General Scholarly Article

The Concept of Dishonesty in British Medical Discipline

Cathal T. Gallagher, PhD; David H. Reissner, LLB

Introduction

In the United Kingdom (UK), the profession of medicine is regulated by the General Medical Council (GMC), while disciplinary hearings are adjudicated upon by the Medical Practitioners Tribunal Service (MPTS). The often-complex interplay between these two bodies has already been described and discussed extensively in this journal and others.[1-4] Since 2002, all charges leveled by the GMC at Tribunal must be assessed in terms of whether the doctor's fitness to practice is "impaired."[5] Although the concept of "impairment" is not defined in statute, it is held to describe a deterioration of the doctor's ability to safely practice the profession of medicine.[4]

Any Tribunal decision that restricts a doctor's ability to practice can be appealed in the High Court (or in the Court of Session in Scotland, or in the High Court of Justice in Northern Ireland) under s.40 of the Medical Act 1983.[6] The Tribunal is bound by previous rulings on the law made by any of these courts.

Here we look at a series of recent appeals against decisions of the MPTS, at which the High Court wrestled with the Tribunal's interpretation of dishonesty, where, in cases where the doctor has denied the allegation of misconduct at their MPTS hearing, this denial has resulted in a more severe sanction than might otherwise have been imposed.

Insight

As a general principle, Tribunals consider insight—an acknowledgment and appreciation of a failing, its magnitude, and its consequences for others—to be essential if that failing is to be addressed and if the risk of recurrence is to be avoided.[7] Before seeking to rectify their performance or behavior a doctor must first gain insight into their misconduct. Such insight must be in evidence before remediation can be attempted.

Future risk is a proper preoccupation of the MPTS following the rulings in several successful appeals lodged by doctors in 2008.[8-10] If a doctor's performance or conduct is faulty, but they do not have sufficient insight, this can give grounds for concern that they are unlikely to be able to address and remedy the fault, and hence that they pose a continuing risk to patients or to public confidence in general.

Dishonesty

In *R v Booth*,[11] the Court of Appeal confirmed the test for dishonesty under English law, resolving a period of uncertainty following the 2017 Supreme Court decision in *Ivey v Genting Casinos*.[12] While

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Ivey was widely welcomed as practically establishing an updated test for dishonesty, which has been applied in subsequent MPTS cases, technically the ruling did not set a binding precedent (as the case was decided on a different point). In *Booth*, the Lord Chief Justice of England and Wales confirmed that the Supreme Court's comments in *Ivey* established that the new two-part test for dishonesty requires consideration of:

1. What the defendant's state of knowledge or believe as to the facts was; and
2. If their conduct was dishonest by the standards of ordinary decent people

In the context of a Medical Practitioners Tribunal, the first part might require the panelists to consider, for example, whether a doctor knew that they were not permitted to remove medicines from their place of work for personal use, while the latter would behoove them to ask if a member of the public would consider such an action to amount to dishonesty (in the form of theft).

At Tribunal, dishonesty is often considered to be "difficult to remediate," as it tends to be viewed as a defect of character. But if a doctor whose career is on the line denies dishonesty and finds their defense rejected, they are at risk of being found to lack insight into their misconduct *because of their denial*. In such cases, dishonesty deemed "difficult to remediate" may be necessarily reclassified as "irremediable."

Although lying to Tribunals and putting forward disingenuous or meretricious defenses cannot be expected to be consequence-free, where a doctor unsuccessfully defends a dishonesty allegation, they are at risk of finding themselves in the Kafkaesque situation of being found for that reason not to have told the Tribunal "the truth" (about being dishonest) and therefore to be compounding the dishonesty. In the words of Justice Mostyn in the recent case of *Towuaghantse v GMC*, "it would amount to saying that your fitness to practice is currently impaired because you have disputed that your fitness to practice is currently impaired."[13] This situation was first identified by Lord Hoffman some 18 years earlier when he questioned if it was normal "to add to the … [original] allegations … [a further] allegation of dishonesty in the event that the respondent doctor had the temerity to deny any of the [original] allegations?"[14]

In the case of *Nicholas-Pillai v GMC*,[15] allegations had been made regarding Dr Nicholas-Pillali's clinical performance during the circumcision of a baby, and his subsequent notekeeping. The Tribunal found that the doctor's performance of the operation did not merit any sanction, but that the notes he subsequently made were intended to mislead. The Tribunal decided that the doctor's name should be erased from the medical register. In his 2008 judgment, Justice Mitting put forward the following scenario: If the accused doctor had given false evidence to the Tribunal about a clinical error, it would not be entitled to treat that as a freestanding instance of misconduct leading to a sanction. The dishonesty at the Tribunal would have to be pursued in separate proceedings, with the charge made the subject of a separate allegation. A distinction is made here between:

1. Proceedings involving allegations of dishonest conduct; and
2. Proceedings which do not involve allegations of dishonest conduct but where the allegations are defended dishonestly.

