PUBLIC RECORD

Dates: 03/06/2024 - 10/06/2024

Medical Practitioner's name:	Dr Michael GOODWIN
GMC reference number:	4045526
Primary medical qualification:	MB BS 1993 University of London

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

Summary of outcome

Suspension, 12 months
Immediate order imposed
Review hearing directed

Tribunal:

Legally Qualified Chair	Mr Simon Bond
Lay Tribunal Member:	Mrs Lorna Taylor
Medical Tribunal Member:	Dr Pavan Rao

Tribunal Clerk:	Mrs Anne Bhatti

Attendance and Representation:

Medical Practitioner:	Present, represented
Medical Practitioner's Representative:	Mr Tom Day, Counsel, instructed by MDDUS
GMC Representative:	Priya Khanna, Counsel

Attendance of Press / Public

In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held partly in public and partly 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 - 06/06/2024

(1) FACTS

1. This determination will be handed down in private. However, as this case concerns Dr Goodwin's misconduct a redacted version will be published at the close of the hearing.

Background

2. Dr Goodwin qualified in 1993 from the University of London. He obtained his FRCA in 1998 and was put on the Specialist Register in 2002. At the time of the index events, Dr Goodwin was practising as Consultant Anaesthetist at the Northampton General Hospital ('the Trust'). He joined the Trust in 2002 and worked there until the termination of his employment on 13 May 2022.

3. The allegation that has led to Dr Goodwin's hearing can be summarised as follows. On one or more occasion between 2019 and June 2021, Dr Goodwin removed a controlled drug, namely XXX, from the Trust and from Three Shires Hospital ('Three Shires'), where he also worked. It is alleged that Dr Goodwin inappropriately self administered XXX in-between procedures and/or during procedures, and worked as a Consultant Anaesthetist on operating lists, whilst under the influence of the drug. It is also alleged that on one or more occasion between 2019 and June 2021, Dr Goodwin dishonestly entered inaccurate information on the Trust's controlled drugs register ('CDR').

4. XXX

5. Initial concerns were raised with the GMC on 6 May 2022 by Mr H of the Trust. Dr Goodwin subsequently made a self-referral to the GMC on 26 May 2022.

The Allegation and the Doctor's Response

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

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

1. On one or more occasion between 2019 and June 2021 you:

   a. removed a controlled drug XXX from:

      i. the Northampton General Hospital NHS Trust (the 'Trust'); **Admitted and found proved**

      ii. Three Shires Hospital; **Admitted and found proved**

   b. inappropriately self-administered XXX:

      i. in-between procedures; and/or **Admitted and found proved**

      ii. during procedures. **Admitted and found proved**

   c. worked as a Consultant Anaesthetist on operating lists whilst under the influence of XXX. **Admitted and found proved**

2. On one or more occasion between 2019 and June 2021 you entered inaccurate information on the Trusts' controlled drugs register (the 'Register'). **Admitted and found proved**

3. You knew the information you were entering onto the Register:

   a. was false; **Admitted and found proved**

   b. would create an inaccurate record of the amounts of XXX:

      i. used during a procedure; and/or **Admitted and found proved**

      ii. disposed of after a procedure. **Admitted and found proved**

4. Your conduct at paragraph 2 was dishonest by reason of paragraph 3. **Admitted and found proved**

5. XXX

6. XXX

The Admitted Facts

7. At the outset of these proceedings, through his Counsel, Mr Tom Day, Dr Goodwin made admissions to the paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

(2) IMPAIRMENT

The Outcome of Applications Made during the Impairment Stage

8. On day two of the hearing, after Dr Goodwin had finished giving his oral evidence, Mr Day made an application on behalf of Dr Goodwin, for the hearing to be held virtually. Mr Day submitted that Dr Goodwin would feel more comfortable dealing with the hearing from home with the support of his family. XXX. He submitted that he did not anticipate there to be any inconvenience or prejudice to any party. Ms Khanna did not oppose the application.

9. The Tribunal granted the application for the parties to attend the hearing virtually from day three.

Witness Evidence

10. The Tribunal received evidence on behalf of the GMC in the form of a witness statement from the following witness who was not called to give oral evidence:

- Dr C, Consultant Orthopaedic Surgeon and Divisional Director for Surgery, the Trust.
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11. Dr Goodwin provided his own witness statement dated 1 May 2024, together with written reflections, and also gave oral evidence at the hearing.

XXX

12. XXX

XXX

13. XXX

14. XXX

15. XXX

16. XXX

17. XXX

18. XXX

    XXX

19. XXX

20. XXX

21. XXX

22. XXX

XXX

23. XXX

24. XXX

25. XXX

26. XXX

27. XXX

28. XXX

29. XXX

30. XXX

31. XXX

XXX

32. XXX

33. XXX

34. XXX

Summary of evidence

Dr Goodwin

35. In his witness statement, Dr Goodwin described a number of difficulties in his personal and professional life, which he said had been acutely stressful XXX. For example, XXX.

36. Dr Goodwin also felt that his job had become more bureaucratic and frustrating, for example because his clinical autonomy had been eroded. He described how getting through his day-to-day job had become a struggle and he said that he had been returning home '*less and less satisfied and more worried*'.

37. As a result of these stressors, Dr Goodwin said that he sought solace from XXX. XXX. He thought that coming forward and admitting XXX would lead to the end of his career. Dr Goodwin acknowledged that, in retrospect, that had been a mistake.

38. During his oral evidence, Dr Goodwin accepted that removing XXX from the Trust and Three Shires, for his own use, had amounted to theft. He said that, initially, he had obtained the drug by taking away any left over XXX and would then adminsister it to himself. Dr Goodwin described how, XXX, he would request more XXX from the drugs cupboard, than were needed for the patient, for his own use.

39. Dr Goodwin explained to the Tribunal that XXX is a drug that XXX in patients undergoing a general anaesthetic, and is one of a number of drugs that is used in general anaesthesia. He stated that whilst the dose of XXX given to patients varies according to

the procedure being undertaken, a typical dose would be XXX. He confirmed that XXX is supplied in XXX.

40. In his oral evidence, Dr Goodwin stated that XXX (in the XXX months up to June 2021) he was taking XXX. He said that he would XXX, whilst in theatre, and then leave theatre to self-administer the drug. Dr Goodwin told the Tribunal that he self-administered the drug XXX and that the effects would typically last for about XXX, albeit diminishing over time. He said that, once he had taken XXX, it would take two to three minutes to feel any effects XXX and that he would feel, '*XXX*'.

