PUBLIC RECORD

Dates: 11/05/2026 - 15/05/2026

Doctor:	Dr Preethi SURESH
GMC reference number:	7558757
Primary medical qualification:	MBBS 2016 Rajiv Gandhi University of Health Sciences - MVJ Medical College & Research Hospital

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

Summary of outcome

Suspension, 12 months.
Review hearing directed
Immediate order imposed

Tribunal:

Legally Qualified Chair	Mrs Emma Gilberthorpe
Registrant Tribunal Member:	Dr Caroline Roberts
Registrant Tribunal Member:	Dr Wasim Qayum

Tribunal Clerk:	Ms Jemine Pemu (11/05/2026 to 13/05/2026) Mrs Jennifer Ireland (14/05/2026 to 15/05/2026)

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Mr Stephen McCaffrey, Counsel
GMC Representative:	Ms Colette Renton, Counsel

Attendance of Press / Public

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

Protecting the Public

Throughout the decision making process the tribunal has borne in mind the statutory duty as set out in s1(1) of the Medical Act 1983 (the 1983 Act) to protect the public. The tribunal has considered the relevance and impact on each of the three distinct parts of public protection to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts and Impairment - 14/05/2026

Background

1. Dr Suresh qualified in 2016 with MBBS from Rajiv Gandhi University of Health Sciences - MVJ Medical College & Research Hospital. At the time of the events giving rise to these proceedings, Dr Suresh was employed as a Postgraduate Doctor undertaking the cardiology training programme at Norfolk and Norwich University Hospitals NHS Foundation Trust. Dr Suresh was working at ST7 level within the East of England Cardiology training scheme.

2. The allegations that have led to Dr Suresh's hearing relate to her conduct on or around 29 February 2024. It is alleged by the General Medical Council (GMC) that Dr Suresh scanned a QR code to confirm her registration at a face-to-face East of England cardiology training day ('the Training'), scanned a second QR code and completed feedback for the Training, automatically generating a certificate of attendance ('the Certificate'), and uploaded the Certificate to her training e-portfolio. It is further alleged that when Dr Suresh carried out these steps, she knew that she had not attended the Training, she knew that uploading the Certificate to her e-portfolio would allow her to falsely claim that she had attended the Training and achieved the corresponding Continuing Professional Development hours. It is alleged that Dr Suresh's actions were dishonest.

3. The initial concerns were raised with the GMC on 21 May 2024 by Professor A, Regional Postgraduate Dean for the East of England, following concerns identified and investigated locally within the training programme.

4. Professor B, a Clinical Professor of Cardiac Medicine and Consultant Cardiologist at Norfolk and Norwich University Hospital, also held responsibility for the education and training of cardiology Specialty Registrars within the East of England Cardiology training scheme. Attendance at training days formed part of the Annual Review of Competence Progression ('ARCP') process, and trainees were informed that attendance at approximately 60% of sessions was expected. Dr Suresh had booked leave between 26 February and 1 March 2024 due to her forthcoming wedding and was therefore not expected to attend the Training held on 29 February 2024. During the Training, a QR code was made available in the morning for attendees to register attendance and, at the end of the day, another QR code was made available to complete feedback forms, with completion of the feedback automatically generating a certificate of attendance. On 1 March 2024, Professor B reviewed the attendance and feedback records and noted that Dr Suresh had registered attendance and submitted feedback despite him not recalling her presence at the Training. He subsequently reviewed Dr Suresh's e-portfolio and identified that the Certificate had been uploaded.

5. Following discussions with the Training Programme Directors, Professor B contacted Dr Suresh on 4 March 2024 seeking clarification. In her response, Dr Suresh admitted that she had not attended the Training but had scanned QR codes shared via WhatsApp. She said she immediately knew it was wrong and did not upload or use the Certificate for claiming any CPD points. She described herself as being in a "chaotic state of mind" in the lead up to her wedding, acknowledged that her actions were wrong and apologised for her conduct. Following this exchange, Professor B noted the Certificate was removed from her e-portfolio. The matter was subsequently escalated to Professor A, Regional Postgraduate Dean for the East of England. In a written response to him dated 2 May 2024, Dr Suresh confirmed that she had received and used the QR codes via WhatsApp and accepted that she had uploaded the Certificate to her e-portfolio before later removing it. She referred to the pressures of balancing work, training commitments and wedding preparations, expressed shame for her behaviour and stated that she had reflected upon the probity concerns arising. Concerns nevertheless remained regarding the inconsistency between Dr Suresh's initial account and her later acceptance that she had uploaded the Certificate to her e-portfolio, following which the matter was referred to the GMC.

The Allegation and the Doctor's Response

6. The full Allegation against Dr Suresh is as follows:

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

1. On or around 29 February 2024 you:

   a. scanned a QR code to confirm your registration at a face-to-face East of England cardiology training day ('the Training'); Admitted and found proved

   b. scanned a second QR code and completed feedback for the Training, automatically generating a certificate of attendance ('the Certificate'); Admitted and found proved

   c. uploaded the Certificate to your e-portfolio. Admitted and found proved

2. When you carried out the steps outlined at paragraph 1 you knew that:

   a. you had not attended the Training; Admitted and found proved

   b. uploading the Certificate to your e-portfolio would allow you to falsely claim that you had:

      i. attended the Training; Admitted and found proved

      ii. achieved the corresponding Continuing Professional Development hours. Admitted and found proved

3. Your actions at paragraph 1 were dishonest by reason of paragraph 2. Admitted and found proved

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

The Admitted Facts

7. At the outset of these proceedings, through her counsel, Mr Stephen McCaffrey, Dr Suresh made admissions to the entirety of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (Fitness to Practise) Rules Order of Council 2004 ('the Rules'). In accordance with Rule 17(2)(e) the Tribunal announced the Allegations as admitted and found proved.

Impairment

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

9. At the outset of this stage, the Tribunal was provided with evidence relating to a previous MPT that took place in December 2021, in which Dr Suresh was given a warning for dishonest conduct.

