PUBLIC RECORD

Dates: 22/06/2026 - 03/07/2026

Doctor:	Dr Ross McDOWELL
GMC reference number:	7332602
Primary medical qualification:	MB BS 2013 University of Newcastle upon Tyne

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Not impaired

Summary of outcome

No Warning

Tribunal:

Legally Qualified Chair	Duncan Toole
Lay Tribunal Member:	Mark O'Brien
Registrant Tribunal Member:	Dr Helen McCormack

Tribunal Clerk:	Matt O'Reilly (22 – 24 June 2026) Alex Currie (25 June 2026 – 30 June 2026) Sewa Singh (1 July 2026 – 3 July 2026)

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Tara O'Halloran, Counsel, instructed by Medical Protection Society
GMC Representative:	Julian King, Counsel

Attendance of Press / Public

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

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 & Impairment - 02/07/2026

Facts stage

1. This determination will be read in private. However, as this case concerns Dr McDowell's alleged misconduct, a redacted version will be published after the hearing with references to confidential issues, XXX, removed.

Background

2. Dr McDowell qualified with an MBBS from the University of Newcastle upon Tyne in 2013. Prior to the events which are the subject of the hearing, Dr McDowell undertook several posts in Emergency Medicine between August 2015 and August 2018. In August 2018, Dr McDowell commenced an ACCS CT1 post in Emergency and Acute Medicine at University Hospital North Tees, followed by ACCS CT2 post in Anaesthetics and Intensive Care. At the time of the events giving rise to this hearing, Dr McDowell was employed by the Northumbria Healthcare NHS Trust as an ST4 in Anaesthetics and was working at the Royal Victoria Infirmary, Newcastle.

3. The allegations that have led to Dr McDowell's hearing relate to his conduct and can be summarised as follows. It is alleged that between 9 March 2024 and 10 March 2024, and on 3 April 2024, Dr McDowell took XXX from the anaesthetic machines at Royal Victoria Infirmary ('the Hospital') and administered himself with XXX when it was not necessary to do so. XXX. It is alleged that Dr McDowell's fitness to practise was impaired by reason of misconduct.

4. Dr McDowell self-referred to the GMC on 9 April 2024.

The Outcome of Applications made during the Facts Stage

5. The Tribunal granted Dr McDowell's application, made pursuant to Rule 16 of the Rules, for the disclosure of documents relating to a Rule 28 application made by the GMC to a Case Examiner to withdraw the case. The Tribunal's full decision on the application is included at Annex A.

6. The Tribunal granted Dr McDowell's application, made pursuant to Rule 34 of the GMC (Fitness to Practise Rules) 2004 as amended ('the Rules'), to admit the disclosed

documents referred to in Annex A into evidence. The Tribunal's full decision on the application is included at Annex B.

7. The Tribunal refused Dr McDowell's application, made pursuant to Rule 41 of the GMC (Fitness to Practise Rules) 2004 as amended ('the Rules'), for the proceedings to be heard entirely in private XXX. The Tribunal's full decision on the application is included at Annex C.

8. The Tribunal refused Dr McDowell's application, made on day 1 of the hearing, pursuant to Rule 17(6) of the Rules, to amend the Allegation. The Tribunal's full decision on the application is included at Annex D.

9. The Tribunal granted Dr McDowell's application, made on day 4 of the hearing, pursuant to Rule 17(6) of the Rules, to amend the Allegation. The Tribunal's full decision on the application is included at Annex E.

The Allegation and the Doctor's Response

10. The Allegation made against Dr McDowell is as follows:

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

1. Whilst working at Newcastle Hospitals NHS Foundation Trust:
    a. between 9 March 2024 and 10 March 2024, you:
        i. took XXX from the anaesthetic machines at Royal Victoria Infirmary; Admitted and found proved
        ii. administered yourself with XXX when it was not necessary to do so; Admitted and found proved

    b. on 3 April 2024, you:
        i. took XXX from the anaesthetic machines at Royal Victoria Infirmary; Admitted and found proved
        ii. administered yourself with XXX when it was not necessary to do so. Admitted and found proved

2. XXX

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

The Admitted Facts

11. At the outset of these proceedings, through his Counsel, Ms O'Halloran, Dr McDowell made admissions to the entirety of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the 'the Rules'. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved. In making the admissions, Dr McDowell was clear that his admission was in relation to XXX, rather than XXX.

Impairment stage

12. 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 before, Dr McDowell's fitness to practise is impaired by reason of misconduct.

The evidence

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

- Dr A Consultant in Intensive Care Medicine and Anaesthesia at the Hospital; witness statement dated 4 December 2025;
- Dr B, Consultant in Anaesthesia and Critical Care at the Hospital; witness statement dated 6 January 2026;
- Ms C, Sister in Anaesthetics and Recovery at the Hospital; witness statement dated 13 January 2026;
- Ms D, Operating Department Practitioner at the Hospital; witness statement dated 14 January 2026.

14. XXX

15. XXX

16. The Tribunal received documentary evidence, which included but was not limited to:

- Dr McDowell's self-referral document, dated 9 April 2024;
- Dr McDowell's written account to the Trust investigation, undated;
- Dr A's initial written account to the Trust, 4 April 2024;
- Dr B's written account of events, 10 March 2024;
- Email correspondence between Ms C and Dr McDowell, various dates;
- Ms C's written account to the Trust, undated;
- Ms D's initial Trust written account, undated;
- Dr McDowell's CV, dated 20 May 2026.

17. Dr McDowell provided his own witness statement dated 20 May 2026 and he gave oral evidence at the hearing.

18. In addition, Dr McDowell provided a Stage 2 bundle, which included but was not limited to;

- Statement provided by Professor G, Responsible Officer, dated 20 April 2026;
- Supplemental Witness statement of Dr McDowell, dated 24 June 2026;
- A reflective statement provided by Dr McDowell, undated
- XXX;
- XXX;
- XXX;
- XXX;
- XXX;
- Testimonials provided by Dr McDowell's partner, colleagues and friends; various dates.

Submissions

On behalf of the GMC

19. Mr Julian King, Counsel, submitted that the Tribunal must first consider the question of misconduct, which he asserted applies here as the legal ground of impairment.

20. Mr King submitted that the following legal principles apply. Misconduct as set out at section 35C(2)(a) of the Medical Act 1983 equates with the previous concept of serious professional misconduct. He submitted the bar for a finding of misconduct is no lower than it was for serious professional misconduct and that misconduct is a separate and distinct concept from impairment (*Cheatle v GMC [2009] EWHC 645 (Admin) paragraph 19*).

21. Mr King submitted a finding of misconduct does not inevitably lead to a finding of impairment and that misconduct is a matter for the Tribunal's judgment. He said that misconduct can be classed as some act or omission falling 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 [professional] in the particular circumstances (*Roylance [2000] 1 AC 311*).

22. Mr King submitted that to make a finding of misconduct, the Tribunal must determine that the facts found proved are a serious departure from the standards of conduct expected from a practitioner. Mr King referred the Tribunal to *Doughty v General Dental Council [1988] AC 164, Privy Council at 173*.