41. Dr Goodwin described self-administering XXX during breaks between procedures. He recalled that on one occasion during a procedure when the patient was under anaesthesia, he had left the patient with an Operating Department Practitioner ('ODP') in order to self-administer XXX. However he said that the patient had been left for only a few minutes whilst he went to the toilet, which was situated only a few yards away. He described how he had tried to go to the toilet on a previous occasion, during the same operating procedure, but that it had been occupied.

42. Mr Goodwin stated that the paperwork for medication would usually be done at the end of an operating list. He said that an ODP would bring the CDR to him which would give the name of each patient, together with the type and quantity of controlled drugs that had been administered to those patients. Dr Goodwin stated that both he and the ODP would sign the CDR, and he acknowledged that the CDR had, falsely, recorded (as against each relevant patient) both the XXX that he had administered to the patient and that which he had self-administered. However he told the Tribunal that the patients' records had accurately recorded the quantity of XXX that had been administered to each patient on the anaesthetic chart.

43. Dr Goodwin was asked whether or not an ODP had ever questioned the quantity of XXX that he had been prescribing to patients. He replied that as a joke an ODP had asked him if was was putting the drug in his coffee.

44. Dr Goodwin stated that he had not self-administered XXX at home as it had not been available to him. He explained that after having taken the drug, XXX.

45. Dr Goodwin accepted that taking XXX when working as a Consultant Anaesthetist was deplorable behaviour and that it had the potential to harm patients. He said he had been aware of this at the time, XXX.

46. Dr Goodwin admitted that amending the CDR to obtain doses of XXX was dishonest. He appreciated that he was in a position of trust as a senior doctor and that his actions let down his colleagues, and had a negative impact upon their professional relationship and the reputation of the medical profession. He said that he deeply regretted this and that the public rightly expected high standards of probity amongst doctors. Dr Goodwin stated that without that trust, the sanctity of the doctor-patient relationship was broken.

47. Dr Goodwin stated that honesty and transparency, probity, ethics, duty of candour are all vital pillars in maintaining public trust in the medical profession. He acknowledged that he had clearly betrayed that trust.

48. XXX

49. XXX

50. Dr Goodwin stated that his past behaviour was, on reflection, deplorable and highly regretful. He acknowleged that his actions clearly had the potential to put patients at risk, and to impact upon the wider public perception of the medical profession. Dr Goodwin said that working in clinical medicine requires clear thinking and sound judgement and that he had put that in jeopardy by his actions. XXX.

51. Dr Goodwin confirmed that he has recently completed a six-week unpaid clinical attachment at University Hospitals Coventry & Warwickshire NHS Trust ('Coventry'). He stated that the attachment had given him an opportunity to put his extensive reflections to good use and that it was his intention to redeem himself and get back to clinical practice. He said that he had learnt from his mistakes and that he knew what could be done to XXX.

52. XXX. He realised that it was his responsibility to have owned up to his mistakes and that he should not have '*edited*' the CDR, which had been dishonest. He acknowleged that he had abused his professional standing and position of trust.

53. Dr Goodwin explained that he had developed resilience in recent times and, for example, had coped with the stresses of these proceedings and the recent XXX without resorting to XXX. Whilst he accepted that there would be stresses associated with returning to work he believed that he had a different mindset, in that he now appreciated that he could only control so much and had to let go of matters that he would previously have found stressful. XXX. Dr Goodwin stated that he had a strong aversion to XXX and did not want to end up in the same situation in which he finds himself.

54. Dr Goodwin stated that he had completed various relevant courses, which included learning on Reflection, Probity, Ethics and the Statutory Duty of Candour. He said that he has heavily reflected on those courses and had read the GMC's updated Good Medical Practice, 2024.

Documentary Evidence

55. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included but was not limited to:
    - Investigation report by Mr G dated 3 November 2021;
    - Supplementary Case Manager's report dated 28 March 2023;
    - Referral from Northampton Hospitals NHS Trust dated 6 May 2022;
    - Disciplinary meeting notes dated 9 May 2022;
    - Email of self-referral from Dr Goodwin dated 26 May;
    - XXX;
    - Email and attachment from Mr H to GMC, attaching Drug Audit Pharmacy document, dated 2 May 2023;
    - XXX.
    - Details of courses attended and CPD, various dates.

56. The Tribunal also received in support of Dr Goodwin, a number of testimonials, all of which it has read.

Submissions

On behalf of the GMC

57. On behalf of the GMC, Ms Priya Khanna, Counsel, submitted that Dr Goodwin's fitness to practise is impaired. She reminded the Tribunal of a number of points of applicable law including the two-step approach, set out in the case of *Cheatle v GMC (2009) EWHC 645*, that should be undertaken when Tribunals are considering the question of impaired fitness to practise. She also highlighted the cases of *Roylance v GMC (no2) (2000) 1 AC 311*, *GMC v Meadow [2006] EWCA Civ 1390* and *Nandi v GMC [2004] EWHC 2317 (Admin)* in connection with the definitions of 'misconduct' and 'serious misconduct'.

58. Ms Khanna submitted that the version of Good Medical Practice dated April 2013 ('GMP') was applicable and she stated that the relevant standards applicable to this case were under Domain 4 of GMP, maintaining trust. Ms Khanna highlighted paragraph 55 of

GMP which states that doctors should be open and honest when things go wrong. She submitted that things had seriously gone wrong in this case, and she reminded the Tribunal that all of Dr Goodwin's conduct had taken place in a hospital environment, when he had been a Consultant Anaesthetist. She stated that Dr Goodwin had not acted out of respect for his patients, XXX.

59. Ms Khanna reminded the Tribunal that Dr Goodwin had admitted to dishonesty and she submitted that paragraph 65 of GMP applied, which states that doctors must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession. She submitted that Dr Goodwin had been obtaining more medications than was required, and attributing it to patients who had not been in receipt of that quantity of that medication. She submitted that such misconduct went to the heart of the relationship of trust that should exist between a doctor and patients.

60. Ms Khanna submitted that the ODPs who were working in the same environment as Dr Goodwin placed reliance on the CDR, which is a legal document, and which had been falsified by Dr Goodwin. Ms Khanna submitted that such conduct had been a serious breach of the standards in GMP, in particular paragraph 71, because Dr Goodwin had falsified the CDR by leaving out relevant information, namely how much of the drug had been used for the patient concerned. She submitted that Dr Goodwin's use had increased to such an extent that, sometimes, the XXX were entirely for his own use.

61. Ms Khanna submitted that during her cross examination of Dr Goodwin, she had asked him to put himself in the shoes of those patients who would have been on the operating table when he was self-administering XXX. She submitted that a member of the public with knowledge of Dr Goodwin's behaviour, would regard his conduct with opprobrium.

