Neutral Citation Number: [2021] EWHC 562 (Admin)

CO/1188/2020

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 10/03/2021

Before :

THE HONOURABLE MRS JUSTICE COLLINS RICE

- -

Between

GENERAL MEDICAL COUNCIL

Appellant

- and -

DR ANTHONY DONADIO

Respondent

- -
- -

Mr Ivan Hare QC (instructed by **GMC Legal**) for the **Appellant**
Mr Nicholas Leviseur (instructed by **Stephensons Solicitors LLP**) for the **Respondent**

Hearing date: 23rd February 2021

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Approved Judgment

Covid-19 Protocol: this judgment was handed down by the judge remotely by circulation to the parties' representatives by email and release to Bailii. The date and time of hand-down is 2pm on 10 March 2021

Mrs Justice Collins Rice:

Introduction

1. The General Medical Council (GMC) appeals under section 40A of the Medical Act 1983 (1983 Act) against a Medical Practitioners Tribunal (MPT) decision of 26th February 2020 to impose a suspension of 12 months on Dr Donadio's registration. The GMC says this sanction is insufficient to protect the public.

Background

2. Dr Donadio had been the subject of a fitness to practise referral in June 2017. He was at the time working as a locum consultant radiologist at London North-West Hospitals NHS Trust. His clinical director, in making the referral, was concerned that his performance might be deficient and that this might be linked to an anxiety condition. She described him 'over calling' abnormalities in radiology results – false positives – at a level so high it had been noted by several clinical departments. As a result, patients were being worried unnecessarily about the prospect of having cancer; and some were having needless further appointments, tests and scans, including unwarranted radiation exposure and invasive procedures. Dr Donadio acknowledged the problem, explained it by reference to anxiety and personal worries relating to his family in Ukraine, and was confident his performance in his next locum posting would be back to normal standards.

3. A GMC performance assessment was undertaken in April 2018, in response to the referral. It found Dr Donadio's professional performance to have been deficient, and that he was fit to practise on a limited basis only. His performance was 'unacceptable' in assessment and clinical management, and gave 'cause for concern' in record keeping and working with colleagues. He was assessed as not demonstrating the ability to work at the level of a consultant radiologist. The assessment recommended he should not be employed at that level, but could work at the level of a supervised junior trainee (level 3 of 9 leading to consultant) and should be 'directly supervised' as such. 'Directly supervised' is the highest level of supervision requirement for doctors working in a hospital. It means any activity they undertake involving patient contact, including consultations, examinations and procedures, has to be supervised, in person, by a named consultant or a suitable nominated deputy: he was not to see patients alone.

4. As a result of this assessment, Dr Donadio was referred by the GMC to an Interim Orders Tribunal (IOT), for consideration of the exercise of its powers under section 41A of the 1983 Act to place him under an interim order making his registration subject to conditions. The IOT sat on 9th July 2018. Dr Donadio was by this time working as a locum consultant radiologist at Kettering General Hospital. He did not attend the IOT and was not represented. The IOT determined there were serious concerns about Dr Donadio's fitness to practise, such as might pose a real risk to members of the public and adversely affect the public interest. The IOT concluded it was 'necessary' (the statutory test) to impose an interim order to guard against this risk, and to avoid seriously undermining public confidence in the profession. It therefore made an order under section 41A(1)(b) of the 1983 Act that Dr Donadio's registration was to be conditional on his compliance for a period of 12 months with certain specified requirements.

5. The conditions ordered were these:

1. He must notify the GMC within seven calendar days of the date these conditions become effective:

   a. of the details of his current post, including his job title, job location and responsible officer (or their nominated deputy) information;

   b. of the contact details of his employer and/or contracting body, including his direct line manager;

   c. of any organisation where he has practising privileges and/or admitting rights;

   d. of any training programmes he is in;

   e. of the contact details of any locum agency he is registered with.

2. He must notify the GMC:

   a. of any post he accepts, before starting it;

   b. if any formal disciplinary proceedings against him are started by his employer and/or contracting body, within seven calendar days of being formally notified of such proceedings;

   c. if he applies for a post outside the UK.

3. He must allow the GMC to exchange information with his employer and/or any contracting body for which he provides medical services.

4. He must only work at a level lower than that of Consultant.

5.

   a. He must be directly supervised in all of his posts by a clinical supervisor, as defined in the Glossary for undertakings and conditions. His clinical supervisor must be approved by his responsible officer (or their nominated deputy).

   b. He must not start/restart work until his responsible officer (or their nominated deputy) has approved his clinical supervisor.

   c. He must seek a report from his supervisor(s) for consideration by this tribunal prior to any review hearing by this tribunal.

6. He must inform the following persons of the conditions listed at 1 to 5:

   a. his employer and/or contracting body;

b. his responsible officer (or their nominated deputy);

c. his immediate line manager at his place of work, at least one working day before starting work (for current and new posts including locum posts);

d. any prospective employer and/or contracting body, at the time of application;

e. the responsible officer of any organisation where he has, or has applied for, practising privileges and/or admitting rights, at the time of application;

f. any locum agency or out-of-hours service he is registered with.

6. The IOT informed Dr Donadio that he was required to comply with these conditions, and that a failure to do so might put his registration at risk; but that during the period the conditions remained in place, as long as he complied with them, he continued to be entitled to hold a licence to practise.

The Medical Practitioners Tribunal Decision

(a) Procedure and Fact-Finding

7. Dr Donadio left the UK in August 2018, to attend to family matters in Ukraine. In the meantime, however, it transpired that he had continued to work as a consultant radiologist at Kettering, unsupervised, as before. The GMC brought proceedings against him in the MPT alleging breach of his interim conditions order. The formal allegations against him were as follows:

1. You worked at Kettering General Hospital between:

a. 9 July 2018 to 10 July 2018;

b. 18 July 2018 to 20 July 2018;

c. 6 August 2018 to 10 August 2018.