23. Mr King made reference to *R (Remedy UK Ltd) v GMC [2010] EWHC 1245 (Admin)* per Elias LJ at 37:

> *"Misconduct is of two principal kinds. First, it may involve sufficiently serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practice. Second, it can involve conduct of a morally culpable or otherwise disgraceful kind which may, and often will, occur*

outwith the course of professional practice itself, but which brings disgrace upon the doctor and thereby prejudices the reputation of the profession."

24. Mr King submitted that serious misconduct has also been described as: "an elementary and grievous failure" (*Preiss v General Dental Council [2001] UKPC 36; [2001] 1 WLR 1296* at para. 28). He submitted that this case is perhaps more relevant to conduct of the first type. Further in *Meadow v General Medical Council [2006] EWCA Civ 1390*; [2007] QB 462 at para. 200, serious misdonduct was described as conduct "which would be regarded as deplorable by fellow practitioners". Mr King submitted this definition is perhaps more relevant to misconduct of the second type.

25. Mr King submitted that likely, there is some cross over between the two principal kinds. Mr King suggested it might be considered notwithstanding the sympathy and concern that can be extended to any person XXX the specific conduct in this case might be of a type that would cause fellow practitioners and indeed the public real concern.

26. Mr King submitted that to demonstrate the gravity of the misconduct, the GMC relies upon the fact that it constitutes a significant breach of a number of fundamental tenets of Good Medical Practice, specifically the following paragraphs:

- XXX

27. Mr King submitted that the misconduct is aggravated by a number of features:

- Previous warning in place from 2020;
- That warning only expired in 2022;
- Repeated nature of the behaviour (9 – 10 March 2024 and 3 April 2024), within a background of much wider misuse;
- The failure to seek support or help until fully exposed (April 2024);
- Initial attempts to deny or hide the behaviour (accepting alternative explanations, suggesting presence in theatre was legitimate – cannula collection);
- An attempt to encourage fellow professionals to hide the behaviour (conversation with Dr A).

28. Mr King submitted that accepting that in 2024, XXX, it is asserted the repeated nature of the behaviour, the Doctor's failure to seek support despite offers of support and initial steps to avoid detection, means that the conduct amounts to misconduct.

29. XXX

30. Mr King submitted that it is not suggested that a level of empathy and support shouldn't be extended to a practitioner in Dr McDowell's situation. Mr King submitted however that it is misconduct and that type of behaviour needs to be identified. Mr King submitted it should be marked and steps need to be taken to ensure safety, standards and the standing of the profession are all secured.

31. Mr King referred the Tribunal to Dr McDowell's own stage 2 statement and submitted that Dr McDowell himself had identified that his actions on 9 March 24 represented "A serious breach of trust", that he had removed himself from clinical availability and created a foreseeable risk to patients and colleagues. Further, that when asked by Dr B what happened, Dr McDowell admits that he "lied to his face". Mr King submitted that deliberately misleading colleagues is a wider factor that the Tribunal can take into account. Finally, that Dr McDowell had accepted the fact that no patients or colleagues came to harm was "more by luck than design", and that he understood that what he had done and the decisions he made fell well short of what is expected of a doctor.

32. Mr King submitted that the behaviour in all the circumstances falls far short of the standards expected and amounts to misconduct.

33. Mr King submitted that the decision on impairment is a matter for the Tribunal and reminded the Tribunal of the overarching objective to assist with their decision making. Mr King referred to *Cohen v GMC [2008] EWHC 581*: Per Silber J:

> *'Any approach to the issue of whether a doctor's FTP should be regarded as impaired must take account of the need to protect the individual patient, and the collected need to maintain confidence in the profession as well as declaring and upholding proper standards of conduct and behaviour. The public interest includes the protection of patients and the maintenance of confidence and standards'.*

34. Mr King referenced the case of *Grant [2011] EWHC 927 (Admin)* (referencing Dame Janet Smith 5th report Shipman inquiry). Mr King suggested one could ask whether the findings of fact show that fitness to practise is impaired in the sense that:

a) He has in the past acted and/or is liable in the future to act so as to put a patient 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.

35. Mr King submitted that the Tribunal should consider not only whether Dr McDowell continues to present a risk to members of the public in his current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.

36. Mr King referred to various relevant case law such as *Grant* (supra), *Hilton [2019] EWHC 1638 (Admin)* and *Uppal [2015] EWHC 1304 (Admin)* and summarized them as follows. The overarching concern is the public interest (not the interest of the individual practitioner) in maintaining confidence in the profession and upholding standards in the profession as a whole, and that the attitude of the doctor, admissions, an isolated incident, testimonials and the risk of repetition are all matters that can be weighed in the balance.

37. Mr King referred to certain relevant steps in the MPTS Guidance for Tribunals (Section three: MPT Hearings > Part B > Stage 2: Impairment > Steps 2(a) to (e)).

38. Mr King submitted Dr McDowell's case sits within the medium range of seriousness. Mr King submitted the specific conduct would be entirely concerning to any member of the public or profession. However, Mr King acknowledged XXX.

39. Mr King identified the following factors in Dr McDowell's case that increased seriousness, as per paragraph 34 onwards of the Guidance:

- Persistent behaviour – from August 23 through to April 24;
- Previous Warning;
- Accounts given to colleagues – encouraging or seeking to provide alternative explanations; and
- Reckless disregard for patient safety or professional standards. Being unavailable and holding both 'DECT' phones for an extended period presented a potential risk to patient safety. XXX.

40. Mr King referred to the paragraphs of the Guidance that relate to consideration of Dr McDowell's personal context, including paragraph 69 which states:

> *69. 'Where a doctor is aware of personal context that may impact on their behaviour, performance, or health at work, they should raise this and seek appropriate support. However, some types of personal context can arise suddenly or cannot be predicted, which may put them outside the doctor's immediate control. This may present challenges that make it difficult for the doctor to deliver good medical practice.'*

41. Mr King submitted that notwithstanding XXX, XXX asserted it was still appropriate to consider an element of culpability overall. Mr King went on to say that even taking into account the significance of XXX, it may still be considered that help should have been sought.

42. Mr King submitted that Dr McDowell's case has involved admissions and very detailed evidence indicating engagement and support being obtained. Mr King accepted that the level of insight displayed by the doctor would go some way to decreasing the ongoing risk.

43. Regarding remediation, Mr King submitted that it may be argued that by stepping away from his previous role is a step to reduce risk. Mr King further submitted that the current Responsible Officer's statement does not detail any additional risks.

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

44. Ms O'Halloran, Counsel, submitted there were two headline points she wanted to raise. XXX

45. The second point Ms O'Halloran submitted is that the GMC refuse to view these issues in context. Ms O'Halloran submitted that the GMC is insisting on rigidity and that this betrays a desire to win their originally pleaded case, rather than reflecting their duties to

regulate fairly. Ms O'Halloran submitted that XXX cannot be divorced from the issue of misconduct, which is why the defence requested that the XXX evidence be included in the bundle. Ms O'Halloran submitted this was to provide the Tribunal with an informed view.

46. Ms O'Halloran submitted that the GMC's suggestion that repetition of Dr McDowell's action increases the level of seriousness, demonstrates a fundamental misunderstanding of XXX.

47. Ms O'Halloran submitted that XXX. This showed that Dr McDowell was aware of a wider issue that had to be resolved. Ms O'Halloran submitted that Dr McDowell had acted on the insight he had gradually developed over two years, had decided to remove himself from anaesthetics and had begun training as a GP. This demonstrates that XXX, he can make informed decisions that reflect his obligations as a doctor.

