PUBLIC RECORD

Dates: 28/06/2021 – 02/07/2021 & 15/07/2021

Medical Practitioner's name:	Dr Ambreen Zahoor MALIK
GMC reference number:	6066144
Primary medical qualification:	MB BS 1993 University of Punjab (Pakistan)

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Not Impaired

Summary of outcome

No warning

Tribunal:

Lay Tribunal Member (Chair)	Mrs Joy Hamilton
Medical Tribunal Members:	Dr Harriet Leyland Professor Irving Benjamin

Legal Assessor:	Mr Paul Moulder (28 June – 2 July 2021) Ms Judith Walker (15 July 2021)
Tribunal Clerk:	Mrs Lorraine Cheetham

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Ms Martina Murphy, Counsel, instructed by 12 Kings Bench Walk Chambers
GMC Representative:	Ms Helena Duong, Counsel

Attendance of Press / Public

In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held in public.

Overarching Objective

Throughout the decision making process the tribunal has borne in mind the statutory overarching objective as set out in s1 Medical Act 1983 (the 1983 Act) to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts - 02/07/2021

Background

1. Dr Malik qualified in 1994 and prior to the events which are the subject of the hearing Dr Malik was employed by CAS Behavioural Health Limited, formerly (known as Cambrian Healthcare Limited) as a Consultant Psychiatrist at Fountains Hospital in Blackburn ('the Hospital').

2. The allegation that has led to Dr Malik's hearing can be summarised as follows: Patient A was an adult male who had been diagnosed with treatment resistant paranoid schizophrenia. He was admitted to the Hospital on 16 January 2016 and was detained under the Section 3 of the Mental Health Act 1983. Dr Malik was Patient A's responsible Clinician and Prescribing Doctor at this time. Patient A was reported to have lacked capacity to consent to treatment. However, it was apparent from his medical records that he had awareness of the medications that he was on and occasionally he would challenge the medical staff about it. Patient A had episodes where he was verbally or physically aggressive towards staff at the Hospital, himself and family members.

3. In January 2016 Patient A was being treated with Zuclopenthixol Decanoate ('ZD') which was administered as a depot injection. Patient A requested a change of ZD to Risperidone following what he claimed to be adverse side effects. On 20 February 2017 Patient A's medication was changed from ZD to Risperidone. In the period, up to and including June 2017 after this medication change, Patient A's condition deteriorated and a plan was agreed with the MDT and Patient A's family to give ZD covertly.

4. Dr Malik recorded in the patient's notes that neither Clozapine nor injectable Olanzapine were viable options. She noted that ZD was the only depot that he had a good response to. She noted that it would be helpful to have covert administration of this medication to establish whether or not his claimed side effects did genuinely arise from the

administration of ZD. It was Dr Malik's belief that ZD was necessary for the patient to recover sufficiently so that he might be able to live in the community. The plan, agreed by all members of the MDT and approved by a Second Opinion Approved Doctor (SOAD) was to inform Patient A of the change to his medication, and give him an explanation of that when he had sufficiently recovered. A 'best interests' meeting was arranged for 24 July 2017 but Dr Malik considered it inappropriate to wait this long for a change of depot in view of his deterioration. Therefore, it was planned to introduce ZD in a week's time. Staff at the Hospital were involved in the making of this plan and instructed that Patient A "must not be made aware of this [ZD depot] prior to administration under any circumstances". Patient A was given a depot injection of ZD on 12 July 2017.

5. On or around 19 July 2017, Patient A was given another depot injection of ZD. He was told at that time by a nurse that the injection was in fact ZD, not Risperidone.

6. On 20 July 2017, Dr Malik noted that Patient A had become agitated when discussing medications. Patient A began to demonstrate tremors, which he attributed to being a side effect of ZD. At this stage Dr Malik was made aware that Patient A had been informed by the nurse that the medication he received had been changed to ZD. Dr Malik had discussed with the Hospital Manager and the Interim Head of Care how best to deal with this situation. They agreed that the patient would be reassured that the medication was in fact Risperidone and the syringe appeared different as it had been produced by a different manufacturer. Dr Malik, accompanied by the Interim Head of Care, then informed him that his depot had not been changed and he remained on Risperidone. Patient A challenged Dr Malik and asked questions about why a different needle had been used. She informed him that this was because it was produced by a different manufacturer.

7. A professionals meeting was held on 24 July 2017, where covert administration of medication was discussed, as there appeared to be some discomfort amongst the nursing staff with the covert administration. An urgent legal opinion was requested on 26 July 2017. On 27 July 2017 Patient A's care plan was updated to say that he was no longer on covert administration and ZD would continue to be administrated using restraint if necessary.

The Outcome of Applications Made during the Facts Stage

8. The Tribunal granted Ms Murphy's application, on behalf of Dr Malik, made pursuant to Rule 17(2)(g) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), that there is insufficient evidence to support paragraph 1(a) and (b) of the Allegation. The Tribunal's full decision is included at Annex A.

9. The Tribunal granted the application, made by Ms Duong, on behalf of the GMC, pursuant to Rule 17(6) of the Rules, to amend paragraph 2 of the Allegation. This application was agreed by Ms Murphy. Accordingly, the Tribunal determined that, given the agreed nature of the application which only sought to amend the date within paragraph 2 of the Allegation from 21 July 2017 to the 20 July 2017, this amendment could be made without injustice to Dr Malik.

