PUBLIC RECORD

Dates: 04/09/2023 - 08/09/2023
17/10/2023 - 06/11/2023

Medical Practitioner's name: Dr Michael WATT

GMC reference number: 3079087

Primary medical qualification: MB BCh 1985 Queens University of Belfast

Type of case
New - Deficient professional performance

Outcome on facts
Facts relevant to impairment found proved

Outcome on impairment
Impaired

Summary of outcome
Erasure
Immediate order imposed

Tribunal:

Legally Qualified Chair	Mr Neil Dalton
Lay Tribunal Member:	Ms Marianne O'Kane
Medical Tribunal Member:	Dr Gabrielle Downey

Tribunal Clerk:	Miss Emma Saunders

Attendance and Representation:

Medical Practitioner:	Not present and represented 04/09/2023 - 08/09/2023, 17/10/2023 - 27/10/2023 Not present and not represented 27/10/2023 - 06/11/2023
Medical Practitioner's Representative:	Mr Matthew McDonagh, Counsel, instructed by Carson McDowell LLP 04/09/2023 - 08/09/2023, 17/10/2023 - 27/10/2023
GMC Representative:	Mr Charles Garside, KC

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 - 02/11/2023

Background

1. Dr Watt qualified as a doctor from Queen's University, Belfast, in 1985.

2. At the time of the Performance Assessment, which forms the basis for the present Allegation, Dr Watt was no longer undertaking clinical practice, having ceased to do so in June 2017.

3. Prior to this, he had been a consultant neurologist since 1996 at the Royal Victoria Hospital, Belfast (Belfast HSC Trust).

4. Dr Watt's Performance Assessment arose out of a wider concern regarding his practice. According to the Performance Assessment report itself,

> *'[…] In December 2016 concerns were raised locally regarding the high number of Dr Watt's patients being managed with epidural blood patching and an internal review was carried out. Further concerns about his wider neurological practice have been raised subsequently. A review of his practice was undertaken by the RCP* [Royal College of Physicians] *between April 2017 and April 2018. The cases were selected from across the range of Dr Watt's practice and focused on three categories - patients with multiple sclerosis, headaches and general neurology.*

The RCP found that record keeping and communication with patients was a concern in nearly all of the 48 patients they reviewed.

It also raised allegations of:

- *incorrect diagnoses (including multiple sclerosis) resulting in inappropriate unnecessary treatment*
- *concerns regarding the doctor's prescribing*
- *inappropriate referrals of patients for epidural blood patching*
- *poor communication with colleagues including failure to seek their advice & input*
- *poor follow up for patients*
- *poor clinical management of patients*

Overall, the report concludes there are significant concerns that Dr Watt lacks the basic disciplines of careful diagnosis, rational management and openness to the opinions of others. The outcome resulted in a GMC [General Medical Council] *referral and a recall of 3000+ patients.* […]'

5. Due to that concern, Dr Watt underwent a GMC-arranged assessment regarding the standard of his practice. He was assessed under eight categories and with reference to the professional standards described in the GMC publication *Good Medical Practice*. The assessment occurred between 7-22 October 2018 and the resulting report was sent to the GMC in December 2018. The assessment team found Dr Watt's performance to be unacceptable in five areas: maintaining professional performance, assessment, clinical management, record-keeping and relationships with patients (Of the remaining three categories, two could not be assessed and, in relation to the third, his performance was found to be acceptable).

6. It is those findings which form the subject of the present Allegation.

The Outcome of Applications made during the Facts Stage

7. On 8 September 2023 the Tribunal issued case management directions. Those directions are set out at Annex A.

8. On 18 October 2023 the Tribunal granted the unopposed application, made in private by Mr McDonagh on behalf of Dr Watt, for the written evidence of Dr A to be admitted

pursuant to Rule 34(1) of the Rules. The Tribunal's full decision on the application is included at Annex B.

9. On 18 October 2023 the Tribunal granted the unopposed application, made in private by Mr McDonagh on behalf of Dr Watt, that matters relating to the 'order of proceedings' should be heard in private pursuant to Rule 41 of the Rules. The Tribunal's full decision on the application is included at Annex C.

10. On 25 October 2023, following submissions by Mr McDonagh and Mr Garside regarding the 'order of proceedings', the Tribunal determined that it would hear the Performance Assessment case (i.e., the Allegation) first, and to the conclusion of Stage Two of the proceedings (should matters get that far), before hearing the application for voluntary erasure. The Tribunal's full decision on this issue is included at Annex D.

11. On 27 October 2023, Mr McDonagh stated that Dr Watt's voluntary erasure application had now been withdrawn and that Dr Watt's legal representatives were withdrawing from the hearing with immediate effect. Dr Watt was neither present nor legally represented at this hearing from that point. The Tribunal then heard an application from Mr Garside to proceed in Dr Watt's absence pursuant to Rule 31 of the Rules. The Tribunal granted that application. The full decision on the application is included at Annex E.

The Allegation and the Doctor's Response

12. The Allegation made against Dr Watt is as follows:

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

1. Between 7 – 22 October 2018 you underwent a General Medical Council assessment of the standard of your professional performance.
To be determined

2. Your professional performance was unacceptable in the following areas:

a. Maintaining Professional Performance;
To be determined

b. Assessment;

To be determined

c. Clinical Management;

To be determined

d. Record Keeping;

To be determined

e. Relationships with Patients.

To be determined

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

To be determined

Witness Evidence

13. The Tribunal received oral evidence on behalf of the GMC from the following witnesses:

- Dr B: Team Leader of the Performance Assessment team.
- Dr C: A medical assessor on the Performance Assessment team.

14. Both witnesses gave evidence to the Tribunal on 27 October 2023.

15. No evidence, written or oral, was given by, or on behalf of, Dr Watt in relation to the Performance Assessment of October 2018.

Documentary Evidence

16. The Tribunal had regard to all the documentary evidence provided by the parties.

17. This evidence included, but was not limited to:

- The Assessors' Report ('*Assessors' report to the General Medical Counsel: the professional performance of Dr Michael Watt […] Assessment conducted October 2018*' ('the Report'), and
- The GMC Handbook for performance assessors (May 2016).

The Tribunal's Approach

18. In reaching its decision regarding facts, the Tribunal has borne in mind that the burden of proof rests solely on the GMC. Dr Watt does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities.

19. In reaching its determination, the Tribunal took into account all the written and oral submissions from the parties.

20. The Tribunal also took into account the advice provided by the Legally Qualified Chair - which was provided in public session and upon which he invited comment. The Tribunal accepted that advice in full.

The Tribunal's Analysis of the Evidence and Findings

21. The Tribunal has considered each outstanding paragraph and sub-paragraph of the Allegation separately and has evaluated the evidence in order to make its findings on the facts.

22. The Tribunal's evaluation of the GMC's case centred upon its consideration of the contents of the 235-page Report placed before it, supplemented by questions the Tribunal asked of two members of the assessment team.

23. As indicated above, Dr Watt's counsel withdrew from the hearing after the GMC had opened its case but before it had called its first witness. Dr Watt himself did not attend, albeit Mr McDonagh indicated that his client expected the hearing would continue in his absence. Consequent upon the above, while the facts forming the Allegation had not been admitted by Dr Watt, the evidence adduced by the GMC in support of the Allegation was unchallenged by him.

<u>The Report</u>

24. The Report followed an assessment of Dr Watt conducted at the Royal Victoria Hospital, Belfast, and the GMC Clinical Skills Centre in Manchester.

25. The assessment team comprised Dr B (Team Leader), Dr E and Dr C (Medical Assessors), and Mrs D (Lay Assessor).

26. From the Report, the Tribunal noted that:

> '*Dr [B] […] is a part time GP in a 5-partner, 10,500-patient training practice [near] Doncaster, where he has been a partner for 34 years. He was Clinical Senior Lecturer in General Practice at Sheffield Medical School until March 2017, and has had experience in professional performance review at a local level through his previous role as chairman of Doncaster Local Medical Committee. Dr [B] was also a GP Trainer for 10 years. Dr [B] has extensive experience in assessment at both undergraduate and postgraduate level and has been an MRCGP Examiner for many years and was Assessment Lead at Sheffield Medical School from 2014 to 2016. At the time of the Report, he had been a GMC Performance Assessor for 8 years and Team Leader since 2013*.
>
> He was appointed to this assessment because of *'his experience in leading GMC performance assessments and writing reports*'. As an 'out-of-specialty' team leader, he did not judge Dr Watt's clinical practice where it was beyond his '*area of expertise'*. Instead, *'a second medical assessor was appointed to ensure that there were always at least two medical opinions available on clinical matters*'.
>
> Dr [E] was appointed '*consultant in 1999'*. A general neurologist, he was '*elected to the Association of British Neurologists Council in 2009, and appointed Chair of the Training and Education committee in 2010, demitting in 2016. Reflecting his interest in education and training, he sits on the standard setting boards for the MRCP Specialty Certificate Examination (SCE) for Neurology, secretary of Neurology SCE exam board, and is a member of the MRCP part 1 exam board. He is an external examiner for the University of Glasgow Year 5 exams, organises and chairs the annual Edinburgh Neurology Course* [and] *organises the weekly local neurology trainee teaching* […]',
>
> Dr [C], '[…] *is a Consultant Neurologist with an interest in MS/neuroinflammatory disease based at the University Hospital of Wales, Cardiff and the Royal Glamorgan Hospital, Llantrisan*. [He] *trained in General Medicine in Great Yarmouth and Wales before entering Neurology and Neurorehabilitation in Cardiff. His Neurology research*

included managing MS patients in a multicentre study as part of the European Beta-Interferon Study Group and he also did work on physiotherapy in chronic MS and the interaction of breathing and swallowing […]. *He trained in clinical neurology in Swansea, Newport and Cardiff and obtained his CCST in 2003.'*

Mrs D '*has been a Lay Assessor for the GMC since 2002 and has carried out assessments in both general practice and a wide range of hospital disciplines*.[…]'

Assessment tools: overview

27. According to the Report, Dr Watt was assessed as a Neurologist working at 'consultant' level and was expected to demonstrate minimum acceptable competence for this role.

28. As indicated, the team chose to base the assessment at Royal Victoria Hospital, Belfast. They also included records from Dr Watt's private practice.

29. In reaching an assessment, the assessment team followed guidance set out in Appendix 2 of the *'GMC Handbook for performance assessors (May 2016)'*. Namely:

'Assessment scale definitions

Assessment of the doctor's performance is based on the GMC guidance in the publication 'Good medical practice', which sets out the standards expected of doctors. During the assessment the doctor is expected to demonstrate safe and competent practice, appropriate to the grade and position in which they are, or were, working.

For individual judgements assigned to comments, assessors must use the following scale:

A Acceptable – performance that is consistent with the performance described in Good medical practice.

U Unacceptable – performance which clearly departs from the performance described in Good medical practice.

For overall judgements of the doctor's performance at each assessment category in the report, teams must use the following scale.

Acceptable *means that the evidence demonstrates that the doctor's performance is consistently above the standards described below. This grade should only be entered if you are satisfied that all or almost all of the criteria are satisfied in all or almost all of the examples that you have seen or heard reported.*

Cause for concern *means that there is evidence that the doctor's performance may not be acceptable but there is not sufficient evidence to suggest deficient professional performance. The grade should be entered if you have evidence of some instances of unacceptable performance but which, in the view of the assessing team, do not amount overall to unacceptable performance. The reasons for using this grade, rather than unacceptable, for this aspect of performance should be described.*

Unacceptable *indicates that there is evidence of repeated or persistent failure to comply with the professional standards appropriate to the work being done by the doctor, particularly where this places patients or members of the public in jeopardy (ie deficient professional performance). This grade should be entered either if you have evidence that the criteria for an acceptable level of performance are regularly NOT being met OR if negative criteria are being met.'*

30. The assessment of Dr Watt involved the following components:

- First Interview and Site Tour

  To gain a greater understanding of the context of Dr Watt's practice, the team conducted a First Interview with him and a Site Tour of Royal Victoria Hospital, Belfast, accompanied by Mr F, Neurosciences Service Manager.

  In terms of the site visit, the team indicate within the Report that they *'did not find any evidence to suggest that Dr Watt's working conditions prevented an acceptable level of professional performance'.*

  At the beginning of the First Interview, the Report confirms that Dr Watt had indicated that *'he felt well enough to go ahead with the assessment process'*.