2. When working as described at paragraph 1 you were:

a. unsupervised;

b. working as a consultant.

3. When working as described at paragraphs 1 and 2 you failed to:

a. notify the GMC within seven calendar days of 9 July 2018 of:

i. your current post, including your job title, job location and responsible officer (or their nominated deputy);

ii. the contact details of your employer and/or contracting body, including your direct line manager;

b. notify the GMC of new posts accepted;

c. inform the following persons of the interim conditions 1-5:

i. your employer;

ii. your line manager.

4. As a result of your actions as described at paragraphs 1 to 3, you were in breach of conditions imposed by the Interim Orders Tribunal on 9 July 2018.

5. You knew that as a result of your actions as described at paragraphs 1 to 3, you were in breach of the conditions imposed by the Interim Orders Tribunal on 9 July 2018 as referred to at paragraph 4.

6. Your actions as described in paragraph 1 to 3 were dishonest by reason of paragraph 5.

8. The MPT considered these allegations at a hearing lasting from 19th to 26th February 2020. Dr Donadio made no admissions, did not attend and was not represented. No oral evidence was heard, but written evidence was received.

9. The MPT found the factual particulars, and the allegations of breach based on those particulars, proved (except as regards 3b – there was no 'new post' involved). It found that these breaches were committed in the knowledge, as from 12th July 2018, of the conditions imposed on him (so the first two days' work specified were undertaken before he knew of the conditions). It found that, from that date, the breaches, committed with knowledge of the conditions, were committed dishonestly.

(b) The Finding of Serious Misconduct

10. The MPT next addressed itself to the GMC manual *Good Medical Practice* on the question of whether this amounted to misconduct. The manual deals with good practice, among other things, in relation to honesty and trustworthiness, acting with integrity, promoting an open culture, treating colleagues with respect and justifying patients' trust in their doctor and the public's trust in the profession. It also says:

> If you are suspended by an organisation from a medical post, or have restrictions placed on your practice, you must, without delay, inform any other organisations you carry out medical work for and any patients you see independently. (paragraph 76)

11. On the question of misconduct, the MPT found as follows:

> 20. The Tribunal considered that Dr Donadio's dishonesty, in continuing to work unsupervised at consultant level beyond 12 July 2018, when he knew he was subject to interim conditions, breached the trust of his colleagues at Kettering, and his employers.

> 21. The Tribunal considered that Dr Donadio's misconduct was not an isolated incident of dishonesty as he continued to work the additional shifts after 12 July 2018, in the knowledge that he was subject to interim conditions.
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> 22. The Tribunal is of the opinion that following the imposition of the conditions, Dr Donadio worked outside the limits of his interim conditions, working unsupervised as a consultant and as a result his standard of work went unsupervised. Dr Donadio's actions had the potential to put patients at risk. The Tribunal was also mindful of Dr Donadio's lack of candour in his communication with the GMC and the MPTS.
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> 23. The Tribunal was satisfied that Dr Donadio chose to put his own interests above the interests of others and above his professional duties as a medical practitioner.
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> 24. The Tribunal considered that Dr Donadio's conduct represented a significant departure from the expected standards of conduct and behaviour relating to honesty and integrity referred to in paragraphs 1, 65, 68 and 71 of [*Good Medical Practice*]. Further, the Tribunal considered paragraph 76 of GMP significant. In respect of this paragraph it noted that Dr Donadio failed to inform anyone of the interim conditions on his registration.
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> 25. The Tribunal concluded that Dr Donadio's conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to serious misconduct."

(c) The Finding of Impairment of Fitness to Practise

12. The Tribunal next had to decide whether, as a result of the serious misconduct it had found, Dr Donadio's fitness to practise was currently impaired. In doing so, it addressed itself to the test set out by Dame Janet Smith in her Fifth Report on the ***Shipman*** case, and cited with approval in *Council for Healthcare Regulatory Excellence v NMC & Grant* [2011] ACD 72, [2011] EWHC (Admin) 927 at paragraph 76:

> Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:
>
> a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or
> b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or
> c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or
> d. has in the past acted dishonestly and/or is liable to act dishonestly in the future.

13. On the question of impairment of fitness to practise, the MPT found as follows:

> 27. The Tribunal recognises that dishonesty is a breach of a fundamental tenet of the profession. Being honest and trustworthy and acting with integrity are at the heart of medical professionalism. The Tribunal also determined that Dr Donadio's dishonesty had the potential to put patients at risk.
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> 28. The Tribunal has borne in mind the case of [*CHRE v NMC & Grant*] and it was satisfied that limbs a, b, c and d are engaged in this case.
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> 29. The Tribunal noted that Dr Donadio's misconduct occurred in 2018. To the Tribunal's knowledge, there has been no repetition of the misconduct albeit he is not currently working in the UK. It considered that dishonesty is difficult to remediate, although it is of the opinion that this type of dishonesty is capable of remediation.
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> 30. The Tribunal is of the view that a doctor must develop insight before any remediation can take place. The Tribunal noted that at the start of this hearing Dr Donadio remained in complete denial of the allegations. Because Dr Donadio was in denial the Tribunal considered it was more likely than not that he has failed to develop any insight. The Tribunal has not been provided with any evidence of insight or remediation by Dr Donadio. Therefore, the Tribunal determined that there remains a risk of repetition.
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> 31. The Tribunal found that even had Dr Donadio demonstrated that he had developed insight and remediated his misconduct, a finding of impairment would have been necessary in order to uphold public confidence in the profession. Doctors occupy a position of privilege and trust. They are expected to act in a manner which maintains public confidence in them and in the medical profession and to uphold proper standards of conduct.
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> 32. The Tribunal is in no doubt that public confidence in the medical profession and the need to uphold proper standards for that profession would be adversely affected if it were not to make a finding of impairment in this case. The Tribunal has therefore determined that Dr Donadio's fitness to practise is currently impaired by reason of misconduct."

