PUBLIC RECORD

Dates: 26/10/2026 - 29/10/2026

Doctor:	Dr Dolin BHAGAWATI
GMC reference number:	6164159
Primary medical qualification:	MB BS 2007 University of London

Type of case	Outcome on facts	Outcome on impairment
New – Misconduct	Facts relevant to impairment found proved	Impaired

Summary of outcome

Erasure
Immediate order imposed

Tribunal:

Legally Qualified Chair	Mrs Aaminah Khan
Lay Tribunal Member:	Mr Paul Hepworth
Registrant Tribunal Member:	Dr Helen McCormack

Tribunal Clerk:	Alex Currie

Attendance and Representation:

Doctor:	Not present, not represented
Doctor's Representative:	Dr Bhagawati was not represented
GMC Representative:	Ms Fiona McNeill, 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.

Protecting the Public

Throughout the decision-making process the tribunal has borne in mind the statutory duty as set out in s1(1) of the Medical Act 1983 (the 1983 Act) to protect the public. The tribunal has considered the relevance and impact on each of the three distinct parts of public protection 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 - 27/10/2026

Background

1. At the time of the events, Dr Bhagawati was a senior clinical fellow in neurosurgery working for Imperial College Healthcare NHS Trust (the Trust). Dr Bhagawati worked in this position from October 2018 to January 2025.

2. The allegations that have led to Dr Bhagawati's hearing relate to his conduct. It is alleged by the General Medical Council (GMC) that on 10 April 2025 Dr C, Associate Medical Director for Professional Practise and Deputy Responsible Officer for the Trust, raised concerns with the GMC about Dr Bhagawati's probity following a local investigation. Dr C reported that on four occasions between June 2022 and November 2024, Dr Bhagawati prescribed medication for himself contrary to Trust policy and GMC guidance. In addition, on two occasions in 2024 it is alleged Dr Bhagawati inappropriately ordered blood tests for himself.

3. Dr Bhagawati is alleged to have attached the prescriptions and blood test requests to a previous appointment he had XXX, which took place in 2019, on a local database called Cerner, which gave the impression that another clinician prescribed the medications and ordered the blood tests. Further, it is alleged that Dr Bhagawati used a temporary, rather than his own, Cerner card, which would have identified him as the person requesting the

tests and medication. The GMC allege that Dr Bhagawati was not honest or transparent when he was questioned about those matters in a meeting with Dr C on 24 February 2025. Dr Bhagawati initially stated he had not ordered the tests and prescriptions himself and that these were ordered by another doctor colleague, on his behalf.

4. After a referral on 10 April 2025, the GMC opened an investigation into the concerns raised and asked Dr Bhagawati to complete and return a Work Details Form (WDF). The GMC issued reminders of the requirement to complete the form, however Dr Bhagawati did not return a completed WDF. The GMC raised an additional concern as a result of Dr Bhagawati not providing the completed WDF when required to do so.

The outcome of applications made during the facts stage

5. The Tribunal granted the GMC's application, made pursuant to Rule 31 of the GMC (Fitness to Practise Rules) 2004 as amended (the Rules), that service had been properly affected and to proceed with the hearing in Dr Bhagawati's absence. The Tribunal's full decision on the application is included at Annex A.

The Allegation and the doctor's response

6. The Allegation made against Dr Bhagawati is as follows:

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

1. Between June 2022 and November 2024, on one or more occasion, you inappropriately prescribed medication for yourself, as set out in Schedule 1 ('the medication'). To be determined

2. Between May and December 2024, on one or more occasion, you inappropriately ordered blood tests for yourself, as set out in Schedule 2 ('the blood tests'). To be determined

3. Between 2022 and 2024, on one or more occasion, you:
   a. used a temporary access card to access the record of a previous consultation ('Previous Consultation') that you attended with Dr A in 2019; To be determined

b. attached the requests for the medication and blood tests to the Previous Consultation. To be determined

4. You knew that your conduct in paragraph 3 would:
   a. give the impression that it was another clinician who had prescribed the medication and ordered the blood tests; To be determined
   b. conceal that you had prescribed the medication and ordered the blood tests. To be determined

5. Your actions as set out in paragraph 3 were dishonest by reason of paragraph 4. To be determined

6. In a meeting on 24 February 2025 ('the Meeting'), when asked about the medication and blood tests, you falsely stated that:
   a. you did not order them yourself; To be determined
   b. Dr B ordered the medication and blood tests on your behalf. To be determined

7. You knew that the information you provided in the Meeting was untrue. To be determined

8. Your actions as set out in paragraph 6 were dishonest by reason of paragraph 7. To be determined

Work Details Form ('WDF')

9. You failed to return to the GMC a completed WDF including details of your current employers, despite the GMC writing to you asking you to do so on each of the following dates:
   a. 27 May 2025, asking for the WDF to be returned by 4 June 2025; To be determined
   b. 30 June 2025, asking for the WDF to be returned by 6 July 2025; To be determined
   c. 12 August 2025, asking for the WDF to be returned by 19 August 2025. To be determined

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

The admitted facts

7. As Dr Bhagawati was not present nor represented, no admissions were made at the outset of these proceedings.

Witness evidence

8. The Tribunal received evidence on behalf of the GMC in the form of witness statements from the following witnesses who were not called to give oral evidence:

- Dr C, Associate Medical Director for Professional Practise and Deputy Responsible Officer for the Trust, dated 17 September 2025.
- Dr A, Consultant Respiratory Physician at the Trust, dated 21 August 2025.
- Dr B, ST4 in Neurosurgery at King's College Hospital, London, dated 22 March 2026.
- Mr D, Investigation Officer at the GMC, dated 17 June 2026.

9. No witness statement was provided by Dr Bhagawati.

Documentary evidence

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

- Imperial College Healthcare NHS Trust policy: Handling concerns about doctor and dentists' conduct, performance and health, 28 April 2025;
- Fact-Finding Review, April 2025;
- GMC referral form with enclosures, 10 April 2025;
- Email chain between Dr C and Dr E (Dr Bhagawati's line manager) at Imperial College Healthcare NHS Trust, 3 January 2025;
- Screenshots from Dr Bhagawati's patient record;
- Emails between Dr A, Dr Bhagawati and Dr E, 24 December 2024 – 3 January 2025;
- Emails between Dr A and Trust pharmacy team, 24 December 2024;
- Incomplete WDF, undated;

- Emails between the GMC and Dr Bhagwati concerning the completion of the WDF, various dates between 7 May – 20 August 2025.

The Tribunal's approach

11. In reaching its decision on the facts, the Tribunal will apply the civil standard of proof. This means that the Tribunal must decide whether, on the balance of probabilities, the GMC is able to prove it is more likely than not that the matters occurred as alleged. The burden of proof rests with the GMC and it is for the GMC to prove the case that it is presenting against the doctor. There is no burden on the doctor to prove or disprove anything.

12. As there are no agreed facts because Dr Bhagawati has not engaged in the investigation or hearing, the Tribunal will assess the evidence in the round. It will consider what conclusions and inferences can be drawn from the documentary evidence. The Tribunal has regard to the fact that Dr Bhagawati had no prior fitness to practise history, which is relevant to assessing his credibility and propensity (the likelihood he has acted as alleged). In relation to dishonesty, the Tribunal applies the test set out in Ivey v Genting Casinos (UK) Ltd [2017] UKSC 67 (SC).

The Tribunal's analysis of the evidence and findings

13. The Tribunal has considered each outstanding paragraph of the Allegation separately and has evaluated the evidence to make its findings on the facts.

Good character

14. The Tribunal acknowledged that Dr Bhagawati is of good character and took that into account throughout their facts determination. The Tribunal noted that Dr Bhagawati's good character is not a defence and whilst it could assist him, the Tribunal found that they could only give this limited weight in this case given the weight of the other evidence available and the differing inconsistent accounts he has given throughout the investigation, including accepting responsibility in his 3 March 2025 email.

Paragraphs 1 and 2

15. The Tribunal reminded itself that there were four separate dates where medications were prescribed and two further dates when blood tests were ordered.

16. The Tribunal noted that it had to consider whether factually Dr Bhagawati had self-prescribed and ordered the blood tests and also whether to do so had been inappropriate. The Tribunal had not been provided with a copy of the Trust Policy on self-prescribing, but it had regard to the GMC's 2021 Guidance Good practise in proposing, prescribing, providing and managing medicines and devices. This Guidance states that where possible doctors must avoid prescribing for themselves or those close to them and sets out steps that must be taken should a doctor self-prescribe, which include making a clear record and informing their General Practitioner.