48. Ms O'Halloran submitted that XXX said in their oral evidence that Dr McDowell has gone above and beyond to remediate. XXX.

49. XXX

50. Ms O'Halloran submitted that XXXX. However, Ms O'Halloran said that the GMC is applying normal standards, XXX and it is not fair to apply ordinary principles of dishonesty in those circumstances.

51. XXX

52. XXX

53. XXX.

54. Ms O Halloran submitted that a doctor who knowingly and freely disregards patient safety for personal convenience, personal gain, indifference, or a settled rejection of professional standards is in a materially different position from a doctor whose conduct arose XXX.

55. Ms O'Halloran therefore invited the Tribunal to conclude that the facts found proved do not cross the high threshold required for a finding of misconduct. Alternatively, if the Panel concludes that the threshold is crossed, she invited the Tribunal to make clear that any finding arises in the context of a XXX, rather than from any deep-seated attitudinal failing or disregard for patient safety.

56. In respect of impairment, Ms O'Halloran submitted that the issue for the Tribunal is whether Dr McDowell's fitness to practise is currently impaired at the date of the hearing and that the purpose of fitness to practise proceedings was protective and forward-looking. She added that in light of the factual and expert evidence above, Dr McDowell was not currently impaired. The question therefore for the Tribunal was whether a finding is required on public interest grounds.

57. Ms O'Halloran submitted there were some factors that the Tribunal may wish to consider regarding Dr McDowell's insight and remediation. These included admissions being made at the earliest stage; Dr McDowell's self-referral and candour; Dr McDowell's developed insight; and Dr McDowell's self-removal from a specialty in which the risk arose.

58. Ms O'Halloran referenced the significant amount of remediation that Dr McDowell has done over the past number of years and continues to do. XXX.

59. Ms O'Halloran submitted that Dr McDowell has always been willing to offer undertakings to the GMC in respect of supervision at work and that Dr McDowell would offer the GMC undertakings irrespective of the outcome of this hearing. Ms O'Halloran suggested that Dr McDowell has always wanted to be open with both the GMC and the Tribunal, to reflect the efforts he had made to get better and not to stigmatise him. Ms O'Halloran submitted that the defence wanted to reflect what Dr McDowell has done and to offer those undertakings as an indication of insight, commitment and reassurance to the GMC.

60. Ms O'Halloran concluded her submissions by saying that doctors are entitled to fairness of procedure, empathy and constructive approaches XXX, and if the GMC do not start treating doctors more fairly and with greater care and compassion, they will find care and compassion leaving the profession.

The relevant legal principles

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

62. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: first whether the facts as found proved amounted to misconduct, and that the misconduct was serious and then whether the finding of that misconduct which was serious poses a current and ongoing risk to public protection requiring restrictive action in response and therefore could lead to a finding of impairment.

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

a) Where on the spectrum of seriousness the allegation lies, based on the facts found proved;
b) The impact of any relevant context known about Dr McDowell and/or their working environment; and
c) How Dr McDowell has responded to the allegation.

64. The Tribunal should consider the guidance in the case of *Nandi v GMC [2004] EWHC 2317 (Admin)* where misconduct was described as:

> *'a falling short by omission or commission of the standards of conduct expected among medical practitioners, and such falling short must be serious". The adjective "serious" must be given its proper weight'*

65. The Tribunal was referred to *Roylance v GMC (No.2) [2000] 1 AC311* where Lord Clyde stated*, 'It is not any professional misconduct which will qualify. The professional conduct must be serious.'*

66. The Tribunal also referred to *R (Remedy UK Ltd) v GMC [2010] EWHC 1245 (Admin)*, where Elias LJ said at 37:

> *'Misconduct is of two principal kinds. First, it may involve sufficiently serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practice. Second, it can involve conduct of a morally culpable or otherwise disgraceful kind which may, and often will, occur outwith the course of professional practice itself, but which brings disgrace upon the doctor and thereby prejudices the reputation of the profession.'*

67. XXX

68. In *Khan*, Mr Justice Warby said the following at paragraph 36 of the Judgment:

> *'36. The authorities make plain that a person is not to be regarded as guilty of professional misconduct if they engage in behaviour that is trivial, or inconsequential, or a mere temporary lapse, or something that is otherwise excusable, or forgivable. There is, as Lang J put it, a "high threshold". Only serious misbehaviour can qualify. I am not sure that the threshold of gravity is quite as rigid or hard-edged as Mr Beaumont suggests. I do not believe that in Walker Sir Anthony May was seeking to crystallise an exhaustive definition of professional misconduct. Rather, he was reaching for a touchstone to help distinguish the trivial or relatively unimportant from that which Judgment Approved by the court for handing down. Khan v BSB [2018] EWHC 2184 (Admin) merits the "opprobrium" of being labelled as professional misconduct. Nor do I read Lang J's decision in [XXX] as seeking to set out precise parameters for what can and cannot qualify as professional misconduct. Indeed, in the passage cited she used three separate terms, "reprehensible, morally culpable or disgraceful". I think it is perhaps unhelpful for this principle to be tied too firmly to particular phraseology. But even on the footing that the right test is that of "seriously reprehensible" it seems to me that, when Mr Khan's behaviour is properly evaluated, it comfortably meets this standard, and that this is in effect the approach which the Tribunal adopted'.*

69. The issue for the Tribunal is whether fitness to practise is currently impaired at the date of the hearing. In *Meadow v General Medical Council [2006] EWCA Civ 1390*, Sir Anthony Clarke MR said the following at paragraph 32 of the judgment:

'In short, the purpose of FTP proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. The FPP thus looks forward not back. However, in order to form a view as to the fitness of a person to practise today, it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past.'

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

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

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

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

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

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

71. In *Grant*, Cox J confirmed that notwithstanding the reference to whether fitness to practise "has been" impaired, the question is always whether it is impaired as at the date of the hearing, looking forward.

72. In *R (Cohen) v General Medical Council [2008] EWHC* 581, Silber LJ said the following at paragraphs 63 and 64:

63 'I must stress that the fact that the stage 2 is separate from stage1 shows that it was not intended that every case of misconduct found at stage1 must automatically mean that the practitioner's fitness to practice is impaired.'

64 'There must always be situations in which a Panel can properly conclude that the act of misconduct was an isolated error on the part of a medical practitioner and that the chance of it being repeated in the future is so remote that his or her fitness to practice has not been impaired. Indeed the Rules have been drafted on the basis that the once the Panel has found misconduct, it has to consider as a separate and discreet exercise whether the practitioner's fitness to practice has been impaired. Indeed section 35D (3) of the Act states that where the Panel finds that the practitioner's fitness to practice is not impaired, "they may nevertheless give him a warning regarding his future conduct or performance".'

73. When assessing Dr McDowell's insight and remediation, the Tribunal will have in mind paragraph 77 of the MPTS Guidance. In terms of insight, the Tribunal will have to determine whether Dr McDowell understands what happened and accepts how he could have acted differently. In terms of remediation, the Tribunal will have to determine if the allegation is remediable, if it has been remedied and if the allegation is likely to be repeated.