62. Ms Khanna submitted that dishonesty breached a fundamental tenet of the medical profession and fell at the top end of the gravity of misconduct. She submitted that Dr Goodwin's behaviour amounted to misconduct which was serious.

63. Ms Khanna submitted that Dr Goodwin had a degree of insight and had made huge progress; she acknowledged that he had done his best to remediate. However, she submitted that that Dr Goodwin no longer had access to controlled drugs and, as a result, it might be easy for him to say that he had done well. However, she submitted that this did not assist the Tribunal in considering the issue of impairment. Ms Khanna submitted that Dr Goodwin had XXX; however, she submitted that there were multifactorial issues at play, one of which was XXX.

64. Ms Khanna submitted that Dr Goodwin's recognition that he had difficulties that might lead him to misconduct was one thing, but there was a fine line between demonstrating insight and blaming such difficulties for the misconduct. She submitted that it was of concern that Dr Goodwin was asserting that he has insight because he had removed himself from the environment in which his misconduct took place XXX. Ms Khanna submitted that it was to Dr Goodwin's credit that XXX, but that his insight was developing at best, but was not fully developed. She submitted that Dr Goodwin's focus had, to a certain extent, been on his appeal against dismissal from the Trust, in order to save his career.

65. Ms Khanna submitted that the seriousness of Dr Goodwin's misconduct justified a finding of impairment, and that the public would be shocked if that finding was not made. She submitted that the conduct took place in the workplace, over a number of years and involved falsifying the CDR in order to facilitate Dr Goodwin's XXX drug use whilst at work. Ms Khanna recognised that no harm had occurred to patients, but she submitted that the risk of harm was neverthless present. She reminded the Tribunal that Dr Goodwin had been a Consultant Anaesthetist, whose job it was to anaesthetise patients and who had been using the very drug on himself during procedures. Ms Khanna submitted that such behaviour struck at the heart of the confidence that the public place in the medical profession.

66. Ms Khanna referred to the case of *Brocklebank v GMC (2003) UK PC 57* and submitted that underlying conditions were capable of impairing a doctor's fitness to practise where there was a risk that the condition could reoccur. She therefore submitted that opioid dependence in remission is capable of being an impairing diagnosis.

<u>On behalf of Dr Goodwin</u>

67. On behalf of Dr Goodwin, Mr Tom Day, Counsel, submitted that Dr Goodwin had admitted that his misconduct was serious and that his fitness to practise is impaired by reason of that misconduct. Mr Day acknowledged that the conduct needs to be marked in order to declare and uphold proper standards in the profession and to maintain public confidence. He also submitted that XXX.

68. Mr Day submitted that Dr Goodwin did not dispute that his conduct had been contrary to GMP; Mr Day stated that it was 'plain and obvious' that GMP been breached. However he disputed Ms Khanna's assertion that Dr Goodwin had obtained XXX entirely for his own use – he submitted that the evidence was that Dr Goodwin had inflated the amount of the drug that had been required for patients in order that he could use some

himself. Mr Day also disputed that paragraph 55 of GMP was engaged in this case. Mr Day referred the Tribunal to the cases of *PSA v NMC (2017) SLT 625*, *PSA v GMC & Uppal (2015) EWHC 1304* and *Sawati v GMC (2022) EWHC (Admin)*.

69. Mr Day reminded the Tribunal that Dr Goodwin said in oral evidence that his testimonials painted him in a better light than how he regarded himself and Mr Day submitted that this evidence was reflective of Dr Goodwin's modesty. Mr Day stated that Dr Goodwin had worked as a Consultant Anaesthetist for 22 years XXX.

70. Mr Day submitted that Dr Goodwin's XXX. He stated that, at no point had Dr Goodwin been of the view that there was an impact on his clinical performance; however, he now recognised that his feeling of control and belief that patients were not at risk, was illusory. Mr Day submitted that when Dr Goodwin was confronted about the issue he reacted with striking honesty, he admitted his behaviour without hesitation or minimisation. He stated that Dr Goodwin had revealed to the Trust information about his conduct that, in all likelihood, would never have been discovered. Mr Day submitted that Dr Goodwin had not sought to downplay what had happened; he had been completely honest and was relieved to have been discovered. Mr Day reminded the Tribunal that Dr Goodwin had described his conduct as '*appalling*' and '*shameful*' and that it would be viewed with '*disgust*'.

71. Mr Day submitted that Dr Goodwin did not dispute that his fitness to practise is impaired, but submitted that this is not a case of a doctor who is innately dishonest. Mr Day stated that Dr Goodwin's behaviour had been an aberration caused by XXX.

72. Mr Day submitted that when Dr Goodwin's XXX, he was the same person as he was before, honest and straightforward; in addition, he immediately ceased consumption XXX. Mr Day submitted that there was a public interest in returning skilled and competent doctors to unrestricted practise. He submitted that the risk of repetition was unlikely XXX. He submitted that Dr Goodwin had full insight into XXX, who he is and into his stressors; Mr Day reminded the Tribunal of Dr D's opinion that Dr Goodwin had good insight. Mr Day stated that Ms Khanna's submission that Dr Goodwin had removed himself from the clinical environment, was an '*error*' because the issue has no relevance to insight.

73. Mr Day submitted that Dr Goodwin had done his best to remediate, had XXX and had reflected deeply. XXX. Mr Day submitted that Dr Goodwin had made huge changes in his life by way of remediation, by XXX and by developing insight. XXX.

74. Mr Day reminded the Tribunal that Dr Goodwin XXX. He submitted that this was to Dr Goodwin's credit, and that a member of the public with knowledge of the case would expect Dr Goodwin's conduct to be marked with compassion and understanding. Mr Day submitted that there was a singular root cause to Dr Goodwin's misconduct and he identified a number of mitigating factors XXX which drove his misconduct; his honesty when confronted; his revelation to the Trust of misconduct that otherwise would not have been discovered; Dr Goodwin's frank and candid evidence to the Tribunal; his complete insight and remediation; that the risk of relapse is low; that no actual harm was caused to patients; no evidence of poor performance on Dr Goodwin's part; the fact that his misconduct was an aberration in an otherwise unblemished career; and that he is a good doctor.

The Relevant Legal Principles

75. 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.

76. In approaching its 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 serious misconduct, could lead to a finding of impairment.