When asked about this in oral evidence to the Tribunal, Dr B confirmed that there was nothing to suggest that Dr Watt was unfit during the assessment.

During the first interview, Dr Watt is said to have '*confirmed that he had ceased clinical practice towards the end of June 2017 He went on to confirm that he had been employed under the pre-2003 consultant contract up until he ceased work in June 2017. This allowed him to undertake his desired level of private work.*

Dr Watt was then asked to talk through his timetable, which he had submitted in his portfolio. He went through his timetable in detail, expanding on his duties and level of support for each of the stated sessions.

Dr Watt said that he had undertaken up to a total of 9 blood patches some weeks.

He was asked about Supporting Professional Activity sessions in his job plan. He replied that he had attended the monthly morbidity and audit meeting and had continued to do so after ceasing clinical work, until he was told to stop attending these meetings in May 2018.

He was also asked about any recent research he had been involved in. He replied that he had been involved in a study with a local cardiology colleague about a year previously when he had acted as a medical assessor for the trial. He also said that he had some involvement in another study, which had been published 3 years earlier.'

- Medical Record[s] Review

An appendix to the Report provides a description of the sample and the hospital numbers of the patients reviewed.

The two Medical Assessors independently reviewed the same 39 records. They reflected six records from the Epilepsy clinic, six from TIA/Stoke clinic (TIA means Transient Ischaemic Attack), seven from the Multiple Sclerosis clinic, and ten from his private practice. In addition, five sets of records were

reviewed from an inpatient setting and five patients who received an epidural blood patch.

In oral evidence to the Tribunal, Dr B was asked about the sample size. He said it was sufficiently wide to reach robust conclusions; explaining that where, as here, patients have complex presentations, the lengthier notes can yield more evidence, including lots of different types of evidence. He referred to *'a large amount of evidence'* having been available from the notes examined. It was not a case, he said, of looking for the number of times an issue comes up, but rather to identify what he called *'patterns of performance'*. In response to Tribunal questioning, he stated that looking at additional sets of notes would not have made a difference to his conclusions. He emphasised that the particular records were not hand-picked cases. Rather, the Trust simply produced for the assessors' consideration a set of consecutive notes from a fixed point in time.

In oral evidence, Dr C shared Dr B's view that the sample of cases was sufficiently robust. He also pointed out that these were not hand-picked cases; they amounted to a fair representation of the in-patient and out-patient workload. The records were, said Dr C, '*representative and valid*'.

- Third Party Interviews

Dr Watt nominated two people to be interviewed by the team; while the assessment team nominated four other people.

The Report continues, '*whilst in Belfast, in became apparent that it would be appropriate to speak with the Clinical Director and consultant neurologist, Dr [G]. The team made arrangements to interview Dr [G] by telephone during the TOC. The assessors corresponded prior to the Peer Review to decide on the choice of Third-Party Interviews. The Third-Party Interviewees were chosen because their previous or current posts would give them direct knowledge of Dr Watt's practice. A verbatim transcript of all of the Third-Party Interviews was provided to Dr Watt and he was given the opportunity to comment on these. Dr Watt's representatives submitted comments on the transcripts and these were fully considered by the team in drafting this report.'*

- Observation of Practice

  The authors of the Report explained that it '*was not possible to conduct an Observation of Practice as Dr Watt was not working at the time of the assessment*'.

- Case-Based Discussion

  Dr Watt was given the 12 sets of notes to be used in the Case Based Discussion on 9 October 2018, to enable him to read over them prior to the discussion the following day.

- Knowledge Test

  Dr Watt undertook a 2-hour test of 120 single best answer questions. The questions were chosen by the Research Department for Medical Education at UCL (RDME) and were either taken from the GMC item bank or sourced from the appropriate college. The test was invigilated by Mrs D and another named person. Prior to the test starting, the Team Leader went through the instructions and an example question with Dr Watt to ensure he understood the format of the test.

- 'OSCE'

  An 'OSCE' is an 'objective structured clinical examination'. During the OSCE, a doctor is presented with scenarios that could arise in the course of a normal working day. They are designed to test that doctor's practical skills, clinical methods and interpersonal skills. The doctor's performance was judged against a reference group of doctors in neurology who have also undertaken the assessments. This reference group included all grades of doctors from junior trainees up to and including consultants. Performance is deemed acceptable if the person assessed achieved the same score or higher than 25% of those in the reference group.

  The role players were briefed by the Team Leader and Medical Assessors to ensure they knew their roles. The scenarios chosen in Dr Watt's case were:

- taking history of seizure from a young male
- TIA management
- upper limbs examination
- telephone advice about head injury
- myasthenia gravis history and management
- end of life issues
- cerebellar examination
- post lumbar puncture headache
- explain diagnosis of motor neurone disease
- Huntington's disease concerns
- epilepsy and antiepileptic drug use in pregnancy
- adult basic life support

The assessors, Dr E and Dr C, observed the OSCEs directly, while Dr B and Mrs D observed remotely via an audio-visual link.

- Second and Third Interviews

Dr Watt was aware that he was entitled to have a supporter present during these interviews. Dr Watt was supported by his lawyer, Mr McMillan, at the Second Interview. He opted not to have a supporter present at the Third Interview.

- Report Review Day

A meeting to review the draft report took place on 6 December 2018.

31. Having regard to the *GMC Handbook for performance assessors* (May 2016), the Tribunal considered that the assessment team had used a variety of validated assessment tools to assess Dr Watt's professional performance.

32. In oral evidence, Dr B was asked by the Tribunal whether the fact that the assessment occurred some 15 months after Dr Watt had ceased clinical practice might have contributed to assessors' findings. However, Dr B advised that the gap was not important as the *'medical record review'* was based on the records made whilst Dr Watt had been in clinical practice.

33. Accordingly, set against that background regarding the context in which the assessment took place, the identity of the assessors who undertook it, the assessment tools used and the assessment scale definitions, the Tribunal now turns to the evidence in relation to the paragraphs and sub-paragraphs of the Allegation.

Paragraph one

34. Dr B and Dr C each confirmed in oral evidence to the Tribunal that the contents of the Report were accurate and true.

35. The Tribunal noted that Appendix 2 of the Report provides 'Assessment Timetables'. These detail 7-10 October 2018 and 22 October 2018 as being the dates on which the Performance Assessment of Dr Watt was undertaken.

36. No evidence to challenge this was provided by, or on behalf of, Dr Watt.

37. Accordingly, the Tribunal found this proved.

Paragraph 2a (Maintaining Professional Performance)

38. In assessing this category, the assessors had relied upon the evidence gathered by the following methods:

- medical record review,
- case-based discussion,
- third-party interviews,
- second interview,
- OSCEs and
- a knowledge test.

39. The assessors' conclusion was that Dr Watt's performance in the category of Maintaining Professional Performance was '*Unacceptable'*. The assessors were unanimous in that conclusion.

40. Dr Watt's score in the Knowledge Test (76.67%) was acceptable. However, the assessment report explained that '*Dr Watt's overall performance was judged unacceptable'* in this area of the assessment '*because of his inappropriate use of diagnostic criteria for SIH*

[Spontaneous Intracranial Hypotension] *and his failure to discuss driving with patients with epilepsy*.' As Dr B explained in oral evidence to the Tribunal, an acceptable professional performance requires more than just a knowledge of the basic science of neurology.

41. The report itself continued,

> *'Dr Watt described an acceptable approach for keeping up to date, which was corroborated by his colleagues. He was able to quote literature regarding Vitamin B12 replacement and evidence regarding the outcome of neuro-surgery for brain tumours. He was also able to quote from the guidelines regarding MS treatment.'*

42. However,

> *'In the Basic Life Support station of the OSCE, although Dr Watt was aware that the compression to rescue breath ratio was 30:2, he did not shout for help or check for safety before commencing CPR and gave an incorrect answer with regard to the rate of compressions.*
>
> *'In a number of patients whom he had seen with a diagnosis of epilepsy, Dr Watt did not give advice regarding driving on any occasion. It is […] important for both patient and public safety to ensure patients with epilepsy follow the DVLA regulations in this regard.*
>
> *Dr Watt explained that he believed that the accepted diagnostic criteria for SIH were too narrow. In his view many patients with symptoms not typically associated with SIH (such as brain stem ischaemia) in fact had SIH and thus warranted blood patching. However, this assertion was Dr Watt's personal opinion, for which he offered no evidence.*
>
> *Dr Watt did not acknowledge that his practice of following up patients for longer periods and more frequently than his colleagues contributed to the overbooking of his clinics* [.]'

43. As indicated above, in determining whether Dr Watt's performance was unacceptable, the assessors took the measure to be whether it was a '*performance which clearly departs from the performance described in Good Medical Practice*'.

44. They found that in relation to the category of *'maintaining professional performance'* it was indeed unacceptable, quoting those parts of the *Good Medical Practice* ('GMP', 2013 edition) they deemed relevant. Namely:

> *'7. You must be competent in all aspects of your work, including management, research and teaching.*
> *8. You must keep your professional knowledge and skills up to date.*
> *9. You must regularly take part in activities that maintain and develop your competence and performance.*
> *10. You should be willing to find and take part in structured support opportunities offered by your employer or contracting body (for example, mentoring). You should do this when you join an organisation and whenever your role changes significantly throughout your career.*
> *11. You must be familiar with guidelines and developments that affect your work.*
> *12. You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work.*
> *13. You must take steps to monitor and improve the quality of your work.*
>
> *22. You must take part in systems of quality assurance and quality improvement to promote patient safety. This includes:*
> > *a) taking part in regular reviews and audits of your own work and that of your team,*
> > *b) responding constructively to outcomes, taking steps to address any problems and carrying out further training where necessary regularly reflecting on the standards of practice and care you provide,*
> > *c) reviewing patient feedback where it is available*.'

45. In reflecting on these matters, the Tribunal had regard to the above. It also took into account all the specific evidence referred to in the report. For example:

> *'In OSCE Station 12, Basic Life Support, Dr Watt did not check if the area was safe and did not shout for help. Dr Watt also stated that he would carry out 30 compressions per minute, which is incorrect, and would be ineffective. The correct rate is 100 - 120 per minute. Dr Watt's score of 24.5 for the Basic Life Support Station in the OSCE reflected these unacceptable elements of the station.'*
>
> And:

In Case […], a 72 year old lady with dizzy spells, Dr Watt did not advise this patient about stopping driving when he made a new diagnosis of epilepsy.

And:

In Case [15], a 26 year old lady with headache, Dr Watt was asked at Case Based Discussion about his management of this patient during her pregnancy, as she had been taking acetazolamide and topiramate, both drugs usually avoided in pregnancy. Acetazolamide is a reasonable initial therapy for Idiopathic Intracranial Hypertension (IIH) and Dr Watt had considered the possible teratogenic effects of this medication, which the BNF recommends should be avoided. Although he justified his use of acetazolamide on the basis of a lecture he had attended at an International Meeting (American Academy of Neurology) he did not comment on his use of topiramate, which is also advised against in pregnancy.

46. The Tribunal noted, too, the evidence within the Report that,

*'At the **Second Interview**, Dr Watt was asked to comment on the considerable number of blood patches he undertook. He replied that this was partly because his colleagues were aware that he had an interest in this treatment and they referred patients to him. He also said that in recent years the condition of SIH had become increasingly recognised, that it was not always apparent on imaging and that patients with recurrent brain stem symptoms, who had previously been thought to have ischaemia, are likely to be suffering from intracranial hypotension. Whilst an increase in referrals of SIH could account for Dr Watt's relatively high number of patches compared to other neurologists, it is apparent that, for this condition, he used different diagnostic criteria which are neither evidence based nor accepted. The assessors judged that this led to misdiagnoses and thus inappropriate patching.*

47. The Tribunal had no objective basis to regard the assessment in this area as anything other than fair and appropriate, nor any reason to question the competence or integrity of the assessors. Accordingly, having regard to -

- The assessors' assessment and criteria deployed;

- The totality of the evidence to which the assessors had referred (as captured in their *'Findings'* within the main body of the Report, as well as in Appendices 3-5); and
- the absence of any evidence to the contrary by, or on behalf of, Dr Watt

- the Tribunal has determined that, on the balance of the evidence, Dr Watt's professional performance was unacceptable in relation to maintaining professional performance.