74. On the basis of the conclusions reached at paragraphs 2b, 2c and 2d of the Guidance, the Tribunal must then go on to decide if the doctor poses any current and ongoing risk to public protection and make a finding on impairment. If there is no current and ongoing risk, the Tribunal should make a finding of no impairment. If there is a current and ongoing risk to public protection, decide to which parts, state the level of risk (low, medium, high) and make a finding of impairment. The Tribunal should give reasons for decision

75. In cases where the Tribunal decides that Dr McDowell's fitness to practise is not impaired, they may go on to invite submissions about whether a warning should be imposed.

The Tribunal's determination on impairment

Misconduct

The MPTS Guidance on impairment: Steps 2a to 2e

76. The Tribunal considered each of the steps in the MPTS Guidance.

Step 2A: Is there a legal basis for considering impairment?

77. The Tribunal had regard to the statutory overarching objective, in terms of public protection. It must act in a way that:

- protects, promotes and maintains the health, safety and well-being of the public ('patient safety');
- promotes and maintains public confidence in the profession ('public confidence'); and
- promotes and maintains proper professional standards and conduct for members of those professions ('uphold professional standards').

78. The Tribunal considered the evidence and began by considering the background to the alleged misconduct.

79. In 2020, whilst working as a Core Trainee at Darlington Memorial Hospital, Dr McDowell inhaled two doses of XXX whilst alone in an obstetrics theatre. XXX. He told those investigating that it was a 'stupid' thing to do. After self-referring, he received a GMC warning which was in place from August 2021 to August 2022, and read as follows:

'XXX'

80. Within a written statement provided as part of a Trust investigation for the matters that led to this hearing, Dr McDowell provided his further reflections on the 2020 incident:

XXX

81. Following the incident in 2020, Dr McDowell returned to anaesthetic practice and completed his core training and a stage 1 top up year. He attempted to secure an ST4 place starting in August 2023 but was unsuccessful. In August 2023, he began a role in South Tees Trust as a Trust grade anaesthetist. Part of this role involved providing weekend "airway cover" in the Friarage hospital Northallerton. XXX.

82. In his witness statement dated 20 May 2026, he states that in August 2023, he felt increasingly restless XXX. He describes that he began to feel like his circumstances at the time were a punishment for his earlier mistake in 2020 and that he had not progressed or achieved what he expected of himself. This significantly affected his sense of self-worth. XXX.

83. XXX

84. In February 2024, Dr McDowell commenced an ST4 post at the Royal Victoria Infirmary. In his witness statement, he states:

> *'I was confident that this was a new opportunity and that I would be able to [XXX]. However, within a short period, it became clear that external changes alone were insufficient XXX.*

85. The specific dates mentioned in the Allegation relate to 9/10 March 2024 and 3 April 2024.

86. On 9 March 2024, Dr McDowell was on shift at the Royal Victoria Infirmary. Dr B, Consultant in Anaesthesia and Critical Care, describes being on shift with Dr McDowell. They had completed a bronchoscopy together around 9pm, before Dr B left the hospital around 10pm. Staff at the hospital attempted to contact Dr McDowell on his 'on call' device at 1.30am and 3am, but there was no response. He answered his phone at 3.10am and then came back to the ward, where he was handed the second 'on call' device. Nursing staff tried to contact both devices at 3.30am and 4am with no response. Dr McDowell answered the phone at 4.30am, but did not speak. Dr B was contacted by a hosptial staff member, as they were concerned that they could not find Dr McDowell. Due to the level of concern, Dr B drove to the hospital. At 4.55am, Dr McDowell arrived back on the ward and appeared incoherent and confused, was unsteady on his feet and did not know where he had been. He was taken to the emergency department on a trolley as a patient. He had very little memory of events between 11pm and 5am and denied taking any medication, alcohol or prescription or non-prescription drugs. Dr B recalls asking Dr McDowell whether he had done anything he should not have.

87. In respect of the 9 March incident, in his reflective statement in the stage 2 bundle, undated, Dr McDowell states:

'…It was decided that I would take first break, so I gave the on-call phone to a colleague with the intention of going to the on call room to get some rest. I did not do this. Instead, I went to an empty anaesthetic room [XXX].
…
This was a serious breach of trust. I removed myself from clinical availability, impaired my own capacity to practise safely, and created a foreseeable risk to patients and colleagues who were entitled to expect that I was fit for duty.
…
On the night of 9/3/24 I do not know for how long I was in the anaesthetic room. From others statements I understand it was several hours and I have no reason to disbelieve this. I awoke on the floor with multiple phones ringing and [XXX].
…
When [Dr B] asked me directly what had happened, I lied to his face. He is a man I liked and respected (still do) and when he offered help I refused due to a combination of fear, pride and ignorance'.

88. On 3 April 2024, Dr McDowell was on shift at the Royal Victoria Infirmary. Operating Department Practitioner Ms D had seen Dr McDowell at around 7-7.30pm in a theatre room holding the circuit to the anaesthetics machine. She asked him what he was doing and he said he had come for some cannulas. He returned the circuit to the anesthetic machine and turned it off.

89. In his reflective statement in the stage 2 bundle, undated, Dr McDowell states:

'At around 6pm the nurse in charge asked if I had had a break. I had not. She suggested that I go take a break and then come back for handover – she would ring me for anything urgent. I initially went to the on-call room. As soon as I entered the room, I knew that I wasn't going to stay there. As though motorised or on wheels I left and went to an empty anaesthetic room [XXX]. Again, I am unsure for how long I was there'.

90. Dr McDowell was later found at the anaesthetic machine by Dr A, who asked him what he was doing. He again stated that he had come to collect a cannula and produced one out of his pocket. She suggested that they sit down to talk and eventually Dr McDowell admitted that he had been inhaling from the anaesthetic machine XXX. In his reflective statement, Dr McDowell explains that he did ask Dr A if there was any way they could *'keep what had happened between us'*. He states, *'I add this to my long list of regrets. [XXX]'.*

91. Dr McDowell was excluded from work in 2024. He has since made the decision to leave anaesthetics and to retrain as a GP and commenced his first year of GP training in August 2025. In his supplemental statement dated 24 June, Dr McDowell explained that although returning to anaesthetics was a possible option, he considered the risks and after discussions with his partner, colleagues XXX, he decided that continuing in anaesthetics would not be in the best interests of patient safety or XXX.

92. XXX

93. XXX

94. XXX

95. XXX

96. XXX

97. XXX

98. XXX

99. XXX

100. XXX

101. XXX

102. XXX

103. In his reflective statement in the stage 2 bundle, undated, Dr McDowell said:

> *'As I have set out in other information available to the GMC/MPTS, [XXX]…I fully accept that my misconduct was not confined to a single incident but formed part of a broader pattern of unsafe behaviour for which I take full responsibility.'*
>
> *[XXX]*

104. XXX

105. XXX. He spoke of the strong network that he now has available to him, that he could rely on in difficult times.

106. XXX

107. The way in which both parties had approached this case was to invite the Tribunal to look at the wider context of Dr McDowell's conduct, namely that it began in August 2023 in particular circumstances. This was important, because Dr McDowell had been candid about this history from an early stage, and in particular in his self-referral to the GMC in April 2024 and he relied on this history to explain his actions in March and April of 2024. Therefore when assessing misconduct, it was important to look at the wider context of Dr McDowell's conduct.