77. In the Fifth Report of the Shipman Inquiry, Dame Janet Smith identified the test to be applied for a finding of impairment. Dame Janet identified the following reasons for unfitness:

> *'(a) that the doctor presented a risk to patients, (b) that the doctor had brought the profession into disrepute, (c) that the doctor had breached one of the fundamental tenets of the profession and (d) that the doctor's integrity could not be relied upon. Lack of integrity might or might not involve a risk to patients. It might or might not bring the profession into disrepute. It might be regarded as a fundamental tenet of the profession.'*

78. In *CHRE v NMC & Grant (2011) EWHC 927 (Admin)* Cox J stated:

> *'the term "impairment of fitness to practise" has not been defined… the concept has the advantage of flexibility being capable of a multiplicity of problems but also the disadvantages that flow from a lack of clarity and definition. Further, recognising fitness*

to practise inevitably involves making a value judgment. In determining whether a practitioner's fitness to practise is impaired…. The relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidences in the profession would be undermined if a finding of impairment were not made in the particular circumstances'

79. Cox J referred with approval to the comments of Dame Janet Smith in her 5th report of the Shipman inquiry which Cox J regarded as a valuable test for panels considering impairment of a doctor's fitness to practise, namely:

    'do our findings in respect of the doctor's misconduct … show that his / her fitness to [practise is impaired in the sense that he/ she:

    (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; and/ or
    (d) has in the past acted dishonestly and/or is liable to act dishonestly in the future'

80. In *Cohen v GMC (2008) EWHC 581* the Court held that the task of the panel, in considering impairment, is to take account of the practitioner's misconduct and then consider it in light of all the other relevant factors known to them. It will be highly relevant in determining if fitness to practise is impaired to consider:

- whether the practitioner's misconduct is easily remediable;
- whether the misconduct has been remedied; and
- whether the misconduct is likely to be repeated

81. In *GMC v Nwachuku [2017] EWHC 2085 (Admin)* it was held that dishonesty will usually lead to a finding of current impaired fitness to practise. The court set out some useful guidance on the principles that are to be applied by tribunals tasked with considering allegations of dishonesty, including the following matters: the timing of admissions will be an important factor to be taken into consideration by the tribunal; evidence of remediation should be carefully scrutinised to see whether the risk of repetition remains, and whether the remediation is sufficient in all of the circumstances of the case; the doctor will also need to demonstrate that responsibility for their actions is fully

acknowledged; and the overarching concern is the public interest in protecting the public and maintaining confidence in the practitioner and the medical profession, when considering whether the misconduct in question impairs fitness to practise

82. The Tribunal must determine whether Dr Goodwin's fitness to practise is impaired today, taking into account Dr Goodwin's conduct XXX 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 Tribunal's Determination on Impairment

XXX

83. XXX

84. XXX

85. XXX

86. XXX

87. XXX

88. XXX

XXX

89. XXX

90. XXX

91. XXX

92. XXX

93. XXX

94. XXX

Misconduct

95. The Tribunal first considered whether the facts found proved against Dr Goodwin amount to misconduct. Misconduct can be found in circumstances where there have been serious departures from expected standards of conduct and behaviour, often identified by reference to the paragraphs of GMP.

96. Both parties submitted that Dr Goodwin's behaviour amounted to misconduct which was serious.

97. The Tribunal identified that the following paragraphs of GMP are relevant, 1, 19, 25, XXX, 35, 37, 65, 68 and 71:

> *'1 Patients need good doctors. Good doctors make the care of their patients their first concern: they…are honest and trustworthy, and act with integrity and within the law.*
> *…*
> *19 Documents you make (including clinical records) to formally record your work must be clear, accurate and legible….*
> *…*
> *25 You must take prompt action if you think that patient safety, dignity or comfort is or may be seriously compromised…*
>
> *XXX*
>
> *35 You must work collaboratively with colleagues, respecting their skills and contributions.*
> *…*
> *37 You must be aware of how your behaviour may influence others within and outside the team.*
> *…*
> *65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.*
> *…*
> *68 You must be honest and trustworthy in all your communication with patients and colleagues…*
> *…*
> *71 You must be honest and trustworthy when writing reports, and when*

completing or signing forms, reports and other documents. You must make sure that any documents you write or sign are not false or misleading.
a You must take reasonable steps to check the information is correct.
b You must not deliberately leave out relevant information.'

98. The Tribunal bore in mind that Dr Goodwin had self-administered a controlled drug on a regular and repeated basis over a period of two years within a clinical setting, whilst working as a Consultant Anaesthetist. During the six months up to June 2021, Dr Goodwin had been taking XXX. He stated that he prescribed extra XXX for patients that he intended solely for his own use. Dr Goodwin also accepted in oral evidence that his conduct in removing XXX from the Trust and Three Shires amounted to theft (albeit the Tribunal noted that no criminal charges had been brought against him). In addition, Dr Goodwin's behaviour in providing false information within the CDR had been dishonest and had been the means by which Dr Goodwin was able to obtain XXX.

99. Dr Goodwin's drug taking occurred at two of his workplace locations, namely the Trust and at Shire Hospital. The Tribunal noted that, during his disciplinary hearing at the Trust, he stated that he would self-administer XXX between cases or after the list. He told the Trust that he could only recall taking the drug during a case on one occasion, when the operation had been completed. He stated that the patient was breathing spontaneously, on an anaesthetic mixture, that the surgery had finished and the surgeons were closing the patient's skin very slowly.

100. The Tribunal was of the view that Dr Goodwin's behaviour had been deplorable for several reasons. He explained to the Tribunal that Consultant Anaesthetists administer large doses of '*highly toxic*' drugs to patients day in, day out and that the patients would die if they were not in a controlled state. By self-administering XXX during the course of his duties, Dr Goodwin had broken the essential bond of trust that should exist between patient and doctor. Albeit that XXX, he selfishly put his own interests before those of the vulnerable patients in his care. That no harm came to any patients was, in the Tribunal's view, a matter of luck rather than judgement; by acting under the influence of XXX, whilst working as a Consultant Anaesthetist Dr Goodwin created a real risk to patient safety and he compromised the care that his patients were entitled to expect from him. The Tribunal took the view that a member of the public, with knowledge of Dr Goodwin's behaviour, would be appalled and might understandably be apprehensive about being treated by him in the future and lose trust in the medical profession.

101. The Tribunal considered that Dr Goodwin has also treated his colleagues, not least the ODPs and surgeons, with contempt and disrespect. Dr Goodwin had put his own

interests ahead of those of his colleagues and had deceived his ODP colleagues into believing that the quantity of XXX set out in the CDR was for the relevant patient. In creating a discrepancy in the records of the Trust and Three Shires, Dr Goodwin acted dishonesty. In addition, he made his ODP colleagues complicit (albeit unwittingly) in that dishonesty, because they signed the CDR believing it to be a true and accurate record.