(d) The Sanction Decision

14. The GMC had sought the sanction of erasure from the register in these circumstances. The MPT instead imposed a suspension for 12 months (with a review, due in March 2021). It is this decision which is the subject of the present appeal.

15. The GMC has issued guidance to MPTs on the imposition of sanctions (Sanctions Guidance (2019)). This guidance, and the MPT's general approach to sanction in this case, are considered more fully below.

16. The reasons the MPT gave, in its sanctions determination, for imposing a sanction of suspension rather than erasure in these circumstances were as follows:

> 30. Dr Donadio's dishonesty was a serious departure from the principles of *Good Medical Practice* and the high professional standards expected of members of the medical profession. The Tribunal noted that although Dr Donadio's misconduct did not relate to his clinical competence, it did relate to his conduct and behaviour within the context of his professional role. The Tribunal considered that dishonesty whilst performing a professional function is particularly serious. The Tribunal determined that Dr Donadio's misconduct undermined the trust and confidence in the medical profession as a whole.
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> 31. Having considered paragraph 97 of the Sanctions Guidance and whether suspension was the appropriate sanction, the Tribunal also considered paragraph 109 relating to erasure. Paragraph 109 lists a number of non-exhaustive factors and the Tribunal considered that a, b, d, h and j are engaged in this case.
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> 32. The Tribunal considered the issue of Dr Donadio's compatibility with continued registration. It noted a finding of fundamental incompatibility with continued registration, as stated in paragraph 92 of the Sanctions Guidance, amounts to a determination that there are no circumstances in which the doctor should be permitted to practise medicine.
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> 33. The Tribunal found that whilst the actions of Dr Donadio and the dishonest conduct proven, had the potential to be fundamentally incompatible with continued registration it was satisfied that, in the circumstances of this case it fell just short of the same. In reaching this decision the Tribunal noted that not every case of dishonesty must result in erasure. Whilst Dr Donadio's misconduct was deliberate and repeated on more than one occasion, it took place over a short period of time after which he removed himself from the workplace. The Tribunal had regard to the fact that Dr Donadio ceased his dishonest conduct before it had been discovered. The Tribunal also had regard to the fact that there has been no repetition of the behaviour since August 2018. The Tribunal is of the view that a period of suspension would be both appropriate and proportionate, notwithstanding the punitive effect it will have on Dr Donadio.
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> 34. Having balanced these factors carefully, the Tribunal concluded that this was a case where the wider public interest could properly be served by imposing a period of suspension. The Tribunal was satisfied that permanent removal from the medical register would be disproportionate.

> 35. The Tribunal found that an order of suspension will send a clear signal to Dr Donadio, the public and wider profession reaffirming the standards of conduct and behaviour expected of all registered doctors. Whilst the Tribunal noted that an order of suspension is punitive in nature, it also took the view that it is necessary to maintain public confidence and uphold and maintain high standards of behaviour within the profession.
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> 36. The Tribunal determined that Dr Donadio's registration should be suspended for a period of 12 months with a review. The Tribunal concluded that imposition of the maximum period of suspension was necessary to mark the seriousness of Dr Donadio's conduct and to send a clear message to Dr Donadio, the profession, and the wider public that repeated misconduct, particularly dishonesty, is not acceptable. Further the period of 12 months will give Dr Donadio the opportunity to demonstrate that he has gained insight into his dishonesty and that he has fully remediated his misconduct.

Grounds of Appeal

17. The GMC appeals the sanction decision only. There is no cross-appeal. This appeal therefore falls to be considered on the basis of the facts found by the MPT, and of its determinations of serious misconduct and resulting impairment of fitness to practise.

18. The GMC's grounds of appeal in this case are that:

    (1) the MPT's failure to erase Dr Donadio fell outside the range of sanctions open to it, given the gravity of the misconduct; and

    (2) the MPT failed correctly to apply the Sanctions Guidance and hence made an error of principle.

The Legal and Regulatory Framework

(i) Appeals from the Medical Practitioners Tribunal

19. Section 40A of the 1983 Act provides the GMC with a right of appeal from a MPT decision on sanction if they consider it not sufficient for the protection of the public. By section 40A(4):

> Consideration of whether a decision is sufficient for the protection of the public involves consideration of whether it is sufficient –
>
> (a) to protect the health, safety and well-being of the public;
>
> (b) to maintain public confidence in the medical profession; and

(c) to maintain proper professional standards and conduct for members of that profession.

20. The correct approach of an appellate court on such an appeal was summarised at Divisional Court level in *GMC v Jagjivan* [2017] EWHC 1247 (Admin), [2017] 1 WLR 4438, at paragraphs 39-40. This is an appeal governed by CPR Part 52, and subject to the test of whether the decision appealed is either wrong, or unjust because of a serious procedural or other irregularity. Since the appellate court lacks the MPT's professional expertise, it must approach the MPT's determinations about what is necessary to maintain public confidence and proper standards in the profession with 'diffidence'. But there may be matters such as dishonesty 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 MPT. In such cases the court will afford an appropriate measure of respect to the MPT's decision, but not more than is warranted by the circumstances. A failure of the MPT to provide adequate reasons may constitute a serious procedural irregularity rendering a decision unjust.