Witness Evidence

10. The Tribunal received witness statements on behalf of the GMC from the following witnesses:

- Professor B, Clinical Professor of Cardiac Medicine and Consultant Cardiologist, Norfolk and Norwich University Hospital, dated 2 August 2024. Professor B also provided a supplementary witness statement, dated 28 March 2025;
- Professor A, Regional Postgraduate Dean for the East of England, dated 18 September 2024.

11. Dr Suresh provided her own witness statement, dated 12 March 2026, and gave oral evidence at the hearing.

12. In her oral evidence, Dr Suresh explained that trainees were expected to attend a number of training days each year, but that many of these had coincided with her on-call commitments. She said that, although trainees were generally granted study leave to attend, those on call were not. She had attended some sessions after night shifts and found this exhausting. Dr Suresh stated that she wrongly believed she needed to achieve around 70% attendance at training days and thought, based on her own calculation, that she was falling short. She accepted that she could have sent a simple email to clarify her attendance position but said she did not do so because of her own personal difficulty in asking for help. She described herself as someone who tended to internalise problems and tried to resolve them alone.

13. Dr Suresh accepted that she knew she had not attended the Training and knew she was not entitled to scan the QR codes or obtain the Certificate. She said that, at the time, she did not think through the consequences and was focused only on getting through the day and meeting what she believed were her attendance requirements. She described her actions as seriously dishonest but said that, when she carried them out, it felt like a single act

aimed at obtaining the Certificate, rather than a series of separate actions. She accepted that this did not excuse her conduct.

14. Dr Suresh said that she later learned she was well above the required attendance level, that attendance was calculated cumulatively across training, and that she had sufficient CPD from other conferences. She accepted that none of this justified what she had done and that the real issue was not the Certificate itself but the dishonest conduct. She said she now recognised that all she had needed to do was seek guidance or explain that she could not attend, particularly as she had already been on approved leave and was not expected to attend the Training.

15. Dr Suresh said that when Professor B contacted her, she wanted to admit that she had not attended and had knowingly used the QR code sent via WhatsApp. She accepted, however, that her initial email was not fully candid because she said she had not uploaded the Certificate, when in fact she had uploaded it to her e-portfolio and later removed it. She explained that, in her mind at the time, she was not going to use the Certificate and wanted to reassure Professor B that she would not claim CPD from it. She accepted that this was not the correct way to express the position and that, when Professor A later asked for her account, she gave the full truth.

16. Dr Suresh accepted that her actions were dishonest and that there would be understandable scepticism given her previous MPT warning for dishonesty. She said she understood why colleagues, supervisors and the Tribunal might question whether she could be trusted in future. She stated that one dishonest act could damage years of trust and reputation. She accepted that, although there was no direct patient harm, dishonesty in relation to a certificate could cause concern about whether similar dishonesty might occur in clinical records or other professional matters.

17. Dr Suresh identified personal stress and poor coping mechanisms as the key triggers in both this case and the previous matter. She said that, in both instances, she had "pressed the panic button" and had taken a dishonest short-term option rather than pausing, thinking properly and seeking support. She accepted full responsibility and said she was not seeking to blame colleagues, the training programme, her wedding or any other external factor.

18. Dr Suresh said that she had reflected extensively over the last two and a half years. She described feeling shame and regret, particularly because she could no longer face consultants and supervisors who had supported her during training. She said they had told her they did not realise she was struggling because she had never escalated the issue. This led her to understand that support had been available and that she had failed to ask for it.

19. Dr Suresh said she had made practical changes since the incident. She had moved to New Zealand, adapted to a new healthcare system and learned to ask colleagues for help. She said becoming a parent had also been a humbling experience which taught her the need to seek support rather than attempt to manage everything alone. She described using a "pause" when faced with difficult decisions and said she now applies the same reflective approach to personal stress that she has previously used in her clinical decision-making.

20. Dr Suresh also said she had undertaken ethics, probity and professionalism courses, which reminded her that honesty and integrity are non-negotiable even in stressful circumstances. She said she intended to include ethics and probity training within her yearly personal development plan as a continuing reminder of her professional obligations.

21. Dr Suresh accepted that this was her second dishonest incident and understood why the Tribunal might view this as a potential pattern. She maintained, however, that she had identified the trigger, namely her poor management of personal stress, and had taken steps to address it. She stated that she took full accountability, recognised the impact on herself, her supervisors, her colleagues, patients and the profession, and wished she could go back and change what she had done.

Documentary Evidence

22. The Tribunal had regard to the documentary evidence provided by the GMC, which included but was not limited to the following:

- Online referral form, NHS East of England, 21May 2024;
- Email correspondence between Dr Suresh and Professor B, dated 4 March 2024;
- Dr B's email to Dr C, dated 21 March 2024;
- Dr Suresh's feedback;
- List of those providing feedback;
- List of those signing in for the cardiology training day;
- Various email correspondence in respect of Dr Suresh's conduct;
- Dr Suresh's response statement, dated 2 May 2024;
- Dr Suresh's Rule 7 response, dated 3 December 2024;
- Dr Suresh RoD PUBLISHABLE December 2021;
- Dr Suresh reflection, dated 8 May 2026;
- RACP Certificate of Completion – Ethics, dated 17 May 2025;
- IW – Probity, Ethics and Professionalism, dated 7 January 2026;

- E portfolio dated 12 November 2024 and 2 December 2024;
- Medical Council of New Zealand – Supervision Report, dated Jan-Apr 2025, Apr-Jul 2025, Jul-Oct 2025 and Oct-Nov 2025.

Submissions

On behalf of the GMC

23. Ms Renton submitted that the Tribunal should apply Guidance for Medical Practitioner Tribunal Hearings 2025 ('The Guidance'), Section 3, Part B, when considering impairment. Referring to *Khan v BSB [2018] EWHC 2184 (Admin),* she submitted that the misconduct was neither trivial nor excusable and engaged the ground of misconduct arising from dishonesty. She submitted that Dr Suresh had accepted her actions were dishonest and that the conduct amounted to a serious departure from the standards expected of a doctor.

