Record of Determinations –
Medical Practitioners Tribunal

PUBLIC RECORD

Dates: 17/07/2018 – 20/07/2018; 14/09/2018

Medical Practitioner's name: Dr Chandranath SARKAR

GMC reference number: 5197151

Primary medical qualification: MB BS 1988 Calcutta

Type of case
New - Misconduct

Outcome on impairment
Impaired

Summary of outcome
Suspension, 4 months.

Tribunal:

Legally Qualified Chair	Mr Nicholas Flanagan
Lay Tribunal Member:	Dr Bernard Herdan
Medical Tribunal Member:	Dr Mojisola Gesinde

Tribunal Clerk:	Louise Henderson

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Andrew Hurst, Counsel, instructed by the Medical Defence Union
GMC Representative:	Mr Robin Kitching, 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 private.

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 and Impairment - 20/07/2018

Background

1. Dr Sarkar qualified in 1988 with an MB BS from the University of Kolkata in India. He came to the UK in 2001 and worked in a variety of fields before completing a Fixed-Term Training Appointment in renal medicine between 2005 and 2007. In 2007 Dr Sarkar returned to India, where he worked as a Consultant Physician and Nephrologist, returning to the UK with his family in 2015. At the time of the events relating to this hearing, Dr Sarkar was practising as a Locum Consultant in General Internal Medicine at the Royal Glamorgan Hospital.

2. The Allegation stems from an initial telephone call on 5 April 2017 in which Dr Sarkar requested Patient A's General Practitioner (GP) to provide him with a supply of Risperidone for him to administer to XXX, Patient A. Dr Sarkar told the GP that he had administered Risperidone to Patient A on a number of occasions without her knowledge or consent, by dissolving the tablets in her tea. He explained that he had purchased a supply in India, following informal advice from a psychiatrist, who had not seen Patient A. This supply had now run out. The GP reported this incident to the relevant safeguarding bodies, which led to Dr Sarkar's actions being investigated by the GMC.

The Allegation and the Doctor's Response

3. The Allegation made against Dr Sarkar is as follows:

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

> 1. Between December 2015 and 5 April 2017, on one or more occasion, you inappropriately administered Risperidone to a family member, Patient A. **Admitted and found proved**
>
> 2. Your administration of Risperidone described at paragraph 1 was inappropriate in that:
>
> a. Patient A was a family member; **Admitted and found proved**

b. Patient A was not under the care of a psychiatrist;
Admitted and found proved

c. it was not clinically indicated; **Admitted and found proved**

d. it was made without Patient A's knowledge;
Admitted and found proved

e. it was made without Patient A's consent;
Admitted and found proved

f. you were acting outside your area of clinical competence in administering a psychiatric medication; **Admitted and found proved**

g. you failed to make any clinical record of the administration.
Admitted and found proved

3. Between December 2015 and 4 April 2017 you failed to inform Patient A's general practitioner that you were administering Risperidone to Patient A.
Admitted and found proved

The Admitted Facts

4. At the outset of these proceedings, through his counsel, Mr Andrew Hurst, Dr Sarkar made admissions to the full 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.

Impairment

5. With no facts remaining in dispute, the Tribunal 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, Dr Sarkar's fitness to practise is impaired by reason of misconduct.

The Relevant Legal Principles

6. 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.

7. 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 that the misconduct was serious, and then whether the finding of that misconduct which was serious could lead to a finding of impairment.

8. The Tribunal must determine whether Dr Sarkar's fitness to practise is impaired today, taking into account Dr Sarkar'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.

The Outcome of Applications Made during the Impairment Stage

9. The GMC initially presented its case on the basis that Dr Sarkar's motivation was one of control and abuse of Patient A. Mr Hurst submitted that any such allegation would have to have been particularised in the list of allegations for Dr Sarkar to be able to defend himself appropriately. Mr Hurst submitted that, in the absence of such a particularised allegation, Dr Sarkar's motive should form no part of the evidence adduced by the GMC or presented by it in its submissions.

10. The Tribunal carefully considered the submissions and authorities submitted by both parties. The Tribunal's full determination on the issue is included at Annex A. In conclusion, the Tribunal therefore considered the matter solely on the basis of the allegations as set out by the GMC and the evidence provided to it at the impairment stage.

Evidence

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

- Witness statement of Dr B;
- Expert Report of Dr C;
- Witness Statement of Dr Chandranath Sarkar, who also gave evidence in person;
- Extract of Medical Record of Patient A;
- Audio recordings and transcripts of two telephone conversations between Dr Sarkar and Dr B at New Park Surgery, 5 April 2017;
- Testimonial from Dr D, who also gave evidence via telephone link;
- Certificates, testimonials and other documentation.

Submissions

12. Mr Kitching, on behalf of the GMC, submitted that Dr Sarkar's fitness to practice is impaired by reason of his misconduct. He stated that following the Tribunal's determination on Dr Sarkar's motive for his actions, it would be inappropriate to reach the conclusion of coercion or control; however, he submitted that this did not mean that the Tribunal should fully accept Dr Sarkar's account.

