Primary Health Lists

The Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care) Rules 2008

[2017] 3197.PHL

Heard on 17 and 18 April 2018 at Royal Courts of Justice, London

BEFORE
Tribunal Judge Atkinson
Dr J Chope – Specialist Member
Ms L Bromley – Specialist Member

BETWEEN

DR ALEXANDER HINSLEY RAJENDRAM

Appellant

and

THE NHS COMMISSIONING BOARD
(KNOWN AS NHS ENGLAND)

Respondent

Representation:

For the Appellant: Dr A Bishop (the appellant's daughter)
For the Respondent: Mr C Geering of Counsel

DECISION AND REASONS

The Appeal

1. This is an appeal against the decision of the respondent dated 6 November 2017 not to include Dr Rajendram on the medical performers list because he is unsuitable under the National Health Service (Performers Lists) (England) Regulations 2013 ('the 2013 Regulations').

The Background and Proceedings

2. The appellant qualified as a doctor in Sri Lanka in 1967. He has worked as a medical doctor in the United Kingdom since 1977. The appellant began working as a GP at the Morecambe surgery, London in 1989 and became a partner in 1995.

3. On 15 February 2012 the appellant visited a patient at her home in order to deliver a letter relating to her housing situation. In the course of the visit the appellant engaged in sexual activity with the patient by hugging, kissing, touching and kissing her breasts, touching her vagina and clitoris, exposing himself and receiving oral sex. Shortly thereafter the appellant left the patient's home.

4. On the same day matters were reported to the police by the patient and her family. The sexual activity was described as being non-consensual.

5. Later that day the appellant voluntarily attended Edmonton police station. During the police interview the appellant admitted in engaging in sexual activity with the patient and said that the activity was consensual.

6. On 24 February 2012 the appellant was suspended from the GMC register on an interim basis.

7. On 27 February 2012 following an oral hearing the appellant was suspended from the NHS performers list.

8. Following a hearing on 9 May 2012, which the appellant did not attend, the appellant was removed by the relevant primary care trust (PCT) from the performers list on the grounds of unsuitability. The PCT was of the view that the appellant was not suitable because of the appellant's breach of professional boundaries and that he was a risk to other patients.

9. On 12 August 2012 the Crown Prosecution Service formed the view that in light of the conflict of evidence relating to issues of consent there was insufficient evidence for the matter to be prosecuted and the appellant was not charged.

10. On 4 August 2014 the appellant was substantively suspended from the GMC medical register for 12 months.

11. On 24 July 2015 the appellant's suspension from the GMC register was replaced with an order for conditions imposed on the appellant's registration.

12. On 26 July 2016 the order for restrictions on GMC registration was revoked and the appellant gave undertakings as to limitations on his practice. The undertakings remain live during the currency of the present proceedings.

13. On 21 December 2016 the appellant applied to re-join the medical performers list.

14. On 6 November 2017 the respondent refused the application on the grounds that the appellant was unsuitable to be included on the list. The respondent came to that view because of: the seriousness of the appellant's misconduct on 15 February 2012; the fundamental breach of trust involved in such misconduct; the particulars of the application form submitted on 21 December 2016 contained elements of dishonesty; and the appellant lacked insight into the serious nature of his actions.

15. It is against that decision of 6 November 2017 that appeal is now brought.

The Law

16. The relevant law is to be found in National Health Service (Performers Lists) (England) Regulations 2013. The relevant provisions are set out in the bundle and it is not necessary to set them out in full here.

17. In brief, regulation 7 makes provision for grounds for refusing an application to join the medical performers list. The grounds include circumstances where the applicant is considered to be unsuitable and cross refers to other provisions within the regulations.

18. It is convenient to note here that appeal is to proceed by way of redetermination of the issues.

The documents and evidence

19. The tribunal was provided with a bundle indexed and paginated to tab 19 page 376 comprising all the filed material on which both parties sought to rely together with other background materials. Prior to the hearing the parties filed a number of further documents including respective skeleton arguments and by the appellant further substantive evidence. It is not necessary to itemize those documents here.