17. The Tribunal referred to the email dated 3 March 2025 from Dr Bhagawati to Dr C and Ms F, head of Medical Professional Standards at the Trust, where Dr Bhagawati changed his previous account given in a meeting on 24 February 2025 and accepted responsibility for ordering the tests and prescriptions himself on a locum Cerner card:

> *"After reading the summary, I would like to not put [Dr B] in a difficult position. Given this, I would like to change my previous statements and accept responsibility for ordering the tests and the scripts for a locum cerner card. I appreciate the seriousness of this statement. If this conclusion of the investigation is for a referral to the GMC then I am happy to self refer."*

18. The Tribunal noted paragraph 5.17 in the Fact-Finding Report written by Dr C and Ms F relating to Dr B, a clinician who Dr Bhagawati had identified as the clinician who had ordered the prescriptions and blood tests on his behalf:

> *'5.17 We have contacted and spoken to [Dr B] who agrees that he knew Dr Bhagawati through his locum shifts and that he would have been using a temporary Cerner card at that time, but denies ever ordering or prescribing medications for Dr Bhagawati.'*

19. The Tribunal also had regard to the witness statement of Dr B, which confirmed that he had not ordered any tests or prescribed any medicine for Dr Bhagawati. The Tribunal referred to Dr Bhagawati's patient record in the evidence bundle that shows that Dr Bhagawati had received the prescriptions and had the blood tests undertaken, as well as the witness evidence of Dr A that sets out that he discovered that blood tests and prescriptions had been ordered in Dr A's name for Dr Bhagawati via a temporary Cerner smart card, which he did not do himself. The Tribunal considered that Dr A gives a clear rationale for why he

knew that he did not order the tests, for example, that they related to the investigation of matters outside of his area of practice.

20. In light of the above, particularly Dr Bhagawati's email of 3 March 2025, where he accepted that he had prescribed the medications and ordered the blood tests himself, the Tribunal found the underlying facts proved in both paragraphs 1 and 2. Further, the Tribunal was satisfied that the self-prescribing and ordering of blood tests was inappropriate as Dr Bhagawati had not followed the GMC guidance on self-prescribing, in particular by using a temporary card and attaching them to another clinician's name, which did not make a clear or accurate record of what had occurred.

21. The Tribunal therefore found that, on the balance of probabilities, both paragraphs 1 and 2 were proved.

Paragraph 3(a) and 3(b)

22. The Tribunal referred to the email dated 3 March from Dr Bhagawati where he admits to using a locum Cerner smart card when he self-prescribed and ordered the blood tests. The Tribunal noted that Dr A describes in his witness statement that he had on 27 December 2024 received an email from Dr G explaining that the blood tests and prescriptions had been ordered in Dr A's name using a temporary smartcard and that the orders were very unlikely to have come from Dr Bhagawati's GP. The process of having to attach prescriptions and blood tests to a previous consultation when using a temporary card was further explained in email correspondence exhibited by Dr A from his enquiries, the Datix response Dr A received and also in the Fact-Finding report of Dr C.

23. The Tribunal referred to Dr Bhagawati's patient records in the evidence bundle, which confirmed that the prescription and blood test requests had been attached to Dr A's account for a patient encounter that he had with Dr Bhagawati in 2019.

24. The Tribunal acknowledged that as Dr Bhagawati was neither present nor represented, they were receiving unchallenged evidence from the GMC on how the Cerner system works. However, Dr Bhagawati had accepted in his email dated 3 March 2025 that he had used a locum card to prescribe and order the tests himself. The Tribunal was satisfied that it followed that the underlying process to order tests included accessing the record of a past consultation with Dr A and attaching the requests to that consultation.

25. The Tribunal therefore determined that, on the balance of probabilities, paragraphs 3a and 3b had been proved.

Paragraph 4(a) and 4(b)

26. The Tribunal was of the view that Dr Bhagawati was an experienced doctor familiar with working at the Trust and would likely know how the Cerner system worked. The Tribunal noted that each clinician had their own Cerner smartcard and found that it is difficult to see why a doctor would use a temporary smartcard and attach requests to a previous consultation, in another consultant's name, unless they wanted to conceal their own responsibility and give the impression that another clinician had carried these out.

27. The Tribunal noted that Dr Bhagawati had initially tried to suggest that his GP had prescribed and requested the blood tests and in the subsequent meeting with Dr C on 24 February 2025 he stated that it was a colleague when being questioned further about his actions. The Tribunal reasoned that these were likely attempts by Dr Bhagawati to give the impression it was not him who had prescribed the medication or ordered the blood tests.

28. The Tribunal considered Dr Bhagawati's email to Dr C and Ms F dated 31 January 2025 in response to their concerns about probity. Dr Bhagawati in that email regarding the issue of his medical records wrote:

> *"Regarding the issue of my medical records – [XXX] blood tests done as evidenced by the attached files. I asked a colleague to request them at Imperial and got them done there [XXX]. The meds prescribed by a colleague are also regular prescriptions for me and appear to have been done via a locum cerner card. I assume the attachment to another clinican(sic) relates to my care from the [XXX] and presumably this was the last encounter for me on cerner."*

29. The Tribunal considered that, whilst Dr Bhagawati knew that he had used a locum Cerner card to order the tests and medications, within this email he was still attributing the orders to another clinician.

30. The Tribunal noted that Dr Bhagawati used the locum Cerner smartcard on six different dates, attaching the requests to other doctors. The Tribunal had regard to the fact that within the Fact-Finding Review carried out by Dr C and Ms F, it was acknowledged that temporary Cerner cards will occasionally be used by doctors if they have forgotten or

misplaced their own Cerner smartcards. However, the Tribunal considered that it was unlikely that this would explain a temporary smartcard being used on each of the six separate dates that medicines were prescribed or blood tests ordered by Dr Bhagawati for himself.

31. The Tribunal also reasoned that if Dr Bhagawati had forgotten his own smartcard, he would have explained this during the initial enquiries. Instead, Dr Bhagawati had provided different explanations that he would have known not to be true at the time.

32. The Tribunal considered Dr Bhagawati's first email response to Dr A's query about the prescriptions and blood tests in his name, dated 24 December 2024. Dr Bhagawati responded:

> *"Dear Dr A I can only apologise - these orders were presumably done under an encounter from when I was [XXX]. The bloods tests were requested via my GP and done at the hospital. I am moving to New Zealand this week so this should not be an issue again. Once again my apologies and hope you have a peaceful festive period."*

33. The Tribunal considered Dr Bhagawati's response in this email alongside his other responses and noted that Dr Bhagawati had provided three slightly different accounts explaining what had happened. The Tribunal found that this indicated Dr Bhagawati knew that his actions would give the impression that another clinician had ordered the blood tests and prescribed the medications, and that he knew his actions would conceal his behaviour. The Tribunal noted Dr Bhagawati's explanation within the Fact-Finding review at paragraph 5.1:

> *"Dr Bhagawati has accepted that he did prescribe these medications for himself. He has explained and we accept that these were [XXX], and that his motivation for self-prescribing was to enable him to pick up the medicines from the hospital pharmacy, as he would have had to make a trip to his local community pharmacy if the GP had issued the prescription. We accept that the registrar rota in Neurosurgery is demanding and that Dr Bhagawati was working long shifts involving anti-social hours during this time."*

34. The Tribunal noted that Dr Bhagawati had essentially told Dr C for the Fact-Finding Report that he had requested blood tests and prescribed medication in another clinician's name due to convenience. The Tribunal noted that this conflicts with other versions he had provided, for example when he named a colleague as having ordered them for him. The

Tribunal was satisfied on the evidence before it that Dr Bhagawati must have known that by using a temporary access card and attaching the prescriptions and blood tests to a previous consultation, he was concealing his own actions by using another colleague's name and account to order them.

35. For these reasons the Tribunal therefore found paragraph 4(a) and paragraph 4(b) proved.

Paragraph 5

36. The Tribunal applied the legal test for dishonesty set out in Ivey v Genting Casinos (UK) Ltd to ascertain if Dr Bhagawati's actions were dishonest. The Tribunal noted that they had found, by finding paragraph 4 proved, that subjectively Dr Bhagawati knew that his conduct would give the impression that it was another clinician who had prescribed him the medicine and ordered the blood tests and that his actions would conceal that he had in fact done so himself.

37. The Tribunal noted that Dr Bhagawati had given three different explanations on different occasions which indicated that he knew what he was doing was dishonest and therefore was attempting to hide his conduct.

38. The Tribunal found that when Dr Bhagawati was challenged on his account and was asked to explain his position, he did not expand further. The Tribunal was of the view that Dr Bhagawati has not provided a clear and consistent account from the initial query to the subsequent investigation. The Tribunal noted that Dr Bhagawati in his email response dated 3 March 2025, when he stated that he did prescribe and order the blood tests himself did acknowledge the seriousness of the matter and said he would self-refer to the GMC:

> *"I appreciate the seriousness of this statement. If this conclusion of the investigation is for a referral to the GMC then I am happy to self refer."*

39. The Tribunal found that Dr Bhagawati therefore did realise when making that admittance that he was admitting to something serious. The Tribunal considered the objective test in Ivey of whether Dr Bhagawati's conduct was honest or dishonest by applying the objective standards of ordinary decent people. In light of its findings as to Dr Bhagawati's knowledge, as set out above, the Tribunal was satisfied, that applying the objective standards of ordinary decent people, Dr Bhagawati had acted dishonestly.