Justice Mitting considered that the former may be considered in the round, including conduct at the hearing as part of the overall picture, but the latter ought fairly to be separately charged. This remained the opinion of the court until 2020, when Justice Mostyn dealt with the case of *GMC v Awan*. Dr Awan had engaged in sexual messaging with a girl he believed to be 13 years old. The Tribunal described his denials as "ludicrous." Justice Mostyn held that "an accused professional has the right to advance any defense he or she wishes and is entitled to a fair trial of that defense without facing the jeopardy,

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if the defense is disbelieved, of further charges or enhanced sanctions."[16] This would appear to hold true regardless of the nature of the accusations against the doctor. However, in subsequent, very recent cases the MPTS has continued to highlight the nature of the original conduct in its deliberations.

In the *Towuaghantse* case, the charge against the doctor was of clinical failings leading to the death of a baby. A coroner's inquest had made several criticisms of the doctor. The Tribunal found little evidence to suggest that he had come to a full understanding and acceptance of what had caused the tragic outcome, by failing to accept any of the coroner's findings. That lack of insight led to a finding of limited capacity to remediate, which critically informed the decision on impairment and hence strongly influenced the decision on sanction. On appeal, Justice Mostyn sent the case back for reconsideration by the MPTS without reference to the appellant's decision to contest the allegations made against him, or to the way he contested them.[13]

The ruling in *Towuaghantse* was considered less than one month later in *Al Nageim v GMC*.[17] In this case, the primary allegation was one of dishonesty. Dr Al Nageim was found to have committed fraud by the retention of over £40,000 (US $48,000) in salary payments he knew had been made in error over a period of 27 months. The Tribunal had noted as an aggravating factor that the doctor "did not tell the Tribunal the truth in his evidence … and did not demonstrate any insight into this."

The decision of the Tribunal was upheld on appeal. In this case, the doctor's defense could be described as "blatantly dishonest." The doctor had advanced a defense about believing he was entitled to keep the money. The Court held this defense involved an allegation of the primary concrete facts rather than of an evaluation of his fitness to practice medicine deriving from those primary concrete facts.

Another way of looking at the issue is to ask whether the practitioner "admits the primary facts but defends a proposed evaluation of those facts in the impairment phase" as proposed by Justice Kerr in the subsequent case of *Sowida v GMC*.[18]

Most recently, Justice Collins Rice carefully considered each of these cases in her ruling on the case of *Sawati v GMC*.[19]

Sawati

Dr Sawati had appeared before the MPTS to answer allegations relating to 6 separate incidents over a period of 4 years. The allegations of misconduct were not very serious in nature, and included:

- Retrospectively adding to medical records without making it clear that the addition was retrospective, with no practical consequence;
- Swapping a hospital shift without ensuring the person she believed she swapped with knew he had to take her place, putting colleagues in a difficult position;
- Absenting herself for two hours from a hospital shift and going to lie down because she was feeling unwell, meaning she was not properly available to patients; and
- Failing to communicate accurately at an interview that she had not enrolled on a particular course which was not mandatory.

In making a finding of misconduct, the Tribunal found that Dr Sawati acted dishonestly in relation to each of the allegations. The doctor had, in its opinion, persistently denied misconduct throughout the hearing, and the Tribunal concluded that her insight was underdeveloped and incomplete. Amongst other things, the Tribunal held that her failure to tell the truth at the hearing was further evidence of her lack of insight.

Dr Sawati appealed the Tribunal's sanction of erasure from the medical register on the basis that there were serious defects in its approach, making the outcome wrong and unfair. Specifically, the issue of how a doctor can have a fair chance before a Tribunal to resist allegations without finding the resistance itself unfairly counting against them if they are unsuccessful, was raised. Dr Sawati claimed the fact she maintained her honesty in her defenses at the fact-finding stage was unfairly held against her when determining a sanction.

THE DECISION OF THE TRIBUNAL WAS UPHELD ON APPEAL. IN THIS CASE, THE DOCTOR'S DEFENSE COULD BE DESCRIBED AS "BLATANTLY DISHONEST."