20. In addition, at and during the course of the hearing, the appellant also submitted, with no objection from the respondent, a CV for the appellant and copy of an unsigned psychiatric report dated 7 July 2014.

21. The tribunal heard oral evidence for the respondent from Ms Galloway and Dr Henderson; and on behalf of the appellant from the appellant himself and his daughter Dr Bishop.

Preliminary Matters

22. The tribunal proceedings were conducted in public. It was noted that should certain matters need to be considered in private an appropriate application would be entertained in the course of the hearing. In the event no such application was made.

23. The tribunal also notes here that it was aware of its duty to act justly and

fairly in determining the appeal, particularly in light of the fact that the appellant was represented by his daughter who is not legally qualified. The tribunal therefore took appropriate steps to enable the appellant and his representative to fully participate in the proceedings; and adopted a variety of measures to enable the appellant to put forward his case, including assisting in the formulation of questions, allowing additional time and being flexible in its approach.

Opening Submissions and evidence on behalf of the Respondent

24. Mr Geering relied on his skeleton argument and made further submissions that may be summarised as follows. The appellant had engaged in sexual activity with a vulnerable patient on 15 February 2012. He had been removed from the performers list in 2012 on the grounds of unsuitability.

25. The GMC, following interim suspension, decided that the appellant's fitness to practice was impaired and suspended him from the medical register for 12 months. The GMC the appellant allowed to return to medical practice with conditions in 2015; and had revoked those conditions on the appellant's undertakings.

26. In 2016 the appellant had applied for inclusion on the medical performers list. In making his application the appellant had made misleading statements that gave rise to questions about his honesty in filling in the application form.

27. On 6 November 2017 the respondent refused the application. The respondent came to that view because of the egregious nature of the misconduct and the appellant's lack of insight as demonstrated by the statements made in his application form.

28. The appellant had not supported his claim of attending a course on professional boundaries by producing the certificates issued by the course providers; nor had he provided documentation relating to his reflective log.

29. The respondent relied on the oral evidence of Ms Galloway and Dr Henderson.

The oral evidence of Patricia Galloway

30. Patricia Galloway is head of practitioner performance and revalidation for NHS England. She adopted her witness statement dated 8 February 2018 as evidence in chief. It is not necessary to rehearse her further oral evidence given in examination. Her evidence may be summarized as follows.

31. Ms Galloway had been involved in presenting the appellant's case to the PCT in respect of its unsuitability decision of 9 May 2012.

32. Ms Galloway had been involved in communications with other teams

within the NHS in considering the appellant's involvement in the NHS induction and refresher scheme for those joining or returning to general practice and in the appellant's application made in December 2016 for inclusion on the medical performance list.

33. Ms Galloway was involved in exchanges of e-mail from 2015 about the administrative route available to the appellant in applying for inclusion on the list. It was accepted that there was a degree of confusion about the procedures. Ms Galloway in the course of those e-mail exchanges was providing information as to the routes available which did not amount to making a decision as to inclusion on the list or otherwise. The induction and refresher course was not open to the appellant because he was subject to undertakings with the GMC.

34. The department in which Ms Galloway works does not deal with the preliminary part of the application process to be included on the medical performers list. Her department deals with and reviews the completed application form. It is not part of her department's role to obtain further documentation in relation to the applications. An application would be presented to the relevant performers list decision panel. It was open to that performers list decision panel to call for further information if it was considered appropriate.

35. It was accepted that the respondent's decision dated 6 November 2017 incorrectly stated that the appellant had been removed by the GMC from the register. The decision however also accurately recorded elsewhere that the appellant had been suspended by the GMC from the register.