21. Court of Appeal guidance is provided by *Bawa-Garba v GMC* [2018] EWCA Civ 1879; [2019] 1 WLR 1929, at paragraphs 60-67. A sanction decision of the MPT is an evaluative decision based on many factors – a 'multifactorial decision'. The appellate court has limited scope for overturning such a decision. Its approach should be conditioned by the extent to which it is at a relative disadvantage. It should interfere only if there was an error of principle by the MPT in carrying out the evaluation, or the evaluation was wrong because if fell outside the bounds of what the MPT could properly and reasonably decide.

22. The need for 'diffidence' has authority at UK Supreme Court level (*Khan v GPC* [2016] UKSC 64, [2017] 1 WLR 169 at paragraph 36). The Court confirmed, however, that an appellate court can more readily depart from an MPT assessment of the effect on public confidence of misconduct which does not relate to professional (clinical) performance.

23. By section 40A(6) of the 1983 Act, the powers of the appellate court include dismissal of the appeal; allowing the appeal and quashing the relevant decision; substituting for the relevant decision any other decision which could have been made by the MPT; or remitting the case back to the MPT for determination.

(ii) Sanctions Guidance

24. The powers of MPTs to impose sanction are conferred by section 35D of the 1983 Act. In exercising these powers, MPTs are required to have regard to the overarching statutory objective of protecting the public (section 35E(3A)). On that basis, the GMC issues Sanctions Guidance to assist MPTs, placing the sanctions regime within that overarching objective. By section 1 of the 1983 Act, that involves the pursuit of the three-fold objectives of protecting, promoting and maintaining the health, safety and well-being of the public; promoting and maintaining public confidence in the medical profession; and promoting and maintaining proper professional standards and conduct for members of that profession. The Guidance indicates that although the MPT should make sure that the sanction it imposes is appropriate and proportionate, the reputation of the profession as a whole is more important than the interests of any individual doctor.

25. The Guidance directs the MPT to approach any sanctions decision by considering all the sanctions available to it, starting with the least restrictive. It should have regard to the principle of proportionality, weighing the interests of the public against those of the doctor.

However, once the MPT has decided that a certain sanction is the minimum necessary to protect the public, that sanction must be imposed even where it may lead to difficulties for the doctor. Examples are given of mitigating factors which may be taken into account, including evidence that a doctor understands the problem, has insight, and attempts to address or remediate it.

26. The Guidance provides that suspension of a doctor's registration will be appropriate for misconduct that is 'serious but falls short of being fundamentally incompatible with continued registration'. Examples are given, including of circumstances where there has been acknowledgment of fault and the MPT is satisfied that the doctor has taken steps to mitigate; where there is no evidence to suggest remediation is unlikely to be successful (e.g. because of previous unsuccessful attempts or a doctor's unwillingness to engage); where there is no evidence of repetition of similar behaviour after an incident; and where the MPT is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.

27. The Guidance provides that erasure from the medical register will be appropriate where this is the only means of protecting the public. Erasure may be necessary, even where a doctor does not present a risk to patient safety, to maintain public confidence in the profession, for example where a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession.

28. Paragraph 109 of The Guidance provides that the presence of *any* of a non-exhaustive list of factors may indicate that erasure is appropriate. That list includes:

    a. A particularly serious departure from the principles set out in *Good Medical Practice* where the behaviour is fundamentally incompatible with being a doctor.

    b. A deliberate or reckless disregard for the principles set out in *Good Medical Practice* and/or patient safety.

    c. …

    d. Abuse of position/trust (see *Good Medical Practice* paragraph 65: '*You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession*')

    e. …

    f. …

    g. …

    h. Dishonesty, especially where persistent and/or covered up…

    i. Putting their own interests before those of their patients…

    j. Persistent lack of insight into the seriousness of their actions or the consequences.

29. Dishonesty is the subject of a specific section of the Guidance. It emphasises that doctors must be honest and trustworthy, and must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession. It deals with a number of example situations.

30. The Guidance does not directly address issues of non-compliance with conditions on registration other than in relation to review hearings (where it directs careful consideration of whether the breach was wilful, that is whether the doctor was culpable; a more serious outcome is likely to be appropriate in cases of wilful breach). However, the references in paragraph 109a. and b. to *Good Medical Practice* may be relevant.

31. *Good Medical Practice* indicates that to maintain their licence to practise, doctors must demonstrate that they work in line with the principles and values set out in that document. There are relevant provisions requiring doctors to: keep up to date with and follow the law, GMC guidance and other regulations relevant to their work; recognise and work within the limits of their competence; be satisfied that they have consent or other valid authority before carrying out any examination or investigation or providing treatment; take part in systems of quality assurance and quality improvement to promote patient safety; share information with patients about their roles and responsibilities within the medical team; always be honest about their experience, qualifications and current role.

Analysis

(i) Compliance with the Sanctions Guidance

32. The MPT, in approaching its sanctions decision, directed itself to its legal duty to take account of the overarching objective of protecting the public. It also directed itself to the Sanctions Guidance, on the basis that it was not strictly binding, but that, should the MPT wish to depart from the Guidance, it would have to give good reasons for doing so. It considered aggravating and mitigating factors. It applied the 'bottom up' approach, and, while it stopped at suspension, it did also consider the possibility of erasure.

33. No issue is taken with this approach in principle. It is consistent with the guidance of the Court of Appeal in *The Professional Standards Authority v Health and Care Professions Council & Doree* [[2017] EWCA Civ 319, [2017] Med LR 301 that a tribunal should have proper regard to the Guidance, and apply it as its own terms suggest, unless the tribunal has sound reasons for departing from it – in which case it has to state those reasons clearly in its decision.