24. Ms Renton submitted that the dishonesty involved deliberate acts designed to create the false impression that Dr Suresh had attended mandatory training. She submitted that Dr Suresh scanned two QR codes, generated feedback for training she had not attended and obtained a certificate of attendance which she later uploaded to her e-portfolio. She submitted that this was done intentionally in order to secure a false attendance record, increase attendance percentages and obtain a professional benefit linked to training requirements. Ms Renton further submitted that the Certificate remained on the e-portfolio until Professor B contacted Dr Suresh and that Dr Suresh was initially not candid about having uploaded it, only later admitting this in her statement to Professor A dated 2 May 2024.

25. Ms Renton submitted that the conduct undermined the fundamental tenets of the profession, particularly the duties of honesty and integrity contained within Good Medical Practice (GMP) *(2024)*. She submitted that doctors are required to uphold high professional standards and maintain public trust, and that Dr Suresh's conduct represented a clear breach of those principles. She submitted that dishonesty ordinarily falls within the higher end of the spectrum of seriousness unless it occurs wholly outside the professional role and involves insignificant benefit, neither of which applied in this case. The conduct arose directly from Dr Suresh's professional responsibilities and related to mandatory training linked to progression towards specialist certification.

26. Ms Renton submitted that the seriousness of the misconduct was increased by several aggravating features. She submitted that the dishonesty was deliberate, sustained and involved multiple steps designed to create a false narrative of attendance and

compliance. She further submitted that the conduct undermined systems intended to maintain training standards and protect the public.

27. Ms Renton placed particular reliance on Dr Suresh's previous regulatory history. She submitted that the earlier proceedings also involved dishonesty connected to administrative aspects of professional practice and deliberate misrepresentation. She reminded the Tribunal that the previous Tribunal had accepted that the earlier dishonesty was out of character and carried a very low risk of repetition, concluding that the proceedings themselves would act as a salutary lesson. Ms Renton submitted that, despite those findings, Dr Suresh had again acted dishonestly during a stressful period in her life. She submitted that both matters arose when Dr Suresh experienced stress and responded through dishonest shortcuts, demonstrating that the underlying risk identified previously had not been adequately addressed.

28. Ms Renton further submitted that the repetition of dishonest conduct despite previous regulatory action showed that the earlier proceedings had not acted as a sufficient deterrent. She submitted that Dr Suresh had received a clear warning regarding honesty and integrity but nevertheless reverted to dishonesty when faced with personal and professional pressures. Although there was no direct patient harm, Ms Renton submitted that Dr Suresh knowingly attempted to circumvent mandatory attendance requirements and provided inaccurate information regarding training attendance. She submitted that the integrity of such systems depends upon honesty from doctors and that any attempt to manipulate them is inherently serious. She therefore submitted that the allegations fell at the higher end of the spectrum of seriousness and that the starting point for assessing current and ongoing risk to public protection was high.

29. Ms Renton submitted that the Tribunal should consider the Doctor's working environment, role, experience and personal circumstances. She acknowledged that Dr Suresh had described stress arising from balancing work, training commitments and wedding preparations. However, she submitted that similar explanations had been advanced during the previous proceedings and therefore offered limited mitigation. She submitted that Dr Suresh should have sought appropriate support rather than resorting to dishonest conduct.

30. Ms Renton accepted that Dr Suresh had admitted the allegations, expressed remorse and undertaken reflection, including attending courses and discussing the matter with senior clinicians. However, she submitted that the previous Tribunal had also found Dr Suresh to possess good insight and remediation, yet further dishonest conduct had nevertheless occurred. Referring to the Guidance, Ms Renton submitted that evidence of insight and remediation carries less weight in higher seriousness dishonesty cases because dishonesty

concerns personal judgement and reactions to stressful situations, matters which cannot readily be externally monitored. She submitted that, despite the reflective work undertaken, there remained a real and continuing risk of repetition.

31. Ms Renton submitted that a concerning pattern was emerging, in that the present misconduct mirrored the earlier concerns and again demonstrated a willingness to resort to dishonesty in response to stress. While Dr Suresh stated that she had made changes to her lifestyle and coping mechanisms, Ms Renton submitted that stress is an unavoidable feature of both life and medical practice and that concerns remained as to how Dr Suresh may respond in future stressful situations.

32. Referring to *Cohen v GMC [2008] EWHC 581 (Admin),* Ms Renton reminded the Tribunal that impairment is a forward-looking exercise. She submitted that Dr Suresh's actions brought the profession into disrepute and would be regarded as deplorable by fellow practitioners. Ms Renton referred the Tribunal to the approach set out by Dame Janet Smith in the Fifth Shipman Report, as referred to in the case of *CHRE v NMC & Grant [2011] EWHC 927 (Admin)* and submitted that limbs (b), (c) and (d) were engaged, namely that Dr Suresh had brought the profession into disrepute, breached fundamental tenets of the profession and acted dishonestly, and remained liable to do so in the future.

33. Ms Renton submitted that the Tribunal must also have regard to the overarching objective, particularly the need to maintain public confidence in the profession and uphold proper professional standards. She submitted that the public rightly expect doctors to act honestly in all aspects of their professional lives and that repeated dishonesty risks undermining wider trust in the profession. She further submitted that a finding of impairment was necessary to reinforce the importance of honesty within the profession and to demonstrate clearly that dishonest shortcuts are unacceptable.

34. Ms Renton therefore submitted that, weighing all relevant factors, Dr Suresh currently posed a high risk to public protection and that a finding of current impairment was required.

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

35. Mr McCaffrey submitted that Dr Suresh accepted from the outset that her actions amounted to misconduct and that the misconduct was serious. However, he disagreed with the GMC's assessment that the case fell within the highest range of seriousness. He submitted that dishonesty, like all forms of misconduct, exists on a spectrum and must be considered within its proper factual context. He submitted that this case concerned a single

certificate forming part of a much wider training programme and e-portfolio process. Whilst he accepted that there was potential for professional gain, he submitted there had in fact been no actual gain.