13. Mr Kitching submitted that Dr Sarkar had breached numerous standards set out in the GMC's *Good Medical Practice* (2013) and *Consent: patients and doctors making decisions together* (2008), and directed the Tribunal to have regard to various paragraphs within these documents.

14. Mr Kitching submitted that the Tribunal should reject Dr Sarkar's account of Patient A's mental health and threats to harm herself as an explanation for his actions; that each time he administered Risperidone to Patient A without her knowledge or consent was not necessarily in direct response to a separate mental health crisis. Mr Kitching submitted that Dr Sarkar was exaggerating the extent of Patient A's mental health problems in order to justify these actions, and that this exaggeration of her symptoms makes Dr Sarkar's treatment of her even more reckless and dangerous.

15. Mr Kitching submitted that the evidence for this exaggeration lay in the lack of evidence in Patient A's medical records of any threats to harm herself. He stated that Dr Sarkar had attended numerous GP appointments with Patient A and had failed to mention his concerns to any treating medical professional. Dr Sarkar's only mention of this was in his phone call to Dr B on 5 April 2017, in which he requested a supply of Risperidone.

16. Mr Kitching suggested that the Tribunal should be wary of the notion that Dr Sarkar's actions were in part related to the cultural differences in approaches to mental health and medical matters between the UK and India. He submitted that, whilst some cultural differences might exist, Dr Sarkar had worked in the UK in the period of 2001 – 2007, and would therefore be well versed with the standards expected of him as a medical practitioner in the UK.

17. He further stated that the seriousness of Dr Sarkar's conduct significantly outweighed any attempts to remediate, and that public interest and confidence in the profession would not be met if Dr Sarkar was not found to be impaired.

18. Mr Hurst, on behalf of Dr Sarkar, submitted that Dr Sarkar was of good character and had no other findings against him in the UK or India, and whilst he conceded that Dr Sarkar's actions were clear evidence of misconduct, that this was an isolated incident in an otherwise unblemished career, and for this reason Dr Sarkar is not impaired.

19. Mr Hurst submitted that Dr Sarkar's administration of Risperidone to Patient A, without clinical indication, her knowledge or consent, were misguided actions made in good faith. He submitted that these actions were that of XXX who believed Patient A would refuse necessary antidepressant medication, and that his administration of Risperidone was an attempt to prevent her from trying to harm herself.

20. Mr Hurst submitted that Dr Sarkar had adopted a more lax practice in his acquisition of Risperidone in India, which would have been normal due to a cultural

stigma in relation to mental health. The combination of this stigma and Dr Sarkar's concerns that Patient A may harm herself led him to seek informal advice from a professional psychiatrist in India, who recommended the Risperidone that he subsequently acquired and administered to Patient A in the UK, without her knowledge and consent.

21. Mr Hurst submitted that Dr Sarkar's accounts of Patient A threatening to harm herself were sincere and accurate, and evidence of these incidents extends beyond Dr Sarkar's witness statement, and can be seen in the transcript of Dr Sarkar's first telephone call with Patient A's GP on 5 April 2017:

> '*…sometimes in the past it all started when she was (inaudible) knife and say that, "I will kill myself," and all the things.'*

22. Mr Hurst submitted that Dr Sarkar's integrity is clear and intact, as is evidenced in the phone call from Patient A's GP 5 April 2017, who explained that she was duty-bound to inform Patient A about the administration of Risperidone without her knowledge. In this call he did not object or attempt to obstruct this from happening.

23. Mr Hurst submitted that Dr Sarkar has shown considerable insight through both his admission to the allegation in full from the outset of this hearing and through his written and oral witness evidence. He submitted that Dr Sarkar has demonstrated significant remediation by way of completing courses and gaining certificates in upholding GMC and GMP standards, including '*Patient Consent*' and '*Prescribing and Administration of Medicines*'. He submitted that his actions were of misconduct but are not at risk of repetition, and that public confidence in the medical profession would not be undermined if Dr Sarkar was not found impaired.

The Tribunal's Determination on Impairment

Misconduct

24. Whilst the Tribunal has borne in mind the submissions made, the decision as to whether Dr Sarkar's fitness to practise is currently impaired is a matter for this Tribunal exercising its own judgement. In so doing, the Tribunal recognises that its primary responsibility is to ensure the health, safety and wellbeing of the public, the promotion and maintenance of public confidence in the profession, and the promotion and maintenance of proper standards of conduct and behaviour.

25. With regard to Dr Sarkar's conduct, the Tribunal identified that many of the paragraphs in *Good Medical Practice* (2013) were relevant, noting that it would interpret them on the basis that Patient A was effectively a patient of Dr Sarkar, even if this was not formally the case. The Tribunal paid particular attention to the following paragraphs:

'12 *You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work.*

14 *You must recognise and work within the limits of your competence.*

15 *You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:*

a *adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient;*

b *promptly provide or arrange suitable advice, investigations or treatment where necessary;*

c *refer a patient to another practitioner when this serves the patient's needs.*

16 *In providing clinical care you must:*

g *wherever possible, avoid providing medical care to yourself or anyone with whom you have a close personal relationship*

31 *You must listen to patients, take account of their views, and respond honestly to their questions.*

32 *You must give patients the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs.'*