48. It therefore found **paragraph 2(a) proved.**

Paragraph 2b ('Assessment')

49. Here the assessors measured Dr Watt's performance in relation to '*History taking, examination, initial investigations and reaching a diagnosis'.*

50. In assessing this category, the assessors relied upon the evidence gathered by the following methods:

- medical record review,
- case-based discussion,
- third-party interviews, and
- OSCEs

51. The assessors' conclusion was that Dr Watt's performance in this category was '*Unacceptable'*. They were unanimous in that conclusion.

52. The assessors assert that,

> '*There were some examples in the Medical Record Review and in the OSCE […] where there was evidence that Dr Watt had taken a relevant history from patients and had carried out a clinical examination. There were examples where he had arranged appropriate investigations. He* [had also] *reached appropriate diagnoses in other Cases.'*

53. However,

'*There were a number of examples where Dr Watt's history lacked sufficient detail to enable him to reach a diagnosis. […]*

There were also a number of cases […]in which there was no evidence that Dr Watt had carried out a clinical examination. In OSCE Station 7, Dr Watt's examination for cerebellar signs was unacceptable […].

As a result of his unacceptably brief histories and failure to carry out clinical examinations, there were a number of examples where Dr Watt was not in a position to make a correct diagnosis. These […] include:

> *In Case […], Dr Watt did not take an adequate history nor perform an examination to exclude other causes for this patient's headache. His proposed management was to perform an epidural patch, an invasive procedure with associated risk that should be undertaken only if there is reasonable diagnostic certainty.*
>
> *In Case […], Dr Watt diagnosed partial seizures in this patient, which was not supported by the history and that was overturned when the patient was reviewed by another neurologist. She was treated unnecessarily with lamotrigine, putting her at risk of side effects.*
>
> *In Case […], Dr Watt diagnosed partial seizures without evidence in the history to support this diagnosis. Again, this diagnosis was overturned at review, but she had received anti-epileptic medication on the basis of an incorrect diagnosis.*
>
> *In Case […], Dr Watt diagnosed Idiopathic Intracranial Hypertension despite the patient having normal optic discs and normal CSF opening pressure at lumbar puncture. The patient had also seen a neuro-ophthalmologist who had concluded that she was not suffering from IIH. However, Dr Watt disregarded this opinion and these objective findings and continued to manage the patient as IIH.*
>
> *In Case […], a patient known to have MS, Dr Watt's limited assessment led to treating the patient inappropriately with DMTs, which carry risks and side effects.*

Case […] was a lady who had been diagnosed with epilepsy some years previously. Although it is not appropriate to comment on the original diagnosis in this assessment, Dr Watt continued to follow this patient up. Despite the fact that she was not responding to several different anti-epileptic drugs, Dr Watt did not consider that the original diagnosis may have been incorrect and continued treating her with medication that was having no effect on her condition.

In Case […], Dr Watt carried out epidural blood patching on this patient without having taken an adequate history or conducted a clinical examination to allow him to reach a diagnosis of SIH.

In Case […], Dr Watt again performed epidural blood patching without any evidence to suggest that the patient was suffering from SIH.

Dr [G] commented that even when investigations were normal therefore not supportive of Dr Watt's diagnosis, he was reluctant to reconsider his initial diagnosis, resulting in patients being followed up and treated for conditions which there was little evidence that they had. […]'

54. In consequence, the Report concludes,

'Dr Watt's repeated unacceptable history taking and failure to examine patients […] led to incorrect diagnoses and unnecessary treatments and procedures which put patients at unnecessary risk. These included patients incorrectly diagnosed with epilepsy and multiple sclerosis – diagnoses that have a major impact on peoples' lives. Many of these patients, on the basis of these incorrect diagnoses, were treated unnecessarily exposing them to potentially serious side-effects and risks.

Although misdiagnosis does occur, for it to happen repeatedly on the basis of inadequate history taking, a lack of clinical examination and failure to reconsider diagnoses when patients' conditions do not improve, represents a clear, persistent departure from Good Medical Practice.

There was evidence in the cases looked at in this assessment where Dr Watt performed the invasive procedure of epidural blood patches with little or no clinical justification for doing so.'

55. In finding his performance unacceptable in this area, the assessors referred to GMP:

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

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

18. You must make good use of the resources available to you (also relevant to Clinical Management)'

56. The Tribunal had no objective basis to regard the assessment in this area as anything other than fair and appropriate, nor any reason to question the competence or integrity of the assessors. Therefore, having regard to -

- The assessors' assessment and criteria deployed;
- The totality of the evidence to which the assessors had referred (as captured in their *'Findings'* within the main body of the Report, as well as in Appendices 3-5); and
- the absence of any evidence to the contrary by, or on behalf of, Dr Watt

- the Tribunal has determined that, on the balance of the evidence, his professional performance was unacceptable in relation to assessment of patients' condition.

57. It therefore found **paragraph 2b proved.**

Paragraph 2c (clinical management)

58. Here the assessors measured Dr Watt's performance in relation to '*Providing treatment, advice to patients or a referral, safety netting, follow-up and working within the limits of competence'.*

59. Again, the assessors' overall assessment of Dr Watt's performance in this regard was *'unacceptable'*. They were unanimous in that conclusion.

60. In assessing this category, the assessors relied upon the evidence gathered by the following methods:

- medical record review,
- case-based discussion,
- third-party interviews,
- second interview,
- OSCEs.

61. In considering Dr Watt's performance in this area, the report found that there were a number of cases where his management was acceptable. These included,

> '*increased steroids in a patient with brain metastases, clopidogrel in a patient with a TIA, lamotrigine or levetiracetam as a treatment for epilepsy, pyridostigmine for myasthenia gravis, gabapentin and clonazepam in a patient with MS. He made an appropriate referral in Case […] and made appropriate follow-up arrangements in two other cases*.'

62. However,

> *'There were a number of examples, […] where Dr Watt's providing treatment was unacceptable. These include:*
>
> *In Case […] Dr Watt prescribed lamotrigine, an anti-epileptic, without rationale.*
>
> *In Case […] he prescribed acetazolamide to a patient with known IIH. However, he prescribed a dose in excess of the maximum licensed dose without justification.*
>
> *In Case […] he prescribed carbamazepine for myoclonus. This is not an appropriate treatment choice for this condition. He then prescribed levetiracetam above the maximum licensed dose without any justification for doing so.*

In Cases […] & […], Dr Watt performed image-guided cervical epidural blood patching for low pressure headache. This is not a recognised treatment for this condition unless evidence for a leak at this level exists and blood patching carries significant risk.

In Case […], Dr Watt recommended lamotrigine for this patient's headache due to IIH. This is not an appropriate treatment for this condition.

In Case […], Dr Watt recommended several medications for headache which were not licensed.

There were examples where Dr Watt arranged treatment for patients without recognising his own limits of competence.

In Case […], Dr Watt did not consider seeking the advice of his MS specialist colleagues in the management of this patient with MS. He treated the patient with high dose steroids without justification. High dose steroid medication has a range of potentially serious side effects. He also recommended a number of different medications which were not appropriate.'

63. The Report also adds that, '*The assessors' findings of Dr Watt's working beyond his limits were corroborated in the Third-Party Interviews and the Second Interview* […]'

64. The assessors explained their judgment that Dr Watt's performance was unacceptable in this area '*was based on the potential risk to patients as a result of the following:*

'Dr Watt's practice of prescribing medication above licensed dosages to patients with epilepsy, with little justification for doing so, and prescribing high dose steroids without indication.

Dr Watt's unacceptable assessment of patients prior to undertaking blood patching has been dealt with in the preceding section of this report. However, his use of this procedure as a treatment and, in particular, his practice of treating patients with cervical epidural patching, a procedure for which there is no indication is considered in this section of the report. There were several examples where Dr Watt performed epidural blood patching without justification and on two occasions this procedure was undertaken at the cervical level, which is not a recognised treatment and carries significant risk.'

65. The assessors add,

'Of particular concern was Dr Watt's failure to recognise his own limits of competence as a neurologist. There were instances where he incorrectly used treatments that would usually be initiated by specialist neurologists […]. Dr Watt's colleagues commented on the fact that he rarely sought their advice on treating complex patients with epilepsy and MS. These patients therefore did not have the opportunity to be assessed and offered management by the most appropriate clinician.

Also of concern was Dr Watt's lack of insight when asked when he would consider involving a more specialist colleague. Dr Watt said that he would do so only when he had tried all the options available. This approach does not acknowledge that there may be alternative diagnoses or management options that he had not considered.'

66. The Report thus cites the following paragraphs of GMP:

'14. You must recognise and work within the limits of your competence (also relevant to Operative/Technical Skills).
15. You must provide a good standard of practice and care. If you assess, diagnose or treat patients you must:
b. promptly provide or arrange suitable advice, investigations or treatment where necessary
c. refer a patient to another practitioner when this serves the patient's needs.
16. In providing clinical care you must:
a. prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health, and are satisfied that the drugs or treatment serve the patient's needs
b. provide effective treatments based on the best available evidence
c. take all possible steps to alleviate pain and distress whether or not a cure may be possible
f. check that the care or treatment you provide for each patient is compatible with any other treatments the patient is receiving, including (where possible) self-prescribed over-the-counter medications
g. wherever possible, avoid providing medical care to yourself or anyone with whom you have a close personal relationship.

18. You must make good use of the resources available to you (also relevant to Assessment)

26. You must offer help if emergencies arise in clinical settings or in the community, taking account of your own safety, your competence and the availability of other options for care.'

67. The Tribunal had no objective basis to regard the assessment in this area as anything other than fair and appropriate, nor any reason to question the competence or integrity of the assessors. Therefore, taking all the above matters into account and having regard to -

- The assessors' assessment and criteria deployed;
- The totality of the evidence to which the assessors had referred (as captured in their *'Findings'* within the main body of the Report, as well as in Appendices 3-5); and
- the absence of any evidence to the contrary by, or on behalf of, Dr Watt

- the Tribunal has determined that, on the balance of the evidence, Dr Watt's professional performance was unacceptable in relation to clinical management.

68. It therefore found paragraph 2c proved.

Paragraph 2d (Record keeping)

69. The assessors' overall assessment of Dr Watt's performance in this regard was likewise *'unacceptable'*. They were unanimous in that conclusion.

70. In assessing this category, the assessors relied upon the evidence gathered by the following methods:

- medical record review,
- case-based discussion.

71. Here the assessors acknowledged that Dr Watt's handwritten entries in the medical records were legible. The assessors also found examples '*where clinical details had been summarised and a diagnosis recorded. In one example, Dr Watt had recorded that he had*

discussed the risk of teratogenicity of a drug with a patient. Dr Watt acknowledged at Case Based Discussion that his record was brief and uninformative on two occasions'.

72. The assessors noted, though, that Dr Watt did not sign his entries in the handwritten notes.

73. Moreover, the assessors stated, '*there were many examples […] where Dr Watt's clinical records did not contain sufficient information to allow another clinician to take over care [.]*
He made no record of the procedure when he carried out epidural blood patching on a number of patients. On two occasions Dr Watt stated at Case Based Discussion that there was sufficient detail in the record to allow another clinician to continue care, however the assessors disagreed and judged the level of detail to be unacceptable (Cases […] & […]).'

74. The Report identifies ten cases where '*Dr Watt's record of his consultation and letter following his consultation with the patient lacked adequate detail relating to diagnosis, medication history and his management plan'*.

75. In five cases relating to patients '*on whom Dr Watt performed epidural blood patching* […], *there was no documentation of the procedure in the patient record'*.

76. Elsewhere:

> *'In Case […], Dr Watt's letter was poorly structured and difficult to follow and was confusing in that it stated that Lamictal has an interaction with lamotrigine when these are the same drug.*
>
> *In Case […], Dr Watt was asked at Case Based Discussion how he had decided what to include in the GP letter. He replied that he had included details of her previous medical history as this would be a useful summary should the patient return to see him. This reply indicated that Dr Watt was using the letter for his own benefit rather than including relevant information regarding her current condition, which would have been more appropriate in the GP letter.*
>
> *In Case […], Dr Watt's record did not include a diagnosis or management plan and made no reference to previous investigation results, which would make it very difficult for another clinician to take over care. At Case Based Discussion Dr Watt said that he*

had documented what he felt had been the appropriate points in the history to change the diagnosis, which would have been an acceptable level of detail to record. However, the record did not contain these described details.'