36. Ms Galloway had been involved in preparing the submission to the performers list decision panel that made the decision of 6 November 2017. That submission included amongst other things information relating to the Crown Prosecution Service decision not to prosecute the appellant.

The oral evidence of Dr Elizabeth Henderson

37. Dr Henderson is a GP and associate medical director for NHS England's London region. Dr Henderson was a member of the performers list decision panel that took the decision to refuse the appellant's application on 6 November 2017. She adopted her witness statement dated 12 February 2018 as evidence in chief. Her oral evidence may be summarized as follows.

38. In coming to the decision about the unsuitability of the appellant to be included on the performers list, the decision panel was concerned about the appellant's continuing lack of insight because of omissions in the application form. In coming to its decision, the performers list decision panel took into account the conduct of the appellant, which was felt to be a fundamental breach of trust between a doctor and a patient, and the application form. It was considered that conditional inclusion would not adequately safeguard patients.

39. In coming to its decision, the performers list decision panel considered only the prepared submission with the history that was submitted to that meeting and the application form.

40. Dr Henderson was of the view that a home visit by a GP should be undertaken where there was a medical need or because of disability. She did not consider that a home visit would be necessary in order to assess a patient's housing situation.

41. The performers list decision panel of November 2017 did not consider it necessary to obtain additional information in order to come to a decision. The application form did not have with it certain documentation, for example the required number of references. If that had been the only issue, then the panel could have called for further information. However, the decision involved broader issues, particular as they related to the misleading answers given on the application form. Dr Henderson was unable to say whether or not the panel on the day formed a view as whether the appellant's misconduct or the filling in of the form was the more serious matter.

42. There were no conditions that could be imposed that would provide adequate protection. It was not workable to impose a condition of continuous supervision.

43. Dr Henderson's view as to the unsuitability of the appellant remained unchanged in the light of the further documentation now available and which had not been before the decision panel.

<u>Opening Submissions and evidence on behalf of the Appellant</u>

44. Dr Bishop on behalf of the appellant relied on her skeleton argument and made further submissions which may be summarised as follows. The respondent's decision was challenged because the respondent had failed to look at the application form as a whole when forming its view as to the significance of the answers given by the appellant. The errors on the application form could have been sorted out a local level had the appellant been approached for further information.

45. The respondent had failed to pay sufficient attention to the GMC's findings. The appellant's position was also supported by a report of a psychiatrist prepared in 2014.

46. The respondent's decision was flawed and had given inadequate weight to other options. As a result the NHS was deprived of the services of an experienced GP in an area where the appellant's services were valued by the local community.

47. It was accepted that the appellant had crossed professional boundaries

but the misconduct had occurred over 5 years ago, there had been no criminal proceedings and the patient had refused to sign a witness statement testifying to the events.

The oral evidence of the appellant

48. Dr Rajendram adopted as evidence in chief his witness statements dated 1 August 2014, 12 February 2016 and 4 April 2018. As with the other oral evidence adduced before the tribunal, it is not necessary to rehearse the full details of that evidence or further evidence given in examination. The evidence may be summarized as follows.

49. The appellant was born in Sri Lanka and excelled at school. He worked in the health service in Sri Lanka. In 1997 he relocated to the United Kingdom and subsequently trained as a GP. In 1989 he became a part time partner and in 2006 a full time partner. In 2011 the appellant took over responsibility for running the practice. Thereafter there was a degree of infighting amongst the practice staff.

50. The appellant is married and has children. The appellant has experienced difficulties within his marriage.

51. The patient who was involved in the sexual activity with the appellant joined the practice in 2010. She preferred to be seen only by the appellant.

52. In February 2012 the appellant engaged in sexual activity with the patient. Later in the day the appellant attended a police interview where he said that he had engaged in consensual sex with the patient.

53. The appellant is of the view that his actions were totally uncharacteristic and feels shame and remorse.

54. The appellant accepts that his actions fell below required standards but that there had been provocation on the part of the patient. The appellant understands the implications of his actions on the profession and the public.

