Every appeal will be limited to a review of the decision of the lower court unless—
>
> (a) a practice direction makes different provision for a particular category of appeal; or
>
> (b) the court considers that in the circumstances of an individual appeal it would be in the interests of justice to hold a re-hearing.
>
> (2) Unless it orders otherwise, the appeal court will not receive—
>
> (a) oral evidence; or
>
> (b) evidence which was not before the lower court.
>
> (3) The appeal court will allow an appeal where the decision of the lower court was—
>
> (a) wrong; or
>
> (b) unjust because of a serious procedural or other irregularity in the proceedings in the lower court.
>
> (4) The appeal court may draw any inference of fact which it considers justified on the evidence.
>
> (5) At the hearing of the appeal, a party may not rely on a matter not contained in that party's appeal notice unless the court gives permission."

23. Paragraph 19.1 of Practice Direction 52D specifies that an appeal to the High Court under s.40 of the Medical Act 1983 will be by way of rehearing. In *Sastry and Okapara v General Medical Council* [2021] EWCA Civ 623, the Court of Appeal considered the

distinction between the approach to be taken in appeals by way of rehearing brought under s.40 and appeals by way of review brought under s.40A. The Court of Appeal held that the approach identified by the Privy Council in *Ghosh v General Medical Council* [2001] 1 WLR 1915, and approved by the Supreme Court in *Khan v General Medical Council* [2017] 1 WLR 169, is appropriate in s.40 appeals ([108]).

24. Nicola Davies LJ, giving the judgment of the Court, observed at [102] to [103]:

> "Derived from *Ghosh* are the following points as to the nature and extent of the section 40 appeal and that approach of the appellate court:
>
> i) an unqualified statutory right of appeal by medical practitioners pursuant to section 40 of the 1983 Act;
>
> ii) the jurisdiction of the court is appellate, not supervisory;
>
> iii) the appeal is by way of a rehearing in which the court is fully entitled to substitute its own decision for that of the Tribunal;
>
> iv) the appellate court will not defer to the judgment of the Tribunal more than is warranted by the circumstances;
>
> v) the appellate court must decide whether the sanction imposed was appropriate and necessary in the public interest or was excessive and disproportionate;
>
> vi) in the latter event, the appellate court should substitute some other penalty or remit the case to the Tribunal for reconsideration.
>
> The courts have accepted that some degree of defence will be accorded to the judgment of the Tribunal but, as was observed by Lord Millett at [34] in *Ghosh*, "the Board will not defer to the Committee's judgment more than is warranted by the circumstances". In *Preiss*, at [27], Lord Cooke stated that the appropriate degree of deference will depend on the circumstances of the case. Laws LJ in *Raschid and Fatnani*, in accepting that the learning of the Privy Council constituted the essential approach to be applied by the High Court on a section 40 appeal, stated that on such an appeal material errors of fact and law will be corrected and the court will exercise judgment but it is secondary judgment as to the application of the principles to the facts of the case ([20]). In *Cheatle* Cranston J accepted that the degree of deference to be accorded to the Tribunal would depend on the circumstances, one factor being the composition of the Tribunal. He accepted the appellant's submission that he could not be "completely blind" to a composition which comprised three lay members and two medical members."

## Grounds of appeal

25. On 20 May 2020, the appellant filed a notice of appeal against the review tribunal's determinations in respect of both impairment and sanction.

26. The first part of the appellant's grounds of appeal alleges that the following findings (made by the 2019 tribunal) are in error:

> "1. Patient A: 1bii, 1ci, 1cii
>
> 2. Patient B: 2bi2, 2bi3, 2ci1, 2ci2, 2ci3, 2ci4, 2ci5, 2cii, 2ei, 2eii
>
> 3. Patient C: 3biv, 3bv, 3bvi2, 3ci, 3ciii, 3di, 3dii, 3gi, 3giv, 3hii, 3hiii, 4i, 4ii
>
> 4. Patient D: 5biii, 5cii, <u>5fi</u>, 5gi, 5giii
>
> 5. Patient E: 6ci, 6cii, 6civ, <u>6cv</u>, 6cvi, <u>6cvii</u>, 6cviii
>
> 6. Patient F: 7aii,
>
> 7. Patient G: 8cii1, 8cii2, 8dii, 8div1, 8div2, 8div3, 8dv, 8eii1, 8eii2, 8eii3, 8eiii
>
> I believe this covers all of the allegations of performance "seriously below the level of a competent GP" except one and therefore I think the imposition of temporary suspension <u>and the variation to close supervision by the MPTS review panel are both</u> unreasonable." (underlining added)