26. The Tribunal also identified a number of paragraphs in *Consent: patients and doctors making decisions together* (2008) as relevant but especially had regard to:

1 *All healthcare involves decisions made by patients and those providing their care. This guidance sets out principles for good practice in making decisions. The principles apply to all decisions about care: from the treatment of minor and self-limiting conditions, to major interventions with significant risks or side effects. The principles also apply to decisions about screening.*

2 *Whatever the context in which medical decisions are made, you must work in partnership with your patients to ensure good care. In so doing, you must:*

a *listen to patients and respect their views about their health;*

b *discuss with patients what their diagnosis, prognosis, treatment and care involve;*

c *share with patients the information they want or need in order to make decisions;*

d *maximise patients' opportunities, and their ability, to make decisions for themselves;*

e *respect patients' decisions.*

3 *For a relationship between doctor and patient to be effective, it should be a partnership based on openness, trust and good communication. Each person has a role to play in making decisions about treatment or care.*

7 *The exchange of information between doctor and patient is central to good decision-making. How much information you share with patients will vary, depending on their individual circumstances. You should tailor your approach to discussions with patients according to:*

a *their needs, wishes and priorities;*

b *their level of knowledge about, and understanding of, their condition, prognosis and the treatment options;*

c *the nature of their condition;*

d *the complexity of the treatment, and;*

e *the nature and level of risk associated with the investigation or treatment.*

13 *No one else can make a decision on behalf of an adult who has capacity. If a patient asks you to make decisions on their behalf or wants to leave decisions to a relative, partner, friend, carer or another person close to them, you should explain that it is still important that they understand the options open to them, and what the treatment will involve. If they do not want this information, you should try to find out why.*

43 You must respect a patient's decision to refuse an investigation or treatment, even if you think their decision is wrong or irrational. You should explain your concerns clearly to the patient and outline the possible consequences of their decision. You must not, however, put pressure on a

patient to accept your advice. If you are unsure about the patient's capacity to make a decision, you must follow the guidance in Part 3.

64 *You must work on the presumption that every adult patient has the capacity to make decisions about their care, and to decide whether to agree to, or refuse, an examination, investigation or treatment. You must only regard a patient as lacking capacity once it is clear that, having been given all appropriate help and support, they cannot understand, retain, use or weigh up the information needed to make that decision, or communicate their wishes.*

27. The Tribunal concluded that Dr Sarkar was clearly in breach of all of these standards to a greater or lesser extent.

28. The Tribunal had regard to the expert evidence in relation to Risperidone from Dr C. Risperidone is evidently a powerful anti-psychotic medication. Dr Sarkar did not have the expertise to diagnose a mental health condition, let alone administer it covertly to Patient A. Dr Sarkar had failed to inform her treating physician of his actions for a significant period of time.

29. Dr Sarkar accepted that the medication was not clinically indicated. The Tribunal considered that his actions were reckless and could have had serious consequences. The Tribunal noted that Patient A did not have the monitoring required to detect and, if necessary, control the potentially dangerous side effects.

30. The Tribunal therefore concluded that Dr Sarkar's conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to serious misconduct.

Impairment by Reason of Misconduct

31. The Tribunal, having found that the facts found proved amounted to serious misconduct, went on to consider whether, as a result of that serious misconduct, Dr Sarkar's fitness to practise is currently impaired.

32. The Tribunal heard evidence from Dr Sarkar regarding events, the insight he had into his actions and the steps taken to remediate his conduct. The Tribunal noted a number of inconsistencies in Dr Sarkar's evidence. The Tribunal took account of the fact that English was not Dr Sarkar's first language, and – given the passage of time since the events in question – made allowance for minor discrepancies in his account of events. However, there were several troubling inconsistencies, including:

- the quantity of Risperidone that Dr Sarkar had acquired – the evidence provided to the Tribunal appeared inconsistent with the information given to Dr B in the telephone transcripts;
- how frequently Patient A had been discovered with a knife threatening to harm herself.

33. Furthermore, the Tribunal found Dr Sarkar to have been somewhat evasive and less than candid in answering questions, where he tended to minimise the seriousness of his actions. In the Tribunal's view, this demonstrated a need to develop further insight into his behaviour.

34. In further relation to insight, the Tribunal bore in mind the cultural differences between India and the UK in relation to perceptions, judgments and stigma in relation to mental health. However, the Tribunal noted that Dr Sarkar had worked as a medical practitioner in the UK between 2001-2007, prior to the events laid out in the Allegation, and determined that Dr Sarkar must have been aware of the standards of the UK's medical regulatory body. Dr Sarkar in fact stated that he had read the latest edition of the Good Medical Practice before he returned to the UK in November 2015. As a result, the Tribunal determined that Dr Sarkar must have known that his actions were in breach of these standards at the time he undertook them.

35. The Tribunal considered the fact that Dr Sarkar has admitted the Allegation, but balanced this with his failure to inform Patient A's GP of his actions, who he attended appointments with, even when her depression was being treated and she was prescribed medication for this.