34. The challenge from Mr Hare QC, for the GMC, is twofold: first, proper application of the Guidance's indicators for suspension and for erasure pointed to erasure, so the MPT departed from the Guidance; and second, no good reasons were given for doing so.

35. Turning first to the Guidance's indicators for a suspension decision, the MPT's overall conclusion was that Dr Donadio's conduct was 'serious but fell short of being fundamentally incompatible with continued registration'. In contrast to the Guidance's approach to indicators for erasure ('any of the following factors…'), the Guidance has a non-exhaustive list of indicators 'some or all of which' being present would indicate suspension. Apart from the general test of a serious breach of *Good Medical Practice* which is *not* fundamentally incompatible with continued registration (and ignoring indicators with no relevance to the facts of this case) the relevant indicators for suspension include: cases of deficient performance and risk to patient safety where the doctor demonstrates potential for remediation; absence of evidence that demonstrates remediation

is unlikely to be successful e.g. because of a doctor's unwillingness to engage; absence of evidence of repetition; and where the tribunal is satisfied that the doctor has insight and does not pose a significant risk of repeating behaviour.

36. Mr Hare points out that, on the MPT's own findings, none of these factors was present, and all of them were contra-indicated. The MPT had found more than an isolated incident. It had remarked upon Dr Donadio's failure to engage and state of denial. It had found no evidence or insight or remediation. It had determined that there was therefore a risk of repetition.

37. Turning then to the Guidance's paragraph 109 indicators for erasure, the MPT stated in its reasoning that it had found factors a., b., d., h. and j. engaged. Factor a. is the obverse of the factor a. indicator for suspension – a particularly serious departure from the principles set out in *Good Medical Practice* where the behaviour *is* fundamentally incompatible with being a doctor. The MPT concluded that there had indeed been a particularly serious departure – dishonesty while performing a professional function, which undermined trust and confidence in the medical profession as a whole. The reasoning set out in the MPT's sanctions determination at paragraphs 33 and 34 (see paragraph 16 above) for nevertheless deciding on suspension is, says Mr Hare, defective on its face in giving undue relevance and weight to the fact that Dr Donadio had had to leave the UK for unrelated reasons, and did not sufficiently address why the seriousness of the departure from the principles of *Good Medical Practice* led to a conclusion that erasure would be disproportionate.

38. Moreover, Mr Hare points out the failure of the MPT to deal in its reasoning with the rest of the indicators for erasure it had itself said were engaged, apart from factor a.. These included the fact that the disregard for the principles set out in *Good Medical Practice* and/or patient safety had been deliberate (factor b.); abuse of position/trust (factor d.); persistent dishonesty (factor h.); and persistent lack of insight into the seriousness of his actions or their consequences (factor j.). These had all been the subject of express adverse findings by the MPT. Mr Hare also notes that the MPT had in addition determined that Dr Donadio 'chose to put his own interests above the interests of others and above his professional duties as a medical practitioner' which engaged factor i..

39. Mr Hare argues that in these circumstances the MPT fell into the very error identified in *GMC v Stone* [2017] 4 WLR 207, [2017] WLR(D) 681, [2017] EWHC 2534 (Admin), at paragraph 53: a failure properly to consider the objective features of the instant case, to demonstrate that their gravity had been fully understood, and then to address and explain how the available mitigation operated to justify the imposition of the sanction of suspension. Instead, there is merely a generalised assertion that erasure would be a disproportionate sanction and that the doctor's conduct was not incompatible with his continued registration.

40. As the court in *Stone* also emphasised, this is not a matter of elevating form over substance; proper regard to the Guidance is important in its own right, and the giving of clear reasons for divergence is part of the MPT's functions in articulating in the public domain how its determinations properly serve the overarching objective. Mr Hare also draws attention to the reasoning of the court in *GMC v Saeed* [2020] EWHC 830 (Admin) at paragraphs 66-67 and 75-77, and invites me to reach the same conclusion, namely, that the failure of the MPT to explain why its own conclusions on the presence of several of the Guidance's indicators for erasure, together with several contra-indications for suspension, does not lead to an erasure decision, is a proper ground for quashing its decision.

41. The decided cases do suggest that having proper regard to the Guidance requires an MPT to do something more than fasten on to 'proportionality', or the difference between misconduct which is 'incompatible with continued registration' and misconduct which 'falls short of being fundamentally incompatible with continued registration', in a generalised or intuitive fashion. That is, after all, to add little to the requirement for the MPT to apply the minimum sanction necessary for the protection of the public. The indicative factors in the Guidance have to mean something. They are of course just that – indicators, and non-exhaustive – and it would be entirely wrong for an MPT to apply them in any sort of mechanistic or deterministic manner. On the other hand, there is clearly a *necessary* part of the MPT decision-making process which involves addressing itself to the indicative factors, building up a picture of the sanction they cumulatively indicate, and then either applying that sanction or explaining with sufficient clarity why not. That is only fair, both to the doctor and to the public.

42. *Sufficiency* of reasoning is, however, the test, and not anything more elaborate. Mr Leviseur, Counsel for Dr Donadio, quite rightly drew attention to the need for an appellate court to avoid narrow textual analysis when considering the reasoning of any tribunal, especially one not composed of professional judges (*GMC v Awan* [2020] EWHC 1553 (Admin), at paragraph 26). The determination needs to be read fairly, and as a whole, to assess the sufficiency of its reasoning (*Saeed* at paragraph 75).

43. Applying all of this to the present case, I agree with Mr Leviseur that, at any rate up until the very point of making its decision on sanction, it is hard to fault the careful and methodical approach of the MPT, including in its referencing of the Guidance. Indeed, the overall impression one gains of these proceedings is one of painstaking conscientiousness, not least in ensuring fairness to the absent and unrepresented doctor.