27. This part of the statement of grounds is in almost identical terms to the grounds of appeal considered and dismissed by Lang J, as recorded in her judgment at [18]. The only differences are that:

    i) The words underlined have been added (including allegations 5(f)(i), 6(c)(v) and 6(c)(vii) which were not found proved by the 2019 tribunal);

    ii) The appellant has removed reference to two allegations which were found not proved (1(a)(i) and 2(b)(ii)); and

    iii) Although the appellant has retained the statement that "this covers all of the allegations of performance 'seriously below the level of a competent GP' except one", he has removed reference to 12 allegations that were found proved by the 2019 tribunal. He does not contend in his grounds of appeal that the following findings made by the 2019 tribunal were erroneous:

        a) Failures to obtain an appropriate history in relation to Patients C and G: allegations 3(h)(i) and 8(a)(i)(2) and (4);

        b) Failures to record an appropriate history in relation to Patients A, C, D and E: allegations 1(a)(ii), 3(b)(ii), 5(b)(ii) and 6(a);

c) Failures to make an entry/record follow-up advice in relation to Patients A and G: allegations 1(b)(i) and 8(e)(iv);

d) Failures to recommend a Digital Rectal Examination on certain dates for Patients D and E: allegations 5(e)(i) and 6(c)(iii); and

e) Failure to request Patient G undergo chemical reagent strip testing of urine on one date: allegation 8(c)(ii)(3).

28. However, in his written and oral submissions the appellant maintained that the 2019 tribunal was wrong to find any failures to recommend a Digital Rectal Examination, so the absence of reference to allegations 5(e)(i) and 6(c)(iii), at least, may have been accidental.

29. In the second part of his grounds of appeal the appellant refers to §59 of the 2019 tribunal's determination of sanction where they stated, having identified the evidence that would assist the Tribunal on review (see §58, quoted in §8 above):

> "Dr Newley will also be able to provide any other information that he considers will assist."

His grounds of appeal continue:

> "The MPTS review panel declined to consider the new evidence concerning Dr Burton's report and the MPTS errors of fact presented to them as they stated this would amount to a re-trial which was not their function. However I was not contesting every determination of the original MPTS panel, only the ones based on the errors in Dr Burton's report and the factually incorrect determinations of the MPTS panel."

### The appellant's application to adduce new evidence

30. The appellant applies under CPR 52.21(2)(b) to adduce and rely on new evidence in support of his appeal. There were four pieces of "new" evidence to which he referred.

31. First, the appellant relied on an email to him from the National Institute for Health and Care Excellence ("NICE") dated 19 January 2017. Secondly, he relied on a "Urological cancers – prostate" flowchart extracted from the National Collaborating Centre for Primary Care (NCC-PC) Referral Guidelines for Suspected Cancer, dated June 2005, which is stamped "OBSOLETE: REPLACED BY NG12". Thirdly, he relied on a letter dated 17 March 2020 from Daxa Vaidya who was employed by the appellant as an Advanced Nurse Practitioner from 2001 to 2016.

32. Each of these three documents was, in fact, evidence that was put before the review tribunal by the appellant. Accordingly, the appellant does not need permission to rely on this evidence on appeal.

33. The fourth document is a letter from the GMC to the appellant dated 9 October 2020. This is the only document that post-dates the review hearing and for which permission is required under CPR 51.21(2)(b). Following the 2019 tribunal, the appellant made a complaint to the GMC regarding Dr Burton, one of the expert witnesses who gave

evidence before the 2019 tribunal. The GMC made a determination under rule 4 that the complaint did not reveal any fitness to practise issues that warranted investigation. Under rule 12, the appellant sought a review of the rule 4 decision. The letter of 9 October 2020 is the rule 12 determination upholding the rule 4 decision.