40. For these reasons the Tribunal therefore determined that paragraph 5 had been proved.

Paragraph 6(a) and 6(b)

41. The Tribunal considered that it was clear on the evidence before it that Dr Bhagawati in the meeting on 24 February 2025 had at that time assigned responsibility to his colleague, Dr B, who he stated had ordered the prescriptions and blood tests on his behalf. This was shown in the notes of that meeting that were sent to Dr Bhagawati to confirm. The Tribunal then noted that in the 3 March 2025 email Dr Bhagawati's account had changed to admitting that it was in fact him who had ordered the medication and blood tests, only after it was made clear that further investigation into Dr B would follow. Therefore, this was an acceptance by Dr Bhagawati that his earlier statement regarding Dr B was false.

42. The Tribunal noted paragraphs 5.15 and 5.16 of the Fact-Finding Report:

> *'5.15 Dr Bhagawati did, in our initial meeting, offer a different explanation, which was that he had asked a friend and colleague within the department to order the tests and medications for him. He identified the colleague as a Dr B who worked occasional locum registrar shifts in the Neurosurgery department at that time. Dr B would have used a temporary Cerner card whilst completing these shifts.*
>
> *5.16 After the meeting Dr Bhagawati contacted us and stated: After reading the summary, I would like to not put [Dr B] in a difficult position. Given this, I would like to change my previous statements and accept responsibility for ordering the tests and the scripts for a locum cerner card. I appreciate the seriousness of this statement. If this conclusion of the investigation is for a referral to the GMC then I am happy to self refer.'*

43. The Tribunal therefore determined that on the balance of probabilities paragraph 6(a) and (b) had been proved.

Paragraph 7

44. The Tribunal considered that Dr Bhagawati had changed his account several times during the investigation of the concerns until he admitted what he had done in the email

dated 3 March 2025. The Tribunal found that as Dr Bhagawati had later accepted that he had carried out the actions himself, it was clear that on the 24 February 2025 when he named a colleague as being responsible that he knew this was untrue.

45. The Tribunal therefore found paragraph 7 proved.

Paragraph 8

46. The Tribunal again applied the legal test for dishonesty set out in Ivey v Genting Casinos (UK) Ltd to ascertain if Dr Bhagawati's actions were dishonest. The Tribunal noted that they had found, by finding paragraph 7 proved, that subjectively Dr Bhagawati knew that he had provided false information in the meeting on 24 February 2025 by naming a colleague when he knew he had undertaken the actions himself. The Tribunal was satisfied that by applying the objective standards of ordinary decent people, that for Dr Bhagawati to knowingly make a false statement in a fact-finding meeting would be considered to be dishonest conduct.

47. The Tribunal therefore found paragraph 8 proved.

Paragraph 9(a), (b) and (c)

48. The Tribunal referred to the witness statement (particularly paragraphs 4-10) of Mr D, the GMC Investigation Officer who had sent the WDF to Dr Bhagawati to fill out and return. The Tribunal also referred to the three emails sent by Mr D to Dr Bhagawati, on 27 May, 30 June and 12 August 2025, asking him to return the WDF. The Tribunal lastly referred to the last correspondence between Dr Bhagawati and Mr D where Dr Bhagawati had sent a document that was not the WDF on 19 August 2025. Mr D informed Dr Bhagawati that he had not sent a completed WDF and requested that it be re-sent, which he did not respond to.

49. The Tribunal also referred to paragraph 98 of Good Medical Practise (GMP):

> *'98. To maintain patient safety, you must cooperate with formal inquiries, patient safety investigations, and complaints procedures. You must provide all relevant information and be open and honest.'*

50. The Tribunal considered that based on the available evidence Dr Bhagawati had not returned a completed WDF to the GMC despite being asked on three occasions to do so. The

Tribunal noted that doctors are obliged whilst under investigation to co-operate with enquiries from the GMC regarding their current working arrangements and ought to return the WDF when requested. The Tribunal was therefore satisfied that Dr Bhagawati was required to return the WDF and failed to return a properly completed WDF, after given multiple chances to do so.

51. The Tribunal therefore found paragraph 9(a), (b) and (c) proved.

The Tribunal's overall determination on the facts

52. The Tribunal has determined the facts as follows:

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

1. Between June 2022 and November 2024, on one or more occasion, you inappropriately prescribed medication for yourself, as set out in Schedule 1 ('the medication'). **Determined and found proved**

2. Between May and December 2024, on one or more occasion, you inappropriately ordered blood tests for yourself, as set out in Schedule 2 ('the blood tests'). **Determined and found proved**

3. Between 2022 and 2024, on one or more occasion, you:
   a. used a temporary access card to access the record of a previous consultation ('Previous Consultation') that you attended with Dr A in 2019; **Determined and found proved**
   b. attached the requests for the medication and blood tests to the Previous Consultation. **Determined and found proved**

4. You knew that your conduct in paragraph 3 would:
   a. give the impression that it was another clinician who had prescribed the medication and ordered the blood tests; **Determined and found proved**
   b. conceal that you had prescribed the medication and ordered the blood tests. **Determined and found proved**

5. Your actions as set out in paragraph 3 were dishonest by reason of paragraph 4. **Determined and found proved**

6. In a meeting on 24 February 2025 ('the Meeting'), when asked about the medication and blood tests, you falsely stated that:
   a. you did not order them yourself; **Determined and found proved**
   b. Dr B ordered the medication and blood tests on your behalf. **Determined and found proved**

7. You knew that the information you provided in the Meeting was untrue. **Determined and found proved**

8. Your actions as set out in paragraph 6 were dishonest by reason of paragraph 7. **Determined and found proved**

Work Details Form ('WDF')

9. You failed to return to the GMC a completed WDF including details of your current employers, despite the GMC writing to you asking you to do so on each of the following dates:
   a. 27 May 2025, asking for the WDF to be returned by 4 June 2025; **Determined and found proved**
   b. 30 June 2025, asking for the WDF to be returned by 6 July 2025; **Determined and found proved**
   c. 12 August 2025, asking for the WDF to be returned by 19 August 2025. **Determined and found 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 - 28/10/2026

The evidence

53. The Tribunal has reviewed its findings of fact. No further evidence was provided to the Tribunal at this stage.

Submissions

GMC

54. On behalf of the GMC Ms McNeill, Counsel, submitted that in line with Rule 17(2)l of the Rules the Tribunal now must decide whether on the basis of the facts found proved Dr Bhagawati's fitness to practise is impaired by reason of misconduct.

55. Ms McNeill made reference to the *MPTS Guidance for Tribunals (the MPTS Guidance) (MPT Hearings > Part B: Stage two - Impairment > Steps 2(a) to (e))* (the Guidance) throughout her submissions. She also referred the Tribunal to the statutory overarching objective of public protection within her submissions. Ms McNeill reminded the Tribunal that no burden or standard of proof applied at this stage and that impairment was a matter for its independent judgement.

56. On the question of whether there is a legal basis for considering impairment (step 2a) Ms McNeill submitted that the facts found proved amounted to misconduct as the ground of impairment. Ms McNeill referred to the case law *Roylance v. General Medical Council (*[1999] 1 AC 311*)* which provides legal principles in defining professional misconduct. Ms McNeill submitted that Dr Bhagawati's misconduct amounts to serious misconduct and that there are a number of serious departures from *Good Medical Practise* ('GMP').

57. Ms McNeill submitted that Dr Bhagawati's conduct was not an isolated incident and comprised repeated self-prescription and repeated dishonesty. She submitted that Dr Bhagawati had failed to cooperate with the GMC investigation in any meaningful way and that this demonstrated a pattern of deliberate and sustained misconduct over several years. She suggested this calls Dr Bhagawati's integrity into question. Ms McNeill submitted that Dr Bhagawati had attempted to conceal his self-prescription by using a temporary access card, which the Tribunal had accepted would give the impression these had been requested by another clinician. Ms McNeill referred the Tribunal to relevant paragraphs of GMP 2024 to assist in setting out her submissions (acknowledging that some of the conduct straddled the earlier version and current version of GMP).

58. Ms McNeill referred the Tribunal to the guidance on impairment in the case of *CHRE v NMC & Paula Grant* [2011] EWHC 927 (Admin) and submitted that Dr Bhagawati's conduct is liable in the future to bring the profession into disrepute and has in the past done so. She

submitted that several fundamental tenets of the profession, namely honesty and integrity, had been breached and noted that the Tribunal had already found Dr Bhagawati acted dishonestly in its previous findings and she submitted that he was liable to do so in future.