102. The Tribunal accepted that Dr Goodwin's XXX had contributed to his misconduct. Whilst that offers some mitigation, it does not excuse or reduce the seriousness of his misconduct, nor the concern that members of the public would be entitled to express about his behaviour.

103. The Tribunal concluded that Dr Goodwin's conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct which was serious.

Impairment

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

105. The Tribunal was satisfied that Dr Goodwin's dishonest misconduct brought the profession into disrepute, and that he had breached the profession's fundamental tenet of acting honestly. The Tribunal bore in mind that dishonesty can be difficult, but not impossible, to remediate.

106. The Tribunal went on to consider whether the misconduct had been remedied. Dr Goodwin had completed courses on the Duty of Candour, Reflection, Insight and Probity. Dr Goodwin provided cerificates of completion in relation to these courses, together with his reflections on each of the courses. However the Tribunal took the view that those reflections were superficial and did little more than summarise the course content as opposed to setting out how he had applied or would apply his learning or by reflecting back in detail on his misconduct. The Tribunal concluded that, although he was to be given credit for XXX and for undertaking courses relating to probity, Dr Goodwin had not adequately remediated his dishonest misconduct.

107. The Tribunal was of the view that Dr Goodwin had made more effort to reflect on the XXX of his behaviour, than on his dishonesty and the wider impact of his misconduct on colleagues, patients, the profession and the wider public interest. Whilst the Tribunal

acknowledged that Dr Goodwin was remorseful and ashamed of his actions, it considered that he had insufficiently reflected on the deceptive, dishonest and persistent nature of his misconduct, or its potential impact of patient safety and public confidence. To that extent his reflections had largely focused on himself and his own circumstances, rather than on the wider public interest. In addition the Tribunal noted that, in his oral evidence, Dr Goodwin had struggled to answer a question put to him about how he would apply his learning on probity to his future clinical practice. Given the extent and seriousness of Dr Goodwin's dishonesty, his lack of detailed reflections on that issue was of concern.

108. The Tribunal was of the view that Dr Goodwin's insight was still developing in relation to his misconduct and, in particular, in relation to his dishonesty. Whilst he had admitted his dishonesty and had been open and candid with the Trust, that had only occurred when his misconduct was discovered.

109. The Tribunal was of the view that there was a risk of Dr Goodwin repeating his misconduct, albeit that he had made good efforts to address XXX from which his misconduct stemmed. XXX. Given his incomplete insight into his dishonesty, the Tribunal determined that there was also a risk of him repeating that behaviour.

110. The Tribunal therefore determined that Dr Goodwin's fitness to practise is impaired by reason of misconduct.

111. The Tribunal considered that a finding of impairment was necessary to protect and promote the health, safety and wellbeing of the public, to promote and maintain public confidence in the medical profession and proper professional standards and conduct for members of the profession. The Tribunal determined that public confidence in the medical profession would be undermined if there was no finding of impairment in this case.

CONCLUSION

112. The Tribunal has therefore determined that Dr Goodwin's fitness to practise is impaired by XXX misconduct.

Determination on Sanction - 10/06/2024

1. This determination will be handed down in private. However, as this case concerns Dr Goodwin's misconduct a redacted version will be published at the close of the hearing.

2. Having determined that Dr Goodwin's fitness to practise is impaired by reason of misconduct XXX, 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

3. The Tribunal has taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction.

4. The Tribunal received further evidence on behalf of Dr Goodwin, namely a letter dated 6 June 2024 from Dr J, Clinical Director for Clinical Support Services, University Hospitals Coventry and Warwickshire NHS Trust.

Submissions

On behalf of the GMC

5. On behalf of the GMC, Ms Priya Khanna, Counsel submitted that the appropriate sanction was for Dr Goodwin to be suspended from the Medical Register. She submitted that Dr Goodwin, over a period of time either before, during or after a number of procedures, self-administered XXX, which had created a very real and tangible risk to patients. Ms Khanna submitted that it was purely happenstance that no harm had been caused by Dr Goodwin's misconduct. She reminded the Tribunal that once Dr Goodwin had been caught by the Trust his behaviour almost automatically stopped. She submitted that it was to Dr Goodwin's credit that he had volunteered a number of facts because had he not done so, the extent of his conduct may not have materialised.

6. Nevertheless, Ms Khanna submitted that this was a very serious case. She reminded the Tribunal that Dr Goodwin was self-anesthetising during procedures and, on one occasion, whilst a patient was on the operating table. Ms Khanna stated that this was a very grave matter and that Dr Goodwin had not only put patients at risk but had also made his colleagues complicit in his dishonesty. She submitted that Dr Goodwin's conduct had involved serious breaches of GMP, had been persistent in that the conduct

occurred over a significant period of time and with an ever present risk of harm to patients.

7. Ms Khanna submitted that the mitigating factors in this case are that Dr Goodwin had admitted his misconduct as soon as the matters came to light, had been candid and had maintained his admissions throughout this process. Ms Khanna submitted that he had, in large part, been open and honest about his use of XXX. Ms Khanna submitted that Dr Goodwin had apologised for his behaviour and had previously practised without any fitness to practise concerns for over well over 20 years.

8. Ms Khanna submitted that the aggravating factors in this case are that the conduct occurred in a clinical setting. In addition, there had been XXX such that, in the months leading up to the discovery of his misconduct, he had been XXX in the course of one day. Ms Khanna submitted that the potential for significant patient harm was always present and it had been pure luck that none materialised. She submitted that any harm that could have resulted to patients would have been attributable to Dr Goodwin's self-prescribing and use of XXX.

9. Ms Khanna submitted that the misconduct in this case was not entirely explained by XXX. She submitted that the GMC maintain that the misconduct occurred in the context of XXX, but not because of it.

10. Ms Khanna submitted that all three limbs of the overarching objective were engaged. She referred to the case *GMC v Rezk [2023] EWHC 3228 (Admin)* ('Rezk'), the report of which Mr Day had provided to the Tribunal. Ms Khanna submitted that the case of Rezk referred to a conditional disposal rather than a suspension. She submitted that Dr Goodwin is very experienced unlike Dr Rezk who was a junior doctor, in training. Ms Khanna stated that one of the considerations in Dr Rezk's case was that a suspension may have led to the loss of his training programme. Ms Khanna submitted that Dr Goodwin was in a very different position in that he is a very experienced Consultant Anaesthetist. Ms Khanna submitted that while it was always a relevant consideration that a good doctor who could practise should be allowed to practise, that was somewhat mitigated by the conduct in this case. She submitted that the severity of Dr Goodwin's conduct that was distinguishable from the case of Rezk. Ms Khanna submitted that suspension was the appropriate sanction in this case.