77. The Report particularised other examples where another clinician would find it difficult to take over patient care. In eleven of the cases considered, the assessors found that '*the lack of information available in the clinical record and in clinic letters would make it very difficult for another clinician to take over or continue the patient's care'*.

78. In those cases referred to in paragraph 75 above, the assessors found the brevity of the clinical record and letter to the GP would likewise have made it very difficult for another clinician to take over or continue the care of these patients.

79. Additionally:

'In Case […], Dr Watt was asked at Case Based Discussion how he had ensured another clinician could take over the care of this patient. He stated that there was enough information in the records over the years to make this possible and he referred to a detailed letter from another clinician. However, the assessors judged that the information available in the records would make it difficult for another clinician to continue the care.

In Case […], a patient on whom Dr Watt performed a blood patch, Dr Watt was asked at Case Based Discussion how he had ensured that another clinician could take over the care of the patient. He replied that, in this case, he felt that the history and diagnosis were clear in the letter from his colleague. Dr Watt acknowledged that he had not documented what discussion he had had with the patient, but felt that the rest of the record was clear. The assessors disagreed, and judged that Dr Watt's understanding of the required record detail was unacceptable.'

80. At the *'Third Party Interview'* stage, three of the people spoken to commented on the limited level of detail in Dr Watt's records and clinic letters. One said that there was often no record of examination and no record of what was discussed with the patient. Another said that the letter to the GP did not contain sufficient information to work out the diagnosis and current treatment.

81. In conclusion therefore, the assessors found Dr Watt's performance in the category of Record Keeping was Unacceptable. The Report explains,

> *'This is judgement is based on the fact the many of Dr Watt's record entries contained inadequate detail regarding history, diagnosis and proposed management plan. In many of these cases another clinician would find it difficult to take over the care of the patient because of the lack of information available.*
> *The judgement of unacceptable is also based on Dr Watt's failure to record any details of the procedure when he performed epidural blood patching. The absence of any details regarding the procedure would put patients at risk should complications arise and another clinician having no indication of what procedure had been undertaken.'*

82. In coming to this assessment, the assessment team indicates that it had regard to the requirements set out in the following paragraphs of GMP:

> *'19. Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.*
> *20. You must keep records that contain personal information about patients, colleagues or others securely, and in line with any data protection requirements.*
> *21. Clinical records should include:*
> *a) relevant clinical findings*
> *b) the decisions made and actions agreed, and who is making the decisions and agreeing the actions*
> *c) the information given to patients*
> *d) details of any drugs prescribed or other investigation or treatment*
> *e) details of who is making the record and on what date.'*

83. The Tribunal had no objective basis to regard the assessment in this area as anything other than fair and appropriate, nor any reason to question the competence or integrity of the assessors. Therefore, reflecting upon these matters and having regard to -

- The assessors' assessment and criteria deployed;
- The totality of the evidence to which the assessors had referred (as captured in their *'Findings'* within the main body of the Report, as well as in Appendices 3-5); and
- the absence of any evidence to the contrary by, or on behalf of, Dr Watt

- the Tribunal has determined that, on the balance of the evidence, Dr Watt's professional performance was indeed unacceptable in relation to record-keeping.

84. It therefore found **paragraph 2d proved.**

Paragraph 2e (relationships with patients)

85. Again, the assessors' overall assessment of Dr Watt's performance in this regard was *'unacceptable'*. They were unanimous in that conclusion.

86. In assessing this category, the assessors relied upon the evidence gathered by the following methods:

- medical record review,
- case-based discussion,
- third-party interviews, and
- OSCEs.

87. In this area, the assessors were considering Dr Watt's performance in relation to '*Communication, information sharing, supporting self-care and treating patients (including carers and relatives) with fairness and respect*'.

88. On the basis of the evidence gathered by the methods above, the Report notes that,

> *'There were a number of examples, […], where Dr Watt explained his diagnosis and proposed treatment to patients clearly and in terms that the patient would understand. At Third Party Interview, Dr Watt's colleagues gave some examples where he involved patients in making management decisions and checked their understanding of the information he had given them. No concerns were expressed with regard to Dr Watt's treating patients with dignity and respecting confidentiality.'*

89. However,

> *'There were a number of examples where Dr Watt did not explain his diagnosis and proposed treatment to patients. He did not explain the possible risks and side effects of medication in* [five cases]. *In* [another case], *Dr Watt performed a cervical epidural*

patch with no evidence of having discussed the potential risks of the procedure with the patient in sufficient detail to allow them to make an informed decision whether to go ahead with the procedure. In the OSCE, there were examples where Dr Watt's explanations were disjointed, at times overly complex, and difficult for the patient to follow […]. In […], some of Dr Watt's comments were blunt and inappropriate.

In Case […], Dr Watt did not discuss the risks and benefits of continuing a treatment generally not recommended in pregnancy and in Case […], although he had some discussion regarding the likely ineffectiveness of the treatment the patient was proposing, he also said that, if she was insistent, then he would be happy for her to go ahead. Although Dr Watt may not have been able to prevent this course of events, a more unequivocal approach might have stopped her travelling abroad for the treatment.

In a number of cases where Dr Watt went on to perform epidural blood patching, there is no evidence of him having discussed the potential risks and side effects of the procedure and in a number of cases there was no signed written consent from the patients (Cases […]). A doctor at Third Party Interview corroborated the lack of written consent.'

90. Based upon their work in this area, as set out throughout the report, the assessors had regard to the requirements set out in the following paragraphs of GMP:

'16. In providing clinical care you must:

[...]

e. respect the patient's right to ask for a second opinion

17. You must be satisfied that you have consent or other valid authority before you carry out any examination or investigation, provide treatment or involve patients or volunteers in teaching or research.

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

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

33. You must be considerate to those close to the patient and be sensitive and responsive in giving them information and support.

34. When you are on duty, you must be readily accessible to patients and colleagues who need information, advice or support. (Also relevant to Colleagues)

46. You must be polite and considerate.
47.You must treat patients as individuals and respect their dignity and privacy.
48. You must treat patients fairly and with respect whatever their life choices and beliefs.
49. You must work in partnership with patients, sharing with them the information they will need to make decisions about their care, including:

a. their condition, its likely progression and the options for treatment, including associated risks and uncertainties
b. the progress of their care, and your role and responsibilities in the team
c. who is responsible for each aspect of patient care, and how information is shared within teams and among those who will be providing their care
d. any other information patients need if they are asked to agree to being involved in teaching or research.

50. You must treat information about patients as confidential. This includes after a patient has died.
51. You must support patients in caring for themselves to empower them to improve and maintain their health. This may, for example, include:

a. advising patients on the effects of their life choices and lifestyle on their health and well-being
b. supporting patients to make lifestyle changes where appropriate.

52. You must explain to patients if you have a conscientious objection to a particular procedure. You must tell them about their right to see another doctor and make sure they have enough information to exercise that right. In providing this information you must not imply or express disapproval of the patient's lifestyle, choices or beliefs. If it is not practical for a patient to arrange to see another doctor, you must make sure that arrangements are made for another suitably qualified colleague to take over your role.

54. You must not express your personal beliefs (including political, religious and moral beliefs) to patients in ways that exploit their vulnerability or that are likely to cause them distress.
55. You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you must:

a) put matters right (if that is possible)
b) offer an apology

c) explain fully and promptly what has happened and the likely short-term and long-term effects.

57. The investigations or treatment you provide or arrange must be based on the assessment you and the patient make of their needs and priorities, and on your clinical judgement about the likely effectiveness of the treatment options. You must not refuse or delay treatment because you believe that a patient's actions or lifestyle contributed to their condition.
58. You must not deny treatment to patients because their medical condition may put you at risk. If a patient poses a risk to your health or safety, you should take all available steps to minimise the risk, before providing treatment or making other suitable arrangements for providing treatment.
59. You must not unfairly discriminate against patients or colleagues by allowing your personal views to affect your professional relationships or the treatment you provide or arrange. You should challenge colleagues if their behaviour does not follow this guidance, and follow the guidance in paragraph 25c if the behaviour amounts to abuse or denial of a patient's or colleague's rights. (Also in Colleagues)
60. You must consider and respond to the needs of disabled patients and should make reasonable adjustments to your practice so they can receive care to meet their needs.
61. You must respond promptly, fully and honestly to complaints and offer an apology when appropriate.
62. You should end a professional relationship with a patient only when the breakdown of trust between you and the patient means you cannot provide good clinical care to the patient.

64. If someone you have contact with in your professional role asks for your GMC registered name or GMC reference number, you must give it to them.

68. You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate. […]'

91. Accordingly, the four assessors jointly reached the conclusion that Dr Watt's performance in the category of *'relationships with patients'* was unacceptable. They state in the Report,

'This decision is based on the fact that there was a failure to explain the possible risks and side effects of medication in a number of cases. The assessors observed complex explanations, which the patients appeared to find confusing and difficult to follow. The judgement of Unacceptable is also based on Dr Watts' failure in a number of cases to discuss the risks and side effects of epidural blood patching and his not obtaining written informed consent from the patients.'

92. The Tribunal had no objective basis to regard the assessment in this area as anything other than fair and appropriate, nor any reason to question the competence or integrity of the assessors. Therefore, having reflected upon the above matters and having regard to -

- The assessors' assessment and criteria deployed;
- The totality of the evidence to which the assessors had referred (as captured in their *'Findings'* within the main body of the Report, as well as in Appendices 3-5); and
- the absence of any evidence to the contrary by, or on behalf of, Dr Watt

- the Tribunal has determined that, on the balance of the evidence, Dr Watt's professional performance was unacceptable in relation to relationships with patients.

93. It therefore found **paragraph 2e proved.**

The Tribunal's Overall Determination on the Facts

94. The Tribunal has determined the facts as follows:

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

1. Between 7 – 22 October 2018 you underwent a General Medical Council assessment of the standard of your professional performance.
Determined and found proved

2. Your professional performance was unacceptable in the following areas:

a. Maintaining Professional Performance;
Determined and found proved

b. Assessment;
Determined and found proved

c. Clinical Management;
Determined and found proved

d. Record Keeping;
Determined and found proved

e. Relationships with Patients.
Determined and found proved

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

Determination on Impairment - 03/11/2023

95. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts found proved, Dr Watt's fitness to practise is impaired by reason of deficient professional performance.

The Evidence

96. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary.

97. No further evidence was received at the impairment stage.

Submissions

On behalf of the GMC

98. Mr Garside, on behalf of the GMC, stated that there were two parts to the question of impairment: first, whether *'deficient professional performance'* had been established and, second, whether as a result Dr Watt's fitness to practise was currently impaired.

99. On the first question, Mr Garside suggested that the Tribunal's *'comprehensive'* facts determination had accurately laid bare the relevant facts and evidence. He noted the Tribunal had accepted therein that the performance assessment had been carried out by people with appropriate qualifications. The Tribunal had also found, he said, that the assessors' conclusions regarding Dr Watt's performance were reliable. Furthermore, he noted that two of the medical assessors on the team had a great deal of experience in neurology and the treatment of the sort of conditions that Dr Watt was treating. Taking all those matters together, Mr Garside submitted that the Tribunal could properly find that Dr Watt's professional performance had indeed been deficient.

100. Turning to the second question, Mr Garside reminded the Tribunal of the assessors' unanimous conclusion in this regard and the reasons they provided for having reached it, including their comment upon Dr Watt's lack of insight.

101. Mr Garside submitted that Dr Watt had not produced any evidence of remediation; nor, as importantly, any evidence of study or any other activity intended to keep his knowledge and skills up to date. This was in circumstances where Dr Watt had not practiced medicine in more than six years. Against that background, Mr Garside invited the Tribunal to find that Dr Watt's fitness to practise was currently impaired by reason of deficient professional performance.

102. No submissions were received on behalf of Dr Watt.

The Tribunal's Determination

103. Whilst the Tribunal has borne in mind the submissions made, the decision whether Dr Watt's fitness to practise is impaired is a matter for this Tribunal exercising its own judgment.