59. On determining where on the spectrum of seriousness the allegations lie (step 2b of the Guidance) Ms McNeill submitted that there are features which increase the seriousness in Dr Bhagawati's case. She submitted that self-prescription may not always result in a finding of impairment, but may when there were aggravating features. Ms McNeill submitted that the conduct of Dr Bhagawati was not divisible and that there was a clear pattern on dishonesty throughout. She suggested that the following features aggravated the self prescribing of Dr Bhagawati:

- He sought to conceal the self-prescription and ordering of blood tests.
- He sought to attach responsibility first to his GP and then to a named colleague.
- He sought to further cover up his initial conduct when brought to his attention by the Trust by blaming that colleague.

60. Ms McNeill submitted that evidence a doctor has been dishonest can represent a particularly serious breach of professional standards and poses a risk to confidence in the medical profession. Ms McNeill submitted that dishonesty will often fall at the higher end of the spectrum of seriousness as per the Guidance.

61. Ms McNeill submitted there were factors in this case that increase the seriousness of the conduct:

- The persistence of Dr Bhagawati's behaviour.
- That after the first instance, Dr Bhagawati's behaviour was premeditated by using the temporary access card each time.
- Dr Bhagawati had abused his professional position by behaving in this way.
- The conduct amounts to a reckless disregard for professional standards.
- Dr Bhagawati's conduct represents an attempt to hide and/or avoid taking responsibility for behaviour or poor performance.
- The undermining of collaborative working.

62. Ms McNeill submitted that this case therefore falls towards the higher end of the spectrum of seriousness and that as per the Guidance the starting point for assessing current and ongoing risk to public protection will be high. She submitted that evidence of relevant

context about Dr Bhagawati's working environment and personal context of the doctor will usually have less impact and carry less weight. She submitted this is because allegations at the higher end of the spectrum of seriousness are generally harder to address.

63. On the consideration of any relevant context known about Dr Bhagawati (step 2c) Ms McNeill submitted that there is no clear evidence which could alter the assessment of seriousness. Ms McNeill acknowledged that within the evidence Dr Bhagawati's behaviour had been attributed to a high workload that he faced during the course of his working day and long hours but submitted that minimal weight should be attached to that. She submitted that it does not provide a meaningful or reasonable explanation as to Dr Bhagawati's conduct and does not mitigate the seriousness of the conduct.

64. Turning to the consideration of how Dr Bhagawati responded to the allegations (step 2d), Ms McNeill submitted that he has shown little or no insight into his behaviour, which has been compounded by his initial denial and later attempts to blame other colleagues. She submitted his failure to respond to queries promptly, cooperate with his regulator and his subsequent disengagement until the day before the hearing gives serious cause for concern. She suggested this indicates an absence of insight or a willingness to acknowledge the seriousness of his behaviour.

65. Ms McNeill submitted that Dr Bhagawati has not taken any obvious or meaningful steps to reduce the risk of repetition. She noted he had left the UK and that the Tribunal is not aware what his current employment status is and is therefore not aware if there is a risk of repetition. Ms McNeill submitted that whilst he has expressed regret his behaviour is not reflective of true remorse or acknowledgement of his behaviour.

66. Ms McNeill referred to the Guidance and submitted that in the absence of meaningful insight it is difficult for a doctor to successfully remediate. She submitted the underlying issue of persistent dishonesty is one that reflects on Dr Bhagawati's attitude and behaviour. Ms McNeill submitted that in the absence of any clear indication as to Dr Bhagawati's status, there is a high and significant risk of repetition.

67. For the Tribunal to decide if Dr Bhagawati poses any current and ongoing risk to public protection and make a finding of impairment (step 2e), Ms McNeill submitted that this is clearly a case where there is a real, current and ongoing risk to public protection. She submitted that though there is no direct risk to patient safety, Dr Bhagawati's conduct seriously undermines public confidence in the profession and fails to uphold professional

standards. Ms McNeill submitted that a finding of impairment is necessary to maintain public confidence in the profession and uphold professional standards. She submitted that Dr Bhagawati broke fundamental tenets of the profession including honesty, integrity, safe prescribing and maintaining trust. She submitted there is no relevant context that decreases the level of risk, little to no insight or remorse, no remediation and nothing to suggest to the Tribunal that the risk has reduced. Ms McNeill submitted that those factors combined with the absence of any engagement demonstrates the risk remains at the highest end.

68. On this basis Ms McNeill submitted that Dr Bhagawati's fitness to practise is currently impaired by reason of misconduct and a finding of impairment is necessary to protect the public, maintain public confidence in the medical profession and to uphold proper professional standards and conduct.

Dr Bhagawati

69. As Dr Bhagawati is neither present nor represented, no submissions were made on his behalf.

The relevant legal principles

70. There is no burden or standard of proof at this stage of the proceedings and the decision of impairment is a matter for the Tribunal's judgment alone. The Tribunal will only make a finding of impairment where there is a legal basis for doing so and where a decision is reached that the doctor poses a current and ongoing risk to one or more of the three parts of public protection which is likely to require restrictive action in response. The three parts of public protection are to protect, promote and maintain the health, safety and well-being of the public; to promote and maintain public confidence in the profession; and to promote and maintain proper professional standards and conduct for members of the profession.

71. 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 should lead to a finding of impairment.

72. To assess whether Dr Bhagawati poses any current and ongoing risk to public protection which may require restrictive action, the Tribunal will consider:

- where on the spectrum of seriousness the allegation lies, based on the facts found proved, the impact of any relevant context known about Dr Bhagawati and/or their working environment, and
- how Dr Bhagawati has responded to the allegations.

73. Whilst there is no statutory definition of impairment, the Tribunal was assisted by the guidance provided by Dame Janet Smith in the Fifth Shipman Report as adapted in *CHRE v NMC and Grant* [2011] EWHC 927(admin). The Tribunal noted that any of the following features are likely to be present when a doctor's fitness to practise is found to be impaired:

' ..the tribunal should consider whether the findings of fact in respect of the doctor. ... show that his fitness to practise is impaired in the sense that he:

a. Has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

b. Has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

c. Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; …

d. Has in the past acted dishonestly and/or is liable to act dishonestly in the future?'

The Tribunal's determination on impairment

Misconduct

74. The Tribunal referred to the Guidance and GMP throughout their decision-making. The Tribunal also referred to *Guidance for MPTS tribunals: Guidance introduction, Case type 2: dishonesty* ('the Introduction Guidance') for specific guidance relating to dishonesty cases.

75. The Tribunal noted that both the 2013 and 2024 versions of GMP apply in Dr Bhagawati's case due to the fact the dates of the incidents in the Allegations occurred both pre- and post-2024. The Tribunal reviewed both versions and considered them to be broadly equivalent in their standards. The Tribunal will refer to relevant paragraphs from the 2024

version of GMP. Referring to one version of GMP will also help to maintain the clarity of the determination.

Is there a legal basis for considering impairment?

76. The Tribunal referred to paragraphs 48, 81, 88, 89, 97 and 98 from GMP:

'48 You must treat colleagues with kindness, courtesy and respect.'

'81 You must make sure that your conduct justifies patients' trust in you and the public's trust in your profession.'

'88 You must be honest and trustworthy, and maintain patient confidentiality in all your professional written, verbal and digital communications.'

'89 You must make sure any information you communicate as a medical professional is accurate, not false or misleading. This means:

a you must take reasonable steps to check the information is accurate
b you must not deliberately leave out relevant information
c you must not minimise or trivialise risks of harm
d you must not present opinion as established fact.'

'97 You must, wherever possible, avoid providing medical care to yourself or anyone with whom you have a close personal relationship. You must follow our more detailed guidance on Good practice in proposing, prescribing, providing and managing medicines and devices.'

'98 To maintain patient safety, you must cooperate with formal inquiries, patient safety investigations, and complaints procedures. You must provide all relevant information and be open and honest.'

77. The Tribunal considered that Dr Bhagawati's conduct had departed from the above standards. The Tribunal was mindful that it had to be satisfied that there were serious departures from the standards expected. The Tribunal noted that dishonesty is inherently serious and that even low-level dishonesty may still sufficiently serious to amount to misconduct. In this case the dishonesty was not an isolated incident but was persistent in that there were six incidents relating to the prescribing and ordering of tests over a two-year

period. The dishonesty in these acts was not the ordering of tests and prescriptions in themselves but the actions that Dr Bhagawati took to conceal the fact that he had made the orders himself. The Tribunal considered that the dishonesty relating to the meeting on 24 February 2025 was serious as it was a false statement that sought to cover up Dr Bhagawati's own actions by naming a colleague as being responsible for the prescribing and ordering of tests. The Tribunal noted that Dr Bhagawati did later change that statement.