On behalf of Dr Goodwin

11. On behalf of Dr Goodwin, Mr Tom Day, Counsel submitted that the appropriate sanction was one of conditions on Dr Goodwin's registration. He submitted that being proportionate meant doing the least necessary in order to protect the public, to maintain confidence in the profession and to uphold proper standards. He submitted that the case law was clear that it was not only the sanction in isolation which does this, but the investigation process, the process of going through a hearing, developing insight and remediation, being cross examined, a formal finding of misconduct and impairment, all serve to perform those functions. XXX. In addition, Mr Day outlined a number of further proposed conditions and submitted that Dr Goodwin would comply with them, and give 100% of his efforts to any conditions that were imposed.

12. Mr Day submitted that the mitigating factors in this case included Dr Goodwin's determination and his passion for his career in helping patients, his need to redeem himself and his maturity in undertaking an observership. Mr Day submitted that XXX was a mitigating factor, whether that was described as a contextual background or part of the causative chain. Mr Day reminded the Tribunal that there had been a lapse of time since the incident, and that Dr Goodwin had been unable to work for a period of three years. In addition, Mr Day stated that XXX. Mr Day acknowledged that a further test to Dr Goodwin's XXX would be a return to work but he submitted that the risk of repetition was sufficiently reduced for that to take place under conditions with a review.

13. Mr Day submitted that Dr Goodwin was an excellent doctor and, in support of that submission, he referred the Tribunal to the testimonial evidence. In addition, Mr Day stated that Dr Goodwin had been clear and unwavering in his remorse and apology for his conduct.

14. Mr Day referred to the case of Rezk and stated that it was helpful guidance on how conditions should be interpreted. He submitted that the High Court found that Dr Rezk needed further time to develop deeper insight, whilst imposing conditions designed to encourage or compel that. Mr Day stated that, in Dr Goodwin's case, that would be addressed by his personal development plan, the development of which was a proposed condition.

15. Mr Day outlined the aggravating factors. He acknowledged that Dr Goodwin's misconduct had involved a serious departure from the standards, put patients at risk, had undermined public confidence in doctors and required action to be taken. Mr Day submitted that Dr Goodwin's drug disorder had impacted his clinical performance and had put patients at risk of harm, albeit that there was no evidence of actual harm.

16. Mr Day submitted that the purpose of conditions was to XXX whilst protecting the public; he submitted that this was what conditions would achieve in this case, and also to allow Dr Goodwin to develop further insight to reassure the Tribunal and the public of the XXX, whilst protecting the public. Mr Day submitted that conditions would benefit both the public and Dr Goodwin - patients would benefit from his return to work because, as Dr J had made clear, there was a shortage of anaesthetists; Dr Goodwin would benefit from being able to return to work and to redeem himself from his misconduct.

17. Mr Day submitted that proportionality was more nuanced than being a matter of balancing the public interest against those of the doctor. He stated that there are often cases where such interests coincided and that Dr Goodwin's case was one such case. Mr Day submitted that Dr Goodwin had arranged a proper planned return to work at Coventry Hospital, which had taken a great deal of interest in helping Dr Goodwin return to unrestricted practise, with effect from 1 July 2024. Mr Day submitted this opportunity at Coventry may or may not be available for Dr Goodwin at the end of a period of suspension. Mr Day submitted that this was a significant factor in relation to appropriateness and proportionality, when considering what sanction should be imposed in this case.

18. Mr Day reminded the Tribunal of its finding that Dr Goodwin had not developed complete insight. In the case of Rezk insight had not completely developed either but the Court had been satisfied conditions were appropriate and that Dr Rezk would comply with them. Mr Day submitted that Dr Goodwin had the ability to respond positively to remediation and training and there was no doubt that he would comply with conditions. Mr Day acknowledged that Dr Goodwin's case was not identical to that of Rezk, but there was a risk of Dr Goodwin losing a supportive, structured placement at Coventry Hospital, whereas in Rezk it was a training contract.

19. Mr Day submitted that the conditions he had proposed carry obligations and impose burdens to take positive action. In addition, the conditions would also impose restrictions, such as informing the GMC about working arrangements, informing a range of professional colleagues about the conditions, not being able to work until a suitable workplace reporter was in place, and they allowing the GMC to monitor compliance and progress. Furthermore, Mr Day submitted that conditions would be seen by the public and the profession as an ongoing marker of disapproval of the doctor's misconduct, taking into account the mitigating and aggravating factors, whilst providing a constructive response to his shortcomings.

The Tribunal's Determination on Sanction

20. The Tribunal had regard to the submissions made by the parties, but was not bound by them. The decision as to the appropriate sanction, if any, is a matter for the Tribunal's own independent judgment.

21. In reaching its decision the Tribunal took account of the Sanctions Guidance dated 5 February 2024 ('SG') and the GMC's statutory overarching objective to protect the public.

22. The Tribunal reminded itself that the main reason for imposing any sanction is to protect the public and that sanctions are not imposed to punish doctors, even though they may have a punitive effect.

23. The Tribunal had regard to the case of *Bolton v Law Society (1994) 1 WLR 512*, in which it was stated that: '*the reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is part of the price*'.

24. Throughout its deliberations, the Tribunal applied the principle of proportionality, balancing Dr Goodwin's interests with the public interest.

25. Before deciding what action, if any, to take in respect of Dr Goodwin's registration, the Tribunal considered the aggravating and mitigating factors present in this case.

Aggravating factors

26. The Tribunal identified the aggravating factors in this case. Dr Goodwin's dishonest misconduct had been persistent and covered up over a number of years, from 2019 to 2021. The misconduct occurred in a clinical setting whilst Dr Goodwin worked at two hospitals. Dr Goodwin had been under the influence of a controlled drug before, during and after theatre, whilst working as a Consultant Anaesthetist. He had put patients, who were dependent on him and under his care, at risk during their procedures. It had been a matter of luck that no patients had actually come to harm.

27. Dr Goodwin had treated colleagues with disrespect by making ODP colleagues complicit (albeit unwillingly) in his dishonesty, because they had signed the CDR believing it to be a true and accurate record. Further, Dr Goodwin lacked sufficient insight into his dishonest misconduct in particular the wider implications.

<u>Mitigating factors</u>

28. Having identified the aggravating factors in this case, the Tribunal determined that the mitigating factors were as follows. Dr Goodwin was a man of previous good character and there was no evidence that he had repeated his misconduct since being challenged by the Trust in 2021. XXX.

29. Dr Goodwin had a good level of insight XXX. He had been committed and had taken proactive steps to address those issues XXX. Furthermore, Dr Goodwin had made early admissions and had been open with the Trust, GMC and during these proceedings; he had revealed information to the Trust which may not have been discovered had he not divulged it. In addition, the misconduct had taken place over three years ago and the Tribunal considered the lapse of time to be a mitigating factor.