55. In filling in the application form the appellant stated that he had been *cleared* by the GMC. He had used the word *'cleared'*, in the sense that he had cleared a hurdle to returning to practice. The appellant had no intention of lying on the form because the NHS had all the details relating to the events in 2012.

56. In terms of the appellant's intention in undertaking a home visit in February 2012, the appellant accepted that the documentation before the tribunal did not refer to him undertaking such a visit with a view to assessing the appellant's housing situation, but he had wanted to listen to the patient.

57. Before the visit of February 2012, the appellant was aware of the appellant's history of having been the victim of sexual abuse, that she was

an alcoholic who had recently relapsed, and had suffered a number of bereavements including matters relating to suicide within the family. The appellant accepted that the patient has highly emotionally vulnerable.

58. The appellant has since been on a course relating to professional boundaries. The appellant accepted that he had missed warning signs: the patient wishing to see only the appellant; the low lighting and closed curtains in the house when he visited. At the time these signs did not flag up any concerns to the appellant. The appellant did not attend the house with a sexual motive.

59. The appellant was of the view that possibly he had been entrapped. He did not blame the patient.

60. He expressed remorse for his actions on the day of the incident. The appellant has not apologized to the patient. The appellant has not seen her since the incident.

61. The background to the incident involved the appellant facing financial strains; having to support family members; and he was faced difficulties within his marriage. The appellant at the time did not recognize the impact such matters had on his judgment. The appellant has always had support from a GP friend, with whom he discussed these difficulties. The appellant found relief in work.

62. The appellant did not accept that issues related to stress had affected his judgment save for the incident in question in 2012.

63. The appellant's circumstances in relation to his wife, finances and family had changed since the time of the incident in 2012. The appellant accepted that there were still pressures in his life in 2016 when he completed the application form for inclusion on the list.

64. The appellant has attended a professional boundaries course over 4 days in total. The appellant acknowledges that he had missed signs relating to the events of 2012. That event was a one-off incident.

65. The appellant accepted that his statements on the application form were not clear, but was of the view that if his name had been searched on the internet it would have revealed all the details.

66. The appellant accepted that he failed to mention on the application form that he was still subject to GMC undertakings. He had used the word 'cleared' in the sense of having cleared a hurdle. The appellant had not mentioned the PCT proceedings because he thought the GMC proceedings were more serious.

67. The appellant was under stress at the time of making the application: both financially and emotionally. The appellant did not have the help of a colleague in filling in the form. The appellant had not provided further

information or evidence of his reflections because he did not think it necessary.

Oral evidence of Dr Bishop

68. Dr Bishop is trainee GP and the appellant's daughter. She adopted as evidence in chief her witness statements dated 30 July 214 and 12 February 2018 as evidence in chief. Her oral evidence maybe summarized as follows

69. In writing her witness statements and in giving evidence she has drawn on both her professional experience as a trainee GP, her post graduate studies in occupational and rehabilitative health, and her own personal experiences. Dr Bishop attests to the various stressors in the appellant's life including his relationship with his wife; within the family as a whole; and his work and financial position. Dr Bishop is certain that the appellant will never have a similar lapse of judgment again.

<u>Closing Submissions on behalf of the Respondent</u>

70. Mr Geering's closing submissions may summarized as follows. The serious nature of the misconduct itself might be thought to be sufficient grounds for finding the appellant to be unsuitable to be included on the list. There had been ample warning signs apparent to anyone that the appellant was putting himself in a position which engaged issues relating to professional boundaries. The harm arising from the appellant's misconduct affected the patient in a number of ways and on how the GPs more generally were viewed by patients.

71. In addition, the appellant had not demonstrated adequate insight, despite the views otherwise of the GMC.

72. The oral evidence from the appellant before the present tribunal showed that the appellant attached blame to the patient and that he was deflecting blame from himself.