78. The Tribunal noted there were two separate categories for Dr Bhagawati's dishonesty, namely in relation to the self-prescribing and the false statement provided in the meeting dated 24 February 2025. The Tribunal was satisfied that in respect of each the conduct was serious.

79. Considering the WDF Allegations, the Tribunal noted that GMP made it clear what was required and that doctors '*must cooperate with formal enquiries, patient safety investigations, and complaints procedures'.* The Tribunal noted that he did not do this despite multiple requests from the GMC for him to return a completed WDF. The Tribunal was of the view that the WDF was an important document for a doctor under GMC investigation to complete and return. By failing to return a completed WDF when required, this could potentially hamper the effective oversight of doctors that the GMC needs to have over doctors under investigation. As such the Tribunal found that the WDF Allegations do amount to misconduct, which is serious.

80. The Tribunal found that based on the case law principles of *General Medical Council v Meadow [2006] EWCA Civ 1390* and *Roylance* Dr Bhagawati's conduct amounted to misconduct. The Tribunal were therefore satisfied there is a legal basis for considering impairment.

<u>Where on the spectrum of seriousness does the allegation lie?</u>

81. The Tribunal referred to paragraph 31 and 33 of the Guidance:

> *31. 'Allegations that are likely to fall at the higher end of the spectrum of seriousness include, but are not limited to:*
>
> - *dishonesty, other than where it occurred outside of the doctor's professional role and was not persistent or repeated, and the value or other benefit derived was not significant'*

32. *'Although cases of violence and dishonesty will often fall at the higher end of the spectrum of seriousness, they can involve a range of behaviour with the circumstances giving rise to the allegation often occurring outside the doctor's professional practice. In these cases, the MPT will need to decide where on the spectrum of seriousness the violence or dishonesty sits.'*

82. The Tribunal noted that Dr Bhagawati's dishonesty occurred on multiple instances and was repeated in different contexts. Dr Bhagawati had attributed his misconduct to a GP, then to a colleague. The Tribunal found that this differentiated repetition compounded his dishonesty and increases the seriousness. The Tribunal acknowledge that Dr Bhagawati did change his previous statement and ultimately accepted responsibility. However, the Tribunal did not consider this sufficient to reduce the seriousness already reached.

83. The Tribunal considered that Dr Bhagawati's behaviour was premeditated. The Tribunal acknowledged that the first instance may have been a spontaneous action, but the five subsequent incidents were premeditated, as the same method with the temporary card was then used to continue to self-prescribe.

84. The Tribunal found that Dr Bhagawati had abused his professional position agreeing with Ms McNeill's submission, namely that he had used his position to access medication and order blood tests himself by using a temporary access card rather than going through conventional channels.

85. The Tribunal found that Dr Bhagawati had demonstrated a reckless disregard for professional standards. In particular the professional standards set out above were found to have been subverted by Dr Bhagawati and he had prioritised his own convenience over those standards.

86. The Tribunal found that Dr Bhagawati's misconduct did undermine collaborative working as he had shown a lack of regard on the impact of his actions on his colleagues, by attaching his prescriptions and tests to another clinician, which would make the entries relating to them in the patient record inaccurate. Additionally, the Tribunal noted that naming other colleagues as being responsible, as Dr Bhagawati did in the meeting on 24 February 2025, would inevitably put those colleagues in a difficult position and would undermine collaborative working.

87. The Tribunal found that Dr Bhagawati had attempted to hide and/or avoid taking responsibility for his behaviour or poor performance by providing three different versions of events when investigated on how the ordering of medications and blood tests occurred.

88. The Tribunal found that Dr Bhagawati's conduct fell at the higher end of the spectrum of seriousness and therefore the starting point for assessing risk is high. The Tribunal referred to paragraph 43 from the Guidance:

> *'43. Where an allegation falls at the higher end of the spectrum of seriousness, the presence and impact of one or more features that may increase serious could make the allegation more serious. Either way, it will stay at the higher end of the spectrum.'*

What is the impact of any relevant context known about Dr Bhagawati and/or their working environment?

89. The Tribunal considered the working context provided by Dr C in his fact finding report, which had highlighted that the repeated prescriptions that Dr Bhagawati had requested were not controlled substances. The Tribunal further acknowledged the findings of the Trust within their investigation that Dr Bhagawati was working long shifts with antisocial hours, and that Dr Bhagawati's blood tests would have been carried out in Hertfordshire whilst he was working long hours in Central London. The Tribunal noted that the explanation for the misconduct could be framed as a matter of convenience on Dr Bhagawati's behalf, however this was carried out in a dishonest way. The Tribunal give credit that Dr Bhagawati was working in a difficult environment.

90. The Tribunal had regard to paragraphs 50 and 59 from the Guidance:

> *'50. The impact that evidence of relevant context has on the assessment of risk, will depend on the nature of the allegation and individual circumstances of the case. However, evidence of relevant context that may decrease the level of risk to public protection posed by the doctor will usually carry less weight in cases that fall at the higher end of the spectrum of seriousness. This is because the risk to public protection arising from these concerns is generally more difficult to mitigate.'*

> *'59. In cases where there is evidence of working environment context that may decrease risk, this will usually have less impact, and therefore carry less weight, where the allegation falls at the higher end of the spectrum of seriousness. This is because*

the risk to public protection arising from these concerns is generally more difficult to mitigate.'

91. The Tribunal noted that Ms McNeill attached minimal weight to this working context. The Tribunal agreed with this assessment and also attached minimal weight to the context. The Tribunal considered that there could have been other ways Dr Bhagawati could have worked around those issues without having to resort to dishonest conduct. The Tribunal determined that after taking the working context into account the level of seriousness remained at the higher end of the spectrum.

92. The Tribunal considered that there was no known relevant personal context and was of the view that personal mitigation can only have limited weight in cases of serious dishonesty, in line with relevant case law. The Tribunal noted that Dr Bhagawati was a senior clinician who should have known better, and that no other relevant context had been provided to the Tribunal.

How has Dr Bhagawati responded to the allegations?

93. The Tribunal referred to paragraph 93 of the Guidance, many of which it noted were present in this case:

93. 'In some circumstances, it may be reasonable to conclude that a doctor lacks genuine, or any, insight. This may be because there is evidence they have:

- *repeated behaviour or poor performance where the circumstances of a previous complaint or concern are similar in nature or raise similar concerns to the current matter*
- *tried to minimise the seriousness or impact of their behaviour, poor performance or health condition*
- *provided an explanation after the event in which they have tried to minimise their own role or culpability, or otherwise sought to blame others*
- *been blatantly dishonest or deliberately sought to mislead the GMC or MPT. This may include, amongst other things, knowingly advancing a case of false primary fact or a defence at the unreal, unreasonable or ludicrous end of the spectrum, and/or*
- *failed to comply with a direction to undergo an assessment or a requirement to produce information/documentation, or significantly delayed complying without any reasonable explanation.'*

94. The Tribunal considered there to be no evidence of any insight or remediation and that Dr Bhagawati has not engaged with the GMC investigation or the hearing. The Tribunal referred to *Cohen v General Medical Council [2008] EWHC 581 (Admin)* which sets out legal principles that asks if the misconduct is remediable, whether it has been remedied and whether there is a likelihood of repetition. The Tribunal noted that dishonesty is generally difficult to remediate, particularly where it is repeated and persistent, as that may indicate an attitudinal issue. The Tribunal determined that given the lack of insight, reflection and remediation, it had not been remedied by Dr Bhagawati.

95. The Tribunal considered the lack of engagement from Dr Bhagawati increases the risk of repetition as the Tribunal do not know where he is or what he is doing. Further, where there has been no engagement with the process or remediation addressing the underlying concerns, there will remain a real risk of repetition. The Tribunal acknowledged that he had expressed regret in an email but noted there was no other evidence that Dr Bhagawati has any kind of meaningful insight, remediation, reflection or understanding of his misconduct. The Tribunal found that there is no evidence that he understands the seriousness of his actions and the impact of his misconduct upon his peers and on the reputation of the profession.

96. The Tribunal noted that the dishonesty consisted of two different types (relating to the requesting of prescriptions/tests and the false account given) and that Dr Bhagawati reacted to the initial probity concern by being dishonest. The Tribunal considered this raises questions about whether this dishonesty is therefore ingrained and attitudinal.

97. The Tribunal considered that it did not have an opportunity to gain an understanding from Dr Bhagawati on why the misconduct occurred and what may be required in terms of remediation. The Tribunal noted that Dr B had said in the evidence that he believed that Dr Bhagawati had “panicked”. The Tribunal considered that there would need to be considerable reflection undertaken by Dr Bhagawati to understand why he responded in the way that he did, but there is no evidence that has been done.