36. Dr Sarkar has undertaken a number of steps to remediate the matter, having shown some insight into his actions and acknowledged his failures. The Tribunal had regard to the number of positive endorsements regarding Dr Sarkar, in particular from his mentor, Dr D, with whom he had discussed his misconduct in some detail. The Tribunal accept that Dr Sarkar has demonstrated good clinical skills and is otherwise a well-respected doctor.

37. The Tribunal welcomed Dr Sarkar and his family's efforts since the incident to continue to integrate into their local community. The Tribunal also took account of his good character and otherwise unblemished medical career in the UK and India.

38. In reaching its conclusion on impairment, the Tribunal has considered all three limbs of the over-arching objective.

39. With regard to protecting and promoting the health, safety and wellbeing of the public, the Tribunal considered that Dr Sarkar had put Patient A - a member of the public - at risk. However, it considered that the chances of repetition of this behaviour were low, and recognised that he is otherwise a good doctor.

40. With reference to the need to promote and maintain public confidence in the medical profession, the Tribunal concluded that a member of the public would find Dr Sarkar's actions reprehensible and public confidence would be undermined if a finding of impairment was not made in this case.

41. With regard to the importance of promoting and maintaining proper professional standards and conduct, having considered all of the facts of the case, it would be entirely inappropriate not to make a finding of impairment in this case.

42. In all the circumstances, the Tribunal considered that a finding of impairment was necessary to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of the profession.

43. The Tribunal therefore determined that Dr Sarkar's fitness to practice is impaired by reason of misconduct.

Determination on Sanction - 14/09/2018

1. Having determined that Dr Sarkar's fitness to practise is impaired by reason of misconduct, the Tribunal now has to decide in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose.

The Evidence

2. The Tribunal has taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction. The Tribunal also had regard of an additional bundle submitted by Mr Hurst, on behalf of Dr Sarkar, which included, but was not limited to:

- Dr Sarkar's Reflections on Prescribing and Consent;
- Confirmation of Booking of attendance on 'Maintaining Professional Ethics Course';
- XXX

Submissions on behalf of the GMC

3. Mr Kitching, on behalf of the GMC, submitted that the appropriate sanction in this case is erasure.

4. In summary, Mr Kitching stated that Dr Sarkar's actions were a significant departure from *Good Medical Practice* and that erasure is necessary to promote and maintain public confidence in the medical profession, and to promote and maintain

proper professional standards and conduct for the members of the profession. He submitted that only erasure in this case would meet the statutory overarching objective.

5. Mr Kitching reminded the Tribunal that the period of inappropriate administration of Risperidone spanned 15 months and could therefore not be classified as an isolated incident. His misconduct therefore related to several instances of covertly administering Risperidone to Patient A over a prolonged period of time.

6. Furthermore, Mr Kitching stated that it was important to recall the Expert Report of Dr C, which emphasised that Risperidone was a powerful antipsychotic drug and that Dr Sarkar did not have the expertise to diagnose a mental health condition, let alone administer such a drug covertly to Patient A. Dr C stated that, due to this covert administration, Patient A did not have the monitoring required to detect and, if necessary, control the potentially dangerous side effects. Mr Kitching reminded the Tribunal that they had considered Dr Sarkar's actions to be reckless and that they could have had very serious consequences.

7. Mr Kitching did not accept Dr Sarkar's evidence in which he stated that his actions were in part related to the cultural differences in approaches to mental health and medical matters between the UK and India. Mr Kitching reminded the Tribunal that Dr Sarkar had worked in the UK in the period of 2001 – 2007, and would therefore be well versed with the standards expected of him as a medical practitioner in the UK, and that the idea that Dr Sarkar was unaware of these standards was implausible.

8. Mr Kitching referred the Tribunal to several paragraphs of the GMC's *Sanctions guidance* ('SG') (February 2018 version) and reminded the Tribunal of its determination on impairment. He highlighted areas which he said indicated why taking no action, or imposing a period of conditional registration or suspension, was not the appropriate sanction in this case, inviting the Tribunal to have particular regard of paragraph 108, which states:

> "***108*** *Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor."*

9. Mr Kitching acknowledged there were some mitigating factors in this case, and that Dr Sarkar had taken steps to remediate, and that he is otherwise a competent and well-respected doctor. However, when balanced with the aggravating features, Mr Kitching stated that the seriousness of Dr Sarkar's misconduct significantly outweighed any attempts to remediate. He stated that his actions are fundamentally incompatible with

continued registration on the medical register, and invited the Tribunal to impose an order of erasure.

Submissions on behalf of Dr Sarkar

10. Mr Hurst, on behalf of Dr Sarkar, submitted that having conditions placed upon his registration would be the appropriate sanction in this case of Dr Sarkar.

11. In summary, Mr Hurst stated that making a determination on sanction was not an algorithmic exercise, and that carefully considering the context was vital to the Tribunal making an appropriate determination. Mr Hurst submitted that Dr Sarkar's actions were made in good faith following the advice of a medical professional in India, and that such actions may have been appropriate in the Indian cultural context. Unfortunately, he had brought this behaviour with him to the UK, and was acting under a degree of naivety without realising the gravity of his behaviour until his initial conversation with Dr B.