36. Mr McCaffrey submitted that the Tribunal should avoid treating all dishonesty cases alike and should instead fairly assess where this particular conduct sat on the spectrum of seriousness. He submitted that the case was unlikely to fall within the lower range but argued that it should not properly be characterised as being at the highest end. He invited the Tribunal to consider carefully the indicators within the guidance and to avoid placing disproportionate weight upon the previous regulatory finding at the outset of its assessment. Whilst accepting that the previous finding was plainly relevant and would weigh heavily on the Tribunal, he submitted that it should be considered as part of the wider assessment rather than defining the seriousness of the present case from the outset.

37. Mr McCaffrey submitted that Dr Suresh had been candid in recognising that the previous finding demonstrated that her earlier insight had not fully developed at that stage and that further personal learning was necessary following this incident. He submitted that Dr Suresh realistically accepted that a finding of impairment was likely in light of the impact on public confidence and the Tribunal's likely concerns regarding whether her insight was yet complete. He therefore did not seek to argue against a finding of impairment but asked the Tribunal to conduct a fair and proportionate assessment of the evidence when considering the level of current risk and the appropriate outcome.

38. Mr McCaffrey submitted that Dr Suresh herself acknowledged that there would naturally be scepticism regarding her evidence and expressions of remorse. However, he invited the Tribunal to approach that scepticism with balance and fairness and to assess the substance of the evidence given. He submitted that there were strong indicators of developing insight and remediation.

39. Mr McCaffrey submitted that this had been a full admissions case from the outset. He argued that an important feature of such cases was whether a registrant, when giving oral evidence, maintained those admissions openly and honestly without minimising their conduct, shifting blame or becoming evasive. He submitted that Dr Suresh had done precisely that. Despite the pressure of the proceedings and the seriousness of the potential outcome, she had consistently supported her admissions and had not sought to dilute or undermine them during her evidence.

40. Mr McCaffrey further submitted that Dr Suresh had provided a detailed and genuine reflective statement. He submitted that reflection is inherently difficult because it requires a

registrant to confront honestly their own thinking and behaviour at the time of the misconduct. He argued that Dr Suresh had spoken openly, without reservation, about conduct she found shameful and embarrassing. He submitted that her evidence regarding her inability to face her course director or look colleagues in the eye was raw and truthful evidence demonstrating genuine remorse rather than something contrived for the proceedings.

41. Mr McCaffrey accepted that aspects of Dr Suresh's evidence had at times been confused, particularly regarding the operation of the e-portfolio and visibility of the Certificate. However, he submitted that this confusion should not be mistaken for evasiveness. He highlighted two particular aspects of her evidence. First, Dr Suresh openly accepted that her initial email to Professor B had not been candid regarding the uploading of the Certificate. He submitted that, despite the pressure she was under whilst giving evidence, she did not attempt to explain away or minimise that failing. Secondly, when questioned about the purpose of uploading the Certificate, Dr Suresh accepted that she intended to use it if needed to demonstrate attendance for training purposes. Mr McCaffrey submitted that this was a difficult and unattractive admission for her to make and yet she answered directly and honestly rather than becoming evasive or dishonest under pressure.

42. Mr McCaffrey submitted that these aspects of the evidence demonstrated honesty and transparency within the proceedings themselves and supported the genuineness of Dr Suresh's remorse. He further submitted that the conduct itself reflected irrational and panicked thinking rather than calculated dishonesty. He argued that the small size of the training event and the fact that those delivering the course knew attendees personally made the conduct inherently irrational and consistent with Dr Suresh's own explanation that she had "hit the panic button" during a period of significant personal stress.

43. Mr McCaffrey submitted that Dr Suresh had since demonstrated meaningful personal development. He referred to her evidence that she had moved country, adapted to a new healthcare system and become a parent. He submitted that these experiences had humbled her and taught her the importance of seeking help and support rather than attempting to manage stress alone. He argued that both the present case and the previous proceedings arose not from clinical dishonesty or attitudinal concerns within practice, but from poor personal responses to stress outside direct patient care. He submitted that Dr Suresh had confronted those issues directly and had shown increasing understanding of the underlying causes of her behaviour.

44. Mr McCaffrey submitted that it would be unfair to characterise the two matters as demonstrating a fixed attitudinal problem, habit or established pattern of dishonesty. He

submitted that Dr Suresh had fully accepted responsibility and had not sought to blame others or avoid accountability.

45. In conclusion, Mr McCaffrey submitted that Dr Suresh accepted there was likely to be a finding of misconduct and likely also a finding of impairment. However, he asked the Tribunal to ensure that any finding was reached within a fair and proportionate context, giving proper weight to Dr Suresh's admissions, evidence, insight, remorse and remediation, and avoiding placing disproportionate reliance upon the previous regulatory finding.

The Relevant Legal Principles.

46. The Tribunal noted that there is no burden or standard of proof at this stage of the proceedings, and the decision on impairment is a matter for the Tribunal's judgement alone. The Tribunal may only make a finding of impairment where there is a legal basis for doing so and where a decision is reached that the doctor poses a current and ongoing risk to one or more of the three parts of public protection which is likely to require restrictive action in response. The three parts of public protection are:

- to protect, promote and maintain the health, safety and well-being of the public (patient safety)
- to promote and maintain public confidence in the profession (public confidence)
- to promote and maintain proper professional standards and conduct for members of the profession (uphold professional standards).

47. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: it must first determine whether the facts as found proved amounted to misconduct, and that the misconduct was serious; and it must then determine whether, as a result, there is a current and ongoing risk to public protection which requires restrictive action in response and which therefore leads to a finding of current impairment of fitness to practise. The Tribunal had regard to and followed the 2025 guidance for MPTS Tribunals ('the 2025 Guidance').

48. The Tribunal had regard to the case of *Roylance v General Medical Council (No.2) [2000]1 AC 311 (UKPC)* which states:

> '*Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a [medical] practitioner in the particular circumstances. The misconduct is qualified in two respects.*

First, it is qualified by the word professional which links the misconduct to the profession [of medicine]. Secondly, the misconduct is qualified by the word serious. It is not any professional misconduct which would qualify. The professional misconduct must be serious.'