The Allegation and the Doctor's Response

10. The Allegation made against Dr Malik is as follows:

That being registered under the Medical Act 1983 (as amended):

~~1. On one or more of the dates set out in Schedule One, you inappropriately instructed nursing staff to administer Zuclopenthixol Decanoate to Patient A, in that you:~~

a. ~~failed to inform Patient A before the administration of Zuclopenthixol Decanoate that his Risperidone injection had been changed to Zuclopenthixol Decanoate;~~ Removed following a successful application under Rule 17(2)(g)

b. ~~formulated a treatment plan requiring nursing staff to withhold from Patient A that his Risperidone injection had been changed to Zuclopenthixol Decanoate.~~ Removed following a successful application under Rule 17(2)(g)

2. On ~~21~~ 20 July 2017 you falsely told Patient A that: Amended under Rule 17(6)

a. he had received Risperidone on 19 July 2017; Admitted and found proved

b. the reason the needle was different was because the Risperidone injection had been manufactured by a different company, or words to that effect. Admitted and found proved

3. You knew the statements you made as referred to in paragraph 2 were untrue. **Admitted and found proved**

4. Your actions as described at paragraph 2 were dishonest by reason of paragraph 3. **To be determined**

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

The Admitted Facts

11. At the outset of these proceedings, through her counsel, Ms Murphy, Dr Malik made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

The Facts to be Determined

12. In light of Dr Malik's response to the Allegation made against her, the Tribunal was required to determine whether Dr Malik inappropriately instructed nursing staff to administer ZD and was dishonest in her communication with Patient A on 21 July 2017. Subsequently there was a successful application to dismiss Paragraph 1(a) and 1(b) and a further successful application to amend the date from 21 July 2017 to 20 July 2017.

13. Dr Malik provided her own witness statement and also gave oral evidence at the hearing.

Expert witness evidence on behalf of the GMC

14. The Tribunal also received oral evidence from the following expert witness:

- Dr B, Consultant Psychiatrist.

Expert witness evidence on behalf of Dr Malik

15. The Tribunal received evidence from the following expert witness on Dr Malik's behalf:

- Professor C, Consultant Psychiatrist.

Documentary Evidence

16. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included but was not limited to:

- Expert report of Dr B dated, 28 February 2018;
- Supplemental report of Dr B, dated 1 August 2018;
- Second supplemental report of Dr B, dated 18 November 2018;
- Care plan for Patient A
- Procedure for covert medication (Internal policy) dated August 2016;
- Addendum report of Dr B, dated 12 June 2021;
- An undated statement of Dr Malik
- Defence expert report of Professor C, dated 20 December 2018;
- Email from Royal College of Psychiatrists regarding covert medication, dated 4 September 2017;
- Employment tribunal statement of Patient A's brother, dated 5 April 2019;
- Dr Malik's ACP 360 feedback report;
- Various testimonial's and colleague feedback in respect of Dr Malik.

The Tribunal's Approach

17. At the outset of the hearing, Dr Malik admitted paragraphs 2a, 2b and 3 of the Allegation. In accordance with Rule 17(2)(e) the Chair announced that those facts were found proved. In reaching its decision on the facts remaining to be determined, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Malik does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e. whether it is more likely than not that the events occurred.

18. The Tribunal was mindful of the legal advice provided by Mr Moulder who stated the Tribunal must form its own judgement about the witness evidence heard before it, and the reliability of witnesses. It noted that it must decide whether to accept or reject such evidence, and where it is accepted, what weight to attach to it.

19. Where relevant to its decision-making process, the Tribunal had regard to the test for dishonesty set out in *Ivey v Genting Casinos (UK) Limited (t/a Crockfords Club) [2017] UKSC 67,* which states:

> *'When dishonesty is in question the fact-finding Tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.'*

20. The Tribunal noted the parties' agreement that Dr Malik was of 'good character', and had no previous regulatory history. It accepted advice that this may be relevant to the question as to whether she was likely to commit misconduct and also relevant to the credibility to be attached to her evidence given to the Tribunal. The Tribunal was referred to the case of *Wisson v Health Professions Council* [2013] EWHC 1036 Collins J:

> *"good character must always be likely to be relevant for the panel where there is a substantial issue of fact to be decided and where the credibility of the registrant in the evidence that he gives, is an issue and it can also go to whether it is likely that he did do what is alleged against him…even general good character evidence can be material where… there are issues of fact that have to be resolved in a hearing before the panel"*

21. The Tribunal bore in mind that while it can draw reasonable inferences from the evidence, it must not speculate. The Tribunal took account of the requirements to examine carefully and fully all the evidence and to give sufficient and clear reasons so that the parties are able to understand why it has reached its decision.

The Tribunal's Analysis of the Evidence and Findings

22. The Tribunal has considered paragraph 4 of the Allegation and has evaluated the oral and documentary evidence in order to make its findings on the facts.

Dr B

23. Dr B told the Tribunal that, in his opinion, the method of administering covert medication involves the patient not being aware that they are being given medication of any sort. He detailed that usually the medication would be given in a concealed manner such as hidden in food or liquid. He stated that this method is used in those who lack capacity and where it is in the patient's best interests to administer medication this way. In his opinion, administering medication to a patient without identifying it was withholding information rather than covert administration. Under cross examination he conceded there is no clear guidance defining the meaning of 'covert'.