98. The Tribunal considered the risk of repetition to be high and noted that the question around a deep-seated attitudinal issue relating to dishonesty also keeps the risk of repetition high.

99. The Tribunal considered that the limbs of *Grant* were engaged by Dr Bhagawati's misconduct in that it brought the profession into disrepute, breached a fundamental tenet of the profession and was dishonest.

100. The Tribunal acknowledged that there were no direct patient safety concerns arising from Dr Bhagawati's misconduct. However, it considered that Dr Bhagawati's actions could undermine trust between colleagues which could then in turn indirectly put patient safety at risk.

101. The Tribunal noted that no information had been provided on whether Dr Bhagawati has kept his knowledge and skills up to date. The Tribunal are aware he is likely in New Zealand but have no information as to what he is doing there.

Tribunal's decision as to whether Dr Bhagawati poses any current and ongoing risk to public protection which may require restrictive action in response and its finding on impairment

102. The Tribunal referred to paragraph 134 from the Guidance and paragraph 87 from the Introduction Guidance:

> *134. 'In cases where the allegation falls at the higher end of the spectrum of seriousness, the starting point for assessing current and ongoing risk to public protection will be high. Evidence of relevant context that decreases risk and evidence of insight and remediation that decreases risk may have less impact and carry less weight because these types of allegations can be more difficult to remediate. Evidence of the doctor having kept their knowledge and skills up to date may also be less relevant. This should be considered by the MPT when they are reaching a view on risk and a conclusion that the doctor poses a current and ongoing risk to one or more of the three parts of public protection requiring restrictive action in response may be needed, particularly as the allegation is likely to engage public confidence.'*
>
> *87. 'Whilst a range of behaviour can be seen, the nature of the departure from the standards expected may mean that a concern or allegation relating to dishonesty falls at the high end of the spectrum of seriousness. Even a single incident of dishonesty can have a significant harmful impact and pose a risk to public protection.'*

Patient safety

103. The Tribunal considered this limb to be engaged as Dr Bhagawati's behaviour had the potential to undermine his working relationships with colleagues which therefore could have impacted patient safety. The Tribunal referred to paragraph 87 from the Introduction Guidance throughout this step in their determination.

Public confidence

104. The Tribunal considered that as the misconduct was dishonesty and a breach of the fundamental tenets of the profession, it would inevitably undermine public confidence in the profession if no finding of impairment were made.

Professional standards

105. The Tribunal considered that as the misconduct was dishonesty and a breach of the fundamental tenets of the profession, it would inevitably undermine the promotion and maintaining of proper professional standards and conduct if no finding of impairment were made.

Conclusion

106. The Tribunal found the findings of misconduct were serious and at a high level of risk, with no evidence of insight or remediation and concerns about a high risk of repetition. The Tribunal acknowledged there was some context but it could only be given limited weight.

107. The Tribunal has therefore determined that Dr Bhagawati's fitness to practise is impaired by reason of misconduct.

Determination on Sanction - 29/10/2026

Submissions

GMC

108. On behalf of the GMC, Ms McNeill submitted sanction is a matter for the Tribunal exercising its independent judgement which should be exercised fairly, transparently and proportionately. Ms McNeill submitted that the Tribunal should review its findings made at

the facts and impairment stages and decide in accordance with Rule 17(2)n of the Rules what the appropriate sanction should be.

109. Ms McNeill referred to relevant paragraphs of *MPTS Guidance for Tribunals (the MPTS Guidance) (MPT Hearings > Part C: stage three – sanction > Step 3: decide on sanction)* ('the Guidance') throughout her submissions. Ms McNeill submitted that the primary purpose of a sanction is to impose the proportionate regulatory response required to protect the public, as per the three parts of the overarching objective of public protection.

110. Ms McNeill stated that the GMC's position was that the erasure of Dr Bhagawati from the medical register would be the only proportionate sanction which would meet the overarching objective. She submitted it would serve to protect the public and act as a deterrent to others.

111. Ms McNeill noted that the Tribunal will need to work through the Guidance and consider the available sanctions beginning with the least restrictive. She submitted that the appropriate sanction would protect the public, be proportionate, transparent and fair. She submitted that the Tribunal should consider the principles of proportionality weighing the interests of the public against those of Dr Bhagawati. She submitted that the need to protect the public will always outweigh the interests of any individual doctor.

112. Referring to the Tribunal's previous findings, Ms McNeill submitted that as Dr Bhagawati's misconduct was determined to be serious, the starting point for the risk to public protection is high. She highlighted that all three limbs of public protection have been engaged, the dishonesty was ingrained and attitudinal, and there exists a significant risk of repetition with no insight or remediation on the part of Dr Bhagawati. Ms McNeill referred to the sanctions bandings at paragraph 62 of the Guidance and noted that a period of nine months suspension to erasure would be appropriate for cases of dishonesty with a high level of risk to public protection.

113. Ms McNeill submitted that erasure would be the appropriate sanction based upon the Tribunal's findings at the impairment stage. She referred to the Tribunal's previous determination that Dr Bhagawati's conduct was premeditated, persistent and with multi-layered aspects of the dishonesty as some examples of the seriousness of the behaviour and the need for a proportionate response. She invited the Tribunal to have regard to the case law of *Khan v General Medical Council [2015] EWHC 301 (Admin)* which indicates that no

sanction short of erasure is likely to be appropriate where proven dishonesty is combined with a lack of insight.

114. Working through the sanctions starting with no action, Ms McNeill submitted that the seriousness of the misconduct, involving an abuse of position, dishonesty and a reckless disregard for professional standards is such that there are no exceptional circumstances to justify taking no action. Ms McNeill noted that the Tribunal has found that Dr Bhagawati poses a current and ongoing risk to public protection and submitted taking no action would not be proportionate or sufficient to protect the public.

115. Moving on to conditions, Ms McNeill submitted any conditions should be appropriate, workable and measurable, as per the Guidance. Ms McNeill noted that the sanctions banding applicable in Dr Bhagawati's case does not indicate that conditions would be an appropriate sanction. She submitted there are no mitigating factors which would lessen the seriousness of the misconduct in order to make conditions appropriate. Ms McNeill further submitted that any conditions would not be workable or measurable. Ms McNeill submitted this is because the Tribunal in its previous findings noted that it does not know where Dr Bhagawati is or whether he is working. Ms McNeill submitted that conditions would not be sufficient to uphold the three limbs of public protection in the absence of clear insight. She submitted if Dr Bhagawati did return to practise there would remain a risk that he would repeat the same or similar conduct.

116. Turning to suspension, Ms McNeill submitted that as per the Guidance the purpose of suspension is to remove a doctor from practise, manage the current and ongoing risk to public protection with the ultimate aim that the doctor should be able to return to unrestricted practise in the future. She submitted suspension would have a deterrent effect and would send a signal to a doctor, the profession and wider public about what behaviour is regarded as unbefitting to a registered medical practitioner. She referred to paragraph 45 of the Guidance:

> *45. 'Suspension may be proportionate in cases where some, or all, of the following factors are present:*
>
> *a. conditions are not appropriate, measurable and/or workable*
>
> *b. the level of current and ongoing risk to public protection is such that it cannot be safely managed with conditions and suspension is necessary to stop the doctor from working and putting patients at risk while they gain insight into any deficiencies and remediate, or undergo medical treatment, and/or*

c. *the level of current and ongoing risk to public protection is such that, although patient safety is not an issue, suspension is needed to maintain public confidence in the profession and/or maintain professional standards.'*

117. Ms McNeill submitted that although all three factors listed in paragraph 45 are applicable as per the Tribunal's previous findings, suspension would still not be the appropriate or proportionate sanction. Ms McNeill submitted that when a suspension is imposed there must be reasonable prospects for a doctor to return safely to unrestricted practise. She submitted that in this case that is not the position either now or within a reasonable time frame.

118. Lastly turning to erasure, Ms McNeill submitted that erasure is the proportionate response when considering the factors indicating that erasure may be appropriate in paragraph 57 of the Guidance. Ms McNeill submitted that all of the factors in paragraph 57 were engaged, with conditions not being appropriate and suspension not being sufficient to protect the public. She submitted Dr Bhagawati's behaviour caused serious harm, with a high risk of harm reoccurring. She noted the lack of insight into the seriousness of the allegations and facts found proven, and the lack of impact of any relevant context. Ms McNeill submitted that the current and ongoing risk to public protection is serious and Dr Bhagawati continuing to hold registration would undermine public confidence in the profession. She submitted continued registration would overall be fundamentally incompatible with the upholding of public protection. Ms McNeill submitted that therefore the only appropriate and proportionate sanction would be erasure.