30. The Tribunal balanced the aggravating and mitigating factors and determined that the aggravating factors far outweighed the mitigating factors. Dr Goodwin's misconduct was very serious, had involved the breach of a fundamental tenet of the medical profession, namely honesty. His dishonesty had been repeated, had taken place over a number of years and had been concealed from the Trust and Three Shires Hospital. As a result, Dr Goodwin's dishonesty was at the higher end of the scale of seriousness. Whilst he had some insight into his dishonest conduct, his insight was limited. Dr Goodwin's misconduct had occurred within two clinical settings, had put patient safety at risk and had contravened a number of paragraphs of GMP. Dr Goodwin was clearly an otherwise good and experienced anaesthetist. In addition, he had been proactive in addressing XXX; whilst this was positive, it did not go all the way to address the public interest, particularly his dishonesty and the persistent and concealed nature of it.

31. The Tribunal considered each sanction available to it in ascending order of severity, starting with the least restrictive.

No action

32. The Tribunal first considered whether to conclude the case by taking no action. The Tribunal was of the view that, having regard to the serious dishonesty in this case, taking no action following a finding of impaired fitness to practise would only be appropriate in exceptional circumstances. The Tribunal determined that there are no exceptional circumstances in this case and that, given the seriousness of its findings, it would not be

sufficient, proportionate, or in the public interest to conclude this case by taking no action.

Conditions

33. The Tribunal next considered whether to impose conditions on Dr Goodwin's registration. It bore in mind paragraphs XXX, 82, 84 and 85 of SG, some of which are set out below:

> *'XXX*
> *…*
>
> *82 Conditions are likely to be workable where:*
> *a the doctor has insight*
> *b a period of retraining and/or supervision is likely to be the most appropriate way of addressing any findings*
> *c the tribunal is satisfied the doctor will comply with them*
> *d the doctor has the potential to respond positively to remediation, or retraining, or to their work being supervised.*
> *…*
> *84 Depending on the type of case (eg health, language, performance or misconduct), some or all of the following factors being present (this list is not exhaustive) would indicate that conditions may be appropriate:*
>
> *a no evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage*
> *…*
> *d willing to be open and honest with patients if things go wrong (Good medical practice, paragraphs 45-46)*
> *XXX.'*

34. The Tribunal was of the view that whilst conditions may be appropriate for cases which XXX, as it involved dishonesty which had been serious and which had put patient safety at risk.

35. The Tribunal considered that conditions could address Dr Goodwin's need for ongoing supervision and drug testing as advised by the medical experts. In addition, the Tribunal was satisfied that Dr Goodwin was likely to comply with any conditions and would respond positively to having his work supervised. Furthermore there was no evidence

that would demonstrate that remediation was unlikely to be successful. However, the Tribunal had identified that whilst Dr Goodwin XXX, his insight into the dishonest misconduct was limited. The Tribunal was of the view that no appropriate, workable, measurable or proportionate conditions could be formulated to address Dr Goodwin's dishonest behaviour or his lack of insight in relation to it. This was not an issue concerning professional practice which could be adequately addressed by conditions of practice.

36. The Tribunal considered the case of Rezk, which involved the case of a trainee doctor whose fitness to practise was found to be impaired as a result of misconduct, namely sexual harassment. The High Court held that it had not been appropriate for a tribunal to take no action in Dr Rezk's case and substituted a sanction of conditional registration. The Court had taken the view that Dr Rezk's conditions, would help him to address the shortcomings in his insight and attitudes. In contrast to Dr Rezk, Dr Goodwin is an experienced consultant with over 20 years' experience as an anaesthetist and 30 years' experience as a doctor; unlike Dr Rezk, Dr Goodwin would not be participating in a structured programme of learning alongside his clinical duties.

37. The Tribunal determined that given the seriousness of its findings, conditions would not be sufficient to protect, promote and maintain the health, safety and well-being of the public, to promote or maintain either public confidence in the medical profession or proper professional standards and conduct for members of the medical profession.

Suspension

38. The Tribunal then went on to consider whether imposing a period of suspension on Dr Goodwin's registration would be proportionate and sufficient to satisfy the overarching objective.

39. The Tribunal considered paragraphs 91, 92, 93, 97 (a), (e), (f) and (g), 120, 125(b), 126, 128, 129, 160, 161, 162(a) (b) of SG to be particularly relevant to its consideration of suspension:

    '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.

92 Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).

93 Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions (see paragraphs 24–49).

…

97 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.

a A serious departure from Good medical practice, but where the misconduct is not so difficult to remediate that complete removal from the register is in the public interest. However, the departure is serious enough that a sanction lower than a suspension would not be sufficient to protect the public.

…

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.'

…

120 Good medical practice states that registered doctors must be honest and trustworthy, and must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession.

…

125 Examples of dishonesty in professional practice could include:

…

b falsifying or improperly amending patient records

…

126 For further detail on a doctor's obligations see Good medical practice paragraphs 69–71 on the duty to keep clear, accurate and legible records, and paragraphs 88–89 and 92 regarding writing reports…and signing documents.

…

128 Dishonesty, if persistent and/or covered up, is likely to result in erasure (see further guidance at paragraph 120–128).

129 Cases in this category are those where a doctor has not acted in a patient's best interests and has failed to provide an adequate level of care, falling well below expected professional standards. This is particularly where there is a deliberate or reckless disregard for patient safety or a breach of the fundamental duty of doctors to 'Make the care of [your] patients [your] first concern' (Good medical practice, page 7).

160 Doctors are expected to act with honesty and integrity and uphold the law – this includes their use of drugs and alcohol. Any serious departure from the standards in this regard that puts patients at risk, or undermines public confidence in doctors, will require action to be taken.

XXX

40. The Tribunal considered that all of these paragraphs applied in this case.

41. The Tribunal was of the view that an order of suspension would have a deterrent effect, sending a clear signal to Dr Goodwin, the public and the profession that this type of dishonest misconduct was unacceptable.

42. The Tribunal considered whether erasure from the Medical Register would be an appropriate sanction in this case. It bore in mind paragraphs 107, 108, 109 (a), (b), (c), (d), (h) and (i) of the SG in particular:

'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.

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 difficult to remediate.
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...
d Abuse of position/trust)...

h Dishonesty, especially where persistent and/or covered up…
i Putting their own interests before those of their patients…'

43. The Tribunal found that all of the above applied. However, it had found that XXX were a contributing factor to the misconduct; he had developed good insight XXX, had undertaken a good level of remediation XXX. Therefore, the Tribunal determined that Dr Goodwin's actions were not fundamentally incompatible with continued registration.