49. In considering impairment, the Tribunal should take account of the misconduct and consider it in light of all other relevant factors in determining whether the doctor's fitness to practise is currently impaired by reason of the misconduct. The Tribunal is required to look forward, not back, but in order to form a view as to current fitness to practise, it may need to take account of the way the doctor has acted or failed to act in the past.

50. The Tribunal had regard to paragraph 76 of the judgment in the case of *CHRE v NMC & Paula Grant [2011] EWHC 927 (Admin)*, in which Mrs Justice Cox set out the helpful and comprehensive approach of Dame Janet Smith in her fifth Shipman Report to determining issues of impairment:

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

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

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

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

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

51. The Tribunal noted that, in order to assess whether Dr Suresh poses any current and ongoing risk to public protection which may require restrictive action in response, the Tribunal should consider where on the spectrum of seriousness the proved facts lie, after taking into account the impact of any relevant context known about Dr Suresh and her working environment and how Dr Suresh has responded to the allegations.

The Tribunal's Determination on Impairment

52. Throughout its deliberations, the Tribunal bore in mind the statutory overarching objective: to protect and promote the health, safety and wellbeing 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 the medical profession.

Misconduct

53. The Tribunal first considered whether Dr Suresh's behaviour amounted to misconduct. It accepted the submissions of both parties that the relevant provisions of GMP were engaged.

54. The Tribunal has had regard to the 2025 Guidance and it has approached the issue of impairment of fitness to practise in the stepped approach outlined.

Step 2a - Legal basis for considering impairment - Misconduct

55. The Tribunal first considered whether the proven facts engaged one or more of the statutory grounds of impairment. In accordance with Step 2a of the Guidance, it considered whether the admitted facts amounted to a sufficiently serious departure from the standards reasonably expected of a registered medical practitioner so as to constitute misconduct.

56. The Tribunal noted that both parties accepted that the conduct amounted to misconduct. The Tribunal was satisfied that Dr Suresh's admitted dishonesty constituted serious misconduct. Dr Suresh knowingly scanned a QR code to falsely register attendance at a training event she had not attended. Several hours later, she received and scanned a second QR code and completed feedback for the event which generated a certificate. She subsequently uploaded the Certificate to her e-portfolio. The Tribunal considered that this was not a single isolated dishonest act, but a course of dishonest conduct that involved a number of separate dishonest acts carried out over a period of time. It considered that this was not a purely spontaneous act or pressing "the panic button". Dr Suresh had opportunities during that period to reconsider her actions and stop the dishonest course of conduct. Instead, she continued and completed the process by uploading the Certificate.

57. The Tribunal accepted the GMC's submission that the dishonesty arose within Dr Suresh's professional life rather than solely within her personal life. Whilst the stressors identified by Dr Suresh related in part to personal circumstances surrounding her wedding and her workload, the dishonest conduct itself related directly to her professional training requirements, attendance record and progression within her training programme. The

Tribunal also noted Dr Suresh's evidence that she uploaded the Certificate because she intended to use it if necessary. The Tribunal therefore concluded that the dishonesty occurred squarely within a professional context.

58. The Tribunal considered that the following paragraphs of GMP 2024 were engaged:

> *'**81** You must make sure that your conduct justifies patients' trust in you and the public's trust in your profession.*
>
> ***88** You must be honest and trustworthy, and maintain patient confidentiality in all your professional written, verbal and digital communications.*
>
> ***89** You must make sure any information you communicate as a medical professional is accurate, not false or misleading. This means:*
>
> ***a** you must take reasonable steps to check the information is accurate*
> ***b** you must not deliberately leave out relevant information*
> ***c** you must not minimise or trivialise risks of harm*
> ***d** you must not present opinion as established fact.'*

59. These provisions collectively emphasised honesty, integrity, transparency, and the need to ensure that information provided in professional contexts is accurate and not misleading.

60. The Tribunal considered whether paragraph 82 of GMP was engaged, '*You must always be honest about your experience, qualifications, and current role. You should introduce yourself to patients and explain your role in their care.*' It did not consider this paragraph to be engaged in this context, however, the Tribunal took the view that, in her conduct, Dr Suresh was dishonest about her training experience.

61. The Tribunal was satisfied that the dishonest course of conduct amounted to serious misconduct.

Step 2b – Where on the Spectrum of Seriousness does the Allegation lie?

62. The Tribunal next considered where the misconduct lay on the spectrum of seriousness. It concluded that the misconduct fell at the higher end of the spectrum of seriousness. The Tribunal considered that there were several dishonest acts within the incident itself which occurred in a workplace setting.

63. The Tribunal accepted that Dr Suresh did not ultimately derive the benefit she sought because the conduct was identified before it could progress further. However, it considered that the potential benefit was significant. At the time she acted, Dr Suresh believed the Certificate and attendance record were important for meeting training requirements and intended to rely upon them if necessary. The Tribunal considered that her intention was to deceive in order to secure a professional advantage connected to her training progression.

64. Furthermore, in considering the level of seriousness, the Tribunal again considered that the dishonest course of conduct involved a number of separate dishonest acts carried out over a period of time.

65. The Tribunal identified a number of features increasing seriousness. It attached weight to Dr Suresh's relevant fitness to practise history involving previous dishonesty. It also considered that the conduct contained an element of premeditation, in that, having scanned the first QR code, Dr Suresh must have planned to scan the second one, and then to upload the Certificate.

66. The Tribunal considered that Dr Suresh's actions undermined a system designed to protect the public by ensuring proper monitoring of professional training and competence. By falsely representing attendance at a training event, the Tribunal considered that Dr Suresh undermined the integrity of a system intended to maintain professional standards.

67. The Tribunal identified a number of factors that are present and may increase seriousness. Considering the starting point, the allegation remains at the higher end of the spectrum of seriousness. As such, the starting point for current and ongoing risk to public protection is high.

Step 2c – the Impact of any Relevant context

68. The Tribunal considered the impact of any relevant context. It accepted that Dr Suresh had received positive feedback throughout her career, was regarded as a good doctor clinically: there were no concerns relating to patient care or her clinical competence. It also recognised that she was an experienced ST7 trainee in the final stages of her specialist training.