24. Dr B stated that if the method of covert medication was to be used then this treatment would need to be reviewed by another health professional at the CQC for a second opinion before commencing. He stated that in his opinion Dr Malik was working in the best interests of the patient and had overtly administered medication but offered a "therapeutic lie" as to its nature. He stated, however, that in his opinion it was inappropriate for Dr Malik to withhold information from Patient A regarding the ZD as he had specifically expressed previous issues with that medication. Dr B stated that as a result the overall standard of care provided by Dr Malik was seriously below the standard expected of a reasonably competent Consultant Psychiatrist because she had clearly breached Good Medical Practice (GMP).

Professor C

25. Professor C told the Tribunal that she understood that there is a duty of candour as set out by the CQC as well as principles set out in Good Medical Practice ('GMP') which doctors must adhere to. She stated that it is best to be honest with patients, however there are exceptions to this which applied to Patient A's case. She stated that Patient A was very unwell and suffering from a severe psychotic illness and it is not unusual to give euphemistic reasons whilst administering medication to an acutely ill patient to assist their recovery. Professor C stated that she would have taken the same action as Dr Malik in that situation that arose with regard to Patient A.

26. Professor C stated that she believed that Dr Malik's actions were 'a last resort' option and she was focused on the outcome rather than the means. Professor C stated it was her opinion that Dr Malik was trying to do the best for Patient A so he could return to the community. She stated that Dr Malik's behaviour did not fall below the standard expected of a reasonably competent Consultant Psychiatrist, given the particular circumstances of Patient

A's case along with the multidisciplinary nature of the decision made regarding Patient A's care. Professor C concluded that she stood by her written statement and opined that Dr Malik's care was of a reasonable standard. In giving oral evidence, Professor C stated that she had lately learned that Dr Malik had expressly discussed with both the Hospital Manager and the interim Head of Care, that Dr Malik would tell Patient A the two untruths, also that the Head of Care had been present with Patient A and Dr Malik when she had done so. In Professor C's opinion, this gave further support to her view of the care provided by Dr Malik having been of a reasonable standard.

Dr Malik

27. Dr Malik confirmed that the method of administrating covert medication was an 'absolute last resort' and confirmed that everyone involved in care had to be on board to safeguard the rights of the patient. She stated that the Mental Health Act made provision for covert medication to be used when it was in the best interests of patients who lacked capacity.

28. Dr Malik told the Tribunal that Patient A had been known to mental health services for a long time and suffered from a chronic relapsing illness. She stated that Patient A had the potential to be back in the community with the right medication and it was her job to try to make this possible. Dr Malik stated that her actions reflected what she believed was in Patient A's best interests.

29. Upon questioning from the Tribunal, Dr Malik stated that Patient A had a risk of becoming aggressive and ending up in the Psychiatric Intensive Care Unit ('PICU'). She stated that the short-term plan was to carry on with the covert medication and await the managers meeting and stated that it 'would have been tragic had he [Patient A] not been given the chance to live his life in the community and been able to reach his potential long term'.

Paragraph 4 of the Allegation

30. Following the successful application in respect of paragraph 1a and 1b, and the admission of paragraphs 2a, 2b and 3, the only remaining factual issue for the Tribunal's determination was paragraph 4 of the Allegation.

31. The Tribunal first noted the background circumstances, which were not in dispute between the parties. It considered that it was relevant that Patient A had lacked capacity and

was being detained pursuant to s3 of the Mental Health Act 1983. It was lawful for Dr Malik to prescribe ZD to Patient A. The decision to administer ZD on a covert basis had been agreed with the clinical MDT. It was not disputed that the arrangement for the covert administration had been a short-term measure, after which the plan was to make full disclosure of the facts to Patient A. Patient A's family had been consulted. Dr Malik had correctly applied for SOAD approval of the change of mode, and the Tribunal had found that the SOAD had approved the full care plan. The inadvertent revealing of the true nature of the depot by the nurse to Patient A had put the doctor in an unforeseen situation, but she had discussed all steps with the MDT.

32. The Tribunal first determined what had been Dr Malik's actual state of knowledge or belief as to the facts. The Tribunal took account of the fact that Dr Malik is of previous good character and accepted her oral evidence. The Tribunal accepted Dr Malik's evidence that covert administration had been an unusual step, but was intended as short-term, with the long-term goal of trying to return Patient A to the community. The Tribunal accepted that Dr Malik believed what she was doing was in Patient A's best interests as he lacked capacity to make decisions regarding his own care. It also noted that the decision to administer ZD covertly involved other healthcare professionals. It was mindful that Dr Malik stated in her oral evidence, in relation to the decision to make the false statements to Patient A:

> *'If the patient had had capacity and I had told him that, I would have been dishonest. If the patient did not have capacity but MDT not been on board with it, I would have been dishonest. If I had told this to the patient and not made a transparent entry in the notes, I would have been dishonest. None of these things happened, I didn't do any of those things, and on this basis I'm saying [it was] not an act of dishonesty as far as I'm concerned.'*

33. The Tribunal considered that Dr Malik was working in the best interests of Patient A. This was not in dispute between the parties. The decision to withhold the information regarding which drug was administered was not Dr Malik's alone, but a view shared by other colleagues and Patient A's family and was part of an agreed plan to enable his health to improve.

34. The Tribunal determined that Dr Malik had clearly been aware of telling Patient A two untruths when she made the false statements. However, it concluded, she had considered that this was justified as being in the best interests of Patient A. The Tribunal accepted that

Dr Malik genuinely believed that she had fulfilled her duty of being open and honest by her discussions with the MDT and Patient A's brother.

35. The Tribunal accepted the submissions made by Ms Murphy that Dr Malik was open and honest in her actions with the rest of her team but she knew she was telling Patient A a 'therapeutic lie'.