44. The Tribunal concluded that an order of erasure would be disproportionate, and not necessary to maintain public confidence.

45. In considering the sanction of suspension, the Tribunal weighed the doctor's interests against the public interest, and again balanced and evaluated the aggravating and mitigating factors found. It bore in mind that any period of suspension may affect Dr Goodwin's offer of work from Coventry Hospital that was due to start on 1 July 2024. In that regard the Tribunal took into consideration the email from Dr J dated 6 June 2024 which stated:

    'The Royal College of Anaesthetists (RCoA) estimates that there is an anaesthetic workforce gap of 1,900 (14%) – which leads to an estimated 1.4 Million patients missing out on surgical procedures every year.

    Many patients are now waiting over 52 weeks since the pandemic - we will not be able to be reduce waiting times without additional trained workforce.
    …
    If Dr Goodwin was unable to commence in July it would delay his return to providing care to patients.'

46. The Tribunal noted that in Rezk, HHJ Lang stated, '*I am satisfied that there is a real risk that a suspension will result in the loss of Dr Rezk's training contract*'. She went on to state that, in such circumstances, it would be difficult for Dr Rezk to get back onto the training programme. In contrast, Dr J's letter stated that if Dr Goodwin was unable to commence work in July 2024, it would delay his return rather than result in Coventry completely withdrawing its offer of work. In addition, given the anaesthetic workforce gap referred to in Dr J's letter, it seemed likely in view of Dr Goodwin's experience and skill, that he would be well placed to return to clinical practise in future should he be able to demonstrate sufficient insight into his dishonest misconduct.

47. The Tribunal also bore in mind the comments HHJ Lang, namely: *‘I readily accept that, if it is necessary to suspend Dr Rezk to meet the overarching objective, then the likely damage to his career prospects should not deter me from doing so*’.

48. The Tribunal also took into account Dr Goodwin’s view, as expressed in his oral evidenced, that he had been effectively suspended since 2021. The Tribunal considered that, whilst this was unfortunate and whilst the lapse of time since his misconduct was a mitigating factor, an order of suspension would not preclude him from working, except as a doctor. In addition, the Tribunal took the view that its primary consideration was the overarching objective, namely the protection of the public, rather than any disruption to Dr Goodwin’s career.

49. In balancing the interests of Dr Goodwin, and in particular his desire to return to clinical practise, against those of the public interest, the Tribunal considered that there was an interest in returning an otherwise good and experienced doctor to practise, particularly given the pressures alluded to by Dr J in her email. However, the Tribunal determined that the seriousness of Dr Goodwin’s misconduct was such that the public interest (as expressed in all three limbs of the overarching objective) would only be met by suspension, whilst providing Dr Goodwin the opportunity to develop insight into his dishonesty.

50. Having determined to suspend Dr Goodwin’s registration, the Tribunal went on to consider the length of that suspension by taking into account the list of factors set out in the SG when considering length of suspension. It found that a number of the factors (particularly as to ‘Seriousness of the Findings’) applied in this case.

51. The Tribunal determined to suspend Dr Goodwin’s registration from the medical register for a period of 12 months. It was satisfied that such a period marked the seriousness of Dr Goodwin’s dishonest misconduct and upheld the overarching objective to protect, promote and maintain the health, safety and well-being of the public, to promote or maintain either public confidence in the medical profession or proper professional standards and conduct for members of the medical profession.

Review

52. The Tribunal determined to direct a review of Dr Goodwin’s case. A review hearing will convene shortly before the end of the period of suspension, unless an early review is sought.

53. The Tribunal wished to clarify that at the review hearing, the onus will be on Dr Goodwin to demonstrate how he has further developed his insight and remediated his dishonest misconduct. Any future Tribunal may be assisted by the following document:

- An up-to-date reflective piece on Dr Goodwin's insight into the dishonest; misconduct and the findings of this Tribunal;
- Any evidence of continuing remediation;
- Evidence that Dr Goodwin has kept his medical knowledge and skills up to date including relevant Continued Professional Development;
- XXX;
- XXX;
- XXX;
- Evidence of future career intentions;
- Current testimonials to cover probity and conduct;
- Evidence of any relevant work Dr Goodwin has undertaken during the period of suspension;
- Any other relevant evidence that Dr Goodwin considers will assist the reviewing tribunal.

Determination on Immediate Order - 10/06/2024

1. Having determined to suspend Dr Goodwin's registration. The Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Goodwin's registration should be subject to an immediate order.

Submissions

On behalf of the GMC

2. On behalf of the GMC, Ms Priya Khanna, Counsel submitted that it was necessary to impose an immediate order of suspension. She submitted that all three limbs of the overarching objective had been engaged and that an immediate order was particularly appropriate where there was a risk to patient safety, although no harm had been caused to patients. She submitted that Dr Goodwin was aware that suspension was very much a possible outcome. Therefore, Dr Goodwin would have had adequate time to attend to any consequences which might flow from such an immediate order being imposed.

3. Ms Khanna referred the Tribunal to its findings regarding the seriousness, the persistent dishonest conduct in relation to self-medicating during before and after procedures. She submitted that given the egregious conduct, it would perhaps be quite surprising if an immediate order was not imposed in a case such as this.

4. Ms Khanna submitted that the interim order of conditions be revoked.

On behalf of Dr Goodwin

5. On behalf of Dr Goodwin, Mr Tom Day, Counsel made no formal submissions opposing an immediate order.

The Tribunal's Determination

6. The Tribunal had careful regard to the submissions made by the parties and to the guidance in the SG including paragraph 172 and 173 which states that:

> *'172 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. The interests of the doctor include avoiding putting them in a position where they may come under pressure from patients, and/or may repeat the misconduct, particularly where this may also put them at risk of committing a criminal offence. Tribunals should balance these factors against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require an immediate order.*
>
> *173 An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor's special position of trust, or where immediate action must be taken to protect public confidence in the medical profession.'*

7. Having considered the submissions, and in light of all the circumstances of the case, in particular having regard to the seriousness of the misconduct, the Tribunal determined that it was necessary to impose an immediate order on Dr Goodwin's registration. The Tribunal was satisfied that the necessity to protect members of the public, public confidence in the medical profession and the need to uphold standards, outweighed the interest of Dr Goodwin in this case.

8. This means that Dr Goodwin's registration will be suspended from today. The substantive direction, as already announced, will take effect 28 days from the date on which written notification of this decision is deemed to have been served, 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.

9. The interim order of conditions is hereby revoked.

10. That concludes the case.