104. It is clear from the design of section 35c of the Medical Act 1983 that the Tribunal must adopt a two-stage approach:

> First, it must decide whether one of the circumstances set out in the section is present (and the relevant one here is *'deficient professional performance'*);
>
> Second, if deficient professional performance is present, it must then go on to determine whether, as a result, Dr Watt's fitness to practise is impaired. Thus, it may

be that despite *'deficient professional performance'* having been found (if that is what the Tribunal finds), it may decide that Dr Watt's fitness to practise is not impaired. (GMC v Cheatle [2009] EWHC 645 [Admin] at paragraph 19)

Deficient professional performance

105. The Tribunal reminded itself that:

- *'Deficient professional performance'* within the meaning of [the Medical Act] is conceptually separate both from negligence and from misconduct. It connotes a standard of professional performance which is unacceptably low and which (save in exceptional circumstances) has been demonstrated by reference to a fair sample of the doctor's work.' Calhaem v GMC [2007] EWHC 2606 (Admin)

- In her Fifth Shipman Inquiry Report, Dame Janet Smith had referred to the distinction to be made between competence and performance. She said that *'competence'* describes knowledge and skills (i.e., what the doctor can do), while *'performance'* describes what the doctor does within actual practice (i.e., what they actually do). A doctor who does not possess the requisite knowledge and skills can never perform well. However, a doctor may be competent (that is, they may possess the requisite knowledge and skills), but nevertheless their attitude and behaviour may be such that their performance is deficient.

- A practitioner should be judged by the standards applicable to the post to which they are appointed and the work they are carrying out, rather than a general allegation that they lack competency (Holton v GMC [2006] EWHC 2960 (Admin))

106. Reflecting on these matters, the Tribunal found that Dr Watt's performance had been unacceptably low across no fewer than five assessed categories; namely, maintaining professional performance, the assessment of patients' conditions, clinical management, record-keeping, and relationships with patients.

107. It considered that each of these areas was central to the effective performance of any competent doctor, and indeed these were areas in which public confidence depended upon proper standards of performance having been maintained.

108. The Tribunal determined that Dr Watt's failures were stark, serious, repeated and numerous across each of these categories. The Tribunal does not rehearse all those failures anew here. They are already set out, in outline, in paragraphs 38-93 of the Facts determination.

109. Viewed in totality, and representing a fair sample of Dr Watt's work, the Tribunal considered that Dr Watt's performance had been characterised by:

- A persistent failure to take adequate histories from patients and carry out clinical examinations;

- A persistent and repeated failure to make correct diagnoses, resulting in patients receiving inappropriate management, which included drugs with serious and toxic side-effects;

- Use of idiosyncratic diagnostic criteria for SIH leading to patients receiving unnecessary invasive treatment (epidural blood patches);

- Missing significant clinical signs, initiating medical treatments and performing interventions that had potential life-altering and/or life-limiting consequences;

- A failure to consider involving specialist neurologist colleagues in the management of complex patients; and

- A failure to discuss risks and benefits of treatments with patients to allow them to come to both informed decisions and give informed consent.

110. Taking into account all the above matters, in tandem with those in its Facts determination, the Tribunal then considered the GMC publication, *'Good Medical Practice'* ['GMP'] (March 2013 edition). GMP covers the fundamental aspects of a doctor's role and identifies the standards a doctor is expected to meet. The Tribunal has determined that, by his performance, Dr Watt was in breach of all the following requirements within GMP:

> *'7. You must be competent in all aspects of your work [….]*
>
> *12. You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work.*

13. You must take steps to monitor and improve the quality of your work.

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

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

> *a. adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient*
> *...*
> *c. refer a patient to another practitioner when this serves the patient's needs.*

16. In providing clinical care you must:

> *a. prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs*
> *b. provide effective treatments based on the best available evidence*
> *...*
> *d. consult colleagues where appropriate...*

19. Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.

21. Clinical records should include:

> *a. relevant clinical findings*
> *b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions*
> *c. the information given to patients...*

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

44. You must contribute to the safe transfer of patients between healthcare providers and between health and social care providers. This means you must:

a. share all relevant information with colleagues involved in your patients' care within and outside the team, including when you hand over care […]

49. You must work in partnership with patients, sharing with them the information they will need to make decisions about their care, including:

a. their condition, its likely progression and the options for treatment, including associated risks and uncertainties...

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

111. In all the circumstances, the Tribunal considered that Dr Watt's performance fell so far short of these standards of performance reasonably to be expected of a doctor as to amount to deficient professional performance. It determined that this had been demonstrated by reference to a fair sample of this doctor's work.

Impairment

112. Turning to the question of impairment, the Tribunal reminded itself that:

a. The question of whether Dr Watt's fitness to practise is impaired is posed, and is to be answered, in the present tense; the Tribunal looks forward not back. However, in order to form a view as to the fitness of a person to practise today, the Tribunal will have to take into account the way in which Dr Watt has acted, or failed to act, in the past (Meadow v GMC [2006] EWCA Civ 1390);

b. Case law has established that it must be *'highly relevant'* in determining if a doctor's fitness to practise is impaired *'that, first, his or her conduct which led to the charge is easily remediable; that, second, it has been remedied; and, third, that it is highly unlikely to be repeated'* (R (on the application of Cohen) v GMC [2008] EWHC 581 [Admin]);

c. The attitude of Dr Watt to the matters which give rise to the specific allegation against him is (in principle) something which can be taken into account either in his favour, or against him, by the Tribunal. (Nicholas- Pillai v GMC [2009] EWHC 1048 [Admin]).

113. In relation to the above considerations, while the Tribunal considered that such conduct could be remedied in principle, there was no evidence presented to the Tribunal to establish that, in Dr Watt's case, it was either easily remediable; that it had been remedied; or that it was highly unlikely to be repeated.

114. In terms of Dr Watt's attitude to the matters that formed the subject of the Allegation, his current lack of engagement with the regulatory process did not enable the Tribunal to discern his present view. The Tribunal noted, though, that there had been no admissions by him, and he had provided no reflections regarding his performance. Neither were there any testimonials that might provide any assistance on such matters.

115. The Tribunal noted, too, the impression that Dr Watt had made upon the performance assessment team. In finding Dr Watt's performance to have been deficient, the team asserted in their overarching *'Summary and Recommendations'* a unanimous opinion that Dr Watt was *'not fit to practise and should cease practice'*. They added,

> *'Dr Watt showed little insight during the assessment... The scope of these deficiencies combined with this lack of insight led the Team to conclude that remediation is unlikely to change Dr Watt's performance […]. '*

116. Those observations were made almost five years ago. Since then, there had remained no expression of insight by Dr Watt nor any evidence of remediation. Neither had there been evidence produced to the Tribunal to demonstrate that, since he had ceased clinical practice, Dr Watt had kept his knowledge and skills up to date.

117. Bearing in mind all these considerations, the Tribunal reminded itself of the question it should ask, per Council for Health Care Regulatory Excellence v. Nursing and Midwifery Council and Grant [2011] EWHC 927 (Admin) at [76]. Namely:

> *'do the findings of fact in respect of this doctor's [deficient professional performance] show that his fitness to practise is impaired in the sense that he;*

a. has in the past acted 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 liable in the future to bring the medical profession into disrepute; and/or

c. has in the past breached or liable in the future to breach one of the fundamental tenets of the medical profession; and/or […]'

(quoting Dame Janet Smith in paragraph 25.67 in her Fifth Report from Shipman).

118. The Tribunal determined that limbs (a), (b) and (c) from the above were all engaged and present in this case.

119. The Tribunal has therefore determined that Dr Watt's fitness to practise is impaired by reason of his deficient professional performance.

Determination on Sanction - 06/11/2023

120. This determination will be handed down in private. However, as this case concerns Dr Watt's deficient professional performance, a redacted version will be published with those matters relating to XXX removed.

121. Having determined that Dr Watt's fitness to practise is impaired by reason of deficient professional performance, the Tribunal now must decide in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose.

The Evidence

122. The Tribunal has considered evidence received during the earlier stages of the hearing, where relevant to reaching a decision on sanction.

123. No further evidence was adduced at this stage of the proceedings.

Submissions

Submissions on behalf of the GMC

124. Mr Garside submitted that, taken together, the facts the Tribunal had found proved, in tandem with those matters identified in the Tribunal's determination on impairment, engaged issues of both patient safety and public confidence in the profession. He reminded the Tribunal that a very large number of patients had been recalled in relation to Dr Watt's work and that a high proportion of those had insecure diagnoses. Mr Garside stated that he could not, and did not, rely on any individual patient's case, but rather that the overall pattern was one of deficient professional performance.

125. With reference to the facts found proved in the Allegation, Mr Garside then invited the Tribunal to find each of the following paragraphs of GMP relating to patient safety and public confidence in the medical profession engaged in this case: 7, 8, 9, 11, 12, 13, 14, 15, 16, 18, 19, 20, 21.

126. Specifically in relation to paragraph 2e of the Allegation, Mr Garside said that Dr Watt had a *'problematical'* relationship with his patients, some of whom did not understand what he was doing or why, due to the inadequacy of his explanations. Dr Watt had, Mr Garside said, his own individual views about diagnoses and treatment; views which were not shared by his consultant colleagues in neurology. Mr Garside suggested that this Tribunal had already identified, in earlier determinations, the relevant paragraphs of GMP engaged in relation to paragraph 2e.

127. Turning to the Sanctions Guidance (November 2020 edition), ('SG'), Mr Garside cited paragraph 17:

> *'Patients must be able to trust doctors with their lives and health, so doctors must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession (see paragraph 65 of Good medical practice). Although the tribunal should make sure the sanction it imposes is appropriate and proportionate, the reputation of the profession as a whole is more important than the interests of any individual doctor.'*

128. He submitted that this paragraph meant the Tribunal must consider the effect upon the public of any sanction imposed. While the interests of the doctor may be said to involve consideration of leniency; if, in reality, the reputation of the profession and of the GMC as a Regulator depended on a more severe sanction, then that was the sanction that the Tribunal must impose.

129. Mr Garside identified a list of mitigating and aggravating factors which, he suggested, the Tribunal should take into account when considering the appropriate sanction.

130. In terms of mitigation, he said the Tribunal could have regard to Dr Watt's XXX his good character. He indicated that Dr Watt had no criminal convictions, nor any *'regulatory infractions'* other than a warning in 2007. That warning was, he said, *'a long time ago and of a different nature'* to the matters the Tribunal was considering. It related to a delay by Dr Watt in preparing a medico-legal report, and the warning had been removed from his record in 2012. The warning aside, Dr Watt had had *'a long career with an [otherwise] unblemished record'*. However, he said, the reality was that the latter end of Dr Watt's career had been the subject of investigation, and his performance, and pattern of work, had become *'sub-optimal'*.

131. In terms of aggravating factors, Mr Garside submitted that there had been no acknowledgement of fault by Dr Watt. Furthermore, the doctor had provided no evidence of remediation, no acceptance of the damage caused to patients, and had displayed no evidence of insight.

132. Mr Garside then considered possible sanctions. He said that, in the light of its findings on impairment, the Tribunal could not conclude that it should take no action. There had been serious and persistent breaches of good medical conduct where patients had, potentially at least, been put at risk, and where Dr Watt had since done nothing to remediate his practice.

133. He clarified that undertakings had not been offered, or agreed, and so were not a matter for consideration.

134. In relation to the imposition of conditions, Mr Garside observed that conditions should be *'appropriate, proportionate, workable and measurable'*. In this context, he said that, insofar as was known, Dr Watt no longer had a connection with any hospital and there was no-one who could supervise his practice. He said, *'it was not known in what circumstances Dr Watt could start working with patients'* or words to that effect. Accordingly, Mr Garside submitted that conditions were neither workable nor measurable. He added that, in any event, the Tribunal could not be satisfied that Dr Watt would comply with any conditions, reminding it that there has been no attempt by Dr Watt to remediate or retrain, nor any evidence of insight.

135. Turning next to the sanction of suspension, Mr Garside considered SG §94:

> *'Suspension is also likely to be appropriate in a case of deficient performance or lack of knowledge of English in which the doctor currently poses a risk of harm to patients but where there is evidence that they have gained insight into the deficiencies and have the potential to remediate if prepared to undergo a rehabilitation or retraining programme.'*

136. Set against this, he submitted that there was a current risk of harm to patients. He repeated that there was no evidence Dr Watt had gained any insight into his deficient performance, nor was there evidence that he had the *'potential to remediate'*. In those circumstances, this was not a case where the serious breaches of GMP could be met by the suspension of Dr Watt's registration.