> *'Patient A lacked capacity to consent to treatment and lacked insight into his illness. Whilst this does not obviate the need to be open with him, sometimes, as both Dr Malik and Professor C explained, this is not possible whilst also acting in his best interests. The Registrant whilst not truthful to Patient A, was honest, open and transparent with <u>everybody</u> else involved in his care who all shared a duty of care. The ordinary decent person would, it is submitted, place substantial weight on this when deciding whether the Registrant had a dishonest state of mind in what she said to Patient A on 20th July.'*

36. The Tribunal was of the view that Dr Malik was acting in the best interests of Patient A and her motivation was solely to improve the health of Patient A so he could return to the community and avoid being admitted to the PICU. The Tribunal were agreed that at the time, Dr Malik genuinely believed that the only option she had to gain the best outcome for Patient A was for covert administration of ZD.

37. The Tribunal next considered how Dr Malik's state of knowledge or belief as to the facts would be regarded according to the standards of ordinary, decent people. It noted it should judge the situation on the basis that such persons would be fully aware of all the facts of the case.

38. In submissions from Ms Duong she stated that:

> *'The Tribunal heard from two expert consultant psychiatrists with considerable experience of treating patients with psychotic illnesses. It is submitted that neither of those experts were able to point to a scenario where a patient was told an overt lie about medication they were receiving'.*

39. The Tribunal determined that, although this was correct, the particular circumstances of this case were unusual and perhaps unique. The guidance gave clear indications as to the duties of a doctor when a patient was not given the full information about their treatment. In

its view, whether there was a distinction between withholding information or positively misleading very much depended on the full circumstances of any case.

40. In this case, it did not accept that any distinction between the two materially affected how ordinary, decent people would regard Dr Malik's conduct. In either case, Patient A had been given ZD without his knowing about that fact.

41. Dr B based his opinion on the broad general statement of the duties of a doctor, as set out in GMP. Professor C acknowledged these principles but stated in her report:

> *'I do not consider that any aspect of the patient's care was seriously below the standard expected of a reasonably competent psychiatrist. Dr B has relied upon generic GMC guidance. It is not logical to argue from the general to the particular, and anyone who has practised "at the coalface" with patients like this will be well aware that such guidance may at times regrettably represent a counsel of perfection more than a feasible scenario.'*

42. The Tribunal preferred the evidence of Professor C to that of Dr B. In the Tribunal's view, Professor C demonstrated that she had a greater experience with patients suffering from acute psychotic illnesses. Professor C told the Tribunal that other members of the MDT were in agreement not to discuss with Patient A that he would be receiving ZD and on the 20 July 2017 Dr Malik was following the agreed plan. SOAD had also approved the plan. Professor C said that she was reinforced in her view, upon hearing that the decision to tell Patient A the untruths had been discussed with the MDT beforehand. The Tribunal was mindful that both Dr B and Professor C stated that Dr Malik was working in the best interests of Patient A.

43. The Tribunal accepted Ms Murphy's submission that:

> *'The choice of treatment or care for patient who lack capacity must be of overall benefit to them, and decisions should be made in consultation with those who are close to them or advocating for them.'*

44. The Tribunal balanced this against the principles set out in GMP and concluded that a there is a responsibility on doctors to be honest with patients. However, in these particular circumstances, this was difficult given Patient A's state of health at the time.

45. Dr B was of the opinion that telling an untruth had the potential to damage the therapeutic relationship between a patient and his clinician. Professor C was of the view that when dealing with a patient lacking capacity it was often impossible to have a therapeutic relationship. In particular, a psychotic patient who has no insight into his illness is unlikely to have a meaningful therapeutic relationship from the outset, and it is unlikely that this would be damaged significantly. She did acknowledge that being untruthful would be unlikely to benefit the relationship. She concurred with Dr Malik's opinion that the therapeutic relationship transferred to those safeguarding the patient's interests.

46. The Tribunal accepted Dr Malik's evidence that she believed the duty of honesty towards a patient lacking capacity is transferred to those safeguarding his interests, in this case the family and the MDT. This view was supported by Professor C.

47. The Tribunal noted the submission from Ms Murphy that:

> *"However, because at all stages there was honesty and transparency between Dr Malik and everyone else involved in the care, her conduct towards Patient A was not dishonest at any point".*

48. The Tribunal determined, in light of the facts that:

- it was agreed that Dr Malik believed that she had at all times been acting in the best interests of Patient A;
- ZD had been the appropriate medication for Patient A;
- the SOAD had approved the care plan, including covert administration;
- at all times there had been honesty and transparency between Dr Malik and everyone involved in Patient A's care;
- the need for the untruths had arisen unexpectedly; and
- the deception had always been a short-term plan, agreed by the MDT

ordinary, decent people, fully apprised of the facts would not regard Dr Malik's state of mind as dishonest.

49. The Tribunal found that Dr Malik's actions at paragraph 4 above were not dishonest, for the reasons given above. The Tribunal has therefore found Paragraph 4 not proved.