44. At the same time, I do share Mr Hare's concerns about the articulation of the sanctions decision itself, even (or perhaps especially) read in the context of the careful account of its thinking accumulated by the MPT in its previous sequence of determinations. On its own findings, the overall picture built up by reference to the Guidance's indicators show absence or contra-indication in the factors the presence of 'some or all' of which would point to suspension; and the presence of multiple factors 'any' of which would point to erasure.

45. On the face of it, that suggests the suspension decision *was* a departure from the Guidance, sufficient to trigger a requirement for acknowledgment of and explanation for that in the MPT's decision. I agree also that the proximate reason given in the sanctions determination - the happenstance of Dr Donadio's departure from the UK in August 2018, and its curtailment of the period of breach - is not easy to relate to the question properly before the MPT: the status of his registration and fitness to practise if and when he should return to the UK and wish to do so. I cannot see that it is capable of amounting to a sufficient explanation on its own, at any rate without some interrogation of its implications for the future protection of the public. The question therefore is whether a sufficient explanation appears, if not there, then from a fair reading of the MPT's decision-making as a whole.

46. On that question, Mr Leviseur had a proposition as to what the overall explanation *is*. The MPT had built up over several days a detailed picture of the merits of this case, the nature of the risk Dr Donadio posed to his patients, and the extent to which the allegations against him turned on the issue of his 'dishonesty'. Dr Donadio's original fault – the risk he had posed to his patients – had been identifying false positives. That was a fault of over-protectiveness, having too much rather than not enough care for his patients. He had carried on working as a consultant at Kettering General Hospital for a few days longer than he

should have, that was all. The only 'dishonesty' involved was simply doing that - knowingly acting in breach of his conditions. This sort of dishonesty was nothing like the sort of acquisitive or deceptive conduct with which the Guidance on dishonesty was concerned. Dr Donadio's transgression, although very properly to be regarded as serious and not to be minimised, was not conduct which was either of the *utmost* gravity or risky enough to warrant striking off as the *only* means of protecting the public. That was the assessment of the professional body whose role it was to assess such matters.

47. The MPT determinations do not state this in terms. Nevertheless, Mr Leviseur's account has a ring of authenticity. There are pointers in this direction in the MPT's reasoning: its strong emphasis on 'proportionality' and on the limited period of the breach (for whatever reason), the reluctance to find there were *no* circumstances in which Dr Donadio should be permitted to practise medicine, and, especially, its apparent discomfort with the 'dishonesty' dimension of this case. Not only did the MPT emphasise that *not every case of dishonesty must result in erasure*, it had expressed the view in its impairment finding that *this type* of dishonesty was capable of remediation.

48. There may be a further clue in the reasons the MPT gave for its decision to impose a review at the end of the suspension period. The finding of lack of insight and remediation had been inevitable on the materials before it. There was Dr Donadio's lack of direct engagement with the IOT and MPT processes (including a pretence that he was out of the country at relevant points). There was also his sustained and strenuous denial of having been given notice of the IOT determination, up to and including blaming others for failures of communication. At no time had he acknowledged his fault. But notwithstanding its findings on lack of insight and therefore lack of a prospect of remediation, the MPT's rationale for imposing suspension *with review* included that it would *give Dr Donadio the opportunity to demonstrate that he has gained insight into his dishonesty and that he has fully remediated his misconduct.*

49. I repeat that the account proposed by Mr Leviseur is not explicit in the MPT reasoning. However, in a spirit of diffidence and avoiding narrow textual interrogation, it may be possible to discern in the MPT analysis an explanation for the discrepancy between the adverse findings it had made and its final swerve away from the erasure sanction indicated by the Guidance. If so, the explanation has to do with the nature ('type') and gravity of the dishonesty found, and its implications for the protection of the public. If that is a fair reading of the MPT decision as a whole, the question would then become whether *that* was a *sufficient* reason for departure from the Guidance.

(ii) Dishonesty and Deliberate Regulatory Breach

50. I agree with Mr Leviseur that the nub of the allegation Dr Donadio faced before the MPT was that he *knowingly* and *deliberately* practised for a short time in breach of the conditions imposed by the IOT. That (aside from the issues of denial) is what 'dishonestly' means in this case, no more and no less, as is clear from the structure of the allegation itself. Mr Leviseur's submissions that the use of the word in the allegation was an unnecessary and pejorative overlay of the simple charge of knowing breach, and Mr Hare's fair acceptance that there are different grades of dishonesty, give pause for thought.

51. The examples of dishonesty given in the Sanctions Guidance itself are not of this 'type'. They deal with conduct such as fraud, falsifying records, fake references and lying CVs. The mischiefs of lying, cheating or thieving in a doctor 'if persistent and/or covered up' are

easy to apprehend, not least as to future trustworthiness, but the MPT seems to have had difficulty in fitting 'knowingly working in breach of conditions' into this mould.

52. There is no doubt whatever about the seriousness with which the decided appeal cases regard dishonesty. I was referred to *Nicholas-Pillai v General Medical Council* [2009] EWHC 1048 at paragraph 27 (untruthful record-keeping), *Khan v GMC* [2015] EWHC 301 (Admin) at paragraphs 6-9 (fake prescriptions for controlled drugs for financial gain), and *GMC v Theodoropolous* [2017] EWHC 1984 (Admin) at paragraphs 35-47 (false record of registration details used to obtain a locum placement). These *are* examples comfortably within what the Sanctions Guidance says about dishonesty, and the appellate courts are unhesitating in their view that dishonesty persisted in, coupled with a lack of insight, is a powerful indicator for erasure. Is the same approach directly applicable to knowing breach of conditions, if that is a different 'type' of dishonesty?