73. Further, the timing of the appellant's expression of remorse at the GMC proceedings did not show that he immediately knew the extent of his wrongdoing.

74. The appellant had also sought to introduce a new explanation as to why he had undertaken a home visit on 12 February 2012, namely that he was undertaking an assessment of the appellant's home. That explanation was nonsensical and shows the appellant to be untruthful. In undertaking the home visit the appellant either knew he was breaching his obligations and was reckless; or he did not know but was culpably blind.

75. In addition to the above matters there was also a risk of repetition of misconduct based on the following considerations. The appellant had

suggested that the patient had been to blame. The appellant claimed that his actions in 2012 had been out of character due to various stresses in his life; and that the misleading replies on his application form were also attributable to stress; however, the evidence did not show that the appellant was able to recognize stress. The appellant's errors in filling in the application form were not limited to minor slips but amounted to a misrepresentation of the regulatory history. It was concerning that in 2012 the appellant had not been able to identify the warning signs about the possible crossing of professional boundaries; and there was a lack of evidence about the appellant's involvement in courses relating to professional matters and on his own reflections.

Closing Submissions on behalf of the Appellant

76. Dr Bishop on behalf of the appellant made a number of submissions that may be summarized as follows.

77. The GMC had found that the appellant in visiting the patient on 15 February 2012 did not attend with the intention of having sex with her. The psychiatric report of 2014 makes mention of the appellant's intention of attending as part of assessing the appellant's housing. The appellant's attendance should be viewed in the context of the evidence as whole which shows his involvement in charitable work and his willingness to 'go the extra mile' in looking after his patients.

78. The GMC's view of the appellant's misconduct is not fundamentally incompatible with continuing to be a registered medical practitioner and that there was no significant risk of repetition.

79. The appellant has shown remorse and insight into his behaviour: he admitted that his behaviour was wrong; he had admitted his conduct immediately in the course of police interviews despite being advised otherwise by his then legal advisers; he had made a full admission in the GMC proceedings; and had acknowledged the effect of his behaviour on the patient, and wider effects on the profession.

80. It was not accepted that the appellant had delayed in showing remorse. The appellant had accepted that he should be suspended by the PCT in 2012 and could have provided documentation showing early expression of remorse if he had been asked to do so.

81. The appellant when filling in the application form for inclusion on the list had believed that his misconduct would be known to the NHS. The appellant had had contact with the NHS team involved in the induction and refresher scheme and had assumed that they would have been in contact with other officers within the NHS. The team responsible for the dealing with the initial application form had held it for 9 months and had not raised issues about its deficiencies with the appellant in that period. If asked, the appellant would have provided more information.

82. To the extent that the appellant had not filed course certificates relating to attendance at a professional boundaries course, then the blame for that lay with the appellant's representative, rather than the appellant.

83. The appellant had taken measures to alleviate the pressures in his life such that his stress was managed.

84. There was no significant risk of repetition of the misconduct. That was the view of the GMC and was the view set out in the psychiatric report of 2014. The appellant has adapted in the way that he seeks help from colleagues and others. The appellant finds work therapeutic. He intends to attend further courses on matters relating to clinical practice boundaries.

Further findings of fact, assessment of evidence and reasons

85. The tribunal considered all the evidence and the submissions. In coming to its decision the tribunal has looked at the evidence as a whole.

86. There are a number of primary facts that are not in dispute, particularly as they relate to the background and history, as noted in the earlier sections of this determination. They need not be repeated here.

87. The tribunal's further findings of primary fact are set out, as necessary, below as part of the tribunal's overall assessment and decision.

88. In making its decision the tribunal considered all the relevant matters noted within the regulations particularly as they relate, under regulation 7(3) to the nature of the matter; the length of time since the events; the actions of other regulatory bodies; and the risk to patients.