12. Furthermore, Mr Hurst emphasised that during a conversation between Dr B and Dr Sarkar, she informed him that she would have to inform Patient A of his actions, and that Dr Sarkar did not object to this. He stated that Dr Sarkar ceased administering Risperidone to Patient A as soon as he became aware of his misconduct, and has faced up to his actions entirely.

13. Mr Hurst submitted that Dr Sarkar now fully understood the gravity of his actions and that he has demonstrated significant reflection, remediation and regret, supported by a number of positive endorsements from other professionals. In particular, he drew the Tribunal's attention to XXX and a letter from Mr E, Directorate Manager at the Cwm Taf University Health Board, which stated:

> *"I firmly believe that Dr Sarkar has not only undertaken all that was asked of him he has gone above and beyond the expected level of reflection and has learnt from his actions."*

14. Mr Hurst submitted that, taking into account the evidence submitted in the former stages of the hearing and the additional material submitted today, a fair-minded and informed member of the public may be troubled by the events that took place, but that they would not accept that erasure is the proportionate sanction in this case. Mr Hurst submitted that the public interest does not lie in ending Dr Sarkar's career, when there is overwhelming evidence to support that Dr Sarkar is continuing to work hard to demonstrate his insight and remediation and make assurances that his actions will never happen again.

15. Mr Hurst submitted that for the reasons set out above, Dr Sarkar's misconduct was not fundamentally incompatible with his continued registration on the medical register and therefore his complete removal from the medical register

would not be in the public interest. Mr Hurst submitted therefore that erasure would be a disproportionate response and would not be appropriate. He submitted that conditions were proportionate to the context of Dr Sarkar's case and would satisfy public confidence in the profession.

16. Mr Hurst submitted that, were the Tribunal not to accept conditions, a short period of suspension could be appropriate. However, he emphasised that anything beyond a matter of some weeks would potentially mean Dr Sarkar would lose his current position, and his visa conditions were such that he and his family might have to leave the UK.

The Tribunal's Approach

17. The Tribunal has had regard to its findings at the facts and impairment stages of the hearing, as well as the oral submissions of Mr Kitching, Counsel, on behalf of the GMC, and Mr Hurst, Counsel, on behalf of Dr Sarkar.

18. The determination of the appropriate sanction is a matter for the Tribunal's own judgment. Throughout its deliberations, the Tribunal has had regard to the principle of proportionality and has weighed the interests of the public with Dr Sarkar's interests. It has also borne in mind the statutory overarching objective as set out in *SG* 14:

> *"**14** The main reason for imposing sanctions is to protect the public. This is the statutory overarching objective, which includes to:*
>
> ***a** protect and promote the health, safety and wellbeing of the public*
>
> ***b** promote and maintain public confidence in the medical profession*
>
> ***c** promote and maintain proper professional standards and conduct for the members of the profession."*

19. The Tribunal recognised all limbs of the objectives to be important but finds sub-paragraphs (b) and (c) of paragraphs 14 of the *SG* to be particularly relevant to this case.

20. The Tribunal reminded itself that the purpose of a sanction is not to be punitive, although it may have a punitive effect. Throughout its deliberations, the Tribunal has applied the principle of proportionality, balancing the interest of Dr Sarkar with that of the public.

Mitigating and Aggravating Factors

21. The Tribunal gave careful consideration to the mitigating and aggravating factors present in Dr Sarkar's case.

Mitigating Factors

22. The Tribunal had regard to the following mitigating factors:

- Dr Sarkar made admissions to the Allegation in full at the opening of the hearing;
- Dr Sarkar has reflected on his actions and shown some evidence and insight into the seriousness of his misconduct;
- Dr Sarkar has taken a number of positive and proactive steps to remediate and is planning to continue his remediation XXX;
- Dr Sarkar has demonstrated clinical competency and is otherwise a well-respected doctor and has a number of positive endorsements from colleagues;
- The risk of repetition is very low.

Aggravating Factors

23. The Tribunal had regard to the following aggravating factors:

- Risperidone is a very powerful antipsychotic drug and administering it, especially covertly, to Patient A put her at significant risk;
- Dr Sarkar had worked in the UK prior to the events that led to this hearing, and therefore would not have been ignorant of the standards expected of him as a doctor in the UK;
- Dr Sarkar had shown some evidence and insight into the seriousness of his misconduct, but there were inconsistencies in his account, and his remediation was limited and required further development.

The Tribunal's Decision

24. In deciding what sanction, if any, to impose, the Tribunal reminded itself that it must consider each of the sanctions available, starting with the least restrictive, in order to establish the most appropriate and proportionate sanction in this case.

No Action

25. The Tribunal first considered whether it could take no action. It noted that when a doctor's fitness to practise is impaired, taking no action usually only arises when there are exceptional circumstances. The Tribunal has borne in mind the overarching objective, which includes to maintain public confidence in the profession and to uphold proper standards of conduct.

26. The Tribunal was of the view that there were no exceptional circumstances in this case which outweighed the elements of the overarching objective identified above. It therefore determined that it would not be adequate, appropriate or proportional to Dr Sarkar's actions found in the facts stage of the hearing, nor in the public interest, to take no action in this case.