137. Rather, he suggested the appropriate sanction in this instance was one of erasure.

138. Mr Garside reminded the Tribunal of the various parts of SG addressing the issue of erasure. In particular, SG §109, wherein the guidance indicates that *'any of the factors identified there may indicate erasure is appropriate'*. Mr Garside submitted that each of the following was present in this case:

> *'a. A particularly serious departure from the principles set out in Good medical practice where the behaviour is fundamentally incompatible with being a doctor.*
>
> *b. A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety.*
> *...*
> *j. Persistent lack of insight into the seriousness of their actions or the consequences.'*

139. Dr Watt's departures from GMP were, he said, *'serious, persistent and put patients at risk'*. They were incompatible with being a doctor, not least because of Dr Watt's refusal to recognise any fault.

140. He submitted, therefore, that the erasure of Dr Watt's name from the medical register was the only means of protecting the public. Dr Watt presented a risk to patient safety. Additionally, given the surrounding circumstances and the massive disquiet that must have been caused not only to those patients recalled, but to their family and friends, erasure

was necessary in this case to maintain public confidence. Dr Watt had behaved in a way that was *'so idiosyncratic and so deficient'* that it was fundamentally incompatible with continued registration.

Submissions on behalf of Dr Watt

141. No submissions were made on behalf of Dr Watt.

The Tribunal's approach to Sanction

142. The decision as to the appropriate sanction to impose, if any, is a matter for this Tribunal exercising its own judgement.

143. In reaching its decision, the Tribunal has taken account of the SG and GMP. It has borne in mind that the purpose of a sanction is not to be punitive, but to protect patients and the wider public interest, although it may have a punitive effect.

144. Throughout its deliberations, the Tribunal applied the principle of proportionality, balancing Dr Watt's interest with the public interest. It has also taken into account the statutory overarching objective.

145. The Tribunal has already given detailed determinations on facts and impairment and has taken those matters into account during its deliberations on sanction.

Mitigating and Aggravating factors

146. The Tribunal identified the following aggravating factors in this case:

- Dr Watt had demonstrated no evidence of insight in relation to his deficient professional performance across the breadth of his clinical practice.

- There has been no acknowledgement of fault and there had been no apology. Neither had there been any acknowledgement of the risk his deficient performance had posed to his patients.

- There was no evidence that Dr Watt has made any steps to learn from and/or remediate his deficient professional performance.

147. The Tribunal identified the following mitigating factors:

- His previous good character. Dr Watt qualified as a doctor in 1985 and began practising as a consultant neurologist in 1996. Over a long career in medicine, Dr Watt possessed a largely unblemished record (apart from the warning referred to in §11 above) - at least, until the advent of the matters forming the subject of this hearing. Mr Garside had indicated that there were no criminal matters recorded against Dr Watt, nor were there any (as he put it) *'regulatory infractions'*, other than the warning.

- XXX.

- For completeness, the Tribunal also considered whether the lapse of time since the performance assessment (which occurred in October 2018) was a mitigating factor. It deemed, however, that it was not, as it could not be said that he had practised without incident since that time, as he had not practised at all since June 2017. The Tribunal considered, too, whether Dr Watt's cooperation with the performance assessment process could be weighted in his favour. However, this was not a mitigating factor either, as cooperation with his Regulator was a prerequisite of his registration.

The Tribunal's Determination on Sanction

No action

148. In reaching its decision as to the appropriate sanction, if any, to impose in Dr Watt's case, the Tribunal first considered whether to conclude the case by taking no action. Taking no action following a finding of impaired fitness to practise would only be appropriate in exceptional circumstances.

149. The Tribunal determined that the seriousness of its findings required the imposition of a sanction. It determined that there were no exceptional circumstances, and it would not therefore be sufficient, proportionate or in the public interest to conclude this case by taking no action.

Conditions

150. The Tribunal next considered whether it would be sufficient to impose conditions on Dr Watt's registration. It bore in mind that any conditions imposed should be appropriate, proportionate, workable, and measurable.

151. It had regard to paragraph 81 of the SG which states:

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

152. While the Tribunal recognised that paragraph 81 did not exhaustively limit the circumstances in which conditions might be appropriate; nevertheless, on the facts of this case, conditions would not be appropriate, proportionate, workable or measurable. There was no evidence to suggest Dr Watt would comply with any conditions, nor was there evidence of how any conditions could be measured in circumstances where Dr Watt was not currently practising medicine. Still more significantly though, the Tribunal did not consider - having regard to the breadth and scope of the performance concerns highlighted by the performance assessment - that the sanction of conditions would be proportionate in this instance. They would be insufficient to meet the public interest and to maintain proper professional standards of conduct for the members of the profession.

153. The Tribunal has, therefore, determined that it would not be sufficient to direct the imposition of conditions on Dr Watt's registration.

Suspension

154. The Tribunal then went on to consider whether imposing a period of suspension on Dr Watt's registration would be appropriate and proportionate. The Tribunal had regard to paragraphs 91-94 of the SG, which state:

> *'91. Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a*

registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.

92. [...] *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 [...].

94. Suspension is also likely to be appropriate in a case of deficient performance or lack of knowledge of English in which the doctor currently poses a risk of harm to patients but where there is evidence that they have gained insight into the deficiencies and have the potential to remediate if prepared to undergo a rehabilitation or retraining programme.'

155. The Tribunal determined, however, that this was not a case where - per §93 above - there had been an acknowledgement of fault, nor one where the Tribunal had an objective basis to find the deficient professional performance was unlikely to be repeated. Neither was this a case where evidence was available that Dr Watt had taken steps to mitigate his actions, or where - per §94 above - Dr Watt had demonstrably gained insight into his deficiencies or displayed *'the potential to remediate if prepared to undergo a rehabilitation or retraining programme'*.

156. The Tribunal went on to consider all the paragraphs in the SG relating to suspension. This consideration included those factors listed at paragraph 97; factors which, if present, would indicate suspension might be appropriate. The Tribunal concluded, though, that the only factor engaged was 97(f) (i.e., *'no evidence of repetition of similar behaviour since incident'*), and then only notionally so - because Dr Watt had ceased to practise in the period since the performance assessment was undertaken.

157. In light of the Tribunal's findings in relation to Dr Watt's failures (failures it had described as *'stark, serious, repeated and numerous'*), it considered that a period of suspension would not be appropriate. Such a sanction would not be sufficient to maintain public confidence in the profession, nor to promote and maintain proper professional standards and conduct for members of the profession.

Erasure

158. The Tribunal therefore went on to consider the sanction of erasure. It considered that SG §107 and 108 spoke directly to the position arising out of the results of Dr Watt's performance assessment:

> *'107. The tribunal may erase a doctor from the medical register in any case - except one that relates solely to the doctor's health and/or knowledge of English - where this is the only means of protecting the public.*
>
> *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.'*

159. In the absence of any expression of insight or any indication of remediation, the Tribunal found that erasure was indeed the only means of protecting the public. Moreover, in addition to the risk to patient safety plainly evident here; erasure was necessary in any event *'to maintain public confidence in the profession'*, given the blatant disregard for standards and safeguards exhibited by Dr Watt as described in the performance assessment report.

160. Looking more widely within SG at the area covering *'other issues relevant to sanctions'*, the Tribunal considered that §129-132, addressing failures *'to provide an acceptable level of treatment or care'*, were pertinent:

> *'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 (set out in domains one and four of Good medical practice on knowledge, skills and performance, and maintaining trust). 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, paragraph 1).

130. A particularly important consideration in these cases is whether a doctor has developed, or has the potential to develop, insight into these failures. Where insight is not evident, it is likely that conditions on registration or suspension may not be appropriate or sufficient.

131. Remediation (where a doctor addresses concerns about their knowledge, skills, conduct or behaviour) can take a number of forms, including coaching, mentoring, training, and rehabilitation (this list is not exhaustive), and, where fully successful, will make impairment unlikely.

132. However, there are some cases where a doctor's failings are irremediable. This is because they are so serious or persistent that, despite steps subsequently taken, action is needed to maintain public confidence. This might include where a doctor knew, or ought to have known, they were causing harm to patients and should have taken steps earlier to prevent this.'

161. Against those considerations, the Tribunal then went on to consider SG §109. This explains that *'Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive)...'* Among those listed there, the Tribunal has determined that each of the following factors is present:

'a. A particularly serious departure from the principles set out in Good medical practice where the behaviour is fundamentally incompatible with being a doctor.

b. A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety.
...
j. Persistent lack of insight into the seriousness of their actions or the consequences.'

162. In addition, the Tribunal having already found (in its Impairment determination at §16) that Dr Watt had failed to '*make sure that* [his] *conduct justifies* [his] *patients' trust in* [him] *and the public's trust in the profession'* (GMP §65); it considered that SG §109d was also engaged:

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

163. Taking all these matters into account, and notwithstanding such mitigation as existed in this case, the Tribunal considered that, having regard to the breadth and scope of the concerns highlighted by the performance assessment, Dr Watt's deficient professional performance was fundamentally incompatible with continued registration. The Tribunal has therefore determined that erasure is the only sufficient sanction which will protect patients and maintain public confidence in the profession.

164. The Tribunal therefore determined that Dr Watt's name be erased from the Medical Register.

Determination on Immediate Order - 06/11/2023

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

Submissions

166. Mr Garside, on behalf of the GMC, submitted that there should be an immediate order imposed. He referred to paragraph 172 of the SG, which reads:

'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.'

167. Mr Garside submitted that it was a case where it was necessary for an immediate order to be imposed for the protection of the public or otherwise in the public interest.

Mr Garside stated that there was an interim order in place on Dr Watt's registration and asked the Tribunal to revoke this if an immediate order was made.

168. No submissions were received on behalf of Dr Watt.

The Tribunal's Determination

169. In making its decision the Tribunal had regard to the SG, including paragraph 172 (quoted above) and paragraphs 173 and 178:

> *'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.*
> *...*
> *178. Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the tribunal based on the facts of each case. The tribunal should consider the seriousness of the matter that led to the substantive direction being made and whether it is appropriate for the doctor to continue in unrestricted practice before the substantive order takes effect.'*

170. The Tribunal had regard to the seriousness of its findings, which it has outlined in detail in its previous determinations.

171. In all the circumstances, the Tribunal determined to impose an immediate order of suspension on Dr Watt's registration. The Tribunal was of the view that it would be inappropriate to allow Dr Watt's practice to be unrestricted before the substantive order takes effect. The Tribunal concluded that this was appropriate and necessary to protect members of the public and was in the public interest.

172. This means that Dr Watt'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.

173. The interim order will be revoked when the immediate order takes effect.

174. That concludes this case.

ANNEX A - 08/09/2023

Tribunal Directions

175. This determination will be handed down in private.

176. Having regard to its powers under Rule 16(1), 16(1)(a) and 16(6) of the General Medical Council (Fitness to Practise) Rules Order of Council 2004 and for the purpose of effective case management, the Tribunal issues the following directions:

1. Dr Watt's representatives and the GMC to prepare written skeleton arguments and supporting caselaw in relation to each of the following applications:

    a) That the voluntary erasure application is heard in private;
    b) That the voluntary erasure application is heard before the GMC continues with its case; and
    c) The substantive voluntary erasure application.

2. The skeleton arguments and supporting caselaw referred to in paragraph (1) to be supplied to the MPTS in order that they are available for the Tribunal by noon on 16 October 2023.

    XXX.

ANNEX B - 18/10/2023

Application to admit evidence

177. This determination will be handed down in private.

178. On 18 October 2023, Mr McDonagh, Counsel on behalf of Dr Watt, made an application for the written evidence from the witness Dr A to be admitted under Rule 34(1) of the GMC (Fitness to Practise Rules) 2004 as amended ('the Rules').

179. In support of his application, Mr McDonagh submitted that, XXX, Dr A was no longer XXX to attend the hearing to be cross-examined nor to act as an expert witness. The reasons for this were set out in correspondence (16 October 2023) XXX.

180. XXX, Mr McDonagh did not seek an adjournment to secure Dr A's attendance.

181. Mr Garside, KC, on behalf of the GMC, did not oppose the application. He said Dr A's evidence could be admitted under Rule 34(1), albeit the weight to be attached to it would be a matter for the Tribunal.

Tribunal's Decision

182. The Tribunal had regard to Rule 34(1) of the Rules, which reads as follows:

> *"The Committee or a Tribunal may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law."*

183. Reflecting upon this, the Tribunal considered that Dr A's evidence was relevant and that it would be fair to admit it in the particular circumstances. The question of the weight that the Tribunal might attach to it would be considered in due course.