108. XXX

109. XXX

110. XXX

111. The Tribunal had regard to the authorities referred to by the parties, in particular the cases of *In R (Remedy UK Ltd) v GMC [2010] EWHC 1245 (Admin)*, *XXX* and *Khan v Bar Standards Board [2018] 29 EWHC 2184 (Admin)*.

112. The Tribunal considers that Dr McDowell's actions in March and April 2024, did amount to misconduct, because XXX, he had made conscious choices XXX. Those choices were made only a year after the expiration of a GMC warning for similar conduct XXX.

113. The Tribunal found that a member of the public who was informed of the wider context of Dr McDowell's conduct would have a great deal of sympathy XXX. However, his actions in March and April 2024 were a consequence of his decision making from August 2023 XXX, and therefore a member of the public, looking at his behaviour in the round, would not consider his actions to be excusable or outside of his control.

114. As a result, the Tribunal determined that there was misconduct in this case and therefore there was a legal basis for considering impairment.

Step 2b Where on the spectrum of seriousness does the allegation lie?

115. When assessing where on the spectrum of seriousness the Allegation lies, the Tribunal referred to the relevant section of the MPTS Guidance to assist their determination, in particular paragraphs 15 - 33. The Tribunal did take into account the relevance of XXX at this stage, whilst reminding itself of its findings in respect of misconduct. The Tribunal considered that the misconduct did not fit any of the examples in the non-exhaustive list, as it could not be described as a departure from professional standards relating to XXX. The Tribunal took into account that the misconduct took place in a clinical setting and had the potential to place patients at risk of harm. The Tribunal therefore considered the starting point to be in the mid-range of seriousness, as the conduct of abusing substances whilst in a workplace setting was serious, but did not extend to a high level of seriousness as set out in paragraph 31 of the MPTS Guidance.

116. When looking at factors which may increase the level of seriousness, set out in paragraph 36 of the Guidance, the Tribunal found that there was relevant fitness to practise history in this case as Dr McDowell had already received a warning in 2020 for similar conduct which should have been in his mind when making the decision to use XXX in August 2023.

117. Whilst Dr McDowell's behaviour was persistent and repeated, the Tribunal did not consider that this should increase the level of seriousness. This is because the repetition was a feature of XXX. Therefore, the Tribunal did not find that these factors should increase the level of seriousness.

118. The Tribunal considered that Dr McDowell demonstrated a reckless disregard for patient safety and professional standards, but that XXX. Bearing in mind XXX, the Tribunal

considered that on balance, this factor, though present, did not move the seriousness out of the mid-range level.

119. Overall, the Tribunal found that the starting point of seriousness at the mid-range remained at the mid-range level after consideration of the factors that may have increased seriousness.

Step 2c - What is the impact of any relevant context known about Dr McDowell and/or their working environment?

120. Paragraph 45 of the MPTS Guidance (MPT Hearings > Part B: Stage two - Impairment) states that there are three types of relevant context: working environment, role and experience and personal context. The impact that evidence of relevant context has on the assessment of risk to public protection will depend on the nature of the allegation and individual circumstances of the case. The Tribunal reminded itself that relevant context can be negative or positive and can therefore increase or decrease the level of risk.

121. The Tribunal considered that personal context was the most relevant type to assess in Dr McDowell's case. The Tribunal found that XXX was relevant to his personal context and has a direct link to his conduct. The Tribunal paid particular attention to paragraphs 70 and 71 of the MPTS Guidance to assist their determination:

> *70. For personal context to be relevant to the medical practitioners tribunals (MPT's) assessment of current and ongoing risk to public protection, there must be a direct link between it and the doctor's behaviour, performance, or health.*
>
> *71. If the personal context that directly influenced the doctor's behaviour, performance or health at the time of the allegation has since resolved, or steps have been put in place to avoid the circumstances arising again and/or to help the doctor cope with those circumstances if they did arise again, this may decrease the level of current and ongoing risk posed by the doctor to one or more of the three parts of public protection because it reduces the likelihood of repetition.*

122. XXX

123. The Tribunal noted that Dr McDowell had moved out of anaesthetics to begin retraining as a GP. The Tribunal found this to be relevant context as it showed Dr McDowell developing insight and remediating XXX. In addition, he took steps to remove himself from an environment XXX, by changing his career path. The Tribunal also noted that Dr McDowell has put in place strategies to avoid a repeat of the circumstances that led to the Allegation, XXX.

124. The evidence from XXX was that in light of all the positive work done by Dr McDowell since 2024, the risk of repetition of the conduct was somewhere between low and negligible. The Tribunal considered that this context did reduce the level of seriousness to the lower end of the spectrum.

Step 2d - How has Dr McDowell responded to the allegation?

125. The Tribunal next considered Dr McDowell's response to the Allegation. The Tribunal noted the MPTS Guidance that it should consider the evidence available to it to establish if Dr McDowell has: (a) shown insight into his own behaviour and whether that insight is genuine; (b) taken steps which have reduced the risk of similar allegations occurring again (remediation), such as participating in training, supervision, coaching or mentoring relevant to the allegation; and (c) kept his knowledge and skills up to date.

126. The Tribunal also noted from the MPTS Guidance that evidence of insight and remediation will have a different impact on the assessment of current and ongoing risk to public protection in each case, depending on the nature of the allegation and individual circumstances of the case.

127. The Tribunal found that Dr McDowell's insight had developed consistently over the last two years since the incident came to light. Dr McDowell's witness evidence and reflective statement indicated to the Tribunal that he had developed a detailed level of insight into his conduct XXX. This included an analysis of XXX, and the impact on patients, colleagues and the wider public.

128. The Tribunal found paragraph 81 of the MPTS Guidance useful in assisting their determination on Dr McDowell's response to the Allegation:

> *'To demonstrate insight, and insight which is genuine, the doctor will need to show they understand what happened and accept how they could have acted differently. This involves showing, where relevant, that they have:*
>
> - *considered the allegation, understanding what went wrong and accept they should have acted differently*
> - *fully understood the impact or potential impact of their behaviour, performance, or health condition*
> - *empathy for any individual affected, for example by apologising*
> - *taken, or are taking, steps to remediate and to identify how they will act differently in the future to avoid similar issues arising*
> - *[XXX]*
> - *complied with the professional duty of candour*
> - *co-operated with earlier investigations into the allegation (if they had the opportunity to do so) and engaged with the GMC's investigation, and/or*
> - *self-referred to their employer and/or the GMC'.*

129. The Tribunal noted that a number of these factors are engaged in this case. It considered that Dr McDowell had reflected on his actions from August 2023 and understood why they were wrong, the risk to patient safety and that he should have sought help at the time. The Tribunal found that Dr McDowell understands the risk of going back to the same behaviour and can stop that by gaining insight into his actions and remediating effectively. The development of insight into XXX and the steps that he has taken XXX, is also clearly of significance and is directly relevant to risk of repetition.

130. Dr McDowell had self-referred to the GMC and been candid XXX. He has expressed apologies and has demonstrated a deep understanding of his behaviours.