69. The Tribunal considered Dr Suresh was an experienced trainee who had used the training portfolio system for several years. It considered that she fully understood the significance of attendance requirements, certificates and e-portfolio documentation.

70. The Tribunal took into account Dr Suresh's personal circumstances at the time, including the pressures associated with her upcoming wedding. However, it agreed with the GMC's submission that these circumstances did not sufficiently mitigate the seriousness of the dishonesty. The Tribunal considered that Dr Suresh appeared susceptible to personal stress and accepted that she had been working hard and under pressure. Nevertheless, it concluded that the personal stressors identified did not justify or materially lessen the seriousness of the conduct.

71. Having considered the relevant contextual factors, the Tribunal was of the view that the risk remained at the higher end of the spectrum.

Step 2d – How has the Doctor Responded to the Allegations

72. The Tribunal then considered Dr Suresh's response to the allegations, including insight, remorse and remediation.

73. The Tribunal acknowledged that Dr Suresh admitted the allegations from the outset and accepted that her conduct was dishonest. It also accepted that she had demonstrated remorse and had undertaken reflective work and relevant courses relating to ethics, probity and professionalism.

74. However, the Tribunal concluded that Dr Suresh's insight remained limited and was still developing. Whilst the Tribunal accepted that Dr Suresh understood in general terms that her actions were wrong and recognised that she could have acted differently, it was not persuaded that her reflections demonstrated full or genuine insight into the underlying dishonesty. The Tribunal considered that, at times, Dr Suresh gave inconsistent evidence and appeared to distance herself from the conduct by focusing heavily upon contextual stressors, workload pressures and personal circumstances. Whilst she accepted responsibility, the Tribunal was not satisfied that she had fully confronted or explored her own dishonest decision-making.

75. The Tribunal also considered that Dr Suresh's reflections tended to focus on stress management and avoiding stressful situations rather than demonstrating a sufficiently developed understanding of why she resorted to dishonesty as a response to stress. The Tribunal was not persuaded that she had yet fully addressed the underlying attitudinal concerns, which had led to the repetition of dishonest conduct.

76. The Tribunal acknowledged that dishonesty is inherently difficult to remediate and accepted that Dr Suresh had undertaken some meaningful remediation through reflective practice and training courses. However, given the limited nature of her insight and the repetition of dishonest behaviour following previous regulatory proceedings, the Tribunal was not satisfied that the risk of repetition had been sufficiently addressed.

77. The Tribunal noted that the previous proceedings in 2021 also involved dishonesty connected to the administrative aspects of Dr Suresh's professional life and arose during a period of personal stress. The Tribunal considered that the similarities between the two matters were significant and supported the GMC's submission that there remained a real risk of repetition.

78. The Tribunal accepted that Dr Suresh remained clinically competent, that there were no concerns regarding her medical knowledge or patient care and that she had maintained her professional skills. However, the Tribunal concluded that there remained a risk of repetition of dishonest conduct.

79. The Tribunal concluded that Dr Suresh's response to the Allegations had no significant impact on the level of risk and remained high.

Step 2e - Tribunal's decision as to whether the Doctor poses any current and ongoing risk to public protection which may require restrictive action in response and its finding on impairment

80. The Tribunal reviewed its conclusions at steps 2 a to d above. The Tribunal determined that a finding of impairment was necessary in this case, engaging all three limbs of public protection.

81. The Tribunal concluded that there is a risk to patient safety because dishonest conduct occurring within a professional context could undermine trust in professional records, training systems and clinical practice.

82. The Tribunal further concluded that a finding of impairment was necessary to maintain public confidence in the profession and uphold proper professional standards, and to send a clear signal to Dr Suresh, the profession and the public that the nature of her misconduct was unacceptable.

83. The Tribunal therefore determined that Dr Suresh's fitness to practise is impaired by reason of misconduct as there is a current and ongoing high risk to all three limbs of public protection.

Determination on Sanction - 15/05/2026

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

Submissions

85. On behalf of the GMC, Ms Renton submitted that the appropriate sanction in this case was one of an upper end suspension. She referred the Tribunal to the relevant sections of the 2025 Guidance, including the sanctions banding indicated in cases of dishonesty.

86. Ms Renton submitted that this was not an exceptional circumstance which would justify taking no action. Further, she stated that it was rarely appropriate to impose conditions in a case of dishonesty, as it is difficult to create a condition to address the risk. She submitted that no conditions could be formulated to address the Tribunal's concerns of an underlying attitudinal issue. She submitted that conditions were not workable in this case.

87. Ms Renton stated that the appropriate sanction was one of suspension. She submitted that it would send out a signal to Dr Suresh and the profession that her conduct was unbefitting a registered doctor, particularly in this case when it might be commonplace for there to be a temptation to circumvent stringent professional requirements by incidences of dishonesty which are trivialised in the moment. She stated that doctors should be reminded that they must actively avoid such temptations and the public be reassured that doctors are held to account for their dishonesty.

88. Ms Renton reminded the Tribunal of its assessment of risk to public protection, and its conclusions on insight and the risk of repetition. She stated that an upper end suspension would allow Dr Suresh to develop her insight, address the concerns of the Tribunal with remediation and reduce the risk to public protection. She invited the Tribunal to direct a review, to allow Dr Suresh the opportunity to present evidence of her personal development to a future tribunal.

89. Ms Renton submitted that this was not a case where erasure was appropriate or necessary, as whilst serious, Dr Suresh's actions are not so incompatible with registration that continued registration will undermine all public confidence in the profession.

90. On behalf of Dr Suresh, Mr McCaffrey agreed that the appropriate sanction was one of suspension, in line with the sanctions bandings set out in cases of dishonesty.

91. Mr McCaffrey acknowledged the Tribunal's findings at the impairment stage, including the limited insight and risk of repetition. He asked the Tribunal to be mindful of the principle of proportionality, taking account of the options both above and below any particular sanction, He stated that Dr Suresh was not currently practising in the UK, which meant a suspension would not impact delivery of health services in the UK, but there may still be an impact on her practice overseas.