The Tribunal's Overall Determination on the Facts

50. The Tribunal has determined the facts as follows:

~~1. On one or more of the dates set out in Schedule One, you inappropriately instructed nursing staff to administer Zuclopenthixol Decanoate to Patient A, in that you:~~

a. ~~failed to inform Patient A before the administration of Zuclopenthixol Decanoate that his Risperidone injection had been changed to Zuclopenthixol Decanoate;~~ Removed following a successful application under Rule 17(2)(g)

b. ~~formulated a treatment plan requiring nursing staff to withhold from Patient A that his Risperidone injection had been changed to Zuclopenthixol Decanoate.~~ Removed following a successful application under Rule 17(2)(g)

2. On ~~21~~ 20 July 2017 you falsely told Patient A that: Amended under Rule 17(6)

a. he had received Risperidone on 19 July 2017; Admitted and found proved

b. the reason the needle was different was because the Risperidone injection had been manufactured by a different company, or words to that effect. Admitted and found proved

3. You knew the statements you made as referred to in paragraph 2 were untrue. Admitted and found proved

4. Your actions as described at paragraph 2 were dishonest by reason of paragraph 3. Found not proved

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct. To be determined

Determination on Impairment - 15/07/2021

1. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts which it has found proved as set out before, Dr Malik's fitness to practise is impaired by reason of misconduct.

The Outcome of Applications Made during the Impairment Stage

2. The Tribunal granted Ms Murphy's application under Rule 17(2)(k) of the Rules, to consider the matter of impairment in two stages. The Tribunal's full decision on the application is included at Annex B.

The Evidence

3. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. In addition, the Tribunal received further submissions from both parties.

Submissions

4. On behalf of the GMC, Ms Duong submitted that it is a matter for the Tribunal whether the facts found proved amount to misconduct and the GMC is neutral on this matter. She stated that the Tribunal must determine if the facts admitted by Dr Malik amount to serious professional misconduct. She referred the Tribunal to the expert evidence which it heard at the Facts stage and requested that the Tribunal bear this in mind when making its decision.

5. On behalf of Dr Malik, Ms Murphy submitted that the threshold for misconduct is a high one. She stated that for the Tribunal to find that Dr Malik's fitness to practise is impaired by reason of misconduct, it must be satisfied not just that Dr Malik's conduct has fallen slightly below the standards of conduct expected of medical practitioners, but that it has fallen seriously below, such that her conduct would be regarded as deplorable by other medical practitioners.

6. Ms Murphy submitted that other than the evidence of Dr B, the GMC has adduced no evidence in support of the contention that charges 2 and 3 amount to misconduct or indeed a finding of impairment based on misconduct. The GMC's case as supported by

Dr B has always been that the conduct described in charges 2 and 3 was dishonest and for that reason amounted to misconduct. Now that the Tribunal has rejected the GMC's contention that the conduct was dishonest, there is no separate and freestanding route by which the Tribunal can conclude that charges 2 and 3 get over the high threshold for misconduct.

7. Ms Murphy stated that given the Tribunal's findings of fact, and its acceptance of Professor C's opinion, the only rational conclusion which the Tribunal can reach is that charges 2 and 3 do not amount to misconduct.

The Relevant Legal Principles

8. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof and the decision of impairment is a matter for the Tribunal's judgement alone.

9. In approaching the decision, the Tribunal was mindful of the two stage process to be adopted: first whether the facts as found proved amounted to misconduct, and then whether the finding of that misconduct which was serious could lead to a finding of impairment.

10. The Tribunal must determine whether Dr Malik's fitness to practise is impaired today, taking into account Dr Malik's conduct at the time of the events and any relevant factors since then such as whether the matters are remediable, have been remedied and any likelihood of repetition. However, the Tribunal first considered whether the facts found proved constituted sufficiently serious misconduct that they could lead to a finding of impairment.

11. The Tribunal has considered the legal advice given to it including reference to *Roylance v General Medical Council [1999] Lloyd's Rep Med 139 at 149,* that:

> *'… professional misconduct is 'a falling short by omission or commission of the standards of conduct expected among medical practitioners, and such falling short must be serious'. The adjective 'serious' must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners.'*

The Tribunal's Determination on Impairment

Misconduct

12. In determining whether Dr Malik's fitness to practise is currently impaired by reason of misconduct, the Tribunal first considered whether the facts found proved amounted to misconduct. Misconduct can be found in circumstances where there have been departures from expected standards of conduct and behaviour, which can be determined by reference to GMP.

13. The Tribunal reminded itself of the conclusions made within the facts determination and noted that it preferred the evidence of Professor C to that of Dr B. It was mindful that Professor C was of the opinion that no aspect of Patient A's care fell below, let alone seriously below, the standard expected of a reasonably competent Psychiatrist.

14. The Tribunal was mindful that making false statements to a patient does go against the principles of GMP. However, it accepted the evidence from Professor C that, in extreme cases such as this one, there may be justification for telling a 'therapeutic lie'. The Tribunal reminded itself of the publications submitted at the fact finding stage which outline when a 'therapeutic lie' might be justified, namely in cases such as this where the patient lacks capacity due to acute paranoid schizophrenia.

15. There was a plan in place for covert drug administration which had been agreed by members of the MDT, Patient A's family and SOAD. The Tribunal was mindful that this plan was agreed as the best course of action and intended to be short term, in order to allow Patient A's health to improve and that Dr Malik intended to inform Patient A about the change in medication when he was well enough.

16. The Tribunal considered if Dr Malik's actions in relation to what she told Patient A on the 20 July 2017 amounted to misconduct. It considered that in the particular circumstances of this case and bearing in mind the Tribunal's previous finding that Dr Malik was not dishonest at this time, her actions did not amount to serious misconduct.

17. In light of this conclusion the Tribunal determined that Dr Malik's fitness to practise is not impaired by reason of her misconduct, pursuant to Section 35C(2)(a) of The Medical Act 1983 as amended.