131. The Tribunal considered if the Allegation has been remedied or is being remedied. The Tribunal considered that XXX had assessed Dr McDowell as fit to practise. The Tribunal noted that XXX but determined that Dr McDowell also recognises this risk within his ongoing remediation. The Tribunal found that Dr McDowell has taken active steps to protect himself from this risk, such as moving away from anaesthetics XXX. He now has a network of individuals from whom he can seek support in difficult times. XXX. The Tribunal considered this to be an important protective factor going forwards.

132. When assessing if the allegation is highly unlikely to be repeated, the Tribunal considered XXX.

133. The Tribunal considered Dr McDowell's reflective statement in the stage 2 bundle, which said:

> *'XXX*
>
> *'I recognise that in the coming months as the MPTS hearing approaches I am likely to be under increased stress and worry. I have taken proactive steps around this – namely being proactive in letting my employer, clinical & educational supervisors and [XXX] know what is going on. [XXX].'*

134. The Tribunal found that these examples from Dr McDowell's witness evidence shows that he has a current understanding of what steps he needs to take to protect himself from XXX that could cause issues. XXX.

135. The Tribunal referred to paragraph 117 of the MPTS Guidance:

> *'Whether the allegation is highly unlikely to be repeated and the impact of this will need to be assessed based on the individual circumstances of the case. In many cases, a conclusion that the allegation is highly unlikely to be repeated will have the impact of decreasing the level of current and ongoing risk to public protection posed by the doctor. However, where the allegation falls at the higher end of the spectrum of seriousness and therefore the starting point for assessing current and ongoing risk to public protection is high, a conclusion that an allegation is highly unlikely to be repeated may be given less weight and therefore have less impact on the assessment of current and ongoing risk.'*

136. The Tribunal determined that the evidence suggests that is is highly unlikely that Dr McDowell's behaviour will be repeated. When taking into account Dr McDowell's response to the Allegation and his level of insight and remediation, the Tribunal determined that the level of seriousness should be reduced even further within the low range.

Step 2e - Tribunal's decision as to whether Dr McDowell poses any current and ongoing risk to public protection and finding on impairment

137. The Tribunal then considered, overall, whether Dr McDowell poses any current and ongoing risk to public protection which may require restrictive action on his registration and make its decision on impairment.

138. The Tribunal accepted the submission of Ms O'Halloran, that in light of the factual XXX evidence, Dr McDowell is fit to practise without restrictions and therefore poses no risk to patient safety. Therefore, the question remains whether a finding of impairment is required on public interest grounds.

139. The Tribunal considered that a member of the public, informed of the full background, in particular the extent of Dr McDowell's insight and remediation into his actions XXX, would not consider that a finding of impairment was necessary to protect and maintain public confidence in the profession and/or to maintain professional standards. This is particularly the case in circumstances where there had already been a finding of misconduct, XXX.

140. On the basis of the conclusions reached at steps 2c and 2d, and its assessment that the behaviour is highly unlikely to be repeated, the Tribunal determined that Dr McDowell does not pose a current or ongoing risk to public protection.

141. Overall, the Tribunal has determined that whilst misconduct was found, Dr McDowell's fitness to practise is not currently impaired as there is no current or ongoing risk to public protection.

142. The Tribunal has therefore determined that Dr McDowell's fitness to practise is not impaired by reason of misconduct.

Determination on Warning - 03/07/2026

1. Having determined that Dr McDowell's fitness to practise is not impaired, the Tribunal considered whether, in accordance with s35D(3) of the 1983 Act, a warning was required.

Submissions

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

2. Mr King, Counsel, referred the Tribunal to paragraphs 2, 7, 10, 15, 16 and 20 *Part D of Section three: Guidance for MPTS Tribunals.* He added that a warning would apply to the future behaviour of a doctor. He stated that in the circumstances of this case, where aspects of paragraph 7 of the MPTS Guidance were engaged, a warning would not prevent Dr McDowell from holding a licence to practise. He reminded the Tribunal of the test to be applied when considering whether a warning was required in a case where the standards fell below the expected standards of a doctor but their fitness to practise was not impaired.

3. Mr King referred the Tribunal to the three questions to be considered as set out in paragraphs 20 - 29 of the MPTS Guidance. He submitted, overall, that a warning was necessary to send a message to the doctor that such behaviour was not acceptable.

4. In response to a question as to a form of wording that might be included in a warning, should the Tribunal decide to issue a warning, Mr King submitted that he had no specific instructions on any proposed wording of a warning.

On behalf of Dr McDowell

5. Ms O'Halloran, Counsel, submitted that the fact that the GMC had not even considered appropriate wording to be included in a warning, goes to the underlying submission that the GMC were asking for a warning to be issued 'for the sake of wanting one', and in order to punish the doctor. XXX. She reminded the Tribunal that it had found that Dr McDowell had addressed the XXX issues which gave rise to the misconduct matters.

6. She submitted that a warning was not appropriate in the circumstances. Ms O'Halloran referred the Tribunal to sections of the previous Sanctions Guidance which she submitted make clear that confidence in the fairness of the GMC processes and the decisions they make was at the heart of being an effective, relevant and compassionate regulator.

7. Ms O'Halloran referred the Tribunal to paragraph 18 of *Part D of Section three: Guidance for MPTS Tribunals.* She said that clearly a warning would not be appropriate where the MPT has decided at Stage 2 of the proceeding that none of the grounds of impairment are engaged, XXX. She acknowledged that XXX, even on the basis of the Tribunal's finding that Dr McDowell had some control over his actions in August 2023. She went on to state that XXX. Ms O'Halloran submitted that whilst it is accepted that Dr McDowell should be held accountable for his actions in August 2023, the matters relating to March and April 2024 were very much a consequence of XXX. She submitted that that was one of the very reasons why the previous warning Dr McDowell was subject to, did not prevent a repeat of his behaviour, XXX.

8. Ms O'Halloran reminded the Tribunal that Dr McDowell has since undertaken a substantiative amount of work XXX, and this was reflected in the Tribunal's detailed and fairly balanced reasons in its determination on facts and impairment. She submitted that a finding of serious professional misconduct of itself was an indication to the public that behaviour of this type was not acceptable. She added that it is clear to any reader as to why it happened, XXX, acknowledging that Dr McDowell has to take some accountability for his actions.

9. Ms O'Halloran submitted that there is no evidence to support any suggestion of an attitudinal issue by the doctor or a reckless disregard for patient safety, particularly when he is well aware of his obligations as a doctor. Further, she submitted that he does not lack insight into XXX, or why he did what he did. XXX. Ms O'Halloran submitted that no further action is required in this case, adding that Dr McDowell has gone above and beyond what would be expected of him XXX. In addition, he has removed himself from a specialty, with a loss of pay and negative impact on his career progression.

10. Ms O'Halloran submitted that Dr McDowell has consistently offered undertakings to the GMC XXX. She added that it cannot be right to issue a warning in order to remind him of something that he already knows that he must not do.

11. In all the circumstances, Ms O'Halloran invited the Tribunal to conclude that no further action is required and that a warning is not necessary.

The Tribunal's Approach

12. The Tribunal has taken account of its earlier conclusions at the facts and impairment stages. It has also taken account of *Part D of Section three: Guidance for MPTS Tribunals* as to the purpose of warnings and the factors to be borne in mind when considering whether or not a warning is required.