92. Mr McCaffrey stated that a review will inevitably be appropriate, and that adds an additional safeguard, as should Dr Suresh not satisfy a future tribunal that she has remedied the deficiencies identified she will not be allowed to return to practice.

93. Turning to erasure, Mr McCaffrey stated that this was not appropriate or proportionate, and that erasure from the register will serve only to remove a valuable and highly regarded doctor from practice and therefore service. He submitted that the Tribunal has recognised that Dr Suresh has started meaningful remediation and begun the process of insight, and that a suspension with a review would afford her a fair opportunity to complete that process.

The Tribunal's Determination on Sanction

94. At this stage, as the Tribunal has decided that Dr Suresh's fitness to practise is impaired it will now consider what is a proportionate regulatory response, if any which is needed to protect the public. At the impairment stage, the Tribunal determined that all three aspects of public protection were engaged. It is for the Tribunal now to consider what regulatory action, if any is needed to protect the public. When deciding whether to impose a sanction, the Tribunal must consider the legal duty under the Medical Act to protect the public.

95. The Tribunal accepted legal advice and the procedure to be adopted under the 2025 Guidance (*MPT Hearings > Part C: stage three – sanction > Step 3: decide on sanction*). 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.

96. In making its decision on sanction, the Tribunal has reviewed its decisions on the facts and impairment and has considered the level of current and ongoing risk that Dr Suresh poses to public protection. It has also considered the sanctions banding for cases involving dishonesty as set out in the 2025 Guidance.

97. The Tribunal is directed to consider the sanctions bandings when reaching its decision as to the appropriate sanction. The sanctions bandings are a guide. The decision on the appropriate sanction if any, is a matter for the Tribunal exercising its own independent legal judgment.

98. In reaching its decision, the Tribunal has to take account of the parties' submissions, the 2025 Guidance and the public protection. The Tribunal will consider whether there is relevant evidence relating to the impact a certain type of sanction will have and/or relevant references and testimonials where available and what impact, if any, they have.

99. The Tribunal will decide on the type and length of sanction. It has to stand back and check if it is proportionate to meet the level of current and ongoing risk posed to public protection.

100. The Tribunal had regard to the submissions made by both counsel and the 2025 Guidance *(Guidance introduction > Protecting the public in specific case types > Case type 2: dishonesty)* at paragraphs 96 to 97:

> *'96 The proportionate sanction in response to an allegation of dishonesty will depend on the extent of the doctor's behaviour and the impact it's assessed to have on each of the three parts of public protection.*
>
> *97 Where the level of current and ongoing risk to public protection is medium or high, this will require consideration of suspension or erasure.'*

101. In this case the Tribunal determined at the impairment stage that Dr Suresh's misconduct relating to her dishonest course of conduct falls at the higher end of the spectrum of seriousness and that the current and ongoing risk to public protection was high. The sanctions banding in this case gives a range of nine months suspension to erasure.

102. The Tribunal reminded itself that the sanctions bandings are intended to provide a guide, and that there may be evidence relevant to the individual circumstances of the case that indicates a sanction which is more or less restrictive than that suggested in the bandings.

103. The Tribunal considered each of the available sanctions in turn, starting with the least restrictive.

No action

104. The Tribunal considered that there are no exceptional circumstances in this case which would warrant the taking of no action in the context of the facts found proved and the Tribunal's determination on impairment. It considered that taking no action would not be sufficient, proportionate, or in the public interest.

Conditions

105. The Tribunal next considered whether to impose conditions on Dr Suresh's registration. It noted paragraphs 19 and 20 of the relevant section of the 2025 Guidance and bore in mind that any conditions imposed would need to be appropriate, proportionate, workable and measurable.

106. As a starting point, the Tribunal considered that the sanctions banding for this case type does not indicate that conditions would be sufficient to meet the level of risk to public protection. Moreover, the Tribunal did not consider that the imposition of conditions would be a proportionate or appropriate response sufficient to satisfy its determined level of the current and ongoing risk to public protection. The Tribunal further considered that it would not be possible to formulate conditions to address Dr Suresh's conduct and, as such, conditions would be unworkable in this case. In all the circumstances, the Tribunal concluded that a period of conditional registration would not be an appropriate or proportionate sanction and would not satisfy the public interest.

Suspension

107. The Tribunal then went on to consider whether imposing a period of suspension on Dr Suresh's registration would be appropriate and proportionate. The Tribunal acknowledged that suspension has a deterrent effect and bore in mind the sanctions bandings table, referred to above.

108. The Tribunal noted paragraphs 44 and 45 of the relevant section of the 2025 Guidance, which state:

> *'44 Restrictive action of suspension is intended to address the level of current and ongoing risk to public protection and is not intended to be punitive. However, as it prevents a doctor from working and earning a living within that profession, it can have this effect. Suspension can also have a deterrent effect and be used to send a signal to the individual doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor.*
>
> *45 Suspension may be proportionate in cases where some, or all, of the following factors are present:*
>
> *a conditions are not appropriate, measurable and/or workable*
> *b the level of current and ongoing risk to public protection is such that it cannot be safely managed with conditions and suspension is necessary to stop the doctor from working and putting patients at risk while they gain insight into any deficiencies and remediate, or undergo medical treatment, and/or*
> *c the level of current and ongoing risk to public protection is such that, although patient safety is not an issue, suspension is needed to maintain public confidence in the profession and/or maintain professional standards.'*

109. The Tribunal acknowledged that dishonesty in any form is serious, although there are different degrees of dishonesty. It noted that there was no evidence that Dr Suresh had gained anything from her dishonesty, although it acknowledged that the potential benefit had been significant. Further, there was no evidence of actual harm to patients, although the Tribunal acknowledged that there was a risk of harm arising from Dr Suresh's actions.

110. The Tribunal took into account its assessment on insight and remediation, at the impairment stage and noted its concerns regarding Dr Suresh's limited but developing insight. It was satisfied that Dr Suresh's conduct could be remedied, but that she has not yet taken sufficient steps to reduce the risk of repetition.