89. For convenience the tribunal has grouped its assessment under the following headings

   i. The seriousness of the appellant's misconduct in 2012
   ii. The extent of the appellant's insight and the risk to patients

The seriousness of the appellant's misconduct

90. It is not disputed that on 15 February 2012 the appellant visited a patient at her home. In the course of the visit the appellant engaged in sexual activity with the patient by hugging, kissing, touching and kissing her breasts, touching her vagina and clitoris, exposing himself and receiving oral sex.

91. There is a dispute, which it is not necessary for the tribunal to resolve for the purposes of these proceedings, as to whether the sexual activity was consensual or non-consensual.

92. The tribunal finds such behaviour on the part of the appellant lies at the very upper end of the scale of professional misconduct. The appellant's behaviour on that occasion amounted to a fundamental breach of trust in the relationship between the appellant and his patient; and is a gross abuse of power.

93. The particular features of that incident that show that the misconduct is to be considered at the most serious end of the spectrum are

i. The nature of the act itself which included penetrative sex in addition to intimate touching
ii. The fact that the patient herself was a vulnerable person as a result of multiple difficulties arising from her own history of being sexually abused; her misuse of alcohol; and her then recent relapse into alcoholism;
iii. The fact that the appellant was aware of the vulnerability of the patient
iv. The fact that sexual misconduct took place within the appellant's own home
v. The fact that the misconduct took place in the course of the doctor- patient relationship

94. In considering whether or not the appellant is unsuitable to be admitted onto the list the tribunal also takes account of the issues of insight and risk as explained further below.

Insight and risk

95. The tribunal finds that the appellant has failed to demonstrate sufficient insight into his behaviour such that the risk to patients has reduced to an acceptable level as explained below.

96. In assessing the appellant's insight, the tribunal finds that there are a number of aspects of the evidence that show that the appellant has a degree of insight; but that nevertheless, such insight that he possesses is materially limited.

97. The tribunal finds that the evidence shows that the appellant has some insight for the reasons identified by Dr Bishop. Thus, the appellant admitted at his first police interview and in subsequent police interviews that he had engaged in sexual activity with the patient, despite being advised by a legal representative to make no comments; and that the appellant had similarly admitted his misconduct in the course GMC proceedings.

98. The tribunal also accepts that the appellant shows an appreciation of the effect of his misconduct on the public's perception of the medical profession and the faith placed in doctors.

99. However, the tribunal finds that are a number of aspects of the evidence

that show that appellant continues to lack adequate insight.

100. The tribunal also notes that the respondent submits that matters relating to the appellant's completion of the application form suggest that the appellant has been dishonest.

101. Given this context it is helpful to set out here the evidence relating to the application form, followed by the tribunal's own analysis.

102. At question 35 of the application form the appellant is asked to indicate yes or no to the question:

> *have you ever been refused admission, conditionally included in, suspended from, remove or contingently removed from any primary care list or equivalent list*

103. The appellant's response, correctly, is recorded as *yes*.

104. The appellant is directly thereafter asked

> *If you answered yes to the above question please provide details and a supportin*g explanation

105. To which the appellant's response is

> *Suspended by GMC and allowed back to practice on 25* August 2015

106. The tribunal finds that response to be minimal at best. The tribunal finds that the response is misleading in that the response does not mention the fact of the adverse PCT decision to remove him on grounds of unsuitability in 2012.

107. However, the tribunal accepts that the appellant may well have framed his answer in the belief that NHS England, in any event, was aware of the earlier decision removing him on unsuitability grounds from the PCT list. With that in mind, the tribunal does not find that the appellant has been dishonest in relation to that response.

108. At question 36 the appellant is asked

> *Have you ever at any time during your career been subject to sanctions, conditions or suspensions imposed by your regulatory body, employer or other NHS body*

109. The appellant's answer to this, correctly, is noted as *yes.*

110. The appellant is then asked

> *If you answered yes please provide details and a*

supporting explanation.