Undertakings

27. No undertakings were presented before the Tribunal for it to consider.

Conditions

28. The Tribunal next considered whether it would be sufficient to impose conditions on Dr Sarkar's registration. The Tribunal has taken account of the *SG*, in particular paragraphs 81 and 85, which state:

> ***"81*** *Conditions might be most appropriate in cases:*
>
> ***(a)*** *involving the doctor's health*
>
> ***(b)*** *involving issues around the doctor's performance*
>
> ***(c)*** *where there is evidence of shortcomings in a specific area or areas of the doctor's practice*
>
> ***(d)*** *where a doctor lacks the necessary knowledge of English to practise medicine without direct supervision.*
>
> ***85*** *Conditions should be appropriate, proportionate, workable and measurable."*

29. The Tribunal considered that imposing conditions may be an appropriate course of action when there are concerns in relation to a doctor's clinical competency, health or knowledge of English. It was not possible to create a workable set of conditions which would be relevant to Dr Sarkar's misconduct in this case.

30. The Tribunal also concluded that conditions would not adequately mark the serious nature of Dr Sarkar's misconduct, nor the seriousness with which the Tribunal viewed it. It therefore determined that conditions would not be an appropriate, sufficient or proportionate response in this case and would not adequately address the public interest in this case.

Suspension

31. The Tribunal went on to consider whether a period of suspension would be an appropriate and proportionate sanction. The Tribunal took into account several paragraphs of the *SG*, in particular paragraphs 91 and 97(a), (e), (f) and (g), which state:

> ***"91*** *Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.*
>
> ***97(a)*** *A serious breach of Good Medical Practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors."*
>
> ***(e)*** *No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.*
>
> ***(f)*** *No evidence of repetition of similar behaviour since incident.*
>
> ***(g)*** *The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.*

32. The Tribunal acknowledged that there was no evidence that any harm had come to Patient A as a result of his covert administration of Risperidone, but was aware of the serious consequences his actions could have had and he had put Patient A at serious risk.

33. The Tribunal accepted that Dr Sarkar has no reported history of misconduct and that the actions that led to this hearing pertain to one set of circumstances, and that Dr Sarkar is otherwise a clinically competent and well-respected doctor. However, the Tribunal found that this did not detract from the seriousness of his misconduct.

34. The Tribunal accepted that Dr Sarkar had acknowledged the gravity of his actions in his reflective statements and that he had taken steps towards remediation, by enrolling on a professional ethics course and XXX. It also had sight of positive endorsements from a number of Dr Sarkar's colleagues. However, the

Tribunal were mindful that Dr Sarkar was in the early stages of his remediation and that his insight and understanding of the seriousness of his actions required further development.

35. The Tribunal carefully considered whether suspension would be a sufficient sanction to maintain public confidence in the profession and promote and maintain proper professional standards and conduct for members of the profession. The Tribunal determined that a fair minded and informed member of the public would be satisfied with a sanction of suspension.

36. In all the circumstances, the Tribunal determined that it would be both sufficient and proportionate to suspend Dr Sarkar's name from the Medical Register. In deciding on the length of the period of suspension, the Tribunal considered that in the particular circumstances of this case, and taking account of the mitigating and aggravating factors set out in paragraphs 21 and 22 above, a period of four months was sufficient to mark the seriousness of Dr Sarkar's misconduct. This should allow for further remediation to take place, whilst also maintaining public confidence in the medical profession.

37. The Tribunal was cognisant of the adverse consequences of which this period of suspension might have for the doctor, but reminded itself that the reputation of the profession and preservation of public trust in the profession, are more important than the consequences for an individual doctor.

Erasure

38. In making its determination on sanction, the Tribunal also went on to consider if erasure would be the appropriate and proportionate sanction in this case. The Tribunal had regard to the *SG*, in particular paragraphs 109a - 109d, which state:

> "***109*** *Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).*
>
> ***a*** *A particularly serious departure from the principles set out in Good medical practice where the behaviour is fundamentally incompatible with being a doctor.*
>
> ***b*** *A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety.*
>
> ***c*** *Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients (see further guidance below*

at paragraphs 129–132 regarding failure to provide an acceptable level of treatment or care).”

d *Abuse of position/trust (see Good medical practice, paragraph 65: ‘You must make sure that your conduct justifies your patients’ trust in you and the public’s trust in the profession’).”*

39. The Tribunal determined that Dr Sarkar failed to uphold the proper standards of behaviour expected of doctors by the public and showed a disregard of the high standards within the profession. Whilst the Tribunal found that his conduct breached fundamental tenets of *GMP*, it determined that it would not be in the public interest to deprive it of an otherwise competent doctor. It therefore concluded, in the context of this case that Dr Sarkar’s actions were not fundamentally incompatible with continued registration as a doctor.

The Tribunal’s Conclusion

40. The Tribunal therefore concluded that the appropriate sanction was one of a suspension for four months.

41. The Tribunal considered whether it would be appropriate to direct a review hearing in Dr Sarkar’s case. It has borne in mind that no doctor should be allowed to resume unrestricted practice following a period of suspension unless the Tribunal considers that he/she is safe to do so.