53. That question was to a degree confronted in *GMC v Nyamasve* [2018] EWHC 1689 (Admin). The doctor there had voluntarily relinquished his licence to practise. Some 18 months later, he worked as a locum for several weeks without declaring that he had relinquished his licence. He had been asked by the locum agency to provide the necessary details but failed to do so. The MPT imposed a 4 month suspension with review. The GMC appealed. The appellate court directed itself to the 'dishonesty' authorities cited above. Interestingly, what it took from *Theodoropolous* was not so much the palpable dishonesty of falsified documentation as:

> the importance of the requirement to hold a licence to practice and the role it plays in protection of the public. A doctor is only allowed to practise if he or she has the relevant licence to practise. The licence can only be obtained on the GMC being satisfied that the relevant doctor has complied with all the requirements as to ongoing training, which are consistent with ensuring that the public is adequately protected from doctors whose competence falls below an acceptable level (paragraph 14)

54. In other words, the court in *Nyamasve* was clearly focused on the 'knowing regulatory non-compliance' element of the case. Reviewing the 'dishonesty' authorities as a whole, the court observed that:

> "Those authorities demonstrate the importance and impact of dishonesty. It is not simply that public confidence in doctors is likely to be diminished if doctors are dishonest. It also has a practical importance in the regime of licence to practise. If dishonesty is practised at the stage of revalidation and obtaining a licence to practise or alternatively a doctor fails to get the necessary licence to practise, then he or she is not being properly subject to the regime, the purpose of which is the protection of the public and the maintenance of proper standards."

The court went on to find that the MPT had failed to attach sufficient gravity to the conduct it had found. The 'dishonesty' of practising unlicensed was deliberate and sustained over a period. The doctor 'was prepared to deceive people as to his ability to practise'. The court was not persuaded he had insight into the issue, and could not be satisfied that, were

the doctor to face similar circumstances in the future, he would not do the same again. It concluded that this was a case of 'serious dishonesty' and quashed the finding of the MPT.

55. The court in *Nyamasve* treated knowing regulatory breach as a species of 'serious dishonesty', part of the pattern established by the 'dishonesty' authorities. Before turning to consider the issues of dishonesty and regulatory breach in the present case, however, the following general observations occur.

56. Where the MPT in *Nyamasve* was held to have gone wrong was in its application of the sanctions regime to the *gravity* of the misconduct before it. If that is a source of error for MPTs in regulatory breach cases, then it is not one the Sanctions Guidance is particularly helpful in avoiding. The Guidance helps with the consequences of dishonesty of the commonplace 'type'. It does not deal directly with regulatory breach, as such. *Good Medical Practice* is also highly focused on the values underlying the regulatory regime, and the obligations of personal integrity that are fundamental to those values, but it does not squarely address, in so many words, the straightforward obligations of regulatory compliance as such.

57. What Mr Hare says about that, as he well might, is that regulatory compliance is so obvious and basic an obligation as not to need spelling out, because it underlies everything any piece of guidance issued within a regulated profession can possibly have to say. That may be true. But a conscientious MPT, addressing itself methodically to the Sanctions Guidance, does not find 'knowing regulatory breach' in the list of indicators for erasure. It finds circumlocutions which might or might not mean the same thing (*blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor*). It finds matters going to the personal integrity of the doctor – sexual misconduct, violence and dishonesty. But it does not find assistance in understanding and evaluating an instance of regulatory breach in terms of its place, in its own right, on any scale of gravity. And it may not be surprising if a conscientious MPT therefore does not reach the conclusion the court reached in *Nyamasve* unaided.

58. Where the 'dishonesty' of regulatory breach is wholly subsumed in its deliberateness and persistence – there are no falsified certificates, fake CVs or active deceptions involved – there is a clear risk that a conscientious MPT will simply find the Sanctions Guidance provisions on dishonesty a poor fit with the facts of a case. The personal dishonesty, however reprehensible or intolerable in a professional in principle, is not the primary mischief. The future risk to the public is not that the doctor will lie and deceive. The risk to the public is that the doctor will practise contrary to their registration or licence status. The focus on the personal dishonesty of so doing (the 'how' of the matter) can mean that sight is lost of the 'what' – the substance of what is going on where doctors practise medicine when their professional regulator has provided that they must not – and the public perspective on that. Charging dishonesty in such circumstances has a potential to distract from the substance of the matter, and the Sanctions Guidance does not assist in minimising that potential.

(iii) Deliberate Regulatory Breach and Gravity

59. It is on the question of gravity – whether the MPT in this case fell into the same sort of error as the MPT in *Nyamasve* – that the competing contentions in this case ultimately turn. If the MPT found the focus on personal dishonesty unhelpful in assessing the gravity of the

case, then was it entitled to cut straight to assessing the merits of the conduct in the way that Mr Leviseur suggests it did and was entitled to do?

60. Any reluctance the MPT may have experienced in this case to force the facts into a mould of 'dishonesty' amounting *in and of itself* to a case of the utmost gravity may be difficult to condemn outright. That is not in any way to understate the seriousness of dishonest conduct in general, a matter on which the authorities have taken a clear line. It is because, in this case, any willingness of Dr Donadio to deceive people into thinking he was still entitled to practise as a consultant unsupervised was a second-order issue to the fact that he was not. The gravity of that fact, the practical reality for the public as well as Dr Donadio's state of mind, had to be considered on its own merits.