111. To which the appellant's response is

> *Suspended in February 2012 cleared by the GMC on 25 August 2015*

112. The tribunal finds that response to be misleading because it suggests that the GMC's concerns about the appellant had concluded; whereas the appellant continued to be subject to undertakings based on a continuing impairment of his fitness to practice.

113. The tribunal also finds that appellant made two declarations in the application form that are factually incorrect.

114. Thus, at declaration 7.g, when asked if had *ever been subject of any investigation by any regulatory body or other body which included an adverse finding*, the appellant declared *no*.

115. And at declaration 7.n, he was asked had *he ever been removed or are you currently suspended from or have you been refused inclusion in or included subject to conditions in any list*: to which the appellant declared *no*.

116. The tribunal finds that those responses, when considered both singly and also in their totality, do not show that the appellant has been dishonest. That is because of the appellant's belief about the information already held by the respondent.

117. However, the tribunal does find that such responses: minimalist, misleading and factually incorrect as found, are matters that undermine his claim to have adequate insight into his conduct, the consequences of the misconduct and its implications as explained further below.

118. The appellant claims that his responses were as a result of a number of stressors, now abated, but that were present at the time of the application and led him respond as he did.

119. However, the tribunal finds that the responses on the application form show that the appellant lacks sufficient capacity to recognize when and why his judgment is being adversely affected by stress. Equally importantly, in consequence, the tribunal also finds that this evidence shows that the appellant does not have adequate capacity to properly deal with stressors in his life by taking appropriate steps to manage his conduct and to ensure that he fully understands the implications and consequences of his actions.

120. This aspect of the evidence is of particular concern because the essence of the appellant's case is that his misconduct should be viewed in the context of the stressors he was facing at the time, and that his

failure of judgment in 2012 was a one off event. However, the evidence shows that on a subsequent occasion, when required to exercise professional judgment, he again failed to recognize the adverse impact stress has on his judgment.

121. The appellant's failure in this regard to recognize the impact of stress on his judgment is all the more concerning given his claim to have attended a professional boundaries course where consideration would have been given to such matters. The tribunal finds that the evidence demonstrates that the appellant has not benefitted from engagement in such courses to an extent that it is reasonably likely that in the future he will be able to effectively recognize and manage himself when faced with stressful challenges.

122. The tribunal thus rejects the submissions to the effect that the stressors in the appellant's have abated and are therefore no longer material. That is because it is a fact of life that stressors may appear at any time and in any form. It is therefore no answer to say that the appellant's circumstances are now different in their particulars.

123. In addition, the tribunal finds that the evidence relating to the application form and its completion by the appellant also show that the appellant has a limited understanding of the regulatory regime and the seriousness surrounding such matters; despite having been involved in regulatory matters for over 5 years. The lack of appreciation of the importance of the medical performers lists and the need to provide evidence about his circumstances tends to suggest that the appellant lacks a degree of insight and understanding of his position.

124The tribunal also finds that the evidence shows that there are further matters that suggest that the appellant lacks sufficient insight.

125. Thus, in oral evidence, the appellant said that he continued to believe that his patient might have entrapped him into engaging in sexual activity with her and that her actions were provocative.

126. The tribunal finds that this aspect of the appellant's evidence suggests that there remains a component in the appellant's thinking whereby he attaches blame to the appellant for the actions that he himself took in so egregiously overstepping the boundaries of a doctor –patient relationship. That is because it does not matter, within the context of the doctor –patient relationship, whether or not the patient was what the appellant calls provocative. Quite simply: it is the appellant's responsibility to act professionally in all circumstances.

127. The tribunal finds this evidence shows that the appellant does not fully appreciate his role in the events of 2012 and has not taken full responsibility for the true extent of his misconduct.