Determination on Warning - 15/07/2021

1. As the Tribunal determined that Dr Malik's fitness to practise was not impaired it considered whether in accordance with s35D(3) of the 1983 Act, a warning was required. The Tribunal invited submissions from the parties on this point.

Submissions

2. On behalf of the GMC, Ms Duong submitted that the GMC maintains a neutral position in the matter of imposing a warning and it is for the Tribunal to determine whether or not one is required. She referred the Tribunal to the Sanctions Guidance and stated that a warning may be appropriate if there has been a departure from GMP. She also referred to various paragraphs of the GMC's 'Guidance on warnings' document (March 2021) ('the warnings guidance') and asked that the Tribunal bear these in mind when making its decision.

3. On behalf of Dr Malik, Ms Murphy stated that this is a single, isolated incident and Dr Malik has not been under any interim order whilst the GMC has been investigating. Ms Murphy submitted that a warning would only be imposed to address a serious response to any concerns raised. She stated that based on the Tribunal's previous findings, a warning is not warranted in this case. Ms Murphy drew the Tribunal's attention to the warnings guidance and stated that a warning should be used as a deterrent where there is a significant departure from GMP, which is not the case in these circumstances. She also outlined various positive testimonials and certificates, which reflected Dr Malik's recent practice, and requested that the Tribunal bear these in mind when making its decision.

The Tribunal's Determination on Warning

4. In reaching its decision as to whether a warning would be appropriate, the Tribunal took account of the specific circumstances of this case and had regard to the submissions provided by both parties. It had regard to the relevant guidance, including the warnings guidance.

5. The Tribunal noted that the decision whether or not to issue a warning is a matter for it alone to determine, exercising its own professional judgement. It took account of the

overarching objective of the public interest and applied the principle of proportionality - weighing the interests of the public with those of Dr Malik.

6. The Tribunal was mindful of all the information before it including the warnings guidance and the submissions made by both parties. The Tribunal had regard to the advice given by the Legal Assessor including the reference to the following paragraphs of the warnings guidance:

> *11 'Warnings allow the GMC and MPTS tribunals to indicate to a doctor that any given conduct, practice or behaviour represents a departure from the standards expected of members of the profession and should not be repeated. They are a formal response from the GMC and MPTS tribunals in the interests of maintaining good professional standards and public confidence in doctors. The recording of warnings allows the GMC to identify any repetition of the particular conduct, practice or behaviour and to take appropriate action in that event. Breach of a warning may be taken into account by a tribunal in relation to a future case against a doctor, or may itself comprise misconduct serious enough to lead to a finding of impaired fitness to practise.*
>
> *13 'Although warnings do not restrict a doctor's practice, they should nonetheless be viewed as a serious response, appropriate for those concerns that fall just below the threshold for a finding of impaired fitness to practise.*
>
> *16 'A warning will be appropriate if there is evidence to suggest that the practitioner's behaviour or performance has fallen below the standard expected to a degree warranting a formal response by the GMC or by a MPTS tribunal. A warning will therefore be appropriate in the following circumstances:*
>
> *- there has been a significant departure from Good Medical Practice, […]'*

7. The Tribunal noted that Dr Malik has had no previous history of impaired fitness to practice and no interim order has been imposed whilst the GMC was investigating. It was mindful of its previous determinations and while it considered that Dr Malik's actions might indicate a departure from GMP, as already stated in paragraph 14 of the previous determination there are times when such a departure could be justified. It relied on the

exceptional circumstances which prevailed at the time of the index event. The Tribunal accepted Professor C's opinion that no aspect of Patient A's case fell below, let alone seriously below, the standard expected of a reasonably competent Psychiatrist. The Tribunal took these factors into account when determining whether there had been a significant departure from GMP sufficient to justify the imposition of a warning and concluded that there had not been.

8. The Tribunal has therefore determined not to impose a warning on Dr Malik's registration.

9. There is no interim order to revoke.

10. That concludes this case.

Confirmed

Date 15 July 2021 Mrs Joy Hamilton, Chair

ANNEX A – 01/07/2021

Application pursuant to Rule 17(2)(g)

1. During the Facts stage of the hearing, after the close of the GMC's case, Ms Murphy made an application of no case to answer under Rule 17(2)(g) in relation to paragraphs 1(a) and (b) of the Allegation of the General Medical Council's (Fitness to Practise) Rules 2004, as amended, (the Rules) which states:

> i. *(g) the practitioner may make submissions as to whether sufficient evidence has been adduced to find some or all of the facts proved and whether the hearing should proceed no further as a result, and the Medical Practitioners Tribunal shall consider any such submissions and announce its decision as to whether they should be upheld;'*

2. The Legal Assessor, Mr Paul Moulder, directed the parties and the Tribunal to the test that should be applied on a submission of sufficiency of evidence and whether there is no case to answer as set out in Regina v Galbraith [1981] 1 W.L.R. 1039 ('Galbraith'), which states:

> b. *'(1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The judge will of course stop the case.*
>
> c. *(2) The difficulty arises where there is some evidence but it is of a tenuous character, for example because of inherent weakness or vagueness or because it is inconsistent with other evidence.*
>
> *(a) Where the judge comes to the conclusion that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict upon it, it is his duty, upon a submission being made, to stop the case.*
>
> *(b) Where however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witness's reliability, or other matters which are generally speaking within the province of the jury and where on one*

possible view of the facts there is evidence upon which a jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury.