13. The Tribunal was mindful that a warning is a formal response which indicates to a doctor that any given behaviour or poor performance represents a significant departure from the professional standards expected and should not be repeated. The Tribunal should therefore consider if there has been a clear and specific departure from the professional standards. If so, provided the allegation just fell short of the Tribunal finding that the doctor's fitness to practise is impaired, the Tribunal will go on to consider the question that if the behaviour or poor performance was repeated, would it likely result in a finding that the doctor's fitness to practise is impaired?

14. It noted that warnings are issued in the interests of maintaining public confidence in the profession and upholding professional standards. They highlight to the wider profession and public that certain behaviour or poor performance is not acceptable.

The Tribunal's determination on warning

Has there been a clear and specific departure from the professional standards?

15. In paragraphs 20-22 of the Guidance, it states that the Tribunal must consider if there has been a clear and specific departure from the current professional standards.

16. The Tribunal reminded itself of its findings at the impairment stage. It had found that Dr McDowell's action amounted to serious professional misconduct. At paragraphs 112 and 113 of its determination on facts and impairment, the Tribunal stated:

> *'112. The Tribunal considers that Dr McDowell's actions in March and April 2024, did amount to misconduct, because [XXX] he had made conscious choices [XXX]. Those choices were made only a year after the expiration of a GMC warning for similar conduct [XXX].*
>
> *113. The Tribunal found that a member of the public who was informed of the wider context of Dr McDowell's conduct would have a great deal of sympathy [XXX]. However, his actions in March and April 2024 were a consequence of his decision making from August 2023 [XXX], and therefore a member of the public, looking at his*

behaviour in the round, would not consider his actions to be excusable or outside of his control.'

17. The Tribunal had found that a member of the public informed of the full background, in particular the extent of Dr McDowell's insight and remediation into his actions XXX, would not consider that a finding of impairment was necessary to protect and maintain public confidence in the profession and/or to maintain professional standards. This is particularly the case in circumstances where there had already been a finding of misconduct, XXX.

18. Overall, the Tribunal did consider that the finding made in respect of misconduct did represent a clear and specific departure from professional standards.

Did the allegation about the doctor's behaviour or poor performance just fall short of a finding that their fitness to practise is impaired?

19. The Tribunal had regard to paragraphs 23 and 24 of *Part D of Section three* of the MPTS Guidance, which state:

'23. If the MPT is satisfied that the evidence clearly supported a finding that the doctor's fitness to practise is not impaired, a warning will not be appropriate, and no further action should be taken.

24. Where the decision was finely balanced but just fell short of the MPT reaching a conclusion that the doctor poses a current and ongoing risk to public protection requiring restrictive action in response – and therefore finding that their fitness to practise is impaired – this will usually indicate that the departure from the professional standards was significant and so a warning may be required. The next question should therefore be considered.'

20. Given the nature of the misconduct found, and in view of the fact that Dr McDowell had previously been issued with a GMC warning for conduct of a similar nature, a warning may objectively be considered appropriate. However, the Tribunal had clearly found that a member of the public, informed of the full background, in particular the extent of Dr McDowell's insight and remediation into his actions XXX, would not consider that a finding of impairment was necessary to protect and maintain public confidence in the profession and/or to maintain professional standards. This was particularly the case in circumstances where there had already been a finding of misconduct, and where Dr McDowell had gone to significant lengths to seek help, XXX.

21. The Tribunal was mindful of paragraphs 15 and 18 of *Part D of Section three* of the MPTS Guidance, which state:

'15 A warning will be appropriate where facts have been found proved that indicate the doctor's behaviour or performance has fallen below the professional standards expected, the MPT has determined the doctor's fitness to practise is not currently impaired, but it is necessary to signal to them that repeating the same, or similar, behaviour or poor performance is likely to result in a future finding of impairment.

...

18 A warning will not be appropriate where:

- *the MPT has decided at stage two of the hearing that none of the grounds of impairment are engaged, or*
- *the allegation relates solely to the impact of a health condition, or solely to the doctor's insufficient knowledge of the English language, given the nature of those types of allegations.'*

22. The Tribunal did not consider that this was an allegation that XXX. After considering the test in paragraph 15 of the guidance, the Tribunal determined that a reasonable and properly informed member of the public being aware of the steps that Dr McDowell has taken to remediate his misconduct would not consider it 'necessary' to signal to the doctor that repeating his behaviour would likely result in a future finding of impairment. The Tribunal concluded that the fact of the GMC investigation and these proceedings, and the finding of serious professional misconduct, will act as a deterrent in itself. Furthermore, the findings in this case will sufficiently serve the need to maintain public confidence in the profession and uphold professional standards.

23. Despite concluding that it was not necessary to impose a warning in this case, the Tribunal wished to make clear to Dr McDowell that a repeat of misconduct of a similar nature in the future would be likely to result in a finding of impaired fitness to practise.

24. The Tribunal was informed that there was an interim order of conditions in place on Dr McDowell's registration. The Tribunal determined to revoke that interim order with immediate effect.

25. That concludes the case.

ANNEX A – Disclosure of documents - 22/06/2026

1. At the outset of proceedings Ms O'Halloran, counsel on behalf of Dr McDowell, made an application for the disclosure of documents by the GMC. This related to an application made by the GMC to a Case Examiner to withdraw the case, pursuant to Rule 28 of the GMC Fitness to Practise Rules ('the Rules').

Submissions

2. Both parties provided written submissions to the Tribunal which they supplemented with oral submissions.

On behalf of Dr McDowell

3. Ms O'Halloran submitted that the application was seeking disclosure of the GMC's Rule 28 application to withdraw this case, together with the underlying reasons, material relied upon, decision and all non-privileged related documents.

4. Ms O'Halloran submitted that on 21 April 2026, the defence was notified that the GMC was proposing to withdraw the allegations. It was understood that this was on the basis that the realistic prospect test was no longer met, having considered XXX, although the precise basis for the proposed application was not disclosed. The defence was invited to provide comments on the proposed application.

5. Ms O'Halloran submitted that those representing Dr McDowell requested a copy of the proposed Rule 28 application and the reasons supporting it on several occasions but that the GMC refused to disclose the Rule 28 application on the basis that there is no legal obligation for them to do so.

6. Ms O'Halloran submitted that in the absence of the application itself, the defence was unable to make fully informed or meaningful representations in response. Notwithstanding this, the defence did its best and submitted a response on 28 April 2026, endorsing the GMC's application and offering undertakings.

7. Ms O'Halloran submitted that on 12 May 2026, the defence was informed that the Case Examiners had refused the application in part. Upon receipt of that decision, the defence reiterated its request for disclosure of the Rule 28 application on the basis that the Rule 28 application constitutes material which may undermine the GMC's case and/or assist Dr McDowell's case. That request was refused.

8. Ms O'Halloran submitted that the defence is entitled to know the basis upon which that conclusion was reached because the application may reveal that the GMC considered, among other matters:

a. XXX;
b. that the Registrant's culpability, impairment, or the overall assessment of the case was materially affected by XXX finding that there was no current impairment;

c. that withdrawal or undertakings was the proportionate outcome;
d. that the public interest did not require the matter to proceed solely on the basis of misconduct, XXX
e. that the evidence, public interest, or realistic prospect test no longer justified continuation of the proceedings in their existing form.

She submitted that any of those matters could plainly assist Dr McDowell's case or undermine the GMC's current case.