42. Having considered all the circumstances, the Tribunal determined that the duration of Dr Sarkar’s suspension, the remediation that he has already undertaken, and the fact that there are no concerns in relation to his clinical practice, means that a review hearing is not required in this case.

Determination on Immediate Order - 14/09/2018

1. Having determined that Dr Sarkar should be suspended from the Medical Register for a period of four months, the Tribunal has now considered, in accordance with Section 38 of the Medical Act 1983 as amended, whether to impose an immediate order to suspend his registration.

2. The Tribunal has borne in mind the test to be applied with regards to imposing an immediate order; it may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor.

Tribunal's decision

3. The Tribunal has taken account of the relevant paragraphs of the *SG* in relation to when it is appropriate to impose an immediate order. Paragraph 172 of the *SG* states:

> *"The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor…"*

4. The Tribunal was mindful that there was no Interim Order to revoke and that Dr Sarkar had been working unrestricted for a period of 18 months prior to this hearing. The Tribunal also noted that neither Counsel submitted that an immediate order of suspension was necessary in this case.

5. In all the circumstances, the Tribunal determined that it was not in the public interest to suspend Dr Sarkar's registration with immediate effect, and the Tribunal did not consider it necessary to make an immediate order.

6. This means that Dr Sarkar's registration will be suspended from the Medical Register 28 days from when notice of this decision is deemed to have been served upon him, unless he lodges an appeal. If Dr Sarkar does lodge an appeal, he will remain free to practise unrestricted until the outcome of any appeal is known.

7. That concludes the case.

Confirmed
Date 14 September 2018 Mr Nicholas Flanagan, Chair

ANNEX A – 19/07/2018

Application to Amend Allegation

1. At the opening of the hearing, Dr Sarkar, through his Counsel, Mr Hurst, admitted all of the facts of the allegation.

2. Mr Hurst has now made an application that the GMC should be required to amend the allegation to ascribe a motive for Dr Sarkar's actions. In the alternative, he submitted that Dr Sarkar's motive should form no part of the evidence adduced by the GMC or presented by it in its submissions.

3. Mr Hurst submitted that whilst Dr Sarkar had admitted to administering Risperidone to Patient A without either clinical indication or her knowledge or consent, these were misguided actions that were made in good faith. He submitted that these actions were that of XXX who believed Patient A would refuse necessary antidepressant medication, and that his administration of Risperidone was an attempt to prevent her from trying to harm herself.

4. The GMC submitted that Dr Sarkar's motivation was one of control and abuse of Patient A.

5. Mr Hurst submitted that the GMC's case against Dr Sarkar extended beyond the allegation, and that it sought to demonstrate Dr Sarkar's actions were coercive and controlling. This amounts to being a serious criminal offence, in accordance with Section 76 of the Serious Crime Act 2015.

6. Mr Hurst submitted that motivation in cases regarding a criminal offence are required to be stated within the allegation, for example, in cases of sexual misconduct.

7. Mr Hurst submitted that if the Tribunal are going to be invited to make determinations regarding Dr Sarkar's fitness to practice based on his motivation, then this should be included in the particulars of the allegation; this would both give the doctor the opportunity to defend himself against this accordingly, and would safeguard the doctor by all allegations being subject to the burden and standard of proof.

8. Mr Kitching, Counsel, on behalf of the GMC, submitted that Dr Sarkar's motivation for administering Risperidone to Patient A should not form part of the factual allegation against Dr Sarkar. He also submitted that it is not the usual practice to include motivation in relation to coercion or control within an allegation.

9. Mr Kitching further submitted that there is an obvious inference to Dr Sarkar's motivation to coerce and control Patient A simply by virtue of the doctor's admission that his administration of Risperidone was neither clinically indicated nor with Patient A's knowledge or consent, and therefore the GMC's reference to motivation was clear at the outset of the allegation. He submitted that therefore the defence had sufficient time to prepare its case.

The Tribunal's Decision

10. The Tribunal reminded itself that where any factual matters are concerned, the GMC had the burden of proving any matters at issue, there being no obligation on the clinician to prove his innocence.

11. The Tribunal considered the authorities presented by Mr Hurst:

- *The Queen (on the Application of Riad Roomi) v General Medical Council*
- *Chatenya Chauhan v General Medical Council*
- *Julia Ann Duthie v The Nursing and Midwifery Council*

12. In paragraph 18 of the decision of Collins J. in the case of *Roomi*, it was noted that the panel members questioned the clinician regarding concerns they had outside of the allegation before it. The allegations solely related to deficiencies in performance, whilst the members' concerns revolved around compliance with appraisals. The court stated:

> *'18 It is also to be noted that questions were asked of Mr Roomi by members of the Panel which appeared to be relevant only to the question of audit and appraisal. No doubt if members of a Panel feel concern based on the material before them on issues which are not contained in the notice of hearing, they are entitled to raise them. But they ought to have been advised that they could not properly rely on them unless they did form part of the allegation made against the practitioner and so they could not properly be taken into account against him unless there was the necessary amendment to the notice.'*