128. The tribunal in these circumstances therefore finds that there is an

unacceptable risk of further misconduct. In coming to this view the tribunal has attached limited weight to a report, dated 7 July 2014, seemingly prepared in the context of the GMC proceedings, by a psychiatrist, Dr Bradley. The report appears to be suggesting, amongst other things, that the appellant would not have engaged in sexual misconduct if he had not been provoked.

129. The tribunal finds the report to be of limited assistance for a number of reasons which may be summarized as follows. The report does not set out the author's expertise in matters relating to sexual misconduct, nor the context in which preparation of the report was requested, nor the instructions in response to which it was compiled; the report itself is unsigned and therefore not necessarily approved by its author; much of the report is a mere recitation of events as described by the appellant; and the report fails to adequately explore the significance of what is described as provocative action by the patient in the context of a doctor-patient relationship

130. The tribunal notes that its assessment of the issues as set out above differs from the assessment found within the GMC proceedings. In this regard the tribunal notes that those proceedings would not have considered the issues relating to the appellant's completion of the application form. The tribunal also notes that the GMC analysis is in any event limited, with no detailed consideration of issues relating to so called provocation by the patient; and the conclusion arrived at appears to be derived by way of assertion rather than by analysis.

131. This tribunal therefore finds that there is good reason to arrive at a view that differs from that of the GMC.

Assessment of unsuitability

132. The tribunal finds that the matters as noted above, relating to the seriousness of the misconduct, inadequacy of insight and risk to patients, all tend to support the view that the appellant is unsuitable to be admitted on to the medical performers.

133. In considering the issue of unsuitability, as well as those matters as set out above, the tribunal also takes account of a number of other matters as explained below.

134. The tribunal notes that in the context of the GMC's proceedings, the view is that the appellant's fitness to practice is impaired by reason of misconduct, but that he is to be allowed to practice on the basis of undertakings limiting his practice.

135. In respect of that view, the tribunal is mindful that the GMC procedures and rules: operate under a different framework from that which relate to

statutory regulation under the medical performers list; are directed to objectives that differ from those under the medical performers list; apply different criteria from that which apply under the medical performers list; and relate to medical practice across all settings, whereas, the medical performers list is restricted to matters concerning GP services provided to and on behalf of the NHS.

136. The tribunal also reminds itself that, in deciding the present application, it is a fundamental principle of administrative law that a statutory body, such as the present tribunal, in exercising discretionary powers must come to its own decision, rather than either delegating its decision to that of another body, or by fettering its own discretion and thereby failing to consider an application on its own merits.

137. The present tribunal therefore considers the present case on its own merits. Accordingly, the tribunal whilst taking account of the GMC decision, attaches little weight to it in determining the appellant's suitability to perform services on the medical performers list. The tribunal has already explained why its views differ from that of the GMC on the question of insight and risk; and why there is no logical impediment to the two bodies arriving at different decisions.

138. In coming to its view, the tribunal has considered the totality of the evidence. It is not necessary to set out every aspect of each piece of evidence included in the bundle and submitted in the course of the hearing. The tribunal notes here that little weight has been attached to the testimonials filed on behalf of the appellant from either patients or colleagues of the appellant. That is because, in broad terms, that evidence variously, do not directly engage with the issues of the seriousness of the misconduct, risk and insight; are partial and, by their very nature, are not objectively representative.

139. Given all of what is said above, the tribunal finds that the appellant is not suitable to be included on the medical performers list.

140. The appellant has engaged in serious sexual misconduct at the highest end of the scale; despite the passage of time there remains an unacceptable level of risk to patients; and the appellant has failed to demonstrate adequate insight.

141. The tribunal in weighing all the matters above finds that such a decision is reasonable and proportionate in all the circumstances and that there is no other viable decision open to it.

Decision

Dr Rajendram's application for admission on to the medical performers list is refused.

The appeal is dismissed.

Judge J Atkinson
Primary Health Lists
First-tier Tribunal (Health Education and Social Care)

Date Issued: 1 May 2018