3. The Legal Assessor advised the Tribunal that the application focussed on the word "inappropriately" in charge 1. This was an ordinary word of the English language, which might mean "not appropriately" and synonyms for "appropriate" might be "suitable" or "proper". He advised the Tribunal it should consider whether based on the evidence presented to it by the GMC the Tribunal was satisfied whether the Allegation could be made out (rather than whether it was made out).

Submissions of Ms Murphy on behalf of Dr Malik

Paragraph 1 of the Allegation

4. Ms Murphy submitted that at this stage the Tribunal is considering only whether it can establish facts which can be found proved. She referred the Tribunal to the judgment in Galbraith and stated that the case should be stopped at half time if either of the following conditions is met:

- There is no evidence to support the allegation; or

- There is some evidence but it is of a tenuous character, for example because of inherent weakness or vagueness or because it is inconsistent with other evidence, and where that evidence, taken at its highest, is such that the Tribunal could not properly conclude that a relevant fact is made out.

5. Ms Murphy stated that Dr Malik does not challenge the accuracy of the factual assertions about what she did at paragraph 1(a) and 1(b) of the Allegation, but she does not accept that what she did was inappropriate. She stated that the GMC will have to prove on the balance of probabilities that what Dr Malik did was 'inappropriate'. However, it is unclear what 'inappropriate' means in this context or by what standard is it being judged. Ms Murphy stated that the GMC is not alleging under Allegation 1 that Dr Malik acted dishonestly. The only description used in paragraph 1 is 'inappropriately'.

6. Ms Murphy stated that the GMC has called no witnesses of fact to establish its allegation of inappropriateness and relies instead only on the documentary evidence. She further stated that the GMC has not produced any guidance on covert medication, from NICE, the CQC, the Royal College of Psychiatrists, or any other professional body which is recognised as setting standards of care in psychiatry, which addresses the standard of care when covertly administering and what would be 'inappropriate' conduct in this context. At the close of the GMC's case therefore, there is no clear evidence of what 'inappropriate' means.

7. Ms Murphy took the Tribunal through the evidence given by Dr B and stated that in none of his first three reports did Dr B use the word 'inappropriate' to describe Dr Malik's actions in relation to Allegation 1. She further stated that Dr B's reasons for thinking that the Dr Malik's actions were 'inappropriate' are vague, have changed more than once (including in his oral evidence to the Tribunal), and have either relied on out-of-date guidelines or have not relied on any guidelines. Ms Murphy told the Tribunal that in Dr B's third report he stated that administering and withholding information on 12th July was not below the expected standard. Ms Murphy submitted that the GMC's case taken at its highest is not capable of proving that Dr Malik's conduct as set out in Allegation 1 was 'inappropriate' and this allegation should not be allowed to proceed further. She submitted that the Tribunal is therefore invited to dismiss Allegation 1 under rule 17(2)(g) of the Fitness to Practice Rules.

Submissions of Ms Duong, on behalf of the GMC

Paragraph 1 of the Allegation

8. Ms Duong submitted that the application is resisted in relation to Paragraph 1 of the Allegation. Ms Duong stated that paragraph 1 of the Allegation is sufficiently particularised and the word 'inappropriate' as set out in the Allegations, is not unique or unusual. She stated that the Allegation says that Dr Malik had 'inappropriately instructed nursing staff' and that she had 'formulated a treatment plan requiring nursing staff to withhold from Patient A that his Risperidone injection had been changed'. Ms Duong stated that this is plainly withholding information from Patient A and this was an inappropriate treatment plan.

9. Ms Duong stated that this Tribunal can readily conclude that there is evidence that Dr Malik's conduct was inappropriate. She reminded the Tribunal of the evidence of Dr B and stated that in his oral and written evidence he develops the reasons why Dr Malik's conduct was inappropriate. She reminded the Tribunal that Dr B stated that Dr Malik's actions were

inappropriate given Patient A's comments with regards to his medication (eg his wish for Zuclopenthixol Decanoate ('ZD') not to be administered). This went against the principles set out in Good Medical Practice. Ms Duong submitted that Dr B gave a balanced and unbiased opinion in relation to his experience of psychiatry and it is up to the Tribunal how they interpret his evidence. She stated that the GMC relied on Dr B's evidence to demonstrate that Dr Malik's conduct was inappropriate. She drew the Tribunal's attention to particular paragraphs of Dr B's report:

> *"In this expert's view the issue of Dr Malik not informing Patient A his medication had been changed and telling a lie is not in keeping with Good Medical Practice as doctors should 'establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law.' Furthermore Good Medical Practice states: 'You must listen to patients, take account of their views, and respond honestly to their questions.*
>
> *A reasonably competent consultant psychiatrist would have prescribed Zuclopenthixol decanoate depot medication to Patient A (given it was authorised within the SOAD certificate), advised Patient A of this decision whilst accepting Patient A's protestations."*

10. Ms Duong stated that it is a matter for the Tribunal to determine whether there is any ambiguity in relation to Dr B's evidence, however Dr B has maintained the view that it was inappropriate for Dr Malik not to inform Patient A of the change of medication and to deliberately withhold information from Patient A.

11. Ms Duong stated that the factual background to the allegations have been admitted by the doctor. In relation to the lack of any documentary evidence, Ms Duong stated that the GMC is entitled to rely on the opinion of an expert as to whether a doctor's conduct was appropriate or inappropriate. She stated that the conduct of Dr Malik, as set out in paragraph 1 of the Allegation, was inappropriate and this has been confirmed by Dr B.