13. In the case of *Chauhan*, the Tribunal noted the analysis of King J, in particular paragraph 6:

> *'I accept the Appellant's analysis that the rules thus require the Respondent to give notice of any particular allegation being pursued against the practitioner and to particularise the facts upon which it is based and it is those facts, where disputed, which the Panel is required to determine in accordance with Rule 17(2). In so far as the Panel, at stage one of its decision process, makes material findings of fact adverse to the practitioner which could themselves have been the subject of a charge of professional misconduct, which however are not within the charges as formulated and*

> *particularised in the Notice of Hearing, then those findings in my judgment cannot properly or fairly be used by the Panel to support its findings under the Notice and in so far as the Panel has so used them, then the Notice findings are liable to be held vitiated and set aside. I agree with Silber J. in Cohen v. GMC [2008] EWHC 581 (Admin) 581, paragraph 48 that findings in relation to any particular charge at stage one "must be focussed solely on the heads of the charges themselves". The observations of Pill LJ in Strouthos v. London underground Ltd [2004] EWCA Civ 402 at paragraph 12 that a "it is a basic proposition, whether in criminal or disciplinary proceedings, that the charge against the defendant or the employee facing dismissal should be precisely framed and that the evidence should be confined to the particulars in the charge" must be equally apposite to hearings before the FTP of the Respondent. An associated principle relied upon by the Appellant is that rehearsed by the Privy Council in Salha v GMC [2003] UKPC 80 at paragraph 14, namely that "it is a fundamental principle of fairness that a charge of dishonesty should be unambiguously formulated and adequately particularised." I should record at once however that the Respondent disputes any breach in this case of any of these principles.'*

14. For completeness, the Tribunal also had regard to the decision of *Duffy* in paragraph 182, though perhaps less useful to the case at hand. It states that where a registrant is accused of manufacturing notes after the event, that this should be encapsulated in allegations and afforded the same procedural protections.

15. These cases make it abundantly plain that it is inappropriate for a Tribunal to consider factual issues that are not particularised in the allegation to be determined, under Rule 17(2) of the Fitness to Practice Rules (2004).

16. The parties agree that where dishonesty or a sexual motivation is alleged, this should be contained within the factual allegations. There are sensible reasons for doing so. There does not appear to be any binding authority in a wholly similar situation as to the case at hand. The three cases cited above do not imply that motivation must be included as a separate allegation in a case such as this.

17. Ordinarily, a registrant's motivations for committing acts of misconduct would not be the subject of a separate allegation, save for the exceptions noted above.

18. The GMC have sought to present this case on the basis that Dr Sarkar's actions in undertaking the conduct in the allegations was in an effort to control or coerce Patient A. This is on a comparable basis to Section 76 of the Serious Crime Act 2015, which created a new criminal offence of controlling or coercive behaviour in an intimate or family relationship.

19. It is important to note that a clinician is entitled to be informed promptly and in detail of the nature of the allegation against him. Moreover, wherever there is any

doubt as to the legal or evidential issues before a Tribunal, these should be resolved in the favour of the registrant.

20. The GMC could have laid a separate allegation of the clinician's exerting coercive or controlling behaviour against Patient A. They did not do so. There are safeguards afforded to a clinician in Stage 1, namely consideration of the allegation by a Case Examiner, the ability to test presenting evidence, the burden and standard of proof, and to ensure there is sufficient evidence to proceed. Similarly, there are practical considerations to consider, such as whether a clinician can provide any evidence in rebuttal, and even whether it is appropriate to provide evidence to a Tribunal.

21. In this case the clinician was informed of the three separate allegations in compliance with The Rules. In particular, allegation 2(c) states that the administration of Risperidone was not clinically indicated; (d) that it was undertaken without her knowledge; (e) without her consent. It was almost inevitable that the purpose or reason behind Dr Sarkar's conduct would be a significant feature of any enquiry into his conduct. The question is whether any specific inference or conclusion should be separately alleged.

22. The clinician admitted all of the allegations at the start of the hearing, and the Tribunal subsequently found them proved. This Tribunal does not find the allegation vague or containing any paucity in detail. Dr Sarkar knows what the allegation is, and he has had time to proffer an explanation for his conduct.

23. It is therefore for the Tribunal to consider at Stage 2 of the process, when considering impairment, to have regard to all of the circumstances of the case as presented.

24. The issue distils into whether the potential conclusions that could be reached by a Tribunal should be separately pleaded in the allegations. These are arguably subjective questions of judgment; that a registrant may find difficult to admit or contest at the factual determination stage. There are also potential evidential difficulties in conclusions being pleaded by regulators, such as the GMC.

25. The Tribunal has carefully considered the submission and authorities brought to its attention. In the Tribunal's judgment, where there is no clear binding authority, the over-arching fairness to the clinician should prevail.

26. It follows therefore that where the GMC invites the Tribunal to specifically consider whether Dr Sarkar's actions were motivated, at least in part, in order to control or coerce Patient A, then, as this has not been the subject of the procedural safeguards afforded at Stage 1, it should not be reasonably considered when considering Dr Sarkar's impairment.

27. The Tribunal intend to continue to consider the issue of impairment in the usual way, having heard from Dr Sarkar in detail. The Tribunal will only have regard to the admitted allegations and the evidence that has been provided to it.