34. The appellant relies on a paragraph of the 9 October 2020 letter which states:

> "You have also asked what weight has been given to both your opinion and Dr Burton's opinion. Unfortunately, I am not able to answer that question as it is not the role of the Assistant Registrar to resolve a conflict of evidence. I can see that you believe that by not taking action against Dr Burton, this indicates that the Assistant Registrar accepted Dr Burton's opinion over yours. However, this is not what the Assistant registrar has concluded. Rather, the Assistant Registrar agreed with our medically qualified colleague who advised that Dr Burton's opinion was reasonably formed based on his interpretation of the NICE guidance and also agreed that those guidelines are open for interpretation. As I have explained above, a differing interpretation is not a fitness to practise issue and we can only intervene when a doctor's fitness to practise medicine is impaired."

35. The appellant places particular reliance on the suggestion "those guidelines are open for interpretation" in support of his submission that the 2019 tribunal was wrong to conclude that he had failed to offer digital rectal examinations (DREs) in circumstances where he should have done so.

36. This application to admit fresh evidence on appeal is governed by CPR 52.21(2)(b), the overriding objective of dealing with cases justly and at proportionate cost (CPR 1.1), and the principles set out in *Ladd v Marshall* [1954] 1 WLR 1489 by Denning LJ at 1491:

> "first, it must be shown that the evidence could not have been obtained with reasonable diligence for use at trial; secondly, the evidence must be such that, if given, it would probably have an important influence on the result of the case, though it need not be decisive; thirdly, the evidence must be such as is presumably to be believed, or in other words, it must be apparently credible, though it need not be incontrovertible."

37. The continued relevance of these principles in disciplinary cases was acknowledged by the Court of Appeal in *GMC v Adeogba* [2016] 1 WLR 3867 where Sir Brian Leveson P held at [31]:

> "The impact of the decision on the public good is, as Smith LJ makes clear, an important feature of the case when it comes to the exercise of discretion but the context of this type of case also requires appropriate consideration to be given to the importance of effective and efficient regulation of the profession. Neither does the decision in *Muscat*'s case nor the observations of Smith

> LJ support the proposition that departure from *Ladd v Marshall* is justified by this principle alone."

38. The 9 October 2020 letter was not available at the time of the review hearing and it is credible evidence, so the first and third *Ladd v Marshall* criteria are met. But in my judgment the letter is incapable of having an important influence on the present appeal.

39. *First*, this is an appeal against the review tribunal's decision, not against the findings made by the 2019 tribunal. At a review hearing, the findings made by the original tribunal are not to be reconsidered (see §57 below). If the 9 October 2020 letter had been available prior to the review hearing, it would nonetheless have been immaterial to the issues to be determined on that occasion.

40. *Secondly*, in any event, the 9 October 2020 letter does not even arguably undermine the findings made by the 2019 tribunal. The letter contains nothing more than a broad, unspecific statement, in the context of a rule 12 determination, that the NICE guidelines were open to interpretation.

41. The 2019 tribunal made its findings having heard extensive expert evidence. Under the heading "Digital Rectal Examination (DRE)", the 2019 tribunal stated:

> "55. The Tribunal received extensive evidence from Dr Burton and Dr Middleton [experts called by the GMC and the appellant, respectively,] in relation to the vital role of DRE in the diagnosis of prostate cancer. <u>That evidence was compelling and harmonious</u>. Dr Middleton stated:
>
> *'The only way a prostate can be assessed in a GP surgery is by the GP performing a digital rectal examination. It is therefore my opinion that all patients with lower urinary tract symptoms and all patients with a raised PSA should be counselled and informed of what the implications might be for the symptoms and signs that are abnormal and a rectal examination should be offered …it is my opinion that if a GP fails to discuss the issue of a rectal examination and therefore fails to offer a rectal examination, then this would be an action that is seriously below the standard expected of a responsible GP'*
>
> 56. <u>The Tribunal heard oral evidence from the experts that there is some ambiguity in paragraphs 1.8.6 and 1.8.8 of the NICE Guidance</u> in relation to when to refer to specialist care but, <u>notwithstanding this, the experts and the NICE Guidance are clear about the duty to recommend DRE in these circumstances.</u> At no time in any of the guidelines was there ever a suggestion that a GP should regard the recommendation and performance of a DRE as an optional activity.
>
> 57. The Tribunal accepted the evidence of both expert witnesses and determined that there is a clear duty upon all GPs to recommend and perform DRE in accordance with national guidance." (emphasis added)

42. Under the heading "Raised Age-Specific Prostate-Specific Antigen (PSA), the 2019 Tribunal noted amongst the areas of agreement between Dr Burton and Dr Middleton with regard to the NICE Guidelines in relation to prostate cancer when the PSA is raised about the age-specific level: "recommend DRE" and "there are no significant risks in performing DRE in a GP surgery". Amongst the areas of disagreement between Dr Burton and Dr Middleton, the 2019 tribunal noted:

> "62. *Dr Middleton*
>
> The NICE Guidance 2005, in particular paragraphs 1.8.6 and 1.8.8, is confusing and contradictory in relation to symptomatic and asymptomatic patients, and also in relation to borderline PSA results.
>
> …
>
> 63. *Dr Burton*
>
> Dr Burton, whilst accepting there are ambiguities which he agreed cause some confusion (paragraphs 1.8.6 and 1.8.8 NICE 2005), said that one should not lose sight of the fact that there is overriding advice, the general tenor of which is that a high PSA should indicate referral because of the risk of malignancy."

43. The view expressed in the 9 October 2020 letter that the NICE Guidelines are open to interpretation is not inconsistent with the 2019 tribunal's recognition, accepting the views of the experts, that there were ambiguities in those guidelines. This does not in any way detract from the 2019 tribunal's findings, based on the "compelling and harmonious" evidence of Dr Burton and the appellant's own expert, Dr Middleton, regarding the circumstances in which DREs were required to be offered, or any of the 2019 tribunal's other findings.

44. In these circumstances, although I have considered the 9 October 2020 *de bene esse* (that is, on a provisional basis), I reject the appellant's application to admit this fresh evidence.

**Analysis and decision**

45. The first part of the appellant's grounds of appeal is an attempt to appeal (again) against the 2019 tribunal's determination. The appellant focused, almost exclusively, in his written and oral submissions, on his contention that the 2019 tribunal made errors in finding that his fitness to practise was impaired by reason of misconduct.

46. This part of his appeal fails, fundamentally, because this is not an appeal against the 2019 tribunal's determination. First, it is not the decision appealed against identified in the Appellant's Notice. Secondly, an appeal against the 2019 tribunal's decision filed on 20 May 2020 would have been long out of time. Thirdly, the High Court has already considered and dismissed the appellant's appeal against the 2019 tribunal's decision.

47. In support of his challenge to the 2019 tribunal's findings that he failed on 15 occasions to undertake DREs, the appellant relied on:

i) the flowchart as demonstrating that a DRE was not recommended for asymptomatic patients with borderline PSA; and

ii) the second paragraph of the email from NICE dated 19 January 2017 - which stated:

> "1.8.2 and 1.8.3 gave guidance on which patients should have been given a DRE and PSA test. 1.8.5 to 1.8.7 gave guidance on what actions should have been taken based on the results of those tests, therefore sections 1.8.5 to 1.8.7 did not indicate that all men of any age need DRE and PSA levels on a regular basis."

- to seek to establish that Dr Barton was an unreliable expert witness.

48. Both of these documents were adduced in evidence before the 2019 tribunal at the sanctions stage and addressed by it (see §7 above). Even if the appellant was right about the management of asymptomatic patients, the 2019 tribunal found as a fact that the relevant patients were symptomatic, so even if the flowchart was assumed to be reliable, it was irrelevant. The NICE email provides no basis for the court to find that the 2019 tribunal's findings, having heard extensive expert evidence over a long period, were wrong.

49. Both of these documents were also relied on by the appellant in his skeleton argument for the appeal against the 2019 tribunal's decision. At [29], before turning to consider the appellant's submissions in respect of individual patients, Lang J observed:

> "On appeal, the appellant made general submissions in respect of digital rectal examinations, the NICE guidelines and PSA levels, submitting that the Tribunal and the experts were mistaken in various respects. In my view, the Tribunal was entitled to reach the conclusions which it did on the basis of the expert evidence and the documentary evidence which it received and carefully considered. I do not consider that the appellant's submissions on appeal in respect of these matters demonstrate that the Tribunal's conclusions were wrong."

50. While the appellant criticises Counsel who appeared for the GMC at the hearing before Lang J for indicating that an application to rely on these documents in support of his appeal against the misconduct findings would be opposed, whereas no application was required to rely on them in support of his appeal against sanction, that was a position the GMC was entitled to take given that the documents had only been adduced at the sanction stage of the hearing. Moreover, it is manifest, on reading Lang J's judgment and the appellant's skeleton argument for his earlier appeal that the submissions made at the hearing before me were essentially a repeat of submissions made to and rejected by Lang J.