Tribunal's Decision

Paragraph 1 of the Allegation

12. The Tribunal considered the evidence it had before it in relation to paragraph 1 of the Allegation and whether or not there was sufficient evidence to find that Dr Malik's conduct

was inappropriate at that time. The Tribunal was mindful that the GMC relied principally upon the expert evidence Dr B both in his oral and written evidence. The Tribunal was mindful that the allegation related to "On one or more dates" being 12 July 2017 and 19 July 2017.

13. As to the first of those dates, 12 July 2017, Dr B's evidence before the Tribunal had been that he did not criticise the administration on this date, which had been performed in response to an emergency. The Tribunal therefore concluded that it had no evidence that Dr Malik's instructions to nurses had been inappropriate on this date. In relation to the administration on 19 July 2017, the Tribunal noted that by then Dr Malik had obtained the opinion of the Second Opinion Appointed Doctor ('SOAD').

14. The Tribunal had regard to the information contained within the documents and considered the SOAD report form which shows that Patient A's treatment plan was a team decision and was agreed by relevant members of the Multi-Disciplinary Team. The Tribunal was of the opinion that there was ample opportunity for any issues with Patient A's treatment plan to be raised and that Dr Malik followed standard procedure with regard to drug administration.

15. The Tribunal accepted the submission that Dr B's view of inappropriateness was based on the broader principles of Good Medical Practice. Dr B had referenced guidance from which he had later resiled, but otherwise did not provide in support of his views other guidance or references for what was a relatively rare set of circumstances. Dr B's view was his considered expert opinion, but the Tribunal took into account that he had not had personal experience of the need for 'covert' administration or the application procedure for SOAD at the time of his earlier 3 reports. In oral evidence, he stated that his criticism concerning Dr Malik's actions in relation to the administration on 19 July 2017 related to the prior decision on 23 June 2017 to engage in the administration of ZD without disclosing to Patient A. The Tribunal noted that by 19 July 2017, Dr Malik had obtained the apparent agreement of the Team and had also the approval of the SOAD. The Tribunal noted the proposed plan set out in the SOAD application and the acceptance of the plan by the SOAD. It did not accept Dr B's view that the failure by the SOAD to expressly state 'covert' administration meant that the SOAD had not agreed to the treatment plan as documented, or that it had been unreasonable not to go back to the SOAD.

16. Having considered the evidence, particularly with regard to approval of the treatment plan by the MDT and SOAD, and submissions, the Tribunal concluded that, taking the GMC's

evidence at its highest, the Tribunal properly directed could not find that Dr Malik's actions in respect of the treatment Patient A was 'inappropriate' as specifically worded in paragraph 1 of the Allegation. Accordingly, the Tribunal determined to grant Ms Murphy's application under Rule 17(2)(g) in relation to paragraphs 1 (a) and (b) of the Allegation.

ANNEX B – 15/07/2021

1. Before hearing submissions on Impairment, Ms Murphy, on behalf of Dr Malik made an application under Rule 17(2)(k) of the Rules, which states:

> *"the Medical Practitioners Tribunal shall receive further evidence and hear any further submissions from the parties as to whether, on the basis of any facts found proved, the practitioner's fitness to practice is impaired."*

Ms Murphy's submissions on behalf of Dr Malik

2. Ms Murphy stated that Under the Medical Act 1983, a doctor's fitness to practise shall be regarded as impaired by reason only of one of the six reasons set out in section 35D(2). In this case the only reason relied upon by the GMC is misconduct (s.35D(2)(a)).

3. She stated that the Tribunal has not yet made any findings as to whether the factual allegations admitted in charges 2 and 3 amount to misconduct. Based on advice given by the Legal Adviser on day 2 of the hearing (in the context of the Registrant's half-time submission) that the question of whether charges 2 and 3 amount to misconduct is determined at stage 2. She stated that the GMC submitted that at stage 2 the Tribunal will consider the question of whether the conduct amounts to misconduct and whether fitness to practise is impaired and the Legal Adviser agreed with this analysis. Therefore, the first part of the impairment stage is to consider if the admitted charges (charges 2 and 3) amount to misconduct. If they do not, then there can be no finding of impairment.

4. Ms Murphy submitted that in this case it is appropriate for the Tribunal to decide the issue of misconduct first before considering the wider issue of impairment. Ms Murphy stated that the facts found proved in charges 2 and 3 are, when properly viewed against the wider background of the treatment of Patient A, incapable of giving rise to a finding of impairment based on misconduct.

Submissions on behalf of the GMC

5. Ms Duong submitted that it is for the Tribunal and the GMC remains neutral on this matter. She conceded that, if procedurally proper, it might be a practical advantage to proceed in this way. Ms Duong stated that she had been involved in a case previously where impairment submissions had been heard in two separate stages. That case went to appeal, for other reasons, and there had been no criticism from the Judge of this approach.

Tribunal Decision

6. The Tribunal accepted the advice of the Legal Assessor who referred the Tribunal to Rule 17(2)(k), pointing out that there was nothing within the Rule to say that the two stages of the Tribunal's consideration of impairment have to be considered together. She said that although impairment was not usually dealt with in two separate stages, the Tribunal could accede to the application if it felt it would be fair and just to both parties to do so. The Tribunal considered the submissions made in relation to proceeding in this way. The Tribunal noted the GMC's position in relation to this and noted that there is nothing in the Rules to preclude the Tribunal from doing this and in the particular circumstances of this case concluded that it would be neither be unjust nor unfair injustice to either party to proceed in this way.