61. I am not therefore able to agree with Mr Leviseur that a simple merits-based approach to the conduct constituting the breach – if that is the explanation for the MPT's failing to follow through its findings in applying the indicators for erasure – is sufficient. That is because thinking in terms of a doctor being guilty only of patient 'overprotectiveness' and working for a few days when he should not, does not adequately account for the regulatory breach involved in doing so.

62. I return to the statutory framework and remind myself that what the IOT did in the exercise of its powers under section 41A(1)(b) of the 1983 Act was to make Dr Donadio's *registration conditional on his compliance* with the requirements imposed. That puts the question of his status in relation to the register, and his licence, immediately in issue in the event of non-compliance, as the IOT letter to him at the time made clear. The IOT moreover had exercised its power on the basis that it was *necessary* to impose the conditions it did *for the protection of the public* and to maintain confidence in the profession. This was not just any regulatory breach, therefore. It was a breach of an order imposed directly on Dr Donadio, after regulatory and legal process examining the specifics of his case, placing detailed restrictions on his registration. He was not entitled to practise as a consultant at all. But he did. Patients were entitled to be seen, diagnosed and treated by him only under direct supervision. That did not happen. The necessary preconditions for the protection of the public and for public confidence in the profession were not fulfilled.

63. It was a breach which was knowing and deliberate. Dr Donadio then went on to deny that he knew about the IOT determination, and to demonstrate a lack of candour and to resist engagement with the regulatory authorities when challenged. Irrespective of the dishonesty of the denial, the lack of submission to a regulatory process he was already *personally* subject to in a *detailed* manner adds to the gravity of the breach of the order itself. The failure to demonstrate insight into breach, and to acknowledge the entitlement of the public to see a consultant radiologist entitled to practise as such when they needed to, is a further aggravation.

64. These facts, as found by the MPT, raised a prima facie case of considerable gravity, going to the issues of public wellbeing, public confidence and the maintenance of professional standards. Moreover, the particular conditions imposed by the IOT on Dr Donadio included transparency conditions. They expressly required him, by way of anti-avoidance, to declare the conditions imposed on him to those with a proper professional interest in knowing about them. Non-disclosure was itself, therefore, not only a species of dishonesty but a further breach of the explicit requirements of the IOT order.

65. These are the reasons why a simple merits-based approach to the underlying conduct is insufficient in this context. It does not grapple with the seriousness of the breach *as such*

and therefore undercuts the formal processes already engaged for the protection of the public. It places too much weight on mitigation, which is, for the same reason, of limited relevance in the professional context (*Bolton v Law Society* [1994] 1 WLR 512).

Conclusions

66. In these circumstances, I reach the following conclusions. I agree with Mr Hare that the MPT's own findings of fact, and determinations on the issues of misconduct and of fitness to practise, triggered the Sanctions Guidance's indicators for erasure and not for suspension. That was not the end of the matter. The MPT did not have to apply the Guidance deterministically, and was entitled to depart from it altogether, provided it gave sufficient explanation for what it was doing.

67. The MPT's proximate explanation for its sanction determination has two problems. First, it does have a flavour of a generalised assertion of the disproportionality of erasure of the kind found objectionable in *Stone* and *Saeed*. Second, it discloses an over-reliance on the mitigation of Dr Donadio's departure from the UK when the relevance of that to the matters before it is not obvious. Again, however, that is not the end of the matter, since the test of whether the MPT has given a sufficient explanation has to be applied by reading its procedures and determinations fairly as a whole.

68. I think it more likely than not that Mr Leviseur is right that the explanation appearing from such a reading is a measure of discomfort with applying the Sanctions Guidance to dishonesty of the 'type' before it, and, more fundamentally, a hesitancy over finding the conduct in itself as being of the utmost gravity such that nothing short of erasure would properly protect the public. While I have some sympathy with a conclusion that the Sanctions Guidance's provisions on dishonesty are not a straightforward fit with the facts and issues of this case, I cannot conclude that a gravity determination based on the conduct alone is a satisfactory explanation for the sanction imposed, since it does not fully address the prima facie case of gravity raised by the fact of regulatory breach in its own right in this case.

69. I remind myself of the appropriate diffidence I must show before thinking of interfering in an MPT decision. I consider this sanction determination susceptible to appellate intervention, for a reason which is squarely within the appellate jurisdiction. It discloses not only an insufficiency of reasoning, but an error of principle. It is an error similar to that in *Stone*, namely a failure properly to assess the gravity of conduct before it, and hence correctly to apply itself to the question of sanction – in this case, by failing fully to address the quality of that conduct as a regulatory breach.

70. This is not a matter on which an appellate court must consider itself at an inhibiting disadvantage in relation to a tribunal. On the contrary, it is the function of appellate courts to uphold the efficacy of regulatory regimes, and of orders made under statutory powers exercised on the grounds of necessity for the protection of the public. Whether or not the Sanctions Guidance assists them to do so, it is imperative that MPT decisions on sanction clearly demonstrate to the public that they also have this fully in mind, and that cases of the deliberate breach of specific restrictions imposed personally on doctors are expressly dealt with *as such*. It is, after all, a matter going directly to the overarching objective. In particular, where a doctor's registration has been made conditional on compliance with certain requirements, and those requirements are not complied with, it is essential that an MPT deals directly with the conditionality of the doctor's registration in its assessment of

the gravity of the conduct before it, and in its approach to sanction, and demonstrates that clearly in the reasons it gives for its conclusions.

71. In all of these circumstances, it is my conclusion that the MPT in this case made an error of principle in its sanctions evaluation resulting in an insufficiency of reasoning for departure from the Sanctions Guidance. That is a serious irregularity vitiating the justice of its conclusion. I allow this appeal on that basis.

Disposal

72. The MPT's determination on sanction is quashed.