Dr Bhagawati

119. As Dr Bhagawati is neither present nor represented, no submissions were made on his behalf.

The Tribunal's determination on sanction

120. In making its decision on sanction, the Tribunal has reviewed its decision on facts and impairment and has considered the level of current and ongoing risk the doctor poses to public protection. It has referred to the sanctions banding for dishonesty with a higher level of risk to public protection as set out in Part C of the Guidance for MPT hearings which suggests a sanction between 9 months suspension up to erasure. In making its decision the

Tribunal also considered the impact each of the available sanctions would have on Dr Bhagawati and balanced that against public protection.

No action

121. The Tribunal referred to the relevant paragraphs of the Guidance, in particular paragraphs 13 and 15:

13. *'Where a doctor's fitness to practise is impaired, it will usually be necessary for the medical practitioners tribunal (MPT) to restrict the doctor's registration to achieve public protection. But there may be exceptional circumstances to justify an MPT taking no action. Exceptional circumstances are unusual, special, or uncommon, so such cases are likely to be very rare.'*

15. *'Taking no action may be proportionate where the MPT is satisfied that undertakings agreed between the GMC and doctor are sufficient to protect the public. Undertakings can be agreed between a doctor and the GMC at a hearing after the MPT has made a finding of impairment. If undertakings are agreed, the MPT may take these into account when reaching its decision on sanction, provided that certain conditions are met.'*

122. Given the seriousness of Dr Bhagawati's misconduct, which involved repeated dishonesty, with a high level of risk to public protection, with no insight or remediation, the tribunal considered that taking no action would not be an appropriate nor proportionate response and would fail to maintain public safety, public confidence or uphold professional standards. The Tribunal further noted there were no exceptional circumstances or undertakings agreed between the GMC and Dr Bhagawati, which as per the Guidance could be considered by the Tribunal to take no action. The Tribunal determined that taking no action would be a wholly inadequate regulatory response.

Conditions

123. The Tribunal had regard to the relevant paragraphs in the Guidance, in particular paragraph 28:

'Conditions may be proportionate in cases where the doctor has shown a degree of insight into the allegation and some, or all, of the following factors are present:

a. *the doctor has demonstrated they are willing and/or able to remediate*
b. *identifiable areas of the doctor's practice need prohibiting, monitoring, or retraining*
c. *the doctor has demonstrated they are willing to be open and honest with patients and others they work with if things go wrong*
d. *the doctor will not put patients at harm, either directly or indirectly, by having conditions on their registration.'*

124. The Tribunal considered that the indicative sanctions banding at paragraph 62 does not suggest conditions would be an appropriate or proportionate response to Dr Bhagawati's conduct. In addition, the Tribunal considered that there were no mitigating factors that would justify deviating from the sanctions banding in the Guidance. The Tribunal further noted that dishonesty does not lend itself easily to conditions, which are intended to address identified failings in a doctor's practice. The Tribunal had regard to the fact that Dr Bhagawati has provided no evidence of insight or that he is willing to remediate or engage with the GMC investigation or any hearing. The Tribunal therefore does not have confidence that Dr Bhagawati would engage with or comply with conditions. The Tribunal determined conditions would not be appropriate or proportionate considering Dr Bhagawati's misconduct revolved around his dishonesty and would not be workable in the circumstances.

Suspension

125. The Tribunal had regard to the relevant paragraphs of the Guidance, in particular paragraph 45:

45. *'Suspension may be proportionate in cases where some, or all, of the following factors are present:*
    a. *conditions are not appropriate, measurable and/or workable*
    b. *the level of current and ongoing risk to public protection is such that it cannot be safely managed with conditions and suspension is necessary to stop the doctor from working and putting patients at risk while they gain insight into any deficiencies and remediate, or undergo medical treatment, and/or*
    c. *the level of current and ongoing risk to public protection is such that, although patient safety is not an issue, suspension is needed to maintain public confidence in the profession and/or maintain professional standards.'*

126. The Tribunal considered that Dr Bhagawati knew his conduct was dishonest and noted that when he ultimately admitted to ordering the medications and tests in his email dated 3 March 2025, he accepted that this was serious and said he would self-refer to the GMC. Despite being aware of the potentially serious consequences of his conduct, the Tribunal found that Dr Bhagawati had not engaged meaningfully with the GMC regarding the allegations of dishonesty and did not provide the Work Details Form (WDF) to the GMC when requested. The Tribunal noted that Dr Bhagawati has a duty as a doctor to engage with his regulator and address any concerns that are raised.

127. Furthermore, the Tribunal considered there to be no evidence that Dr Bhagawati has any insight, has reflected or has undertaken any remediation, meaning the ongoing risk to public protection is high. The Tribunal noted that it does not know whether Dr Bhagawati is working currently or if there has been any change in his attitude. The Tribunal was not convinced that his engagement via email the day before the hearing to say he may wish to engage with the process in the future if the case was adjourned, goes any way to showing proper engagement or a willingness to remediate in future.

128. The Tribunal noted that the indicative sanction banding is between 9 months suspension up to erasure but considered there to be very few redeeming features both in how Dr Bhagawati conducted himself in relation to the misconduct or his actions since. The Tribunal found that Dr Bhagawati had not demonstrated any of the steps a Tribunal may expect a doctor to undertake during the investigation or hearing. Again, the Tribunal noted that there was no evidence of reflection, timely development of insight or of Dr Bhagawati taking steps to remediate. The Tribunal concluded that it would be unfounded wishful thinking to suspend Dr Bhagawati in the hope that he may seek to engage and take steps to remediate in future.

129. The Tribunal noted that whilst suspension is intended to give a doctor a pathway back to registration, Dr Bhagawati has not given any indication that this would be the outcome if suspension were imposed. The Tribunal considered the only engagement Dr Bhagawati has carried out is an email the day before the hearing that he would like to engage with the process at some future point. The Tribunal considered this was not sufficient to justify suspension.

130. The Tribunal determined that whilst all the factors listed in paragraph 45 of the Guidance are applicable, for the reasons listed suspension would not be the appropriate

sanction given the persistent dishonesty combined with a lack of insight and remediation and would be insufficient to protect the public interest.

Erasure

131. The Tribunal had regard to relevant paragraphs in the Guidance, in particular paragraphs 55 to 57:

> *55. 'Erasure is action available for those cases where a doctor's behaviour, performance, or the impact that a health condition is having on their ability to practise safely and effectively,[16] is incompatible with continued registration at this point in time. It means the level of current and ongoing risk the doctor poses to public protection is so significant that they should not be allowed to practise.*
>
> *56. Erasure takes away a doctor's registration which means they are no longer entitled to practise in the UK at all, or anywhere else where they are required to hold GMC registration. It is used to protect the public in the most serious cases. It also has a deterrent effect as it sends a signal to the individual doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor.*
>
> *57. Erasure may be the proportionate response where:*
>
> *a. conditions are not appropriate, measurable and/or workable and suspension is not sufficient to protect the public*
> *b. the doctor's behaviour or performance is such that it caused serious harm, and the risk of harm recurring cannot be mitigated sufficiently through putting conditions or suspension in place*
> *c. the doctor has shown a persistent lack of insight into the seriousness of the allegation about their behaviour or performance and the potential or actual consequences, and/or*
> *d. the seriousness of the facts found proven and/or impact of any relevant context that increased the current and ongoing risk to public protection mean the effect of the doctor continuing to hold registration is such that it will undermine public confidence in the profession.'*

132. The Tribunal was of the view that all four factors listed in paragraph 57 are present in Dr Bhagawati's case. The Tribunal considered that the ongoing risk to public protection and the risk of repetition meant that Dr Bhagawati's continued registration would undermine public confidence in the profession. The Tribunal in particular noted paragraph 57c to be

pertinent as Dr Bhagawati has not engaged with the process despite several reminders from the GMC and the MPTS and has shown a persistent lack of insight. The Tribunal had found that suspension would be insufficient to protect the public interest and would undermine public confidence in the profession and the maintenance of professional standards.

133. The Tribunal considered paragraph 56 to be relevant with regard to the deterrent effect erasure would have and the signal it would send to Dr Bhagawati, the profession and the wider public.

134. The Tribunal noted that a sanction of erasure would be consistent with its previous findings which placed the current and ongoing risk to public protection on the higher end of the scale. The Tribunal reminded itself that it had found multiple factors that increased the level of seriousness, with only one factor that could be considered to reduce the risk. The Tribunal noted that the lack of insight and lack of remediation demonstrated meant the Tribunal had very limited basis to consider any sanction below erasure. The Tribunal also considered that a decision of erasure would be consistent to the relevant case law principles in *Khan* which was highlighted in Ms McNeill's submissions.

135. The Tribunal concluded therefore that Dr Bhagawati's misconduct is incompatible with continued registration at this time and determined that his name should be erased from the medical register.