ANNEX C - 18/10/2023

Application for matters relating to the 'order of events' to be heard in private

184. This determination will be handed down in private.

185. Mr McDonagh, Counsel on behalf of Dr Watt, made an application under Rule 41 of the GMC (Fitness to Practise Rules) 2004 as amended ('the Rules') for matters relating to the 'order of events' to be heard in private.

186. The reference to 'order of events' related to whether the Tribunal should first hear the substantive case of impairment by reason of deficient professional performance or should instead hear an application for voluntary erasure.

187. Mr McDonagh submitted that both parties were in agreement that the application should be heard in private in accordance with Rule 41XXX of the Rules as the application would necessarily involve a discussion of XXX.

188. Mr Garside KC, on behalf of the GMC, did not oppose the application. Mr Garside made it clear, though, that his agreement related to this aspect of the case only.

189. XXX.

190. Having regard to the submissions of the parties, the Tribunal determined there was no basis to depart from the general position set out in Rule 41XXX when considering the 'order of events' issue. Accordingly, the Tribunal granted Mr McDonagh's application. For the avoidance of doubt, however, the Tribunal indicates that the Rule 41XXX decision is limited to this stage of the proceedings, and at each stage hereafter Rule 41 will be considered afresh.

ANNEX D - 25/10/2023

Application in respect of order of proceedings

191. This determination will be handed down in private.

Background

192. Subsequent to the GMC opening its case, and before it called its first witness, Dr Watt submitted an application for voluntary erasure ('VE').

193. Mr McDonagh, counsel for Dr Watt, submitted that the VE application should be considered before the GMC continued with its case. Mr Garside, on behalf of the GMC, submitted that it should not. On 8 September 2023, the Tribunal gave directions for the parties to supply written skeleton arguments addressing this issue. Having received those written submissions, on 18 October 2023 both parties also made oral submissions.

Submissions

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

194. At the core of the submissions on behalf of Dr Watt was the assertion that, if the GMC were permitted to continue with its substantive case before the VE application was heard, this would create XXX.

195. XXX

196. Mr McDonagh supplemented his written submissions by stressing that XXX was accepted by 'both sides' XXX. Accordingly, any public interest in hearing the substantive case first ('public interest' being distinguished from 'public clamour', per *Re JR168 and Another's Application (Suspension of police constable)* [2023] NIKB 83) was outweighed by XXX that could be occasioned if the PA went first.

197. Mr McDonagh submitted that the issue was not about Dr Watt's reputation - that, he said, had been 'lost already' as a result of other processes which had already taken place (for example, the Trust report and the Neurology Inquiry) coupled with the news media coverage. XXX.

198. Given XXX, Mr McDonagh submitted the Tribunal should only decide whether to XXX after having heard the VE application. XXX

199. XXX

200. XXX

201. XXX

202. XXX

203. Mr McDonagh therefore invited the Tribunal to apply '*common sense*' to the situation. He said the Tribunal should not XXX but should instead permit VE to be heard first.

204. Mr McDonagh added that he was not aware of anything in the rules, or in any caselaw, that addressed the issue of the order of proceedings.

<u>On behalf of the GMC</u>

205. For his part, Mr Garside submitted that, having opened the case for the GMC, he should be permitted now to continue with that case, and that a VE application could be heard later in the hearing.

206. Like Mr McDonagh, he was unaware of anything in the rules, or in any caselaw, that addressed the issue of the order of proceedings. He submitted that it was a matter within the Tribunal's *'unfettered discretion'*.

207. Mr Garside submitted that if the VE application was heard first, and if it were to be successful, it would mean there would never be a public airing of the matters which formed the subject of the PA. These were matters in which there was a genuine public interest; a public interest which could not, on a proper understanding of the facts, be characterised merely as public clamour. (He said that the reason he had supplied the Tribunal with a copy of Volume 1 of the Independent Neurology Inquiry Report ['INIR', June 2022] was to give it a wider contextual framework in relation to Dr Watt.).

208. Moreover, these were not admitted matters. In that regard, Mr Garside reminded the Tribunal of §39(b) of the GMC's '*Guidance on making decisions on voluntary erasure applications…*' ('the Guidance', March 2021), viz:

> *'Our ability to revive concerns will be greater if the doctor has admitted the allegations against them.* […] *The admissions would then be considered as part of any subsequent restoration application. If the doctor denies the allegations or disputes any facts, a more cautious approach to granting VE or advising on AE should be used. In these circumstances, it may be safer to allow the current case to progress up to the point a decision is reached on the key issues, which in some cases may include a tribunal determination as to whether the doctor's fitness to practise is impaired.'*

209. He added that if the application for VE was heard first and was successful for reasons which were not apparent to the public, it would be viewed as a *'cover-up'*. A further concomitant would be that other misconduct matters, not before this Tribunal, would not be able to be pursued.

210. Mr Garside, therefore, acknowledged that the Tribunal now had to undertake a balancing exercise; weighing the real public interest in the substantive PA case being publicly heard and considered first against XXX

211. He reminded the Tribunal of the statutory overarching objective. Namely, to:

a. protect and promote the health, safety and wellbeing of the public
b. promote and maintain public confidence in the medical profession
c. promote and maintain proper professional standards and conduct for the members of the profession.

212. XXX

213. XXX

214. XXX

215. XXX

216. XXX

217. Finally, Mr Garside added that it would be wrong for this Tribunal to be influenced by the outcome of the previous Tribunal.

The Tribunal's approach

218. In considering this issue, and in the absence of any specific guidance on the order of proceedings, the Tribunal - in seeking to deal with the application fairly and justly - took as its starting point the statutory overarching objective. Namely, to protect, promote, and maintain the health, safety, and well-being of the public. In order to do so, the Tribunal recognised that it must act at all times 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.

219. Against that background, the Tribunal reminded itself first that, in the absence of admissions by Dr Watt to the facts in the Allegation, there was reason to be cautious in considering any VE application before the substantive PA case, per §39b of the Guidance, as set out in §18 above.

220. Secondly, the Tribunal bore in mind that, having thus far only dealt with a range of adjunctive issues, it had not yet had the opportunity to consider the detail of the substantive

PA case, beyond having heard the GMC's case opening. In other words, no GMC witnesses had been called, and no opportunity had yet presented itself to gain an understanding of the strengths or otherwise of the GMC's evidence.

221. Thirdly, the Tribunal was aware more generally that in certain cases involving allegations of poor performance, there was a public interest in the concerns being fully investigated and ventilated before a Tribunal. This may be, for example, because a doctor's allegedly deficient performance has been linked to serious harm to patients or resulted in significant public concern. The Tribunal considered that this was indeed such a case, bearing in mind the observations of McAlinden J during the Judicial Review before the High Court of Northern Ireland ([2023] NIQB 46) in relation to the decision taken by the previous Tribunal in relation to Dr Watt:

> '[…]
> *[30] Whilst the strong public interest elements at play in any substantive decisions that the GMC and MPT are tasked with making might be said to be obvious, the importance of the type of decisions that are taken by the MPTS is clearly demonstrated by the facts of the present case. The recall process regarding Dr Watt involved the recall of 2,500 patients in May 2018; a further 1,044 patients being recalled in November 2018; and a third recall of 209 patients in April 2021. The third recall related to patients seen by Dr Watt between 1996 and 2012. In addition to Dr Watt's NHS patients, 67 private patients of Dr Watt seen at the Ulster Independent Clinic and Hillsborough Private Clinic were also recalled. A review of 927 of Dr Watt's high-risk patients found that 181 of those patients received a diagnosis that was described by Robin Swann, the then Health Minister as "not secure." In a separate review, the Belfast Trust examined case notes of 66 patients who had undergone blood patch procedures under Dr Watt's care and found that for 45 of those patients (68.1%) there was no clinical evidence supporting the need for such a procedure. For 46 of the 66 patients (69%) care was deemed unsatisfactory and fell below expected standards. The Belfast Trust issued a statement which included the following:*
>
> > *"We are deeply sorry for this and for the undue hurt these patients experienced."*
>
> *[31] It is no exaggeration to state that the announcement that Dr Watt had been granted VE in a private hearing without any analysis of the quality of care and treatment he had provided to his patients over many years was greeted by widespread*

dismay, if not outrage. The GMC itself publicly stated that Dr Watt's patients had suffered "immense harm" and that it was "extremely disappointed" by the MPTS decision, stating that it "felt it was in the public interest for allegations" against Dr Watt "to be heard by the tribunal in an open and transparent way." The then Minister for Health stated that it was:

> *"another distressing day, in what has been a long sequence of distressing days for the former patients of Dr Watt and their families...There was an expectation of a full GMC hearing and there will be profound disappointment that this is not happening. I very much share that disappointment... I can assure patients and families that I am determined to do everything in my power to repair the damage inflicted on public confidence by the neurology recall."*

222. Accordingly, set against those considerations but not being bound by them, the Tribunal's view was that, in the absence of a sufficient reason to do otherwise, 'Stage One' of the substantive PA hearing (i.e., the facts stage) and, should matters get that far, 'Stage Two' (the consideration of impairment) should proceed before the VE application is considered.

223. The Tribunal then considered, though, whether there was sufficient reason to do otherwise. In other words, whether XXX properly necessitated hearing the VE application first.

XXX

XXX

224. XXX

225. XXX

226. XXX

227. XXX

228. XXX

229. XXX

230. XXX

231. XXX

XXX

XXX

232. XXX

233. XXX

234. XXX

235. XXX

236. XXX

237. XXX

238. XXX

XXX

239. XXX

XXX

XXX

240. XXX

241. XXX

242. XXX

243. XXX

244. XXX

245. XXX

246. XXX

247. XXX

XXX

248. XXX

249. XXX

250. XXX

251. XXX

252. XXX

253. XXX

254. XXX

255. XXX

256. XXX

257. XXX

258. XXX

259. XXX

260. XXX

Tribunal's analysis and determination

XXX

261. XXX

Analysis

262. XXX

263. XXX

264. XXX

265. XXX

266. XXX

267. XXX

268. XXX

269. XXX

270. XXX

271. XXX

Conclusion

272. Overall, in appraising the above matters justly and fairly, the Tribunal considers the position to be this. There is indeed a risk XXX in Dr Watt's case. XXX

273. However, the assertion on behalf of Dr Watt that XXX, had not been made with a sufficiently cogent evidential underpinning to enable the Tribunal properly to determine that it was necessary that the VE application should be heard before the substantive PA case. This was particularly so in circumstances where XXX

274. In those circumstances, therefore, and for the reasons set out earlier in this document (§28-32) the Tribunal's determination is that it will hear the substantive PA case first, and to the conclusion of Stage Two of the proceedings (should matters get that far), before it hears the VE application.

ANNEX E - 02/11/2023

Service and Proceeding in Absence

275. This determination will be handed down in private. However, as this case concerns Dr Watt's deficient professional performance, a redacted version will be published with those matters relating to XXX removed.

276. On 27 October 2023, following the Tribunal's determination on the 'order of proceedings' (Annex D), Mr McDonagh, counsel for Dr Watt, together with the rest of his legal team, withdrew from the case. From that moment, Dr Watt was neither present nor was he represented at the hearing. The stage matters had reached was that the GMC had opened its case but had not yet called its first witness.

277. Mr Garside, counsel for the GMC, then applied for the case to proceed in Dr Watt's absence.

278. He submitted that there had been good service in accordance with GMC (Fitness to Practise Rules) 2004 as amended ('the Rules'), and a service bundle was produced in this regard.

279. In relation to whether the Tribunal should exercise its discretion to proceed, Mr Garside said that the balance of fairness in this particular case required the case to proceed. Mr Garside stated that the Tribunal had no power to compel Dr Watt's attendance and there was nothing to make him attend if he did not want to. He submitted that the Tribunal could be confident that the lawyers who had just withdrawn had the appropriate

and necessary discussions with Dr Watt before taking that decision and, as Mr McDonagh had said, Dr Watt expected the proceedings to continue in his absence.

280. Mr Garside returned to the issue of fairness. He stated that the Tribunal should ensure fairness to the practitioner, but also to the public and the GMC. He submitted that, in this case, Dr Watt had made a decision with full advice and knowledge of the implications. Mr Garside stated that the public interest required that proceedings were dealt with as expeditiously as possible, so both the public and Dr Watt knew the outcome. He also submitted that the balance of fairness was in favour of the Tribunal continuing with this hearing in Dr Watt's absence.