111. The Tribunal took into consideration the feedback documents provided in support of Dr Suresh, acknowledging that these were not produced by colleagues aware of these proceedings. The documents all indicated that Dr Suresh is a good doctor, who was well regarded by her colleagues. None of the feedback raised concerns about Dr Suresh's probity.

112. The Tribunal then went onto consider whether erasure was the most appropriate and proportionate sanction, as required by the 2025 Guidance. It had regard to paragraphs 55 and 57 of the relevant section of the 2025 Guidance, which provides:

> *'55 Erasure is action available for those cases where a doctor's behaviour, performance, or the impact that a health condition is having on their ability to practise safely and effectively, is incompatible with continued registration at this point in time. It means the level of current and ongoing risk the doctor poses to public protection is so significant that they should not be allowed to practise.*
>
> …
>
> *57 Erasure may be the proportionate response where:*
>
> *a conditions are not appropriate, measurable and/or workable and suspension is not sufficient to protect the public*
>
> *b the doctor's behaviour or performance is such that it caused serious harm, and the risk of harm recurring cannot be mitigated sufficiently through putting conditions or suspension in place*
>
> *c the doctor has shown a persistent lack of insight into the seriousness of the allegation about their behaviour or performance and the potential or actual consequences, and/or*
>
> *d the seriousness of the facts found proven and/or impact of any relevant context that increased the current and ongoing risk to public protection mean the effect of the doctor continuing to hold registration is such that it will undermine public confidence in the profession.'*

113. Although the misconduct found proved was serious, the Tribunal was not satisfied that it was so serious that it warranted complete removal from the register. It determined that erasure would be disproportionate, having regard to the steps Dr Suresh has taken so far to remediate her actions. Further, it was satisfied that it was possible for Dr Suresh to remediate her conduct and to further develop her insight. Consequently, the Tribunal did not find that Dr Suresh's misconduct was incompatible with continued registration at this point in time. The Tribunal was satisfied that the public can be protected and professional standards upheld through a period of suspension. The Tribunal was also satisfied that, in the circumstances as outlined above, public confidence would not be undermined by allowing Dr Suresh to continue to hold registration, despite the seriousness of the facts admitted and the current and ongoing risk to public protection.

114. Having regard to its findings as set out above, and given the circumstances of this case, the Tribunal determined that suspension is the most appropriate sanction. The Tribunal then went on to consider the length of suspension and whether to direct a review prior to the end of the period of suspension.

Length of suspension

115. In determining the length of suspension, the Tribunal had regard to paragraph 46 of the relevant section of the 2025 Guidance which states:

> *'46 The MPT will need to decide the appropriate length of time that suspension should be put in place for, up to the maximum of 12 months. The following factors will be relevant:*
>
> *a the assessment of the level of current and ongoing risk to public protection posed by the doctor*
>
> *b the reasons for assessing suspension as being the proportionate response*
>
> *c the amount of time the doctor is likely to need to remediate, complete treatment for and/or recover from a health condition that is having, or is likely to have, an impact on their ability to practise safely and effectively, and/or*
>
> *d the amount of time the parties will reasonably need to prepare for any review of whether the doctor continues to pose a current and ongoing risk to public protection requiring restrictive action in response or is safe to return to unrestricted practice.'*

116. The Tribunal reminded itself of the suggested range of suspension within the higher level of risk sanctions banding for dishonesty cases of nine to 12 months. It also took into consideration that this is the second occasion on which Dr Suresh has been the subject of an MPT for dishonest conduct, and that she was previously issued a warning. Considering the gravity of the misconduct, the need to send a message that such serious misconduct was unacceptable, and to give Dr Suresh sufficient time to develop her insight and remediate her conduct, the Tribunal was of the view that the maximum length of suspension was needed in this case.

117. The Tribunal acknowledged that a period of suspension would undoubtedly have an impact on Dr Suresh but was of the view that this is outweighed by the need to uphold professional standards and maintain public confidence in the profession.

118. The Tribunal concluded that a period of suspension for 12 months was the appropriate and proportionate response. This period reflects the seriousness of Dr Suresh's misconduct, her regulatory history, and her current level of insight. Further, it will allow Dr Suresh time to fully develop insight into her conduct and address any underlying attitudinal concerns creating a risk of repetition.

119. The Tribunal determined to direct a review of Dr Suresh's case. A review hearing will convene shortly before the end of the period of suspension. The Tribunal wishes to clarify that at the review hearing, the onus will be on Dr Suresh to demonstrate how she has developed insight and remediated her misconduct. It therefore may assist the reviewing Tribunal if Dr Suresh provides:

- Evidence of insight;
- Evidence of targeted learning to remediate her dishonesty - She may wish to consider an extended programme, with small group work and/or coaching; and
- Evidence of coping strategies to deal with stressful situations.

Determination on Immediate Order - 15/05/2026

120. Having determined that Dr Suresh's registration should be suspended for a period of 12 months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether her registration should be subject to an immediate order.

Submissions

121. On behalf of the GMC, Ms Renton submitted that there was no application for an immediate order in this case.

122. On behalf of Dr Suresh, Mr McCaffrey made no submissions.

The Tribunal's Determination

123. The Tribunal had regard to paragraphs 83 and 84 of the 2025 Guidance (*MPT Hearings > Part C: stage three – sanction > Step 3: decide on sanction > Immediate and interim orders following sanction)*, which provide:

> *'83 The decision whether to impose an immediate order is at the discretion of the MPT based on the facts of the case. When deciding if an immediate order is needed the MPT should consider the seriousness of the proved allegation and the level of current and ongoing risk to public protection posed by the doctor.*

84 It will not usually be appropriate for a doctor to hold unrestricted registration until a sanction takes effect in cases where:

a the doctor poses a risk to patient safety

b the risk to one or more parts of public protection is high, and/or

c immediate action is needed to maintain public confidence in the medical profession.'

124. The Tribunal considered that, in light of its assessment of the level of Dr Suresh's current and ongoing risk to public protection, an immediate order was necessary in this case. It considered that all three parts of public protection were engaged and that the factors set out in paragraph 84 were present and indicated that an immediate order was necessary.

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

126. There is no interim order in place.

127. That concludes this case.