Justice Collins Rice quashed the sanction and referred the case back to a differently constituted Tribunal for a fresh determination of sanction, giving the following guidance that they (and future Tribunals) should look at when considering the interplay of insight and dishonesty:

1. A rejected defense of honesty may be more relevant to an overall assessment of conduct where dishonesty (in the form of deceit, fraud, forgery or similar) is the primary allegation than where a primary allegation of other misconduct is aggravated by a secondary allegation that it was done dishonestly (as, for example, in a case involving the covering-up of clinical inadequacies). That is to say that all cases are fact-sensitive, and the Tribunal's position may be different when the registrant has done something dishonest than if they have done something that is not itself dishonest but does it in a dishonest way.
2. What, if anything, the doctor is positively denying? There is a difference between denying "primary facts" (what happened and what the doctor did or did not do) and denying "secondary facts" (the evaluation

of the primary facts through the lens of what the doctor knew or thought), and the choices available to them. Resistance to the objectively verifiable is potentially more problematic behavior than insistence on an honest subjective perspective.

3. Whether there is evidence of lack of insight other than the rejected defense.
4. The nature and quality of the rejected defense. Was it a blatant and manufactured lie, a genuine act of dishonesty, deceit, or misconduct in its own right? Did it wrongly implicate and blame others, or brand witnesses giving a different account as deluded or liars? Or, conversely, was it just a failed attempt to tell the story in a better light than eventually proved warranted?

Justice Collins Rice observed that before a Tribunal can make fair use of a rejected defense to aggravate sanctions, it needs to remind itself that registrants are properly and fairly entitled to defend themselves. The judge overturned the Tribunal's determination and sent the case back to the MPTS for a re-hearing so that a differently constituted Tribunal could make a fresh determination on sanction.

When the case was re-heard, the Tribunal's previous findings of fact and misconduct remained intact; only the appropriateness of the sanction was under consideration. The GMC's counsel (prosecuting) took the unusual step of advising that the Tribunal should be careful to avoid using Dr Sawati's defense to the charges of dishonesty as an aggravating factor in making their determination. He did, however, subsequently put forward the argument that while Dr Sawati's denials did not aggravate the dishonesty set out in the charges, they did deprive her of the mitigation which would be available to a doctor who has acknowledged their dishonesty, apologized, and worked towards trying to remedy that dishonesty.

Applying the 4 steps set out above, the Tribunal firstly determined that 3 dishonesty incidents involved allegations where the dishonesty was a secondary allegation. It went on to note that Dr Sawati had, by and large, admitted the primary facts which formed the basis of allegations that involved dishonesty. Her denials were primarily limited to her own dishonesty and state of knowledge. The Tribunal accepted that there was no significant evidence of a history of failure of insight into dishonesty. Finally, the Tribunal determined that there was no basis from which it could conclude that Dr Sawati's rejected defense amounted to a blatant lie or was itself a deception, or a counter-allegation that others were at fault.

The Tribunal determined that in the circumstances of this case, it would be unfair to regard Dr Sawati's maintained innocence as an aggravating feature in any way. Furthermore, new evidence, in the form of a reflective diary and additional character references demonstrated that Dr Sawati had gained additional insight since her original hearing. In the circumstances, the Tribunal concluded that her misconduct was not, as it had initially determined, "fundamentally incompatible with continued registration" and that the sanction of erasure from the register would be disproportionate. It therefore decided that a sanction of a 6-month suspension was sufficient to protect the public interest.

ANOTHER WAY OF LOOKING AT THE ISSUE IS TO ASK WHETHER THE PRACTITIONER "ADMITS THE PRIMARY FACTS BUT DEFENDS A PROPOSED EVALUATION OF THOSE FACTS IN THE IMPAIRMENT PHASE" AS PROPOSED BY JUSTICE KERR IN THE SUBSEQUENT CASE OF *SOWIDA V GMC*.

Conclusion

The interplay between dishonest acts—whether involving primary or secondary dishonesty—and the potential aggravation of these by mounting a defense which may itself be interpreted as dishonest has long been an issue at Medical Practitioners' Tribunals. Justice Collins Rice's 4-point guidance requires tribunals that have found a defense to be dishonest to look at questions such as whether the primary allegation was dishonest, what is being denied and whether the dishonest defense is the only evidence of a lack of insight. In doing so, and by drawing upon determinations made by her fellow High Court judges over a period of 20 years, Justice Collins Rice has finally provided a simple framework by which future Tribunals may reproducibly deal with dishonesty as applied to medical discipline in the UK.

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About the Authors

Cathal T. Gallagher, PhD, is Reader in Healthcare Ethics and Law, University of Hertfordshire, Hatfield, UK.

David H. Reissner, LLB, is Honorary Professor of Pharmacy and Medicines Law, University of Nottingham, Nottingham, UK.

Correspondence should be addressed to:
Cathal T. Gallagher, PhD, University of Hertfordshire, Hatfield, Hertfordshire, AL10 9AB, UK. Phone: +44 (0)1707 285 075. Email: c.t.gallagher@herts.ac.uk

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