Tribunal's decision

Service

281. The Tribunal considered the rules relating to service, having regard to the advice provided by the Legally Qualified Chair. On the basis of that advice, it noted that, in accordance with Rule 31,

> *'Where the practitioner is neither present nor represented at a hearing […] the 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.'*

282. Taking into account the specific notice requirements under the Rules (R15, R40 and paragraph 8 of Schedule 4 of the Medical Act 1983), the Tribunal was satisfied there had been good service in this case. In an exchange of emails on 27 July 2023 with Mr McMillan (the solicitor authorised to receive Dr Watt's correspondence), the MPTS had provided the necessary information relating to the date, place and time of the hearing, Dr Watt's right to attend and be represented at the hearing, his right to adduce evidence and to call and cross-examine witnesses, information relating to the Tribunal's power to proceed in his absence, and information regarding the Tribunal's powers of disposal. Dr Watt had also been sent (among other things) a notice of the Allegation and the hearing bundle. The correspondence had been acknowledged by Mr McMillan that same day.

Proceeding in absence

283. The Tribunal then went on to consider whether it should exercise its discretion to proceed in Dr Watt's absence, having regard to the advice on the law provided by the Legally Qualified Chair, as below.

The law

284. **1R v Hayward, Jones and Purvis** [2001] QB 862, CA; **R v. Jones (Anthony)** [2003] 1 AC 1, HL

285. Rose J, handing down the judgment of the Court of Appeal, Criminal Division (Rose LJ, and Hooper and Goldring JJ) said:

> *'22. In our judgment, in the light of the submissions which we have heard and the English and European authorities to which we have referred, the principles which should guide the English courts in relation to the trial of a defendant in his absence are these:*
>
> > *(1) A defendant has, in general, a right to be present at his trial and a right to be legally represented.*
> >
> > *(2) Those rights can be waived, separately or together, wholly or in part, by the defendant himself. They may be wholly waived if, knowing, or having the means of knowledge as to, when and where his trial is to take place, he deliberately and voluntarily absents himself and/or withdraws instructions from those representing him. They may be waived in part if, being present and represented at the outset, the defendant, during the course of the trial, behaves in such a way as to obstruct the proper course of the proceedings and/or withdraws his instructions from those representing him.*
> >
> > *(3) The trial judge has a discretion as to whether a trial should take place or continue in the absence of a defendant and/or his legal representatives.*
> >
> > *(4) That discretion must be exercised with great care and it is only in rare and exceptional cases that it should be exercised in favour of a trial taking place or continuing, particularly if the defendant is unrepresented.*

(5) In exercising that discretion, fairness to the defence is of prime importance but fairness to the prosecution must also be taken into account. The judge must have regard to all the circumstances of the case including, in particular: (i) The nature and circumstances of the defendant's behaviour in absenting himself from the trial or disrupting it, as the case may be and, in particular, whether his behaviour was deliberate, voluntary and such as plainly waived his right to appear; (ii) Whether an adjournment might result in the defendant being caught or attending voluntarily and/or not disrupting the proceedings; (iii) The likely length of such an adjournment; (iv.) Whether the defendant, though absent, is, or wishes to be, legally represented at the trial or has, by his conduct, waived his right to representation; (v) Whether an absent defendant's legal representatives are able to receive instructions from him during the trial and the extent to which they are able to present his defence; (vi) The extent of the disadvantage to the defendant in not being able to give his account of events, having regard to the nature of the evidence against him; (vii) The risk of the jury reaching an improper conclusion about the absence of the defendant; (viii) The seriousness of the offence, which affects defendant, victim and public; (ix) The general public interest and the particular interest of victims and witnesses that a trial should take place within a reasonable time of the events to which it relates; (x) The effect of delay on the memories of witnesses; (xi) Where there is more than one defendant and not all have absconded, the undesirability of separate trials, and the prospects of a fair trial for the defendants who are present."

(6) If the judge decides that a trial should take place or continue in the absence of an unrepresented defendant, he must ensure that the trial is as fair as the circumstances permit. He must, in particular, take reasonable steps, both during the giving of evidence and in the summing up, to expose weaknesses in the prosecution case and to make such points on behalf of the defendant as the evidence permits. In summing up he must warn the jury that absence is not an admission of guilt and adds nothing to the prosecution case.'

286. The appeal by Jones against conviction was dismissed by the House of Lords. Lord Bingham of Cornhill, at [6], said that the Court had:

'… a discretion, to be exercised in all the particular circumstances of the case, whether to continue a trial or to order that the jury be discharged with a view to a further trial

being held at a later date. The existence of such a discretion is well-established … But it is of course a discretion to be exercised with great caution and with close regard to the overall fairness of the proceedings; a defendant afflicted by involuntary illness or incapacity will have much stronger grounds for resisting the continuance of the trial than one who has voluntarily chosen to abscond.'

287. Lord Bingham, at XXX:

'XXX.

14. First, I do not think that "the seriousness of the offence, which affects defendant, victim and public", listed in paragraph 22(5)(viii) as a matter relevant to the exercise of discretion, is a matter which should be considered…

15. Secondly, it is generally desirable that a defendant be represented even if he has voluntarily absconded...'

288. Lord Nolan, at [18]:

'In the case of an absconding defendant the critical question for the judge is whether the defendant has deliberately and consciously chosen to absent himself from the court.'

289. Lord Hoffmann, at [20]:

'But I do not read the European cases as laying down that a trial may proceed in the absence of the accused only if there has been a waiver of the right to a fair trial. The question in my opinion is not whether the defendants waived the right to a fair trial but whether in all the circumstances they got one…'

290. Lord Hutton, at [38]:

'The discretion of a judge to proceed with a trial in the absence of the defendant is one to be exercised with great care, but in my opinion there can be circumstances where in the interests of justice a judge is entitled to proceed, particularly where the defendant has deliberately absconded to avoid trial.'

291. Lord Rodger of Earlsferry, at [54]–[68] (prosecuting counsel looked to see whether there are any areas that ought to be highlighted in view of the fact that the defendants were not present or represented; the judge's summing up was obviously of even greater importance than usual; the jury were told specifically that they must not speculate as to the reasons for the defendants' absence, that they should not assume that the defendants' failure to attend court in any way at all established that either or both of them were guilty, and that they should carefully assess the evidence as they would have done had the defendants been present and had they been represented by counsel.)

292. 18. Turning to the applicability of the above law to the current hearing, the Legally Qualified Chair directed the Tribunal's attention to GMC v Adeogba; GMC v Visvardis [2016] EWCA Civ 162, [2016] 1 WLR 3867. Therein, giving the lead judgment, Sir Brian Leveson P had said:

> *'13. Assuming that service can be established within the Rules, it was not in dispute between the GMC and [A] that the relevant Panel (as appropriately advised by its legal assessor) must approach the decision under Rule 31 whether to proceed in the absence of the medical practitioner by reference to the principles developed by the criminal law in relation to trial in the absence of a defendant. Thus, the starting point is R v. Hayward, R v. Jones, R v. Purvis QB 862 [2001], EWCA Crim 168 [2001] in which an experienced Court of Appeal (Rose LJ, Hooper and Goldring JJ) distilled the domestic and Convention authorities and set out guidance … (at [22(3)–(5)]).*
>
> *[…]*
>
> *17. In my judgment, the principles set out in Hayward, as qualified and explained by Lord Bingham in Jones, provide a useful starting point for any direction that a legal assessor provides and any decision that a Panel makes under Rule 31 of the 2004 Rules. Having said that, however, it is important to bear in mind that there is a difference between continuing a criminal trial in the absence of the defendant and the decision under Rule 31 to continue a disciplinary hearing. This latter decision must also be guided by the context provided by the main statutory objective of the GMC, namely, the protection, promotion and maintenance of the health and safety of the public as set out in s. 1(1A) of the Medical Act 1983. In that regard, the fair, economical, expeditious and efficient disposal of allegations made against medical practitioners is of very real importance.*

18. It goes without saying that fairness fully encompasses fairness to the affected medical practitioner (a feature of prime importance) but it also involves fairness to the GMC (described in this context as the prosecution in Hayward at [22(5)]). In that regard, it is important that the analogy between criminal prosecution and regulatory proceedings is not taken too far. Steps can be taken to enforce attendance by a defendant; he can be arrested and brought to court. No such remedy is available to a regulator.

19. There are other differences too. First, the GMC represents the public interest in relation to standards of healthcare. It would run entirely counter to the protection, promotion and maintenance of the health and safety of the public if a practitioner could effectively frustrate the process and challenge a refusal to adjourn when that practitioner had deliberately failed to engage in the process. The consequential cost and delay to other cases is real. Where there is good reason not to proceed, the case should be adjourned; where there is not, however, it is only right that it should proceed.

20. Second, there is a burden on medical practitioners, as there is with all professionals subject to a regulatory regime, to engage with the regulator, both in relation to the investigation and ultimate resolution of allegations made against them. That is part of the responsibility to which they sign up when being admitted to the profession.

[…]

23. Thus […] Assuming that the Panel is satisfied about notice, discretion whether or not to proceed must then be exercised having regard to all the circumstances of which the Panel is aware with fairness to the practitioner being a prime consideration but fairness to the GMC and the interests of the public also taken into account; the criteria for criminal cases must be considered in the context of the different circumstances and different responsibilities of both the GMC and the practitioner.'

293. Reflecting upon all the above principles, and considering them with the utmost care and caution, the Tribunal noted the following.

294. Dr Watt knew he had a right to be present at the hearing and a right to be represented. He had decided in advance of the hearing that he would not attend. In correspondence dated 23 August 2023, Mr McMillan had written to the GMC to confirm this.

295. Those representing Dr Watt chose to withdraw from the hearing on 27 October 2023. Before doing so, Mr McDonagh had stated that Dr Watt understood that the matter would continue uncontested in his absence.

296. No adjournment was sought by or on behalf of Dr Watt. Indeed, Mr McDonagh asserted before withdrawing from the hearing that *'no one could countenance this case going part heard well into next year'* or words to that effect.

297. Moreover, there was no information to indicate that, if the Tribunal nevertheless decided to adjourn the hearing of its own volition, Dr Watt would attend on any subsequent date, nor that any legal representative would attend on his behalf. In those circumstances, an adjournment would serve no purpose.

298. While the Tribunal could not speculate about the reason for Dr Watt's absence (no particular reason having been given at the point the application to 'proceed in absence' was made), it considered it could reasonably infer that Dr Watt's absence was due to the position previously articulated on his behalf, as captured within those papers which had formed the basis for the earlier, withdrawn 'voluntary erasure' application. Namely, that a risk XXX, precluded him either from preparing for the hearing of the substantive case or attending and participating in it.

299. XXX

300. XXX

301. XXX

302. XXX

303. XXX

304. XXX

31. XXX

305. XXX

306. XXX

307. Against that background, the Tribunal then went on to remind itself that the general public interest, and the particular interest of victims and witnesses, meant that the hearing should take place within a reasonable time of the events to which it relates. The performance assessment under consideration was already almost five years old. The four professionals who had undertaken the performance assessment report were available at this hearing. The Tribunal was mindful of the effect of delay on the memory of these witnesses if the case was adjourned further.

308. As a competent and diligent Tribunal, composed of independent, impartial professionals conducting themselves with integrity and without bias, it was satisfied that it would not reach an improper conclusion about Dr Watt's absence, nor infer anything as a result of that absence.

309. The Tribunal recognised that Dr Watt's absence meant that he could not challenge the GMC case. For its part, though, the Tribunal could, and would, question the authors of the performance assessment report to get a fuller understanding of the basis for their conclusions, the evidence they had relied upon, and the methodology they had deployed.

310. More generally, in being asked to reach any determination on the case going forward, the Tribunal recognised that it could rely upon the Legally Qualified Chair to provide clear, accurate and relevant advice to help ensure a fair and just hearing.

311. In all the circumstances therefore, recognising that fairness *'encompasses fairness to the affected medical practitioner (a feature of prime importance) but it also involves fairness to the GMC'*, and bearing in mind that *'the fair, economical, expeditious and efficient disposal of allegations made against medical practitioners is of very real importance'*, the Tribunal has determined that the hearing should proceed in Dr Watt's absence.