51. The only document that was not relied on before the 2019 tribunal or Lang J (aside from the 9 October 2020 letter which I have addressed above) is the letter of 17 March 2020 from Ms Vaidya. The appellant seeks to rely on this as evidence that the findings of fact that he did not request that Patient G undergo either ambulatory blood pressure

monitoring (ABPM) or home blood pressure monitoring (HBPM) on certain dates were wrong.

52. The 2019 tribunal gave detailed consideration to the evidence in finding that the appellant did not request Patient G undergo either ABPM or HBPM (§397 *et seq*). Addressing these findings, Lang J stated:

> "94. There were a number of allegations that the appellant failed to request the patient to undergo: (1) and ECG; (2) ABPM or HBPM; and (3) chemical reagent strip testing of urine. In its findings in respect of allegations 8(c)(ii)(1), (2) and (3), on 4 May 2012, the Tribunal recorded that, in the rule 7 response, the appellant said that he did not offer anything other than home blood pressure monitoring as the patient's hypertension had not been confirmed and he considered that her menopausal symptoms could be the cause. In his witness statement, he said he may have offered ABPM. The Tribunal concluded that he had not asked the patient to undergo any of these tests and, according to the expert witnesses, he should have done so in the light of the patient's elevated blood pressure over a number of consultations.
>
> 95. On appeal, the appellant has sought to challenge the expert evidence as to the requirement to conduct these tests, arguing this was only after hypertension had been confirmed that an ECG or chemical reagent strip testing would be required. I am not satisfied that the appellant has established that the expert evidence on this issue was flawed and therefore that the Tribunal's findings were wrong.
>
> 96. The same allegations were made in respect of the consultations on 3 January 2014 and 27 February 2014. As, by that stage, the elevated blood pressure had continued for some time, the case for undertaking such tests had become even stronger. The Tribunal recorded that the appellant accepted the opinion of the experts and conceded that these tests should have been offered to the patient. In those circumstances, the appellant has no arguable ground of appeal.
>
> …
>
> 99. During submissions on Patient G, at 3.45pm on the first day of the hearing, 15 minutes before the conclusion of his submissions, the appellant asked if he could introduce new evidence. I indicated that that was not possible. It would be an exceptional course to admit fresh evidence on an appeal of this kind and, in my view, far too late in the progress of this appeal to do so."

53. The letter from Ms Vaidya purports to state her recollection of difficulties monitoring Patient G's blood pressure, as she was a small, obese woman. Ms Vaidya states, without reference to any dates or records, her recollection that "Ambulatory BP monitoring was

unsuccessful on two separate occasions due to cuff not staying in position". Ms Vaidya was employed by the appellant for 15 years as his Advanced Nurse Practitioner: if he had wished to call her as a witness, he could easily have done so. There is no justification for seeking to adduce evidence from her (in the form of a letter) after the appeal against the 2019 tribunal's decision has already been heard and dismissed. It is far too late to do so and, in any event, an asserted recollection in a letter, which is inconsistent with the appellant's recollection much closer in time to the consultations, provides no arguable basis for finding that any conclusions of the 2019 tribunal were wrong.

54. The appellant also contended that the 2019 tribunal failed to understand his templates. However, he acknowledged that these were all points he had advanced unsuccessfully to the 2019 tribunal and on appeal to Lang J. He is not entitled to re-run his appeal against the 2019 tribunal's determination under the guise of an appeal against the review tribunal's decision. The attempt to do so is an abuse of process.

55. During the hearing, the appellant sought to challenge the 2019 tribunal's decision on the basis that the expertise of the medical member of that panel did not match his own expertise. That is not a ground of appeal raised in his grounds on this appeal, or the appeal against the 2019 tribunal. He is not entitled to raise it at this stage, or in the context of an appeal against the review tribunal's decision. In any event, it has no merit. There is no requirement that the expertise of the medical member should match that of the registrant, and the 2019 tribunal was properly supported by expert witnesses.

56. The second part of the appellant's grounds of appeal is that the review tribunal was wrong not to correct the alleged errors in the 2019 tribunal's determination by reference to the evidence to which I have referred. In my judgment, this submission misapprehends the statutory scheme. It was not the role of the review tribunal to act as if it were an appellate tribunal with powers to revisit findings made by the 2019 tribunal and upheld on appeal by the High Court.