9. Ms O'Halloran submitted that the defence also relies on the MPT (Medical Practitioners Tribunal) Record of Determinations of [Dr K] dated 21 November 2025. She submitted that in that case, the defence sought disclosure under Rule 16 of the GMC's Rule 28 application to withdraw the allegations and the material underpinning them and the Tribunal granted the application. The Tribunal expressly held that the material was potentially relevant and should be disclosed in the interests of fairness.

10. Ms O'Halloran submitted that the case of [Dr K] is particularly significant because that Tribunal recognised that the reasons advanced by the GMC in support of a withdrawal application may themselves constitute material capable of assisting the doctor or undermining the GMC's case. She submitted that reasoning applies with equal force in this case as, if the GMC previously concluded that the allegations should be withdrawn, the analysis underpinning that conclusion may be directly relevant to the issues now before this Tribunal.

11. Ms O'Halloran submitted that in the interests of fairness, the defence therefore sought disclosure of:

a. the GMC's Rule 28 application to the Case Examiner;
b. any covering note, memorandum, recommendation, or case analysis submitted in support of that application;
c. any material placed before the Case Examiner for the purposes of that application.

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

12. Mr King, counsel, on behalf of the GMC, opposed the application for the disclosure of the GMC's Rule 28 Application to a Case Examiner to withdraw the allegations. He said that the request for disclosure has been considered and declined and that the defence is already in possession of all relevant material. He said that the withdrawal decision dated 11 May 2026 has been provided and this is a comprehensive document identifying that the doctor's referral to a MPT should be partially withdrawn, XXX.

13. Mr King submitted that the application sent to the Case Examiner was an internal administrative document, and that this administrative material was not capable of undermining the GMC's case or assisting Dr McDowell's case. He said the decision document sets out the basis on which the misconduct allegation continues, XXX. He submitted that the decision document supplies a full rehearsal of the consideration of XXX, considers issues of

culpability and impairment, proportionality of partial withdrawal, as well as public interest considerations.

14. In respect of the case of [*Dr K]*, Mr King submitted that the Tribunal is not bound by such a decision and should apply consideration to the present matter accordingly. He submitted that disclosure of additional material is not appropriate and there is no obligation or requirement for the GMC to make such a disclosure and invited the Tribunal to reject the application.

The Tribunal's Decision

15. The Tribunal considered Rule 16 of the Rules, which states:

> *(1A) The power to give directions under the provisions of this rule may also be exercised by—*
>
> > *(a) the Chair of a Medical Practitioners Tribunal, where the Chair is appointed as a Case Manager for proceedings before that Tribunal; or*
> > *(b) the Medical Practitioners Tribunal itself,*
>
> *and references to a Case Manager in these Rules are to be construed accordingly*
> *…*
> *(6) Directions issued by the Case Manager may include, but are not limited to, such of the following as he considers appropriate having regard to the nature of the allegation, any representations made by the parties and all other material factors-*
>
> > *(a) that each party disclose to the other in advance of the hearing—*
> >
> > > *(i) any documentary evidence in their possession or power relating to the allegation…"*

16. The Tribunal considered that the documentation which is requested as part of this application was submitted as part of a formal process set out in Rule 28. It was therefore not a correct characterisation to describe the application to the Case Examiner as an internal administrative document. Dr McDowell's representatives did not have an opportunity to see those documents when making representations.

17. The Tribunal considered that there had been a decision made to withdraw the allegations in respect of XXX. The application to withdraw the case and the underlying reasons for that may be material that could undermine the GMC's case or assist the case of Dr McDowell.

18. The Tribunal therefore determined to grant the disclosure application and exercised its case management powers under Rule 16.

Annex B – Application to admit evidence – 24/06/2026

1. Parts of this hearing were heard in private in accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 (the Rules). This determination will be handed down in private due to the confidential nature of matters under consideration. However, as this case concerns Dr McDowell's alleged misconduct, a redacted version will be published at the close of the hearing.

2. Following the Tribunal's decision (at Annex A) directing the disclosure of documentation, the Tribunal heard an application to admit that documentation into evidence.

Submissions

3. Ms O'Halloran made an application under Rule 34 for those documents to be admitted as they are fair and relevant. She said that she understood that the application was not opposed by the GMC.

4. Mr King submitted that whilst the GMC and the defence may not share the same view in relation to the level of relevance of these documents and how they may assist the Tribunal in its decision making, admitting the documents into evidence was not objected to. He explained that there were three relevant documents: the 'AR', which was a document setting out the rationale for sending a request to the Case Examiner; the 'CARF', which was the request to the Case Examiner; and the decision paper of the case examiner. Mr King submitted that it was fair and relevant for the Tribunal to see all three documents.

Tribunal's Decision

5. The Tribunal noted that the application to admit the three documents was unopposed. The Tribunal considered that the documentation was potentially relevant as it concerned the background to the allegations being formulated by the GMC. The Tribunal was of the view that it would be both fair and relevant to admit these documents into evidence.

6. The Tribunal therefore granted the application to admit the aforementioned documents into evidence pursuant to Rule 34 of the Rules.

Annex C – Application to hold hearing entirely in private – 24/06/2026

1. This application has been handed down in private pursuant to Rule 41 as it relates to confidential matters.

2. At the outset of proceedings, Ms O'Halloran, counsel on behalf of Dr McDowell, made an application, pursuant to Rule 41 of the GMC (Fitness to Practise Rules) 2004 as amended ('the Rules') for the proceedings to be heard entirely in private.

Submissions

3. Both parties provided written submissions to the Tribunal which they supplemented with oral submissions.

On behalf of Dr McDowell

4. XXX

5. XXX

6. XXX

On behalf of the GMC

7. Mr King, counsel on behalf of the GMC, opposed the application to hear the case in private. XXX.

8. XXX

9. XXX

10. XXX

The Tribunal's Decision

11. The Tribunal considered Rule 41 of the Rules, which states:

> ***41.***
> ***(1)*** *Subject to paragraphs (2) to (6) below, hearings before the Committee and a Medical Practitioners Tribunal shall be held in public.*
> ***(2)*** *The Committee or Medial Practitioners Tribunal may determine that the public shall be excluded from the proceedings or any part of the proceedings, where they consider that the particular circumstances of the case outweigh the public interest in holding the hearing in public.*
> ***(3)*** *Subject to paragraphs (4) to (6), the Committee or a Tribunal shall sit in private, where they are considering-*
>
> > ***(a)*** *whether to make or review an interim order; or*
> > ***(b)*** *the physical or mental health of the practitioner.*
>
> …

12. The Tribunal reminded itself that the starting point for cases is that they should be heard in public as set out in Rule 41(1). XXX.

13. The Tribunal took into account that the case involves an allegation of misconduct. However, it is accepted that there is likely to be significant evidence which relates to XXX.

14. XXX

15. However, the Tribunal considered that both parties are represented by experienced counsel who can navigate between public and private settings when giving their submissions. The Tribunal concluded that the general principle that hearings should be heard in public, was important and that could be achieved in this case, provided that the Tribunal moved into private session where XXX were being discussed.

16. The Tribunal therefore refused the application to hear the entirety of the proceedings in private.

Annex D – Application to amend the Allegation – 25/06/2026

XXX

Annex E – Application to amend the Allegation – 25/06/2026

XXX