Determination on immediate order – 29/10/2026

136. Having determined to erase Dr Bhagawati's name from the medical register, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Bhagawati's registration should be subject to an immediate order.

Submissions

GMC

137. On behalf of the GMC, Ms McNeill submitted that an immediate order would be indicated if the Tribunal considered it necessary for the protection of the public or it is otherwise in the public interest. Ms McNeill submitted that in light of the Tribunal's previous findings it may be that the Tribunal considers an immediate order necessary, particularly as

there is no interim order in place and there is little if anything known about Dr Bhagawati's current employment status. Ms McNeill submitted that this is clearly a case which warrants an immediate order to satisfy the overarching objective.

Dr Bhagawati

138. As Dr Bhagawati is neither present nor represented, no submissions were made on his behalf.

The Tribunal's determination

139. The Tribunal had regard to the relevant paragraphs of the Guidance, in particular paragraphs 79, 81, 83 and 84:

> *79. 'The MPT may impose an immediate order where 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. Where the MPT has imposed a sanction of conditions, it may impose an immediate order of conditions. Where the MPT has imposed a sanction of suspension or erasure, it may impose an immediate order of suspension.'*
>
> *81. 'When deciding if an immediate order is needed, the MPT should balance these considerations against the other interests of the doctor, which may be to return to work pending the outcome of any appeal, and against the wider public interest which may require an immediate order is put in place.'*
>
> *83. 'The decision whether to impose an immediate order is at the discretion of the MPT based on the facts of the case. When deciding if an immediate order is needed the MPT should consider the seriousness of the proved allegation and the level of current and ongoing risk to public protection posed by the doctor.'*
>
> *84. 'It will not usually be appropriate for a doctor to hold unrestricted registration until a sanction takes effect in cases where:*
>
> *a. the doctor poses a risk to patient safety*
> *b. the risk to one or more parts of public protection is high, and/or*
> *c. immediate action is needed to maintain public confidence in the medical profession.'*

140. The Tribunal determined that an immediate order would be necessary in light of its previous serious findings. The Tribunal noted that the findings were so serious that erasure was determined to be the appropriate sanction, and it therefore would not be consistent to allow Dr Bhagawati to remain unrestricted on the medical register during any appeal period. The Tribunal considered that all three parts of paragraph 84 of the Guidance are engaged in this case.

141. The Tribunal therefore determined that an immediate order is necessary to protect the public and that it is in the public interest.

142. This means that Dr Bhagawati's registration will be suspended from the date on which notification of this decision is deemed to have been served upon him. The substantive direction, as already announced, will take effect 28 days from that date, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

ANNEX A – - 27/10/2026

Service and Proceeding in absence

143. Dr Bhagawati was neither present nor represented at the hearing. The Tribunal therefore considered whether to continue with the hearing in his absence.

Submissions

144. The Tribunal was provided with a proof of service bundle by the GMC, which included various correspondence between the GMC and Dr Bhagawati. The Tribunal was also provided with a recent email from Dr Bhagawati to the GMC dated 25 October 2026, in which he stated he had only recently become aware of the hearing from the MPTS website, that his intention was to be voluntarily erased from the GMC and if that was not possible, he requested a different hearing date so that he may be able to attend.

145. Ms McNeill, Counsel, submitted that all reasonable efforts had been made to serve notice on Dr Bhagawati. Ms McNeill highlighted to the Tribunal that Dr Bhagawati's registered email address had been used by him yesterday to communicate with the GMC, which was the same email that had been used to communicate with him throughout. She submitted that the Tribunal as a result can be confident that Dr Bhagawati's registered email address was a valid one.

146. Ms McNeill submitted that Dr Bhagawati has been informed of his obligations and expectations in respect of this hearing through regular correspondence and referred the Tribunal to documents in the proof of service bundle. Ms McNeill highlighted that the notice of hearing had been emailed twice on 21 and 22 September 2026 to Dr Bhagawati's registered email as well as an attempted delivery by Royal Mail to provide the notice of hearing via special delivery post, which had been returned to sender. Ms McNeill submitted that Dr Bhagawati had previously acknowledged that his email address was correct and he had been invited to confirm an updated postal address, but he had not done so. She submitted that pursuant to Rule 31 all reasonable efforts had been made by both the GMC and MPTS to serve the notice of the hearing and as a result the Tribunal should proceed in Dr Bhagawati's absence as he is aware of the hearing but has chosen not to attend.

147. Ms McNeill submitted that in all the circumstances the Tribunal should allow the hearing to proceed in Dr Bhagawati's absence as that would be the fair, proportionate and

expeditious way of dealing with the matter. Ms McNeill stated that if Dr Bhagawati's recent email was to be considered as an application to adjourn, any adjournment was objected to.

The Tribunal's decision

148. The Tribunal considered Rule 31 of the Rules:

> *'31 Where the practitioner is neither present nor represented at a hearing, the Committee or Tribunal may nevertheless proceed to consider and determine the allegation if they are satisfied that all reasonable efforts have been made to serve the practitioner with notice of the hearing in accordance with these Rules.'*

149. The Tribunal also had regard to the new Guidance for MPTS Tribunals, Section 1 on procedural matters, specifically the paragraphs on proceeding in a doctor's absence.

Service

150. The Tribunal considered if there had been proper service of the Notice of Hearing on Dr Bhagawati. The Tribunal reminded itself that Dr Bhagawati's email address had continued to be used as recently as 25 October 2026 to communicate with the GMC. The Tribunal referred to the proof of service bundle and found that Dr Bhagawati had been made aware that the hearing was proceeding on numerous occasions. For example, Dr Bhagawati had responded to an email in August 2026 regarding a case management hearing. Additionally, although Dr Bhagawati appeared to be no longer resident in the UK, he had retained a consistent email address throughout. The Tribunal noted that if his registered email or postal address had changed, it would be his responsibility to notify the GMC of this.

151. The Tribunal considered that within the bundle there was clear evidence that all reasonable efforts had been made by both the GMC and MPTS to notify Dr Bhagawati of the hearing and to deliver important updates regarding the progress of the hearing, via both email and tracked post. The Tribunal reminded itself that Dr Bhagawati had been responding intermittently via email as recently as yesterday from the same email address used throughout. The Tribunal considered it likely that Dr Bhagawati would have been aware of the hearing and that proceedings were ongoing.

152. The Tribunal therefore determined it was satisfied that there had been proper service upon Dr Bhagawati in accordance with the Rules.

Proceeding in absence

153. The Tribunal next moved to consider whether to proceed in Dr Bhagawati's absence. The Tribunal referred to Dr Bhagawati's email to the GMC sent on 25 October 2026 that he would not be able to attend the hearing due to the time difference. He said in the email that his intention is to pursue voluntary erasure and if this is not satisfactory, he requested a different date to allow him to attend. The Tribunal considered that this was in essence a request to adjourn the proceedings. The Tribunal decided to address this as part of the consideration of whether to proceed with the hearing in his absence.

154. The Tribunal noted that no good reason had been put forward for Dr Bhagawati's absence and the adjournment request. Dr Bhagawati had not provided details about the length of any adjournment sought and the significant time difference issue, which he had referred to, would also apply to any future hearing. The Tribunal referred to the legal principles in the relevant case law of General Medical Council v Adeogba [2016] EWCA Civ 162, General Medical Council v Visvardis [2016] EWCA Civ 162 and R v Jones [2002] UKHL 5. The Tribunal reminded itself that it has to balance the interests of Dr Bhagawati with the public interest. The Tribunal considered that Dr Bhagawati is aware of the hearing as there is significant communication from the GMC to Dr Bhagawati about the hearing and it concluded that he had voluntarily absented himself. The Tribunal was of the view that there is a history of poor engagement from Dr Bhagawati with the GMC and that this gives little reassurance to the Tribunal that an adjournment would lead to Dr Bhagawati's future attendance. The Tribunal considered that as the allegations in this case are serious and date back to 2022, there would be strong public interest to expeditiously dispose of the case.

155. The Tribunal acknowledged that Dr Bhagawati had alluded to some family health issues which could explain his engagement difficulties. However, in the Pre- Hearing Meeting (PHM) between Dr Bhagawati and the Case Management team of the MPTS in August 2026 the Tribunal noted that Dr Bhagawati had already said he would not be attending this meeting and that he wished to give up his registration. The Tribunal found that Dr Bhagawati has had sufficient notice of the hearing and opportunity to prepare and could not see that an adjournment would be in the interests of justice.

156. The Tribunal therefore determined to proceed in Dr Bhagawati's absence.

XXX SCHEDULE 1

Date	Medication prescribed
22 June 2022	XXX
26 September 2023	XXX
17 October 2024	XXX
21 November 2024	XXX

XXX SCHEDULE 2

Date of blood test ordered
24 May 2024
20 December 2024