57. In *Yusuff v General Medical Council* [2018] EWHC 13 (Admin) Yip J addressed the approach to insight at the review stage:

> "17. At paragraph 51 of the Sanctions Guidance, Tribunals are informed that it is important to consider insight, or lack of, when determining sanctions. Paragraph 52 makes the following observations:
>
> > 'A doctor is likely to lack insight if they:
> >
> > a. refuse to apologise or accept their mistakes
> >
> > b. promise to remediate, but fail to take appropriate steps, or only do so when prompted immediately before or during the hearing
> >
> > c. do not demonstrate the timely development of insight
> >
> > d. fail to tell the truth during the hearing.'

Insight and denials

18. It would be wrong to equate maintenance of innocence with a lack of insight. However, continued denial of the misconduct found proved will be relevant to the Tribunal's considerations on review. As paragraph 52 of the Sanctions Guidance makes clear, refusal to accept the misconduct and failure to tell the truth during the hearing will be very relevant to the initial sanction. At the review stage, things will have moved on. The registrant may be able to demonstrate insight without accepting that the findings at the original hearing were true. The Sanctions Guidance makes it clear that at a review hearing the Tribunal is to consider whether the doctor has fully appreciated the gravity of the offence and must be satisfied that patients will not be put at risk if he resumes practice. …

20. I conclude having reviewed all the relevant authorities that at a review hearing:

a. The findings of fact are not to be reopened;

b. The registrant is entitled not to accept the findings of the Tribunal;

c. In the alternative, the registrant is entitled to say that he accepts the findings in the sense that he does not seek to go behind them while still maintaining a denial of the conduct underpinning the findings;

d. When considering whether fitness to practise remains impaired, it is relevant for the Tribunal to know whether or not the registrant now admits the misconduct;

e. Admitting the misconduct is not a condition precedent to establishing that the registrant understands the gravity of the offending and is unlikely to repeat it;

f. If it is made apparent that the registrant does not accept the truth of the findings, questioning should not focus on the denials and the previous findings;

g. A want of candour and/or continued dishonesty at the review hearing may be a relevant consideration in looking at impairment."

58. The review tribunal made no error in rejecting the appellant's invitation to reopen findings of fact made by the 2019 tribunal. I have carefully considered the transcript of the proceedings before the review tribunal. It is evident that the review tribunal properly applied the guidance given in *Yusuff*. The review tribunal took into account the evidence on which the appellant relied, but it was entitled to regard the letter from Ms Vaidya, the flowchart and the NICE email as immaterial to the issues that it was considering.

59. The appellant contends that the review tribunal was wrong to find that he was "rigid in his view about his own clinical practice" (§46 of the review tribunal's determination on impairment, see §11 above). In my judgment, the review tribunal's assessment was fair and manifestly open to them on the evidence. The review tribunal did not place undue weight on his unwillingness to accept a number of the failings that the 2019 tribunal found provided. They took into account that the new guidelines would prevent repetition of his failings in relation to DRE, and he would not be working as a sole practitioner. Nevertheless, the appellant had not practised for more than four years and the review tribunal were entitled to find that there was limited evidence that he had kept his clinical skills and knowledge up to date. In addition, having regard to the evidence that the 2019 tribunal suggested would be helpful at the review stage (see §8 above), the review tribunal made no error in finding that the appellant had provided limited evidence of insight or remediation.

60. The appellant appealed against both the determinations of impairment and sanction, but his appeal against sanction was based on his submission that the review tribunal should have found his fitness to practise was not impaired by misconduct. I have rejected that contention. The appellant did not mount any separate ground of challenge against the sanction imposed and, in my judgment, the review tribunal made no error in directing that the appellant's registration should be subject to conditions.

61. The appellant sought to suggest that he is in a 'catch-22' situation because he does not accept a number of the 2019 tribunal's findings. The reality is that he provided little evidence of insight or remediation even in respect of findings he accepts, and his ability to show that he has kept his clinical skills and knowledge up to date should not have been affected by his view of any of the 2019 tribunal's findings. The review tribunal considered that his misconduct is capable of remediation and, although he does not accept some of the 2019 tribunal's findings, he is capable of responding positively to conditional registration. He has the opportunity to do so, if he wishes to take it.

## Conclusion

62. There is no basis for overturning the decision of the review tribunal in relation to impairment or sanction. This appeal fails and is dismissed.